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Social Work in Community Mental Health Teams:

An Ethnographic Study with Two Community Mental Health Teams

**Thesis submitted for the degree of Doctor of
Philosophy**

**By Lakshika Sajeevanie Liyanage
School of Applied Social Sciences**



March 2012

Abstract

Within the Community Mental Health Teams (CMHTs) in UK, Approved Mental Health Practitioners (AMHPs) and Mental Health Social Workers (MHSWs) from Local Authority Social Services Department (LASSD) work alongside other mental health professionals from health service backgrounds, promoting a multi-disciplinary model of working. However little is known about the impact of this model on these professionals. This research endeavoured to understand mental health social work interventions in multidisciplinary CMHTs in respect of:

1. The practice of general mental health social work
2. The impact of 2007 MHA on social work practice.
3. Mental Health Act assessments (statutory role)
4. Contributions to interdisciplinary mental health teams
5. Barriers and difficulties in integrated working

An ethnographic approach in two CMHTs was employed in drawing upon secondary data, observations and interviews with AMHPs, MHSWs, other mental health professionals and service users, facilitating a rich understanding of the social work role from different perspectives. Bronfenbrenner's (1977) 'Ecology of Human Development Theory' provided the conceptual and theoretical framework for the study, by identifying the different systems social work professionals interact in their practice.

The findings reveal tensions in the microsystem (CMHT) on role definition, losing professional identity, difficulties in care coordination and stigma and status of social work professionals. Tensions in the exosystem include: poor collaboration between LASSD and the Mental Health Trust, fragmented relationships between AMHPs/MHSWs and LASSD, difficulties in working in specialist teams and the medical dominance in CMHTs. Findings on the macrosystem reveal impact of policies and legislation on social work professionals' roles.

I intend that these results will contribute significantly to the development and profile of MHSWs and AMHPs, as a professional group, and in turn will improve and develop the quality of social work support within mental health services. This subsequently will improve outcomes for service users, carers and communities.

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List of Abbreviations

1. AMHP	-	Approved Mental Health Practitioner
2. AOT	-	Assertive Outreach Team
3. ASW	-	Approved Social Worker
4. CAMHS	-	Child and Adolescent Mental Health Services
5. CMHT	-	Community Mental Health Team
6. CPA	-	Care Programme Approach
7. CPN	-	Community Psychiatric Nurses
8. CRHT	-	Crisis Resolution and Home Treatment
9. CSIP	-	Care Services Improvement Partnership
10. EIP	-	Early Intervention in Psychosis
11. ESRC	-	Economic and Social Research Council
12. GSCC	-	General Social Care Council
13. LA	-	Local Authority
14. LASSD	-	Local Authority Social Services Department
15. MHA	-	Mental Health Act
16. MHPIG	-	Mental Health Policy Implementation Guide
17. MHSW	-	Mental Health Social Worker
18. MHT	-	Mental Health Trust
19. MWO	-	Mental Welfare Officer
20. NHS	-	National Health Service
21. NIMHE	-	National Institute for Mental Health in England
22. NSF	-	National Service Framework for Mental Health
23. NWW	-	New Ways of Working
24. OT	-	Occupational Therapists
25. PSW	-	Psychiatric Social Worker
26. R&D	-	Research and Development
27. REC	-	Research Ethic Committee
28. REF	-	Research Ethics Framework

Declaration

I wish to clarify that this thesis is my own work. The data presented are original and were collected by me over a six month period between May 2009 and January 2010 in two Community Mental Health Teams in the UK. All the names of people and places are anonymised or changed in order to protect the identity of the participants. Appropriate recognition of any references has being indicated where necessary.

Statement of Copyright

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My heartfelt thanks to all the staff members in the two CMHTs, for sacrificing their precious time for my interviews and volunteering to take me for home visits and for all the other little helps they offered me. Sincere thanks to the service users who gave me interviews and their consent for my presence during the home visits. I hope the findings of this study highlight your concerns and views and will be addressed in the near future.

Many thanks to all the officials from the Mental Health Trust, Local authority Social Services Department and the NHS for your approval for this research, guidance and encouragement. Sincere thanks to Ms.Helen Charnley – Post Graduate Director and Ms.Jill Lea – The Research Secretary of the SASS who always extended their official and unofficial support during these years. I offer my sincere gratitude to Dr. Michaela Griffin for proof reading the thesis; hardly anybody else will offer such help.

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Chapter 1 - Introduction

The role of the Mental Health Social Worker (MHSW), and associated training requirements, have changed significantly since the initial introduction of mental health social work hundreds of years ago. These changes have been influenced by a multitude of factors. One major factor is the change in societal needs, with the transition from a traditional to an industrialised global society. Consequently, many new social problems have occurred and the traditional contribution of mental health social work has needed to respond, to suit the changing needs of society. In order to meet these needs, new government policies, legislation and laws have been introduced over the centuries and mental health social work, as a profession, has been significantly influenced by these changes. Related political factors are the increasing prominence given to social inclusion, human rights and partnership and interdisciplinary working in mental health care provision. From an analysis of these historical factors, the future of mental health social work remains uncertain, particularly with the revisions to the 1983 Mental Health Act (MHA). With the implementation of the 2007 MHA, the direction is expected to change significantly again and some scholars (Ramon et al, 1999) fear a loss of power and prestige to the existing role of MHSW.

Given this background, it is important to explore where the unique contribution of MHSWs currently lies in the field of contemporary mental health care. In promoting the role of MHSWs, it is also of immense value to search for the best approach that they should use to enhance the quality of their work. In doing this, it is important to understand the difficulties and barriers MHSWs face in their day-to-day practice. Understanding these difficulties and barriers will provide the social work professional bodies and social workers' employers with a better opportunity to help to address social workers' concerns, about how to deliver a better service. This, in turn, will help to improve the social work service for people who use it and their carers and will continue to support the unique contribution of the social work profession in the field of mental health. It is this contribution that this PhD seeks to explore further, in an attempt to enhance the evidence base for mental health social work practice in the 21st Century.

My own back ground as an academic at the Sri Lanka School of Social Work also informed me in carrying out this research. While doing field visits and other educational and community activities with my students in the psychiatric hospitals in Sri Lanka, I encountered hundreds of long-stay patients. Some of them had been in these hospitals for more than ten years and some for more than half of their life. This situation persuaded me to think and study more of how the deinstitutionalisation movement took place in several other countries including the UK. However, I was not well informed about community care for mentally ill people during that period.

When I started my Masters degree in Social Work Studies at Durham University I read more about the closure of the psychiatric hospitals in the UK and the opening of the Community Mental Health Teams in the 1980s. While studying for the Masters Degree I had the opportunity to meet my former supervisor who had been researching 'Interdisciplinary Working in Mental Health' and I became more interested in social work intervention in mental health care. Then I read extensively on the history of psychiatric social work in the UK and how different policies and legislation had informed the development of the roles of Mental Health Social Worker and Approved Mental Health Practitioner. This understanding persuaded me to engage in more research on the social work contribution to CMHTs which I thought in turn would help to yield fresh knowledge to take back with me to develop the current mental health care system in my country.

1.1 Rationale for the study

Historically mental health issues have been dealt with by a predominantly medical approach and it is relatively recently that people have started to consider the social aspects of mental illness. As a result, there are only a limited number of studies looking at the social aspects of mental health.

Despite some important and pioneering work, social research in the field of mental health remains a relatively underdeveloped area. However, with the implementation of the NSF (National Service Framework) and associated strategies, it is becoming increasingly recognised that social aspects are significant, both in contributing to mental distress or breakdown, and in relation to recovery– and hence there is a need to develop a more effective research and evidence base in the area (Tew and Gould, 2006:1619).

This lack of emphasis on researching the social aspects of mental health has limited the number of studies focusing on social work interventions in contemporary mental health services. Literature on MHSWs' contribution to practice in mental health settings is hardly found, although there are a few UK studies that focus on MHSW's job satisfaction and workforce problems (Evans and Huxley, 2006, Evans *et al.*, 2006, Foster, 2005, Prosser, 1999, Reid *et al.*, 1999b). There is also very little research into the "decreasing number of Approved Social Workers (ASWs)" (Huxley *et al.*, 2005b) and 'team working and impact of integrated working on mental health social workers' (Carpenter *et al.*, 2003, Onyett, 2003, Thornicroft and Szmukler, 2001).

The literature reveals that MHSWs, as the only professionals from a social services background, bring their social model of practice into increasingly interdisciplinary mental health teams. Undoubtedly they continue to play a prominent role in these modern interdisciplinary teams. But this is not without its problems. The literature exposes a number of difficulties that MHSWs face. Nathan & Webber (2010:15-16) explaining the bureau-medicalisation of mental health care:

Within UK adults' social services departments the future role for social work is not as certain, as the personalisation agenda (Her Majesty's Government: 2007) has renegotiated the role social workers play. However, mental health social workers have additionally been faced with marginalisation within mental health trusts, to which the majority are now seconded or employed. Indeed, it is probably not an exaggeration to suggest that Mental Health Social Work is in crisis, or at least at a turning point in its long history.

These ideas emphasise that mental health social work is now at a turning point or what is considered by some to be in crisis. The literature on mental health social work also reveals a number of issues associated with integrated working and the MHSW's role. Reid *et al* (1999b:306) explain the many difficulties faced by multidisciplinary team members. These pitfalls include, 'loss of professional identity, role blurring, role ambiguity arising from pressure to provide generic skills, conflict between disciplines arising from their different training, theoretical frameworks and approaches, and difficulties arising from ambiguities or differences in views about the leadership of the team'.

Steve Onyett, who has extensively studied team working in mental health services, has also identified a number of problems faced by MHSWs in integrated teams. A collaborative study reported that social workers fared badly compared with other professionals on burnout, job satisfaction, team and personal role clarity in mental health teams (Onyett *et al.*, 1997).

Carpenter *et al.*'s (2003:1100) findings strengthen this idea and emphasise that "Social workers were somewhat less positive about team functioning than other professionals and also experienced more role conflict". In the same study Carpenter *et al* (2003:1093) identified a number of differences in these difficulties faced by Community Mental Health Team (CMHT) members according to their professions, with social workers tending to identify less strongly with their profession and perceiving the teams as being less participative. Social workers also gave lower ratings for their job satisfaction in the team, and experienced greater role conflict and more stress when compared with other professions.

Thornicroft and Szmukler (2001:423), citing Carpenter and Barnes, explain that the studies in the UK on multidisciplinary team functioning and interprofessional attitudes show that 'Social workers score comparatively poorly in terms of both team and professional identities and are also less clear about team objectives'. Further to this they report that the social workers consider their status in society to be significantly lower than that of other professionals in the mental health teams. Thornicroft and Szmukler (2001:423) also found that MHSWs were inclined to believe that other mental health professionals had a poor opinion of social workers knowledge and professional competence and that this was significantly underestimated.

Previous research also identified social workers' fears of 'losing their professional identity'. They explain this as a result of joint working in CMHTs which are dominated by workers employed by the Mental Health Trust (MHT) and the medical model of working. Carpenter *et al* (2003:1099) citing Norman & Peck (1999) report that:

Social workers emphasised the importance of values and professional culture of their discipline; these they viewed as being central to their professional identity. They were concerned by what they saw as a threat to social work culture, and thus social work itself, by working in CMHTs which were dominated by health service workers.

Foster (2005) also reports some persistent workforce problems, including professional isolation and a lack of supervision and resources for some social workers in CMHTs. Ramon (2009:1619) stresses that mental social work is detached from the mainstream social work in UK and has become a minority group within both mental health and social work as a result of being in CMHTs, which are dominated by the health professionals.

This growing body of research reveals the difficulties and fears of MHSWs in working in increasingly interdisciplinary settings. This evidence shows the importance of conducting more in depth research to understand these difficulties and barriers faced by MHSWs, in order to address them and improve the service. However as Fisher *et al*, (1984:ix) describe, 'research is not always welcomed in social services especially when it concerns an area which gives rise to such widespread anxiety as mental health social work'. Fisher's ideas highlight the difficulty in researching a highly complex area, such as mental health social work. Mental health social work is complex due to the nature of the discipline. It includes:

- working with service users
- working with carers
- intervening using a range of different therapies
- understanding statutory duties
- different models for understanding mental distress
- being the only representative from the Local Authority Social Services Department (LASSD) among a majority of health service staff in the CMHTs

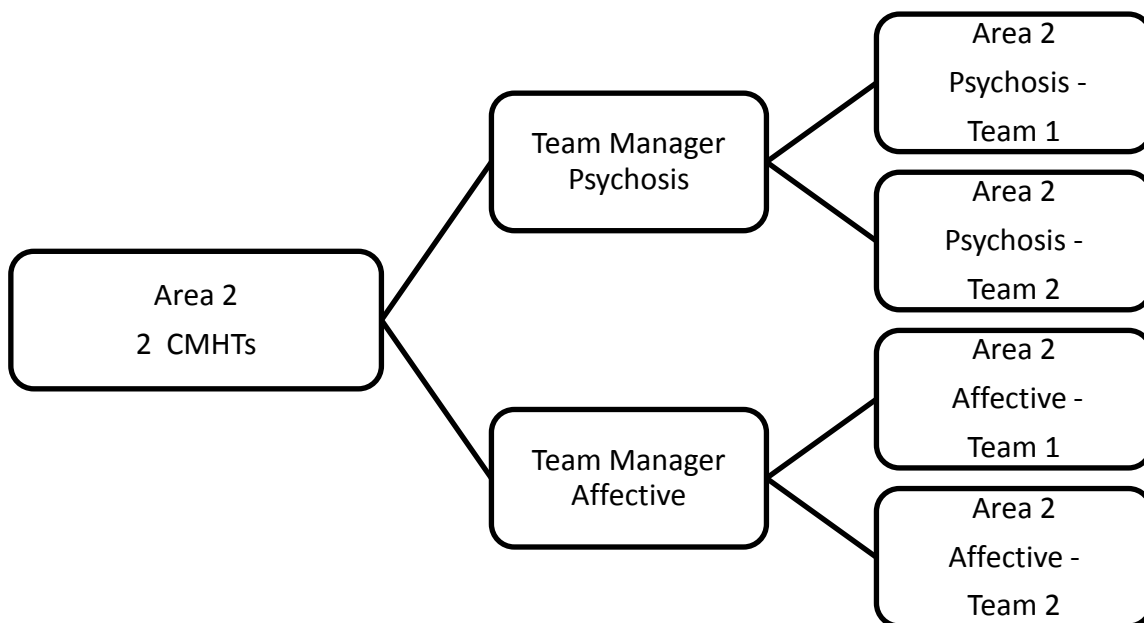
1.2 The Context of the Study

Social work with people who experience mental health problems occurs in a wide variety of settings including residential and day-care establishments, as well as in hospitals and service users' homes. Within the limited time period for this research, the study's focus was confined to the work carried out by community-based area teams, in order to understand in more depth the nature of the social work contribution. In this study 'AMHP' and 'MHSW' are used to introduce the specific

professions while 'social work professionals' is used to represent both AMHPs and MHSWs.

The two CMHTs researched for this study belong to one MHT in the North East of England and the Local Authority (LA) is also located in the North East of England. These two teams are located in two different geographical locations; however both teams are named as Area 2 teams. They have been subject to recent reconfiguration and each team comprises of two distinct teams; one for 'Psychosis Disorders' and one for 'Affective Disorders'. The two psychosis teams and the two affective teams are managed by two different managers.

Figure 1.1 – Management Structure of the Teams



The study was conducted with an ethnographic approach; I had the opportunity to be with the teams for 6 months on an honorary contract from the NHS, after successfully completing all the NHS research ethics procedures.

1.3 Aims and Objectives of the Study

The underlying purpose of this study is to use the historical information on mental health social work gathered as a part of the literature review, together with MHSWs' current experience and perspectives, alongside the perspectives of other mental health professionals and service users, to describe and understand in more detail the mental health social work contribution to community mental health services. The aim has been to help to improve the quality of the social work contribution within contemporary mental health services more generally and will undoubtedly result in improving outcomes for service users, carers and communities. Importantly, such research will also contribute to the development and profile of MHSWs as a professional group. To achieve this aim, I endeavoured to understand mental health social work interventions in respect of:

1. General mental health social work including involvement in care planning, assessments of individuals' needs and social care interventions.

The general understanding of the role of MHSWs is that they should provide a psychosocial perspective, to balance the bio-medical understanding of mental distress contributed by the medical profession. In this research I aimed to find out if this general understanding is correct in a real mental health team setting.

2. Changes to the existing roles and duties of MHSWs as a result of the 2007 MHA and how these are impacting on practice.

The MHA 2007, implemented from October 2008, did not replace the 1983 MHA but amended the earlier legislation. In respect of the implications for social work there were major revisions to the 1983 Act. In this research I specifically focus on the introduction of the role of Approved Mental Health Practitioner (AMHP)¹, which opened up the previous ASW (Approved Social Worker) role to other disciplinary groups. I examined the social worker's role

¹ Previously called as Approved Social Worker (ASW) by the 1983 Mental Health Act and now called as AMHP by the 2007 Mental Health Act

in the light of the introduction of AMHPs and the possible challenges this could bring to the social work profession.

3. Mental Health Act assessments (statutory role)

The key professionals with responsibilities for assessing a person's need for possible compulsory admission to hospital, or for guardianship, are two doctors and an AMHP (ASW previously). AMHPs are responsible for arranging the assessments for the person concerned. Most of the AMHPs are social workers and this research study looks at how the statutory duties of being an AMHP impact upon their other duties in a CMHT.

4. Contributions to increasingly interdisciplinary mental health teams and services.

The literature suggests that over the years mental health teams have become increasingly interdisciplinary, with different professionals from different disciplines working together under the same roof. One objective of this study was to explore the MHSW's and AMHPs role and contribution to these interdisciplinary mental health teams and to find out how the staff members from other disciplines view this contribution.

5. Barriers and Difficulties in integrated Working

The prevailing literature reveals a number of difficulties social work professionals face in CMHTs. In this research one of my objectives was to identify these barriers to social work practice in CMHTs at different levels including the team level, organisational level and policy level.

1.4 Research Questions

With the intention of fulfilling the above objectives of the research study, I developed a number of questions.

1. What are the roles, duties and responsibilities of MHSWs and AMHPs in a CMHT?

2. What is their specific/unique contribution (if any) to the functioning of a multidisciplinary team?
3. How do they feel about working in a multidisciplinary team?
4. What are their academic, professional, training qualifications and needs?
5. What is the status of MHSWs and AMHPs within a CMHT and among service users?
6. Are there any barriers to their effective functioning in the CMHT?
7. What are the challenges posed by the 2007 MHA to their job prospects?
8. What would help to improve the quality of mental health social work intervention in integrated working and develop social work professionals' contribution for a better service?

1.5 Research Methods

To address these research questions I employed an ethnographic approach. Firstly, I interviewed a sample of MHSWs, AMHPs, people who use the service and other mental health professionals, in the two CMHTs, about their experiences of the mental health social work contribution to modern, increasingly interdisciplinary mental health services. The other mental health professionals included team managers, Occupational Therapists (OTs), Community Psychiatric Nurses (CPNs), psychiatrists, psychologists, advance practitioners, expert practitioners, support workers, nurse consultants, link workers and day centre workers. Further to these interviews, I observed the two teams at work, attended team meetings, joined home visits and collected secondary data in order to develop a better understanding of the team functioning, including MHSWs' and AMHPs' contributions. The evidence collected helped an understanding of both the advantages and difficulties MHSWs and AMHPs face in these teams. It has been used subsequently to offer suggestions for change identified, together with recommendations about how improvements in services might be achieved.

1.6 Chapter Breakdown

This thesis comprises of seven chapters. This first chapter provides an overview to the thesis by firstly presenting a note on the current context of mental health social work in this country. Secondly it presents the rationale for the study using a summary

of previous research related to this topic; I discuss the factors that led me to do the research in this area. Next I introduce the context where this research took place and then explain the research aims, objectives and subsequently the research questions. Finally, in this introductory chapter I present a brief summary of the approach and methods I used to collect the data.

The second chapter contains a review of the relevant literature, which includes a detailed account of the origin and development of mental health social work in the UK. This is discussed alongside the major policy changes since the early 20th century up to the 2007 MHA and how these changes have impacted on the social work profession and social work practice. Later, in this chapter, I explain some of the basic and most important concepts in this research.

The first section of the third chapter presents a detailed account of previous research findings on mental health social work, including a number of issues ranging from the individual worker's personality to the impact of policies and legislation on social work practice. This section then leads to a discussion of the methodological issues I found with past research on topics associated with mental health social work. The second part of this chapter focuses on the theoretical and conceptual framework for the current study. This is based on Bronfenbrenner's (1977) 'Ecology of Human Development Theory' and describes four levels of influence on social work professionals' contribution to CMHTs, based on findings from previous research.

Chapter 4 explains the research design and methodology, starting with an explanation of the project design and preparation and the reasons for choosing an ethnographic approach to conduct this research. Next, I describe the sampling procedure, including the selection of teams, accessing and developing effective relationships with the teams and the selection of participants. After this I present a detailed account of the data collection procedure and then the data recording and data analysis methods implemented in the research. Ethical issues are explained in the next section, focusing on the complete ethical approval process to meet the requirements of the National Health Service (NHS), LASSD and Durham University. Also, in this section, ethical considerations with the participants are reflected upon and the methods used to overcome those restrictions are described.

In chapters 5 and 6 respectively, I present, analyse and discuss the findings of the research. A thematic analysis is used and the key themes and sub themes identified are presented in relation to the theoretical and conceptual framework. These results are categorised under the micro, meso, exo and macro systems. Chapter 5 includes the discussion on the microsystem and its impact on the social work force detailing the findings related to the role, duties, responsibilities, status, stigma and the impact of statutory duties on AMHPs. Some persisting workforce issues within the CMHTs, especially identified by the MHSWs and AMHPs, including case load size, difficulties in paper and computer work, supervision issues, clashes between MHA assessment duties and care coordination, are also discussed here.

The sixth chapter first presents the limitations I had in studying the mesosystem. Then this chapter presents the findings related to the exosystem and the macrosystem, where AMHPs and MHSWs are directly affected by the different practices as regular members in these two systems. In this chapter, findings related to the integration between the MHT and the LASSD, how this relationship has influenced the AMHPs and MHSWs, use of social and medical models and the relationship between social work professionals and LASSD, are included. Finally, in this chapter I discuss the changes in mental health policies and legislation, including the New Ways of Working (NWW) and the 2007 MHA and how they have made a difference to the working in CMHTs and subsequently to the social work force.

The last chapter contains the concluding remarks. Here, I present a brief discussion on the key messages derived from study findings. Chapter 7 also presents a methodological critique where I detail my experiences throughout the research process including the difficulties and barriers I faced, the limitations of this research and my suggestions to overcome those limitations in order to develop further research in this field. Finally, I discuss the recommendations for mental health social work service development that accord with the contemporary agenda for change in the MHT and the LASSDs to ensure an enhanced mental health social work force in the 21st Century.

Chapter 2: Literature Review Part 1

2.1 Introduction

This chapter provides a review of the literature pertinent to my research study. First I introduce a chronological history of the evolution of mental health social work in the UK, emphasising the changes that have occurred over the decades. In particular the policy changes, since the 1920s until the introduction of the 2007 MHA, are discussed in relation to how they have influenced the roles, responsibilities and the work settings of MHSWs. Next, some important topics related to this study, including CMHTs, multidisciplinary and integrated working and finally the social and medical models that inform care and treatment approaches in mental health services are explained.

2.2 The Origins of Mental Health Social Work

2.2.1 The Early Period

“Social work has changed as society and our social knowledge have changed; it has been transformed because the social agencies from which it is practised (hospitals, LAs, voluntary societies) have modified their original aims and conceptions” (Timms, 1964:1). Tracing back the history of social work as a profession, it has its roots in the struggle of society to deal with poverty and its resultant problems, originating as a response to the social crisis which occurred in Western Europe and North America after the Industrial Revolution, ‘more particularly, in the response of certain philanthropists to conditions in the middle decades of the 19th century’ (Timms, 1964:2). Timms (1964:2) further explains that:

Of special importance are the principles and procedures involved in the first forty years of life of the Charity Organisation Society. It is these that most clearly show the gradual emergence of a new social role, that of the informed and professional friend, whose activity was different from that of the squire, clergy-man or usual family friend.

Indeed, the history of social work intervention in mental health settings dates back to the 1800s, when the wife of the psychiatrist Alfred Meyer visited her husband's patients to learn more about their home backgrounds; she was later referred to as a 'social worker'. However, as Timms (1964:3) reveals "the first extension of social work occurred in the medical field when in 1895 the first almoner was appointed which has established a SW in a large, though still voluntary institution, in which medicine was clearly the first discipline and healing the main purpose". Ramon (2006:133-148) citing Timms (1964) reveals that the first traceable assignment of social workers to mental health settings was reported in the 1920s when a social worker was appointed to the Tavistock Clinic, a centre for psychotherapeutic training and treatment, opened in 1923 in London. The second such appointment occurred shortly after in 1927, to the Jewish Child Guidance Clinic in Hackney.

These developments occurred alongside the passing of the Mental Deficiency Act of 1913 that established the Board of Control; its first recommendation in 1928 was that a mental hospital should have "someone analogous to the almoner of a large voluntary hospital, whose task it would be to allay the patient's anxieties about home conditions during treatment, and to help him with employment and domestic difficulties after discharge" (Jones, 1972:245). As Jones (1972:245) further emphasised, this recommendation was evidently made with developments in the training of psychiatric social workers (PSWs) in mind. These responsibilities continue to be reflected in the General Social Care Council (GSCC) National Occupational Standards (2002) that govern social work practice today.

The Royal Commission on Lunacy and Mental Disorder (1924-1926) was appointed on 25.07.1924 by the then Home Secretary, the Rt Hon. Arthur Henderson. The main responsibility of the Commission was to 'inquire into the existing law and administrative machinery in England and Wales in connection with the certification detention and care of persons who are, or who are alleged to be of unsound mind' (Jones, 1972:238). The Royal Commission's Report revoked the legal view of mental illness replacing it with a more medical understanding and the consideration of social factors in respect of rehabilitation and after-care (Jones, 1972:244).

The subsequent 1929 Local Government Act and the Mental Treatment Act of 1930 continued to highlight the consideration of social factors in society's response to

those with mental health problems. The Local Government Act 1929 introduced a change of language for defining mental illness; for example 'poor law' was replaced by 'public assistance' and 'pauper' was replaced by 'rate-aided person' (Jones, 1972:246). The Mental Treatment Act of 1930 basically did four things.

1. Reorganised the Board of Control
2. Made provisions for voluntary treatment
3. Gave an official blessing to the establishment of psychiatric out-patient clinics and observation wards
4. Abolished out-moded terminology and brought the official expressions used in connection with mental illness more into line with the modern approach to the subject.

(Jones, 1972:249-250)

2.2.2 Closed to Open Door Wards

Jones (1972:244) emphasises that this shift was reflected in changes inside mental hospitals, with patients being allowed to wear their own garments and being supplied with small articles like materials for writing that had previously been considered unnecessary. In some hospitals occupational therapy was introduced, as efforts were made to increase the therapeutic value of a patient's stay. This included the availability of industrial therapy as well as the introduction of a range of new physical treatments such as electro-convulsive therapy (ECT), psycho-surgery, lobotomy and insulin coma treatment. As a consequence of these changes, mental hospitals that had been labelled as 'closed door' institutions for centuries began to experiment with open door policies. The introduction of 'open wards' encouraged the melting away of the 'closed door' label and the parole system came to exist. As Jones (1972:258) describes, "the parole system did much to break down the barriers between the mental patient and the community outside". Goodwin (1997:8) expressed that "Concurrent with these developments, admission rates to the mental hospitals tended to increase, while average lengths of stay tended to decrease", suggesting that these new treatments were helping in the early discharge of some people back into the community. Alongside these shifts it perhaps was not surprising that a more social perspective was encouraged in relation to rehabilitation and aftercare.

2.2.3 A Social Perspective and the Development of Training Courses

In July 1930, the Board of Control held a conference in Westminster, in which the subject of after care and the relationship between social work with people with mental health problems and that of general social services was taken into account. Most of the participants agreed that social care was a necessary part of the patients' treatment and rehabilitation, if they were to return to conditions of normal living. Some emphasised that 'integration of patients back into society were one for the general social worker, who was in close touch with other statutory services'. It was during this conference that many important issues were raised that influenced the development of mental health social work as a profession. Indeed as Jones (1972:255, 1975:125) reveals, the then Secretary of the Central Association for Mental Welfare, Miss Evelyn Fox, made a clear-cut and valuable statement about the task of a MHSW.

Social work was more than sympathy and common-sense. It was a skill which could be communicated, a technique to be acquired. Where a social worker worked in conjunction with a psychiatrist, her task was to provide him with the social background of the case and then to act as his instrument in adjusting domestic situations where necessary. In the after-care phase, when the patient no longer needed psychiatric treatment, the social worker continued this difficult and delicate task of social readjustment until the patient was capable of managing his own situations.

She also emphasised that any person undertaking this work should be trained.

What could be construed as the first group of English PSWs were trained by the Commonwealth Fund of America in 1926 (Jones, 1972:245). In 1929, the first training course specialising in psychiatric social work in England was started in the Department of Social Sciences at the London School of Economics. This course was of one year duration and was open only to mature and experienced social workers, usually of some academic standing (Jones, 1972:246/259). Basic training courses for social workers were started in London, Liverpool and Birmingham Universities, combining an academic course in social theory and social policy with practical work experience under supervision. Subsequently the Joint Universities Council for Social Studies made requirements with regard to professional qualifications and the Universities recognised these qualifications by the award of certificates and diplomas (Jones, 1972:259). The setting up of these training programmes reflected the belief

that social workers should have a professional role to play in the care of the mentally disordered (Hoggett, 1996:52). The first degree course for social workers was instituted in the University of Manchester in 1937. As Jones (1972:259) explains, those who completed these courses found settings to work in; some entered mental health services and practised social case-work in mental hospitals and out-patient clinics.

Recommendations made by the Feversham Committee in 1939 included the need for a 'minimum standard and a national qualification to be established for MHSWs, accompanied by a rise in status and salary-scale'. These issues were later taken up by the Mackintosh and Younghusband Committee (Jones, 1972:269). As Jones (1972:271) further describes, by 1944 PSWs were employed by the Provisional National Council for Mental Health to deal with the after-care of the service personnel discharged on psychiatric grounds. By 1946 there was at least one PSW employed in each mental hospital. However, according to Jones (1960:159) in 1946, "Dr.Blacker² had drawn attention to the fact that the development of community care was likely to be hampered by the shortage of trained SWs in the field".

2.2.4 The Dominance of Hospital Based Care and Social Work as a Profession Allied to Medicine

In December 1942 the British Government published the report on 'Social Insurance and Allied Services, generally known as the Beveridge Report, which shaped social policy in England for the rest of the twentieth century. In 1946 The National Association for Mental Health (NAMH) was formed to provide training for MHSWs and residential care staff. Two years later in 1948, following the Second World War, the NHS Act located the major responsibility for mental health with County Councils. As Roberts (2002) explains "The main inheritance of the NHS was a system of over 100 asylums or 'Mental Hospitals' with an average population of over 1000 patients in each". However official figures reveal that many of these mental hospitals were overcrowded by 1954 when the resident population reached a peak of 152,000

² Dr. Blacker - The report and recommendation of Dr. C.P. Blacker on a survey of the Mental Health Facilities in England and Wales begun in October, 1942, under the sponsorship of the Ministry of Health.

(Stewart, 2008). Despite the earlier glimmers of community treatment during the 1930s, it seemed that hospital based care had become dominant again in the late 1940s and early 1950s. Bailey (in press) connects this with “the introduction of psychotropic drugs like ‘chlorpromazine’ and the reliance on psychiatry as a profession to provide the answers to mental distress through medically based care and treatments”.

Jones (1972:291) identifies three movements during the early 1950s that reinforced each other. These were the development of new drugs to treat mental illnesses, the beginnings of the ‘open-door’ policy in mental hospitals and the appointment of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, which started a movement for the reform of the law which was to culminate in the 1959 MHA. Jones believes that the coincidence of these three movements was fortunate, since they reinforced each other.

In response to the overcrowding issue, the 1954-1957 Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (The Percy Report) marked the turning point in official policy from hospital-based to community-based systems of care (Stewart, 2008). As Rogers and Pilgrims (1996:69) reveal, the Percy Report states:

It is now generally considered in their best interests that the patients who are fit to live in the community should not be in large mental institutions such as the present mental and mental deficiency hospitals..... The Local Authority should be responsible for preventive services and for all types of community care for patients who do not require in-patient hospital services, or who have had a period of treatment or training in hospital and are ready to return to the community.

Thus began a reversal of the hospitalisation trend so that by 1959 only 12% of admissions to mental illness hospitals were compulsory, with a tendency towards shorter periods of in-patient treatment and increased availability of outpatient care (Roberts, 2002).

These developments in community care were supported by the 1959 MHA which repealed all previous legislation concerning lunacy, mental treatment and mental deficiency and reinforced the Mental Treatment Act of 1930, stating that treatment should as far as possible be provided on an voluntary basis by enabling most

psychiatric admissions to occur informally (Stewart, 2008). The other main objective of the legislation was to allow local councils to take responsibility for the social care of people who did not need in-patient medical treatment (Roberts, 2002). As Hoggett (1984:74) reveals the 1959 MHA “emphasised the development of community care that coincided with the restructuring of the profession and training of SWs in LA health and welfare services, following the Younghusband Report³” also of 1959. As Jones (1972:302) emphasises “in 1959 the mental health services of local authorities, and social work generally, received considerable stimulus and support from the publication of the Younghusband Report, which had long urged upon Government the importance of restructuring the social work services”. Younghusband report had recommended that two types of social workers should be trained and employed.

1. Professionally trained and experienced case-workers to undertake case work in problems of special difficulty. In mental health work, this grade would consist of PSWs, who would have psychiatric consultation and themselves provide case work consultation for Mental Welfare Officers (MWOs).
2. Officers with a general training in social work and a new qualification known as the National Certificate in Social Work. Training for this certificate would involve two years’ full time study or the equivalent, and would take place in colleges of further education. In addition ‘welfare assistants’ would be employed and given in-service training to help them to deal with ‘straightforward or obvious needs’.

(Jones, 1972:303)

Jones (1972:303) further reveals the recommendation of setting up a ‘National Council for Social Work Training’ and a national staff college to give impetus to training. She emphasises the duty of the LAs as:

In the LAs, better working conditions were imperative. It was recommended that salary levels and salary-structure should be reviewed; that more senior posts should be established, and that clerical help and transport should be provided on a much more generous scale (Jones, 1972:303).

3. Report of the Ministry of Health working party on the provision of training for social workers (1955) chaired by Eileen Louise Younghusband. The subsequent report which is known as ‘Younghusband Report’ led to the establishment of a Council for Training in Social Work and a Social Work certificate.

Jones (1960:164) also reveals that by this time there were approximately 1,100 social workers in mental health departments excluding PSWs. The Younghusband Committee had recommended that this number should be doubled, making it possible to reduce the 'over-heavy case-loads to enable the workers to concentrate on case-work and prevention more fully'.

During this period, a model out-patient clinic consisted of a psychiatrist, a psychologist, a PSW, a nurse and a secretary. Jones (1972:297-298) writes that under the NHS, conditions in the outpatient clinics gradually improved. However, 'clinical psychologists and PSWs remained in very short supply although most clinics have had a social worker attached'. The short supply of trained social workers had been a concern since the inception of the role. Jones (1972:301) explains, back in 1946, Dr. Blacker had been very despondent about the prospect of training enough qualified social workers to run adequate services in the community and had estimated that over a thousand were needed at once. The Mackintosh Committee Report (June 1951) on 'the supply and demand, training and qualifications of social workers in the Mental Health Service' took an equally dismal view of the situation estimating that, on the basis of existing facilities, only 65-70 PSWs could be trained annually.

Between 1928 and 1950, 523 students in all had qualified as psychiatric social workers. Of these, 331 were currently working in the United Kingdom, and the wastage rate was known to be very high. 65 were working in mental hospitals, and only 8 in local authority mental health departments. The other 258 were divided between out-patient clinics and child guidance. This very skewed distribution reflected patterns of training and professional expectations. By 1956, the number of psychiatric social workers in local authority mental health departments had risen from 8 to 32; but many local authorities had, for all practical purposes, abandoned the attempt to attract these qualified workers into their employment. They had looked elsewhere for their social workers, and other methods of training had to be considered.

(Jones, 1972:300-301)

The mental health social work force faced many changes prior to the subsequent Seebohm reorganisations⁴ in 1968. During the period from 1959-1968 the mental health social work force consisted of MWOs and PSWs. The MWOs were appointed

⁴ Seebohm reorganisations - Report of the Committee on Local Authority and Allied Personal Social Services chaired by Frederic Seebohm, HMSO, 1968

under the 1959 MHA and replaced the Duly Authorised Officer (DAO) who under the previous Lunacy Legislation was responsible for carrying out the practical arrangements for transporting the patient to hospital. The 1959 Act removed magistrates from the process of making the application for all compulsory civil admissions, under the Lunacy Laws and gave the MWOs new responsibilities in this regard. Jones (1972:312) reveals that the 1959 MHA “repeals all previous lunacy, mental treatment and mental deficiency legislation, and provides a single code for all types of mental disorder”. According to Rapport (2005), MWOs were usually men, located in the hospitals and community and although not professionally qualified social workers, many had received in-service training and some had nursing backgrounds. Hoggett (1996) explains, under the 1959 MHA, LAs were free to appoint any or all of their social workers as MWOs as they thought fit.

In contrast, PSWs were professionally qualified social workers, usually women, attached to Child Guidance Clinics and, as such, divorced from adult psychiatry (Rapaport, 2005:44). The PSWs were thus ideologically separate from their MWO counterparts due to the psychodynamic training they had received. The Association of Psychiatric Social Workers (APSW) maintained a professional register of qualified staff and was involved in professional training. Ramon (1985) explains that ‘this protracted gender division in mental health social work arose as an unintended consequence of the APSWs’ resistance to amalgamate with its DAO counterparts’. As Rapaport (2005:44) further describes this separation disappeared with the amalgamation of the mainly female PSWs and largely male MWOs into a single workforce that became part of the same LA service as a result of changes recommended by the Seebohm Report of 1968. According to Jones (1972:351) social work as a profession had made striking advances in the post Seebohm. She predicted that “it is no longer impossible that this should in future become the dominant viewpoint and psychiatric medicine would almost become a profession ancillary to social work”. However, as Rapaport (2005:44) emphasises the weakness of the Seebohm Committee was that ‘it focused mainly on the structure of the services and ignored the diversity within social work resulting in social workers working in specialist areas becoming generic social workers overnight’.

By 1961 it was clear that specialist workers such as PSWs were unlikely to be forthcoming in large numbers (Jones, 1972:331). Most of the workers in LA health

and welfare work had a common task and required a common training. As a result, from the early 1960s' social work courses in the Universities had a generic focus, so that students preparing for medical, psychiatric, child care or probation social work had the same generic training except for their field placements, which were related to their chosen career path. Jones (1972:331) further reports that 'The Health Visitors and Social Workers Training Act of 1962' set up 2 councils namely the 'Health Visitors Training Council' and the 'Council for Training in Social Work' by supporting the implementation of many of the Younghusband's proposals. Subsequently, the National Institute for Social Work Training was founded in 1963 and fulfilled many of the functions of a staff college. By this time institutions for further education had started courses for the Certificate in Social Work, under the direction of the Council for Social Work Training, and 'for the first time, workers were being trained specifically for LA work (Jones, 1972:331). Meanwhile, there were dramatic changes to the professional bodies in social work as the Association of Psychiatric Social Workers (APSW) had their farewell dinner in 1969 and one year later in 1970 the British Association of Social Workers (BASW) had their first Annual General Meeting (Jones, 1972:333). As Rapaport (2005) explains "in 1971, all social work training became the responsibility of the Central Council for Education and Training in Social Work (CCETSW⁵) and the Certificate of Qualification in Social Work (CQSW) became the new recognised professional qualification, which by 1981 had adopted a generalist approach".

Consequently, the creation of Local Authority Social Services Departments (LASSD) in 1971 meant that generic social work had a central place in public services, including those provided to people with mental health problems, for the first time. By 1972 PSWs and MWOs had been transferred to the social services departments and as Jones (1960:161) reveals most of them were expected to take a mixed case-load and it was no longer possible to separate mental health work from other kinds of social work. The MWO service was generally assumed to have benefited from this change, with an influx of more trained social workers to take on the role. With the reorganisation of the NHS in 1973 hospital social work, including that provided in

⁵ CCETSW was the Central Council for Education and Training in Social Work set up in 1971 and replaced by the GSCC in 2001. This was a statutory authority charged with promoting education and training in social work, recognising courses and awarding qualifications throughout the United Kingdom.

psychiatric hospitals, was transferred to the LASSDs. This meant that in relation to the mental health social workforce those with particular skills in the field of mental disorders became eligible for appointment as MWOs. In 1975, the White Paper 'Better Services for the Mentally Ill' set out to reinforce these changes in a blueprint for a local approach to mental health care, integrated at a strategic level to include the LAs, NHS and the voluntary sector. The new NHS Act of 1977 further supported this strategic integration of services by giving power to Health Authorities to transfer money to support LAs to develop shared services.

The subsequent Green Paper 'Care in the Community' of July 16th 1981 applied specifically to mentally handicapped, mentally ill and elderly patients⁶ (in that order). This suggested practical ways of moving money and care from the NHS to local councils and voluntary associations, in order to discharge long-term patients from mental handicap and mental illness hospitals so that they could be looked after in the community (Roberts, 2002).

As Rapaport (2005:44) explains, during this time growing concerns about social work practice lead to the Barclay Report⁷ (1982) 'Social Workers: Their Role and Tasks'. This was commissioned by the Secretary of State for social services and reinforced these policy developments in mental health to progress care in the community. This was seen as a Government prospectus for the future planning of social work. As Stewart (2008) writes, this report recommended that, 'people in need should no longer be seen as isolated individuals, but in terms of their relationships with family, friends, local community etc'. He further detailed that social services should be organised on 'a local patch basis' and put changes in place in the financial resourcing of mental health care to allow this to happen. Nevertheless, money continued to be spent on hospital services rather than that in the community.

The Barclay Report had clarified that social workers required two kinds of knowledge:

⁶ This was the language used in the Act and these terms are now changed as follows.

1. Mentally handicapped - Learning Disabilities
2. Elderly People – Older Adults

⁷ Barclay Report - Commissioned by the Secretary of State for Social Services, this Working Party was established by the National Institute for Social Work in 1980 "to review the role and tasks of social workers in Local Authority Social Services Departments and related voluntary agencies in England and Wales and to make recommendations" (Barclay, 1982, p.vii).

- Practical knowledge - the structure of the daily world, neighbourhood, area and agency and how these can be made available to people.
- The knowledge that gives meaning to behaviour and explains different human processes.

(Rapaport, 2005:46)

2.2.5 The 1970s to 1980s

During this period from the 1970s to the 1980s, social work, as a profession allied to medicine, retained a focus on case work, group work and community work (Ramon, 2009:1615-1622). As she further explains, this included:

1. Self-directed group work, which put together community development with empowerment principles (Mullender and Ward, 1991)
2. Networking and community care (Trevillion, 1992);
3. Paying attention to institutional abuse, child and elder abuse, and the strong connection between abuse and mental ill health (Stanley et al, 1999);
4. Anti-discrimination and its implications, for ethnic minorities, disabled people, women and poor people, has been a much more pronounced feature of training in social work than in any other helping profession;
5. Empowerment and participation (Braye and Preston-Shoot, 1995) (Beresford and Croft, 1993)
6. User involvement in policy making and in research (Barnes and Bowl, 1990)

(Ramon, 2006)

This indicates that, during the period of 1970s to 1980s, the direction of social work practice was focused more on individual and community aspects. Rapaport (2005:46) describes the 1970s generally as a period of high optimism for social workers because “reasonable sources were available to meet the challenges posed by the new social services departments and the number of qualified social workers was increasing”.

2.3 A New Era

2.3.1 The 1983 Mental Health Act

From the 1950s until the 1980s, social work in mental health settings was provided as a relatively autonomous contribution from a profession allied to medicine. However, the 1983 MHA highlighted a significant change in this approach. Prior to this Act, treatment for people with mental health problems could be considered to be “uni-professional” provided by psychiatry as the dominant profession (Bailey, in press). As Bailey further explains, multi-disciplinary working was influenced significantly by the 1983 MHA and is characterised by many sharing the work of caring for the mentally ill.

The 1983 MHA defined the boundaries between the skills and roles of different professional groups more clearly than the 1959 MHA. It replaced the role of the MWO with that of the ‘Approved Social Worker’ (ASW), outlining a clear and a more important role for social workers than the 1959 MHA. This Act also established the central principles of respect for individual liberty and freedom of choice, values that have underpinned the ASW role since its inception. This is a highly significant area of social work practice. Sheppard (1990:3-4), citing Cochrane (1983), describes this as a “recognition of the significance of social factors in mental illness, extensively chronicled in the social psychiatry literature and the previously apparently limited analysis of social factors in assessment for compulsory admission”.

Sheppard (1990:2) describing the 1983 MHA emphasises that:

The 1983 Act, like its predecessor the 1959 Act, involves major issues of civil rights insofar as it gives specific professionals – doctors, police and Approved Social Workers– the right to admit individuals in particular circumstances and against their will’. In fact the issues are endowed with even greater complexity because of the uneasy relationship between the perceived treatment needs of the patient, and his ‘normal’ rights to choose whether or not to obtain treatment.

In relation to compulsory admissions (sections), the 1983 Act confronts this in three ways.

1. By providing criteria under which a person may be compulsorily admitted
2. By giving the patients the right – except under section 4 – to appeal
3. By giving the nearest relative the right of discharge and also of appealing to the Mental Health Review Tribunal.

(Sheppard, 1990:2-3)

Anderson-Ford and Halsey (1984) cited by Sheppard (1990:70) suggest that “the 1983 Act was more civil liberation than its predecessor, and that the clearer ASW role is intended to balance the power of the medical profession”. However, to achieve these aims, Sheppard (1990:70) suggested the need for two conditions ASWs should develop:

1. A social risk orientation, rather than a mental health orientation.
2. An appropriate conceptual framework to analyse risk.

However Rogers and Pilgrim (2001) point out the 1983 MHA was ‘flimsy in its impact on service improvements, particularly because of its focus on improving the rights of forcibly detained patients at the expense of promoting a more community oriented response generally to care provision’.

2.3.2 The Approved Social Worker (ASW)

“Working with users and carers, social workers promote an unique holistic, recovery orientated, values based social care/social inclusion model that is able to challenge the dominant, task orientated medical model” (NIMHE, 2006:3). The social worker’s role in mental health continues to be very wide and includes responsibilities in respect of the prevention, detection of mental illness, rehabilitation and support. In addition to these general duties, social workers approved under the 1983 MHA played a key role in the process of admission and hold a great deal of power. As Rapaport (2005:48) emphasises “The introduction of the approved social worker (ASW) under the Mental Health Act 1983 was the jewel in the crown of many of the social work aspirations that had surfaced in the 1970s”. Sheppard (1990:1-2),

describing the ASW role, writes “this work therefore involves not just good practice, but the civil liberties of the individuals involved: hence it is a matter not just of professional interest but socio-legal concern”.

To work effectively in this role, social workers must undertake a minimum of 2 years specialist post-qualifying training, in accordance with the CCETSW requirements, plus the completion of an advanced course to practice as an ASW. However, in most cases, they still have to carry a generic case load as well. ASWs’ training requirements set out by CCETSW included:

1. An in depth knowledge of mental health law
2. Detailed knowledge of the local mental health services
3. Detailed knowledge of models of mental disorder
4. Promotion of social work values and AOP

ASWs have the statutory responsibility for assessing someone’s needs and providing care and treatment in the least restrictive manner. They also have the responsibility for making an application for compulsory admission to a psychiatric hospital, where this was deemed necessary and recommended by medical practitioners. The LA, through the warranting of ASWs, thus became a more integral player in determining whether someone with mental health problems could be cared for in the community.

According to Sheppard (1990:3-4) “ASWs possess a number of powers and duties, many of which reflect their position as ‘social analysts’, and inherent in powers such as those of entry and inspection (section 115) and applying for a warrant to search for and remove patients (section 135) where social factors (e.g. neglect, ill treatment, not being under proper care) are paramount”. As he further describes, the powers for compulsory admission held by the ASWs can be considered in combination with professional issues and civil rights.

The professional issues are complex, since there is a combination of factors which makes the ASW unique in social work: when undertaking assessments for compulsory admissions he is acting as an independent professional in his own right rather than as an agency representative; he is expected, by law, to possess ‘appropriate competence’ and not to act ‘in bad faith’ or ‘without reasonable care’; he is working in an environment independent of the courts where he is legally required to co-operate with a separate profession –

medicine – in order to section a patient; and the field in which he works is defined as mental health rather than social work (hence the Mental Health Act).

(Sheppard, 1990:118)

Sheppard defines ASWs as gatekeepers in compulsory admission assessments and they should equally weigh the civil rights of the individual with the need for compulsory admission. In the compulsory admission process it is important to understand the different roles played by ASWs and doctors. In this assessment process the ASWs' role is unique and significant, in that they identify the underlying social problems that are manifest by a person becoming mentally unwell. Sheppard (1990:137) asserts that ASWs have a distinctive role to play as this involves "considering 'all the circumstances' of the case: including, in addition to past and present state of mental disorder, the social, familial and personal factors relevant to the case". Sheppard (1990:120-121, 137) further explains this is 'related to the social work task while also defining mental health issues socially' and ASW role is "concerned with mental health, under the MHA, as a social rather than a health problem".

According to Sheppard ASWs are expected to perform a wider role than assessments for compulsory admission. Anderson-Ford and Halsey (1984), cited by Sheppard (1990:137), explain that the DHSS Consultative Document produced by the Social Work Services Group in 1981 determines that:

ASWs should have sufficient knowledge and skill to gain the confidence of colleagues in the health services, clients and relatives, and they should fully understand the contribution of members of other disciplines and of the relevant facilities provided by the services for which they work.

When assessing a person, ASWs need to have an overall perspective of the context, not only the particular person. Sheppard (1990:130) summarises this into three main areas of knowledge and skills:

- Know which roles are significant to assess, e.g. employment, parental, home care etc.
- Evaluate the role in relation to sub cultural expectations. What is expected of this person in their role in their particular circumstances (middle class, working class, black, white, female, male and so on)?

- Identify what constitutes adequate role performance of the particular tasks or expectations attached to the role.

This indicates that the ASW role clearly deals with an overall perspective of a client's situation when assessing them under the MHA. ASWs can:

- Act as adviser or consultant to other colleagues, both in terms of case management, or assessing the mental health state of the client.
- Be involved in training and development of other departmental staff.
- Be involved in the development of resources for the mentally ill provided by the department and linking up existing resources where appropriate for mental health needs.
- Develop better liaison and collaboration with health professionals, particularly psychiatric.
- Improve links with existing voluntary facilities and be involved in the development of new facilities.

(Sheppard, 1990:137-138)

Here it is apparent that the potential contribution of the ASW role to an effective mental health service is significant. However, Rapaport (2005:49) reveals that there are many obstacles for ASWs offering this contribution. These include the 'ASW Forums advocated by the Social Services Inspectorate (Department of Health, 1981) which, known to have been discouraged by senior management, (Rapaport: 2005) otherwise would have help to advanced the professional development if been properly implemented across England and Wales'.

2.4 Further Changes beyond the 1990s

Rapaport (2005:50) describes the 1990s as a 'period of cultural, social and political change, where the asylum closures were officially completed and the healthcare services began to aspire to anti-discriminatory practice and consensual care'. She further emphasised that social work, in line with a number of policies, 'has at last regained a mechanism for registration under the GSCC set up under the Care Standards Act 2000 and a new social work degree has been instituted'.

2.4.1 The NHS and the Community Care Act 1990

Consequently, it was the NHS and Community Care Act 1990 (Department of Health, 1990b) that legislated a change in the traditional territory of the mental health profession and made all the legal changes necessary for the implementation of the White Paper 'Caring for People: Community Care in the Next Decade and Beyond' (Department of Health, 1989). With the implementation of this Act, the NHS, in collaboration with the LAs and independent sector organisations, became responsible for assessing needs collaboratively, designing care packages, and ensuring their delivery through a more coordinated range of care provision, to ensure that people with mental health problems received appropriate levels of treatment and support in the community (Stewart, 2008). As Rapaport (2005:50) reveals "Government policy broadly promoted the ideals of service user empowerment for adults under the NHS and Community Care Act 1990 and for children under the Children Act 1989". She further emphasises that "The 1990 Act provides the framework for the twin health and social services systems of the care programme approach (CPA) and care management (CM) that underpin care planning and monitoring arrangements"⁸.

2.4.2. The Care Programme Approach (CPA)

The CPA for people with a mental illness, referred to specialist psychiatric services, was published by the Department of Health in 1990, with effect from 1 April 1991 (Department of Health, 1990a). The CPA is a specialist variant of care management for people with mental health problems and requires Health Authorities, in collaboration with social services departments, to put in place specified arrangements for the care and treatment of mentally ill people in the community. It set out a practice framework for Health Authorities in England, giving guidance on how they should fulfil their duties as laid out in the NHS and Community Care Act 1990 (Stewart, 2008). The CPA was intended to serve all psychiatric in-patients considered for discharge, and all new users involved with specialist psychiatric services.

⁸"The two systems have been declared one and the same (Effective care co-ordination in mental health services. Modernising the Act, a policy booklet. London:D of H. Care Programme Approach, a policy booklet. London: D of H), section 47, in line with the Griffiths report recommendations, identifies social services as having care management duties to assess a person's community care needs". (Rapaport,2005:50)

According to the CPA, the health and social services assess need, provided a written care plan, allocate a care coordinator, make arrangements for support outside of hospital prior to discharge and then regularly review the plan with key stakeholders. In this sense, the CPA can be regarded as a crucial point in the integrated working between Health and social services. As Villeneuve *et al* (2001), cited by Larkin and Callaghan (2005:339), explain '83% of the respondents in their survey had felt that the introduction of the CPA had acted as a catalyst to joint working, and that its strength was in developing a co-ordinated package of care, which codified practice and helped clarify both individuals and agency responsibility'. Larkin and Callaghan (2005:339) also regard the CPA as a crucial driver for inter-professional working and emphasised that it has become the framework for care delivery in mental health. The CPA has significantly contributed to a change in the role of social workers in the CMHTs with this introduction of joint working between health and the social services and also with the introduction of the 'Care Coordinator' role, which is discussed further in the following paragraphs. Problems in the implementation of the CPA, particularly for individuals considered a risk of losing contact with services, were manifest in the early days of its implementation with the result that 'The Mental Health (Patients in the Community) Act' (Department of Health, 1996a) was implemented in 1996. In 1999 the CPA was simplified to standard and enhanced levels, the term key worker was changed to care coordinator, and emphasis was placed on risk management, employment and leisure, and the needs of the carer (Department of Health, 1999a).

2.4.3 Care coordinator

"Effective care coordination is about getting the user in the right place, at the right time, with the right interventions" (Department of Health, 1990a). The Care-Coordinator was described as the main link between the people who use the mental health services and the care team trying to help them. The care coordinator should be:

- Someone who has regular involvement with the service user and is in a good position to know their changing needs.
- Able to communicate freely with the rest of the care team and call meetings, when necessary.

- Competent in the delivery of mental health care.
- Aware of the services available to users and carers and be able to access those services on their behalf.

When the CPA was first introduced care coordination was undertaken by CPNs, psychiatrists and social workers. OTs joined later depending on how they featured as part of community services. However, in the modern CMHTs, care coordinators are mainly the CPNs, OTs, ASWs and MHSWs. They are expected to perform a number of duties to ensure that the services people receive are appropriate and coordinated properly.

Being a care coordinator also requires good communication and coordination skills. The Department of Health (1990) provides a summary of their duties; comprising sections on the assessment process, care package designing, sharing information and continuity of care. These duties include the importance of proper assessment to understand both the health and social care needs of the service users and identifying the right services to meet those needs. Also emphasised is the need of explaining and discussing the care package with service users and educating the care team on the needs of service users. The care plan for each service user must be in written form so that these parties can share it. With respect to the issues on continuity of care, the care plan should be carried out, as agreed and appropriate actions should be taken if it is not. It also advised to pay attention to the changing needs of the service user, to hold reviews where necessary and then do changes to the care package accordingly. The Department of Health (1990a) also stressed the need to provide proper information on the care package when the service user moves between different care settings or to different localities, in order to continue proper care. Finally, the care coordinator's duty is to make sure that carer's needs are understood by organising a carer's assessment and putting them in touch with the right support services (Department of Health, 1990a).

As the CPA (Department of Health, 1990a) further describes "whilst there are a lot of responsibilities associated with being a care coordinator, they are not limitless. Sometimes other professionals involved in the user's care may not do their job or may behave unprofessionally. They are accountable for this through their own management / organisational structures. However, the care coordinator must take

appropriate action to ensure the user's care is delivered properly". As explained by the Department of Health (1990a) this could be achieved by:

- Approaching the worker concerned to see if the problem can be resolved.
- Where the problem cannot be resolved this way, approaching that person's manager.
- Letting the care team know there is a problem and making contingency plans, as necessary, to ensure that the user receives the care they need.

The guidance on 'Effective Care Coordination in Mental Health' requires organisations to provide effective workload management schemes, so that care coordinators have the capacity to carry out their duties properly. Whatever the changes it had undergone, the role of the care coordinator still remains vital in the CMHTs, as they are the connection point between the service users, carers and the other mental health professionals.

2.4.4 Revisions to the 1983 Act

Initial revisions to the 1983 MHA were always regarded as a compromise in legislative terms, as the policy makers were really trying to introduce compulsory treatment in the community. This intention was reflected in the Government's strategy 'Modernising Mental Health Services: safe, sound and supportive' (Department of Health, 1998a); this offered a broad plan for raising standards and promoting partnership in health and social services through the establishment of 'National Service Framework for Mental Health' and a National Institute for Clinical Excellence (Department of Health, 1999b).

Modernization policies for mental health services were introduced in a series of policy documents, by the New Labour administration post-1997. They implemented the NSF for Mental Health (Department of Health, 1999b), which was a key component in the policy approach to mental health. The NSF for Mental Health emphasized national standards for mental health services, reinforced the CPA and, together with the 'NHS Plan' (Department of Health, 2000) and the 'Mental Health

Policy Implementation Guide' (MHPIG) (Department of Health, 2001), set out the blue print for contemporary mental health services and models. These service reconfigurations redeployed MHSWs to work alongside other professions in Assertive Outreach Teams (AOTs), Crisis Resolution and Home Treatment (CRHT) and in the CMHTs. In some localities social workers are employed by the MHTs rather than LAs, which renders questionable specific social work contribution to an increasingly health led infrastructure of mental health service provision. Huxley *et al* (2008:477) summarise the later developments as follows:

The standards for joint working and the integration of care management with the Care Programme Approach (CPA) were set out in the "Effective Care Coordination in Mental Health Services – Modernising the Care Programme Approach' (Department of Health 1999). The Mental Health Policy Implementation Guide (Department of Health, 2001) clarified that CMHT assessments should be a unified health and social care process (p:8), with social assessments forming part of CPA, and CPA itself reflecting joint health and social services policies and procedures.

However, with these changes, the original expectations of a MHSW's role is also in doubt, as now in the CMHTs there seems to be no difference in what the social workers and the other mental health professionals from health back grounds, are engaged in as care coordinators. As Rapaport (2005:51) reveals, there is an overlap between the ASW and the CPN roles in the CMHTs. She further stresses that "care management did not enable ASWs to demonstrate a distinctive role from other healthcare professionals as they had nothing to offer and the unique position of the ASW as an independent social expert was starting to be eroded". Some scholars also fear the heavy burden that the care coordinator's role brings to social workers. These fears come as a result of social workers coordinating the full care package for a service user including the medical aspects, which social workers are not properly trained to do. In addition, Rapaport (2005:51) also reveals that CPN numbers are gradually increasing while the ASW numbers have fallen and continue to fall. This has been further influenced lately by the serious political setbacks to the public perceptions of social work as a profession.

2.5 The Mental Health Act 2007

2.5.1 Changes to the existing acts

Alongside the NSF (Department of Health, 1999b) developments, in 2002 the government published a draft bill, which, according to Dent (2007), was universally criticised. A further draft was published in September 2004 and was subject to scrutiny by a joint parliamentary committee, which described it as fundamentally flawed. In March 2006 the Department of Health announced that it was dropping the draft bill and would instead make amendments to the 1983 Act (Dent, 2007). After further deliberations The Mental Health Act 2007 (Department of Health, 2007a) received Royal Assent on 19 July 2007 and came into effect from October 2008. This did not replace the 1983 Mental Health Act, as originally intended, but instead amended the earlier legislation. It was also to introduce "deprivation of liberty safeguards", through amending the Mental Capacity Act 2005 (Department of Health, 2005), and to extend the rights of victims by amending the Domestic Violence, Crime and Victims Act 2004 (Home Office, 2004). The main changes to the above acts are described in the Mental Health Act Overview (Department of Health, 2009) and a summary of the important changes is presented below.

2.5.1.1 Amendments to the Mental Health Act 1983 (in respect of adults with mental health issues)

The 2007 MHA importantly changed the definition of mental disorder, so that a single definition applies throughout and references to categories of disorder are abolished. Criteria for detention are provided that introduce a new appropriate medical treatment test, which applies to all the longer-term powers of detention. A major implication for social work practice is the changes to professional roles. The new Act broadened the group of practitioners who could take on the functions previously performed by the ASW and the responsible medical officer (RMO). Some of the other important changes were in respect of the nearest relative. The Act gives patients the right to make an application to the county court to displace their nearest relative. It also enables county courts to displace a nearest relative who it thinks is not suitable to act as such the provisions for determining the nearest relative now include civil partners amongst the list of relatives. Supervised Community Treatment

(SCT) allows certain patients with a mental disorder to be discharged from detention, subject to the possibility of recall to hospital if necessary. It also introduces new safeguards for patients receiving electro-convulsive therapy. For the Mental Health Review Tribunal (MHRT), the Act introduces an order-making power to reduce the time before a case has to be referred to the MHRT by the hospital managers. Introduction of the Independent Mental Health Advocate role places a duty on the appropriate national authority to make arrangements for help to be provided by independent mental health advocates. Finally, the introduction of the principle of age-appropriate services requires hospital managers to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age.

2.5.2. Changes to the professional roles

2.5.2.1 Responsible Medical Officer (RMO) to Responsible Clinician (RC)

The Act has introduced two new roles, the Approved Clinician and the Responsible Clinician. Section 145 (1) of the 2007 Act defines an approved clinician as “A person approved by the appropriate national authority to act as an approved clinician for the purposes of the Mental Health Act 1983”. A responsible clinician is the approved clinician who has been given overall responsibility for a patient’s case. Approved clinicians who are designated as responsible clinicians will undertake the majority of the functions previously performed by Responsible Medical Officers under the 1983 Act (NIMHE, 2008). Hospital managers are responsible for ensuring local protocols are in place for allocating responsible clinicians to detain and for Supervised Community Treatment patients. LASSDs authorise approved clinicians to act as responsible clinicians for guardianship patients. Certain decisions, such as renewing a patient’s detention or placing a patient on Supervised Community Treatment, can only be taken by the patient’s responsible clinician (NIMHE, 2008). The professionals who can act as an approved clinicians are:

- Registered medical practitioners (doctors)
- Chartered psychologists
- First level nurses whose field of practice is mental health or learning disabilities

- Registered occupational therapists
- Registered social workers

These professionals are expected to bring expertise from their own backgrounds to this new role.

2.5.2.2 ASWs to Approved Mental Health Practitioners (AMHPs)

The new act has broadened the group of professionals who can carry out the statutory duties previously executed by the ASWs. As a result the AMHP role is now open to:

- First level nurses whose field of practice is mental health or learning disabilities
- Registered social workers
- Registered OTs
- Chartered psychologists

This inclusion of different professionals is expected to harness expertise from their individual backgrounds but within an established set of values and standards of practice that pertain to the AMHP role (NIMHE, 2008). Opening the role to non social work staff is also viewed as a solution to address the shortage of AMHPs in some areas. Parker (2010:19) suggests:

The inclusion of other professionals has occurred to address the shortages of ASWs in some areas (Huxley *et al*, 2005a) and reflects changes in service provision in line with integration of health and social services into multidisciplinary community mental health teams (NIMHE, 2005; Rapaport, 2005). The change also recognises that drawing AMHPs from nursing and other disciplines may add to the diversity and quality of the role (Jones *et al*, 2006) and create a further path for career progression for mental health workers.

The LA retains responsibility for approving AMHPs; however the requirement that AMHPs are employed by the LA has been removed in the new act. AMHPs must be approved by only one LA, but they can be authorised to act on behalf of a number of English LAs with whom they have an agreement. They must be approved for five years. The LA is responsible for ensuring that the AMHP is competent to practice as an AMHP. The role of the LA in warranting AMHPs has been retained, under the revised legislation, in an attempt to sustain the focus of the role on anti-oppressive

practice and the promotion of social work values in fostering recovery from mental distress.

The roles and responsibilities of the AMHPs are very similar to that of the ASWs, but in relation to the Supervised Community Treatment⁹ there are some additional responsibilities. NIMHE (2008:8) explains that:

AMHPs as individuals with functions of a public nature, are also bound by various duties on public authorities under the Human Rights Act 1998, the Mental Capacity Act 2005, the Equality Act 2006 and other anti-discrimination legislation; all of which contribute to the need for an AMHP to be independent in their decision-making and for their role in safeguarding the rights of the patient.

Educational and Training Requirements of AMHPs

Despite being open to non social work staff, as Parker (2010:20) explains, ‘AMHP training is still directly linked to the GSCC post-qualifying social work framework (like the previous ASW training), with requirements for AMHP training being specified by the GSCC and linked to the Post Qualifying (PQ) higher specialist award, which requires assessment at Masters level’. As Section 114A of the 2007 MHA (Department of Health, 2007a) explains, persons who are or wish to become AMHPs should complete a course approved by the relevant council, in accordance with rules made by it. They must demonstrate a certain level of professional competence, capacity and ability to undertake and complete the training programme at the PQ Higher Specialist Social Work Award level, as recognised by the requirements set out in the GSCC PQ framework. Finally, with all these qualifications, they have to be nominated by a LA or other employer for the training course.

Asking the candidates to complete the PQ Higher Specialist Social Work Award ensures the need for AMHPs to learn social perspectives of mental health. Parker (2010:20) describes, “Leaving AMHP training within social work post-qualifying framework goes some way to reassure that the social perspective and the core social work values remain embedded with the training”. However there are concerns

⁹ Arrangements under which patients can be discharged from detention in hospital under the Mental Health Act, but remain subject to the Act in the community, rather than in hospital.

about the independence of the role when undertaken by the non social work staff and fears around the future of the social work contribution in mental health.

The GSCC (2010:Section 51) states that; ‘The primary purpose of the training is to ensure the competence of professionals that may include social workers, nurses, occupational therapists or psychologists who are being considered for approval as AMHPs in accordance with the relevant mental health legislation to carry out statutory responsibilities under the Mental Health Act 2007’. The GSCC (2010:Section 51) further stresses that:

AMHPs must represent and maintain the values, integrity and relevance of the social perspective on mental distress, and training must enable AMHPs to articulate the social perspective through the role and responsibilities laid on them. Training must also prepare all AMHPs, regardless of individual profession backgrounds, to be able to assert an alternative social perspective to the medical view and act independently.

Parker (2010:20) emphasises that “this responds to many of the initial concerns expressed when the change in professional roles was announced, with concern that the AMHP would not be independent of medical influence (BASW, 2005), and concerns regarding the potential loss of the independence of the ASW role and uncertainty about the future role of social work in mental health (Merchant *et al*, 2007)”. Therefore, it has been essential for programme providers to reflect on course content and, in particular, how the emphasis on social perspective flows through the programme and assessment strategies.

As Parker (2010:19) further explains “the reform of mental health law in England and Wales with the amendments to the Mental Health Act 1983 has important implications for education and training of AMHPs in terms of the professional background of students and academic level of the award”. By now many Universities are providing post qualifying courses in Mental Health Social Work that are being revised in line with the AMHP requirements, even though the GSCC as the social work professional body currently continues to retain responsibility for their accreditation. The need for a Masters level qualification for AMHP training has raised many concerns (Parker, 2010:20). Many scholars question the need, validity and appropriateness of academic knowledge in Masters Level to perform in a practical role such as an AMHP. On the other hand some argue that for the decision making

in such complex situations AMHPs need a higher level of education plus the necessary skills and training.

2.6 The Multidisciplinary Dialogue

2.6.1. The Community Mental Health Teams (CMHTs)

With the post war developments in mental health policy, as explained earlier, the need for more community based treatment teams occurred because of the closure of the long stay psychiatric hospitals. As Brooker (2009:164) explains:

Associated with these post-war developments has been one area on which those working in mental health services may agree a consensus – there is a need to replace large psychiatric hospitals with community provision for those people who would have traditionally been admitted to the asylums. The development of generic, community based, mental health teams for working age adults, with a multidisciplinary membership, often providing services to a geographically defined catchment area service, has been central to this community provision.

The origin of CMHTs can be traced back to the 1960s in the USA where Community Mental Health Centres (CMHCs) were opened as a ‘system for delivery of services’ and were seen as a network. Jones (1972), in explaining the CMHCs in the UK, emphasised that the ‘CMHCs in the UK have more often been equated with buildings and the conception has never been as grandiose as in the USA although a UK CMHC movement has had its proponents’. In the literature, CMHCs were associated with CMHTs and these terms, at times, have been used interchangeably.

In the UK CMHCs only appeared widely in the late 1980s, although there were reports about individual centres, but no national overview. Brooker (2009:165) describes the first national conference on CMHCs in 1987 (Boardman *et al* 1988) and the first survey of CMHCs in 1987/88, in tracing the history of CMHCs in the UK. As he reports; ‘in 1987 the British CMHC was considered an innovation, an occasional departure from more traditional forms of psychiatric service’. At that time the debate on their role and contribution concentrated on two areas: the potential neglect of people with long-term mental illness and the possible advantages of a new

style of service exploring accessibility, multidisciplinary skills, and sensitivity to the needs of users and local communities.

Sayce *et al* (1991) cited by Brooker (2009:165) further describes how in the 1987/88 survey, conducted in the UK, a CMHC was defined as that “which provided adult services, was outside hospital, staffed by a multidisciplinary team and conducted at least some direct patient work from the centre but offered more than structured day care”. Carpenter *et al* (2003:1082) explain the two main features that the CMHTs share as:

1. Responsibility for delivering and co-ordinating a specialized level of community-based care for defined populations.
2. Multidisciplinary in composition.

CMHTs in England include psychiatric nurses, psychologists, OTs, and psychiatrists who are employed by the MHTs and SWs seconded by LASSDs. As Carpenter *et al* (2003:1082) describe “the presence of SWs in CMHTs is intended to promote integrated mental health care, although the extent to which health trusts and social services departments have been able to achieve this goal varies considerably”.

Since their implementation in the 1980s, CMHTs have gradually increased in numbers. According to Sayce *et al.* (1991), CMHTs have doubled in number approximately every 2 years throughout the 1980s. As Brooker (2009:166) describes “CMHTs are now ubiquitous and a core means of delivering secondary mental health care in England. CMHTs have grown from 81 in 1987 (Sayce *et al*: 1991) to 826 by spring 2006 (Centre for Public Mental Health, University of Durham). In England there is now one team per 38,868 adult population with a total of 13,502 care staff”.

In the UK, CMHTs are managed by health authorities, some by health and social services jointly, a very few by the LASSD alone or by the voluntary sector. The Spectrum of Care (Department of Health, 1996b:5) emphasises that the CMHTs should cover defined population groups, which means that each team is responsible for delivering and co-coordinating a specialised level of care. This (Department of Health, 1996b:5) further explains that all the professional groups in the CMHTs:

Have skills specific to their particular profession, and will have other skills in common with others. They are expected to use skills in a flexible way, so that

they can work together as teams to meet the full range of the people referred to them. If they need to treat a patient in hospital they should continue to provide care and support during the admission as well as at home after discharge.

The MHPIG (Department of Health, 2001:66) valued the CMHTs as the mainstay of the system and the core of local specialised mental health services, which newer services are developed around. CMHTs are expected to work with other specialist teams covering early intervention; assertive outreach; home treatment; the needs of those with co-morbidity; black and minority ethnic communities; homeless people; or mentally disordered offenders (Department of Health, 1999b:47). As Brooker (2009:169) emphasises, the MHPIG (Department of Health, 2001) reiterates the central importance of CMHTs, but leaves open the possibility of CMHTs changing their role over time to work more closely with primary care. Brooker, (2009:6-7) citing the Department of Health (2001) describes this as:

CMHTs, in some places known as Primary Care Liaison Teams, will continue to be a mainstream of the system. CMHTs have an important indeed integral, role to play in supporting service users and families in community settings. They should provide the core around which newer service elements are developed. The responsibilities of CMHTs may change over time; however they retain an important role. They, alongside primary care will provide the key sources of referral to the newer teams. They will also continue to care for the majority of people with mental illness in the community.

The MHPIG for CMHTs recommended that each CMHT serve a population of 10,000 – 60,000 depending on the local levels of morbidity and travelling distances. It suggests a staffing of 8 whole time equivalent (WTE) care co-ordinators each with a maximum case load of 35 people (and suggests a maximum caseload for the team of 300-350). The suggested staff mix is:

- 3-4 CPNs
 - 2-3 ASWs
 - 1-1.5 OTs
 - 1- 1.5 Consultant Psychologist
 - 1 Consultant Psychiatrist
 - 1-1.5 other medical staff
 - 1-3 support workers
 - 1-1.5 WTE secretaries
 - Reception staff
 - IT and audit support
- } Care coordinators

The staff listed in the MHPIG is limited to the usual professional groups that presently work in many CMHTs. However, other Department of Health policy documents suggest that additional staff will be required to achieve other policy objectives. This staffs includes:

- Pharmacists
- Dual diagnosis workers
- Learning difficulties worker
- Employment leads
- Psychology assistants
- Support Time and Recovery (STR) workers
- Support workers for those from BME communities
- Employment specialist worker

Carpenter *et al* (2003:1083) pointed out that 'CMHTs were found to be comparatively effective, especially in comparison to primary care teams. Nevertheless, considerable variation was evident'. Further, 'The Positive Approaches to the Integration of Health and Social Care in Mental Health Services' (Department of Health, 2002:18) describes that 'CMHTs function best as discrete specialist teams comprising health and social care staff under single management.' However, Carpenter *et al* (2003:1083) conclude 'there is yet no evidence concerning whether team functioning can be promoted by greater integration of health and social care services'.

Surveys done on CMHCs during the late 1980s and early 1990s report 'improved access but with a result of seeing an increasing number of patients with short term disorders' and 'large variation in the extent to which they served sufferers of severe mental illness' and 'access for the severely mentally ill' as the main CMHC shortcomings (Brooker, 2009:165).

2.6.2 Integrated and Multidisciplinary Working in CMHTs

2.6.2.1 Mental Health Integration Policy

The integration of health and social care in mental health services has been complex. The UK government policy has placed considerable emphasis on the need for inter-professional working in mental health (Huxley *et al.*, 2008, Larkin and

Callaghan, 2005). Leathard (1994:338) identified Government documents, such as 'The Community Care Act' (Department of Health, 1990b), 'Building Bridges' (Department of Health, 1995), 'The New NHS: Modern and dependable' (Department of Health, 1997), 'Our Healthier Nation' (Department of Health, 1999c) and 'Partnership in Action' (Department of Health, 1998b), as some of the key documents in driving forward the inter-professional agenda. Further to these documents, Huxley *et al.* (2008:476) report that 'The Health and Social Care Act' (2001) promoted integration through the development of care trusts between health and social services, and the 2006 White Paper 'Our Health, Our Care, Our Say: A New Direction for Community Services' (Department of Health, 2006) offered further opportunities to develop a more joint approach, to strategic needs assessment, finance, inspection and other infrastructure elements needed to support better integrated working between health and social care. As Huxley *et al.* (2008:476) explain "these legislative measures are designed to remove statutory barriers to closer integration of health and social care, but contain very little guidance about the active promotion of new ways of working together". Since the election of the New Labour government in 1997, integrated, multi-disciplinary working has remained a central feature for UK health and social care provision.

It is important to understand here the rationale for multi-disciplinary teams. Couchman & Dawson (1995) explain that multi-disciplinary teams have been considered as being a means of achieving the co-ordination that is required to achieve effective community care. As described by Columbo (1997) the rationale for multi-disciplinary teams is to solve a range of complex problems in the treatment, management and care of service users with Serious Mental Illness (SMI) by a group of professionals with different disciplinary backgrounds through an open exchange of their skills and ideas.

Social workers have been working in multidisciplinary CMHTs, while employed by LAs, for more than two decades. However, the decision to go for integrated trusts was announced as part of the NHS plan in 2000. The government publication 'Positive Approaches to the Integration of Health and Social Care in Mental Health Services' (2002) stated that the integration of health and social care in mental health has been a central plank of government policy for a number of years. Most importantly service users have consistently said they value receiving services from

one integrated organisation (Department of Health, 2002). This integration process has been very complex and has varied from Trust to Trust. A major aspect of team working includes the integration of different professionals working in the same multidisciplinary team. However, the literature suggests that there are many implications for social work practice as a result of integrated approaches to care delivery. Davies (2007:56) explains, “within CMHTs the ‘forging’ of an integrated approach to service delivery has had a number of implications for the delivery of services and for the professionals themselves, including social workers”. Davies (2007:57) further describes these implications as follows:

The organisation of CMHTs is central to their functioning (Onyett *et al*, 1997) as by bringing together this range of skills from the different professional groups, it is anticipated that a more effective care-coordination can be achieved, compared to professionals acting independently in the delivery of services to people with SMI. In principle, this inter-professional working is considered to provide a number of benefits including: the expansion in the range of skills that are available to meet the complex needs of service users and the creation of tension within mental health services that is required to facilitate an innovative practice environment.

Davies (2007:54) citing (Atkins & Walsh, 1997) emphasises that:

To this end, an integrated approach between different professionals and agencies is considered an important element in improving service quality (For example, in order, that ‘services move around the person, not the person around the service’), service delivery needs to be integrated and meet continuity of care. People should experience their services, as being well co-ordinated in order for them to make a difference in the quality of their lives.

The aspiration of this approach is to ‘provide service in which the boundaries between primary health care, secondary health care and social care do not form barriers seen from the perspective of the service user’ (Department of Health, 1990). Thus, in policy terms, agency and professional boundaries were perceived as barriers to continuity of care and the creation of teams the chosen method of overcoming them (Davies, 2007).

Different scholars have described the benefits as well as challenges in integrated working. Hannigan (1999:28) points out, “Distinctions between the concepts, values and consequently the activities of professional groups in CMHTs present both challenges and opportunities for joint work”. Sheppard (1990:73) describing the opportunities offered by working in unified teams explains the ‘encouragement of

'seepage', a process in which values and concepts flow from one professional group to another'.

Hannigan (1999:30) sees that the involvement of different professional groups in the provision of mental health services presents both challenges and opportunities for effective joint working. He reveals two challenges that need to be overcome for effective joint working:

1. The limited understanding by professionals of the concepts, values, language and activities of other disciplines.
2. The encouragement of inter-professional boundaries by separate initial training.

He also reveals the opportunities that exist by placing workers from different traditions in unified CMHTS which are:

1. The 'seepage' of values, concepts, knowledge and skills from one professional group to another
2. Shared inter-professional education and training

(Hannigan, 1999:30)

Whatever the benefits integrated work bring into CMHTs, it is important to understand that for the effective functioning of any team, certain aspects of team working have to be completed. Davies *et al.*(2007:65) citing Borill *et al.* (2000) explain that; "for teams to be effective there should be clear, shared team goals with build-in performance feedback, as where teams are set clear targets at which to aim and they receive feedback on their performance, their performance is generally improved". As they further explained:

Consequently, this lack of clarity and set aims had made workers unclear about the benefits that came from working in integrated teams so that the 'present arrangements [were] actually encouraging boundaries rather than eroding them'. In this way, staff were also found to be personally defining their own professional boundaries and had an overly restrictive sense of professionalism (seen as a barrier to effective team working) so that on occasion, strategies were identified where staff regulated and limited the demands made on them" (Davies, 2007:65).

Some other scholars also point out the importance of having clear cut aims and goals in the teams, as well as the importance of conducting training programmes to

develop understanding on each other's professional roles and challenge some of the professional identities. Davies (2007:65) explains:

“For collaboration to occur, it is necessary that individuals are both confident in their own role and respect the expertise and roles of other professionals. In order for professionals to construct identities of themselves and an understanding of others, ‘it is necessary to establish both uni- and multi-professional developmental training programmes at local level, to allow professions to see themselves as others see them, and so challenge and modify their own professional identities’ (Jones & Norman, 1998). This is also more likely to occur when professionals are clear about the aims of the team and their own personal role as a practitioner.

Hannigan (1999:30) further explains that; “It is not the case that effective joint health and social care provision can necessarily be achieved through ‘goodwill and co-operation’ alone, as the Audit Commission (1992:23) has suggested. The previous government’s Green Paper, ‘Developing Partnerships in Mental Health’ (Department of Health, 1997) acknowledged that fundamental problems in care co-ordination do exist, at structural, financial, organizational and professional levels”. The Green Paper proposed four options for change and invited comments on each.

Option 1

A single mental health and social care authority, with sole responsibility for planning and commissioning services.

Option 2

Either health or local authorities be designated with the responsibility for planning and commissioning both health and social care services.

Option 3

Joint health and social care bodies would unite mental health budgets and be accountable to local authorities for the planning and purchasing of social care and be accountable to health authorities and GPs for the planning and purchasing of health care.

Option 4

Health and local authorities agree to delegate particular responsibilities from one agency to another.

(Hannigan, 1999:30)

Huxley *et al* (2008:477) referring to the ‘Modernising Adult Social Care’ research programme, explain that; “health staff’s unfamiliarity with social care perspectives,

and lack of knowledge of referral and other processes, can act as a barrier to partnership or service integration”. Further, referring to Cestari *et al.*'s 2006 study Huxley *et al* claim that; ‘they had found evidence that assessments of mental health and social care needs are being kept apart in some services, which was not the policy intention’. In further describing this issue Huxley *et al* (2008:477) explain:

Implementing Fair Access to Community Services (FACS) in an integrated setting was made even more challenging by the culture difference between health and social care, producing resistance on the part of nurses to incorporate FACS into their initial screening assessments. Some health staff do not necessarily see meeting social care needs as a priority, and those who define the health service and themselves as not providing social care may not make appropriate judgements about the necessity for an assessment of social needs. There may also be staff whose background and training focused insufficiently on the ability to detect and assess social needs, whose assessment may therefore be cursory and/or out of line with FACS criteria.

Kings Fund Commission (1997) has also pointed out some issues with relation to multi-professional working. As Norman & Peck (1999:217) describe:

“the Commission points to disagreements between mental health care professionals about what constitutes mental health and illness and sees debates about effective approaches to treatment as a particularly divisive issue, which causes tensions in joint working at agency and team level. The results are communication difficulty, and conflict about leadership, effective team management and role identification, issues that stunt the development of community mental health teams.

The commission has further recommended that ‘multi professional training and education’ as a long term possible solution to overcome these issues. Norman & Peck (1999:219-220), in looking at ‘why the staff in many CMHTs do not strive towards achieving good inter-professional working’, had identified the following reasons.

1. Loss of faith by mental health care professionals in the system within which they work;
2. Strong adherence to uni-professional cultures;
3. Absence of a strong and share philosophy of community mental health services;
4. Mistrust of managerial solutions to the problems of inter-professional working.

They further clarify this as follows:

“Roles and responsibilities of mental health staff are integral to the professional persona and are likely to be defended vigorously. In seeking an identity, a sense of worth, mental health care professions will seek to distinguish their roles. These roles and responsibilities are reinforced by professional ideologies, models of working, professional training, status and reward” (Norman and Peck, 1999:228).

It is also worth stating here some ideas from Onyett (1999:79) that “the amount of time team members spend with each other will be influenced by operational features such as whether the team has a shared physical base, how much time they spend in meetings together and whether the team has a policy of joint working”. Price & Seagal (2005) cites by Davies (2007:64), have also suggested:

In order for service provision to be more effective, following the move to integration, a combined approach in which the medical model is used in combination with other models of care may be the most efficient way of working with people who have SMI. Although the approach recognises the challenges that can impede inter-professional collaboration, intertwining the medical model with other models of care has distinct limitations, as well as merits!

Lankshear (2003:61), cites by Davies (2007:61), identifies the areas for possible conflict and confusion between the professional groups who comprise a multidisciplinary CMHT, as follows:

1. Differences in world view
2. Professional identity
3. Pay
4. Educational Background
5. Status and attitudes
6. Assertiveness of members of the team, and the assumption that the doctors would be the leaders

As Davies (2007:61) reports Lankshear (2003) has identified ‘that the sources of conflict that largely appeared to affect professionals were predominantly caused by external forces’. Thus, workers in teams had formed strategies to deal with the new ways of working as: ‘demarcation’, which refers to professional groups establishing

clear professional boundaries in order to preserve the ‘professional identity’”. Davies (2007:61), presenting data from his research, explains that Lankshear (2003), had identified a small number of social workers who adopted this strategy as they felt ‘like cuckoos in the nest’ due to a feeling of isolation and the loss of support from others of a similar background”. Rogers & Pilgrim (2001) report that ‘clinical psychologists are more concerned than other professions about being drawn into inter-professional teams, ‘perceiving that this would entail losing professional status and jeopardising their apparent ambition of becoming as powerful and autonomous as psychiatrists’. Onyett *et al.* (1997), Craik *et al.*(1998) and Peck & Norman (1999), cited by Davies (2007:62), suggest that “The fear and loss of professional identity in CMHTs has also been widely documented for occupational therapists who have been advised against assuming a generic key worker role by their own professional body”. This indicates that integrated working in CMHTs has led different professionals to many issues with their professional identities.

Some scholars emphasise the change of roles that integrated working brings into CMHTs. Onyett *et al.*(1995), cited by Davies (2007:64), emphasises that “With the introduction of integrated working within CMHTs, workers have been required to move away from their traditional professional roles and into newly designated roles that are more generic”. Davies (2007:64) further explains about ‘role blurring’, by giving the examples of a social worker who has to monitor the side effects of medication and a clinical psychologist who has to help to organise accommodation for clients. He emphasises that “any member of the team can deliver many of the critical ingredients of good care, even if the aspect of care being delivered is not traditionally associated with that profession”. Wall (1998), cited by Davies (2007:64), reports that ‘when staff share tasks and operate outside of their area of expertise there is resultant loss of efficiency with consequential detrimental outcomes for service users’. However, Davies (2007:64), citing Burns (2004), suggests more positively that the willingness of ‘highly trained staff members to ‘stretch’ themselves outside of their job description (but within their personal competence) is viewed as a preferential option, in that not too many individuals are involved in the care of one patient’. Davies (2007:64) reveals that “this approach to working was viewed by Singh (2000) as being a facilitator to improving the effectiveness of running an effective community mental health team”. Davies (2007:64-65) in referring to

research conducted by Brown *et al.* (2000), which was based on 'professionals view shortly after moving to integrated teams', reveals that, "there had been a 'blurring of roles' in the teams following integration, so that staff were required to undertake tasks for which they had not been specifically trained". As Brown *et al.* (2000) further reports, "practitioners in this research also showed concern towards 'the agendas and policies of their senior colleagues and a lack of leadership to provide the various professionals with clearly defined goals'".

2.6.3 The Medical and the Social Models

The term 'medical model' appears to have been invented by clinical psychologists sometime in the late 1960s. As Grobstein & Cyckowski (2006), cited by Davies (2007:63), emphasise 'it has always been perceived, at least by the medical profession, as a somewhat derogatory term, as people tended to imply that the medical model was simply concerned with physical illness and physical treatments'. According to Rogers & Pilgrim (2001), in the area of mental health service provision, the medical model has traditionally been regarded as dominant. They also consider that the medical model is the predominant model in the development of contemporary mental health policy. However, Davies (2007) explains that a major criticism about the medical model is that it does not utilize a holistic approach when making a diagnosis, as it does not take social factors into consideration. As a result he further explains that "this criticism has ignited debate of the medical model, which plays a significant role in the delivery of mental health services" (Davies, 2007:63).

Grobstein & Cyckowski (2006), cited by Davies (2007:63), discuss this issue further stating that:

Some theorists suggest that the model needs to be expanded to address the link between social context and illness, i.e. the social determinants of health (WHO, 2003). Duggan (2002) suggested that by the beginning of the 21st century it was clear "that a reconnection is required between the roots of public health and the developing approaches that impact on all the determinants of health and not just those that relate to biology and lifestyle". Others report that such an approach has already been incorporated into a medical model and that the past history of a service user, the family history of that individual and environmental factors have, for some time, been used in deciding upon a diagnosis.

Norman & Peck (1999) emphasise that; “this perception of the dominant ‘medical model’ approach to service delivery is further assimilated in CMHTs where the Consultant Psychiatrist is, in the UK, said to be legally responsible for all CMHT patients, although not for the clinical practice of colleagues from other CMHT professions”. Plews *et al.* (2000) and Snelgrove & Hughes (2000), cited by Davies (2007:60-61), explain that, ‘however, some commentators have stated the perceived dominance of the medical model has been blurred by the more medically-orientated practitioners ‘tracking’ into more social territory’.

These literature sources indicate that the medical model of mental health care had been dominant over the years, which had been a major concern among many people. The importance of addressing both the social and medical context of mental illness has been highlighted by many scholars and now, with the introduction of the ‘New Ways of Working’, there is more emphasis on considering social factors in mental health care provision. As a result, some changes have been made to the service provision through the introduction of ‘Recovery Model’¹⁰ in line with the social model.

2.6.4 Good practice in integrated working

Good practice in integrated working, according to studies referenced below, is a result of a combination of different factors, which range from individual level, team level up to the organizational level supported by government policy. Below from section 2.6.4.1 – 2.6.4.5 I have described some of these important issues in good practice in integrated working.

2.6.4.1 Operational Policy

Over the years the mental health integration policies have developed in a way that suits the integrated work system in CMHTs. Larkin and Callaghan (2005) identify the

¹⁰ “The recovery ‘model’ requires a change of approach on the part of both the professionals and the service users. Service users have to be prepared to step out of the ‘sick role’ and start to regard themselves as autonomous people with the capacity to come through a period of mental distress and develop their individuality, self awareness and self acceptance. Professionals need also to look at people’s potential, and to stop being managers and start being facilitators. They need to start looking first at people’s potential for development rather than at how their mental distress may restrict their lives.” (MIND)

importance of different professionals working from the same base following the same protocols and policies. Indeed, Onyett (1994) identifies that these common protocols and policies should be clearly identified within the operational policy. Thomassy and McShea (2001) cited by Larkin & Callaghan (2005:339) explain that 'problems in effective planning of patient care are sometimes the result of poor collaboration between health care professionals, each of whom uses different priorities and protocols to assess and plan'. This shows the importance of having a common operation policy within one team for different professionals.

2.6.4.2 Communication

Communication and decision-making processes are key issues for teams. Larkin & Callaghan (2005:339), quoting several writers, explain this issue as follows:

Hunt (1983) argues that teams that do not hold regular meetings of all members, which provide opportunity for policy making and resolution of difficulties, do not warrant the title of 'team'. The reason being, that the basic requirement of a team is that members engage in face-to-face interactions and engage in co-operative and co-ordinating activities. Lowe and O'Hara (2000), in their study, found that regular team meetings held a distinct advantage in enabling the team to carry out its work. Molyneux (2001) reported that 'communication was facilitated by weekly case conferences which gave an opportunity to plan the work of the whole team with patients'. A study by Bennett-Emslie and McIntosh (1995) also found that team meetings were seen as key components in aiding communication and understanding between different professionals.

Larkin & Callaghan (2005) found that 60% of their research respondents from mental health teams had identified that meetings happened in their teams. However, these respondents demonstrated that meetings had not influenced their perceptions of interprofessional working.

2.6.4.3 Geographical Proximity

"Shared premises enable informal, frequent encounters between team members and provide opportunities for information sharing" (Larkin and Callaghan, 2005:339). Larkin & Callaghan (2005:343) further suggest that "when professionals share an office space they are pushed into identifying more structured means of organising themselves, communicating with each other and having clarity about how they are

going to work together”. Shared location is also identified as a benefit for the service users, as they do not have to move from place to place in searching for different services when many professionals are working under the same roof.

2.6.4.4 Supervision and Appraisal

Supervision issues in integrated teams have always been controversial. Different professionals from different backgrounds emphasise the importance of getting supervision from their own discipline, to develop themselves in order to improve the service they provide. However, with the integrated teams this does not seem to work effectively, as most of the staff from social services had supervision from somebody from the medical background. Ovretveit *et al* (1997:26) suggest that “The subject of supervision is one of the most confused issues in team organisation and management. Different professionals have different interpretations and experiences of what supervision means to them within their profession”. Larkin & Callaghan (2005:344) observed professional supervision in integrated teams as a very sensitive issue and they believe that the ‘joint supervision policy may have caused the respondents to challenge their perceptions of inter-professional working within their teams’.

2.6.4.5 Clarification of roles and responsibilities

In the integrated teams it is equally important to have a very good understanding of other professionals’ roles as well as one’s own. As Larkin & Callaghan (2005:340) explain, different individuals have their own duties within the teams, however it is necessary to have an understanding of each other’s role from the onset. They further emphasise that lacking this clarification of each other’s role might cause ‘confusion, tension and possibly rivalry’ inside the team. Larkin & Callaghan (2005:340) further explain this by quoting some other research as follows:

Onyett (Onyett, 1995) identifies that lines of accountability must be clarified based on the identification of shared roles and responsibilities of team members, and separation of these from the specific and unique skills, which individuals and disciplines contribute to the team. Norman & Peck (1999) reinforce this and state that ambiguous roles may have negative consequences, and lead to unclear lines of responsibility and accountability. Hunt (1983) found that if team members’ expectations of each other’s roles

are in accord few problems might occur. She stresses that if there are serious perceptual discrepancies considerable difficulties may arise within the team.

Larkin & Callaghan (2005:344) further report that on the whole, professionals in the mental health teams they researched identify their roles as well defined. However, they had found significant differences among different professionals about their perception of how well their role is recognised and understood within their teams. Based on those results, they suggest “there is some conflict between the fact that the professionals perceive that their role is clearly defined but that their role is not recognised and understood within their teams”. Larkin & Callaghan further emphasises that ‘whilst individuals are clear about their professional roles, the team as a whole is not clear about the roles and responsibilities of those within it and this may possibly lead to problems within the team’. Larkin & Callaghan (2005:344), citing Norman & Peck (1999) and Hunt (1983), emphasise that ‘ambiguous roles and serious perceptual discrepancies may cause negative consequences and lead to unclear lines of responsibility, accountability and difficulty within the teams’. Finally, Carpenter *et al* (2003:1100) confirm the “importance of enhancing role clarity and reducing role conflict in ensuring positive outcomes for community mental health staff”.

2.7 Conclusion

It is clear from this historical account that in the mental health field, the social work contribution has moved from specialist to generic and then back to specialist, influenced by changes in the profession. As a whole these changes have occurred in accordance with social, legal and policy developments in England. With these developments, CMHTs became multi-disciplinary allowing social work professionals to work alongside other mental health professionals from health services. The teams were predominantly dominated by the psychiatrists, until the introduction of the New Ways of Working and Recovery Model. These changes helped to decrease the powers of the consultants, allowing more opportunity for social aspects to be integrated in the treatment plans. However, the literature reveals continuing medical dominance in many CMHTs, causing a number of problems for the social work professionals. Mental health social work has needed to respond and inform

increasingly integrated working in CMHTs, as well as sustain a social perspective alongside medical models of treatment and care delivery; these issues have informed the research questions. The conceptual and theoretical framework used in this study helps to explore and understand this contribution in a more robust and systematic way.

From here the third chapter moves to the second part of the literature review. In this next chapter I discuss a number of issues social workers face in the CMHTs related to integrated working and the conceptual and theoretical framework I employed in this research.

Chapter 3 - Literature Review part 2

3.1 Introduction

This third chapter concludes the literature review. It identifies a number of issues faced by MHSWs and AMHPs, which are related to integrated working in multidisciplinary teams. It then goes on to discuss the conceptual and theoretical frameworks employed in this research.

3.2 Issues with Social Workers in CMHTs

3.2.1 Role Definition, Role Clarity and Role Conflict

There is limited published research concerning the clarity of the role of the social worker in CMHTs. To discuss this, it is important to understand what role clarity and role conflict means. Carpenter *et al* (2003:1092) define role clarity and role conflict as:

“Role clarity concerns the extent to which staff are aware of what is required of them by the organization, including goals and tasks, and whether they feel they have the authority to carry out their responsibilities”.

“Role conflict is a measure of competing demands on the individual worker, inadequate resources, incompatible requests, and disagreement at the level of management”.

Larkin & Callaghan (2005:345) suggest that the issue of role definition and clarity among different professionals, and their perceptions of how well their role is recognised and understood, should be addressed in future research. They recognised that such research should examine the “relationship between the professionals’ perception of their own roles, how they view others’ perceptions of it and what effects this then has on inter-professional teamwork within the team”.

For the practice areas this finding has implications for the way in which inter-professional working is conducted within the teams. It is suggested that the practice area address these role issues and considers if they are impacting on other areas of team work and practice. Further development of the teams may be required to bridge the gap between the perceptions of professionals’ own roles and how well they perceive their roles to be recognised and understood (Larkin and Callaghan, 2005:345).

Carpenter *et al* (2003:1081-1082) have also identified poor perceptions of team functioning and a higher level of role conflict among social workers in multidisciplinary CMHTs. They distinguish 'role conflict' which they found as a "significant predictor of stress and of job dissatisfaction, while role clarity promoted job satisfaction". Nathan & Webber (2010:21) described role conflict as follows.

Alongside the increasing managerialism within the NHS, social workers are experiencing the increasing marginalisation of the psychosocial dimension in general, and the social work perspective in particular within CMHTs (Blinkhorn, 2004, Huxley *et al.*, 2005a). The social care role has been subordinated within mental health trusts resulting in social workers not feeling valued and their role not being understood.

Reid *et al* (1999b:305) confirm social workers prominent preoccupation with role conflict and role ambiguity compared with other mental health professionals. According to their report, role conflict was most evident for social workers undertaking MHA assessments which they described as the most stressful aspect of their job. Reid *et al.* (1999b:305) further emphasise that MHSWs reported "an intense conflict between a duty and a wish to act as patients' advocates and represent their interests, and a responsibility to ensure that patients, and, in particular, others are safe". In this study (1999b:306), MHSWs also apparently spoke of frustrations occasioned by the lack of understanding of their role by other professionals. They also had felt that they 'lacked an opportunity to work with patients beyond housing problems and duties relating to detention under the MHA'. Peck & Norman (1999) cited by Carpenter *et al* (2003:1099) stress the importance of a professional culture in the CMHTs.

Social workers emphasised the importance of values and professional culture of their discipline; these they viewed as being central to their professional identity. They were concerned by what they saw as a threat to social work culture, and thus social work itself, by working in CMHTs which were dominated by health service workers.

All these literature sources confirm that social workers experience role confusion and tensions with the clarity of their role, as they believe other team members do not understand their role properly. Social workers have also highlighted the importance of having a proper professional culture in their place of work, the CMHTs.

3.2.2 Professional Rivalry

Goodwin (1997:139) reports that as a result of the changes in the mental health system, there was an increase in the level of conflict and rivalry between different agencies and professional groups. According to him, the psychiatrists, in particular, see their position threatened and the different concerns and priorities of different professionals in the teams tended to conflict.

Goodwin (1997:139-140) further explains that:

In England the Audit Commission (Audit Commission, 1986:56) noted that there is considerable 'professional fragmentation' amongst groups responsible for the treatment of the mentally distressed people. Social workers are often perceived by psychiatrists as lacking relevant skills and of failing to prioritize people with mental health problems in their work (House of Commons, 1985:3156) General practitioners, too, share this wariness of the role of social workers in the provision of treatment.: 'Doctors often feel that social workers do not "back them up", particularly in obtaining compliance with medication, and are chary of co-operating with people who not only do not have a medical or nursing training, but may have had no formal training at all!' (Royal College of General Practitioners, 1985).

Goodwin (1997:140), citing Freeman *et al.* (1985) reveals that 'Conflicts between different professional groups no doubt still represent major constraints to the development of community-based mental health care'. He further cites a review of developments in psychiatric services by Sartorius (1987:153) which emphasises that: 'The list of inter-professional tensions in the field of mental health is long and the battle fierce, and there are no signs that it will be abate'.

However some recent research shows that this rivalry is not as prominent in modern CMHTs as was in the previous times. Professor Louis Appleby (2007:9) reports that a consultant psychiatrist at Charing Hospital emphasised that "The professional rivalry between the psychiatrists and the psychologists is waning. There is much more openness and none of us think we have all the answers for every patient." This can be understood as a result of the changes in mental health policies, especially the New Ways of Working initiative in mental health. With these ideas, it is important to find out whether there is any professional rivalry between the CMHT members and, if so, how it has impact on social work professionals' role in the CMHTs.

3.2.3 Stress and Burnout

Singh (2000:417) citing Maslach & Jackson (1986) describes 'burn-out' as "the long-term negative effect of such stress and includes emotional exhaustion, tendency to develop cynical and negative attitudes towards others and negative self-evaluation, especially regarding personal accomplishment at work". Singh (2000:417) citing Prosser *et al* (1996) further explains 'burn-out has been reported among both hospital and community staff, with higher levels in community mental health workers'. According to Evans *et al.* (2005:147) burnout is "exhaustion resulting from excessive demands on energy and resources".

Carpenter *et al* (2003:1095) explain that "job satisfaction and stress were highly correlated. That is, the less satisfied a person was with their job, the more stress they were experiencing; staff with high job satisfaction were less likely to be stressed". These studies reveal that with the high level of stress, MHSWs are more liable to job dissatisfaction.

Huxley *et al.* (2005a) report a large survey of MHSWs, where they found high levels of stress arising from overwork, vacant posts, a lack of access to service resources and the pressures of constant change and reorganisation. An initial quantitative study on 'Improving support for mental health staff' (Reid *et al.*, 1999a) reveals that MHSWs, who are employed by LAs, have lower levels of job satisfaction and higher levels of burnout than NHS staff either in hospital or in the community. Carpenter *et al.*(2003) citing Leary & Brown (1995) and Prosser *et al* (1996:,1999)reveal high levels of stress or burnout among community-based mental health staff. Carpenter *et al.* (2003) also cite a large cross-sectional study by Onyett *et al.* (1997), of 445 team members in 57 multi-disciplinary CMHTs. In this study, Onyett *et al.* (1997) found significant differences between professions in terms of job satisfaction and stress. This report further reveals that consultant psychiatrists, social workers, nurses and psychologists were particularly stressed, but psychiatrists and OTs were significantly more satisfied with their jobs than were social workers.

Carpenter *et al* (2003:1082) suggest that this dissatisfaction among social workers in CMHTs is a consequence of their marginal position in the team. This marginal position is a result of having a different employer (social workers are seconded to the

CMHT by the LA) where social workers can lose their professional identity as a result of role blurring with health professionals. They also stressed the difficulties social workers can face, in a medically dominated hierarchy, as a result of clashing values and beliefs between the medical and social model of mental health care.

3.2.4 Difficulties in Integrated Working

As a result of the integration of health and social care services, social workers now work alongside a majority of professionals from health backgrounds in mental health teams. MHSWs and AMHPs are both expected to work as care coordinators in these teams. This raises a debate about how a professional, with a grounding in the social model of mental distress, can balance their disciplinary contribution, with the expectation that they will plan and offer a full care package to a service user in the same way their health colleagues do. Carpenter *et al.* (2003:1082) explore this as follows:

In the UK and internationally, integration between health and social services characterises the future of mental health care (Carpenter & Barnes, 2001), but little is known about the effects on staff of working with different organisational models and whether the effects are the same for the different professions.

In recent research, Svennevig (2007:9) revealed that almost all the social workers in her study had felt the importance of remaining in integrated teams; however, many felt that they lost their professional identity within these teams. This is a clear indication of the many difficulties social workers face, when working in integrated teams.

3.2.5 Gaps in skills and knowledge

The modern multidisciplinary CMHTs are generic in nature and the MHSWs in these teams have to perform a broad range of duties, in order to deal with clients with different needs, including severe and enduring mental illnesses. Reid *et al.* (1999a:306) pointed out that, MHSWs are not generally trained to deal with all types of mental illnesses and, as a result, there are gaps in their skills and knowledge, when meeting these demands in the generic CMHTs. This has resulted in differentiation of functions within community services for mentally ill adults and

opportunities for staff to develop specialist skills with particular client groups have been limited. This may leave staff feeling that they have relatively few strategies available for coping with some of the most difficult service users, in terms either of opportunities for onward referral to specialist teams, or of skills available within the team”.

Nathan & Webber (2010:21), citing McCrae *et al.* (2004), point out that;

Other mental health professionals are incorporating much of the social work role, but as suggested earlier, social workers are also being incorporated into a psychiatric hegemony replicating the work of their mental health colleagues using medical idioms such as ‘patients’ and ‘diagnosis’, formulating their work in terms of ‘treatment’ and generally feeling less able to challenge the institutional structures within which they operate.

This literature reveals that there are gaps in skills and knowledge among social workers, when working in these modern multidisciplinary teams. The gaps include the knowledge and skills to deal with specific clients, which have subsequently led to social workers feeling dissatisfaction in their jobs.

3.2.6 Case load size

Case load sizes in CMHTs appear to contribute to the levels of stress experienced. Even with the increase of CMHTs and new specialist services, reducing the size of caseloads has been problematic. However, Reid *et al.* (1999b:307) describe how:

Recent research has shown that smaller caseloads do not necessarily reduce stress in staff; such a reduction may need to be combined with clear strategies for making good use of the time with clients that is gained. A more balanced caseload, with a mixture of severe and less severe problems, and more crucially being able to share responsibility for the more difficult and worrying clients on a caseload, may also be helpful. Staff might find their task easier if they more frequently had the opportunity to work jointly with a colleague. Such joint working would be made easier by lower team caseloads.

This implies that mental health staff can perform better with a balanced and reasonable amount of cases. This also leads to work load issues for AMHPs in these CMHTs, who have to take up a big number of cases as care coordinators while still engaged in MHA assessment duties. AMHPs must give priority to their MHA assessment duties, which sometimes cause cancellations and delays in their work as care coordinators. In this sense, allocation of a big number of cases to AMHPs

raises questions about the efficiency of the care coordinator's role when undertaken by AMHPs, which in turn can have an impact on the service users whose care coordinators are AMHPs.

3.2.7 Overlap in work

As stated earlier, CPNs, SWs and OTs all work as care coordinators in modern multidisciplinary teams, responsible for designing and undertaking care packages for service users. What they do in their role is very similar, except that CPNs give medication by injection which social workers are not trained to do. Prevailing literature (Gillam: 1994/ Sheppard: 1990/ Rapaport: 2005) discusses this overlap of roles between CPNs and SWs. This raises the question of why different professionals are employed as care coordinators to perform the same duties, without any opportunity to practice their own profession. However, with the recent changes in the mental health services, both MHSWs and CPNs use a bio-psycho-social model as care coordinators and, in this sense, it is important to understand whether there is any overlap of work in a real team setting.

3.2.8 Multiple Demands & Lack of Resources

Reid *et al* (1999a) report 'multiple demands' and 'lack of resources' as some other pressures that have an effect on social workers in integrated mental health teams.

- **Multiple Demands**

Three quarters of the doctors, all team leaders and one third of the social workers described particular difficulties in managing multiple demands on their limited time, particularly when crisis work or unscheduled emergency contacts needed to be fitted in alongside other routine work. Administrative demands were a major aspect of work found stressful for most community staff, but were especially prominent themes amongst CPNs and social workers. One team leader thought paperwork accounted for around 75% of her time. Community staff described experiencing a variety of negative effects from work overload and the conflict between competing demands. (Reid *et al.*, 1999a:305)

- **Lack of Resources**

Lack of resources was the third most frequently mentioned source of pressure at work. Problems identified here included lack of administrative support, a poor working environment, lack of staff, and also a lack of clinical and

specialist services to which clients could be referred. An absence of adequate community resources such as supported housing and day services was an additional source of pressure at work. (Reid *et al.*, 1999a:305)

Further to this, Singh (2000:420) also reveals that; “Inadequate resources, especially the rapid reduction in acute bed numbers and pressures of bureaucracy, excessive and poorly managed workloads and the blame-culture have all made community working stressful, and in some cases ineffective”.

With these ideas from the literature, it is important to examine the multiple demands made on social workers in the CMHTs and the availability of resources to fulfil those demands. Through this it will be easier to consider how the social work professionals and their work in the CMHTs are affected by the absence of necessary resources.

3.2.9 The impact of statutory duties on AMHPs

The literature reveals some evidence of the impact of statutory duties on AMHPs. According to Evans *et al.* (2005:153) their research shows that 35% of their sample (n=55 ASWs) did not do any other work at all at the same time as undertaking MHA assessment duties; only 19% regularly combined statutory assessments with other work. As Evans *et al.* (2005:153) emphasised, ‘this reflects the often urgent, complex and concentrated nature of ASW assessments as well as the ASWs’ feelings of professional and moral obligation to complete an already started MHA assessment.’ They found that this has sometimes resulted in AMHPs cancelling or postponing their other duties as care coordinators, causing distress to both the practitioners and the service users.

Reid *et al.* (1999a:306) explain the ‘mechanics of detention under the Mental Health Act’ as a further source of stress for ASWs, ‘because of factors such as long waits for police and ambulance, workers’ fear for their own safety and concerns that patient’s might leave before assessment could be completed’.

Evans *et al.* (2005:153) describe how the differences between the constraints faced by the ASWs and non-ASWs. “While ASWs are involved in crucial decision-making about the liberty of individuals, their options are in reality constrained by the legislative framework, and by limited availability of alternatives to admission in many

areas, where as non-ASWs do not have to work with these constraints to the same extent". In addition to this they further explain "ASWs have limited choice about acting in the ASWs role once they are trained, and can face added pressures to do so because of ASW vacancy rates and more than 1/3 of ASWs were thinking of leaving their job".

These studies indicate how statutory duties can have an impact on AMHPs' work.

3.2.10 Challenges from the 2007 Mental Health Act

The recent legislation changes introduced the new role AMHP which replaces the ASW. As Ramon (1996) emphasises, the UK is the only European country that gives social workers a prominent role in the assessments for compulsory admission to psychiatric hospitals. According to Evans *et al.* (2005:145-146), the main argument in favour of using social workers (who have to be approved as ASWs under the MHA of 1983 if they undertake this role) is that they provide an independent judgement, which is less likely to result in clinical team collusion in decision-making, ensuring that the individual's rights are better protected than they might otherwise be. The second argument for the use of social workers in this role is that a social care professional may be better able to broker arrangements for care in the community. Whatever the importance of having social workers as AMHPs, the MHA has now changed and the AMHP role is opened to medical professionals, as explained earlier. Rapaport (2006), cited by Ramon (2009:1620), explains this new situation as a 'loss of the monopoly position social workers occupied in the role of ASW'. Ramon (2009:1620) further explain this situation as follows:

The loss of the monopoly position social workers occupied in the role of the ASW in England and Wales, now open to most mental health professional within the AMHP role (Rapaport, 2006), was particularly justified by the government as due to a lack of research evidence supporting continuance of that monopoly. Indeed, the reluctance of the workforce and of employers to participate in research, to co-own it and to even understand in full its importance is one of the more central weaknesses of the profession as a whole, but one that had affected directly the power of mental health social work. This is an area in which improved collaboration between researchers, practitioners, employers, users and carers could make a difference for the future of mental health social work.

Nathan & Webber (2010:16), citing Pecukonis *et al.* (2003), argue that the uncertainty of the MHSWs role extends to the USA, 'where there are concerns that all social work in health care settings will be consumed by other health professionals'. They find an equivalent form of this crisis in the UK, with the demise of MHSW, and by the bringing of the generic mental health practitioner into action. Nathan & Weber (2010:16) further emphasise that "this has undoubtedly being reinforced by the Mental Health Act 2007, which replaced Approved Social Workers (ASW) with generic Approved Mental Health Professionals (AMHPs) in England and Wales". Terry Bamford, Director SPN and co chair of NIMHE New ways of Working for Social Work group (Bamford, 2007), has also revealed his concerns about the challenges posed by the new MHA.

Social workers in mental health are feeling beleaguered. They are expecting to lose their statutory role as Approved Social Workers. The nature of the training programme for the new role of Approved Mental Health Professional (AMHP) is uncertain. Their nursing colleagues are benefiting from Agenda for Change. They see the serious financial problems of the NHS forcing mental health Trusts to rein back on initiatives promoting social inclusion as they retrench to their core business, which is too often seen as the provision of acute care. The proliferation of new teams and new roles leaves social workers as a minority group in mental health practice, uncertain of their future.

Nathan & Webber (2010:16) also explain that:

Indeed, paradoxically, the move to specialisation in MHSW based within the mental health trust structure has had a powerfully beneficial effect on the representation of professional social work. It is because of the move to specialist training and practice that the skills base in MHSW has markedly increased. However, social workers in these settings are now facing what, potentially, could see the very existence of the profession threatened with a newly created generic mental health worker (and for statutory work, the AMHP), coming into being. The genericist position would mean the end of a professional base in MHSW, whose primary function has been to ensure the long-held tradition of promoting psychosocial perspectives.

A recent study by Svennevig (Svennevig, 2007) shows that social workers are positive about the opening up of the AMHP role to other professionals; however their major concern is about the ability of other professionals to maintain the independence of the role, when it is undertaken by other professionals from health back grounds. These ideas reveal a certain level of uncertainty in the AMHP's role, when undertaken by the health professionals, rather than this change being a

challenge for social workers. In this sense, it is important to look at the real challenges 2007 MHA brings to social workers.

3.2.11 Integration of Social and Medical Services in the CMHTs

In CMHTs management is shared by the health and social services and both services have to be equally represented in the team functioning. As Lingard & Mine (2004:6) explain:

When developing integrated CMHTs, senior management within the NHS and Local Authorities need to ensure that the cultures of their organisations recognise and reward behaviour that promotes integration by staff at all levels of the organisation. Joint working and commitment to this ideology is positively supported within CMHTs if the following is in place:

- A co-ordinator/manager who is skilled in developing joint agency working methods
- pooled budgets with dedicated resources for CMHG activities
- a dedicated/shared office/base
- shared case records
- regular team meetings
- being able to access health/social services resources regardless of discipline
- routine and shared training of health and social care professionals

However, even years after integrated working and CPA were introduced; there are still doubts about the value and practicability of the social model in mental health. There are also signs of social services not being represented accordingly in the team functioning. Some scholars (Ray *et al.*, 2008:3-4) also fear the diminishing of the distinctive contribution of social work to mental health services, as a result of the emphasis on professional collaboration and integration.

The training of social workers in mental health services has been key in providing critical perspectives drawn from a broad range of social sciences. In particular, it has supported social models of understanding, which can challenge or complement clinically-oriented medical models of mental illness. The widespread adoption of anti-oppressive and anti-discriminatory approaches in social work education and training has developed professional

awareness and understanding of issues such as power, oppression and social exclusion, and social workers have become more aware of their own potential for oppression towards users. Their practice is formally underpinned by a commitment to promote social justice and challenge oppression, and social workers are potentially well placed to help other mental health professionals work with the people who use mental health services and collaborate on ways to recovery.

(Ray *et al.*, 2008:3-4)

This literature emphasises on what social workers can bring into enrich the social model in CMHTs. However for social workers to bring this specific contribution to their mental health teams, these teams should have to have well established system of integrated working between the LASSD and the MHT. In this sense, it is important to research the collaboration between these two organisations, which will undoubtedly have an impact on the provision of a better integrated service in the CMHTs.

3.3 Methodological Issues with Past Research

“Research is not always welcomed in social services especially when it concerns an area which gives rise to such widespread anxiety as mental health social work” (Fisher *et al.*, 1984:ix).

Despite the changing nature of the social work contribution to mental health services, it has remained relatively unexplored in the academic literature. There are only a few studies on mental health social work that can be found in England. Most previous studies have not focused directly on the social work role in CMHTs, even though they have attempted to understand issues related to multidisciplinary working as a whole. Most of the research focusing on mental health social work and integrated working has implemented a quantitative approach. Huxley *et al.*'s (2005b) research focused on ASWs in CMHTs and used a postal survey in 1992 and a telephone survey in 2002. On both occasions, they collected data about the numbers of ASWs employed and the number of active ASWs (i.e. continuing to undertake statutory duties under the mental health legislation). The 2002 survey had included a number of open-ended (free text response) questions about the “full complement” of ASWs and vacant posts. However, this research hasn't focused on any aspects of social work intervention within CMHTs.

A qualitative study of attitudes of service managers and academic staff, involved in social work education (McCrae *et al.*, 2004), explored the prospects for mental health social work in the eyes of key stakeholders; it employed qualitative interviews with senior mental health service managers and academic staff from institutions providing social work training. It is clear that in this research the voice of the social worker is not properly heard, as the researchers collected data only from the service managers (who were not all from social work backgrounds) and academics, who did not necessarily have sufficient experience of working in the CMHTs.

'The National Survey of Approved Social Workers in UK: Information, Communication and Training Needs' (Fakhoury and Wright, 2004) was based on postal questionnaires, sent out to a random sample of 200 ASWs attached to CMHTs. They recorded only a 56% response and I consider that such a low return rate would not represent the overall situation of ASWs in the UK; this research did not focus on the other MHSWs in the CMHTs.

A study by Svennevig (2007) directly focused upon the social worker's role in a particular integrated mental health service. This study was carried out in 2007, using a variety of methods in collecting data, including written questionnaires, 6 monthly reports and supervision and case load listings and a review of some government policy documents. This research of course collected some valuable data pertaining to the social worker's role in mental health teams. However, it is still missing the potentially valuable contribution from having direct contact with the social workers in person, listening to their voices and observing their work. The limitation with a questionnaire based survey is that it does not always provide the opportunity for a researcher to achieve an in-depth understanding of the feelings and thoughts of busy staff members, who are already struggling to complete a heavy load of paper and computer work related to their jobs.

I suggest that, given the limitations of the above examples, it is clear that any research focusing on social workers' role in multidisciplinary teams must be with them, listen and observe them in order to understand the reality of their role, which is not clearly revealed in the prevailing literature. A qualitative study, directly engaging the social workers in person and in their work places, provides the opportunity to understand how social workers interact with other mental health professionals in

their teams and with its service users and their views and attitudes towards social workers. Social workers are required to be in CMHTs and do not work according to an individual agenda, where other people's views are crucial in reaching an exact idea about the social workers' contribution. Hence it is obvious that analysing an interview or a questionnaire only offers no opportunity for any researcher to clearly understand the real team setting where the particular social worker is working. This is also a real disadvantage as the team settings vary. From the few examples of research discussed above, it is clear that most of the methods employed in previous studies have not been totally successful in collecting the richest data pertaining to the social workers role. As described, they seem to be somewhat distracted from the real scene, which is the normal daily functioning of a social worker in a mental health team. This is where the importance of an ethnographic study emerges. In the prevailing literature, it is hard to find any research which had employed an ethnographic approach to understand the social work contribution in mental health setting, and this is where the uniqueness of my own research lies.

3.4 The Theoretical and Conceptual Frame Work

3.4.1 The Relevance of the Model

The theoretical and conceptual framework employed in this study is the 'Ecology of Human Development Theory' by Bronfenbrenner (1977). There are a few reasons for selecting this framework to develop this research study. Basically, this model was selected to guide this research because it offered a concrete framework to account for the contribution of MHSWs in CMHTs. This research study aims to use the historical information on mental health social work, together with MHSWs' current experiences and perspectives, alongside the perspectives of other mental health professionals and service users, to describe and understand in more detail the mental health social work contribution to community mental health services. To fulfil this aim it is vital to understand mental health social work as a part of a system, rather than an individual profession. This can only be done by placing social workers in their team environment surrounded by their team members, team leaders and, importantly, with the people who use their services. This small, but diverse, system

is the CMHT, which is governed by the MHT and the LASSD. These two organisations are governed by government policy and regulation and it is understood, through reviewing the literature, that government policy and legislation are also affected by the societal and global issues.

In this sense it is clear that mental health social work lies in a nested interacting system and, in order to understand social worker's role and contribution, it is important to understand this whole system rather than studying them as separate individuals. Bronfenbrenner's Ecology of Human Development Theory allows space to understand this whole system by placing these different parties into an integrated and nested system, making it clear and easy to understand the influence and collaboration between each system. The theory also facilitates an understanding of the diverse nature of mental health social work. MHSWs and AMHPs roles are diverse in the CMHTs as they interact across a range of domains, including practicing/balancing statutory and non statutory duties, team working and organisational constraints, as the only professionals from a social background in the CMHTs. In this sense Bronfenbrenner's theory is very practical and applicable in understanding this whole system and all these other issues surrounding those systems.

3.4.2 The Ecology of Human Development Theory (Bronfenbrenner, 1977)

Bronfenbrenner described the ecological model as; 'a holistic, dynamic-interactional systems approach, based on human ecology. It can be visualised as a nested arrangement of interacting systems, rather like a set of Russian dolls, with the individual located at the centre. Each system operates fully within the next larger sphere' (Bronfenbrenner, 1979). Bronfenbrenner (1977) originally used his theory to examine a child's human development in respect of:

- (1) The individual's perspective of the environment
- (2) The environment surrounding that individual
- (3) The dynamic interaction between the individual and the environment

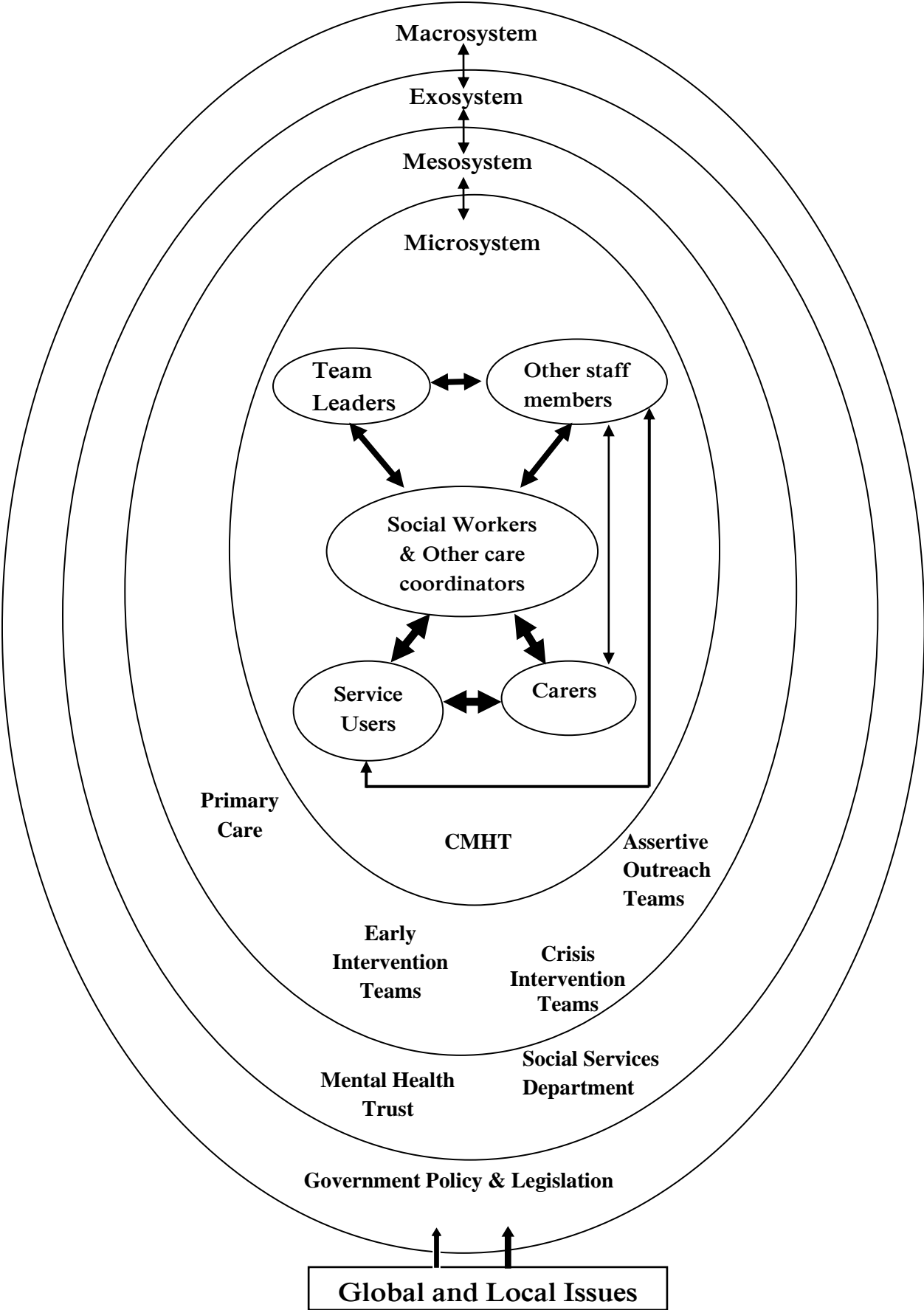
Hawley (1950) introduced 'social ecology' as the study of people in an environment and the influences on one another. After this, Urie Bronfenbrenner (1977/1979)

refined his theory to include four levels, the micro, meso, exo and macro. These four levels represent the influences as interpersonal or individual, organizational, community and intercultural. There are many adaptations to this original theory by Bronfenbrenner. Adeyi *et al* (2000:284) explain: “The Ecological Framework has gained increased recognition in the field of health promotion and has been applied to investigations of many different health issues”. However, this is probably the first time that this model has been applied to understand the role of MHSW in the interdisciplinary CMHT environments. This model describes four levels of influence on social worker’s contribution to CMHTs which are:

1. Microsystem – Individual social workers/service users/carers/team members and team managers
2. Mesosystem – Primary Care and other mental health teams
3. Exosystem - Mental Health Trust and Social Services Department
4. Macrosystem - Government Policy and Legislation

This is shown diagrammatically in figure 3.1 in the next page.

Figure 3.1: The Ecological Model



Since it could not be assumed that team membership mediated the ways in which team members experienced their work, it was important to examine professional identification alongside team identification. Since the salience of team membership for different disciplines could not be predetermined, inclusion of professional identification allowed exploration of whether these two identifications were in the main complementary or competing. It may be that in order to feel a positive identification with a group, an individual has to be able to discriminate the team's aims and their own role in achieving it.

In understanding this microsystem: the CMHT, it is important to identify the different professionals working in the CMHTs, their roles and responsibilities and their relationship with other staff members. Below I have used the definitions (The Royal College of Psychiatrists, 2009) to define some of the key professionals in CMHTs.

Clinical Psychologists

All psychologists entitled to call themselves clinical psychologists must be registrant practitioner psychologists with the Health Professions Council (HPC), which is the regulator of health professionals. Chartered Psychologists are those who have fulfilled the criteria set down by the British Psychological Society (BPS). The BPS maintains a Register of Chartered Psychologists that is open and available to the public, both in written form and on line. Clinical psychologists are trained in psychological treatments. They will usually meet regularly with service users for a number of sessions to talk through problems and find ways of solving them.

Nurses

Nurses in the CMHTs (CPNs) are registered with the Royal College of Nursing and work outside hospitals, usually visiting service users in their own homes, out-patients' departments or family doctors' surgeries. CPNs can help people to talk through their problems and give them practical advice and support. They can also give medicines and monitor their effects. Some nurses have received extra training in particular problems and treatments, such as eating disorders and behaviour therapy and are sometimes called nurse therapists.

Occupational Therapists

Occupational therapists (OTs) belong to the Royal College of Occupational Therapists and they help people to regain skills for service users' daily lives and help them to regain their self-confidence. This can be through doing practical things in a relaxed environment, or talking with other people in groups.

Pharmacists

Pharmacists train for five years to become specialists in medicines and are registered under the professional body of Royal Pharmaceutical Society. As a part of a mental health team, they offer expert advice to doctors and nurses about the benefits and side-effects of different medications. They are also available to talk to patients and their carers about their medication and answer their questions.

Psychiatrists

A psychiatrist is a medical doctor with special training in mental illnesses and emotional problems. They belong to the Royal college of Psychiatry. Each team has a consultant who has completed their professional training and is often involved in the first assessment of someone's problems. They may also have training in psychotherapy.

Social Workers

Social workers are registered with the GSCC. They are an essential part of the CMHT, although they may be employed by the LA rather than the MHT. They may be able to help with financial and housing problems and play an important part in helping with child-care issues.

Approved Mental Health Professional

The Approved Mental Health Professional (AMHP) will usually be a social worker, but can be any member of the CMHT. They have had further training to equip them to assess if someone needs to be taken to hospital using the MHA. They cannot decide to admit someone to hospital on their own, but will usually need the agreement of two independent doctors.

The care coordinator

The Care Coordinator is the main link between the mental health team and the person who uses the service. Usually in CMHTs care coordinators are a CPN, OT or a SW.

Others

Besides these main professions, CMHTs may include other sorts of workers. These other professionals can include outreach workers, mental health workers, benefits workers, support workers, recovery workers, vocational therapists, art therapists and

psychotherapists. More and more staff, without professional qualifications in health or social care, also work with such teams because of their special knowledge and skills. These include people who have had mental health problems, advocates, and workers from day centres or housing organisations. Specialist old age psychiatry teams may include other professionals such as speech therapists or physiotherapists. These workers may also see people in their own homes.

3.4.3.1 Team working in the micro-system

The integration of service provision, which resulted in joint working in the CMHTs, is believed to increase the quality of care as well as enhance service efficiency and cost-effectiveness in the field of mental health. The Royal College of Psychiatrists (2009) explains:

As well as their professional skills, the team members will have experience in understanding the distress that goes with mental illness. They can all offer support and encouragement. By working together, they try to make sure that the team has a clear picture of your (service user) difficulties and strengths. Then, they can plan the right help for you. Staff work closely together and so they often learn a lot from each other. You may find that nurses can deal with many social and work-related problems and that Occupational Therapists and social workers know something about medication.

In providing an effective service for the clients, it is essential for the team to be well coordinated. However, with a number of professionals from different educational, training, professional and service back grounds working under the same roof, there are always issues with team working in CMHTs. Goodwin (1997:141) reports that:

Even in countries such as England where community care policy is under central direction, there have been substantial problems with coordinating services. Overall, the lack of coordination between services involved in the development of community care has proved to be a substantial problem in many countries.

Rees *et al* (2004:528), citing a number of authors, emphasise that in order to achieve the benefits of integrated working, integration needs to occur in; strategic planning and development, management processes and direct patient care. They further describe that:

At an operational level, services in the UK are generally organized within community mental health teams (CMHTs) which comprise of both health and social care professionals). However, independent professional cultures and differing models of mental illness have been found to lead to interprofessional conflict and role ambiguity within CMHTs. These difficulties are compounded by a lack of joint management and accountability. At a strategic level, parallel or even competing policies from health and social care agencies (e.g. the care programme approach and care management) can also compromise and confuse joint working.

As an integral and important part of the CMHT, social workers interact with all the other mental health professionals on a daily basis, basically in the same way that other mental health professionals do in these teams. In the microsystem this interactional process is very important for the individual worker, as well as for the team functioning. In this regard, when studying the social worker's role in the CMHTs, it is important to get the opinions of the other professionals working with them in this interactive environment. This is to help to identify how other mental health professionals perceive the role of their social work colleagues in that particular environment. In the same way, in this micro system, social workers interact with the service users on a daily basis. Service users also can provide a good account of their care coordinator, as care coordinators are the main point of contact between the service user, the CMHT and its services. Subsequently, perspectives of the other professionals as well as the service users definitely offer a broader understanding and clarification of the social worker's role in the microsystem.

The next levels in this ecological system are the mesosystem, exosystem, and macrosystem. These are settings in which the social worker may or may not be present but have powerful influence on the social workers' functioning in the CMHT.

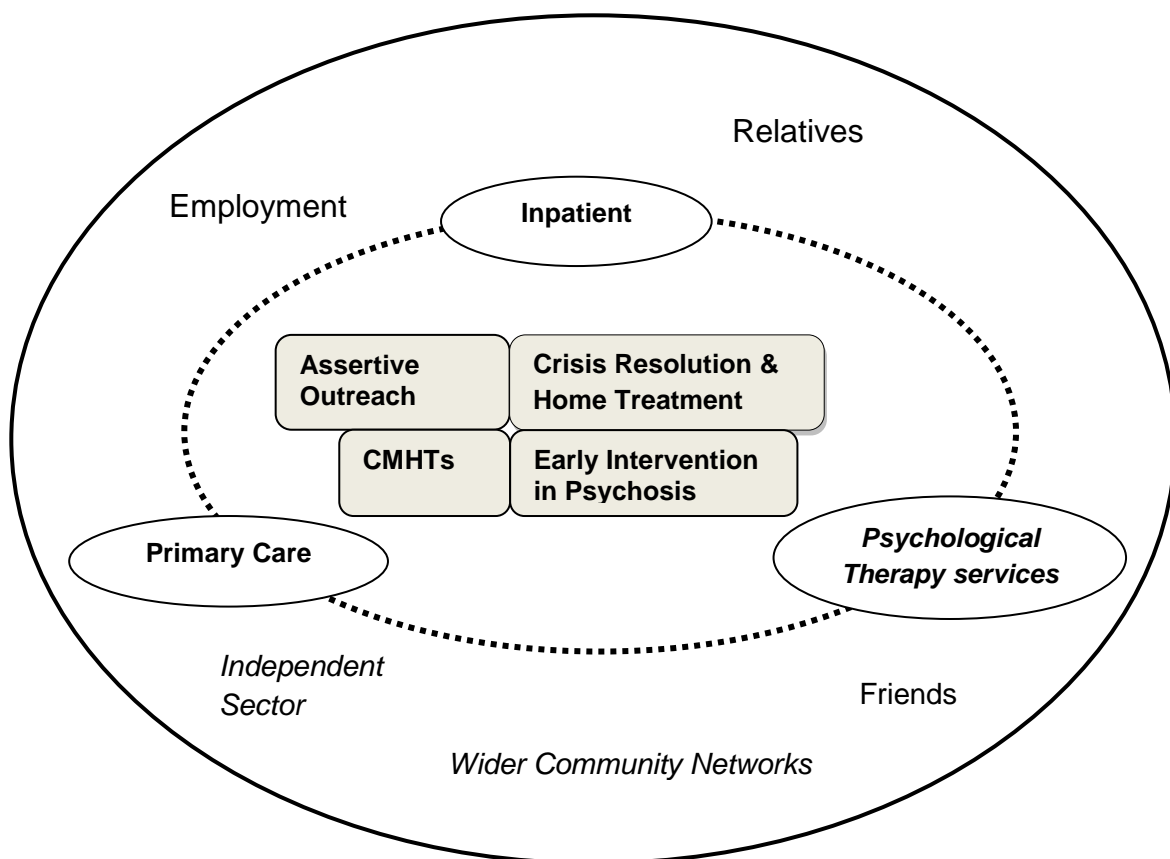
3.4.4 Mesosystem – CMHTs, Primary Care and other Mental Health Teams

The mesosystem consists of the other Mental Health Services functioning under the same MHT. Until the 1990s, it was only the CMHTs that operated in the community. In July 1998 the Secretary of State for Health, Frank Dobson, declared that 'community care had failed' and called for a 'third way' in mental health that would "steer a path between a reliance on putting all mentally ill people in institutions 'out of sight – out of mind' and community care where people with mental health problems

could be 'left off the books' thereby putting themselves and others at risk" (Fennel, 1999:104). This statement led the Department of Health to invest in new mental health services, which are distinguished from other generic CMHTs, to support the delivery of adult mental health policy locally. The MHPIG identified these new services as the Assertive Outreach Teams, Crisis Resolution and Home Treatment Services and Early Intervention for Psychosis Services. Now these new services work alongside the Primary Care Services and the CMHTs.

Figure 3.3 below shows the systemic relationship between different teams within the mental health care system.

Figure: 3.3: Systemic Relationship between Different Teams within the Mental Health Care System



(Bailey, 2012)

As Bailey (2011 (in press)) describes here, 'all of the above 'hard system' elements are connected by the Care Programme Approach that hinges upon collaborative working between mental health professionals and agencies (DH, 2008)'. This provides a picture of how different teams are joined together in providing services for clients. Below I briefly explain what each of these teams do and their relationship with the CMHTs. By doing this, I attempt to clarify what sort of an impact these teams could have upon social workers working in CMHTs.

Primary Care

The MHPIG (Department of Health, 2001:62) reveals that only a very few Primary Care Trusts (PCTs) provide as well as commission the full range of mental health services. Typically more specialised services are provided by MHTs, and a variety of key services are provided by local councils as well as in the non-statutory sector, and the charitable and voluntary sectors. The MHPIG emphasises "this means that the quality of work at the interface between primary and specialised services, or between health and social care, or statutory and non-statutory services, are very important and a number of models exist for the provision of primary and specialised mental health care, designed and to improve the quality of partnerships at the interfaces" (Department of Health, 2001:62). Goodwin (1997:90) reports that in England, unlike in any other European country, the role of general practitioners in the identification and treatment of mental health problems has been encouraged and an estimated 9% and 35% of GPs time is taken up with dealing with mental illness (Royal College of General Practitioners, 1987). The MHPIG identifies this as 'a way to promote more effective partnerships between primary and specialised services, and ensure that patients can access services more easily'.

The drive towards a primary-care NHS that characterised government policy in the early nineties, notably with the introduction of GP fund holding, has been a significant factor in influencing the work of CMHTs. The financial mechanisms that have allowed the GPs to buy community services, using money top sliced from funds that would formerly have been allocated to Trusts, placed many CMHTs in a contradictory position.

(Onyett, 1999:21)

This means there is always a direct relationship between the Primary Care and the CMHTs and the strength of this relationship is very important for the effective functioning of both groups.

Crisis Resolution and Home Treatment Teams (CRHT)

CRHTs are for adults (16 to 65 years old) with severe mental illness with an acute psychiatric crisis of such severity that, without the involvement of a CRHT, hospitalisation would be necessary. Crisis resolution/home treatment can be provided in a range of settings and offers an alternative to inpatient care and is a 24 hours a day and 365 days a year service. These teams are multidisciplinary and the team members come from both health and social services.

As explained by National Institute for Mental Health in England (NIMHE, 44) “given the wide range of functions of the CMHT, the CHMT has some natural limitations on its flexibility and adaptability. CMHT workers will have booked commitments for assessment, direct sessional work in Primary Care settings, and structured case management responsibilities in the community. Out of hours capacity is very limited”. In this sense the relationship between the CMHTs and the CRHTs is very important, as CRHTs can support and complement CMHTs by ‘offering a more intensive and flexibly responsive service during crisis, supporting the additional CMHT input which is often required to maintain functioning in the community during difficult times and responding to urgent referrals directly or after preliminary screening by the CMHT’ (NIMHE). The many advantages of a well established relationship between these two have been identified by the NIMHE (44) .

- The large majority of referrals from the CMHT to CRHT would lead directly to CRHT support.
- Productivity of having representatives of the CRHT team regularly attending the CMHT weekly team meeting.
- Care Coordinators in the CMHT can alert CRHT staff of concerns about individuals (prior to crisis).
- Regular meeting between the two teams keeps both teams informed, and makes for easier liaison with care coordinators around arranging joint visits during the phase of acute care.

- The CMHT can be alerted by CRHT that they have started work with a new individual to the service and that further ongoing input from the CMHT is required. This advance planning from both teams can allow time for appropriate and considered allocation of case coordinators from within the CMHT.

These advantages are expected to reduce the work load and stress among all the care coordinators, including the MHSWs and the AMHPs in the CMHTs, and also save a considerable amount of time.

Assertive Outreach Team (AOT)

The AOTs, also known as 'Assertive Community Treatment' teams provide long term and intensive support to people who are suffering from a mental health problem and are judged to be the most vulnerable. AOTs support people who have historically avoided contact with mental health services. Care and support for these people are offered in their homes or some other community setting, at times to suit them. AOTs are multidisciplinary and the team composition is basically very similar to a CMHT. A co-characteristic of a AOT is the low ratio of service users to workers compared to the CMHTs (usually ten clients per caseload) (The Sainsbury Centre, 2001).

With regard to the relationship between the CMHTs and the AOTs, basically AOTs accept referrals from CMHTs and transfer service users back to CMHTs when they have maintained stability over a six month period. The care co-ordinator is responsible for managing the process, which involves joint visits with the proposed care co-ordinator from the CMHT. If there is a dispute between the AOT and the CMHT over the responsibility for a case, then it will be referred to the appropriate CMHT Manager and AOT Manager to resolve. Importantly, all CMHT's have an identified link worker from the AOT, who will attend CMHT meetings at a mutually agreed frequency (Dorset Health Care, 2003:6-7).

This mutual relationship between the AOTs and the CMHTs is important in providing an effective mental health service for service users. It is also important for the care coordinators in the teams, as this relationship can help them to organise their care coordination work in a better, organised manner.

Early Intervention in Psychosis (EIS)

The EIP Service is a specialist service for people aged 14-35 with a first presentation of psychotic symptoms, or people in the first three years of psychotic illness are treated. The MHPIG (2001:43) explains that an EIP service should be able to:

- Reduce the stigma associated with psychosis and improve professional and lay awareness of the symptoms of psychosis and the need for early assessment.
- Reduce the length of time young people remain undiagnosed and untreated
- Develop meaningful engagement, provide evidence-based interventions and promote recovery during the early phase of illness Early intervention is a specialist service.

The EIP service takes direct referrals from the CMHTs, Child and Adolescent Mental Health Services (CAMHS), primary care, CRHT team, forensic services, AOTs, other mental health services and acute medical services (including A+E). The Dorset Health Care NHS Trust (2003:Section 6.3) identifies the close link between EIP and CMHT as follows:

CMHT's continue to be responsible for the care of an individual when referred until the EIS have completed their assessment and it has been agreed who is appropriate to take on the care of the individual. In the case where the individual referred is not suitable for the EIS then this is discussed with the CMHT. In such circumstances this will be discussed with the relevant CMHT and following agreement a letter detailing the outcome of the assessment and reasons why the individual is unsuitable will be sent to the CMHT and other relevant professionals involved, i.e G.P. When appropriate joint assessments and joint working will occur with CAMHS or the CMHT's to ensure an individual's specific needs are met.

As described above the strength of the relationship between the CMHT (micro system) and the other mental health services; PCT, CRHT, AOT, EIP (mesosystem) helps to improve the coordination between these teams, which in turn helps in the effective management of the teams. This effective management definitely helps to improve the work conditions of each staff member within the team, including the MHSWs and the AMHPs, helping them to extend a better service to the service users. As the NIMHE (45) emphasises:

Because of the presence of Crisis Resolution/Home Treatment, the CMHT is less concerned with fire-fighting all problems while trying to maintain a focus on severe mental illness. Staff in the CMHT can more fully deliver a range of therapies and support in a planned way, including direct work and liaison in the GP surgery. Delivering specific interventions like cognitive behavioural therapy needs time and structure in the workload planning of CMHT workers. This can lead to better relationships between GPs and their mental health colleagues.

Under these circumstances, understanding the relationship between the microsystem and the mesosystem is important in understanding social worker's role in an overall perspective.

3.4.5 The Exosystem

The Local Authority Social Services Department (LASSD) and the Mental Health Trust (MHT)

In the conceptual and theoretical framework of this study, the exosystem refers to two organisations, namely the LASSD and the MHT. As permanent members of the CMHTs, social workers become regular members of these two organisations and are affected by the different practices that occur within them. Hannigan (1999:26), citing Muijen & Ford (1996), describe how:

The implementation of the 1990 Act made the purchasing of mental health care the responsibility of three separate groups: local authority social services departments, health authorities and GP fund holders. Joint commissioning by these three groups and jointly agreed strategies for the prioritisation of services for people with severe mental health problems are now amongst the recommended 'basic requirements' for effective interagency working (Health, 1995).

Social Services Departments are part of each LA throughout the UK. Because of government policies and new ways of financing services, health and social services and the voluntary sector are becoming more intermingled. CMHTs, run by the NHS, employ professionals from both health and social services. The majority of social workers work in integrated, multidisciplinary teams, with a mixture of secondment to or direct employment by MHTs. The LA employs and appoints all the AMHPs and most of the MHSWs who are on its payroll. Some MHSWs are appointed by Agencies. However, there are some disparities in pay and conditions between NHS

and social care staff (CSIP, 2006:27-30). Huxley *et al* (2008:481) also acknowledge this by stating that “social Care, in partnership contexts, can be marginalised within a health paradigm”. Hannigan (1999:29) describes a range of structural, operational and professional level barriers that could possibly challenge the effective and efficient provision of community mental health care. The structural level barriers include:

- Multiple purchasers with different principles, priorities and mechanisms.
- Arbitrary divisions of responsibility between the ‘health’ and ‘social’ domains, with separate policy and guidance for each.
- Unshared geographical, financial and other boundaries; and
- Unpooled resources.

This literature shows that there are barriers related to joint working between LASSD and the MHT which can make an impact on the smooth functioning of the CMHTs which in turn can impact the social work contribution to these teams.

3.4.6 The Macrosystem

The macrosystem here refers to the Policy and Legislation that impact upon mental health social work practice and the institutions in which this is delivered.

Government Policies and Legislation

Looking back at the slow pace of de-hospitalisation in Britain, Jones (2000:183), citing Jones (1993), explains that “this time lag has been attributed to the lack of centralised co-ordination and legislative commitment to mental health reforms by successive British governments”. She contends that “the impetus for the quickening pace of psychiatric hospital closure and the provision of community-based mental health facilities in Britain has been attributed to the ideology of the ‘New Right’, as introduced into British politics by the Conservative government of Margaret Thatcher in 1979”. As Jones (2000:183) further explains:

This change in the national political context has had two major consequences for mental health service provision: firstly, the processes of de-hospitalisation

and de-institutionalisation became incorporated into the general restructuring of health and social care provision, culminating in the 1990 NHS and Community Act; and secondly, the influence of New Right politics resulted in the tightening grip of central government over local government, with the introduction of more centralist and interventionist policies than had been experienced in previous decades (Mohan, 1995) it is argued that the power shift between central and local government in Britain, since 1979, has created more effective state mechanisms to enable the top-down implementation of national policies to the local level.

This literature shows that the mental health policies in the UK have changed with governments. Table 3.1 below, presented by Goodwin (1997:112) summarises the variations that have arisen within post-war mental health policy development according to different regime types.

Table 3.1: Post-war Mental Health Policy Development According to Different Regime Types

	Onset	Pace	Style
Liberal	Early	Fast	Emphasis upon rehabilitation. Poor quality of long-term support services.
Conservative	Late	Slow	Emphasis upon maintaining the status quo. Minimum state provision based on the principle of subsidiarity.
Social democratic	Late	Fast	Emphasis upon social rights. Good-quality services.

(Goodwin, 1997:112)

In summary Goodwin explain this table as follows:

Governments within conservative regimes may well tend to be more proactive in organising the administration and delivery of services. Social democratic regimes may face curtailment of the quality of social care services, together with a refocusing of service provision upon returning people to their place in the labour market. Liberal regimes may well face a reversal of policy development (Goodwin, 1997).

According to Carpenter (2000:611) Goodwin's analysis recognises "that the varying political nature of welfare regimes has significantly mediated pressures to social control and economic rationalisation". He argues that "these are most pronounced in 'liberal' regimes ruled by market ideology and limited welfare rights, where there is an early shift to the community in the 1950s and 1960s, presumably referring to Britain and the USA". Huxley *et al* (2008:49) also explain the influence of government type on policy changes as:

In the UK, the New Labour Government introduced a focus on severe illness in the National Service Framework (Department of Health, 1999) but also modernised the care planning process (Kingdon, 1994); Department of Health, 1999a), community mental health services through the introduction of new teams (assertive outreach, early intervention and crisis resolution) (Department of Health, 2000) and partnership mental health trusts, which permitted the employment of social workers and other social care staff from the local authority in National Health Service (NHS) trusts; it was argued that the changes would produce a more integrated service (Venables *et al*, 2006). All these changes were intended to produce better outcomes (Holloway, 2001).

Goodwin (1997:160) argues that "rather than being a policy designed first and foremost to address the needs, wishes or interests of people with mental health problems, its primary purpose was to reconcile the various and often conflicting pressures upon governments". Jones (2000:183), citing Wilson & Game (1998), explains that:

In Britain, with increased centralisation, there are more effective state mechanisms to enable the effective top-down implementation of national policy to the local scale. This is not to say that all autonomy at the local level has been taken away by national government in Britain, but that the opportunity for local discretion has arguably been reduced.

These literature sources show us that the nature of the government can have a major influence in forming the mental health policy of a particular country. This influence can in turn affect the social work professionals working in the field of mental health.

3.4.7 Global and Local Issues

In this theoretical and conceptual framework, global and local issues refer to how the national policies and legislation have changed over the years, in accordance with the local needs as well as global changes and needs and also, importantly, with the new trends in mental health systems. It is important to understand these changes as government policy and legislation in the macrolevel are passed down to the two organisations; the MHT and the LASSD in the exosystem, then to the other mental health teams in the exosystem and the CMHTs in the microsystem, where they are implemented. As members of the CMHTs, social workers have to follow this policy and legislation and, in this sense, that global and local issues can clearly have an impact on social workers in the microsystem.

Mohan (1996) has developed an approach in relation to the British NHS reforms of the 1990s, which looks at policy issues at the; 'Macro-' (international), 'Meso-' (national) and 'Micro-' (local) levels. Carpenter (2000:610) reports that Mohan has pointed out "the British reforms occurred in an international context in which there was pressure to converge towards cost-containment and institutional change encouraging decentralisation and choice". Mohan (1996:683), in this analysis, under the micro level explains the enduring dilemmas of welfare provision as "at this level the focus is on the processes operating either internally within the NHS or within British society. The conflict between managerial and professional prerogatives is a persistent theme in analyses of health care policy". Carpenter (2000:610), citing Mohan (1996), maintains that in this analysis, at the micro level, pressures such as the interplay of managerialism, professionalism, labour market shifts, technological changes and consumerism may also operate.

Pilgrim and Rogers (1999), cited by Carpenter (2000:614), reason:

The 'risk' of violence and disorder by mentally disturbed people has been a significant (often disproportionate) policy concern, leading to delegation to professional groups and debates about procedures and rights. At the same time there has been considerable national variation in the way that this has affected particular mental health policy regimes, in which interest groups and the mass media have played a significant role. They make the important point that civil liberties issues have figured strongly in the USA illustrating the strength of 'liberal' traditions, whereas professional discretion has been a stronger feature of British and European systems. In both Britain and the USA

a strong 'anti-psychiatry' tradition emerged which also portrayed mental health users as the victims and not just the perpetrators of violence.

This national/societal influence towards policy changes was further described by Goodwin (1997:146) as follows:

1. The National Schizophrenia Fellowship, a charity representing service users and their families, supports a suspension of further deinstitutionalisation until greater resources and a more adequate organization of services within the community can be created.
2. Since New Year's Eve, 1992, when Ben Silcock climbed into the lions' cage at London Zoo, the attention given to the plight of discharged mental patients and also to those people they have attacked has increased dramatically.
3. The killing of Jonathan Zito by Christopher Clunis, of Jonathan Newby by John Rous, and a number of other cases have helped generate a moral panic over the continued running down of the mental hospitals.

Reflecting these concerns, in 1996, the government announced plans for the building of 5,000 beds in new residential units to accommodate psychiatric patients who have failed to cope in the community. Goodwin also identifies financial pressure as a reason for moving towards community care in the UK:

The advanced capitalist societies are increasingly prone to ever more severe economic problems, and consequently ever higher levels of restraint within state welfare budgets are increasingly evident. It is not simply that the development of an adequate community care policy has suffered as a result of a lack of finance, but rather community care policy has arisen precisely because it allows for a cost-cutting process made necessary by the nature of the socio-economic system (Goodwin, 1997:51).

In establishing his position, Goodwin (1997:52) quoted Andrew Scull's (Scull, 1984) ideas, that "the process of deinstitutionalisation has primarily been the result of a need to reduce costs, and the ideology of community care has provided the legitimating cover under which the programme has commenced". He also explains that scholars, like Mangen (1987:77) and Ungerson (1995:39), have also seen 'deinstitutionalisation policies as results of 'cost cutting' and 'desire to save money' in many European countries and these scholars have concluded that 'these policies are driven largely by ideas of reducing expenditure – namely that it is cheaper and more cost-effective to care for people in the "community"'.

Nathan & Webber (2010:17) provide an account of how global issues have been influential in shaping the UK mental health policies, as follows.

Mental Health Services are largely shaped by government-initiated policy agendas that claim to be evidence-based. The introduction of assertive outreach teams in the UK, for example, was based on the US model of assertive community treatment (Stein & Santos, 1998) which was effective in reducing hospital admissions and time spent in hospital (Marshall & Lockwood, 1998). Assertive Outreach teams were introduced in the UK despite national research evidence showing that there were no significant gains when compared to standard case management (Burns *et al*, 1999).

Carpenter (2000:610), citing Bourke (1998), argues that:

The internationalisation of mental health was something which emerged within the wider left-liberal climate of anti-facism, reform of the world economy and creation of institutions associated with new attempts to promote security through the United Nations. Out of this geopolitical climate the World Federation for Mental Health formed and the Mental Health Committee of WHO was established. This latter was strongly influenced by the 'advanced' models that had been pioneered by British-American war-time psychiatry, in conditions that had immensely boosted the profession's scope and reputation.

It is also evident throughout the literature that the 'Strength Model' in the US and the 'Trieste Model' from Italy has supported global trends towards shaping mental health policies throughout the world. All these prevailing ideas reveal that there are several local and international trends influencing the development of mental health policies in the UK. From these sources, it is clear that globalisation and societal influences have made and can make an impact on the forming of government policy and legislation.

According to Sheppard (1990:148), social policies have a great influence on the position of the ASW.

The activities of the ASW have an even wider context than that of the immediate family or locality; that of social policy relating both to mental health generally and compulsory admission in particular. In approaching this area we have come full circle, because the concept of ASW as gatekeeper is dependent on social policy which grants ASWs their powers and duties through the Mental Health Act. Social policy, then, refers in this context to the legislation and policies which underlie the compulsory admissions, and which governs the circumstances and procedures in which they take place.

These literature sources assure us that the Government Policy and Legislation has been influential in changing mental health service provision in the UK and, as a result, had helped shape the social worker's role.

3.4.8 Conclusion

The prevailing literature reveals a number of issues pertaining to the social work profession in the CMHTs. In general, there are issues for both MHSWs and the AMHPs regarding the clarity and definition of their role and they seem to face a conflict with this. Gaps in skills and knowledge, multiple demands combined with lack of resources, heavy case loads, professional rivalry and overlap in work, are identified in the literature as the problems social workers face in integrated and multidisciplinary CMHTs. These issues had predominantly caused them stress in their work and the literature reveals high levels of job burnout among social work professionals in CMHTs. AMHPs, in the CMHTs, experience some problems specific to their role, as a result of engaging in both statutory duties and shouldering a considerable amount of care coordination work. These include the obligation to prioritise the MHA assessment duties, which can require the cancellation and missing of care coordination duties, alongside other sources of stress, like fear of their own safety, long waits for Police and ambulances and the emotional exhaustion of sectioning a service user. This chapter also discussed the possible challenges the 2007 MHA could bring to the social work profession, by opening the AMHP role to non social work professionals. These include the loss of monopoly position social workers occupied in the role of ASW and maintaining the independence of the role when undertaken by medical professionals.

The methodological issues in the review of past studies of mental health social work in CMHTs have been identified. They are that this research has not focused on MHSWs and AMHPs particularly in CMHTs, it has not taken the views of service users and other professionals working in these teams into consideration and most of the research has relied heavily on quantitative methods and has not focused on the importance of understanding the real work setting.

In this second section of the literature review, I have explained the conceptual and theoretical framework used in my own research. I have utilised the 'Ecology of Human Development' Theory by Bronfenbrenner (1977), which helped me to identify the social work professional's position in a nested culture. This concept takes account of the individual worker's personality, and the understanding of the social work role by other professionals and service users within the CMHT, the impact of

the MHT and LASSD, the effect of government policy and legislation and societal and global influence towards social work contribution to CMHTs.

In the next chapter I will present a detailed account of the design of this study, the methodology utilised, including the data collection and the data analysis processes and all the ethical issues pertaining to the research.

Chapter Four: Research Design and Methodology

4.1 Introduction

This chapter describes the evolution of this project; the research design and methodological considerations and the field work process. This is organised into six sections, starting with the project design and preparation in 4.2, in particular the ethnographic approach and the sampling procedure. Issues related to accessing the teams and developing relationships are also discussed in this section. In section 4.3 the methods used to collect primary data are outlined, these include participant observation and semi structured interviewing. This section also includes the piloting of interview guides, secondary data collection and the data recording issues. Section 4.4 details the use of NVivo to organise the large amount of data collected and explains how these were analysed, using a grounded theory approach. The penultimate section, section 4.5, describes the process for gaining ethical approval from the relevant authorities to commence the study and the ethical considerations of participant involvement. Finally, in section 4.6, I discuss some of the drawbacks of the approach and reflect on the research design and methodology as a whole.

The research is designed to meet the aims and objectives of the study; therefore it is worthwhile to reiterate them here. The underlying purpose of this study is to understand the mental health social work contribution to community mental health services, with the aim of improving the quality of that contribution within contemporary mental health services. This, I hope, will result in improving outcomes for service users, carers and communities and will also contribute to the development and profile of social workers as a professional group. To achieve this aim, I endeavoured to understand mental health social work interventions in respect of: social work professionals' involvement in care planning, assessments of individuals' needs and social care interventions, their specific/unique contribution to interdisciplinary mental health teams and services, MHA assessments (statutory role), challenges posed by the 2007 MHA to MHSWs' job prospects, barriers and difficulties in integrated working and their educational and training needs, in order to develop their contribution for a better service.

As described in the literature review, social work professionals are a part of an integrated system which has connections with other systems in the field of mental health service provision. To find answers to the research questions and fulfil the research aims and objectives, it is very important to place the social work professionals in this nested system and understand them as a part of the system, rather than as single professionals. Therefore, in order to meet this requirement, I employed Urie Bronfenbrenner's Ecology of Human Development Theory (1977) as the theoretical and conceptual framework of this study.

4.2 Project Design and Preparation

4.2.1 A Qualitative Approach – An Ethnographic Study

The literature review reveals that most of the earlier research on mental health social work uses methods such as interviews or questionnaires. These studies have drawn conclusions based upon reductionist approaches and in the absence of any direct observations of mental health social work in practice. Consequently, these accounts are limited and do not necessarily provide a true reflection of how mental health social work professionals function in a real setting. Criticisms of these methodological approaches highlight that participants may not bother to provide detailed answers to a questionnaire and some might not even return the questionnaire at all. The prevailing social work literature draws attention to the heavy case loads due to staff shortages in the CMHTs (Huxley *et al.*, 2005b), which would suggest such reductionist approaches are likely to yield a poor response. This heavy work load is exacerbated for AMHPs when they are on duty and have to work out of hours, on weekdays or at weekends. This would suggest that staff have limited time to provide detailed answers to a questionnaire. Also, as they are dealing with people who have mental illnesses, there might be occasions that they have to cancel their other commitments and give priority to service users in crisis situations. This led me to conclude that a researcher must employ more responsive research methods to collect data from social work professionals in mental health teams.

Given these considerations, the literature suggests that research, which aims to explore and describe the mental health social work contribution to CMHTs' ways of

working, should allow for the capture of rich data about their experiences. I decided that the researcher would be best placed in the team environment, to observe and understand the real setting where social work professionals interact with other mental health professionals and with the people who use the service. Hence, in order to understand and document the contribution of social work professionals, this study employed an 'ethnographic' approach, which is a qualitative approach with its roots in anthropology and participant observation. This allowed for the collection of rich primary data.

The literature reveals fundamental differences between sociological ethnographers and anthropological ethnographers.

The ethnographic realms favoured by sociologists are the secular, economic, political, public and instrumental aspects of daily life. Ventures into the sacred, emotional, moral, private, and expressive areas of life are common for anthropologists. (Van Maanen, 1988:22)

As Van Maanen (1988:21-22) further describes, 'sociologists tend to focus their work on urban contexts, literally close to home where the culture of interest is at least partially known at the outset of a study. In contrast anthropologists work more on small, remote, semi-isolated social systems and spend a long time including lengthy revisits.' Another difference between the two disciplines is the way they present their findings and the writing styles in ethnographic research. As Van Maanen explains, ethnography in anthropological writing offers a 'less urgent and more leisurely presentation'. In contrast, writing in social sciences on ethnography looks more into the findings of the ethnographic researcher rather than 'being entertained, challenged, or enlightened about the nature of social science'. In this sense, unarguably, this research is developed on the sociological ethnographic tradition and not a typical anthropological ethnographic study.

Ethnography and participant observation have some characteristics in common. As Bryman (2004:292) describes:

Many definitions of ethnography and participant observation are very difficult to distinguish. Both ethnography and participant observation draw attention to the fact that the participant observer/ethnographer immerses him- or herself in a group for an extended period of time observing behaviour, listening to what is said in conversations both between others and with the field worker, and asking questions.

As Bryman (2004) further explains the term 'participant observation' seems to imply just observation, even though researchers often do more than just observing.

I introduce this research as an ethnographic study for two reasons. Firstly, Bryman (2004:292) explains, "the term 'ethnography' is sometimes taken to refer to a study in which 'participant observation' is the prevalent research method but which also has a specific focus on the culture of the group in which the ethnographer is immersed". As (Spradley, 1980: 10/30/31), cited by Schwartzman (1993:4) explains:

Ethnography requires researchers to examine taken for granted, but very important, ideas and practices that influence the way lives are lived, and constructed, in organisational contexts. Because ethnographers are directed to examine both what people say and what people do, it is possible to understand the way that everyday routines constitute and reconstitute organisational and societal structures.

Ethnographic study gives me the advantage of observing the everyday routine and the culture inside a CMHT. Understanding the cultural context of the two CMHTs is of key importance to an understanding of the role of a MHSW and their contribution to the multidisciplinary team. The second reason is that, as Bryman (2004:292) explains "the term 'ethnography' has an additional meaning, in that it frequently simultaneously refers to both a method of research and the written product of that research". In this sense, the term 'ethnography' is particularly applicable to this study as it involves both a research process and the documentation of the final outcomes of the research as a PhD thesis.

According to prevailing literature (Bryman, 2001, Lugosi, 2006) there are two methods in ethnography namely overt and covert ethnography. Covert ethnography means carrying out the research without disclosing the researcher's identity as a researcher. As Bryman (2001:292) describes, "one way to ease the access problems is to assume a covert role-in other words, not to disclose that fact you are a researcher". In overt ethnography the researcher introduces himself to the context and openly explains all aspects of the research to the participants. As Schwartzman (1993:53) explains:

The role adopted by the researcher can determine the methods she or he can use in the organisation. For example a covert researcher will not be able to

conduct formal interviews and in contrast the overt researcher may worry about not being able to observe the natural behaviour of workers.

As this study is conducted in two closed settings and raises a number of ethical issues, like gaining consent from participants, the covert role is not appropriate. By implementing an overt role, I was also able to access a variety of secondary data like office reports and other research findings, gain entry to a number of formal meetings, conduct formal interviews with staff members and service users and join the staff members on home visits.

Ethnography is a way of learning about a completely different culture. As I had no previous work or research experience in a similar environment, it was vitally important for me to experience a real team setting, to get a thorough understanding of how the multidisciplinary mental health teams function. As Schwartzman (1993:53) explains, ethnography allows the researchers to go into the field instead of bringing the field to them and helps researchers to learn a culture from the inside out.

The issue of the researcher as an outsider or an insider to the group studied is an important one that has received increasing exploration by social scientists, often because they find themselves studying a group to which they are not a member (Dwyer and Buckle, 2009:57).

Initially I was an outsider to the teams. I was not a permanent member of the teams and I had no office time and no official or any particular duties assigned to me. In this sense I was an outsider to the teams. However with time I gradually became an insider; not an official insider, but an 'unofficial insider' with no case responsibilities. The literature identifies this process as a result of participant observation.

As a social researcher you may initially be an outsider to a particular group, but as you spend more time with them, you become more of an insider. The latter is often the case when using participant observation as a social research method (Rabe, 2003:150).

Being an outsider or an insider offers both advantages and disadvantages to the research study. Rabe (2003:156) pointed out that, "Insiders cannot always obtain all the information they need, precisely because of their insider status". As Dwyer &

Buckle (2009:55) citing Asselin (2003) point out, 'it is best for the insider researcher to gather data with her or his "eyes open" but assuming that she or he knows nothing about the phenomenon being studied". In this sense, as an outsider I always had my eyes open as I was new to the CMHTs' culture and everything that happened there was new to me. This gave me the opportunity to be more objective as an 'outsider' and this subsequently informed my field work observations. Because of the lower expectations of active participation in the social world of the team members, I had freedom, time and space to carry out my own work in searching for the data I needed.

As Schwartzman (1993) further explains ethnography is a 'cyclical process' as the major research tasks like observation, interviewing, questioning, recording and analysing of data are repeated over and over again. This cyclical aspect of ethnography provides the opportunity to design and redesign the study while the research process is continuing, which in turn enhances the quality and accuracy of the collected data.

In presenting the ethnographic data, as Van Maanen (1988:49) emphasised, 'the native's point of view' has to be clearly introduced; 'Unlike a traveller's tale or an investigation report, an ethnography must present accounts and explanations by members of the culture of the events in their lives - particularly, if not exclusively, the routine events'.

Van Maanen further explained how this can be achieved:

Extensive, closely edited quotations characterise realist tales, conveying to readers that the views put forward are not those of the field worker but are rather authentic and representative remarks transcribed straight from the horse's mouth. (Van Maanen, 1988:49)

With respect to this requirement in ethnography, when presenting the findings I include relevant quotations from the formal and informal interviews. This helps to provide a 'realist account' of the culture, which is the 'most prominent, familiar, prevalent, popular, and recognised form of ethnographic writing' according to Van Maanen (1988:45).

4.2.2. Sampling Procedure

4.2.2.1 Selection of the Teams

Coming from an academic background in Sri Lanka, I was not very familiar with the community mental health services in England. This became apparent during the initial development of the research proposal. The Department of Health web site gives certain information on the mental health services available, however it does not provide an in depth idea of the locations, structures and the functioning of the teams. In this sense, it became important for me to consult colleagues who were familiar with the mental health system in the North East area of England. Initially, it was intended that the focus on the mental health social work contribution would be part of a wider project that was exploring new ways of working in two CMHTs, in the North East. One of these teams operated according to a very traditional model of practice, led by the psychiatrists and dominated by a medicalised approach to care delivery. The other team had been adopting a different way of working for some time, with the consultant having delegated tasks to nurse prescribers and CPNs, in accordance with taking on the New Ways of Working for psychiatrists outlined by the Government Policy the 'New Ways of Working' (Department of Health, 2007c).

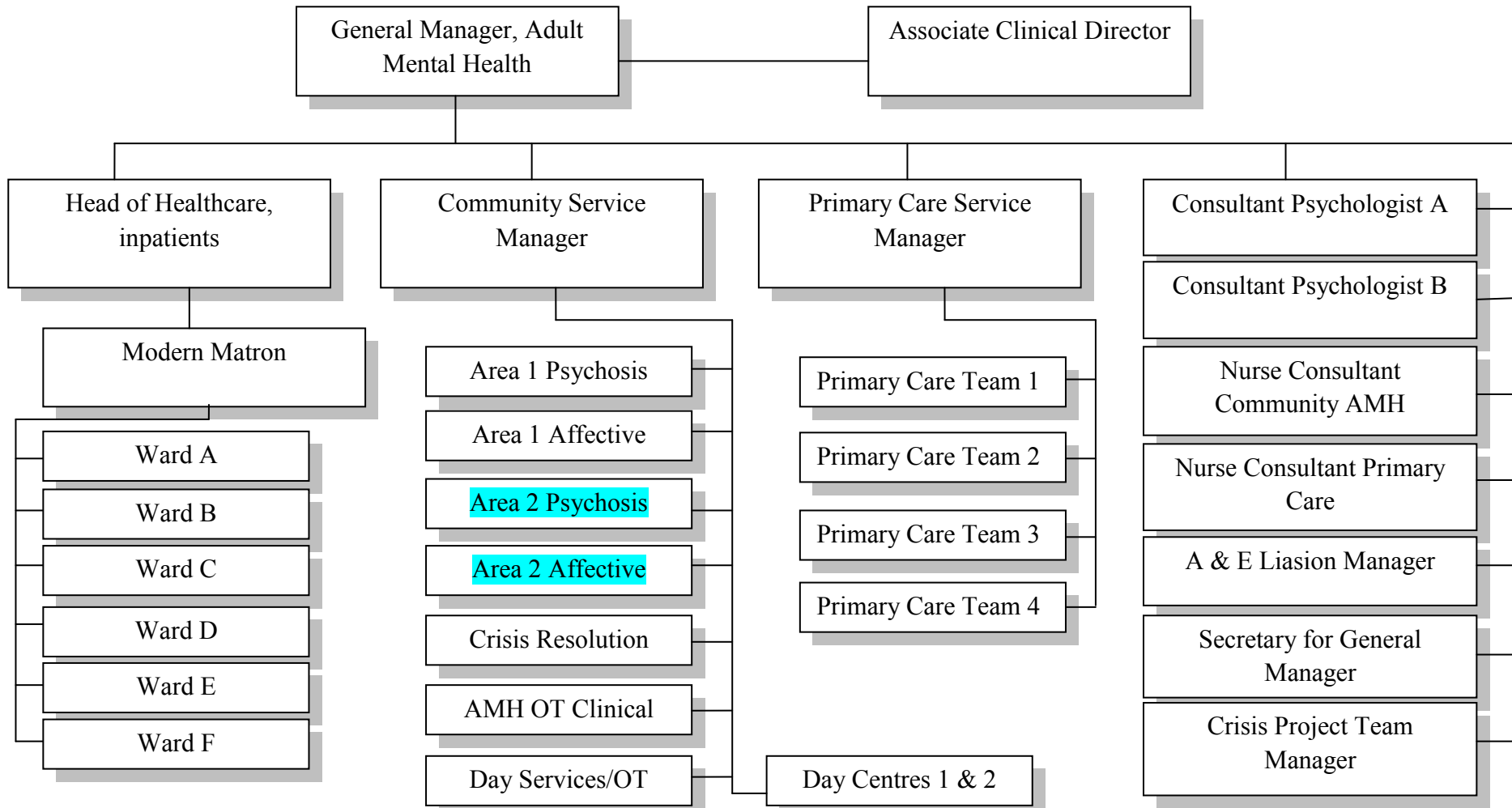
Based upon the available information, I developed a draft research proposal which was then presented for discussion with some key officials in the field. As described in the conceptual and theoretical framework, CMHTs in the microsystem are functioning under the MHT and the social workers are appointed by the LASSD, which is the exosystem. So it was compulsory to gain permission from the exosystem to implement this research in the CMHTs in the microsystem. The first such meeting was held with the General Manager of the Adult Mental Health team and with the Social Care Lead for that particular MHT. During this meeting it was clear that both were keen to pursue the research, but the teams were in the process of being reconfigured and, by the time the intended field work would commence, the two teams would be working in accordance with a new set of arrangements.

I took this into consideration, and given the time constraints, with the approval from my supervisor I decided to proceed with the research proposal and applied for ethical permission from the NHS, with the aim of submitting amendment forms informed by the structural changes if needed. This is further discussed with the

ethical issues in section 4.5 below. These initial meetings gave me an insight into the model of health system in the country, the structure of the MHT to which these two teams belonged to and the recent changes occurring in the field of Adult Mental Health Services. As an ethnographic researcher, these initial meetings also allowed me to build up the important relationships with the people in the microsystem and the exosystem, who I would be working with during the course of the study.

By the time of the first meeting with the Team Managers, the reconfiguration of the teams was almost completed. The two teams I intended to work with had moved into one building and are now functioning as one big CMHT. This CMHT is now called the 'Area 2 Team' and is divided into two specialist teams namely Area 2 Psychosis Disorders Team and Area 2 Affective Disorders Team. This Area 2 CMHT now works together with another CMHT from the same MHT, but which is located in a different geographical area, which is also called the 'Area 2 team'. This second Area 2 CMHT also comprises of an Area 2 Psychosis Disorders Team and an Area 2 Affective Disorders Team. Affective disorders teams in both Area 2 teams are led by one manager and the psychosis disorders teams are led by another manager. Figure 1 explains the organisational structure of this MHT and the highlighted boxes indicate the teams I worked with.

Figure 4.1 - Organisational Structure of the Mental Health Trust



4.2.2.2 Accessing the Teams and Developing Relationships

While I was waiting for ethical approval from the Research Ethics Committee (REC), I attempted to make connections with the teams so that I could begin the field work as soon as the ethical approval was granted. I understood that this initial induction would otherwise be time consuming and prolong the research time frame.

Access and entry issues always play a major role in the field work process, as the first step in collecting data. In approaching the teams the best approach I identified from the literature (Fetterman, 2010, Schwartzman, 1993) was an introduction to the team members by somebody who is close, accepted and trusted within the teams. Fetterman (2010:36) demonstrates this as the 'best ticket into the community' because this ticket can 'open doors otherwise locked to outsiders'. As Fetterman goes on to explain:

This facilitator should have some credibility with the group either as a member or as a friend or associate and in return the ethnographer benefits from this. The trust the group places in the intermediary will approximate the trust it extends to the ethnographer at the beginning of the study. Ethnographers thus benefit from a halo effect if they are introduced by the right person (Fetterman, 2010:36).

In qualitative research the person who introduces the researcher into the field is called the "gatekeeper" (Schwartzman, 1993:3-4). From the initial discussions with the senior manager in the MHT, I understood the team managers were the "gate keepers" and could introduce me to the teams' environment. Schwartzman (1993:4) further describes 'The importance of how one presents oneself to gate keepers in an organisation is also crucial for setting up particular expectations about one's research, and even for gaining entry into a setting'. In accordance with Schwartzman, I prepared myself for this first meeting by organising the necessary documents, such as the research proposal, information sheets, flyers and also the draft questionnaires and consent forms, which I could present for discussion. I also prepared myself by thoroughly studying the research proposal to answer any questions they might ask during the meeting and dressed accordingly on the day, as I understood how important this first encounter would be for the success of the whole field work process.

During this meeting this manager also introduced my supervisor and me to the manager of the other team, and we allowed time to explain the study plan to her as well. This meeting progressed very well and helped me to build my confidence in approaching the two managers again to start the fieldwork, once I had gain the necessary ethical approval.

Before starting the field work, I decided to meet the members of the two teams, to introduce myself and to share information about the study. I felt this was very important for the smooth running of the research as I am from a very different culture with no experience in working in a similar system. As Schwartzman (1993:53) describes:

First encounters are also the first time that informants and researchers have to observe each other. No matter what role one tries to adopt in the field work situation, in the beginning informants will make sense of the researcher in the way that they make sense of all other strangers who appear to begin to ask questions. For this reason organisational ethnographers have been seen as evaluators, consultants, federal investigators, spies from other companies or agencies and journalists.

Given this, I understood the importance of properly presenting myself to the team members so as not to arouse any suspicions about the role I would play within the teams.

Despite a few cancellations of appointments with one team at the start of the research, the team manager was very cooperative and helpful and provided me with all the facilities I needed to continue my fieldwork. I had the opportunity to address the team members in a short lunch time meeting; I explained the research to them and handed over the flyers and information sheets. After this successful meeting, I met the other team manager and set up the initial steps for my stay with that team. In both teams I was assigned a staff member from the Administration Staff that I mainly liaised during my time with the teams. On a separate day, I had the opportunity to introduce myself and the research to the staff members of this second team during an Allocation Meeting. According to Schwartzman (1993:48-49) access issues and first encounters provide researchers with a rich source if data.

It is in these encounters that the most dramatic differences between the ethnographer's culture and the informant's culture will be apparent. The surprises, differences, misunderstandings, and such that occur in these

encounters may foreshadow major research concerns and issues; however, in the beginning, researchers may not know how to interpret what these differences reveal about themselves and their informants. This is why it is extremely important to take detailed field notes in the beginning of one's field-work.

In agreeing with Schwartzman, during these few initial meetings I wrote down lengthy field notes which provided me with an opportunity to retrieve a very rich understanding of the functioning of the teams and their staff members. This in turn helped me in the data analysis process. As the data analysis was started during the very first week of field work this helped me to revise and redesign some aspects of the research. I considered this flexibility as a major advantage of doing an ethnographic study.

To complete the fieldwork, my initial plan was to spend first three months with one team and the next three months with the other team. This basic plan was changed after discussing the time constraints with the staff members. During the very first days I observed the duty schedules of the staff members and I understood that, as a part of their care coordination work, they must spend a considerable time outside the office and, once they return from the home visits, they are required to complete all the data on PARIS, which is the computer system newly introduced to NHS. Also they must sometimes cancel other commitments, to respond to crisis situations related to their clients. In this sense, I understood that three months with each team would not allow me to have sufficient contact with the members and to schedule the interviews. With this understanding, I changed my initial plan to spend two to three days a week with each team for up to six months. This decision gave me the opportunity to plan the interviews more than five months ahead, which suited with staff's extremely busy time tables. It also gave me the opportunity to become a familiar figure within the teams, which in turn helped me to participate in more of the team events, including team meetings and home visits.

Heeding advice from Schwartzman (Schwartzman, 1993), during these six months I made a conscious effort to develop relationships in the field, which helped me to appreciate why the team members think, act and feel in the way they do. This in turn helped me to change some of my presumptions about team working in CMHTs, which I gained through studying the literature. For example the prevailing literature (Goodwin, 1997) reports professional rivalry in multidisciplinary working and a lower

perceived status of certain professions, which I very rarely observed during these six months. I started to see things for myself as a part of these teams and not as an outsider. This helped me to clearly observe the stresses experienced inside the real working environment.

During the field work period I gathered primary data through observation, participation in meetings and other team activities, home visits and semi structured interviews. In addition to the primary data, some secondary data pertaining to the role and function of mental health social work was gathered, which is described further in section 4.3.

4.2.2.3 Selection of Participants

Once the teams were selected and the field work process commenced, my next milestone was to identify the sample. As Punch (1998:194) describes, 'the clear principle involved in qualitative sampling is that the sample must fit in with the other components of the study'. In qualitative research, the selection of subjects occurs in different ways, depending on the purpose of the study. As Fetterman (2010:35) explains, there are two approaches to reaching sampling decisions. First to choose who and what not to study, that is to filter out those resources of information that will add little to the study. Secondly to select who and what to study, that is the sources that will most help to understand life in a given community. As he further explains, ethnographers typically use an informal strategy to begin fieldwork, such as starting wherever they can to 'slip a foot in the door'.

Most ethnographers use the big-net approach conducive to participant observation-mixing and mingling with everyone they can at first. As the study progresses, the focus narrow to specific portions of the population under study. The big-net approach ensures a wide-angle view of events before the microscopic study of specific interactions begins. This big picture helps refine an ethnographer's focus and aids the field worker in understanding the finer details that he or she will capture on film and in notes for further analysis (Fetterman, 2010:35).

Fetterman (2010:35) explains that ethnographers rely on their judgement to select the most appropriate members of the sub culture or unit, based on the research question. To identify these most appropriate members, qualitative researchers use 'purposive sampling', a non probability sampling strategy, meaning sampling in a

deliberate way, with some purpose or focus in mind. In other words, the sample is “hand-picked” for the research. This research study mainly utilises a combination of ‘snow ball sampling’ and ‘judgemental sampling’; two basic sampling methods that come under the heading ‘purposive sampling’.

At the initial stage of the research I utilised the snow-ball sampling method, which helped to create the sample by asking every respondent to name one or more contacts who could contribute to the study. Thus, with every interview, more is learned about the system and the target sample is developed by utilizing the personal contacts among the staff members who are already interviewed. This method initially helped me to identify a number of staff members to interview.

Subsequently, when the field work progressed, I became more familiar with the team members and found it easier to select and reach the staff members for interviews. With this increased confidence, after the first two months, I changed my sampling method to judgemental sampling. As Westfall (2009) explains “In judgmental sampling, the person doing the sample uses his/her knowledge or experience to select the items to be sampled”. With the available time and resources I did not choose to go for extreme case sampling, but selected maximum variation sampling, as one of my targets was to interview at least one staff member from each professional back ground, as well as a maximum number of social workers. This method worked very well as I managed to interview almost all of the staff members who possessed different occupational titles within the CMHTs.

Listed below are the staff compositions of the two CMHTs teams in the two locations. They are named here as Location A and Location B. Both comprise a Psychosis and Affective team in each location. In CMHTs, staff members are appointed by the MHT and the LASSD and in the following two charts, ‘Service’ refers to which service the particular staff members belong to and ‘Common’ refers to staff members in one location working for both Affective and Psychosis teams.

Table 4.1: Location A Staff Details

Position	Affective	Service	Psychosis	Service	Common	Service
Team Manager	1	Health	1	Health		
STR	1	Health				
CPN	6	Health	4	Health		
Link Worker	2	Health	1	Health		
Social Worker	4	Social	1	Social		
Approved Social Worker	1	Social	1	Social		
OT	1	Health				
OTA	1	Health				
Psychologist					1	Health
Consultant Psychiatrist	1	Health	1	Health		
Advanced Practitioner	1	Health				
Admin					1	Health
Secretary	1	Health	1	Health		
Secretary to the consultant	2	Health	2	Health		

Total number of staff members – 36

Table 4.2: Location B Staff Details

Position	Affective	Service	psychosis	Service	Common	Service
Team Manager	1	Health	1	Health		
Support worker	3	Health	2	Health		
OT Technician					1	Health
Advanced Practitioner	1	Health	1	Health		
CPN	7	Health	5	Health		
Link Worker			1	Health		
Social Worker	4	Social	1	Social		
OT	2	Health				
STR Worker	3	Health	1	Health		
Specialist Practitioner					1	Health
CBT Therapist					2	Health
Psychologist					1	Health
Nurse Consultant			1	Health		
Service Manager					1	Health
Expert Practitioner*	1	Social				
Staff Grade Psychiatrist	1	Health	1	Health		
Consultant Psychiatrist	1	Health	1	Health		
Clinical Lead	1	Health				

Total number of staff members – 46

*Is also a qualified AMHP and takes up statutory duties with the team.

The team manager for the Affective teams in both locations is the same person and the team manager for the Psychosis teams in both locations is the same person.

One of the difficulties that qualitative researchers often face is the difficulty in pre-specifying the number of people to be interviewed and observed. Different scholars had presented different ideas about the appropriate number for a sample. As Morse (2000:3) explains:

Estimating a number of participants in a study required to reach saturation depends on a number of factors, including the quality of data, the scope of the study, the nature of the topic, the amount of useful information obtained from each participant, the number of interviews per participant, the use of shadowed data, and the qualitative method and study design used.

As ethnographers collect data through both observation and interviews, I found it difficult to pre-specify the number of participants at the beginning of the study. For this research, the sample for observation is all the staff members in Location A and Location B CMHTs, which were altogether around 80 staff members. The service users' group is limited to those who come to the teams' premises to meet their care coordinators and to those who I met during the home visits and other activities with the staff members. My approach was informed by the research questions; the focus of this research is on the social work contribution to CMHTs and I needed to understand this from the social work professionals' perspective as well as the perspectives of other members of these teams. With this objective, for the semi structured interviews, the research literature suggests the need to include all the MHSWs and AMHPs and a representative sample from other staff members with the teams. Below is a summary of my interview sample from the staff members.

Table 4.3: The Interview Sample from Staff Members

Profession	Number Interviewed
Advanced Practitioners*	1
AMHPs	3
Consultant Psychiatrists	1
Consultant Psychologists	1
CPNs	5
Link Workers	1
MHSWs	7
Nurse Consultants*	1
OTs	2
STR Workers	1
Team Managers	1
Total	24

* The Advanced Practitioner and the Nurse Consultant are referred to as 'CPN's in all the quotes to protect their privacy as they are the only two bearing those specific professional titles.

The sampling procedure for the service users was different from that of the staff members. There are approximately 700 service users with the two CMHTs in both locations. In accordance with agreement with the Ethic Committees, I had permission to interview only the service users who could consent to be interviewed, who were approached by their care coordinators and interviewed in CMHTs' premises. With these restrictions and with the time limitations I decided to include a sample of 10 service users for the interviews. It was difficult for me to identify the service users who fell into this category for a number of reasons. First I am not a qualified mental health professional in this country and I am not employed by the particular MHT. I am working with the two CMHTs, on an honorary contract from the NHS for a particular period of time, for the purpose of the research study. In this sense, I have no right to access the service users' health records, to identify their health status. Another reason is that even though I accompanied staff members on

some home visits, I did not meet the service users on a daily basis to discuss the interview issue with them. Due to these circumstances, I had to seek help from the care coordinators to select service users for the interviews; they are the people who always interact with the service users and know the up-to-date details about them. In doing this, first I discussed my objective of interviewing the service users with all the staff members I interviewed and provided them with the Information Sheets and Invitation Letters, which were designed for the service users. I also approached some very familiar staff members and discussed this with them. Finally I asked the two administrative staff members (who were assigned to support me during my stay with the teams) to help me with finding service users for interviews. As the health conditions of the service users fluctuate so often, even after agreement was received for an interview I had to frequently enquire of the care coordinator whether the service user was well enough to participate.

This sample I selected for interviews represents the microsystem in the conceptual and theoretical framework of this study. As explained in chapter three, all these people in the interview sample interact with each other on a daily basis inside the microsystem. They are very capable of explaining the social work professional's role and contribution to these CMHTs and, as regular members of the microsystem, can make a huge impact on their role. In this sense it is very important to listen to their ideas to get a proper understanding of the social work professional's role and contribution to CMHTs.

4.3 Data Collection

4.3.1 Field Work in Ethnographic Studies

Fieldwork is an essential part of any qualitative study, especially in an ethnographic study where the fieldwork process provides the essence of the research. As Thomas (1993:41) describes, "our study can be no better than the data we collect". The value of ethnographic fieldwork is that it gives the researcher the opportunity to discover practically how people understand and behave in their own environment. It is practical in the sense that the research is done by the researcher going into the

subjects' environment rather than taking them out of their own environment. This gives the ethnographer the opportunity to observe their natural behaviour and address the gap between what they say and how they actually behave. In ethnographic fieldwork the researcher is able to have direct and personal contacts with the subjects in the field and to place their 'lived experience' in a specific local context (Schwartzman, 1993:3-4). As Fetterman (2010) believes field work is the hallmark of research and it provides many benefits including a commonsense perspective to data. Here I must agree totally with Fetterman, as the fieldwork process gave me insight into the real functioning of these two CMHTs. As explained earlier in this chapter, I am a visitor in this country and a stranger to the mental health system. All I knew about the team's functioning was what I read in books, journals and papers and what I heard from other people. But the real team settings were different to my assumptions. Without any argument I can state that the fieldwork process allowed me to understand the reality of the teams' experiences, which I would not have found out if I decided to collect my data just through a questionnaire, through interviews or through focus group discussions.

There are many advantages in adopting an ethnographic approach, which I personally experienced during my field work process. It facilitated my learning in several ways. According to Spradley (1980), cited by Schwartzman (1993:3-4/48), "ethnography provides researchers with a way to examine the cultural knowledge, behaviour and artefacts that participants share and use to interpret their experiences in a group". As Schwartzman (1993:4) further explains "in conjunction with this, ethnography also requires researchers to examine taken for granted, but very important, ideas and practices that influence the way lives are lived, and constructed, in organisational contexts".

The ethnographic process allowed me to examine the issues in detail and in depth as I was not restricted to the specific questions in a questionnaire. The interviews I had were semi structured (see 4.3.2 Primary Data Collection) and conducted with the help of interview guides (Appendices 8, 9 & 10), but there was plenty of opportunity to make changes to the guide as the interviews progressed. When new information emerged through participatory observation and interviews, I had the opportunity to change my framework and directions easily.

Another advantage of ethnographic field work is that the ethnographers have the advantage of observing what people say and what they really do in their local context. According to Schwartzman (1993:4), “in an ethnographic study it is possible to understand the way that everyday routines constitute and reconstitute organisational and societal structures”. As I was based with the two CMHTs for six months, I became a familiar figure inside their premises and data collection became more informal, relaxed and sometimes fun. The length of time in the field allowed me to leisurely plan the interviews, which in turn perfectly matched the busy work routines of the staff members. Another advantage of employing a qualitative research method, such as ethnography, is that the methods used in this kind of research are adaptable for use with a wide range of subjects. For example, as this research sample includes service users, it became a benefit that I had no lengthy forms or questionnaires to be completed by them, which might sometimes be inappropriate or difficult for some of the service users to complete. So, as Schwartzman (1993:4) explains, “ethnography is a particularly valuable method of research because it problematises the ways that individuals and groups constitute and interpret organisations and societies on a daily interactional basis”.

4.3.2 Primary Data Collection

After deciding the sample, as explained in section 4.2.2.3, my next step was to start the data collection and I prepared for this by reading about the CMHTs and studying the earlier research done in this area. The first impression I had, after reading a research thesis, was the potentially enormous number of difficulties faced by a researcher in a similar environment. However, I was aware of the danger of having pre-conceptions of a group, so I made this a point to prepare myself for any kind of difficulty. As Thomas (1993:41) reflects:

As with any research, it is not a particular method that is good or bad. A data gathering strategy is simply a tool. We must not look at the actual collection of data as something neutral or as something that cannot be changed. Good ethnography requires flexibility.

By this stage I was aware of the importance of adopting flexible methods in the field and I started to make some changes to my initial plan. In section 4.2.2.3., I described

how I changed the sampling methods and the length of time I was to be based with the two teams.

Primary data are the specific information any researcher collects by employing various methods. I started the primary data collection procedure with two basic methods in ethnography- namely observation and interviews, which are described in detail below.

4.3.2.1 Participant Observation

Participant observation is of high importance in the fieldwork process of ethnographic studies (Fetterman, 2010:37). Mack *et al* (2005:13) introduce participant observation as “a qualitative method with roots in traditional ethnographic research, whose objective is to help researchers learn the perspectives held by study populations”. Mack *et al* give a descriptive account of what we can learn from participant observation.

Data obtained through participant observation serve as a check against participants’ subjective reporting of what they believe and do. Participant observation is also useful for gaining an understanding of the physical, social, cultural, and economic contexts which study participants live; the relationships among and between people, contexts, ideas, norms, and events; and people’s behaviours and activities-what they do, how frequently, and with whom. (Mack *et al.*, 2005:14)

By analysing the prevailing literature on both ‘ethnographic research’ and ‘participant observation research’ I found no significant difference between the observation processes in these two types of research. According to Fetterman (2010):

Participant observation is immersion in a culture. Ideally, the ethnographer lives and works in the community for six months to a year or more, learning the language and seeing patterns of behaviour over time. Long-term residence helps the researcher internalize the basic beliefs, fears, hopes, and expectations of the people under the study. (Fetterman, 2010:37)

Agreeing with Fetterman, I spent six months with the 2 CMHTs, 2-3 days a week with each team. The days to be spent with each team were generally decided depending on the scheduled home visits, interviews or team meetings; otherwise if there was no scheduled event I spent time in one of the CMHTs reading secondary data and generally observing each and every aspect of the team’s work routine, as

well as how they interact with each other. Observation also included individual and team behaviour, listening to formal as well as informal conversations and asking questions to gather data about team functioning and individual workers' contributions. Being located in the team premises gave me the opportunity to participate in team meetings and join in the home visits, as well as observing the daily functioning of the team. It also helped me to participate in different meetings and to join in the home visits, sometimes without any prior schedule or plan.

In understanding the social work professionals' contribution to a multi disciplinary team, it is important to collect evidence of other professionals' views of the changing nature of the MHSWs and AMHPs contribution to increasingly interdisciplinary teams and services, who interact with them on a daily basis. Participant observation enabled me to do this by providing the opportunity to closely observe the team members while working in their offices, participating in team meetings and in general discussions. Through this close observation I managed to understand how they share responsibility for day to day mental health interventions and practice and how a multi disciplinary approach is facilitated with service users.

Another important fact I discovered, through observation, is how it helps to understand some issues within teams that were very valuable to me as a researcher, but very general for the team members, which they feel not worth mentioning to me at all. For example; the day-to-day duty reporting, case allocation, procedures for home visits and recording them etc. Perhaps in the interviews or meetings they would not talk about these issues because they become so common in their daily work routine. For this reason these opportunities for observation are of immense value to the researcher, unfamiliar with the team setting.

According to De Walt & De Walt (2002) as cited by Fetterman (2010:38):

Participant observation sets the stage for more refined techniques-including projective techniques and questionnaires-and becomes more refined itself as the fieldworker understands more and more about the culture. Ideas and behaviours that were only a blur on entering the community take on a sharper focus. Participant observation can also help clarify the results of more refined instruments, by providing a baseline of meaning and a way to re-enter the field to explore the context for those (often unexpected results).

Participant observation needs close contact with the research participants in their own environment, to understand the truths hidden behind the scenes. But while

becoming close to the participants, I also understood the need to keep the 'professional distance' of the researcher. As Fetterman (2010:37) explains, "participant observation combines participation in the lives of the people under study with maintenance of a professional distance that allows adequate observation and recording of data". Brewer (2000:59-60) also confirms this idea, stating "participant observers must attempt to 'maintain the balance between 'insider' and 'outsider' status; to identify with the people under study and get close to them, but maintaining a professional distance which permits adequate observation and data collection". For example, when joining home visits I shared car journeys with the staff members. This helped me to get much closer to them and discuss certain issues of my field work process, like planning another home visit or finding a service user for an interview; however I was always careful not to talk about the issues related to the other staff members, like cancellation of appointments, which I assumed may sometimes cause unnecessary problems within the team.

Brewer (2000:60) further explains about the advantage of this as "A proper balance in the participant observer's dual role as part insider and part outsider gives them the opportunity to be inside and outside the setting, to be simultaneously member and non-member, and to participate while also reflecting critically on what is observed and gathered while doing so". Keeping this professional distance also helped me in being unbiased when it came to the interpretation of data.

Another benefit of participant observation is it helps the researchers to uncover important facts, related to research problems, that were unknown at the beginning of the study (Mack *et al.*, 2005:14). When designing my research proposal, my general understanding was that in a multi disciplinary CMHT, all the different professionals would join in designing a care package for a given service user. I assumed that the advantage of having a multi disciplinary team is that a particular service user would benefit from the services of different professionals such as the CPNs, OTs and for social workers in a jointly designed care package. However, what I observed through participation in the team meetings and daily activities was very different. In the team meetings new services users were allocated to the staff members by the team leader and it was the individual staff member's responsibility to design the whole care package for that given service user. He or she may ask for assistance from other staff members, for example MHSWs, AMHPs and OTs need help from CPNs for

depot injections etc, however it was not a joint care package as I had assumed. This observation enhanced my understanding of how the microsystem works and, in turn, provided the opportunity to redesign some of the questions in my interview guides. As Mack *et al.* (2005:14) further describes:

This is the great advantage of the method because, although we may get truthful answers to the research questions we ask, we may not always ask the right questions. Thus what we learn from participant observation can help us not only to understand data collected through other methods, but also to design questions for those methods that will give us the best understanding of the phenomenon being studied.

As discussed above, there are various strengths in participant observation. To summarise them, as Mack *et al* (2005:15) explains, the main strengths are, it 'allows for insight into contexts, relationships and behaviour' and 'can provide information previously unknown to researchers that is crucial for project design, data collection, and interpretation of other data'. As an ethnographic researcher, I used all these benefits in designing, redesigning and developing my fieldwork.

Overcoming the weaknesses of participant observation

As well as the above strengths, participant observation has some weaknesses. Mack *et al* (2005:15) explain one of these weaknesses as the 'time consuming' nature of the method. Though participant observation element was time consuming, in my experience in this research, it went hand in hand with other methods I used in the field. This made it seem less time intensive and much depends on the researcher's ability to plan and schedule events. With a limited time period for the fieldwork, I entered the field with a reasonable time plan. I did not just spend my time observing, but undertook the interviews, joined in the team meetings and home visits and collected secondary data concurrently with the observations.

Mack *et al* (2005:15) describe another difficulty with participant observation as 'documentation relying on memory, personal discipline, and the diligence of the researcher'. This is because it is hard to write down everything that is important while you are in the act of participating and observing. Even though you are an overt observer, it can be very distracting and problematic to take down notes in the field whenever you want; especially when you are in meetings, home visits or any other social gathering, as some people might be suspicious or think they are unimportant.

This happened to me during the first months in the meetings, where I tried to take down notes while the meetings were in progress. Some of the issues that they discussed seemed useful to me in understanding how the system worked, yet were obviously very general issues to the staff members and seemed unimportant.

While listening or joining in informal discussions and other kind of interactions with the staff members and service users, I always encountered many phenomena that were important and relevant things to my study. In these situations I made detailed notes as soon as I got back to my seat or reached home, before they faded from my memory. These field notes helped me to refresh my memory and made it easy to transfer them to my fieldwork diary at the end of the day. This fieldwork diary contained all the things happened throughout the day and I managed this on a daily basis. I also had the benefit of using the data recorder in all the interviews and most of the team meetings, so that I did not have to write down everything during the interviews and meetings. Use of the data recorder also gave me the advantage of taking down more clear observation notes, while recording the speech.

Mack *et al* (2005:15) describe a further weakness in participant observation:

It is an' inherently subjective exercise, whereas research requires objectivity. It is therefore important to understand the difference between reporting or describing what you observe (more objective) versus interpreting what you see (less objective). Filtering out personal biases may take some practice.

I found that this was true when starting to describe an event, as the event always goes together with our own experiences and biases. In this situation, I noted down whatever I experienced; however; when transferring the notes into my field work diary, I practised writing more objective notes, as this allowed me to think of the previous notes with a clear and relaxed mind at the end of the event. Finally, it is important to mention here that although participant observation has some weaknesses, in all aspects of it, participant observation proved to be a very powerful tool in this research.

4.3.2.2 Qualitative Interviewing

Qualitative interviews can be classified into three broad types, structured, unstructured and semi structured interviewing (I-TECH, 2008). In structured interviews researchers ask the same set of questions, in the same order, using the

same words, to different interviewees and they are convenient for comparing different interviewees' answers to the same questions and when a team of researchers is involved in conducting interviews" (Oka and Shaw, 2000:15). In unstructured interviewing, normally there are no structured questions, but the interviewer starts the interview with one single question prepared. Here the interviewee is allowed to answer freely and the interviewer is able to expand in relation to the response. According to Bryman (2004), unstructured interviews are very similar in characteristic to a conversation. In this research my aim was to focus the interviewee's attention to several specific areas, related to the research topic, rather than limiting the interviewees to a set of rigid questions or letting the interviewee express their ideas on one given point. In this sense, this research did not utilise either structured or unstructured interview methods, but employed semi-structured interviewing with the use of interview guides (Appendices 8, 9, 10), which contains a list of fairly specific topics to be covered. These topics were basically identified from the literature and adjusted to incorporate them into the conceptual and theoretical framework.

Semi Structured Interviewing

As Oka & Shaw (2000:15) describe:

Semi-structured interviews: sometimes called guided interviews, these are somewhere between structured and unstructured interviews in format in that the researchers prepare interview guides that consist of a set of questions. The guides allow researchers to generate their own questions to develop interesting areas of inquiry during the interviews.

Fetterman (2010:36) explains "First the ethnographer must ask the right questions for a given research study. The best way to learn how to ask the right questions – beyond the literature search and proposal ideas-is to go into the field and find out what people do day to day". This is a good theoretical as well as a practical idea for any ethnographic research; however with this research it was not possible to wait until the beginning of fieldwork to think of the questions to ask, as I had to submit the interview guides to the RECs for ethical approval before commencing the fieldwork. I prepared three different interview guides, to match my research sample one for MHSWs and AMHPs, one for all the other mental health professionals with the teams and the third for service users. However the interview guides were piloted

after the beginning of fieldwork (as described below) and some revisions were made consistent with Fetterman's (2010) criteria.

Piloting the interview guide

As explained above, three interview guides were prepared at an early stage of the research, to meet the requirements of the REC, to find answers to the research questions and to address the research aims. Once the interview guides were approved by the RECs, my main focus was on piloting them. The delay in getting the ethical approval (see 4.5.1) subsequently affected my time plan to start the field work. This also influenced the time period given for my fieldwork by the honorary contract with NHS as I received ethical approval approximately six months after I received the honorary contract. This made me feel obliged to start the fieldwork as soon as possible and I decided to pilot the interview guides after starting the field work, to keep with my time schedule. These circumstances persuaded me to use the first two interviews, which I had with a MHSW and a CPN, who were the professions common to most CMHTs. As these two interviews proceeded smoothly, without any new suggestions from the interviewees, I decided to move ahead with the same interview guides. Hence these two pilot interviews gave me an early opportunity to clarify some issues regarding the team's structure and also helped me to develop my style of questioning.

Piloting the interview guide for the service users was done with the support of the care coordinators. There had been some changes to the teams' structures, as a result of the reconfiguration, and this led me to make some changes to this interview guide for service users. From what I observed and learned from the staff members, AMHPs, MHSWs, CPNs or OTs are not known to their clients by their professional titles, but known only as their care coordinators. Also, as I previously explained, the design of care packages was different from my earlier assumptions and, in this sense; the interview guide did not match the changes in how the teams functioned. So after discussions with the staff members and my supervisor, I made substantial changes to the interview guide for the service users, to match the present situation.

Planning the interviews

Planning the interviews at the beginning of the fieldwork became an important issue with the staff members' busy work routine, where they spent half their time visiting service users and the other half in the office. To address this issue, when scheduling the interviews I explained that my fieldwork plan was to spend six months with them so that they could give me any date for an interview, within the first five months of my stay. This suited the busy time schedules of the staff members and also helped me in rescheduling the interviews cancelled due to unforeseen circumstances, such as staff members responding immediately to a client in crisis.

It was also important to consider the length of the interview, once again taking their busy work schedules into consideration. Robson (2001) argues that an interview which is less than half hour duration is likely to be no value, but anything over an hour could be unreasonable for busy interviewees. With this point in mind, all the semi-structured interviews in this research were limited to forty five to sixty minutes in duration. In most cases, when I invited a staff member to be interviewed, their first question was 'how long does it take?' And when I confirmed it would be less than one hour they all seemed reassured, which in turn made me feel confident about my decision of the duration of the interview. This is important both for the interviewer and interviewee, because if the interview is too long it might affect the quality and value of the process.

As a sojourner to English culture, I was also mindful of some misunderstandings which could occur in interpreting language and non verbal expressions. Some verbal as well as non-verbal explanations can have different meanings to those from my own culture and what I have learned through the past few years in England. As Denzin and Lincoln (1994:80) explain:

The interview is a conversation, the art of asking questions and listening. It is not a neutral tool, for the interviewer creates the reality of the interview situation. In this situation answers are given. Thus the interview produces situated understandings grounded in specific interactional episodes. This method is influenced by the personal characteristics of the interviewer, including race, class, ethnicity and gender.

The above point was crucial in interviewing both staff members and service users, as they were from different ethnic, cultural, religious and employment back grounds to

mine. Hence, I always explained my back ground to the interviewees at the beginning of the interviews. This initial explanation helped me to avoid some of the difficult situations I might have faced during the interview, such as understanding the slang, colloquial language and some non verbal expressions (like nodding the head which means 'yes' in some cultures and 'no' in others). Also the interviewees got the opportunity to stop me and ask any questions if my questions were unclear. Fortunately, none of the interviewees found my accent difficult to understand and all the interviews ran very smoothly. There were some instances where I found it difficult to understand some terms and, in almost all these cases, I asked them to explain it to me in easier terms. This worked very well throughout the research period, however when it came to transcribing I still found some difficult places where I had to ask for the help of an English friend to explain the terms to me. This was done without revealing the interviewee's names, the team's name or their position with the team, so that there were no concerns about confidentiality.

Flexibility in interviews

In the literature on qualitative interviewing, there is much greater interest in interviewer's point of view. As Bryman (2004:320) describes one advantage of qualitative interviewing is the flexibility of the schedule.

In qualitative interviewing, interviewers can depart significantly from any schedule or guide that is being used. They can ask new questions that follow up interviewer's replies and can vary the order of questions and even the wording of questions. As a result qualitative interviewing tends to be flexible, responding to the direction in which interviewee take the interview and perhaps adjusting the emphases in the research as a result of significant issues that emerge in the course of interviews.

A very good example of this is how one staff member described the stigma attached to the social workers as "nurses are seen as angels and social workers are seen as child catchers" (CPN 2). This statement helped me in the later interviews to discuss the possible stigma attached to the social workers with other staff members. The literature describes how not having a set of relatively rigid questions had been very helpful for qualitative researchers throughout the past. As an example of this Beardsworth and Keil (1992:261-262), cited by Bryman (2004:321), explain how this has been helpful in their research on vegetarianism where they carried out 73 relatively unstructured interviews.

The interview programme was not based upon a set of relatively rigid pre-determined questions and prompts. Rather the open ended, discursive nature of the interviews permitted an iterative process of refinement, whereby lines of thought identified by earlier interviewees could be taken up and presented to later interviewees.

As the research progressed, through frequent observation and what I already learned from the interviews, I was more aware of the functioning of the teams and the roles of the staff members. This helped me to slightly change my interview guides with social work professionals and other mental health professionals and develop later interviews with them, to explore the concept of integrated teams and issues with the new MHA. Some data collected from the earlier interviews was also used in moderating the questions. As Fetterman (2010:39) explains this process “slowly but surely, the questions become more refined as the researcher learns what questions to ask and how to ask them”.

Through meeting and greeting the staff members during my stay with the teams, I understood that as any other individuals, the team members have different perspectives and their own values. My growing familiarity with the team members helped me in using different approaches for each interviewee. For example, there were staff members who were extremely helpful and greeted me personally whenever they saw me and insisted that I asked them for any help I needed. When interviewing these staff members, I had more opportunity to explore some areas that I felt less clear about and felt free to ask any questions I had. Another tactic was listening to the interviewees’ more interesting personal accounts of their experiences, sometimes after the interview or while travelling with them, to and from home visits.

Overcoming the Disadvantages of Qualitative Interviews

As Schwartzman (1993:58) explains a disadvantage of ethnographic interviewing can be the interviewer trying to interpret in his or her own terms what is said by the interviewees. “The ethnographic interviewer should avoid translating what an informant says into the researcher’s own theories or terms, or telling the informant what he or she is feeling or experiencing, or interrupting an informant during his or her response to a question” (Schwartzman, 1993:58). I took this advice into consideration throughout the fieldwork process and always used it as a guide to

leading the interviews without being biased and interrupting the interviewees in any way.

The Overall Progress with the Interviews

Using the sampling techniques (described in 4.2.2.3), by the end of my field work I had interviewed 24 staff members from both teams. I managed to interview almost all the social workers within the two teams, which is seven in number, except for two social workers who cancelled the appointments without any information and another social worker who joined the team during the last few days of my field work. All the three AMHPs with the two teams were interviewed, including one of those AMHPs working as an Expert Practitioner as well. I also managed to interview seven CPNs, (including one of those working as an Advanced Practitioner and another one working as a Nurse Consultant), and two OTs working as care coordinators (one OT is also a Day Services Manager), who were all from health service. The interview sample also included a team manager, a consultant psychiatrist, a clinical psychologist, a support worker and a link worker, all NHS employees (see table 4.3).

I faced many constraints in finding service users for the interviews, as described earlier. However by the end of my fieldwork, I managed to interview two service users. These two service users are very important in this study as they both have had CPNs as their care coordinators previously and now have AMHPs as their care coordinators. This provided me with an excellent opportunity to explore the similarities and differences between social work professionals and CPNs as care coordinators, from the perspectives of service users. Their participation also provided me with the opportunity to clarify and develop a thorough understanding to the data I collected on the roles and responsibilities of AMHPs, through interviewing and observing the AMHPs. It was valuable to hear about social work professionals' contribution from this very different perspective.

Finally, it is worth mentioning here, that all these interviews gave me a very rich understanding of different perspectives of the social work professionals' roles in the multi disciplinary mental health teams.

4.3.3 Secondary Data

As proposed in my research design, going beyond the traditional ethnographic methods I collected some secondary data in order to give my research questions a clearer focus. Secondary data is data that has already been collected and collated for some reason other than the current study. It can be used to contribute to the knowledge base or inform decisions pertaining to the primary data collection. There are usually many documents associated with research settings and secondary data can include census, government reports, organisational figures, data bases, library sources, reports from professional bodies etc.

As secondary data for this study, I mainly focus on documents related to the microsystem, exosystem and the macrosystem. These included documents pertaining to the organisational structures and functioning of the MHT and the LASSD in the exosystem, legislation and Policies in the macrosystem, relevant to team functioning and roles and responsibilities of staff members, and also research reports published by the MHT. A vast number of minutes from team meetings from both CMHTs were collected, which led me to a better understanding of the functioning of the microsystem.

There are many advantages in collecting secondary data. Firstly, it can be a valuable source, for interpreting some of the primary data more insightfully; this secondary data did provide answers to some research questions. For example, one of the questions I asked staff members focused on their educational and training requirements. In one team I found a full research report on 'the training requirements of staff members', which was done a few years before my research commenced. This report provided some statistics and further evidence to enhance the primary data I had already collected on this issue. Some of the secondary data helped to better define the team settings and changes occurring within the organisational structure after the recent reconfiguration. Secondary data is often more easily available from a wide variety of sources and collected much faster than primary data. This is very important for a time constrained study like this.

According to Burgess (1991:124), cited by Oka and Show (2000:16), there are some issues that the researchers should be aware of when dealing with secondary data.

Although these documents describe first-hand accounts of situations, we should not accept them uncritically and "it is essential to locate them in context." where they were produced. On the other hand, secondary sources are transcribed or edited from primary sources, and we should remember that they may include errors that the transcribing and editing processes made.

Being aware of these issues, I took the necessary steps to re-assure myself that these secondary data were accurate. I did this by checking the reliability of particular data sources with the senior staff members and by comparing one account with others and tried to balance the various accounts.

4.3.4 Data Recording

Data recording is highly important in interviewing. When the interviews are lengthy it is much harder to remember everything as human memory is limited. It is also difficult to continue an interview efficiently while trying to take notes because the interviewer is then not be able to pay full attention to the flow of the interview. According to Bryman (2004:321), "qualitative researchers are frequently interested not just in what people say but also in the way that they say it and if this aspect is to be fully woven into an analysis, it is necessary for a complete account of the service of exchanges in an interview to be available". As Bryman (2001:322) further explains:

Because the interviewer is supposed to be highly alert to what is being said, following up interesting points made, prompting and probing where necessary, drawing attention to any inconsistencies in the interviewee's answer-it is best if she or he is not distracted by having to concentrate on getting down notes on what is said.

With this point in mind, both semi structured interviews and some group meetings were audio recorded electronically, with permission from relevant parties. A digital voice recorder was used and the recordings were transferred to a pass word protected computer. Heritage (1984:238), cited by Bryman & Emma (2003:489), has suggested a number of advantages in recording and transcribing interviews, such as helping to correct the natural limitations of our memories. Audio-recording allows a more thorough examination of what people say and permits repeated examination of the interviewee's answers. As Heritage (1984; 238) further suggests it 'opens up the data to public scrutiny by other researchers, who can evaluate the analysis that is

carried out by the original researcher of the data'. It allows the data to be reused in other ways from those intended by the original researcher-for example in the light of new theoretical ideas or analytic strategies.

The literature suggests that it is very important to be flexible in the use of audio-recording, as there can be a number of disturbances. There can be refusals by participants to use the recorder or refusals to answer questions, environmental disturbances or audio-recording equipment breaking down. According to Bryman (2004:323) "a further element is that, interviewers often find that, as soon as they switch off their recorders, the interviewee continues to ruminate on the topic of interest and frequently will say more interesting things than in the interview". This emphasises the need to be ready with a paper and pencil at all the times and to not completely depend on recording devices.

During my field work, no interviewee objected to the use of the voice recorder in any individual interview. However preparation with a paper and pencil appeared very important to me, as a number of interviewees exposed themselves more freely once the voice recorder was switched off. I found these post interview discussions very useful, sometimes in relation to understanding some interviewees' personal views and experiences regarding their work. There was one occasion where the team manager did not give me permission to use the voice recorder at a meeting. It was an important team meeting where some officials from the MHT also attended to listen to the staff members' questions on the team reconfiguration. In this case, I took notes as soon as possible and at the end of the meeting I collected some documents related to the discussion, which were distributed among the participants. Use of the voice recorder also helped me in clarifying some of the language issues I faced during the interviews, as described earlier in detail under semi structured interviews in section 4.3.2.2.

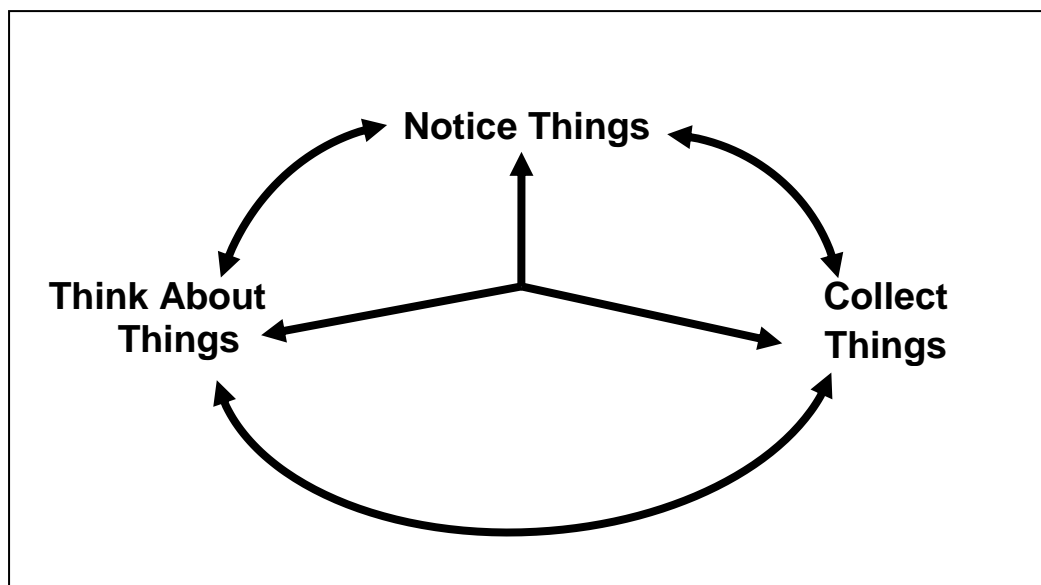
4.4 The Data Analysis Process

Unlike in quantitative research, data analysis in qualitative research can occur before the data collection process has been completed. As Hammersley and Atkinson (2007:158) explain:

In ethnography the analysis of data is not a distinct stage of the research. In many ways it begins in the pre-fieldwork phase, in the formulation and clarification of research problems and continues through to the process of writing reports, articles and books. Formally it starts to take shape in analytical notes and memoranda; informally, it is embodied in the ethnographer's ideas and hunches. And in these ways, to one degree or another, the analysis of data feeds into research design and data collection.

In this research the data analysis process began during the first few weeks of data collection. During these very first weeks the data gathered through observation, informal discussions and secondary documents were analysed daily and used to shape the ongoing data collection. This process continued throughout the field work period and after the interviews were started the data collected through the interviews was also used to modify the ongoing research. This iterative and progressive process can be clearly understood using the below diagram by Seidel (Seidel, 1998).

Figure 4:2 - Qualitative Data Analysis Process



As Seidel (1998) explains, figure 4.2 shows that qualitative data analysis process is not linear, but it is iterative and progressive because it is a cycle that keeps repeating. Seidel further describes "qualitative data analysis process is 'Recursive' because one part can call you back to a previous part and it is 'Holographic' in that each step in the process contains the entire process".

Indeed, Coffey and Atkinson (1996:2) suggest that “we should never collect data without substantial analysis going on simultaneously. Letting data accumulate without preliminary analysis along the way is a recipe for unhappiness, if not total disaster”. This method of analysing data in qualitative research which is ‘doing data analysis while collecting data’ is called the “principle of interaction between data collection and analysis” (Erlandson *et al*, 1993:114 cited by Oka and Shaw, 2000:17). As Hammersley and Atkinson (2007:158) explain, “This iterative process is central to the ‘grounded theorizing; promoted by Glazer Strauss, in which theory is developed out of data analysis, and subsequent data collection is guided strategically by emergent theory.

In this sense, this research has employed a grounded theory in analysing the data. According to Kelle *et al*, (1995:42) “in grounded theory the researcher starts by reading and carefully analysing a small amount of data and then ‘codes’ (read: analyses) the data (most often text) by following very detailed and complex procedures and ‘rules of thumb’”. This is exactly what was done in this study where I read field notes, team meeting reports and listened to the interviews on a daily basis and analysed them. This procedure helped me to shape the ongoing data collection process. As Kelle *et al* (1995) further explain, in grounded theory, during the analysis, the researcher continually asks questions about the data and checks them by constantly comparing different instances of data. While in the field I used a variety of methods to compare the data. First, I tried to compare them with my pre-existing knowledge on certain issues and read secondary data and relevant literature for more information. If doubts persisted I tried to clarify them by talking to a more familiar and friendly staff member, which always resulted in getting a very good clarification of the issue. Kelle *et al* (1995) also advised on the importance of ‘writing ‘memos’ on, for example, his or her ideas about codes, their interrelations, new directions for the research etc., and draws diagrams visualizing his or her thinking about the data’. The writing of memos had been very useful throughout the field work. This helped me to have a good conceptual structure of the collected data at the end of the field work period.

By the end of the field work period I had already generated key themes and sub categories through the ongoing analysis. With a variety of data in hand, my next

step was to systematically organise them to reach proper categories and themes. For this purpose, I selected the computer-assisted qualitative data analysis software (CAQDAS) 'NVivo' to organise the large amount of raw data that emerged from the data collection methods outlined above. NVivo is a software package that allows researchers to manage, shape and make sense of gathered information quickly and effectively, and also to code text while working at the computer and to retrieve the coded text. As Bryman (2004:418) reveals, NVivo takes 'over the manual tasks associated with the coding process including the physical task of writing marginal codes, making photocopies of transcripts of field notes, cutting out all chunks of text relating to a code and pasting them together'. The researcher identifies patterns and relationships on which to base an analysis of the findings and it is understood that, the computer takes over the manual labour involved in the systematic data analysis but the researcher is still the primary interpreter of the data. What I found most interesting and useful, in NVivo, is that it provided the opportunity to store all the data and other associated information files like external documents in one place. When I was familiar with the system it was so quick for me to reach them and very easy to move from one to another file.

In data analysis there was one thing that I should acknowledge and it is that there are sometimes biases in qualitative data interpretation. For example, if I spoke often to a particular staff member I tended to believe what he or she said and sometimes this affected me during the process of analysing data. Therefore, I took necessary steps to correct my beliefs by ensuring that evidence for the analytical findings also existed in the data, and that different interpretations of the data could be reconciled. In this way, I believe that the research conclusions are demonstrated to be grounded in the real-world patterns that emerged from the research findings.

4.5 Ethical Issues

4.5.1 Ethical Approval from Authorities

"Given the plurality of methodologies used in social science there is a diverse range of risks that professional social science has to manage, both for the research subject and the researcher, as well as more formal risk-related considerations that derive from legal or regulatory provisions" (ESRC, , 2006:21). This means the researcher

has to undergo a proper ethical evaluation of their proposed study to identify these potential risks and harms. Ethical considerations applied to me in this research study because of the direct contact with staff and users of the services of mental health teams. At the beginning of the research, I was unaware of the ethical procedures in England as I was from a background where formal research ethics procedures are less developed. After identifying the limitations to my own knowledge, I discussed this with my supervisor and she provided me with the initial guidance on where to apply for ethical approval and which people to be contacted. As Butler (2002:245) emphasises:

At all stages of the research process, from inception, resourcing, design, investigation and dissemination, social work and social care researchers have a duty to maintain an active, personal and disciplinary ethical awareness and to take practical and moral responsibility for their work.

With this in mind, before applying for ethics committees' approvals I first studied the Research Ethics Framework (REF) of the Economic and Social Research Council (ESRC), Code of Ethics for Social Work and Social Care Research (Butler, 2002) and the Code of Ethics and Conduct (The British Psychological Society, 2006).

This research study needed multi-agency ethics approval, namely the approval from the LA and the MHT, because the staff members in the CMHTs are appointed by these two authorities. The first agency I contacted regarding ethical approval was the LA. Gaining approval from LA was relatively easy, as my supervisor had previously contacted the Research Approval Group there and discussed my research proposal. In completing the necessary forms, I had to learn many new things on risk analysis tools and it gave me the insight into the ethical barriers, which might occur during the research process. With the ethical approval from the relevant LA, my next target was to complete the NHS research ethics documents. With the help of the then Acting Manager of the Research & Development (R&D) Department of the particular NHS Trust, I learned the whole process of gaining REC and R&D ethical processes. In accordance with the research governance requirements of the MHT, I also had to obtain Criminal Records Bureau (CRB) clearance and an Honorary Contract from the NHS to work with the teams. Honorary contracts are a tool used by the NHS to ensure that non-NHS researchers are contractually bound to take proper account of the NHS duty of care, and to follow the requirements of research governance at

every stage in the conduct of their research (The NHS R&D Forum, 2005). On completion of the CRB clearance and the Honorary Contract, I started working on the Integrated Research Application System (IRAS) for REC and R&D approval. After facing a panel from the REC, and with some revisions to the consent forms, the favourable ethical opinion for the research was granted by the REC and the R&D. The whole process of ethical approval took nearly six months and this was a very frustrating time. However, I clearly understood the importance of such a tough procedure as this kind of research can sometimes cause distress to a vulnerable group in the community and to the researcher herself, if necessary procedures are not well considered. Bowling (2002:158) explains the role of the REC as follows:

Investigators frequently complain about the time and expenses involved in ethical committee submissions.....However, individuals need protection in relation to their privacy and protection from manipulation by the research; also required is the protection of the aura of trust on which society and the community depends; and the good reputation of research requires preservation.

Finally, with the ethical approval from the university, I commenced the fieldwork. However, during this time the two teams had been reconfigured (see 4.2.21). According to the NHS ethical approval letters, any changes to the fieldwork process after gaining ethical approval must be communicated to the REC and R&D Department. With this information on hand, I submitted the 'Substantial Amendment' forms to the REC and R&D Department. These 'Substantial Amendment' forms were reviewed promptly by the REC and R&D Department and confirmed their agreement for me to continue the research.

4.5.2 Ethical Considerations with the Participants

In any research it is important for the researcher to protect the participants from any kind of harm and risk and respect their rights (Bowling, 2002:158). As Couchman and Dawson (1995), cited by Holloway (1997:55), explain, the rights of the individuals are that, 'they are not to be harmed; that they give their consent on the basis of information and knowledge about the research, that their participation is voluntary and that the researcher follows the rules of confidentiality and anonymity'. Code of Ethics and Conduct (British Psychological Society, 2009:19) further describes, "Consider all research from the standpoint of research participants, for the

purpose of eliminating potential risks to psychological well-being, physical health, personal values, or dignity". In doing this in accordance with the social work values, Butler (2002) emphasised:

Both the process of social work/ care research, including choice of methodology, and the use to which any findings might be put, should be congruent with the aims and values of social work practice and, where possible, seek to empower service users, promote their welfare and improve their access to economic and social capital on equal terms with other citizens.

4.5.2.1 Information and Consent

I ensured that all participants were clearly informed of all aspects of the research and throughout the whole research I attempted to build mutual respect and confidence between myself as the researcher and the participants. I provided the participants with flyers (Appendix 1) and information sheets (Appendices 2 & 3) regarding the research and my contact details, as the main researcher, for further information on the study. At the beginning of the study, I gave information sheets to all the staff members and in the case of any staff members missed out I e-mailed them the information sheet well before the interviews. As a result, by the time of the interviews all the staff members were well informed about the study, and before the interview started I always inquired whether they had managed to read the information sheet. If they had not done so, I took five minutes to explain the research and answered their questions. With the service users I followed the same routine, and also explained the research to them when I met them during home visits. By the time of the interview they were all well informed about the research and only then did I ask them to complete the consent form (Appendices 6 & 7). Both in the Information sheet and in the consent form I explained that I wanted to record the interview, however before the interviews started I always asked them for their permission to record the interviews.

4.5.2.2 Confidentiality and Anonymity

During the field work process, particular attention was paid to preserve the participants' human rights and respect their dignity and individuality. Participants were thoroughly informed that any details given by them would be kept confidential

and would be used only for the purpose of this research, unless otherwise stated and they had given their permission.

As a matter of confidentiality I kept all the collected data in paper form locked in a cupboard and the soft data is saved on a password protected computer. According to the University regulations and the research needs, the collected data will be kept with me until I complete my course of study.

Throughout the research, personal identification information was collected only when gaining consent from the participants and, after that no, identification information was taken from them. Before the interviews they were informed that no individual names, professional status or direct quotations which could reveal the identity of individuals would be used when publishing the results, unless explicit permission has been obtained, for example for single professionals within each of the teams. Throughout the field work process there was only one objection to this procedure, where one interviewee refused to have his name written in the consent form. This was a special case which occurred due to a disorder the participant is suffering. In this case I used an agreed pseudonym in his signed consent paper for identification purposes.

4.5.2.3 Ethical issues pertaining to Risk

“Risk is often defined by reference to the potential physical or psychological harm, discomfort or stress to human participants that a research project might generate. This is especially pertinent in the context of health-related research” (ESRC, , 2006:21). One of the major concerns of the REC was the risks for participants in this research. Even though this research was not particularly looking at service users’ own health related issues, it nevertheless involved people who were experiencing psychological difficulties or mental health problems, as I proposed to accompany practitioners on home visits and interview some service users. As the Research Ethics Framework (ESRC 2006:21) further describes:

Social science raises a wider range of risks that needs to be considered by RECs. These include risk to a subject’s personal social standing, privacy, personal values and beliefs, their links to family and the wider community, and their position within occupational settings, as well as the adverse effects of revealing information that relates to illegal, sexual or deviant behaviour.

This suggest to social science researchers that ethical issues in social research are not limited only to the research participants, but can encompass a wider group of people or a whole community. These risks can be difficult to identify during the design stage of a research study. However, researchers must carefully anticipate the potential ethical issues that might arise when the research progresses. As the REF (ESRC, 2006:21) explains:

Such risks may be difficult or impossible to quantify or anticipate in full prior to the start of a social science research project, especially in longitudinal, qualitative research. Nevertheless, researchers should endeavour to determine possible risks and their management (not least through the methodological strategy and instruments they adopt) prior to the start of a project, which may then require more formal ethics review.

At the beginning of the research I was confident that there would not be any risks to participants. Alongside this confidence I was also very aware of the possibility of service users or staff disclosing distressing information during the course of interviews. In accordance with the Research Ethics Framework (ESRC, 2006) advice, before the interviews all the participants were informed that I would provide an opportunity for them to 'debrief' if they disclosed any information that distressed them. I ensured that should service users disclosed any distressing information I would be prepared and available to debrief them and if the staff disclosed any distressing information, a colleague or a senior member from the staff would be available to offer support.

4.5.2.4 Participants' Freedom

In social research it is important for the participants to have freedom and choice in all aspects of the interviews. As Butler (2002:245) explains:

The social work and social care researcher will at all times respect the individual participant's absolute right to decline to participate in or to withdraw from the research programmes, especially when the researcher, is by any means, in a position of authority over the participant.

In respecting this, all the participants were well informed that if they did not want to answer any of the questions, their choice would be respected and those questions would remain unanswered. During the interviews all the participants were encouraged to express their ideas freely and none of their statements were

interrupted or stopped by myself. Also the participants' were informed on their right to stop the interview at any point and request that their views were not included in the study.

Finally, as Butler (2002:246) explains, "the publication of social work research findings should properly and in proportion to their contribution, acknowledge the part played by all participants to the research process". I have respected this ethical imperative by presenting my findings and conveying my appreciation and gratitude to everybody who supported me throughout the research process in the acknowledgement page.

4.6 Reflections

In this chapter I have attempted to explain the whole fieldwork process. This started with me explaining the design of the research and preparation for the field work process. This section particularly focused on my choice of ethnographic approach, the sampling procedure and issues with accessing the teams. Next I described the process of collecting primary and secondary data and the methods I used. I have also discussed the benefits and drawbacks of those methods and what type of data was collected using these particular methods. Under this section I also explained how I piloted the interview guide and the data recording techniques I used. This led to an account of the subsequent data analysis process where I explain my choice of grounded theory approach to analyse the data and the use of NVivo.

When considering the fieldwork process as a whole I consider it has been successful. I have found many advantages in adopting an Ethnographic approach and managed to collect a sufficient amount of data for my research. Despite the initial problems in meeting the team leaders and gaining access to the teams, the rest of the process developed satisfactorily. In general, both of the teams were supportive and some staff members have been especially supportive. They volunteered to find more participants for the interviews and organised home visits on my behalf. This helping hand was much appreciated, considering the amount of work they are expected to complete on a daily basis. This support also helped to understand the relationships between team members in the microsystem. There

were some occasions where interviews and meetings were cancelled without prior notice; however the reasons for those cancellations were usually obvious. It is well understood that the teams are dealing with mentally ill service users and the priority should always be given to those service users rather than any other commitment.

In general, the interviews progressed very well and there were few cancellations. Some staff members volunteered to spend more time after the interviews and some even offered me two appointments to discuss my questions. These interviews have been very fruitful in clarifying some unclear issues relating to policies and team functioning. I was often offered the opportunity to accompany staff on home visits, which helped me to understand the professional relationship between the service users and care coordinators. The shared car rides to and from the home visits provided an opportunity to discuss personal views regarding my research topics and general issues with the research. I often used these instances to ask for the help of the staff member to reach another staff member who had been difficult to contact.

One of the limitations of the research was the low number of service users I interviewed. In the research proposal I planned to interview 10 service users from both teams, but as the research progressed this initial plan changed due to a number of obstacles. Firstly there were the ethical constraints that my sample of service users should include only people who were able to consent to participation and the interviews should be conducted only in the teams' premises. When I discussed these limitations with the staff members they promised to talk to their clients and during the home visits I also had the opportunity to explain this to the service users. However the problem I found here was something unexpected; AMHPs, MHSWs, CPNs and OTs in the teams are all called care coordinators and the service users know and refer them as their care coordinators rather than by these job titles. So the issue of interviewing them with regard to social work professionals' role became difficult. With respect to this issue, the best possible solution to emerge was to contact the service users who already knew that their care coordinator was an AMHP or a MHSW. In this case we identified only a very small number of such service users and among them only a handful of were capable of consenting for themselves. Finally, I eventually completed only two interviews with the service users. This issue is further discussed as a limitation of this research in the final chapter.

The inclusion of different professionals and service users in the interview sample helped me to understand and explain the contribution of mental health social work, from a range of different perspectives. This I considered as a major aspect of understanding the social work contribution in the microsystem, as AMHPs and MHSWs are an important and obligatory part of this integrated system. I am confident that these interviews provided an opportunity to clarify and develop a thorough understanding of the ethnographic data gained through observing the functioning of the teams.

Researching two teams rather than one allowed me to compare different ways of practising, using the same model of care, by social work professionals and their colleagues. If I had studied only one team, I may have ended up with a limited understanding of the model. The governing policies, team managers and team structures are almost same with the two CMHTs, however even with these similarities I found some differences in the way the teams operated on a day to day basis.

In concluding I must say that the whole research process has been a challenge for me. Coming from a different country with a very different cultural, religious and economic back ground and with no prior experience of research in this kind of an environment, the only strengths I had to overcome all these issues were my ambition and determination. In reaching my target I satisfactorily faced most of these challenges and obstacles and managed to complete the data collection process almost on time, with an enormous amount of data in hand to subsequently proceed into the data analysis process.

In the next two chapters I present my findings from the research. In chapter 5, I will discuss the emerging key themes and sub themes related to the microsystem in the theoretical and conceptual framework.

Chapter 5

Social Work Professionals and the Microsystem

5.1 Introduction

The Ecology of Human Development Theory, of Urie Bronfenbrenner (1977) presents a holistic view of the person's development and it holds that development reflects the influence of several environmental systems. These nested environmental systems have bi-directional influences within and between the systems. By using Bronfenbrenner's model as the theoretical and conceptual framework for this study, I attempted to gain a holistic view of the social work professionals' role in their immediate environment and the other nested systems they interact with. This subsequently helped me to understand the influences from other systems on social work professionals' role in the CMHTs.

This chapter particularly focuses on the microsystem, which is the CMHT, social work professionals' immediate environment. The CMHTs include the AMHPs, MHSWs, other mental health professionals, team leaders, service users and carers. My embeddedness within the micro-system as an ethnographic researcher helped me to understand the real work setting of the CMHTs and made the data collection process easy within the microsystem. Although I began the ethnography as an 'outsider', which assisted the objectivity of my study, I was bound over time to become more of an 'insider' (as explained in chapter 4) a process that had a critical impact upon my objectivity. It is not that I ever entirely became an 'insider' within the CMHTs, rather that my 'embeddedness' within the CMHT made me both an 'insider' and an 'outsider', which is usual in ethnographic work.

In Bronfenbrenner's theory, individuals are not just passive recipients of experiences in this system, but active participants who help to construct the system. Accordingly, in the CMHTs, social work professionals are an active, essential, part and always interact with the other team members, service users and the carers. In this sense, it is important to look at AMHPs' and MHSWs' roles, as a part of their immediate

environment, rather than as individual professionals. By interviewing and observing all the mental health professionals (including the social work professionals) and some service users, I attempted to develop a holistic understanding of the social work contribution within the CMHTs. Alongside my research questions, introduced in Chapter One, in this chapter I attempted to describe and discuss the key themes and sub themes that emerged through the study.

In doing so, I present the findings from 26 semi structured interviews, secondary data, together with the findings from observations during a period of six months, with four specialist teams in two CMHTs. Observation was carried throughout the fieldwork period, during home visits, team meetings and by generally observing each and every aspect of the teams' daily work routine. This also includes listening to formal and informal conversations as well as how professionals interact with each other. Observation was unstructured in a general sense; however there were instances where I looked for specific information by observing some behaviour, which is further explained at a later stage in this chapter.

All the data gained throughout the study period was organised and analysed using Nvivo 8. I started coding the data by applying brief verbal descriptions to small chunks of that data and, throughout the analysis, I altered and modified the analysis in the light of experience and as ideas developed. The data analysis process of this study started at a very early stage, this helped me to adjust some of the earlier codings as the full picture emerged. Based on codings, key themes and sub themes materialised, which integrated substantial sets of these codings. These identified themes were then categorised under the micro, exo and macro systems, using the conceptual and theoretical framework. This helped me to understand the emerging themes in relation to the different systems social work professionals interact with. Quotes from the interviews, notes from the field work diary and sections from secondary data documents are included, to illuminate the discussion. All the used quotes are presented using the professionals' general job titles with numbers (e.g. MHSW1, AMHP1, CPN1, and OT1). 'AMHP' and 'MHSW' are used to introduce the specific professions while 'social work professionals' is used to represent both AMHPs and MHSWs.

This chapter contains five basic themes identified within the microsystem.

1. Roles and responsibilities of AMHPs and MHSWs in CMHTs
2. Special contribution by AMHPs and MHSWs to CMHTs
3. Different issues and problems related to their roles
4. Difficulties and barriers to effective care coordination
 - Common to both AMHPs and MHSWs
 - Specific to AMHPs
5. Stigma and status of social work professionals

5.2 Role and Responsibilities of AMHPs and MHSWs in the CMHT

5.2.1 Roles and Responsibilities of MHSWs

In understanding the MHSWs' contribution, it is very important to understand what their roles and responsibilities actually are in the CMHTs. In the literature review in chapter 3, I discussed a number of issues pertaining to role confusion, role blurring and role overlap, and the resulting concerns expressed by social work professionals about losing their professional identity and role conflict. In this section I attempt to describe and discuss the findings of this research in respect of MHSWs' role in CMHTs and the perspectives of different professionals working with them.

5.2.1.1 Definition of MHSW's Role

In understanding what MHSWs really do in multidisciplinary teams, I asked the interviewees what they think of as the MHSW's role. Without any professional background differences, all the interviewees identified the MHSW's role as the same as any other 'care coordinator' within the CMHT, although they all identified the extra MHA assessment duties affiliated with the AMHP's role.

"My view is that a social worker's job and a CPN's job within a mental health team is to look at a person's social care needs, their health care needs, their mental health needs, their emotional and psychological well being, their employment, their benefit entitlement so a holistic approach to a person. You see I struggle, I don't see any difference between a SW and a CPN, within the context of mental health....."
(AMHP 3)

“They do very much the same work in their care co-ordinator role as would a CPN or an OT, so that aspect of the work isn’t specific to them being a social worker”.
(Consultant Psychiatrist 1)

“I think it’s their job to be care co-ordinators, I don’t think of people as social workers or nurses. I tend to think of them as care co-ordinators and it’s their job to manage a group of patients, to aid their recovery, to navigate them through the services, to offer a range of therapeutic interventions that will aid the recovery” (Team Manager 1)

“It’s no different than the role of the nurse as a care coordinator. That’s what you are doing; you are managing and coordinating of care....social workers would be doing it exactly the same as any other MH staff”. (CPN 3)

All these four different professionals said that they do not see any difference between the role of a social worker and the other care coordinators, from other professional back grounds. To further clarify this issue, I observed the weekly Allocation Meetings and care coordinators in their daily work routine. Through this observation it was clear that social work professionals are allocated the same tasks as for any other care coordinator and are not expected to do anything different from them. However, most of the professionals seem quite unclear and confused about the clarity of MHSW’s role and there appears to be much overlap in the jobs within the CMHTs.

5.2.1.2 MHSW’s Role – As Understood by Other Professionals

Brown *et al* (2000) explain that staff members of integrated teams must be both confident in their own role and respect the expertise and roles of other professionals, for collaboration to occur. During the field work period, a common complaint I encountered from the social work professionals was that the staff members in the CMHTs do not understand their role properly and these professionals see no difference between their role and a MHSW’s role.

“Probably very much the same as I see my own role. I think in their training they are maybe more up on the diversity and the equality from that kind of point of view, but I don’t know. I sometimes find it quite difficult”. (CPN 5)

“Well from my point of view, my expectations are the same as if they were a CPN or an OT; I don’t differentiate between them at all. In terms of general working with the patient, assessing them, looking at risk, providing therapeutic input, all that sort of thing, that’s generic really and I don’t sort of differentiate between social workers, OTs and CPNs in doing that generic role”. (Consultant Psychiatrist 1)

“I don’t think we understand each other’s original roles very well, I think we’re just expected all to do the same thing and you can’t be very good at everything”. (OT 1)

However, there were some other professionals who showed a reasonable understanding of the MHSW’s background and what particular services they could expect from them as care coordinators.

“I think it’s important not to get caught up in the interventions and what people do but to look at the knowledge base that people bring. What social workers bring to the team is a non-medical knowledge base, one that’s rooted in such things as systemic therapy and systemic theory as well as sociological and epidemiological theory, which is not something that’s taught to nurses, psychologists or psychiatrists particularly. So I think what they bring, it’s not so much that they do anything differently, it’s the knowledge base and the perspective that they offer”. (CPN 7)

“The social workers tend not to be as knowledgeable as the nurses obviously on things like medication, physical illness, that sort of thing, but they are sometimes more knowledgeable on things like the role of social services, housing benefits, those sorts of things, as a big generalisation”. (Consultant Psychiatrist 1)

However it is clear through the interviews that most of the other professionals do not have a good understanding of the distinct uni-disciplinary contribution that social work professionals can bring into CMHTs. It is also clear that most of the professionals do not see a difference between the MHSW’s role and the role of other care coordinators. This is because core elements of care coordination are shared and the distinct disciplinary contribution is blurred, because of the prioritisation of care coordination. This issue seems to lead to role confusion and role blurring in the integrated teams. Lack of understanding of each other’s role was also emphasised by all the AMHPs, which is further discussed under section 5.2.2 on AMHP’s role and responsibilities in CMHTs.

5.2.2 AMHP’s Role and Responsibilities in CMHTs

AMHPs are an important part of any CMHT, as they carry out both care coordination work and MHA assessment duties. They are also seen as a valuable resource by other professionals because they provide advice on issues related to MHA assessment. As discussed earlier, there is now an opportunity for a number of other professionals to qualify as AMHPs under the 2007 MHA. However, in these two teams, all the AMHPs are social workers and their role consists mainly of care

coordination work and MHA assessment duties. An AMHP explains his role with the team as follows;

It was a combination of being a care coordinator and an AMHP, we do both. We have a similar case load as others and, in addition to that, we also have to do AMHP work which is run a rota one or two times a week and basically any requests for Mental Health assessment under the MHA, it would come to you under the rota. Then basically you have to drop everything else and respond to that, that's the first priority. (AMHP 1)

This quote emphasises a practical difficulty, which is the conflict of priorities that AMHPs face when doing both care coordination and AMHP duties. In the next section I explore this issue in more depth, together with the understanding of an AMHP's role from different viewpoints.

During the fieldwork period I understood that AMHPs were extremely busy and had to cancel other commitments to prioritise MHA assessment duties. My own experience of scheduled home visits and interviews with AMHPs being cancelled was a very good example of this. However, from the dialogue within the teams and with individuals, it was apparent that AMHPs were very knowledgeable and committed to their work. They had built up very good relationships with the team members. Nevertheless, the informal discussions and formal interviews with AMHPs revealed a number of problems they faced in their work, including how they were perceived by the colleagues in the team.

"I think some of the health colleagues don't appreciate fully that it's a legal responsibility. And also kind of just how much does it involve in the AMHP work. And it's still this issue about understanding what we do. (AMHP 1)

"No, I don't think they do understand because when I've an assessment and then I have to drop everything and do that and I don't think they know about like the case notes, about what I've got to do and how much responsibility I've got when I'm doing a MHA assessment". (AMHP 1)

A MHSW explained his ideas about the AMHP's role as follows.

"I think they are extremely vulnerable in the CMHT, have very little back up, possibly not given enough support, more of a distinct group. It's very hard to be a care co-ordinator for somebody that you've sectioned so that would have to be looked at. I think the pull between being dragged out to do the assessment when you're on duty and being a care co-ordinator, you're going to really struggle because you haven't got the back up here. You have a team manager who is now dragged between two

sides and you often cannot get somebody to talk to about what's going on, on a daily basis". (MHSW 5)

Even though all the AMHPs reported that other staff members do not understand their role sufficiently, this was not echoed by the other professionals I interviewed.

"they can provide a different point of view, they can help steer us towards good practice, more so than somebody who hasn't done more additional training because they're very, very skilled in using the MHA as well as probably having a greater understanding of mental capacity, deprivation of liberty, the human rights act.....". (Team Manager 1)

"I've heard them say you know, you're there, you're in work, you've done your days work, something comes in, it has to be dealt with, it has to be dealt properly and one of the things I will say is over the last 40 years I've met a lot of AMPHs and they all take it very seriously, you know they realise that you don't deprive somebody of their liberty lightly, I've not come across any who don't treat it properly". (CPN 1)

These ideas reveal that even though the AMHPs are not very satisfied with how they are perceived, many other professionals within the teams seem to respect and understand the AMHP's role. Still, through the observation, I found that, when the AMHPs have to go for MHA assessment compulsory duties leaving their other work behind, this sometimes causes some distress and tension among the other staff members, especially when they are dealing with high case loads. Both service users I interviewed also seemed to have a fairly good understanding of the AMHP's role. One service user showed his understanding about the AMHP's role as follows.

"You're lucky if you get a really good social worker, I mean XX¹¹ is a good one, his time-keeping's not always 100% but sometimes with him being an ASW he can get called away, he does have like a busy life but time-keeping needs to be improved really for the social care because otherwise, that's disrespecting the time of the client". (Service User 2)

"XX sometimes maybe gets distracted by an emergency call or something but it would be nicer if they let you know if they're going to be late but then again, I don't really know that much. Supposedly it's a difficult job and they've got to have a lot of strings to their bow". (Service User 2)

Service users also emphasised the importance of good time-keeping from AMHP's side, as lateness or missed appointments sometimes cause them distress and

¹¹ The real name of the AMHP care coordinator is anonymised on ethical grounds

inconvenience. These ideas once again show the issues related to prioritisation of AMHPs' work in the CMHTs.

The above sections, 5.2.1 and 5.2.2, explained the roles played by general MHSWs and AMHPs in a CMHT and their duties and responsibilities. In summary, the MHSW's role in the CMHT is care coordination. They work as any other care coordinator within the team. The role of the AMHP in the CMHT only differs with their MHA assessment duties; otherwise they act like any other care coordinator within the team. With their further training, AMHPs seem to have more knowledge on medication management rather than the other MHSWs. Also, they seem to be more respected and valued by the team management and other colleagues in the teams.

During the Team Allocation meetings, care coordinators are allocated service users for whom they have to develop a full care package. Depending on the mental health status of the service user, care coordinators arrange, daily, weekly or monthly meetings with their clients. The CPNs, OTs, MHSWs and AMHPs all have the same routine duties as care coordinators. The only exception to this is where CPNs administer depot injections, as MHSWs, AMHPs and OTs are not trained to do this. However, under some circumstances if there are not enough CPNs to take on service users who need depot injections, these service users are allocated to other care coordinators. Then those non-CPN care coordinators, with service users receiving depot injections, have to ask for the help of a CPN with the injections.

There are two implications of this. Firstly, most of the service users take time to build up relationships with new people. Once they get used to one care coordinator, they do not like anybody else to know their situation. So it can be assumed that by having two people involved in care coordination, the service users are less comfortable with their care package. Secondly, as the Team Manager 1 revealed, by appointing one care co-ordinator they expect to prevent resource-waste in care coordination. In this sense, having two people in the care coordination procedure can be considered as a waste of resources. As Team Manager 1 further revealed;

"I would see no reason why I can't expect the social worker to have an awareness of the drugs we give people and what the side effects might be and there's no reason why they can't monitor the side effects".

Therefore, it is important to consider moderating social work education and training, to fill in this gap to prevent the waste and respect the rights and needs of the service users.

5.3 Special Contribution by AMHPs and MHSWs to CMHTs

In this section I look at my findings on MHSWs' and the AMHPs' special contribution to CMHTs, in relation to the social model. Social work has traditionally been associated with the social model and understanding. However, with the integration of health service and social services in the CMHTs, and the teams functioning under the MHT, the teams are understood to draw more on the medical model.

I found no indication of a specific contribution made by the MHSWs to the CMHTs, other than while acting as care coordinators AMHPs carry out specific MHA assessment duties. However, it is also understood, and some other professionals acknowledged, that if they need particular help with social benefits or housing in designing a care package for a service user, they tend to go to a social work professional in the team for that information, as they believe they are more knowledgeable on those issues.

“Yes there’s the medication side of it we’re a bit more expert on, but then again, the way social workers are trained, as a nurse you didn’t receive a lot of training around housing, finances and things like that. So then we can get a lot of that from social workers. It’s a really good working relationship” (CPN 1)

Some other professionals also emphasised that if they have any problems with the MHA related issues, they will probably go to an AMHP to clarify that issue. These findings indicate that AMHPs and MHSWs are capable of providing that practical social model guidance within the integrated teams, which is acknowledged as a benefit to the effective functioning of the integrated teams. However, it is important to pay attention to what actually MHSWs are trained to do and what they are capable of doing, rather than supporting each other in the integrated teams.

Referring to relevant literature, Gould (2006) emphasised that the training of social workers in mental health services has been key in providing critical perspectives drawn from a broad range of social sciences. NIMHE (2005) describes that in particular, it has supported social models of understanding, which can challenge or

complement clinically-oriented medical models of mental illness. Under their current role as care coordinators, what social work professionals really do is coordinate the care for the service users. In this role it is questionable if the social work professionals in CMHTs really get the opportunity to shine as social workers amongst the other care coordinators. As CPN 7 revealed, in section 5.4.2., during her teaching in a University she had encountered in practical terms how social workers shine during presentations about family work and family cases, where they bring all their practice and theory out. However, she added that social workers do not get that opportunity in their day to day practice in the integrated CMHTs.

In this sense it is difficult to understand how MHSWs make any distinctive contribution through social work practice to the integrated teams. Newly qualified MHSWs appointed to the CMHTs start practising under the medical model and focus more on the medical aspects in care coordination. This has become a real concern among the senior social work professionals, as they believe the newly qualified MHSWs are being inducted more into the medical model and totally out of social model. What is understandable through these findings is that the distinctive contribution of social work professionals is diminishing in the CMHTs.

5.4 Different Issues and Problems Related to AMHPs' and MHSWs' Roles in CMHTs

5.4.1 Role Clarity and Role Confusion

With the integration of social services with health services, it was originally supposed that professionals from both services will bring their own specialism to care coordination. However, it seems that, at the moment most professionals are confused about this aspect of social work professionals' role as care coordinators.

"Care coordinator is an umbrella term; I think it dilutes the social worker's role. I thought the original premise for integration was that we bring our specialism.....So comparatively speaking there's no difference in what I do to what my colleague CPNs do....There's an expectation that you will do all this work and yet you start having real serious doubts about what you are doing and where it should stop. I don't think there is an exact role, that's the problem, I think it's been lost, I think because of care co-

ordination the role of a social worker has been subsumed by general whatever it is.” (MHSW 2)

A Consultant Psychologist who provides supervision to care coordinators expressed her ideas as follows:

“I often forget whether the people who come for supervision whether they’re CPNs or whether they’re social workers in the background, because their roles as care co-ordinators are almost the same. And some of the social workers have attended some therapy training as well and then asked for supervision on the therapy work so it’s sort of difficult for me to distinguish between the social workers and the other people in the team. To be very honest, I’m not always clear what a care co-ordinator’s role is”. (Consultant Psychologist 1)

Some of the professionals believe that if the care coordinators do not introduce themselves to the service users in their professional title then they will find it difficult to find out which profession they come from, as they are both doing the same job.

“I think if myself and one of the social workers out there went into assess a client and didn’t introduce ourselves as ‘I’m X(name), I’m a CPN’ or ‘I’m Y(name), I’m a social worker, I think the client might struggle to determine what profession we come from, I think there’s very much a blurring of roles now”. (CPN 6)

5.4.2 Role Overlap

All the interviewees were asked about role overlap, as it is discussed as a common theme in the literature. There were mixed responses to this question. Some professionals saw that there is a definite overlap of roles in the CMHTs.

“Yes, there’s lots of overlap because some of the things that CPNs are doing would be typical social work roles and some of the things that we do, apart from giving depot injections, are exactly what a CPN does. So there is quite a broad overlap”. (MHSW 4)

“Then very often you would find that the CPNs would take on clients who might need medication administered, for example, like depot injections, whereas the social workers would take on people who didn’t need that; but we’ve always had a huge overlap anyway in what we do”. (CPN 1)

“..... there may be a lot of overlap in the role and there are times that I am called, somebody just refers to me as their CPN, somebody else might refer to me as their social worker as well, and I think the social workers probably get the same thing, that

the patients aren't quite sure why they've got a social worker or why they've got a CPN" (OT 1)

However, there were many professionals who believe that there is no role overlap in the CMHTs as they have their own case loads. There were another set of professionals who actually supported the existence of role overlap in the CMHTs; in fact, they viewed this overlap as something good for the team.

"Yes, very much overlap, but I think that's a good thing, I think it's good, I think if we keep very boundaried then that becomes quite clumsy for the patient, because then they've got a social worker to see for their benefits and a nurse to see for their injection. I don't think that's very helpful. I think we can all do the same role, but I think what's got lost is what is our unique knowledge base so I think we could all do the same job but we can come from quite a different perspective and that's where the richness comes from". (CPN 7)

One Team Manager agreed that there is lot of overlap; however she believes that this overlapping prevents a lot of wasteful duplication of effort, inside the CMHT.

"I think there's a lot of overlap, I think there always has been overlap but I think the beauty of care co-ordination is I'm not going out to visit someone and then saying 'oh I'll have to get the social worker out to sort you a new house out from social benefits'. I would do that and I would see no reason why I can't expect the social worker to have an awareness of the drugs we give people and what the side effects might be and there's no reason why they can't monitor the side effects. So, there's always been an overlap but at least this time you're being more efficient because rather than having 2 people in you've only got one. I think a lot of the work that we did was overlap and we overlapped into social work and they overlapped into health so having that integrated approach I think prevents a lot of waste". (Team Manager 1)

A Consultant Psychiatrist agreed that there is overlap but he believes that each profession brings something special to their duty, so he does not see anything wrong with this overlapping.

"Yeah, I suppose it is but they're working generically so they're each coming from different backgrounds but doing work which I think they can all bring something to, even though there is overlapping. So they still have their own specific areas, for instance, the CPN giving depot injections that the social workers can't do, social workers may be doing MHA assessments which a CPN can't do, but of course these days a CPN can become an AMPH. So yeah, I suppose it is overlapping but I don't think there's anything fundamentally wrong with that". (Consultant Psychiatrist 1)

This idea convinced me that most of the professionals consider there is not any wasteful overlapping of roles; or if there is overlapping it is to achieve a better, more

integrated service. However this is something which should be considered further while reviewing the original purpose of integrating health and social services. The original intention was that each profession should bring their own specialism into practice. Yet, what I observed is that during the Allocation Meetings new cases are allocated to whoever has the lightest case loads at the time, rather than their professional specialism. Generally, CPNs are allocated cases involving depot injections, but this sometimes changes according to the availability of a CPN.

5.4.3. Losing Professional Identity

The prevailing literature discusses the loss of the social worker's professional identity in multidisciplinary teams;

Early work on the concept of multidisciplinary teams (e.g. Payne 1982) saw professional identity as important and desirable, so as to survive the knockabout environment that a multidisciplinary team could become. Moreover, multidisciplinary team work is seen as isolating members from the departments and professions from which they originated and thus deprive them of a sense of support and professional identity from others of a similar background (Berger 1991). This was believed to be particularly acute for social workers who were often outposted from their own departments into an environment dominated by others with NHS backgrounds (Brown et al., 2000:426).

As Brown *et al* (2000) described above, some scholars have discussed social workers' losing their professional identity in the CMHTs as they are now working in teams, which function under the control of the MHT and working alongside the professionals with NHS backgrounds. In these two CMHTs I observed, issues related to loss of professional identity were mainly raised through the interviews with AMHPs and MHSWs; not many other professionals believe that social work professionals are losing their professional identity.

"It is. It's devaluing to be quite honest, I don't feel like a social worker anymore"
(AMHP 2)

"The only thing different now is all the professions sitting together. In real terms, in terms of how I am as an individual worker, there is not a huge difference. But in terms of what we've lost, I think that we've lost a lot. And that's the whole identity of you as a social worker, you know about the notion of being a profession and I think that goes to a great threat. And I think that will continue. (AMHP 1)

Some social workers feel that they have become more like CPNs rather than social workers in the CMHTs, once again emphasising that they have lost their social work identity.

“So they would become pseudo CPNs as far as I can see and lose the identity of social workers and it would come as a major shock to them if they went back into a social work agency, because they wouldn’t understand commissioning and that’s basically where social workers’ heads are at now isn’t it, commissioning? Well I think it is”. (MHSW 5)

“Social workers have lost their identity really and become more like CPNs”. (MHSW 5)

Also some senior AMHPs and MHSWs explained their concerns regarding newly qualified MHSWs not getting proper social work practice in a CMHT. It seems that these senior social work professionals are disappointed and worried about how newly qualified social work professionals quickly get absorbed into the medical model, if their first appointment is to an integrated CMHT (Field work diary/09.09.2009). A MHSW expressed his concerns in this regards as follows.

“I’m just thinking of the people now who are left in the team who are social workers, they’re newly qualified workers and I don’t think they’ve got a social work identity. I don’t think they come from anywhere that’. I mean one of them is a nurse anyway and the other one is so newly qualified and has never done any social work stuff and is so being trained up by CPNs that you’ll never know that they’re social workers and what they’ll end up with”. (MHSW 5)

However, none of the newly qualified MHSWs expressed concerns about losing their professional identity. They did not see any difference between what they are currently engaged in vs. their social work role. I also identified this issue throughout my informal discussions with the AMHPs and the MHSWs. Still many other professionals do not believe that MHSWs are losing their professional identity. I identify this as a gap between other professionals’ understanding of social work professionals’ background, what they are really capable of doing, what they are trained to do and what they really like to do. However, CPN7 revealed that she considered that social workers have no professional identity and what she really expects social workers to bring into the CMHT.

“I don’t think they have (professional identity) and I think that’s a shame and I think it could be different to that but I think social workers for some reason as a profession have allowed themselves to be eroded quite significantly. I work at a University

running the Masters in Psychosocial Interventions and we have a lot of social workers on it, and the time that they shine is when we do the family work and they present the family cases and they shine. You know they get 100% whereas the nurses get 40% because they really come out, they bring all their theories out, they bring all their practice out, I don't think they get that opportunity in day to day practice". (CPN 7)

This provides further evidence to suggest that social work professionals in CMHTs have no opportunities under the current system to express their own professional identity.

In summarising the above, I found from interviews and observations that role definition, role clarity, role confusion and concerns about professional identity, are all relevant to and play a significant part in social work professionals' daily routine. As these findings reveal, social work professionals still feel their role is not clearly understood and valued. The implications of this can be considered in the light of the revelations in the BASW Policy Paper on 'Social Work's Contribution to Multidisciplinary Teams' where Godden *et al.*, (2010:4) emphasise that "human beings in work and social settings need to feel that they are understood and their roles are clear and valued by others. Without such role clarity people can feel dissatisfied and undervalued". In this Policy Paper they explain the relevance of this to the multidisciplinary working in CMHTs as follows;

Multi disciplinary working can be beset by problems of individual staff, or groups of staff feeling the malcontent of role confusion. In a social work context role adequacy (feeling knowledgeable about ones work) and role legitimacy – believing that one has the right to address certain client issues is very important for professionals, and particularly important for social workers who can be perceived as suffering from a lack of clarity regarding their role. Feelings of role adequacy and role legitimacy appears to be variable depending upon the particular team, its makeup, supervision and support, the degree of isolation and degree of training, knowledge, specialisation, leadership and the degree that other professionals understand the role of social work (Loughran *et al* 2010). (Godden *et al.*, 2010:4-5)

The dominance of the medical model was also identified as a point where social work professionals lose their professional identity, as they start to feel like they are working for the MHT rather than the social services.

5.5 Difficulties and Barriers to Effective Care Coordination

5.5.1. Difficulties and Barriers Common to both AMHPs and MHSWs

From the findings of the study it is clear that AMHPs and MHSWs are well integrated within their teams and valued by their team members. They have also built up positive relationships with their clients and successfully contribute to the smooth functioning of the teams. However, while interviewing and talking to them, I discovered some persistent workforce issues which involved; administration of medication, case load size, paper and computer work and supervision issues. Some of these are relevant to both MHSWs and AMHPs; however there are some specific problems that are faced only by AMHPs, which I will discuss in section 5.5.2.

5.5.1.1 Administration of Medication

One of the difficulties social work professionals often face is responsibility for monitoring medication. Like other care coordinators in the CMHT, they are expected to monitor the side effects of medication given to service users. However, it is important to remember that they are not trained in medication management, unlike their CPN colleagues.

*“I think one of the problems with ourselves, as well, is that we’re all supposed to be doing everything and I will miss out on things like medication. I’ll know about medication, don’t get me wrong, but I won’t know all the side effects of medication”
(AMHP 1)*

“Monitoring the kind of side effects of medication and stuff like that, now that is something that we’re all expected to do as care co-ordinators. I think it’s a dangerous business because social workers don’t have training in and nor do OTs. So we’re being expected sometimes to do kind of a role that we’ve not been trained to do and that we could make mistakes in”. (OT 1)

It is understood that all the care coordinators are expected to deliver a full care package for their individual clients. Even though service users who need depot injections are normally allocated to CPN care coordinators, there are still many service users who are on other medication and under the care coordination of AMHPs, MHSWs and OTs. MHSWs and OTs report that the monitoring of medication can be stressful, as they believe they have not received a sufficient training on this. Compared with the MHSWs and OTs, AMHPs had received more training on medication and it is also obvious that through years of experience

MHSWs and OTs also develop competence in medication management. However, some newly qualified MHSWs are worried about the impact of their inexperience on service users, as for the service users it does not matter whether their care coordinator is a MHSW, OT or a CPN, when it comes to medication. They expect the same level of expertise on their medication from their care coordinators. This has become a real challenge for MHSWs and OTs as care coordinators.

5.5.1.2 Case Load Size

Almost every care coordinator with the team has a case-load of around 35 individuals, except the AMHPs who have a smaller case load than this. A common complaint made by most of the care coordinators is that the heavy case loads cause them stress and have an effect on the quality of work they do. With all the paper work and computer work to be completed on a daily basis, they feel more stressed with a heavy case load.

Care coordination is not a job that can be done seated in one place, like other office jobs. They have to go out on scheduled home visits, as well as some very urgent and immediate home visits. During field work I understood how busy the work routine of the care coordinators; I personally observed how service users regularly phoned them and sometimes appealed for an immediate visit. Some phone calls last for half an hour or more, taking a considerable time from the care coordinator's day. The significance of these calls has to be acknowledged, as I never saw any care coordinator refusing these phone calls, nor refusing to make the home visits requested by the service users. Some care coordinators even volunteered to take their clients to the GPs or to other important appointments, showing great understanding of their clients' needs. This emphasises the need for more care coordinators in each team and smaller case loads.

5.5.1.3 Paper work Load and Difficulties with PARIS¹²

The assessment, documentation and information system in the CMHTs is different from the social model informed documentation system social work professionals used when they worked in social services. Social work professionals prefer to be

¹² PARIS – the new computer system with the Health Services

working directly with service users and resent this increased bureaucracy, as they feel like they are losing an important part of their job.

“You fill out the paperwork and if you don’t then your head’s on the block. But what happens is that it’s the same thing that’s happened with me and in childcare. I always used to think it was more important to see people than spend hours filling out forms and I think you get down to the lowest common denominator if you’re dominated by what happens on this computer system rather than what happens in real life with people”. (MHSW 5)

Among the other care coordinators, AMHPs and MHSWs are the only members from the social services and this can be seen as a disadvantage for them while working with the NHS computer system ‘PARIS’. Almost all the social work professionals expressed concerns about this new computer system in health and related how much they missed ‘SSID’¹³ the social services’ computer system. As they explained, the PARIS system is health led, base on a medical model and does not provide space for social work assessments.

“Because the computers here are linked to the health authority, they’re not linked to the County Council ones, so you can’t actually link up straight away to the network so that’s quite difficult”. (AMHP 2)

“I think the computer system we’ve got doesn’t recognise social work and it’s a very medical modelled that we’ve to fill out”. (MHSW 5)

“You have to say what your diagnosis is and I don’t particularly fit into a system that wants to diagnose somebody to start off with. Then you have to say distinctively like what interventions are you using. I mean when I’m seeing somebody hopefully for the first 5 to 10 minutes, what my term would be, the language I’m used to using is that I would be engaging or joining that person. I would be getting to know what changes had occurred and I don’t know this system allows that to happen”. (MHSW 5)

As emphasised in these quotes, social work professionals in these two CMHTs often find it difficult to deal with PARIS and they regard it as a waste of time. Another complaint about PARIS was that the medical modelled nature of PARIS labels service users. They also revealed that, under PARIS, there is no opportunity to make a detailed home visit report as it mostly comprises of tick boxes.

Having PARIS, as the CMHTs’ computer information system, has also had an impact by keeping social work professionals away from their own social services system ‘SSID’. Previously, social work professionals were used to operating SSID, where

¹³ SSID – Social Services Information Directorate

they were able to read and update themselves with information circulated by the social services. They now complain that they are missing important information from their own service about training etc. and feel that they do not belong to social services anymore. They also complain that as PARIS is totally different from SSID, they have forgotten the basic elements of using SSID and feel de-skilled by having to work completely on PARIS. One team complained that they have no computers with access to SSID in their office, while some in the other team complained about having no time to spend on two different computer systems.

At the time of the study, within the two CMHTs this issue seemed to be very complicated, as many of the workers were attempting to learn the new system. There were some scheduled training sessions on PARIS within the CMHTs, so I assume that by now most of them are competent in using PARIS. However, being competent in the PARIS will not necessarily resolve all the concerns of social work professionals for two reasons. Firstly, they will continue to miss all the news and information they received through SSID. Secondly, they have to continue to record their assessments on PARIS, which they explained as a system designed to fit a medical model of need.

5.5.1.3 Supervision Issues

Another burning issue with the social work professionals in these two CMHTs is supervision. Team managers in these CMHTs are from health services and this has resulted in social work professionals having their supervision from somebody outside their own service and profession. There are very strong opinions held about social work professionals not receiving supervision from a professionally qualified social worker in their own service. This is seen as important in continuing their professional development as well as for the benefit of service users'.

"I'm a social worker and I'm managed by health. I haven't had social work supervision for a long, long time and I find that quite different". (AMHP 2)

"I think we haven't got anybody we can sort of just go to for real sort of social workers concerns, issues. There's nobody really to go to for that because the management are Health so you can't really go to them, you can but they don't know everything" (MHSW 6)

“In the Older Person’s Team every 5 weeks perhaps I would have an hour’s meeting with my manager to look at the case loads, issues that might be arising, looking somewhere down the line saying ok, ‘can we discharge this person?’. Also part of that would be ‘right, where do you want to be in 2 years time, what’s your professional development going to be like because as you know, we have ongoing training?’ and you’d say ‘well I’d like to do this, I’d like to do post qualification awards’ or whatever and yeah, that would be part of your ongoing strategic relationship with your manager. In health it’s a case of ‘get on with it’”. (MHSW 4)

As well as the MHSWs and AMHPs, some other professionals from health backgrounds also emphasised the importance of social work professionals receiving specialist supervision from their own service.

“I think it’s important that the social workers have some kind of professional supervision as social workers. We do a lot of reflecting back to the person saying ‘I think this is what you’ve just said...’, you quite often get the light bulb going on over their head and most people who participate in clinical supervision find it useful and it’s not always, it should be people who have an insight into each other’s role, now I think for something like that for social workers; whether they want to call it clinical supervision, professional supervision, whatever, I think that sort of model and there’s a vast amount of literature on it would really help because it would help them a) deal with issues of transition, b) help them be really clear about what it is they do and are as social workers, I mean I get that in my own supervision but as a nurse and it is incredibly helpful”. (CPN 1)

These quotes emphasise the importance of providing specialist social work supervision for social work professionals in CMHTs. This missed opportunity, not receiving proper social work supervision, may have a direct influence on the quality of work social work professionals carry out. What social work professionals expect is to have supervision from their own service, so that they get the opportunity to discuss issues regarding their clients and their own job prospectus.

At the moment AMHPs have their own forum in the particular County, where they discuss issues related to AMHP work. However, this cannot be considered as a replacement for a supervisor from the social services, as these forums are held once a month or so and cannot depend on this in getting solutions to some of their pressing concerns on a daily basis. In one CMHT, MHSWs have the opportunity to approach an expert practitioner (who is an AMHP as well) for their supervision; however this has to be considered alongside the heavy amount of work this expert practitioner has to carry out, as the only AMHP and expert practitioner in that team.

This expert practitioner stressed that the MHT should understand the importance of this job and appoints at least one expert practitioner to each specialist team. However, there is no such post with the other CMHT and most of the complaints regarding supervision for social work professionals came from this particular team.

5.5.2 Difficulties and Barriers Specific to AMHPs

5.5.2.1 Prioritisation of Roles

When undertaking an assessment under the mental health act, 35% of ASWs (n=55) did not do any other work at all at the same time and only 19% regularly combined statutory assessments with other work. This reflects the often urgent, complex and concentrated nature of ASW assessments. Once an ASW has started to work on an assessment, they feel a professional and moral obligation to see it through to completion. (Evans et al., 2005:153)

Interviews, informal discussions with staff members and observations in this study provided further evidence to support the findings of Evans *et al* (2005), as they revealed that AMHPs have to give priority to their MHA assessment duties over and above care coordination responsibilities. In fact my own experience of the scheduled interviews being cancelled can be taken as a good example.

Received a call from the secretary at Y¹⁴ House around 9.30am to inform the cancellation of the interview with X¹⁵. X has to go for an urgent home visit and had asked the secretary to give me the message.

07.08.2009 - Field Work Diary

Consequently, there were many cancellations of appointments and other commitments. During the interviews AMHPs explained how they deal with this;

“Well it’s the issue we have and it’s only the AMHPs who have this problem, nobody else in the team does our work. We try to avoid cancelling appointments but we can’t, and you have to ring and apologise to people. In general most of the clients actually quite understand. They know that we don’t do this purposely and it’s emergency and it’s the nature of the work we do”. (AMHP 1)

AMHP1 further described how this affects his work as a care coordinator.

“Massively, you avoid care coordination work on the days when you are actually on the rota. But the problem is it working it in general, this month I had 3 MHA

¹⁴ Y - Name of the CMHT

¹⁵ X - An AMHP with the team

assessments. So that's 3 full days out just doing that. One day in a week perhaps, say at least you are actually doing something else avoiding care coordination work". (AMHP 1)

AMHP2 and AMHP3 revealed their difficulties as follows.

"It's not as good, but I would have to cancel my appointments if I get a call out and do what I've got to do for my MHA assessment. A lot of the clients don't like it and they'll get sick to get phone calls to say 'I'm sorry, I can't come today, I can't see you I've got an assessment on' but what I do with all my clients when I pick up somebody I go 'I'm an AMHP' and you have to be aware that if I get a MHA assessment that is my priority and if I have to cancel your appointment that's the reason why'. So they have to know that and if there's any problem with any of my clients I would have to ask a colleague to go out and see them". (AMHP 2)

"The AMHP role, I could never be an advocate in a situation where I'm behaving as an AMHP because I'm compromised and conflicted by my role which is to make a decision about whether or not that person should be detained under the MHA". (AMHP 3)

These quotes indicate two other problems that arise through taking up MHA assessment duties and care coordination duties at the same time. Firstly, asking another staff member to visit their client, in the absence of the AMHP, can cause distress among some of the service users. Service users often prefer to continue with one care coordinator and have the regular intervention and attention of that same person rather than having different people visiting them.

Secondly, when AMHPs work as care coordinators, this might sometimes affect the therapeutic relationship they have with service users. However through my observations I understood that almost all the AMHPs have built up very good relationships with their service users over the years. According to CPN7, AMHP duties do not have any effect on the therapeutic relationship between the service user and the care coordinator. However she emphasised the appalling attitude of the general public towards social workers which predominantly comes through media.

"Many years ago CPNs were asked if they would like to be able to detain patients and the resounding response was that 'oh no', it would spoil the therapeutic relationship with the patient, I think that's a nonsense, I've seen social workers on this team who are excellent and the fact that they have to detain someone doesn't alter their therapeutic relationship with that individual. But I think the general public have a particularly appalling attitude to social workers and that's predominantly through the media (CPN 7)

However despite this CPN's views, all the three AMHPs I interviewed revealed that this has an effect on the relationship between them and their service users. They also agreed that most of the time they managed to maintain the therapeutic relationship, even though it is sometimes emotionally disturbing for the AMHP himself.

5.5.2.2 Other Difficulties in AMHP Work

Evans *et al.* (2005:146) described how;

While ASWs are involved in crucial decision-making about the liberty of individuals, their options are in reality constrained by the legislative framework, and by limited availability of alternatives to admission in many areas, whereas non-ASWs do not have to work with these constraints to the same extent.

In addition to this, Evans *et al.* (2005:146) further revealed that; "while ASWs have limited choice about acting in the ASWs role once they are trained, and can face added pressures to do so because of ASW vacancy rates and more than 1/3 of ASWs were thinking of leaving their job". Reid *et al.* (1999b:306) explain the 'mechanics of detention under the MHA' as a further source of stress for ASWs, 'because of factors such as long waits for police and ambulance, workers' fear for their own safety and concerns that patient's might leave before assessment could be completed'. As well as these issues, I found some other difficulties that AMHPs face in the CMHTs.

"There was a kind of a real brain drain for a while in X¹⁶. People were just leaving, they didn't like the X set up. They had this feeling that X is completely swamped by health and it's one of the reasons. Also the fact that you know they are being paid less and also they felt the ASW role was not valued. Because if you look at the case load we have, we were always banging on about the fact that we couldn't do all the AMHP work and say something like keep up paper work updated, which is a real issue, a disciplinary offence is. So we were saying we can't do both and it's very much like just get on with it". (AMHP 1)

This above quote emphasises a number of other difficulties AMHPs face in CMHTs and below I discuss some of these difficulties.

¹⁶ X – name of the team

Dearth of AMHPs

As revealed by the three AMHPs I interviewed, there is a dearth of AMHPs in these two CMHTs. There are only three AMHPs for the four specialist teams in these 2 CMHTs, which mean one specialist team has no AMHP attached.

“Certainly some places I’ve worked there’ are very few ASWs on the ground and they tend to be quite overworked, have to work extra shifts and things, so getting more people available I think can only be a good thing!”. (Consultant Psychiatrist 1)

“Nationally the picture, the number of ASWs is low and I think that nationally they’ve said let’s have this AMHP and in some ways I can understand why they’ll do that, because they’ve got this great lot of nurses who could go off and train to do that and then you can stop treating AMHPs as a special case because AMHPs are on a different salary scale to MHSWs”. (Team Manager 1)

“I’ve got a meeting this afternoon in the ASW forum and that’s one thing they would be talking about constantly for years, our numbers are dwindling, morale is low which is understandable because we’re always doing assessments but, there is a real lack of people around”. (AMHP 2)

There seem to be different reasons for this shortage of AMHPs and this had a negative impact on the remaining AMHPs, in terms of increased work load and limitations on the mutual and practical support available to each other, to assist with MHA assessment difficulties. The interviews offered the following reasons, by way of explanation:

I can understand why people would leave the profession because I think it’s not an even playing field. I sometimes think the general public view nurses as, kind, they gonna go in, help people, the doctor’s sent them and you’ve got this whole NHS culture that everybody in Britain love the NHS and you’ll probably pick that up as you go around. We all love the NHS, but social workers sit outside of that part in a lot of people’s minds and I think that makes it difficult for them to go in and often they go into very difficult situations with very specific roles to do. So if it’s going into detain somebody who’s got no insight and doesn’t realise they’re ill, they view them with a lot of animosity and a lot of hostility and I think that’s really, really difficult for them to deal with. It certainly makes me wary about thinking ‘do I want to be an AMHP? I’m not sure that I do”. (Team Manager 1)

An AMHP also relates this to difficulties they experience in their work;

“I think the CPNs see us, the nurses see us frazzled at times, at quite in difficult roles and they’re thinking ‘I don’t want to do it”. (AMHP 2)

Another reason for fewer AMHPs is that qualified AMHPs leave the AMHP job and go back to practice as general social workers.

“We’ve got somebody in X¹⁷ who’s a qualified AMHP and isn’t practicing as an AMHP. Now my view is they shouldn’t be on mental health teams because I want people on mental health teams who are willing to train and to practice; because if you have a lot of people you take off loads of pressure off the ones that’s there because the ones that’s there are frequently on duty in-case they get requests for a MHA assessment”. (Team Manager 1)

Even though this role is now open to health professionals, there were no health professionals in these two teams who were willing to become qualified as an AMHP. My finding was confirmed by the comments of a number of other professionals within the teams.

“You’re actually right, I haven’t heard of anyone who wants to; I’m not sure why that is”. (Consultant Psychiatrist 1)

However an OT informed me that she did not know that the new AMHP role was open to other professions, until I told her. This indicates that some staff members were not aware of the changes made by the 2007 MHA at the time of the study being conducted. MHSW who would like to get qualified as an AMHP explained the difficulties in getting the AMHP training as follows;

“When I first came here and I said to A¹⁸, he said it didn’t matter about undergoing the training and to be honest, part of it is they don’t like losing people for the time that the training takes. Does that make sense? This is a bit sad really”. (MHSW 3)

As a result of this dearth of AMHPs, the remaining AMHPs find it extremely difficult to cope with the entire workload by themselves. An AMHP expressed his feelings about how he desperately needs a support of another AMHP in his team as follows.

“In old mental health teams we were actually in social services. There were 8 ASWs, all based together. In legal point of view one of the problematic things of AMHP work ASWs have to do some tricky legal issues. I mean the other day, what I desperately needed was another AMHP to discuss the legal points because there can make some huge gaps, which we are left to cope with. Before there was a kind of knowledge base in the team, it was quite easy. In the previous teams we’ve got somebody who knows everything about that, that’s gone. That’s changed, you are isolated”. (AMHP 1)

¹⁷ X – Name of the team

¹⁸ A – name of an officer with the team

This quote emphasises the potential contribution a pool of AMHPs could make in helping each other with difficult situations and dilemmas arising in MHA assessment duties. With the heavy work load these AMHPs carry at the moment they do not find enough time to visit AMHPs in other teams, to seek advice in these difficult situations.

All these ideas revealed the problems of the dearth of AMHPs in the CMHTs and the impact of not having sufficient numbers in the teams. However; there seems to be no immediate solution to this problem, other than opening up the AMHP role to health professionals. But with these two CMHTs this does not seem to have been effective, as there were no health professionals willing to train and qualify as AMHPs.

Working Overtime and Other Stresses

All the interviewees in this study agreed that the AMHP role is 'very difficult' and some team members expressed concern for AMHPs who work overtime.

"If they're required at the end of the day then they have to go and then they have to think about childcare arrangements and all of that, that working parents would find very difficult to accommodate, you know if someone is having to be sectioned they have to be sectioned at that time, so the out of hours working I imagine would cause difficulties for parenting". (OT 2)

"I like to keep my nights to myself". (Consultant Psychologist 1)

"Because it's a hassle, it's hard and it's a hassle. I don't think people are particularly keen on being an AMPH because they see how the social workers have to run around all over the place and it's really hard and social workers are really good, far better than CPNs at flexible working. You know they know if they start a MHA assessment at 3pm they're not going to get it finished to 8pm or 9pm or 10pm. CPNs are very rigid in the way that they work; you can't even get CPNs to do family visits in the evening". (CPN 7)

A CPN emphasised concerns over caseload size, amount of paper work plus over time work which can be a real drain on the AMHPs.

"I know of colleagues who have done all of that and then have come off the rota so they are no longer officially AMPHs, even though they have the qualification, and the reason they do it quite often is simply because of work load issues. But if you are the person on the rota as the duty AMPH and a request for an assessment under the Act comes in you will need to go and do it, whether that request comes in at 9.30am on a morning or 4.55pm on an evening. And certainly you get the AMPHs coming in on a morning absolutely shattered because they've been out on an assessment and getting somebody to hospital and doing all the paperwork and they've maybe got to

bed at 1am in the morning, and that's after a full day at work with your clients and I think that is a huge drain on them". (CPN 1)

Some of the CPNs emphasised firmly that they never want to become AMHPs because of high levels of stress associated with the job. These stresses are physical and psychological, physical in the sense of working continuously for long hours and sometimes receiving physical threats to the worker by clients and carers. Psychologically means being with a really ill person and facing all the hazards around detention.

"The AMHP position within social worker has become less and less attractive over the years to people because it is hugely stressful. I had people who have physically hit me, threatened me, come to the office to threaten me, knives, bottles, I mean you go into situations whereby people are very paranoid, very deluded, you have to co-ordinate doctors, police, go in with police vans, police dog handlers. So the reason why I'm making this point is for several reasons; not every social worker can do it because it is about making life changing and life altering decisions for people who are very vulnerable and very seriously mentally disordered, and we've got people who have done it and said 'I don't want to do this anymore, I can't do it anymore, I'm burnt out, I'm stressed out, I'm not making good decisions and I'm going to stop". (AMHP 3)

"It's an incredibly hard role because it's not just the fact that you might be called out at 4.55pm and be out till 1am in the morning and you are physically tired, there's the emotional drain of being with someone who is unwell, manifesting massive symptoms of mental ill health, often massively distressed and you've got the emotional drain as well, it's horrific. You know by the time that person gets into hospital, we get some medication into them and even if they're on the most intensive level of observation we have a rule of thumb that nobody does it for more than an hour and it's the emotional drain more than anything else, well that and in hospital very much the boredom as well, because when the person's there on medication they are there with their eyes closed and snoring but you still can't leave them but when they're awake, they are often expressing the same thing that the poor social worker may have had for 5/6 hours nonstop, it's awful". (CPN 1)

As revealed through these quotes, almost all these professionals agreed that AMHP duties are very stressful and they can bring massive distress and exhaustion to the worker.

In summarising, in section 5.5.1 and 5.5.2, I revealed a number of findings related to difficulties and barriers AMHPs face in CMHTs. Only a very few studies are available on the impact of statutory duties on AMHPs and this literature reveals high levels of stress, burnout and dissatisfaction of their job, which are similar to the findings of this

research in which AMHPs identified a number of difficulties in their work including workload, lack of understanding of their job, overtime work, lack of support from the social services, dearth of AMHPs in the teams, risk to their own safety and physical and psychological exhaustion.

Compared with the general MHSWs, AMHPs are most dissatisfied with their job, stressed and 'burnt out'. They feel that they are not valued in their role and that other team members do not understand their responsibilities properly. However, this is the personal opinion of the AMHPs and was not supported by the interviews with the other professionals. They showed a reasonable understanding of the burden and stresses attached to the AMHPs' duties. With this understanding, they emphasised that they did not want to become AMHPs, even though the new MHA gives them the opportunity to do so.

AMHPs were also disappointed with the high case load they were allocated for care coordination. As described above, AMHPs have to prioritise MHA assessment duties over the care coordinating duties. They explain this as disturbing to the effective relationship between them as care coordinators and the service users. This issue is related to the shortage of care coordinators and AMHPs with the teams. This has resulted in remaining AMHPs shouldering heavy care coordinator responsibilities and MHA assessment duties, which have consequently made them feel over stressed and burnt out.

It is also important to note here, both the physical and psychological exhaustion that the MHA assessment duties bring to AMHPs. Working overtime and sometimes the actual physical risk can affect the physical and psychological health of AMHPs. With all these difficulties they are generally feeling their jobs demand too much of them. Some AMHPs revealed that in their LA many AMHPs had given up the role during the past few years and some had stopped working as AMHPs and gone back to work as generic social workers. Even since the AMHP post has been open to other mental health professionals, through the 2007 MHA, there seem to have been no immediate requests from social workers or from any other mental health professional in the two teams to achieve the AMHP qualification. This situation has to be addressed immediately, as AMHPs are seen as very important in the smooth running

of a CMHT, which is a fact that revealed through both the literature and confirmed by the findings of this research.

5.6 Stigma and Status of Social Work Professionals in CMHTs

As revealed in the literature review, the status of social work professionals relative to other professionals in integrated teams is the subject of discussion in the literature as is the stigma attached to the social work profession. Over the decades the social work profession has been stigmatised widely within the media, especially after the deaths of Victoria Climbié and Baby P. The literature revealed cases of social work professionals being stigmatised by media, by service users and sometimes within their teams. Most of this negative representation and reputation has been related to child care social workers; however, it seems that the label of stigma is attached to almost any social worker. With this understanding, I included questions in the interview guide on the status of social workers and any stigma associated with this role. Also throughout the field work period, I carefully observed the team behaviour in official and unofficial contexts and behaviour and the relationship between social work professionals and other staff members to help me understand this issue.

5.6.1 Perspectives of Social Work Professionals of Their Status in the CMHT

All the 24 mental health professionals I interviewed were asked the question ‘How do you perceive the status of a social worker in your team?’ The answers I received were different from social work professionals and other mental health professionals in the CMHTs, and also from newly qualified MHSWs to experienced social work professionals. All the AMHPs expressed very strong opinions about their status in the integrated teams.

“Probably bottom of the pecking order I think. AMHPs are viewed quite differently, you know if you are a general social worker I think then it’s definitely. AMHPs are seen slightly different, because we do something that’s kind of outside the team. But still think probably would be seen as bottom of the pecking order”. (AMHP 1)

“I think that there are stereotypes, nurses towards social workers and social workers towards nurses. There is with several of the nurses in this team my personal

relationship would be they will attempt to denigrate the social work profession, that they aren't as qualified as nurses or that they bring different skills and knowledge and expertise to the party, but my personal belief is that evidence is not there". (AMHP 3)

Next are examples of comments from the newly qualified MHSWs regarding their status in the CMHT, which are very different from the AMHPs' ideas.

"In our team we work really well together, really well in the X¹⁹ Team. I don't know about the Y²⁰ Team. CPNs OTs there are a lot of us over there and we just work together and there is no status [difference] you know. We work as a team and it doesn't matter what you are. It's really a good team. So nobody tells names, we're just even. We get on with our job, which is good. (MHSW 1)

"I find it all fits in quite well, I mean I get on with the other people, my colleagues, I don't know how they view social workers as being different to other mental health workers. Certainly I feel that I get treated with the same level of respect within the team as everybody else does, I don't feel like the social workers are thought any less of, like I said". (MHSW 3)

As revealed through the above quotes, most social work professionals have a strong sense of their poor status within the teams and this feeling is stronger among the AMHPs. However the newly qualified MHSWs did not see any difference in the status between social work professionals and the other mental health professionals in these teams.

5.6.2 Other Mental Health Professionals' Perspectives on the Status of Social Work Professionals in CMHTs

It is very important here to emphasise the other mental health professionals' opinions about social work professionals' status in the team, as they are very different from how AMHPs and some MHSWs perceived their status.

"I don't think it's any different to anybody else in the team. I've never come across instances where it makes any difference, as I said, I'm not even always aware quite frankly whether someone is a social worker or a CPN or an OT because they work as a care co-ordinator and do fundamentally the same work. So I've never noticed there to be a problem at all". (Consultant Psychiatrist 1)

A Link Worker in one team, who is also a care coordinator emphasised that;

¹⁹ X - name of a specialist team in one CMHT

²⁰ Y – name of the other specialist team in the same CMHT

“I see the status I suppose as an equal with the other professions in mental health. I see it as equal status with say occupational therapy, nursing, social work”. (Link Worker 1)

Almost all the CPNs I interviewed insisted firmly that social work professionals have a status equal to any other professional within the team.

“As far as I’m concerned they’re equals. There’s a lot of skill and a lot of experience, a lot of professional experience and a lot of life experience with our social work colleagues. I perceive them as equals. I think it must be very hard in this day and age on the back of Baby P and all the other enquiries, I think social workers get an awfully bad press and there’s an awful lot of good natured teasing goes on in the office, there’s a lot of banter”. (CPN 6)

“I don’t see it as any different. I don’t see it any different at all. I would see it as equal, that’s how I see us”. (CPN 4)

These quotes revealed a broad acceptance of the equal status of social work professionals within their CMHTs. All the interviewees from the other mental health professions emphasised that they do not see any difference between social work professionals and themselves; however most of them conceded this is not the same with the service users and the general public.

5.6.3 Stigma attached to Social Work Professionals

The broad acceptance for social work professionals, emphasised by the other mental health professionals within the CMHTs, is not the same in the wider community. During the past few years media attention has focused on detrimental accounts of the role and performance of social work professionals. The damaging impact of media portrayals has stigmatised social services resulting in people regarding social workers and social services negatively. This impact particularly, but not exclusively, associated with child care social workers, has spread through all the branches of social work. With AMHPs having powers to detain people under the MHA, people see them differently.

Some professionals revealed that, even though they do not see any difference in social work professionals’ status within the team, it is not the same outside the team.

“I perceive it as the same as anybody else working within the team, but I agree that the public don’t perceive that and I think that nurses are seen as angels and social workers are seen as child catchers really” (CPN 2)

“I think the stigma is possibly more with the client groups than it is with other professionals in the staff. Often find going out and seeing the clients but as soon as you mention social worker they attached that to top cases and start worrying ‘if that SW comes in and then would take my children away’. It’s more with clients than it is with staff groups or professionals”. (CPN 3)

CPN2 revealed her own experience of a difficulty she had with transferring a service user to a social work care coordinator, as follows.

“I was just recently trying to hand somebody over to a social worker and she said I don’t mind being handed over and the social worker and I had visited, I don’t mind having you but I just wouldn’t want a social worker and the social worker was there and it was her that she was talking to and I said ‘oh, she is a social worker’ and it was stuff from the past, a long time ago that she’d had a bad experience with social workers and she just said that she didn’t want a social worker.

According to CPN2, this was a result of ‘media portrayal’ connecting child deaths with social workers, especially after the Baby P’s case. MHSW6 expressed his ideas as follows.

“I think, sometimes because of bad press and media coverage and what people perceive the role of a social worker is, can sometimes affect the way they view what we’re going out there for. So when we’re going out working with somebody with mental health problems, but if there’s a family some service users immediately say if it’s a social worker that they’re a bit more careful in what they might be saying. (MHSW 6)

It is also understood that it is not just the media that has caused this stigmatisation; there are also issues related to the MHA assessment duties that they have to carry out as AMHPs and there are concerns about a potential threat to their welfare benefits. CPN7 explained this as follows.

“I think I’ve come across a lot of clients who are wary of social workers on two counts; I think there’s the impact that social worker has on childcare, you know the issue of the social workers will take your children off you and you’ll never get them back and the other one is that some clients, some not very well informed clients see direct link between social workers and benefits and they think if social workers get involved you might lose your benefits and both as you know, both these issues are false, but I think it’s a popular myth.

MHSW1 explained her personal experience as follows;

“At first when I get a service user I say 'I'm a social worker ' and they say 'What?' You see the word social worker is stigmatised, and then I have to sit down and explain, 'although I'm a social worker I'll do exactly the same as any other care coordinator'. I think people see social workers as taking children out of their homes, you know what I mean, but I say, that's not my role at all. I mean if they have children I will refer them to appropriate service. Yes there is stigma around social workers”. (MHSW 1)

There were some professionals who actually had personal experience of the stigma associated with social workers.

“I was given a case of a woman and I contacted her in the first time and I spoke to her to make an appointment. I gave her 'I'm a social worker on the MH Team' and she said 'no, I'm not going to see you, I'm not having a social worker, I don't want you, I want someone else'. She has had bad experience in the past, children taken away in her view and had her children adopted subsequently, and she does have a young child now. So there's lots of suspicion and it's difficult to build a relationship, sometimes people have strong pre- conceived ideas”. (MHSW 2)

“Yes, I've had experience, 'I don't want to see a social worker, I have had people say 'I don't see a social worker', but what does a social worker do, they just take children away, you know that's what they think. But I think the other problem is with me being an AMHP that's an added bonus like the view is 'oh hospital, they can force you to go into hospital” (AMHP 2)

“Yes I have a couple of times because of them having worries about the social worker. I suppose this thing about they might take my kids off me or the social worker making some judgement about them being unfit and it's been usually to do with kids. So yeah, that I have come across that they've perceived the social worker as being a bit of a threat, oh god, I don't want the social services involved”. (OT 1)

It seems that there are a number of other issues that lead service users to reject social work professionals as their care coordinators.

“I think people that have got experience of in-patient seem more often than not to look for nursing, I think it's possible that they have a greater attachment to the nursing care that they've received type of thing and they kind of look for a CPN rather than a social worker.” (MHSW 7)

“I sometimes think that some of the people who have got the most complex problems are often the ones who haven't always received the education so they may have had contact with SWs before and that can often colour the view; because a lot of families that we come across, you know their parents have had problems so they then have contact with children social workers and so they may view them as coming in and taking, you know they took us away from me mum and dad and then you've got the hurdle to get over” (Team Manager 1)

However the two service users I interviewed demonstrated a very good understanding of the role of their care coordinators, who are both AMHPs. They

even seemed to be aware of the MHA assessment duties their care coordinators have to do and what they do specifically as care coordinators. During the home visits with MHSWs and AMHPs, I observed a good understanding and a very good relationship between these professionals and the service users. One service user who had a CPN care coordinator prior to the present AMHP care coordinator explained her perception as follows.

“I think a lot of people think of social workers as people who come and take your family apart or because you can’t manage or you can’t cope with everyday life, but that basically isn’t the case. It’s just someone whose title is a little bit different who is probably doing the same job as a CPN. I don’t talk to XX²¹ any differently to what I did to YY²² and XX doesn’t talk to me about anything sort of personal unless I want to talk about it in which case I can and I don’t feel there’s any difference”. (Service User 1)

There are some professionals who believed that once you explain the changes inside the team, and that the social work professionals are now doing the same job as CPNs, people are ready to accept them as their care coordinators.

“Once you explain to them the role and how the teams have changed, usually patients are ok; I think they see the difference in the roles now because we’ve been working a few years now and when we used to do the screening assessments and if we got people in for initial assessment and there was me and a social worker assessing them we would say what we were but we’d also say we do more or less the same job and they accepted that”. (CPN 4)

“I think still that stigma is there, and I think that it will never ever go. Because some other service users we talk to say ‘oh I don’t want a social worker involved’. But once you explained their role and explain you know that ‘they are not there to do that, they are there to help you they are there to look at your social aspect then your housing and everything else”. (Link Worker 1)

“I would say the stigma is not as bad. I think there’s only one case in all the time I’ve been in here, where someone said ‘haaa a social worker’ and we spent five minutes to sit down and say ‘that’s not their role in this case. They are coming to do exactly the same job as me’. You know then the client was fine”. (CPN 3)

It is also noted that some MHSWs prefer to introduce themselves to the service users as ‘care coordinators’ rather as social workers. This as they explained is sometimes to avoid the reaction service users have on the title ‘social worker’.

²¹ XX - Name of her present care coordinator who is an AMHP

²² YY – Name of her previous care coordinator who is a CPN

“I tend to call myself a care coordinator with a lot of people. Maybe it is because of the reaction the word social worker gets sometimes from patients, carers. And certainly from the consultant’s point of view I had patients in front of the consultant say ‘I want a nurse’ and the consultant actually open up and say ‘well XX²³ is a social worker, but she does exactly the same job as a nurse. So that’s good and I don’t feel that there’s stigma attached in that level and higher level as well”. (MHSW 2)

“Yeah, I mean most people will think I’m their CPN if you like, they’ll say ‘oh you’re my CPN’ and I’ll just reply ‘well I’m your care co-ordinator”. (MHSW 7)

This idea was further supported by Team Manager1, who confirmed that she prefers to introduce social work professionals as care coordinators, rather than by the professional title ‘social worker’.

Sometimes the service users prefer to have CPNs as their care coordinators. This is not because of personal feelings about a particular social worker, but historically CPNs had been the care coordinators and the service users still have the view that CPNs know better than social workers about their medication etc.

“I was initially started off co-working with a CPN, and then she pulled out and I ended up being the main worker, the only worker and this person said ‘no offence to you but I want a CPN, I don’t want a social worker and they think that you don’t know as much about the medication and about their needs as a CPN does”. (MHSW 3)

“They say very clearly they don’t want a social worker and the reason being that they have this, the public image of social workers..... But sometimes, people do only see the headlines that’s there and a lot of the time nurses are being viewed as nurses will help, you know they’ll say to me ‘I’d rather have a nurse, I don’t want a social worker, they’re too interfering’ there’s nobody more interfering as me but because you’ve got that title ‘nurse’ you’re viewed different by the public”. (Team Manager 1)

For some professionals choosing or refusing a care coordinator depends on what the service user actually expects from each discipline through care coordination. As an OT explains:

“I have come across people who will say they want a social worker because they believe a social worker is going to be more practical use to them and more helpful, there are other people who are a bit frightened of having a social worker, you know what does that mean, are they going to take my kids away from me or something like that”. (OT 1)

“Unless they want something, unless they see that they need housing or benefits, they will usually prefer a nurse I think”. (CPN 2)

²³ XX – Name of the SW interviewee

During the fieldwork period, I attempted to understand how the other staff members regarded and interacted with the MHSWs and AMHPs. Only once during these six months did I encounter a problematic situation regarding MHSWs and it was during an Allocation Meeting. During the meeting it was revealed that one service user is now studying to be a social worker and then there were lots of talk about social workers and lots of laughter among the group.

One thing I couldn't understand was their attitude towards social work. Each time they mention the word social work or social worker they had a nasty laugh. One team member revealed about one of her clients who will be discharged very soon and is expecting to study social work. Once again that nasty laugh was there and I really couldn't understand the reason for that.

Field Work Diary - 21.07.2009

First I understood this interaction as expressing sarcasm about the value of social workers; however it was revealed to me, by a MHSW, that there was not any sarcasm intended at all, it was just banter and joking among the team members. This was further understood during the interviews where both social work professionals and CPNs talked about the very friendly jokes and banter exchanged about the reputation and status of the two professions.

During my fieldwork, I had the opportunity to join a MHSW visiting a service user in a hospital. This was her first visit to meet this service user.

At one moment the patient seem to be curious about what's going to happen to him after discharge. This was already explained at the meeting, but the patient was tearful all the time and may have not listened properly or forgot. Then X²⁴ said that she's his care coordinator and will be looking after his needs after discharge. Then the patient asked whether X is a CPN and X said that she's social worker but do the same things as the CPN's do. She again explained him what a care coordinator will do and then he agreed by nodding his head.

Field Work Diary – 19.08.2009

It seemed that the service user did not understand the term 'care coordinator' and also during his more than 20 years time with the Mental Health Services he only has had CPNs.

In summarising my findings on the status of social work professionals in the CMHTs and the stigma attached to them, I identified different views and ideas during the

²⁴ X – Care coordinator

study. In a general sense, the positive relationship and acceptance I found within the CMHT members was not reflected in wider society, as almost all the interviewees gave examples of difficulties social work professionals face in the communities outside the CMHT. Examples included service users refusing having social workers as their care coordinators, and a number of reasons were identified to explain this refusal.

- Service users do not have a clear understanding of AMHPs or MHSW's role as a care coordinator and how they work as any other CPN.
- For some service users, throughout their time with the mental health service, their relationship had been with CPNs and as a result they want to stick to what they're used to.
- They do not trust the qualifications and skills of social work professionals to work with patients.

These preconceptions, developed through personal experience or media influence, have resulted in some service users and carers refusing AMHPs and MHSWs as their care coordinators. There were a number of MHSWs and AMHPs in my interview group who had personal experience of being rejected by the service users as care coordinators. In some of those cases, with careful explanation and clarification of the social worker's role, service users have accepted to have them as their care coordinators. However, in some cases, service users have insisted that they did not want to see social workers, in most of the cases not as a personal objection to a particular social worker, but to social work as a profession.

One important thing apparent through the interviews and informal discussions is that this stigma has not been allowed to undermine the AMHPs' and MHSWs' professional performance. All the AMHPs and MHSWs expressed that whatever the negative impact the media portrayal of social workers and some people's prejudices and fears aroused, it had not had a serious influence on their work efficiency. They accepted that they might experience emotional distress during certain incidents; but they had not allowed them to affect the quality of the service they provide. However,

they all personally agreed that there should be more awareness of their role among the wider community.

5.7. Conclusion

In this chapter I discussed the social work professionals' roles and responsibilities in the microsystem that is the CMHT. By observing and by interviewing people from the CMHT, their immediate environment, I managed to get a holistic view of how social work professionals' roles are perceived and of their relationship with other mental health professionals and service users. I consider this holistic understanding of social work professionals' contribution as unique to this research, because previous published research has not attempted to get a holistic understanding of their roles. As discussed in the literature review, the perception of social work professionals and their relationships with others are crucial for the effective functioning of the CMHTs.

In the next chapter I will focus on mesosystem, exosystem and macrosystem and their impact on social work professionals' roles in the CMHT.

Chapter 6 –Social Work Professionals and the Mesosystem, Exosystem and Macrosystem

6.1 Introduction

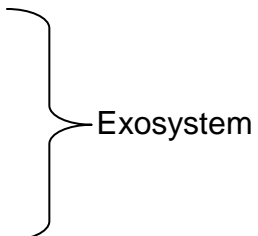
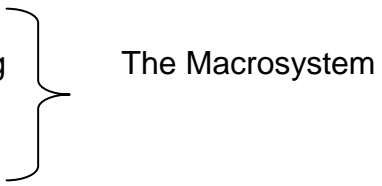
The previous chapter presented my findings on the CMHTs – the microsystem in the theoretical and conceptual framework of this study. This included findings about AMHPs' and MHSWs' roles and responsibilities, their special contribution to CMHTs, problems associated with their roles, difficulties and barriers to effective care coordination and stigma and status of social work professionals.

However, above the microsystem, there are systems that control and govern the overall functioning of CMHTs. As the findings of this study reveal, these systems have an impact on CMHTs staff including the social work professionals. In this chapter I present, analyse and discuss the findings related to these other systems, namely the mesosystem, exosystem and the macrosystem. As explained earlier, in Bronfenbrenner's Ecology of Human Development Theory, the mesosystem provides the connection between the structures of the microsystem, and the exosystem explains links between a social setting in which the individual does not have an active role and the individual's immediate context. The exosystem in this study comprises the MHT and the LASSD; the two organisations that appoint staff to the CMHTs and manage the CMHTs. AMHPs, MHSWs and other care coordinators are not active participants in these two organisations, however as regular members of the CMHTs, they are directly affected by the practice and operation of these two organisations. The macrosystem, in the theoretical and conceptual framework of this study, refers to the policies and legislation affecting MHSWs and AMHPs and the institutions in which they function.

It is important to state here that my embeddedness as a researcher within the CMHT meant that I was very much an 'outsider' with reference to the mesosystem, exosystem (including the ethics committee) and the macrosystem. This lack of 'insider' status within Primary Care and other mental health teams in the mesosystem limited the findings on potential to study the impact of the mesosystem

on social work professionals. Furthermore, my 'outsider' status in relation to the exosystem, in particular the Ethics Committee, limited my access to service users. This limited access affected the scope of my study by limiting the service user perspective.

The findings related to the exosystem and macrosystem are presented under the following themes in this chapter.

1. Collaboration between the LASSD and the MHT
 2. Relationship between the LASSD and the Social Work Professionals
 3. Medical Dominance and Individual Personalities
 4. Separation into Psychosis and Affective Disorders Teams
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5. New Ways of Working
 6. Social vs. Medical Model and Integrated Working
 7. The 2007 MHA and its Impact on Social Work Professionals
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As in the previous chapter I use the findings from semi-structured interviews, observation and secondary data to analyse and discuss the impact of these three systems upon AMHPs and MHSWs in the CMHTs in the microsystem.

6.2 The Mesosystem – CMHTs, Primary Care and other Mental Health Teams

The mesosystem consists of the Primary Care and the other Mental Health Services functioning under the same MHT. The MHPIG identified these services as the Assertive Outreach Teams, Crisis Resolution and Home Treatment Services and Early Intervention for Psychosis Services. These teams are distinguished from other generic CMHTs and they work alongside the Primary Care Services and the CMHTs to support the delivery of adult mental health services locally.

In chapter 3.4.4 I explained in detail about these teams and their relationship with the CMHTs. By doing this I attempted to identify the possible impact that these teams and their members can have on social work professionals in the CMHTs. Through this prevailing literature I managed to identify a number of impacts that these teams can have on the CMHTs and in turn on social work professionals working in these CMHTs. However there were a number of problems in identifying these impacts during the research study period.

As explained under the section on ethics this research study had a number of barriers in gaining ethical approval to conduct the research in the CMHTs. If I was to work with the Primary Health Care and the other mental health services in the area, I had to submit separate ethics forms to gain access to these teams. This made the ethics procedure more complex and risked delaying the commencement of the study. Another difficulty in working with these teams was the time limitation. These teams were not located in close proximity presenting practical problems resulting from the time to travel between the teams. So for a time restricted study of this nature it became practically difficult to research in all these teams.

6.3 Exosystem: The LASSD and the MHT

6.3.1. Collaboration between LASSD and the MHT – Different Power Structures

In order for the effective functioning of the integrated CMHTs, there must be very good collaboration between the MHT and the LASSD. The MHT is the lead organisation for both of these CMHTs; however, both LASSD and the MHT have joint responsibilities for the staff. Whatever documented powers the LASSD has, during the interviews and informal discussions many staff members expressed their concerns about the relationship between these two organisations. They feel that this crucial and essential collaboration between the two organisations is not working strategically. It's clear from the interviews that staff from the MHT hold the position that the LASSD in this area as having been weak and unsupportive, while the social work professionals perceive the MHT as powerful and dominant.

“We feel that social services just don’t figure in this organisation at all. Everything we get is from health. We can understand because social services is said by health that this is going to be the model. Social services say you are the lead agency therefore you manage the model”. (AMHP 1)

“Health has the lead and they say what’s going to happen. It feels more dictatorial.. the nurses go along with ‘yes, ok’, and then our managers go ‘yes, that’s ok’ but no one comes to us and says ‘how do you feel about x, y and z”. It’s a huge Trust, we don’t have a lot of power and because we don’t have that lot of power then it feels like they introduce things and we have to go along with it and I don’t necessarily believe all the things they’re introducing is the right thing”. (AMHP 2)

This can be identified as the organisation’s dominance in integrated working and the differences between the two power structures. Even though a very good partnership between the two organisations is very important, some professionals identified it as a waste of time to wait for approval from LASSD, for each issue within the CMHT, as this LASSD has not been supportive.

“There’s a very weak LA in this area. It’s not the same throughout the Trust. In other areas the LA works in partnership with health. In this area it’s a much more uncomfortable relationship. When we did the reconfiguration across the trust, everywhere else was able to change the services about 6 months before. The LA here just wouldn’t respond, wouldn’t come to meetings and they wouldn’t discuss it with us, they just kept saying no and we had to keep sending papers”. (CPN 7)

“The Trust has to make its own strategic operation decisions, besides I don’t think it can seek the approval of SSs all the time, in fact generally liaising with the social services can be very difficult and can take a long time. One example of that was when we moved from generic CMHTs to the functional teams affective and psychosis. One of the things that held that up for many, many months was trying to get an agreement from social services, now if we did that we would never make a decision”. (Consultant Psychiatrist 1)

6.3.2 Differences between Policies

All the interviewees agreed that service integration at an organisational level is very important; however they all expressed their concerns regarding the difficulties in achieving this, especially when each organisation has different policies and procedures.

“I think the integration is ok. In X²⁵ I think it does work because I think everybody works as a care co-ordinator. I don’t think the boundaries are necessarily there, the problem we had in the past is that SSs, they’ve got different management structures, we had different sets of notes, it was barriers, they weren’t necessarily the individual

²⁵ X - Name of one of the CMHTs

worker's barrier, it was more of a systems approach between SSs and our Trust". (CPN 5)

Some professionals pointed out the differences in human resource policies between the MHT and the LASSD. Sometimes, when the MHT introduces new policies in to the CMHTs, AMHPs and MHSWs doubt whether the LASSD has been really involved in policy discussions and implementation, because in most cases social work professionals were not kept informed of these changes by their own organisation.

A team manager identified problems related with the integration process as follows;

"I suppose as an organisation the NHS just does not handle change well. A lot of people at this level will say to you that they feel as though change is imposed on them and they've got no ownership of it, whereas we all know that the best way of getting people on board with change is getting them involved. But it's a top down movement and I think it's driven by improved efficiency and getting the service better and improving it. But it's also driven by financial pressures as well". (Team Manager 1)

MHSW 4 stressed that the MHT is getting the 'social workers on the cheap' because the pay scales of social work professionals are poorer in this area, compared with the CPNs, although they do the same work and carry similar case loads as CPNs. Still, there are a few professionals who believe that social workers are well looked after and are provided with benefits by the social services that the MHT has not.

"Our mileage is changed now and we have our mileage taken away. You only get 23 pence a mile where as social services are well looked after and they actually get their money and they get their loans." (Link Worker 1)

"I think social workers are more nurtured by social services than health workers are, from working with them I see the social services as better employers than the NHS, a lot better, I think they care about their work force more, I think there's more of a blame culture with the NHS, definitely". (CPN 1)

These findings reveal that the overall relationship between the two organisations has been unsatisfactory. This can be explained by different power structures (a dominant MHT or a weak and unsupportive LASSD) and different human resource policies in the two organisations. When comparing these findings with the literature, it is clear that this weak collaboration between the two organisations is not specific to these two CMHTs, but this relationship has been tense generally. Reid *et al* (1999:306) state that "overall, relationships between social services and NHS teams were

perceived as tense and the integration between the services limited". This is also supported by a recent BASW Policy Report which says that;

Repeated reforms and reconfiguration have not eliminated the tensions between the health and social care perspective. Tensions include: financial, power and authority in multidisciplinary teams, the support that various professionals receive, issues to do with lack of clarity of role and diversity in terms and conditions of employment. (Godden et al., 2010:5)

These studies lend weight to the findings of this research and emphasise the need to address those issues to develop better integrated services. Other interviewees pointed out, as a result of some issues between the LASSD and the MHT, the number of social work professionals within the mental health sector is decreasing, indicating signs of a diminishing social work contribution to the mental health teams.

"Now personally in the last 10 days, I know of 4 of our social workers who are leaving; I know there are those issues between Health and social services and as a consequence the social work contribution to mental health services has been very seriously injured, . I think that's a process that's continuing and ultimately, other than the statutory function that the LA, has in terms of AMHPs, the social work contribution will continue to diminish". (AMHP 3)

6.3.3. Relationship between the LASSD and the Social Work professionals

6.3.3.1 Abandonment from LASSD

Most of the MHSWs and AMHPs felt that they have been abandoned by their own service and this has been a disadvantage for their career. They also revealed that they feel that the LASSD have handed over everything to the MHT and they do not feel like they are working for the LASSD anymore. What they get from LASSD is now limited to their salary and they do not feel connected with their own organisation. They felt that they have been implanted in the CMHT, by the social services, and they do not feel part of the CMHT either.

"I don't feel like I'm part of social services anymore, it's all health orientated. We don't feel part of health. In the same time we don't really feel part of social services because we feel almost like they don't actually want us". (AMHP 2)

"I think we're a forgotten sort of, we're here because we're managed by Health. I think it's just we'll just let Health get on and manage that and I think sometimes we're a bit let down really or sort of not thought about it in the same respect as maybe some other social workers in other teams and other areas.". (MHSW 6)

Some professionals reveal they need more involvement with the LASSD, which once again indicates that the relationship they have at the moment is unsatisfactory.

“I think we need to have more involvement with social services. I think so many things change within the social services and we’re not part of it, we need to have days that we’re together to think about the strategies, the problems, the issues, you know from social services, not just within health”. (AMHP 2)

One MHSW expressed that it would be better to be appointed by the NHS rather than by the LASSD, as currently neither organisation is bothered about the social workers.

“I feel like we’re kind of a bit in the middle, because we are an integrated team and it’s predominantly run by the NHS. The LA tends to just take a back seat, they’re quite happy to provide social workers and pay the salaries but they don’t get actively involved in any other way. NHS is not so bothered either. I would say I don’t feel really as valued as an employee I feel it would better if social workers were employed by the NHS and so we’re all coming from the same”. (MHSW 3)

This was not just the opinion of social work professionals, some CPNs described how social workers had revealed to them that they do not feel like a part of the LASSD, anymore as they are isolated and get no support or news from them.

“I think in the last 10 years social workers have been badly let down by their professional leaders. It doesn’t affect the team functioning on a day to day basis but I think effects the mindset of the social workers. They always feel that they don’t get the support from the LA that they’d like to get and they don’t, they’re correct, in this area they don’t”. (CPN 7)

In these two CMHTs there are ‘agency social workers’, supplied by independent agencies, not by the LASSD. These agency social workers have very strong ideas about how the LASSD treats their own social workers. One Agency MHSW expressed her views on how the LASSD had let down its employees in different ways.

“X²⁶ don’t seem to have a clue or a care what happens to any of the social work staff either. I would not work for that money, for those holidays in a system like this on a long term basis, no. I mean the X County Council staff in terms of social workers are the worst paid in the whole region; they’re on £2,000 less every grade than anywhere else and there is no support and no training, nothing no comes from X, it’s like a vacuum2.” (MHSW 5)

²⁶ X – Name of the LA

A team manager expressed similar concerns and explained why she thinks that social workers feel so.

“The MHSWs would say they feel abandoned by their home organisation. They’ve said that to me on frequent occasions and I think that’s quite sad. It’s difficult for them to not to think that, you know because people forget to send us training courses round and you have to chase up those sorts of things and that still happens. I mean that’s improved an awful lot, but they do talk about this feeling like they’re not wanted by their own organisation because they’ve been left to the mercies of the MHT”.
(Team Manager 1)

This indicates that even the team management experience this damaged relationship between the LASSD and its social work professionals.

6.3.3.2 Missing Information and Contacts from the LASSD

Almost all the AMHPs and MHSWs complained about lack of communication between them and the LASSD. This has been caused by social work professionals being located in the CMHTs, away from the LASSD premises and other social work teams.

This has made it difficult for the social work professionals to keep up-to-date with information from the LASSD and they live with the disappointment of thinking that their own service had abandoned them and have let them down.

“I think it has an impact sometimes on keeping up to date with any changes or developments within the social services or the LA because we’re not on the systems, the SSID system. We haven’t got really access to that. I think you are forgotten about really because you’re managed by Health. You’ve health managers then you don’t get a lot of, you know maybe information is not filtered through to staff here as it should be probably”. (MHSW 6)

It is clear from the above quote that social work professionals are not up to date with the information from the LASSD, which might have an impact on their career.

“I only found out about this personalisation agenda recently and I was like going ‘I’ve never heard of it’ it’s quite scary actually. Because I’m a social worker, the NHS has got the lead, I think social services have forgotten about us and I was like well I feel detached. I don’t feel like as part of the social services network, I feel part of the Health network rather than social services. I’m an AMHP I’ve got a separate role within the team as well and I think that’s quite difficult to be honest to try to merge them together and trying to work it together as well”. (AMHP 2)

As same as they missed important information on policy developments from the social services, they also missed opportunities to meet their social work colleagues as they are not located together.

“You feel like you’re forgotten, you’re here and you’re working here and you’re managed by Health and the majority of people are Health professionals. And in terms you lose that contact you had with other social workers, the only time you get that is maybe on training courses where you see people again. So you’re very much on the outside of the LA. I think although you’re employed by the LA and paid by the LA, that’s about as much as you get really”. (MHSW 6)

6.3.3.3 Fewer Facilities from the LASSD

As understood through the interviews and informal discussions, one reason for the dearth of AMHPs and for the dissatisfaction of the role is the fewer facilities offered to social work professionals by the relevant LASSD. The salaries of AMHPs and MHSWs appointed by the LASSD seem to be amongst the worst in the area.

“I don’t know what it is, what the answer is nationally, I can talk about ‘X’²⁷. In ‘X’ believe that the pay, holidays aren’t favourable when you compare them with other LAs and I think that is why we have got a big problem in ‘X’”. (Team Manager 1)

“We’re kind of an ageing population. If you go to an ASW meeting it has more people of my age, 50,s than younger and I think a lot of us were doing extra work for a couple of thousands a year. And you know the top the grade of social workers is not much difference. We’ve regional variations in salaries because people are actually thinking they’ll get paid more in some places 10 or 5 thousand a year if you are an AMHP. But I think if they increase the salary a bit and that will probably attract some people who have a genuine interest in mental health. We can see a natural kind of progression you know in the social worker’s role”. (AMHP 1)

“There are issues around pay and conditions, I can be sitting here with a nurse, she gets more annual leave than me, she gets paid more than me, the career options that are available to me as a social worker are less than they would be for the nurse We’re finding that our workers are leaving for better paid employment in more specialised posts”. (AMHP 3)

“I also think the need to look up the support mechanisms that aren’t in place because they’re often at the very cutting edge of mental health in the very rawest form when people are really unwell and you’ve often got a lot of high drama going on with the families are very distressed, you might have the police there taking people off to hospital and that’s incredibly stressful and if you don’t get the support part of it right people think why am I doing this and then they’ll make that decision to come off the rota and we as a county have let them do that, now I personally feel quite strongly we shouldn’t”. (Team Manager 1)

²⁷ ‘X’ denotes the name of the relevant Local Authority

These quotes indicate that less pay, less holidays and less concern about AMHPs' needs have deterred AMHPs from working in 'X' area. As one of the AMHPs emphasised, at 'X' the AMHP group is an ageing population and there seems to be no new recruit despite the AMHP role being opened to other professionals. However a Team Manager, while accepting the deficiencies with the LASSD, also emphasised the importance of them to be cautious about the investment in training AMHPs, as some AMHPs tend to leave the statutory duties after the training.

“an issue within this County is we have employed people to become MHSWs and usually when we employ them it's on the proviso that they will do their AMHP training and then people say they don't want to and sometimes that's to do with the fact that you might get a call for a MHA assessment at. Well, if you've got kids to pick up it's not always conducive with family life because that assessment could go on until 8pm, 9pm, 10pm so it's not terribly family friendly. I think if we invest the money to train people it's fair to expect them to do what we've paid for but I don't think the answer is just force them to do it, I think we need to look at why do they feel unable to do it and is there anything we could do that would make them feel supported”. (Team Manager 1)

However it is clear from the team manager's point of view that to avoid AMHPs leaving their statutory duties it is important to consider all the other pressures associated with AMHP work and the lack of support and facilities available to them.

6.3.4 Medical Dominance and Individual Personalities

The literature discussed the medical dominance of the CMHTs. With the 'New Ways of Working' been introduced, it was expected that the medical model's dominance would be eroded and the 'Recovery Model' should be implemented, taking medical, psychological and social models into consideration. However, as the literature reveals the medical model is still very prominent in CMHTs, although many service users would benefit from a more social model of care.

The question of medical dominance was raised in all the interviews and throughout the field observation I attempted to identify this by observing team meetings and other decision-making discussions within these two CMHTs. Through the observation also I found that with one team there is no medical dominance by the psychiatrist.

They talked about the client's symptoms, about his behaviour during the past few

days and many other things about the discharge plan. It was a discussion with the participation of all the parties present and they took each and every aspect of the care plan into consideration. Dr. Y²⁸ led the discussion, but he asked everybody about their opinions and it was very effective according to my understanding.

Field Work Diary - 19.08.2009

Interviewees gave a mixed response to this question, as some confirmed there is medical dominance; some said there is not and some blamed individual personalities for this dominance rather than the issues with the model. Some interviewees thoroughly believe that there is no medical dominance within these teams at all.

"I wouldn't have said there was medical model dominance anyway, I would say teams have moved beyond that and that there is a more inclusive model than that". (OT 2)

"No I don't think so because we don't only work within the medical model and many of the CPNs don't particularly work in the medical model either. The medical model is there for diagnosis, for treatment, for medication and aspects of risk assessment. But the generic care co-ordinator's work isn't really firmly following the medical model; it's taking a much more generic way forward". (Consultant Psychiatrist 1)

Some interviewees agreed that they had experienced medical dominance in most of the places they previously worked; however, within these two teams it was not perceived as prominent and is changing.

"I think there certainly used to be, but I think over the years, we personally have a very good consultant within the X²⁹ team who is very open to listening to what you've got to say". (SW 6)

"I don't know if it is here, I mean past experience of working in other teams, there was definitely a dominant medical model, the consultant was at the top of the tree and after that would come the nursing staff and then come the social workers but I certainly don't think it works like that here". (CPN 2)

Some professionals believe that it is not the medical model that dominates, but it is the personalities of individual psychiatrists and care coordinators. Two CPNs explained as follows.

"I think part of that depends on the personality of the psychiatrist and part of it depends on how disempowered the care co-ordinators are. So the worst mixture is a really dominant psychiatrist and a really disempowered care co-ordinator and that's what you tend to find in areas where you've got a strong psychiatrist". (CPN 7)

²⁸ Y – Name of the psychiatrist

²⁹ X – Name of the specialist team in one CMHT

“The medical model is alive and I think it will be for many, many, years. It’s not the same medical model that was alive when I worked at X³⁰ Hospital, a large institution when we had a medical superintendent. Those days are gone, but the medical model is still there. But I do think it depends on the personality of the consultant, predominantly”. (CPN 6)

Some interviewees have previous personal experience in other CMHTs with excellent psychiatrists who worked with a team perspective, while some interviewees have experience with psychiatrists who had the same sort of psychiatric training; however they worked without a team perspective and decided that they needed to see every single patient. This resulted in the whole team being completely disempowered, as they could not discharge anyone without the psychiatrist seeing them first. As these interviewees further described, when this happens people think of it as the medical model dominating, rather than the personality of the individual psychiatrist and the lack of confidence of the care co-ordinator.

In summary, my findings reveal mixed opinions on the medical dominance within the teams. One of the ideas was that there is ‘discipline dominance’ in the CMHTs, where the MHT and the medical model dominate the team. Another idea is that it is the individual personalities of the consultants that dominate, rather than the medical model. It is clear that the discipline of medicine still dominates to a certain extent in these teams, although it is less visible than the prevailing literature suggests. It should also be noted here that there are differences between how and to what extent this happens in the two CMHTs. This is because in one CMHT there was more evidence of discipline dominance and individual personality dominance, compared to the other. It is also important to state here that none of the professionals see any discipline or personality dominance with the team managers even though both of them were from a NHS back ground. In fact, they appreciate the team managers for always being fair although it is hard for them to do so in a more health-orientated system. As described under section 6.2.2, health is the leading organisation for these two CMHTs and consequently the operational policies for these teams are still implemented by health and the MHT also makes most of the key decisions regarding them. This has subsequently led to the existence of medical dominance in these two CMHTs.

³⁰ X – Name of a mental hospital

6.3.5 Separation into Psychosis Disorders and Affective Disorders Teams

As described earlier, after the team reconfiguration, the two CMHTs were divided into 4 specialist teams, two Affective Teams and the Psychosis Teams. This division has been criticised within the teams and most staff members seem to dislike this concept. Issues with the specialist team concept are discussed here under the exosystem rather than in the microsystem, because the separation was introduced through the MHT and the LASSD in the exosystem. Some staff members were even unaware of where and how this change was implemented, which again indicates the lack of communication between the social work professionals and the LASSD and the MHT.

*“Specialist teams- I’m not particularly a big fan of at all, I don’t think it’s a good idea”.
(Consultant Psychologist 1)*

“I don’t know where it came from, but I don’t think other areas of the country run this whacky system”. (MHSW 5)

There are a number of problems associated with the Psychosis and Affective team distinction. During my fieldwork, I had the opportunity to observe a meeting on the ‘Team Configuration’, which members from both CMHTs and officials from the MHT attended. Staff members from one team presented a list of their concerns about the specialist teams to the officials from the MHT and these concerns are similar to the findings of this research.

6.3.5.1 Labelling of Service Users

There were concerns over the labelling of service users into the categories of ‘psychosis disorders’ and ‘affective disorders’, as this was perceived as diagnostic labelling representing the medical model. Team members expressed that this was in conflict with the ‘New Ways of Working’, which was originally expected to reduce labelling service users by diagnosis.

“I just think in the last couple of decades we’ve moved away from labelling people with diagnostic labels in a very rigid sort of way and now we find we’re using diagnostic labels to actually determine how and where by whom people get their service and of course you can’t always label everyone precisely. Sometimes people are unusual or difficult diagnostic and you’re not sure, and that sometimes leads to arguments back and forth or people getting into the wrong teams”. (Consultant Psychologist 1)

6.3.5.2 Difficulty in Diagnosis and Transferring Cases

A major concern about separation into functional teams is the difficulty of separating service users into psychosis and affective categories. This factor is much discussed during the team meetings, as some of the symptoms diagnosed are mixed and not easy to categorise under one label. For example, a clinical psychologist raised the issue of a service user having clinical depression with psychotic features and psychosis diagnosed clients with affective problems, like PTSD or anxiety or depression.

“Original guidelines for deciding on speciality are not followed. It is not simple and there is no clear definition of what is included in each service and this seems to be causing conflict with disagreements about whether a patient should be in Psychosis or Affective Disorders Team. Some transfers are blocked due to lack of agreement on speciality. Decisions made by the access team may be questioned”. (Secondary Data – 02.11.2009)

“I think that’s a load of old nonsense because within psychosis clearly there is mood disorder, with an affective disorder there is also psychosis. Where do we then start pigeon holing people for example with a brain injury who may have psychosis and affective degenerative physical conditions which then inevitably impact in those situations”. (AMHP 3)

These interview findings were supported by secondary data where staff members of the two CMHTs have identified and documented other problems related to transferring cases between the teams.

- I. *There are not enough female CPNs in the Psychosis Team to cover depot injections, therefore the patients have remained in care coordination with the Affective Disorders Team.*
- II. *Transferring cases increases workload as the patients are new to the receiving care coordinator and time is needed to establish a relationship. Also extra work involved prior to transfer with requirement to review and complete FACE, SARN, new care plan before patient can be transferred if not due.*

Problems as a result of this increased workload in the specialist teams were mentioned by a MHSW and a consultant psychologist as follows.

“I think everybody has got amazingly busier. But I can’t see for what reason, the work was covered before. But it doesn’t seem to be now”. (MHSW 5)

“We certainly feel that we are massively overloaded at the moment and I haven’t got nearly enough time to do it properly”. (Consultant Psychologist 1)

With this re-configuration into specialist teams, some staff members revealed their concerns over the continuity of care of the service users. Consultants are now

specialised and there are different consultants for the community and different consultants for in-patients and the transfer of patients between these consultants had been problematic. Staff members seem to be unsure of the roles of the consultants, particularly in relation to in-patients.

Some staff members identified this reconfiguration as difficult for both service users and the staff members.

“I only have one Psychosis and the reason I’ve kept that one is because the person would find it difficult to start working with somebody else”. (MHSW 6)

“I think it’s at a transitional stage at the moment, it’s been difficult for the clients because some of the less well clients have had to change care co-ordinator and change is very difficult, so that has been very unsettling for some clients and I suppose the staff have found it unsettling as well”. (OT 2)

“There has been an increase in responsibility placed on care coordinators as well as the number of tasks which fall to care coordinators. Caseloads are too high to be able to complete all that is asked of us”. (Secondary Data – 02.11.2009)

According to secondary data, this *‘Transfer process could be more effectively managed centrally rather than care coordinators searching for a willing recipient. Since no one is keen to take new very complex and time consuming cases these people have been hard to transfer’.*

6.3.5.3 Missing Professional Opportunities

Some of the professionals revealed that this separation into specialist teams has limited their professional scope and now they are missing some aspects of their job that they found rewarding. Some of them also found it hard to choose which team they wanted to joined.

“The other thing is that it takes away from the variety that for me is really an important part of psychiatry It just makes it all the less interesting when you’re dealing with some patients and not others and certainly my favourite way forward would be what we had here previously which was a good comprehensive locality CMHT. I think that’s a far better model”. (Consultant Psychiatrist 1)

“I think some members of staff didn’t want it specialised so purely, they quite liked having a few psychosis cases on their caseload so that they sort of had different areas of expertise that they could use”. (OT 2)

There are many professionals who still prefer to work in generic CMHTs, rather than in these specialist teams, however they emphasized that they do not have any other option rather than cooperating with whatever the changes happen in the teams. This

also shows that there had not been enough consultation between the staff of these two CMHTs and the MHT and the LASSD, prior to the decision of moving to specialist teams.

6.3.5.4 The Availability of Managers and Difficulties in Management

As described in the literature review, these four specialist teams are managed by only two team leaders. As the two affective disorders teams and two psychosis disorders teams are based in two different geographical locations, these two team managers have to split themselves across these two areas. Almost all the team members found this very uncomfortable, as it makes it difficult to find a manager when needed. So the team members revealed that they found a manager based in one geographical location as more accessible. Some staff members are concerned about management issues associated with this change, where the managers hardly find time to deal with the problems in the teams.

“I think in terms of the management, management has been stretched so thinly that’s been difficult as well because they don’t have the time to give you the support maybe, it’s not their fault”. (OT 2)

6.3.5.5 Training and Qualifications for the Staff

One of the major concerns for the mental health professionals with this team reconfiguration is whether they have the right qualifications, training and skills to work in a ‘specialist’ team. This concern was raised by a number of MHSWs as they identified themselves as not having enough knowledge of certain disorders. This issue was raised during the ‘Team Configuration’ meeting.

“We are now in specialist teams and would like to know if there is going to be training so that we actually become specialists (training to enable therapies to be used rather than brief taster courses)”. (Secondary data – 02.11.2009)

The literature revealed that training and qualifications for staff members has been a problem since the development of the generic CMHTs.

The emphasis of recent service development in the UK has been on the development of generic teams, in which workers are required to fulfil a broad range of functions with a full spectrum of individuals with severe and enduring mental illnesses. Differentiation of functions within community services for mentally ill adults and opportunities for staff to develop specialist skills with particular client groups have been limited. This may leave staff feeling that they have relatively few strategies available for coping with some of the most

difficult service users, in terms either of opportunities for onward referral to specialist teams, or of skills available within the team. (Reid *et al.*, 1999b:306)

With the findings of this study, it is clear that, even after separating into specialist teams, the staff members are still facing the same problem of not having specific skills to work with some of the most difficult clients. This is a crucial point to be addressed by both authorities in order to reduce the work stress among the staff members and in particular to develop an effective service for the people who use it.

6.3.5.6 High Case Load with the Affective Disorders Teams

There were also concerns about the high case loads of the Affective Disorders Team, as which disorders are covered by the umbrella term 'Affective' is not well defined.

"The Affective Disorders Team does not actually feel like a specialised team as it includes bi-polar disorder, depression, eating disorders, alcohol problems, personality disorders. Few patients require only monitoring and therefore it is difficult to provide a good safe service to everyone when caseloads are high". (List of concerns on specialist teams handed over to the MHT by the staff of the CMHTs on 02.11.2009)

As the below data reveal, not having an 'Assertive Outreach Team' (AOT), as other MHTs do, has also resulted in more psychosis cases pouring into the Psychosis disorders team. In other services, AOTs and CMHTs work closely together (as explained in section 3.5.3) to transfer service users back after the service user's condition is stabilised.

"Why has AOT not been kept as a speciality, as in other areas, but expected to be absorbed into the psychosis team. Is there not now a need for AOT as this service will not be able to be provided with the higher caseloads of the Psychosis Team?" (List of concerns on specialist teams handed over to the MHT by the staff of the CMHTs on 02.11.2009)

Introducing an AOT could be understood as a better solution for the higher case load and related stresses among the CMHTs' staff members. In addition, there is existing literature (Dorset Health Care, 2001) that provides evidence that the introduction of AOTs have contributed to reducing the work related stresses among mental health social work professionals. Some professionals identified that this change has been especially problematic in this locality, with the high case loads and complexity of work in the geographical locations.

“A³¹, this was 5 or 6 year ago now, they went through this process of changing the specialist teams. But I think because ‘A’ is a smaller area and there are less people to work with, that change ran smoothly and there were no problems with it. It’s a little more difficult here, it’s not as well organised really but there have been one or two more problems in this area than there was in ‘A’. (MHSW 6)

This suggests that the higher caseloads in this locality have resulted from the complexity in the geographical location of the team and also because of the lack of other mental health services. The secondary data from team meetings reveal that the complexity of the geographical location relates to the high student population, from a particular university in this area, which was a factor also revealed during the weekly Allocation Meetings.

6.3.5.7 Opportunity for Discussion

During the interviews and general observation, it became clear that the staff members in both teams have experienced many problems with the move to specialist teams. However, they have not had an opportunity to discuss these problems with any senior managers in the MHT, since the inception of the reconfiguration. In their report to the MHT management they wrote; *“Staff would like time to discuss concerns regularly” (List of concerns on specialist teams handed over to the MHT by the staff of the CMHTs on 02.11.2009)*. I clearly observed that during the team meetings staff reported the problems they identified with high caseloads, difficulties transferring cases between the Psychosis and Affective teams and distress caused to service users through changing care coordinators.

Overall I felt it was an important meeting to the team. But it was clear to me that some members still have questions and doubts regarding the new changes. It was visible from their faces that some of them were not satisfied with the given explanations.

(06.07.2009 – Field Work Diary)

They had the same agenda where they discussed the absentees, discharges, referrals, assigning care coordinators and then came to any other business. Some issues regarding the heavy case load in the Affective Team and car parking were raised by ‘x’³². Team Manager informed that car parking issues will be slightly solved once the new building is completed; however she didn’t give an exact answer for the heavy case load issue. She said since the teams were reconfigured very recently, it will take time to separate the cases between the two teams.

³¹ ‘A’ refers to a separate CMHT belongs to the same MHT

³² ‘x’ – a SW

The same question was raised by many staff members during the business meetings; however I observed that none of these questions were satisfactorily answered at any meetings.

6.3.5.8 Early Days - A Slow Process

It should be noted here, that the field work was carried out within the early days of the reconfiguration of the teams and some of these problems arising from the reconfiguration may have been solved by the time I documented the findings.

“We still haven’t got purely specialist teams yet because it’s early days. So within the psychosis team I think I’ve got about 65 affective cases at the moment, because we only went into specialist teams in March and changing people over has got to be handled very sensitively. I think that people get quite attached to the workers they’ve got, the workers might be in the middle of a therapeutic intervention, it’s really damaging if they changed workers now. It’s a work in progress; it’s not a complete work yet”. (Team Manager 1)

It was understood that all the cases with the two CMHTs would be gradually allocated to the relevant specialist team; Affective Disorders or Psychosis Disorders and the whole service reconfiguration was in progress. However, what is important to consider is, even when the process of reconfiguration is completed some of the other issues I discussed earlier (for example the ethical issues with labelling service users, the need for relevant training and qualifications for care coordinators to work in specialist teams, missed opportunities for professional development and satisfaction) will continue unless and until they are properly addressed by the MHT.

6.3.5.9 Benefits of Specialist Teams

Among the 26 interviewees, only two staff members thought that the specialist teams were good for both service users and staff members.

“It was to be more specialised so it’s better patient care. If you’re only doing one thing you become expert at it. On the staff side we’ve sort of chosen who we’d want to work with, so that makes it better for us, we work with something that we’re really interested in”. (CPN 4)

“People have lots of doubts but it’s not got anything to do with the model, it’s got to do with their own anxieties and their own insecurities and they’re own worries about being exposed because it’s a very different way of working than the generic CMHT. When you’re in specialist teams it’s much more stripped down and people have to actually say what they’re doing. So for many, many years, many, many staff have

done a lot of drinking tea and having chats with patients but not actually doing any therapeutic interventions, whereas in the old X³³ area staff had had 5 years to get their head around it. So everything that these teams are going through now, in the X area they all went through that in 2000". (CPN 7)

Without rejecting all new things as 'bad' or accepting them as 'good', it is important to understand both the positive and negative sides of any concept in order to improve the service. As the above quotation by CPN 4 suggests, specialist teams might provide better care for the service users through the expertise that develops with specialism. Taking the second quotation by CPN 7 into consideration, I believe that the MHT and the LASSD both have to take necessary steps to understand these personal 'anxieties' and 'insecurities' care coordinators face, in working in specialist teams. Without understanding these anxieties and insecurities it is unfair to blame the staff members, who I personally observed as very dedicated to their care coordination duties. Once these deficiencies are identified it is important to find solutions for them and empower the care coordinators to work with the new model.

6.4 Macro-system: Government Policies and Legislation

Government policies and legislation have been influential in shaping the current mental health system in the UK. As identified from the literature, there are policies that promoting multi agency working, working together, partnerships and integration, which have had an impact on the social workers role in mental health settings. In this section I present the findings on the effects of these policies and legislation, in shaping the AMHPs and MHSW's roles in the CMHTs.

6.4.1 The New Ways of Working (NWW)

The NWW has made many differences to how the team functions. As discussed earlier in section 6.2.4, before the New Ways of Working was introduced, mental health teams had been dominated by those with a medical training. As some of the interviewees revealed, this new approach has helped the teams to be away from the medical dominance.

³³ X - name of the area

“We were coming towards the NWW model. So we are very much what would be either nurses led or social worker led service. So our patients aren’t routinely seen by medics. We could manage our case load and if there are any concerns about risks, about behaviour, about need and changes for medication we would then make an appointment to see the medic. Changes would be made and that they would be discharged from medics back to our care”. (CPN 3)

In the CMHTs doctors traditionally run the outpatient clinics and with the changes the nurse practitioners can also run and manage clinics, as well as some medics which mean the role of the consultants has changed radically. As CPN 3 reveals, this might also help the MHT to make some savings as it cost less to employ two nurse practitioners rather than one consultant. This CPN also suggested that this will probably give the consultants more capacity to deal with the most complex service users.

Even though the NWW changes had been introduced some years before, there still seems to be medical domination of the teams, especially within one team, where consultants seem to dominate the final decision-making process.

“This team has always been very integrated. As long as I’ve been here the New Ways Working has been here, so I don’t really know any other way. I guess I’m getting glimpses of it now in Y³⁴. Y has been much more of that sort of medical model”. (Consultant Psychologist 1)

This is in contrast to what is expected by the New Ways of Working and has a negative impact on the staff and then to the services they provide. The New Ways of Working explains how a team should share responsibilities equally, rather than one single professional in charge of the whole caseload, as follows.

Good, modern, governance-driven, person-centred care requires distribution of responsibility, not delegation. Individuals are responsible themselves for the care they give, and no single individual is in charge of all clients on the caseload of the team. It is a natural and appropriate development for the most experienced and skilled clinicians of all professions to deal with people with the most complex needs and to support and develop the less experienced team members, thus building a more competent and capable team. The team culture should be towards each individual taking personal responsibility for the governance of their work in an atmosphere of openness. (Department of Health, 2007b:3)

The NWW also emphasised the importance of adequately preparing staff members to work with the New Ways of Working framework.

³⁴ Y – Name of one of the two CMHTs

Team learning and development includes the needs of trainees, Trainee psychiatrists, psychologists, nurses, social workers, allied health professionals and others are adequately prepared for NWW. (Department of Health, 2007b:8)

However, it is very clear from the study findings that staff members are not satisfied with the amount of training they get to work in a specialist integrated team. As they explained, they need 'proper training rather than brief taster sessions' to work successfully in these teams.

6.4.2 Social vs. Medical Model and Integrated Working

In the modern integrated CMHTs, there are staff members from both social and medical services working alongside each other. MHSWs from the LASSD are trained in a social model and the CPNs, OTs, psychiatrists, psychologists and advance practitioners are all trained in a medical model. However, as explained by Carpenter *et al* (2003:1082) "*little is known about the effects on staff of working with different organisational models and whether the effects are the same for the different professions*". Under this section I attempted to describe my findings on how the social and medical model influences the practice in CMHTs and what advantages and disadvantages the models' features and the differences between them have brought to the staff members, especially to the social work professionals and people who use their services.

"It's important to get both. I mean yes the medication will stop the mood, but the social model in mental health that means help them to build confidence to go out and meet the people and to live lives to the full. I think it's important to work together both medical and social model". (MHSW 1)

Instead of the main differences in practice being between these models, there seem to be some other practical differences between the social and medical staff.

"Just for the practicalities of following guidelines and basically the protocols that we need to follow, we follow health..... they're not totally different but there's still things that we shouldn't be defaulting from and I don't think they're totally different, I don't but there's certain things, attire, clothes. I would never ever dream of coming to work in a pair of jeans, never. I've never been allowed to". (CPN 2)

Another concern among the social workers about integrated working is that, as these CMHTs are under the MHT and are working more with a medical model, there is more possibility of social workers' forgetting their training in the social model.

“As a new worker I'm probably more avidly social model than many of the social workers that are here and you do have social workers that freely admit the social model comes less to the front of your mind the longer that you've been here. I mean some people do describe it as losing skills because the theories and models don't immediately leap to mind, that maybe the first thing that you look at is a medication review or something like that. I think there's a lot more can be done to bring social model into mental health, a heck of a lot more”. (MHSW 7)

As discussed in the previous chapter, this can be identified as akin to the experience of social work professionals' losing their professional identity. Senior social work professionals revealed their fears over newly qualified social workers easily getting trained into using the medical model and forget their social work origins. The above quote, by MHSW 7, reveals that the same thing can happen to senior MHSWs who have been working in the CMHTs, under a medical model, for a longer period.

6.4.3 Advantages and Difficulties in Integrated Working

As I observed throughout the fieldwork period, integrated work brings both advantages and disadvantages to CMHTs' staff. Davies (2007:56) explains, “within CMHTs the ‘forging’ of an integrated approach to service delivery has had a number of implications for the delivery of services and for the professionals themselves, including SWs”. Davies (2007:57) further describes these implications as follows;

The organisation of CMHTs is central to their functioning (Onyett *et al*, 1997), as by bringing together this range of skills from the different professional groups, it is anticipated that a more effective care-coordination can be achieved, compared to professionals acting independently in the delivery of services to people with SMI. In principle, this inter-professional working is considered to provide a number of benefits including: the expansion in the range of skills that are available to meet the complex needs of service users and the creation of tension within mental health services that is required to facilitate an innovative practice environment.

In the next two sections I explain my findings on the benefits and tensions in integrated working and then will move into discussing the missing components of effective integrated working.

6.4.3.1 Advantages in Integrated Working

As some professionals revealed, integrated work enables them to interact with each other on a daily basis, as they are now based in one building. Consequently, this has led to social work professionals, nurses and other care coordinators learning a lot from each other about their work models, which can be identified as a positive aspect of New Ways of Working.

“I think because of the integration now that they’ve taken a lot more from the nurses and the nurses taken a lot more from them”. (Link Worker 1)

“Absolutely I will always go to my CPN colleagues and if it’s something about medication, ‘what is this and what are the side effects’ like that. And they will do the same in certain issues like housing or whatever. I think we all began to pick up more information about each other’s”. (AMHP 1)

“If we are stuck with something we can also ask the social workers and say ‘have you ever come across this? What would you do? And who would you refer to? Is there any support that this person can get?’ So we can use their knowledge and take it back to our own work as well”. (CPN 3)

There are other benefits of integrated working for service users as they can get the service of many professionals under the same roof.

“I remember the days when social services and social workers were based in another building and I think those days were particularly unhelpful to the client because then there was lots of arguments about who saw the social worker and who saw the nurse and there was never a blend of conversations or case discussion, I don’t think those days were particularly helpful. So I think disintegration, which I know some services are looking at, is a seriously bad move, I think both professions would lose a lot”. (CPN 7)

This combination of using two different models in integrated working can be considered as very important in providing a better service.

“I think what you’ve got to do is acknowledge they come from different professional backgrounds and take the best out of each because I think if you get both that approach the chances are you won’t miss much and I think the patient gets a better service”. (Team Manager 1)

Many staff members reported the benefits of having professionals from different backgrounds under the same roof as this brings the opportunity for them to discuss difficult issues through informal discussions.

“It’s a positive thing and they see a different way of looking at things because if it’s all one profession you can get quite entrenched and have a particular professional view but if you’re having challenges to that from a variety of professions then that actually, increases the ability of the healthcare practitioner to function and to see the whole picture and I’d say it increases the positive experience of patient care as well”. (OT 2)

“It’s a two way exchange. Some of the nursing staff are wiser about medication and illness models, the social workers are invariably much more tuned in about benefits and things like that. They tend to have a ready knowledge of facilities that are available in the community and 9 times out of 10 if you’re struggling for some information like that, if you ask one of the social workers you’ll get an answer straight away, it’s very, very useful having them alongside”. (CPN 6)

A Team Manager explained how the integrated team concept has being enormously beneficial within her team.

“I think I’ve learnt a lot from watching how the social workers work in the sense of I think they are more creative. Sometimes I think health professionals get totally focused on the medical model and they go along that route and they think our way’s right and nobody else is. But actually I think the MHSW has a more holistic approach and I think we as professionals have benefited enormously from sitting next to colleagues who are social workers. I’m a big fan of integrated teams”. (Team Manager 1)

Some other team members including CPNs, MHSWs and support workers also agreed with the idea that having other professionals around has been beneficial as each professional brings their own expertise to the team.

“All that lump of it is the same but social workers, OTs and CPNs all have the little branch-offs where they’ve a bit more expertise. When you’re all working together you’ve got a better service” (CPN 4)

“Everybody’s doing the same job, but I think there is an exchange of skills, ethics and values between the medical people and the social worker side. Just slightly different ways of working but informally you share an awful lot of information and you share an awful lot of culture certainly around medications and around diagnosis and that kind of thing”. (MHSW 7)

With all the above comments from different professionals it is clear that integrated working has been very useful to all the team members. All interviewees favour integrated working as it brings great benefits to both service users and staff. However it is also understood that if the two models do not work with a high level of understanding it can cause certain problems for staff.

6.4.3.2 Difficulties in integrated working

As well as all the benefits integrated work brings, there are some difficulties that social work professionals face in integrated teams on a daily basis. These difficulties

range from the very simple to very difficult issues, which can have an impact on their work routine. An AMHP clearly described the practical difficulties of integrated working as follows.

“Even things like the ordering of the forms we use, that used to be very simple system and there’s a new kind of form which has come out which call ‘high dot’ and it is basically to trying to identify people who are on high dose antipsychotics. Part of this identification process involves a very simple kind of formula to identify who is on a certain level of combination of medication which can be dangerous. So we were been told about it at the meeting. I just happened to say ‘well has social services agreed for us actually doing simple calculation? Have they agreed for us actually to be a part of the identification process, when somebody’s health is on risk like this’? And they looked at me and said ‘well social services agreed that we are the lead agency’ and then I said ‘that’s not what I’m asking, what I’m asking is that have they agreed for us to do something which is very much a nursing role. I said ‘I’m not doing it until my boss in social services being said yes we are agreed to this’. Because the implications for example where if I was to do it wrongly my social services boss will ask ‘who told you to do this? Where did you learn to do this?’”. (AMHP 1)

The above quote shows that there are a number of difficulties faced by the AMHPs and MHSWs, which basically occur as a consequence of the staff members coming from two different organisations. These difficulties vary from using a simple form, to the use of computer system and also social service staff obeying certain principles coming from the MHT, which directly impact on social work professionals’ daily job routine. This shows that even though AMHPs and MHSWs are appointed by the LASSD, they still have to abide by the MHT’s operational policies, as the CMHT is functioning under the MHT. This is also confirmed by a team manager as follows.

“Yes, I do, I think it causes problems, an example would be an ASW has to go out and assess someone and they fill in a form called an SS66 and that form has to be put on social services database which is different from the database all the rest of us use. But we’ve got no choice but to put it on so you’re putting the same assessment on twice and that takes up time, it takes up valuable resources. So you’ve got to have admin trained in both systems. They’re the difficulties you get and they’re everyday difficulties”. (Team Manager 1)

This has created barriers not only for the individual worker, but also to the team management, as they have to deal with two different information management structures. A team manager reveals the managerial level difficulties in integrated working as follows.

“I think it’s really difficult because as a team manager I manage staff that work two different organisations. Sickness, disciplinary, appraisal policies are different. So you’re using two systems all the time. I’ve got two budgets that I’ve got to look at one’s social care, one’s health”. (Team Manager 1)

There seem to be some practitioners who actually appreciate and feel very positive about integration; however they also acknowledged that there are many difficulties in integrated working.

“I was very positive in working in a multi disciplinary team. I’ve never been negative. It can be difficult, sometimes we discussed with the staff members you can feel a little bit out. Most of the training opportunities are come up well evolves from health perspective. Leave I’ll deal with the team manager. However any additional leave or negotiations with things like that have to speak to the HR down in County Council. Then my manager has to complete a form and sometimes they don’t know which form”. (MHSW 2)

All except for one newly qualified MHSW, the AMHPs and MHSWs in this study sample explained numerous difficulties they face in integrated working, while acknowledging the benefits of joint working. To summarise these complaints, they included disparities in salary, leave, mileage allowances and flexible working hours, difficulties in accessing funds for training courses, getting supervision from their own profession and accessing the social services intranet. They further emphasised that the MHT is not taking social services systems into account and because of that AMHPs and MHSWs do not neatly fit into the integrated CMHTs.

6.4.3.3 What is missing in Integrated Working

The government publication ‘Positive Approaches to the Integration of Health and Social Care in Mental Health Services’ (NIMHE, 2003) stated that the ‘integration of health and social care in mental health has been a central plank of government policy for a number of years. Most importantly service users have consistently said they value receiving services from one integrated organisation (NIMHE, 2003). This indicates that the service users have a preference for the new integrated system rather than the old system. However with the current approach to integrated working, it is important to understand whether the service users really achieve the benefits they expect from an integrated service.

Davies (2007:54) emphasises that the,

Aspiration of this approach is to 'provide services in which the boundaries between primary health care, secondary health care and social care do not form barriers seen from the perspective of the service user' (Department of Health, 1990). Thus, in policy terms, agency and professional boundaries were perceived as barriers to continuity of care and the creation of teams the chosen method of overcoming them.

This clearly indicates that there are boundaries obstructing the achievement of the prime objectives of integrated working, and this was also revealed through the semi structured interviews. As discussed in section 2.6.4, good practice in integrated working includes the integration of operational policies, geographical proximity, communication, supervision and appraisal and clarification of roles and responsibilities. There are some professionals who believe that even though they now remain under one roof, achieving geographical proximity, there is no real integration between the staff members. A CPN explains what she expects from integrated working:

"To me an integrated team would be us all working together and we don't. We all work in the same office in isolation, unless I specifically request a favour of a social worker and you can ask these things, you can ask advice and help. But my understanding of an integrated team would be that the patients would have access to both, you either get one or another and we all just share an office". (CPN 2)

This CPN further emphasised that while there is a lot of informal discussion between practitioners, ultimately one professional is responsible for his/her individual case load, which she believed as not real integrated work. For her, integrated working would mean sharing responsibility and getting other staff members' perspective on care packages for her patients, not working in isolation but to have an understanding of each other's clients as well. However, as she explained, because of the sheer volume of people that come through, care coordinators come to know only about their own clients.

Some professionals believed that integration is very important; however there should be more opportunity for each professional to engage more in their own profession-related issues. What really happens in these integrated teams now is, all work as care coordinators and learns to perform each aspect of care coordination. As discussed earlier, this is sometimes difficult for the care coordinators as they do not

have proper training and the professional backgrounds to perform certain duties.

“I think we should remain integrated, joint working, joint teams. But not make everybody the same. So I think we all should be care co-ordinators, but the social workers perhaps get the opportunity to do some of the most complex family work and the nurses get the opportunity to do the complex therapy or the complex prescribing and the OTs get the opportunity to use their skills for occupational therapy assessments”. (CPN 7)

“I think an integrated team is really, really good, working kind of side by side, but I don’t think we need to be doing the same job because I think we’re losing the kind of individual skills of each profession”. (OT 1)

It is also important to understand here the rationale behind the introduction of multi-disciplinary teams. Columbo (1997) explains that professionals with different disciplinary backgrounds in the treatment, management and care of service users with SMI should, together, be able to solve a range of complex problems through an open exchange of skill and ideas as the rationale for multi-disciplinary teams. However, I did not observe such integration in the teams I worked with; hence it is difficult to conclude the teams are following these guidelines and principles. As the above CPN described, it is more about individual workloads and ultimately each individual care coordinator is responsible for his/her own clients.

If the original ideas and principles of fully integrated working and sharing responsibilities were put into practice in the CMHTs, this would offer a solution for the problems of job overlap and loss of professional identity, emphasised by the social work professionals. However, as I understood through the observation and interviews, with the large number of cases pouring into the teams, with limited numbers of care coordinators and with limited budgets, it is very difficult for the management to implement such changes in their teams.

6.4.4 The 2007 MHA and its impact on Social Work Professionals

6.4.4.1 Challenges for Social Workers

As explained earlier (3.2.10) many scholars (Bamford: 2007, Nathan & Webber: 2010, Ramon: 2009, Rapaport: 2006) feared that the 2007 MHA challenges the social work profession by opening the AMHP role to other professionals. Ramon (2009:1620) explains this as the ‘loss of monopoly position social workers occupied in the role of the ASW’, which had affected directly the power of MHSW. She further

emphasised the need for improved collaboration between different parties, in order to make a difference in the future of mental health social work. Taking Ramon's and other scholars ideas on board, the next section addresses the research question on 'challenges posed by the 2007 MHA' discussing my findings about the real challenge of the 2007 MHA to SWs.

In contrast to the literature that says that the 2007 MHA challenges SWs, all the interviewees in this study emphasised that it does not.

"I don't think it's a threat to the social workers, psychologists being AMHPs, OTs, to be fair I don't have a problem with nurses, OTs". (AMHP 1)

"I don't think so, because it will be the same role but carried out by other people and I think that if it were to be an OT, a senior practitioner nurse, whatever, I think the challenge is for them to be as professional as social work colleagues have been within that role of an AMHP". (CPN 1)

Some professionals did not see it as a threat; in fact they saw it as a positive development to begin overcoming the problems associated with the AMHPs' responsibilities, including increasing the number of AMHPs and relieving pressure from their work loads.

"I think it's a positive thing, so there's not going to be a shortage of AMPHs working in that role. It's going to have less demand than their time, so they are going to be less pressured. (CPN 3)

One team manager believes that it is not difficult for other professionals to become AMHPs, as long as they get the necessary training. However she revealed her concerns about the likelihood of CPNs training to practice as AMHPs.

"I don't think nurses will like to be AMPHs generally. I can't explain it, because of their background, where they've come from, their nursing education. I think you tend to work more on a caring, I'm being very general, it would be difficult for us to limit people's freedom but on the other hand, we work in the hospitals, I don't know". (Team Manager 1)

According to the AMHPs and MHSWs, CPNs do not want to take up the AMHP post because of the heavy responsibilities and stresses associated with AMHP work. These include, less pay, lengthy training they have to undergo to qualify as an AMHP, heavy responsibilities including working with law.

“I’ve spoke to quite a number of CPNs, ones that have been around a long time and they’ve got no interest in taking that role on. They’ve seen how it impacts on your workload. So there’s a huge responsibility on the AMPH to get it right and I think the CPNs just don’t really want to take that role on at all”. (MHSW 6)

“They see us frazzled, running around like idiots and it’s not exactly a glamorous job, If I had my time over again I’m sure I’d never do the AMHP training or the ASW training, I would have done something else so I think they see us and our dissatisfaction and the legal stances”. (AMHP 2)

According to three CPNs, it all depends on the individual personalities. Two of them emphasised that they have no problem with social services staff getting the opportunity to learn about medication and do injections; they think it would make more people available to do the job, which is better for the team. They believe that in the same way some social workers have no issues with other professionals taking up the AMHP duties. So they suppose it depends on the individual staff member rather than their membership of a certain profession.

“I think again, some of it comes down to individual personality, I think if you want to be precious about your profession and precious about your skills and defensive I think you could say that yes, it is going to be a challenge, whether I think it’s more inclined to do is to create a more rounded and more knowledgeable and a more skilful core of individuals who are better equipped to look after people with mental health problems in the community which is what we’re here for” (CPN 6)

With these ideas it is clear that there is no objection from the social work professionals’ side to other professionals taking up the AMHP role. However; some professionals expressed their concerns about the independence of the AMHP role if it is practised by medical professionals. This will be further discussed in section 6.3.4.2. It is also very clear from the findings that there has been no sudden mass influx of medical professionals willing to train as AMHPs. This raised the question can the problem of dearth of AMHPs be solved just by opening this role to a number of other professionals without understanding the job associated issues?

6.4.4.2 Independence of the AMHP’s Role

Ramon (1996) reports, ‘UK is the only European country that gives social workers a prominent role in the assessments for compulsory admission to psychiatric hospital’. Evans *et al* (2005) also report that;

The main argument in favour of using SWs (who have to be approved as ASW under the MHA (1983) if they undertake this role) is that they provide an independent judgement, which is less likely to result in clinical team collusion in decision-making, and ensures that the individual's rights are better protected than might otherwise be. A second argument for the use of social workers in this role is that a social care professional may be better able to broker arrangements for care in the community (Evans *et al.*, 2005:145-146).

However, as revealed previously, this role which is called the 'AMHP' is now open to health professionals, including medics. According to Anderson-Ford and Halsey (1984), cited by (Sheppard, 1990:72), 'the ASW role is intended to balance the power of the medical profession' and to achieve this aim, they suggested the need for two elements;

1. ASWs should develop a social risk orientation, rather than a mental health orientation.
2. They should develop an appropriate conceptual framework to analyse risk.

So the opening of the AMHP role to medical professionals has aroused fears among some professionals in respect to this original objective. Svennevig (2007) reports that current ASWs have no issue with medical professionals becoming AMHPs; however, they are concerned about the medical professionals' ability to maintain the independence of the role. Svennevig's findings are very similar to the findings of this study, where all the social work professionals and some other professionals expressed their fears about the role losing its independence, if practised by the medical professionals. They emphasised the importance of maintaining independence when undertaking MHA assessments.

"You had two doctors and somebody who's outside that organisation. So I think it's a very important role we should remain independent". (AMHP 1)

"A huge professional cost because you lose the independence of the AMHP, who is currently protected, by the LA as being completely independent from the Trust". (AMHP 3)

All the AMHPs and some MHSWs expressed their concerns about CPNs taking on the AMHP role, as they believe that doctors are powerful in the health system and nurses would not challenge a doctor's decision because of this professional hierarchy. Some pointed out that, because of the medical model training CPNs receive; they will not look into the social aspects when assessing service users.

“I think most nurses are less likely to feel confident about challenging the views of the consultant. But I think social workers are much more likely to go in and challenge those kinds of preconceived notions. I think where you have a care manager who’s a nurse that’s not going to get addressed, they’re just going to take it and going to agree with the consultant because nurses traditionally don’t go against the consultants for all the best reasons in the world”. (AMHP 3)

“The concern I would have with it, in terms of nursing staff doing MHA assessments, would be if they come through totally medicalised training; ward nursing, there’s a very strict hierarchy of control of power there, they take it right up to consultant. It’s not as bad as it used to be, but it’s still a hierarchy; sometimes consultants have God like power” (MHSW 7)

It was not just the professionals from social services who expressed these concerns, a few health professionals did as well.

“The thing is they were supposed to be kind of apart from a kind of person who was an assessor or whatever who was apart from health. So it’s not quite as objective a role I think if it’s not a social worker”. (OT 1)

From these quotes it is clear that social workers in the AMHP role act independently from the MHT and, with their social model training, have the ability to challenge the views of consultants. However, it is doubtful whether somebody from the MHT can really be or have the ability to be independent enough to challenge the decisions of somebody who is senior to them in their own organisation’s hierarchy. Only CPN7 emphasised that this independence depends on the personality of the AMHP, regardless of their professional back ground. However, it is important to understand that the teams are now working under the New Ways of Working and the medical model or medical dominance is not as prominent as it was decades ago. It is also important to remember that while it is difficult to generalise, the literature reveals there is still medical dominance in most of the teams. This implies that health professionals can be biased in favour of the consultant’s decisions, rather than being totally independent as social workers in AMHP role.

6.5 Conclusion

In this chapter I attempted to look at the influence from the exosystem and macrosystem on CMHTs and how that influence has had an impact on AMHPs and MHSWs contribution to CMHTs. In researching the exosystem, I looked at how far the two organisations in the exosystem; the MHT and the LASSD are integrated with

each other, and how this relationship in exosystem has influenced the social work professionals in the microsystem. I also discussed the relationship between AMHPs, MHSWs and the LASSD and their feelings about the support they get from their own service. Finally, I discussed the impact of macrosystem on social work professionals. Under this section I detailed the changes in mental health policies and legislation in UK, which has had a significant impact on social work professionals in the field of mental health service. This has been through the implementation of the NWW and the 2007 MHA particularly, and these policy changes have made a difference to the work of mental health teams and in turn to the social work professionals working in these teams.

To summarise the findings of this study- the integration between the LASSD and the MHT in this area does not seem to work perfectly. This was revealed through the interviews, where most of the interviewees explained that the MHT in this area is dominating and the LASSD is weak and unsupportive. The relationship between the social work professionals and their own service, the LASSD, also looks damaged as most of the AMHPs and MHSWs emphasised that they feel that they are forgotten, abandoned and unsupported by the LASSD. Their complaints included low salary, not receiving information from the LASSD, limited access to training opportunities and the LASSD's lack of intervention in the decision-making processes of the MHT.

Social work professionals also revealed their concerns about the medical model implemented in their teams. As an AMHP explained:

Health has to be the lead agency in delivering services to people with mental disorder. The social services department is the lead agency in delivering services for people with learning disability and all our managers appear to be coming at this from a learning disability perspective and we were under-represented and I think the social work contribution was undervalued. There are no team managers now that I am aware of are employed by social services, so that now all our social work staff are directly line managed by people from health backgrounds and I think that has all kinds of implications for how social workers develop their knowledge base around social care models". (AMHP 3)

This clearly indicates social workers' experience of being managed by health professionals only. Social work professionals' main complaints are about not getting proper social work supervision, opportunity for further training and being required to use of NHS computer system, which they explain is suited to the medical model of mental health. Almost all the staff members from health back grounds appreciated

that social work professionals bring a unique contribution to the CMHTs, which is the social model and holistic approach. However, the AMHPs and MHSWs were worried that under the current arrangements they do not have real opportunities to practice according to the social model, as most of the assessments are based on the medical model. MHSWs are also expected to learn more about the medical aspects of their clients' needs, including certain medication, which is specifically difficult for them. Fears were also expressed that newly qualified MHSWs are not developing appropriate social work values as they would in a social work culture, others were concerned that experienced social work professionals working in the health led system for years would forget their back ground and training in the social model.

The study's findings revealed that all the AMHPs and MHSWs appreciate the benefits of joint working; especially the advantages of being under one roof, which allows them to share their knowledge and learn from each other. However the findings emphasise a number of difficulties they face under the New Ways of Working, which they categorised as managerial level difficulties and individual level difficulties. Under this system, managers find it difficult to work with two different management structures and AMHPs and MHSWs find it difficult to work under the domination of the MHT and medical model. It is understood, through the data, that sometimes it is not the medical model that dominates, but the individual personalities of the consultants and the care coordinators. However, it is also clear that even after years of integration, there are still signs of medical model's influence within these teams.

Another finding of this study is the open dislike for the specialist team concept expressed by the CMHT staff. All except two CPN interviewees clearly revealed their dislike for the concept of Affective Disorders and the Psychosis Disorders teams. They emphasised that, in many ways, this new concept is clearly in conflict with the principles of the NWW and not a staff or service user friendly concept. There were also concerns about the MHSWs' ability to work in specialist teams. Most of the interviewees explained that they do not have enough experience, training and skills to work in a specialist team and emphasised the need to improve relevant skills and knowledge, in order to provide a better service for their clients.

In discussing the challenges posed by the 2007 MHA to the social work profession, none of the interviewees see the 2007 MHA as such a challenge. All the team members from the LASSD and the MHT regard this change as a potential way of overcoming the shortage of AMHPs and issues related to that shortage, such as work over load and other stresses. However, most people questioned the extent to which the AMHP can be independent if the role is carried out by a health professional, as they can sometimes be influenced by the status of consultant psychiatrists, as senior professionals in their own organisational hierarchies.

It is also interesting to consider here the ideas of CPN 7, who explained that she does not see the 2007 MHA as a challenge to the social work profession, but the 1983 Act as the start of their demise.

"I think that 1983 Act was the start of their demise because as soon as they started just doing all their other skills, all their knowledge base, all their therapeutic skills went and they became the people who did the MHA and it became very reductionist, just like you could reduce a nurse's job down to doing an injection. So I think before that social workers would have this really broad spectrum, a social worker has got a huge knowledge base and a huge amount of skills to offer and if you reduce them to just the MHA then you're doing our clients a disservice really and the other professionals on the team." (CPN 7)

As she explained here, social workers have a huge knowledge base and a variety of skills to work with different types of service users, however with the introduction of the 1983 Act, social worker's role has been limited. As a result of the 1983 Act, social workers became labelled as somebody who sectioned clients and, as discussed in the literature review, this can be one reason for the stigma attached to mental health social work professionals and consequently why service users sometimes refuse them as their care coordinators.

Finally these findings show different benefits and difficulties social work professionals face in the exosystem and in the macrosystem and how they affect the individual social workers in the microsystem and social work as a profession. In the next chapter I will discuss the limitations of this research and then present my concluding remarks.

Chapter 7 – Discussion and Conclusion

7.1 Chapter Overview

In this final chapter, I reiterate the initial objectives and methodology of this study and then revisit the overarching research questions. Next I provide a methodological critique of the study, including the strengths and limitations of adopting an ethnographic approach and implications for future research. In conclusion, I present my recommendations for the development of mental health social work services, which accord with the contemporary agenda for change in the MHT and the LASSD.

7.2. A Summary of the Objectives and the Methodology Employed

The underlying purpose of this study was to use the existing literature on mental health social work, together with MHSWs', service users' and other mental health professionals' experiences, to describe and understand in more detail the mental health social work contribution to CMHTs. By undertaking this study I wanted to explore the difficulties MHSWs and AMHPs face in multidisciplinary CMHTs. This has implications for their training and professional development as a means of improving the quality of the social work contribution within contemporary mental health services. Being able to define what is meant by quality contemporary mental health social work will result in improved outcomes for service users, carers and communities and, importantly, it will also contribute to the development and profile of MHSWs as a professional group. This study is timely, in keeping with the 'Social Work Reform Board' Agenda, whose main objective is to "develop a system in which there are sufficient high quality social workers to help children, young people, and adults, in which social workers are well supported and in which the public feels confident" (Department for Education, 2011).

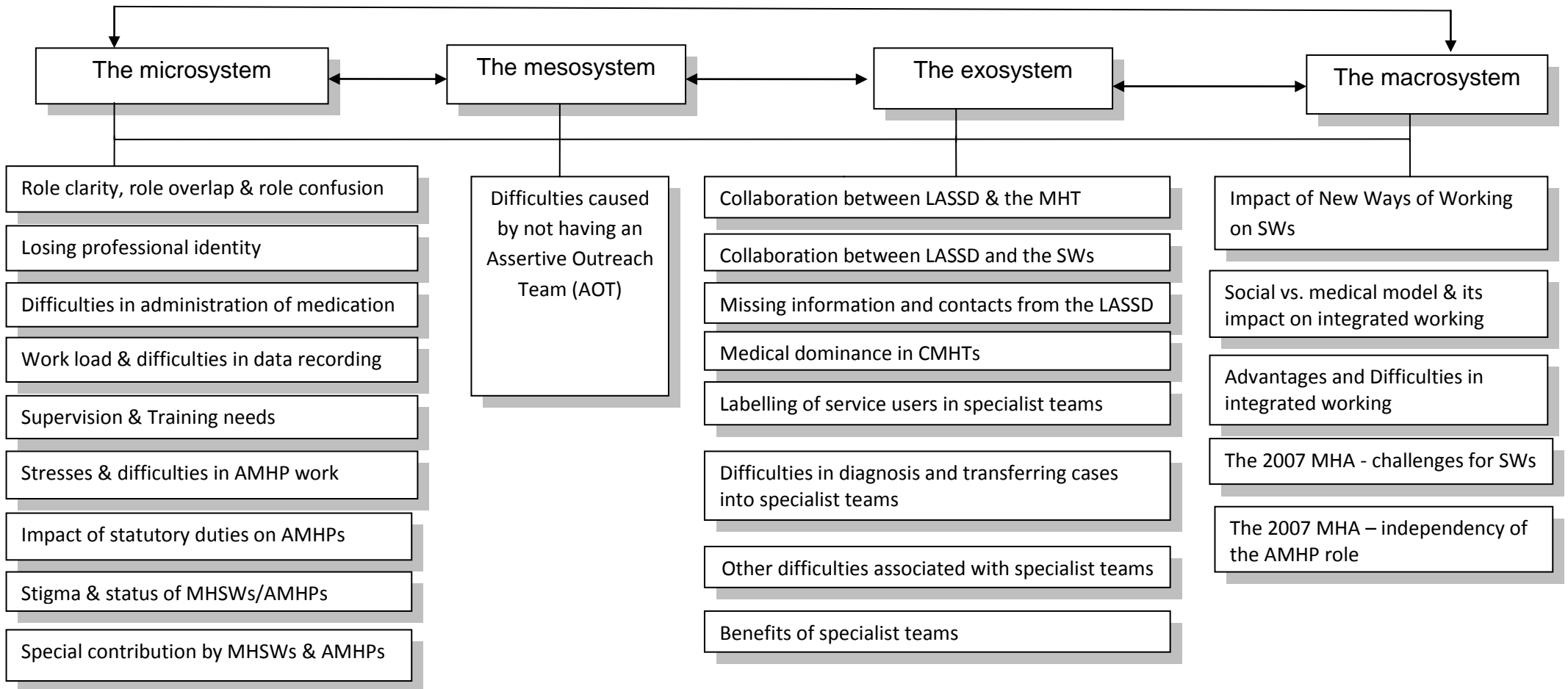
In order to fulfil these objectives, I implemented an ethnographic study in four specialist teams in two CMHTs for a period of 6 months, spending 2-3 days a week with each team. To ensure that the views of all the professionals and the two service users were fully understood, they were reviewed in relation to observations, interviews, secondary data and the existing literature. Existing literature was initially

surveyed in order to have a basic understanding of the social work contribution to CMHTs, with which to inform the interview guides (Appendices 8, 9 & 10). Then the findings from the interviews, observations and secondary data were analysed, using a thematic approach and NVIVO as a software tool. In taking a systematic approach to understand the mental health social work contribution to multidisciplinary working, I used Bronfenbrenner's Ecology of Human Development Theory (1977) as the conceptual and theoretical frame work for this study. This framework provided me the opportunity to look at social work contributions at different levels of functioning with a holistic approach.

7.3 Key Messages of the Research

The key messages of this research are discussed below under the different systems identified in the theoretical and conceptual framework and in relation to the research questions. Figure 7.1 displays a summary of the key themes identified through the study, which are related to the effective functioning of social work professionals in the micro, meso, exo and macrosystems. It is clear from Figure 7.1 that MHSWs and AMHPs face numerous issues within each of these systems and some of these issues lie either in one or more of the systems mentioned above.

Figure 7.1 Summary of the Key Themes



7.3.1. Social Work Professionals and the Microsystem - The Key Messages

7.3.1.1 Roles, Responsibilities and Duties of AMHPS and MHSWs

My first research question looked at the roles, responsibilities and duties of AMHPs and MHSWs, in the CMHTs and how these aspects are understood by other professionals and service users in the microsystem, which is their immediate environment. As identified in the literature, in an integrated team it is very important to have a good understanding of each other's role for its successful functioning.

The existing literature revealed that social work professionals complain about the lack of understanding of their role by health professionals. All the participants in my research identified the preliminary role of MHSWs in CMHTS as care coordination and they act as any other care coordinator in their teams, including managing medication. They also clearly identified that the role of the AMHP in the CMHT only differs in respect of their MHA assessment duties; otherwise they also perform similar duties to any other care coordinator. As the data revealed, even though the AMHPs believe that their statutory responsibilities are not well understood by health colleagues, almost all the participants, including some service users, showed a very good understanding of AMHP's role. However there was distress and tension among the other staff members when AMHPs have to re-prioritise MHA assessment compulsory duties in front of care coordination work. This frustration arose due to the high case load team members have to shoulder, in the absence of the AMHP care coordinators.

Very few of the interviewees in the study showed a reasonable understanding of the MHSWs' background and what they are actually trained and capable of doing instead of what they are assigned to do in the CMHTs. This issue is related to the uni-disciplinary vs multidisciplinary contribution to the CMHTs and had led to role confusion; role blurring; lack of role clarity and role overlap in the integrated teams.

As explained in section 2.6.2, by integrating social services with health, it was originally supposed that both services would bring their own specialism to care coordination. However, I found that, most of the MHSWs are confused about their current role as care coordinators. They believe that they do not have any opportunities to function fully as social workers, in their current care coordinator role,

because they have to combine this with duties traditionally associated with CPNs and OTs. Social work professionals were clear that they are not educated and trained to undertake these tasks.

Role overlap is understood as another consequence of integrated CMHTs. All the care coordinators from different professional back grounds perform similar tasks to each other in their role as care coordinators, except where CPNs are appointed as care coordinators to service users who need depot injections. This raised questions about having different professionals as care coordinators and some understood this as an overlap in roles. However, most of the interviewees in the study were convinced that there is not any overlap of roles in the teams. Some were convinced that, even if there is any overlap, it helps promote better practice within the integrated teams. Still, considering that the original purpose of integrating social and health services was: 'each profession bringing their own specialism into practice' I found that this is not happening in practice in these integrated CMHTs. Generally, the care coordinators are asked about their willingness to take up cases according to their expertise during the Allocation Meetings; but what I observed was that new cases are allocated to whoever has the smallest case load, rather than the required expertise or specific disciplinary knowledge.

This situation also led to questions on professional identity of care coordinators. Professional identity is of immense value to any professional group. The issue of social workers losing their professional identity is discussed in the literature (Godden *et al.*, 2010) and was also a major complaint from the AMHPs and MHSWs in this study. Some MHSWs described how they function more as CPNs than social workers in their care coordinator role. This, they see as a result of working in CMHTs governed by the MHT, which is an organisation dominated by a medical model, and working alongside the professionals with a medical model training. All the three AMHPs and the senior MHSWs expressed their concerns about the future of mental health social work, due to newly qualified MHSWs not gaining experience of good social work practice under these CMHTs. I clearly understood their worries, as none of the newly appointed MHSWs I interviewed identified any difference between what they now do as care coordinators and what they have been trained and educated to do as social workers. Nevertheless, most of the professionals with health back

grounds did not believe that MHSWs are losing their professional identity. I identified this as another gap in these professionals' understanding of social workers' backgrounds, their education, training and what they are actually capable of doing and what they like to do as social workers. As CPN 7, for example, revealed social workers in these CMHTs have no opportunity to shine as social workers under the current system.

With this understanding about the social worker's role, in order to improve their contribution to the mental health field it is vital to understand the uniqueness of social work profession, which I had further discuss and made as a suggestion at the end of this chapter in section 7.5.1.

7.3.1.2 Stigma and Status of Social Work Professionals in CMHTs

The prevailing literature discusses how social workers are stigmatised as a profession, by their clients and work colleagues, and how their status is poor in the CMHTs, compared to other professionals. One of my research questions on the 'status and stigma of social work professionals in CMHTs' focused on understanding this issue. Findings of this research do not totally support the idea that social work professionals have a relatively poor status within the CMHTs. All the interviewees, except three AMHPs and two MHSWs, emphasised that both AMHPs and MHSWs have equal status with other professionals in their teams.

Nevertheless, it is understood through media reports and the existing literature, that social workers are often stigmatised in society; most recently as a result of infamous cases, such as Baby P and Victoria Climbié associated with child care social workers. However this stigmatisation of child care social workers seems to have spread across all areas of social work, including mental health social work. The service users, I interviewed and observed during home visits, showed a very good understanding of the social workers' role and expressed their appreciation towards their social work care coordinators. However; most of the staff members from both health and social services agreed that there is still stigma associated with social workers that is perceived by service users and their carers. Staff members reported personal experiences of clients refusing to have social workers as their care coordinators, not intended as a personal offence to the individual worker, but in a

reaction to the title 'social worker'. I identified three reasons for this stigma associated with social workers' roles in the community.

1. Service users do not have a clear understanding of AMHPs/MHSWs' roles as care coordinators
2. Some service users have developed relationships with their CPNs during their involvement with mental health services and as a result they want to stick to what they are used to.
3. Service users do not trust the qualification and skills of social work professionals to work with mentally ill people, as they believe social workers are there to look at only the social aspects and will not address the medical issues.

In tackling this stigma, it is very important to improve awareness among service users and carers of the actual roles of MHSWs and AMHPs as care coordinators. This awareness could make a positive impact on the mental health social work profession, as in the past (as some of the interviewees revealed through recounting their experiences), these explanations have helped to build very positive relationships between service users, carers and social work care coordinators. It is also important to appreciate here that almost all the social work professionals I interviewed emphasised that this stigma had not particularly affected their morale, even though they had sometimes temporarily felt emotionally disturbed, stressed and devalued. However; they acknowledged the importance of raising awareness about their role in the wider community, which will unarguably help to strengthen their relationships in the microsystem and will help to improve work efficiency.

7.3.1.3 Difficulties in Care Coordination

There were a number of findings in relation to the research question on 'barriers to social workers effective functioning in CMHTs'. The findings under this question revealed that care coordination is sometimes complex for MHSWs as they have difficulties in monitoring medication. Even though service users who need depot injections are normally allocated to CPN care coordinators, there are still many service users who are on other medication and under the care coordination of MHSWs and OTs. In this sense, the care coordinators have to develop a very good understanding of medication to keep on track with the care package, monitor the

side effects of medication and also to answer various questions raised by their clients. Both MHSWs and OTs found this stressful, as they believe that they have not received sufficient education and training on medication management in order to monitor signs, symptoms and side effects of medication. Compared to MHSWs and OTs, AMHPs had received a further training on medication as a part of their AMHP training. This difficulty was especially relevant to newly appointed MHSWs and OTs, as the service users expect the same level of expertise regarding medication from their care coordinators irrespective of their professional background.

Another major complaint from the social work professionals concerned the difficulties in using PARIS, the huge amount of administrative work generated and the amount they must complete on a daily basis. They basically consider PARIS as a waste of time, based on a medical model and a way of labelling service users. Using PARIS has also meant that they have missed important information from the LASSD, as they do not have frequent opportunities to use SSID. Within one team there are no computers with SSID, restricting the social work professionals' connection with the LASSD. Within the other team there are a few computers with SSID. However both AMHPs and MHSWs complained that PARIS is totally different from SSID and as a result they have forgotten the basic elements of using SSID, while some complained about having not enough time to spend on two different computer systems. There were many complaints about the high number of cases they have to deal with and the amount of paper work they still have to complete alongside the on-screen work. Most social work professionals identified that they could use this time they spend on documentation now more effectively supporting their clients in the community. This, they mentioned, is what they are trained to do and what they prefer to do and an important part of being a social work practitioner. I identified this as an important issue to be addressed by the LASSD and the MHT, in order to develop the efficiency of social work service provision.

7.3.1.4 Difficulties in AMHP Duties

As explained in section 5.5.2.2, there is a shortage of AMHPs in the CMHTs. As a result, remaining AMHPs have to be on the AMHP work rota more often and this has increased their work load. Consequently, they miss some of their care coordination work as care coordinators.

Due to this shortage, AMHPs are mostly isolated in their own teams without any other AMHP to ask for help when they need it, with difficulties in MHA assessment duties. As AMHP1 revealed, these discussions with AMHP colleagues are sometimes very important in taking crucial decisions related to MHA assessment duties. This problem has also been identified in the literature (Davies: 2007, Sainsbury Centre for Mental Health: 2000), however there seems to be no immediate solution for this, except opening the role to the health professionals by the 2007 MHA. During the period of my field work this did not look like a reasonable solution to fill the gap, as there was no immediate willingness among the other professionals to qualify as AMHPs due to two main challenges associated with the AMHP role.

1. AMHPs in the CMHTs have to shoulder a case load as care coordinators, alongside their MHA assessment duties. Priority is always given to MHA assessment duties resulting, in the cancellation of appointments and home visits to the clients whose care they care coordinate. Even though AMHPs attempt to manage the relationship between them and their clients, by minimising these cancellations, sometimes it causes distress to both parties. In some cases, other care coordinators provide cover during their absence, which is not always preferred by service users due to their concerns about continuity and familiarity with their mental health conditions and privacy.
2. When AMHPs work as care coordinators, this can sometimes cause confusion among their clients about AMHPs' statutory powers. With the stigma attached to their roles, service users often think that AMHPs will use their statutory powers to section them, while care coordinating. As the AMHPs emphasised, this confusion can affect the therapeutic relationship between the two parties.

Through observation I understood that the AMHPs within these two teams have built up very good and strong relationships with their clients over the years. However AMHPs acknowledged that these tensions are sometimes emotionally disturbing for them as individuals.

7.3.1.5. Supervision and Training Needs

One of my research questions focused on understanding ‘what would help to improve the quality of mental health social work intervention in integrated working and develop their contribution for a better service?’ A number of issues were identified in addressing this question. One of the key findings was that social work professionals lack the opportunity to get proper social work supervision. They stressed the importance of getting supervision from somebody from their own service, which they emphasised as a crucial factor for their professional development as well as for the quality of service provision. Davies (2007:217) presented the importance of this professional leadership as:

Given this lack of professional leadership/role models, Social Workers reported that they felt that they had lost some of their power and that their professional identity had been blurred. As a result, they stated, the social factors of service provision were not being promoted as part of the care of people with SMI³⁵.

Norman & Peck (1999) also reported that social workers in their study were “clearly concerned about their place in the teams and saw strong professional support and supervision as crucial, in ensuring a distinctive social work contribution to community mental health services” (Carpenter *et al.*, 2003:1099). This literature together with the findings of my research clearly convey the message that social workers value supervision from their profession and own service, to secure the inclusion of social factors in the distinctive social work contribution to CMHTs.

For the research question on social work professionals’ academic, professional, training qualifications and needs, I identified two specific types of training needs.

1. Training needs of MHSWs to perform more effectively in their specialist teams
2. Programmes to develop integrated working among the staff members.

Consistent with Fakhoury & Wright’s (2004) findings, the majority of the MHSWs in this research expressed concerns regarding having the appropriate knowledge and skills to work in integrated specialist teams. They were especially concerned about their level of understanding of medication issues and their lack of expertise in certain therapies like CBT (Cognitive Behaviour Therapy) and DBT (Dialectical Behaviour

³⁵ SMI – Severe Mental Illnesses

Therapy). At the moment only CPNs can administer the depot injections; this has caused problems in the CMHTs as sometimes there are not enough CPNs to be care coordinators for all the service users who need them. In such cases, service users are allocated to social work or OT care coordinators and these care coordinators must get the help of a CPN to administer the injections.

Gibbon *et al.* (2002) highlighted that team development is crucial before the introduction of an integrated approach to working and thus training programmes to develop integrated working among the staff members can be identified as very important. However, during participant observation and the interviews, I learned that the employees of these teams have not had many opportunities to develop their team skills, to work in an integrated environment. As Hannigan (1999), cited by Davies (2007:252), suggested this situation is resulting in team workers being produced who 'fail to comprehend the language of those educated in alternative disciplines'. Hannigan (1999:30) reveals two challenges that need to be overcome for effective joint working:

1. The limited understanding by professionals of the concepts, values, language and activities of other disciplines.
2. The encouragement of inter-professional boundaries by separate initial training.

Davies (2007:252) citing King (2001), suggests that when professional groups have different experiences of team working this can affect the cultural integration of teams, and 'can result in inter-professional tensions and be a barrier to effective working'. Consistent with Hannigan (1999) and King (2001), within these teams the lack of understanding about each other's professional back grounds sometimes causes tension among the professionals. As AMHPs described, during the interviews, some of their health colleagues are not totally aware of their responsibilities with the MHA assessment duties and complain about them missing some care coordination work.

As a result some staff members believe an opportunity to participate in team building events would open the doors for them to discuss their roles with each other more, and subsequently will help them to have a better understanding of each others' roles, duties and professional background. This will unarguably help to strengthen the work efficiency in the microsystem. Davies (2007:245-246) emphasised that "Such

training could be used to overcome some of the traditional barriers to effective team working, such as the fact that certain skills are needed to manage interprofessional relations and to clarify the roles within teams”.

7.3.1.6. Special Contribution by Social Work Professionals

Social work professionals, with their social model training, were expected to bring their unique contribution to the multidisciplinary CMHTs. The research question on ‘the Specific/unique contribution of social workers (if any) to the functioning of a multidisciplinary team’ was aimed at exploring this issue. My findings indicate that the distinctive contribution made by the MHSWs to the CMHTs is diminishing. Almost all the interviewees emphasised that there is no specific contribution made by social workers; rather they act as any other care coordinator, except that AMHPs have specific MHA assessment duties. It should also be emphasised that some professionals acknowledged the assistance offered by social work professionals, particularly with issues related to social benefits or housing, and the subject expertise of AMHPs related to MHA related issues. This acknowledgement clearly indicated that social work professionals are capable of providing a distinctive contribution to the multidisciplinary teams. However, the findings of this study reveal that they do not get the opportunity to contribute this distinctive knowledge and experience of the social model to the CMHTs for two main reasons.

1. After the integration of health and social services CMHTs teams are now functioning under the MHT and the teams are understood to be based on a medical model, limiting the opportunities for pure social work practice.
2. Under their current role as care coordinators, they must take responsibility for all the aspects of a care package, rather than offering a distinctive service based on their social model education and training.

The findings of this research and previous research (Gould, 2006, NIMHE, 2005) emphasise that social work professionals are capable of providing a distinctive social model service to the CMHTs that health professionals are not generally capable of. With these ideas, I suggest that the duties and responsibilities of MHSWs and AMHPs as care coordinators in the CMHTs should be revised, to allow them to extend a more distinctive service based on the expertise of their own discipline.

This study shows the importance of understanding the social work role within the microsystem rather than attempting to understand practitioners as separate individuals. Team members, service users, carers, team managers all interact very closely in this nested system, and each person, each decision taken in this system has an impact on every other's role. This allowed me to understand a number of difficulties social work professionals face in the CMHTs and some of their specific needs to improve service provision, through the eyes of many people who interact and can have an impact upon social work professionals' role in the CMHTs.

7.3.2 Social Work Professionals and the Exosystem – The Key Messages

The exosystem in this study comprises the two organisations that employ the staff members in the CMHTs. MHSWs and AMHPs are seconded to the CMHT by the LASSD, while all the other staff members are appointed by the MHT. The two CMHTs I worked with are managed by the MHT. As a result, these two groups of social work professionals are always managed by both organisations and are affected by the relationship between them. It was also revealed that the social work professionals are affected by the relationship they have with the LASSD. This clearly indicates that the exosystem, in this ecological systems framework can have a direct impact on social workers' role in the CMHTs, in the microsystem.

7.3.2.1 Relationship between Social Work Professionals and the LASSD

Findings from this study reveal a broken relationship between the LASSD and the AMHPs and the MHSWs and a number of organisational factors were identified as barriers to social work making an effective contribution to the CMHTs. Social work professionals stressed that after they joined the CMHTs, they felt that their own service, the LASSD, had abandoned them and extended no support to them at an organisational level. Because of this broken relationship, social work professionals complained about missing information, training and other opportunities from the LASSD.

It is important for the LASSD to provide necessary facilities to improve the work capacity of its staff. One of the major problems identified was the difference between payments to social work professionals from this LASSD and other employers. As

revealed by the interviewees from both health and social services, social work professionals' pay in this LA is relatively low compared to the other LAs and agencies. There are also differences between the salary scales of social work professionals and other care coordinators (CPNs and OTs). They identified this as the major reason that most of the AMHPs and MHSWs left these two CMHTs. As the AMHPs revealed in their interviews, a number of their AMHP colleagues who obtained their qualification, with funding from this LA, left shortly after qualifying to, work in other LAs with better salaries.

Issues were also identified related to lack of opportunities extended by the LASSD for the professional development of MHSWs and AMHPs. Almost all the interviewees emphasised that they have no means of accessing news updates from the LASSD, as they are based in the CMHTs without any connection to the LASSD, except for their monthly salary. As a result they did not receive news on changes that were occurring within the LASSD, training and professional development opportunities. They also complained about missing opportunities to meet and discuss new trends in social work with their other social work colleagues. As a solution to this some of them suggested the possibility of having computers with access to the social services network, in order for them to keep to date with organisational development in the LASSD. However, others did not see this as a solution, as with their heavy case loads and busy schedules they still would not find time to log into two different computer systems.

This whole situation has caused the social work professionals to lose faith in their own service and started to feel themselves as neither a part of the MHT nor the LASSD.

7.3.2.2 Collaboration between LASSD and the MHT

Consistent with the literature (Reid *et al*: 1999), this research did not find a satisfactory collaboration between the LASSD and the MHT. Most of the interviewees with a social work background emphasised that the LA in this area is very weak and the MHT, on the other hand, is powerful and dominant. This was confirmed by the example of setting up specialist teams, when, the social workers complained, the LA had not been involved in the decision- making. Some

professionals from a health background revealed that it was not the dominance of the MHT that damaged this important collaboration but the unsupportive/disinterested character of the LA. This, combined with the dominant character of the MHT, was highlighted by some as showing the differences between power structures of two organizations, especially when dealing with policies. These findings indicate that there is a difference of opinion between the health and social work professionals with regard to the reasons behind the unsatisfactory relationship between the two organizations. In conclusion the findings of the research study are not strong enough to identify that one party is actually responsible for this damaged relationship. However it is clear from the study findings that the social work professionals, in these CMHTs, are the victims of this weak relationship, as they are directly affected by the lack of collaborative decision-making by the two organisations.

7.3.2.3 Separation into Psychosis and Affective Teams

Psychosis disorders and Affective disorders team concepts are not very common in the CMHTs or in many MHTs; in fact some have never heard of the distinction. The moving into these specialist teams was initiated by the MHT covering this area, and the CMHTs must accept this change as the MHT is their management body. A major finding of this study is that there are numerous difficulties associated with this specialist team concept, which was introduced into these two CMHTs recently. A few years ago this system had been introduced into another CMHT in a separate area, within this same MHT, and had been successful due to the small size of the CMHT. However, within these two CMHTs there were many criticisms from all the professionals, about this new system.

Most of the interviewees revealed their concerns about the diagnostic labelling of service users into categories, such as psychosis disorders and affective disorders. They explained this separation as in conflict with the 'New Ways of Working' principles, which was originally expected to reduce the labelling of service users with their diagnosis.

There were many difficulties associated with separating service users into psychosis and affective teams.

1. Some of the symptoms diagnosed presented by service users are mixed and difficult to categorise under just one label.
2. The Psychosis Team in one CMHT has not got enough female CPNs to cover the depot injections, which has resulted in service users remaining in the care coordination of the Affective Team.
3. Care coordinators were not keen on taking on new, very complex and time consuming cases, which makes the transfer process difficult. As a solution for this, some staff members suggested that the transfer process should be managed centrally rather than the care coordinators searching for willing recipients.
4. Transferring service users between the teams has increased the work load of care coordinators, as each time the care coordinators change they must build new relationships with the new clients. They are required to produce new care plans or study the previous plans, which subsequently require them to complete a large amount of paper and computer work.
5. The separation causes difficulties for the service users, as they have to frequently change their care co-ordinators which they find unsettling and disturbing.
6. There are difficulties in transferring patients between consultants and the continuity of their care. Staff members were unsure of the roles of the consultants, particularly in relation to in-patients. There are different consultants for the community and different consultants for the in-patients and this split has led to a lack of continuity, which most of the staff described as unsuccessful.
7. There were problems for care coordinators in choosing which team they wanted to work with, and they missed professional opportunities when dealing with only one category (either psychosis disorders or affective disorders) of service users. Some of the professionals emphasised that in the specialist teams, they missed the variety of their former roles, and they would prefer to go back to the previous comprehensive locality CMHTs.
8. Team managers are less available, as they manage two teams in two different locations. This situation has made the staff members very uncomfortable by making it difficult to find a manager when needed. As a solution to this problem, staff members suggested the possibility of having one manager based in one CMHT and managing both Psychosis Disorders and Affective Disorders teams in that location. This seems to be a very positive suggestion, as before the reconfiguration this had worked properly. However, it is

important to maintain a very close relationship between the two CMHTs, for the effective running of both teams.

9. There is an unmet need for extra training and relevant qualifications to work in specialist teams. Even within the generic CMHTs the opportunities for staff to develop specialist skills with particular client groups were limited (Reid *et al*: 1999)). Most of the MHSWs identified themselves as lacking the knowledge on certain disorders and the training and skills to practice certain therapies. At the time of the research they sometimes got the opportunity to attend brief taster sessions on certain therapies; however, they emphasised that what they really want is complete training courses, rather than these brief taster sessions to improve the quality of their work. This is a very crucial point to be addressed by both authorities, in order to reduce the work stress among the staff members, build their confidence to work in specialist teams and subsequently to offer an effective service for the service users.

It is important to reiterate here that my fieldwork was carried out during the early days of the reconfiguration and some of the issues discussed here might have been successfully answered by now. However, as most of the staff members stressed, they needed time and opportunities to discuss the difficulties they faced while working in the specialist teams, in order to develop a better service.

Finally, there were only two staff members who emphasised the importance of specialist teams. According to their argument, in a specialist team one may find staff members who are interested and have expertise in that particular field, which will subsequently lead to provide better care for the service users. Still, in order to produce these 'expert staff', the team management and the MHT should first identify the difficulties associated with this specialist teams and then take necessary steps to address them satisfactorily.

With these ideas it is clear that the exosystem has an impact on the microsystem in two ways.

1. The relationship between the two organisations; LASSD and the MHT in the exosystem:

A strong and well balanced relationship between these two organizations is vital for the effective functioning of the CMHTs, because the decisions taken by them in the exosystem have a direct impact on the social work professionals in the microsystem.

2. The relationship between the LASSD (exosystem) and the social work staff seconded to the CMHTs (microsystem) by the LASSD:

Social work professionals in the CMHTs feel the relationship between them and the LASSD department has broken and they show no trust in their employer. This has had a huge impact on their roles and some have very negative feelings about their position as MHSWs/AMHPs. In this sense, the LASSD should take the necessary steps to improve their relationship with its employees, building up their confidence and morale while working under different management arrangements and out of the LASSD's own premises.

7.3.3. Social Work Professionals and the Macrosystem – The Key Messages

Different policy and legislation that govern the CMHTs are passed down to them by the macrosystem through the MHT and the LASSD in the exosystem. The findings of this study clearly reveal some of those policies and legislation that have made and can make a direct impact on social work professionals in the CMHTs. The main focus in this study was on the mental health integration policy and the MHA 2007.

7.3.3.1 Impact of Mental Health Integration Policy on Social Work Professionals

As agreed by all the interviewees in this research, integrated working has in a way helped to improve the mental health service provision. Sharing the same office premises had facilitated physical proximity and this, in turn, helps the staff members to share their knowledge and skills and work together as a team. This has brought benefits for service users, as all the health and social care professionals they see are now located in one place. These positive aspects of integrated working have also been identified in the literature (Gulliver *et al*: 2002, Davies: 2007). However, professionals also report that there are many difficulties working in an integrated team. Social workers, as the only professionals from the LASSD, can be identified as the professional group who underwent most changes following the integration of health and social services.

Firstly, social workers have found their place of work is dominated by the medical model of mental illness. As these two CMHTs are functioning under the MHT, every other person, except AMHPs and MHSWs, in these two teams represents the MHT.

All the other staff (a relatively large number compared to the number of social work professionals) were appointed by the MHT; the policies, regulations, data bases, team management and supervision that shape and support their practice are based on the medical model. Consequently, social work professionals feel isolated from the mainstream team culture.

Secondly, social workers have found a medical approach to service provision in the CMHTs. Social work professionals, from their social model based education and training, prefer to view each client, as a 'whole person', when preparing the care plans, whereas the health professionals focus mainly on the 'symptoms' presented by their clients. As the social work professionals emphasised, even the data recording systems, including PARIS, are based on the medical model and do not provide space for a good social work report. The terminology social workers would use to describe service users is different from that of health professionals, which they found very disturbing. This has caused stress and anxiety among the social work professionals, as they feel they are moving away from real social work values and practice in the integrated CMHTs. Most of the senior social work professionals expressed their fears about the future of social work practice in CMHTs, as the newly appointed social workers are introduced directly to a medical model dominated culture and service, when they begin their practice in these integrated CMHTs.

Thirdly, social work professionals identified that the LASSD management made a relatively small contribution to strategic decision-making in the CMHTs. As a result social workers have to follow whatever the MHT decides, which sometimes means that they are carrying out health-related tasks and practising in a way that does not have the approval and support of the LASSD.

7.3.3.2 Impact of the 2007 MHA on Social Work Professionals

With the changes to the ASW role from the 2007 MHA, this role is now carried out by Approved Mental Health Practitioners (AMHP). It is now open to health professionals causing fears among scholars (Bamford: 2007, Nathan & Webber: 2010, Ramon: 2009, Rapaport: 2006) (see chapter 3.2.10) about the implications of the 'loss of the monopoly position SWs occupied in the role of the ASW' (Ramon, 2009:1620). In contrast to this literature, findings of this study identified that this is not perceived on

the front-line as a challenge to the social work professionals' 'monopoly'; in fact some interviewees saw it as a possible solution to the dearth of AMHPs and with the potential to reduce the work pressure on AMHPs. None of the interviewees in this study identified this as a challenge to the social work profession. However some emphasised other concerns related to the opening of the role to health professionals.

The first issue they raised is concern about compromising the independence of the AMHP role, when it is practised by health professionals and MHT employees. This concern has been raised in the literature (Svennevig, 2007) and the findings of this study were very similar to that of Svennevig's (2007). Current AMHPs have no issue with health professionals' competence to practice as AMHPs; however they are not confident about the health professionals' ability to maintain the independence of the role. The social work professionals explained that health professionals are unlikely to challenge the decisions of consultants, due to the hierarchical structure of the health system. One health professional also revealed that her understanding was that the AMHP role must be apart from health, and if the AMHP is not a social worker, the role cannot be carried out as objectively and independently as it is meant to be. As Evans *et al* (2005:145) explain the main argument in favour of using social workers as ASWs is "that they provide an independent judgement, which is less likely to result in clinical team collusion in decision-making, and ensures that the individual's rights are better protected than might otherwise be". Throughout the interviews it was clear that social workers in the AMHP role act as an independent opinion, separate from the MHT, and with their social model training have the ability to challenge the views of consultants.

Nevertheless, it is also important to understand that the CMHTs are now following under the 'New Ways of Working' policy and practice guidance and there are signs that the rigidity of the hierarchical system in some CMHTs is diminishing. This might lead to other professionals as well as consultants having more say in decision-making processes. In such circumstances, health professionals might also gradually feel able to challenge the consultants in final decision making, which could be regarded as an essential step towards the opening up of the AMHP role to health professionals. However this requires further investigation, before a conclusion can be drawn, as the AMHP post was very new at the time of this study and I did not meet a single AMHP, from a health back ground or profession.

The second argument presented by Evans *et al* (2005:145-146) for the use of social workers only in this role is that 'a social care professional may be better able to broker arrangements for care in the community'. However, this view can be challenged as with proper training on the social aspects of people's needs and resources, within AMHP training, even the health professionals can learn this aspect of the AMHP role.

The next issue is whether or not other professionals are likely to want to practice as AMHPs. Almost all the health professionals I interviewed said that they do not want to be AMHPs as they have personally observed the 'busy and stressful' lives of their AMHP colleagues. The stresses they mentioned included heavy responsibilities in working with law, poor pay and lengthy training.

As a conclusion I argue that there are practical obstacles to the opening the AMHP role to health professionals and the difficulties associated with the AMHP role must be solved in order to overcome these obstacles. This indicates that the macrosystem needs to have a better understanding of the practical functioning of the microsystem, as it seems the changes to the AMHP role have not been based on proper research into the ASW role. Even the policy of mental health team integration should have been based on more research on a larger scale, to identify the difficulties and barriers different professionals face in the integrated teams. Only by solving these difficulties can the macrosystem expect to develop mental health service provision and achieve the objectives of service integration in the microsystem.

7.4 A Methodological Critique

7.4.1 Strengths of the Study

7.4.1.1 Use of an Ethnographic Approach

I consider the biggest strength of this study was the opportunity to be a part of the teams as an ethnographic researcher. As explained in chapter 4, as an international student with no prior experience of the mental health system in the UK, I found it really important to obtain practical experience to develop an extensive understanding of how the mental health system works in England. Before entering the field, all I

knew about the mental health services in England was what I had read and understood from academic and grey literature and the impressions gained through discussions with my colleagues and supervisor. If I had chosen to undertake a more empirically-based study, relying upon questionnaires, surveys and interviews, I would never have been able to gain the rich diversity of data I collected as an ethnographer. Being an ethnographic researcher allowed me to be a part of the teams, joining in their official meetings as well as informal discussions and home visits. Using an ethnographic approach also allowed me the time I needed to approach the staff members, given their busy work schedules. This in turn allowed me to organise my field work in a sensible manner, giving me the opportunity to save and use my time during the cancellations of scheduled meetings, home visits and interviews.

7.4.1.2 Using a variety of Methods

Being an ethnographic researcher opened doors, enabling me to use a variety of methods to collect data, including participant observation, semi structured interviews, secondary data and participation in home visits and team meetings. The interviews provided opportunities to clarify the meaning of data I collected in participant observation and the secondary data provided further insights to assist the analysis. As a result, by using a variety of methods, I managed to ensure that the data gained from one source was reviewed accordingly with the data gained from other sources, so that the views of all the interviewees were fully understood in context.

7.4.2 Limitations of the Study and Implications for Future Research

7.4.2.1 One MHT and One LASSD

Both CMHTs covered in this study belong to the same MHT. All the mental health professionals in these two teams were appointed by the same MHT and all the social work professionals were appointed by the same LASSD. Though the teams are located in two different geographical locations, the team managers are the same for both and are employed by the same MHT. Generally, there are no major differences between the two teams in practice, even though one of the teams is understood to be more medically dominated. In this sense, I believe that if I had the opportunity to work with teams from different MHTs and LASSDs, I would have been able to collect

data that might have highlighted the differences in social work contributions to CMHTs in different MHTs.

7.4.2.2 Field Work Period

I spent a total of six months in the field, which was an appropriate period of data collection for a study of this size. A longer period may have resulted in me collecting too much data to manage, while a shorter period may have restricted the scope of the study. The timing of the study meant the fieldwork occurred during a transitional period for both teams. Reasons for this were the introduction of the MHA 2007 and reconfiguration of the two teams into four specialist teams. As explained in section 6.2.4, most staff did not support the concept of specialist teams, however some accepted that the teams are rather new and with time most of the problems associated with the specialist teams may be solved. With the time limitations for my study, I had only 6 months to spend with the teams and therefore I did not have any further opportunity to follow up this particular matter. During the period of fieldwork some of the staff was still unfamiliar with the changes that had happened after the introduction of the 2007 MHA. In the two CMHTs all the three AMHPs I met were from a social work background. This limited the opportunity for me to observe and understand how professionals from health backgrounds might practice MHA assessment duties and answer some of the concerns including those about the independence of the AMHP role, if it is practiced by non social work professionals. Recognising this limitation, I believe that a longitudinal approach to the collection of data would have provided more information about the ongoing influence of the changes in the teams and the impact these changes had on staff.

7.4.2.3 Limits of Access and Data Collection

A major limitation of the study arose because of the ethics committees' restrictions on meeting and interviewing service users. I am aware that the voice of service users is as important as the voice of professional team members in understanding the contribution of social workers. However, I was only allowed to meet service users during joint home visits with staff members and to interview them only within the CMHTs' premises. Some of the scheduled home visits were cancelled as a result of service users changing their minds about meeting me, basically due to their

fluctuating mental health status. Some other appointments were cancelled by the staff members, if they considered the service user was a risk to others or likely to be intimidated by the presence of an outsider. In this sense, I had to rely on team members to identify service users who were willing to be interviewed and this led to fewer service users being interviewed than I had hoped. If I had been able to interview ten service users, as I originally intended, this would have provided more data to enrich and strengthen the study findings.

7.4.2.4 Sample Size

Consistent with a study of this scale, I believe the number of participants I interviewed was sufficient and I am also satisfied with the opportunities I had to interview professionals from different professional backgrounds. However I missed interviews with two MHSWs in one team and a few key professionals in both teams, including a team manager and another consultant psychiatrist. There were various reasons for this. Scheduled interviews with the two MHSWs were cancelled and despite reminders, these two MHSWs did not contact me to reschedule them. However I believe the number of MHSWs I interviewed was enough to yield meaningful results. One interview with a team manager was cancelled due to an emergency meeting she had to attend and the consultant psychiatrist did not respond to my approaches at all. I attributed this with these workers' busy time schedules and the priority afforded to their clients. However, I believe if I had managed to interview them I would be able to compare the ideas of the two team managers and the two consultant psychiatrists, which should have added further value to my findings.

7.5 Suggestions for Service Development

Based on the findings from this research and the recent literature, I have summarised the issues that need to be addressed satisfactorily, in order to develop the social work contribution to multidisciplinary CMHTs.

7.5.1 Understanding Social Work as a Unique Profession

Through the literature it is evident that all the models of a mental disorder (disease model, the psychodynamic model, the behavioural model, the cognitive model and the social model) are relevant to overall mental health. According to Gardner *et al* (2004:14), research demonstrates that service users' primary concerns are around: living conditions, work and occupation, relationships, ethnicity, culture, gender and sexual orientation, and society's acceptance or non-acceptance, finances, inclusion and citizenship, well-being, appropriate medical treatment and choice, respect as "whole persons", and access to mainstream services like education, health and leisure. Literature further reveals that "Sustaining good mental health and supporting those with problems is a complex and multifaceted task that involves social, political and economic issues as well as medical factors" (Ray *et al.*, 2008). It is therefore evident that just one model is not sufficient in designing a successful treatment plan and will not answer all the concerns of service users. Importantly, the social model is the only model which focuses on environmental and relationship factors that cause mental distress. And this is where the social work profession can bring a unique contribution in responding to the needs of mentally ill people.

Through the findings of this study and the prevailing literature it is clear that the social work profession is very important in the service provision for mentally ill people through their social model practice. This contribution has been valued by service users in many ways. For example, a study of mental health service users in Westminster in the late 1990s cited financial difficulties (nearly 90% of service users were unemployed and living on benefits) family relationships, accommodation, social isolation and practical problems as of pressing concern to them. They valued social workers and other professionals who took these issues seriously and at the same time treated them with respect (McDonald & Sheldon; 1997). A similar survey undertaken in Leeds revealed that service users valued talking, listening and counselling services provided by social workers highly, followed by advice on benefits (Leeds Mental Health Unit: 1997; (Davis, 2004:24). And the SCIE Research Briefing 26: Mental Health and Social Work reveals "there is evidence that people who use services value some of the more 'traditional' contributions that social workers can make in helping them, and integrated services in multi-agency settings should recognise this" (Ray *et al.*, 2008).

According to (CSIP, 2006:3) “working with users and carers, social workers promote an unique holistic, recovery orientated, values based social care/social inclusion model that is able to challenge the dominant, task orientated medical model and this is reflected in the competencies required. This model should continue in the future”. The importance of including the social model in responding to the needs of mentally ill people is the point that I wish to highlight here. This does not mean that treatment should be based only on the social model; but should be a combination of both medical and social models that can be implemented in the CMHTs that include social workers who have received training in the social model.

Social work is a unique profession which can bring a social perspective to the care plans for service users of mental health teams. This has to be clearly understood by the CMHT management in the microsystem; the MHT in the exosystem and policy makers in the macrosystem, when designing and assigning duties to MHSWs. So the responsibility for this lies with all the three systems. Addressing this issue will give MHSWs the opportunity to engage more in what they are good at doing and what they like to do, making effective use of their professional education and training. This will also help to reduce the stresses associated with role confusion, role clarity, role overlap and role blurring and allow MHSWs to provide better service to service users, carers and the community. This would also match the original expectation of integrated working which involves each profession bringing their own expertise to the team.

Finally, as Alan Yates, the Chief Executive of Mersey NHS Trust said to social care staff: “The problem with you social workers is that you are obstreperous, bolshie and always looking to change the system you work in, and that’s why we need you in this Trust” (Gardener *et al*, 2004:18).

7.5.2 Addressing the Issues with Career Structure, Educational and Training Requirements and Professional Development

7.5.2.1. A Clear Career Structure

It is understood through the study that the professional development of the social workers was not sufficiently addressed within these teams. Most of the social work

professionals were concerned about the lack of career structure available to them within the CMHT. They argued that nurses can reach 'consultant' position in the CMHTs, but there is no such clear career structure available for social work professionals. Some scholars ((Blinkhorn, 2004:20); (Duggan et al., 2002:17)) have argued the importance of such a role for mental health social workers, which they believe would give some sort of 'parity in terms of raising the profile of social workers and to assist in the concerns around recruitment and retention'. This type of position will give mental health social workers equal status with the other mental health professionals in mental health teams and encourage the social work profession to address the lack of leadership within the profession. Duggan *et al* (2002:17) argued this position as follows:

With the withering of organisational bulwarks, the responsibility for the preservation and extension of the social model must reside with the profession itself. The challenge might be more successfully addressed if there were clearly identifiable leaders and experts in the field, with a status commensurate with that of their health service colleagues.

Tony Gardner (Chief Executive, Cornwell Partnership Trust) (Gardener *et al*, 2004:10) writing about the appointment of a 'Head of Social Work' position in their Trust argued that this position would help the recognition of social work values and ensure that all perspectives within mental health care are equally delivered. In some localities there is a career pathway for social workers; for example:- Social Worker; Senior Social Worker; Principal Social Worker and Head of Social Work. I suggest that MHTs could usefully consider this career path in order to address the concerns with social work professionals' career structure.

7.5.2.2 Meeting the Educational and Training Requirements

As well as the issues with the career structure, social work professionals were also very concerned about the difficulties they have in care coordination work in their multidisciplinary teams and they emphasised the need to improve their knowledge and skills in order to meet those demands. Most of the MHSWs emphasised the difficulties they face in administering medication as, in their social work qualification, they are not currently exposed to a substantial knowledge about different medication. This is the same with the provision of psychological therapies. Currently, they have

the opportunity to take up short taster sessions (in-service) on certain therapies; however these courses are identified as insufficient to develop effective service provision. In order to overcome this barrier, it is crucial to adapt social work education and training or to develop efficient in-service programmes at the beginning of social work professionals' careers in the CMHTs. Better and equal access to therapeutic skills and trainings like cognitive behaviour therapy (CBT), dialectical behaviour therapy (DBT) and psycho-social intervention (PSI) are considered highly valuable in meeting the demands of care coordination. This would undoubtedly help to improve the self confidence of newly qualified care coordinators and subsequently help to develop service provision.

It is also important to look into the possibilities of training social work professionals and OTs to administer Depot injections, in order to address the shortage of CPN care coordinators. This would prevent the waste and respect the rights and needs of service users of the CMHTs, by being able to offer the whole care package through just one care coordinator.

In meeting the workforce developmental needs different localities use different approaches such as annual appraisal; supervision; Post Qualifying Training; social worker/AMHP Forums; Continuing Professional Development and Personal Development Plans, which this particular MHT could also attempt in addressing its workforce development needs.

7.5.2.3 Improving Supervision

Professional supervision is an important part in the development of any profession. However; in these CMHTs all the AMHPs and some of the MHSWs did not have the opportunity to have supervision from their own profession, causing them much stress. This issue is already evident in the literature, for example: "Where social workers were line managed by somebody from a different discipline, they had frequently campaigned for separate 'professional' supervision" (Blinkhorn, 2004:22). In addressing this issue I suggest that each MHSW/AMHP should be given the opportunity to have professional supervision from a senior professional with a social work background. This could be arranged within the microsystem, the CMHT, by allocating senior MHSWs and AMHPs to supervise less experienced workers in that

particular team. For the senior professionals supervision should be arranged through the LASSD and provided through another senior social worker or a social work qualified manager. This I understand as the basic responsibility of the team management. However the team management also requires strong support from the MHT and the LASSD in the exosystem, in finding resources and making agreements for this arrangement from other CMHTs within the same MHT and LASSD.

Such a supervision plan would provide the social work professionals with the opportunity to link back to their own department which is the Social Services Department and the Local Authority which they had been deeply missing since they started working under a health dominated environment after the health and social services integration. This would subsequently help social work professionals to reduce their feelings of isolation and abandonment from their own service.

7.5.2.4 Team Development Programmes

As well as management having a clear picture of social workers' role in the CMHT, it is also important to increase this understanding among other staff members. As MHSWs and AMHPs are the only professionals from a social services background in the CMHTs, there is more risk that other staff members will not understand their role clearly. This can sometimes lead to social work professionals feeling isolated and devalued within the teams, which can affect their work performance. This issue has to be clearly identified and addressed by team management in order to boost morale and develop the service. This should be started within the social work professionals' immediate environment, the CMHT. One way of doing this could be team development sessions or workshops organised within the teams, which would allow all staff members to develop a mutual understanding and respect for each others' roles. Effective team functioning techniques could also be used in such gatherings, which subsequently would enable members together to work more effectively as a team.

It is also important to consider the service users and their carers as a part of the team and include them in the team functioning. This I understand as a crucial part of the integration process..

7.5.3 A Positive Integration Process

Nobody wanted to turn the clock back despite the complexity of the changes and relatively high stress levels. The overall impact of the Care Programme Approach (CPA) AND Care Coordination, as well as integrated mental health teams and the National Service Framework (NSF), was one of greater co-operation, understanding and collaboration to the benefit of those receiving services” (Blinkhorn, 2004:15)

As Blinkhorn suggests, and as confirmed through the findings of this study, it is clear that there are a number of deficiencies in integrated working that have resulted from difficulties and barriers in the integration process. However, even with these deficiencies the integration process is very much valued by all the mental health professionals and by the service users. In this sense it is clear that the integration process is very important in providing a better mental health service; however to reach the full potential of integration there are certain issues to be addressed. These issues include; limited human and physical resources, stigma attached to social work professionals and concerns over the dominance of medical model over social model. Issues around the relatively small social work staff feeling isolated among the majority of health staff with the health values, culture and style should also be taken into consideration.

“Evidence suggests that collaboration between disciplines in Community Mental Health Trusts (CMHT) has been far from optimal not to adapt their practice to the ‘lowest common denominator’ – the medical model. In such circumstances, the development of Care Trusts and integrated Mental Health Trusts using Health Act Freedoms and flexibilities may mean that the skills and understanding of proponents of the social model, particularly social workers, will not be supported by the ethos of services” (Duggan *et al.*, 2002:9)

The LASSD and the MHT that the two CMHTs in this study belong to have equal responsibilities for the successful functioning of the integrated CMHTs. However, I did not find that there was effective collaboration between them, and this directly affected the professional lives of AMHPs and MHSWs. In order to succeed in this integration process, there should be regular consultation between both these organisations in the exosystem, regarding changes or the introduction of new procedures/policies and working practices. They should come to a full agreement before the implementation of such changes. This must be done at a senior

managerial level and there should be an obligation to feed back the decisions taken during those meetings to the CMHT members, through the immediate team managers. There should be a regular flow of information from exosystem to the social work professionals' immediate environment in the microsystem. This procedure would keep the social work professionals updated with the changes as they are agreed and help them to practice with confidence that their own service had been involved in the planning and decision-making. It is also important for both organisations to come to settlements about the inequalities in the terms and conditions of employment including salary, holidays, fuel allowance etc. in order to retain and motivate all staff to work together for a better service. The importance of developing core values, knowledge and skills within the CMHTs should also be acknowledged for integration to work in a mutually respectful manner.

In addressing these issues around integration it is vital to remember that for a positive integration process the voices of service users and carers, as well as staff members should also be addressed. The literature identifies the use of evidence from service users' and carers' experiences and expertise in guiding the process for a positive integration process.

This suggests that in developing integrated mental health services fit for the twenty first century the established psychiatrically driven service priorities need to be widened to accommodate a focus on the totality and complexity of individuals' lives, rather than just symptomatology and psychiatric service use. This is more than a matter of health accommodating social care interests. It is a matter of health and social care professionals and researchers recognising that service user experience and expertise needs to be acknowledged and actively worked with in delivering on the integration agenda set by government (Gardener *et al*, 2004:25).

For an effective integration process there needs to be effective leadership that involves understanding the uniqueness and values of different disciplines which can create the best environment for service users and staff.

While making a successful integration process, it is also necessary to address the issues regarding the loss of the social care perspective in increasingly integrated teams. As Blinkhorn (2004:15) emphasised, this can be addressed through the "active support of senior managers to promote a holistic system, which included

positive risk taking and a proper engagement of staff in planning, and implementation”.

7.5.4 Strengthen the Collaboration between the Social Work Professionals and the LASSD

As in Bronfenbrenner’s theory (1977), each system in the theoretical and conceptual framework and their relationship with other systems is equally important for the development and wellbeing of the individual social workers. However the findings of this study revealed a damaged relationship between the LASSD in the exosystem and the social work professionals in the microsystem. This has also been identified through the literature.

Professional isolation due to a lack of effective link back into Social Services. (Blinkhorn, 2004:15).

In some areas, significant groups of staff have spoken of being “cut adrift” or “abandoned” by their previous host organisation, the Local Authority (Gardener *et al*, 2004:15)

In order to reduce this professional isolation and link back to the Social Services the relationship between the social work professionals and the LASSD has to be improved. In improving this relationship and to build social work professionals’ trust in their own service, it is important to have regular consultation between the two parties. This could be done through organising monthly/quarterly meetings between the social work professionals from all the CMHTs under one LASSD, with the senior management of that particular LASSD. In essence there should be effective communication between these two parties.

It was revealed during the interviews that AMHPs in the LA have their own AMHPs’ Forum each month, where they discuss their professional concerns. However, MHSWs have no other opportunity to discuss similar issues other than the informal discussions with their colleagues in the same CMHT. Therefore, I propose the establishment of a MHSWs’ Forum, with the compulsory attendance of a senior manager representing the LASSD. This may open up opportunities for MHSWs to have their voices heard when they raise their concerns and have those concerns conveyed to the LA through its representative.

Another option is to consider the possibility of appointing a managerial level officer from the LASSD to the CMHTs. Depending on the human resources available with the LASSD and the size of the CMHT, this could either be one officer to each single CMHT or one officer to each 2-3 CMHTs.

These three developments would help the social work professionals to raise their concerns and to get updated news from their own service, including training and other professional development opportunities. This would undoubtedly help them to feel part of their own service and make them feel more secure in their profession, while working in multidisciplinary CMHTs functioning under the leadership of a different organisation.

7.5.5 Appointing more care coordinators

The shortage of care coordinators in the CMHTs had been identified as a barrier in providing an effective service through the literature as well in this research. “It has been recognised that the number of mental health social workers will need to be maintained if integrated services are to remain genuinely multidisciplinary in nature” (Ray *et al.*, 2008). In these two CMHTs all the care coordinators had a case load of around 30-40, which they described as too much for effective service provision. As a result the AMHPs also had to shoulder a large amount of care coordination work, in addition to their MHA assessment duties. Almost all the care coordinators (from both health and social services) emphasised that they feel stressed by these heavy case loads and I suggest that this issue has to be immediately addressed by the MHT. It is the responsibility of the MHT to appoint more care coordinators to these teams in order to fill in this gap and develop a more effective service provision.

7.5.6 Tackling the stigmatisation of social work

The media influence on the social work profession is enormous, especially on child care social workers and it is spreading across to social work professionals in the field of mental health. The stigmatisation of social work professionals in the CMHTs is understood to be a result of misunderstanding about their role within the team. In this sense, it is important to educate service users that social work care coordinators act as any other care coordinator in the team. To do this, I propose that the GP practice,

when referring clients to the CMHTs, explains to service users and their carers the different services they encounter in the CMHT, including the roles of the MHSWs and the AMHPs as care coordinators. This also can be addressed through television and paper advertisements by the NHS, and also through leaflets available at NHS sites. I also suggest the possibility of developing a new website or a separate section in the NHS website about the services provided by the CMHTs, including who service users will meet there, the duties and responsibilities of staff and the services and support available. There is some information available through the Royal College of Psychiatrists website (<http://www.rcpsych.ac.uk/mentalhealthinfo/treatments/communityteams.aspx>), however it does not provide enough information for a clear understanding of the social work professionals' roles within the CMHTs.

7.5.7 Reconsider the concept of specialist teams

The separation of the CMHTs into Psychosis and Affective teams has aroused much stress, confusion and arguments within these CMHTs. All except two of the interviewees stressed their preference to go back to the previous generic CMHTs. As explained earlier, there are many problems associated with the functioning of these specialist teams. These difficulties range from the qualifications of the staff members to work in a specialist team, to the initial concept of labelling service users according to their diagnosis.

In this sense, it is important for the MHT to reconsider the idea of going back to generic CMHTs. This possibility could be considered by beginning with a survey of staff members in the CMHTs, looking at their job satisfaction in the specialist teams and the success rate of their functioning. Another point to be highlighted here is that CMHTs need to find processes that suit their local situations and local people rather than replicating models that have been successful in different environments.

7.5.8 Having an Assertive outreach Team (AOT)

Even though the impact of mesosystem had not been extensively researched in this study, the prevailing literature and some ideas from the staff members highlighted the importance of having an AOT in the area. During a team meeting on 'team

configuration', the staff members presented a list of concerns to the officials including the following:

"Why has AOT not been kept as a speciality, as in other areas, but expected to be absorbed into the psychosis team. Is there not now a need for AOT as this service will not be able to be provided with the higher caseloads of the Psychosis Team?"

As this concern reveals, not having an AOT, as other MHTs do, has resulted in more psychosis cases pouring into the Psychosis disorders team. In other services, AOTs and CMHTs work closely together (as explained in section 3.5.3) to transfer service users back after the service user's condition is stabilised.

Introducing an AOT could be understood as a better solution for the higher case load and related stresses among the CMHTs' staff members. In addition, there is existing literature (Dorset Health Care, 2001) that provides evidence that the introduction of AOTs has contributed to reducing the work related stresses among mental health social work professionals. This clearly shows that the mesosystem can make an impact upon the social work professionals in the CMHTs and this could usefully be the subject of future research.

7.5.9 Appointing Health Professionals as AMHPs under the 2007 MHA

As revealed under the findings sections in chapter 6, the opening of the AMHP role to health professionals may have implications for its independence. This issue has to be clearly addressed through appropriate training for AMHPs. In doing this, AMHPs should consider wider social context and culture when assessing a person under the Mental Health Act. This has to be done while providing support to enable the new AMHPs to follow and respect the initial principles and values of the AMHP role. While providing this training it is crucial to be vigilant about how new AMHPs from health service backgrounds undertake AMHP duties and take immediate steps to avoid them being biased and dominated by consultant psychiatrists and senior health professionals in their own organisations.

It is also important to investigate the different stresses and barriers associated with the AMHP duties, which could be done through a nation-wide survey. Such research would inform the relevant authorities of the reasons why most health professionals

are not willing to be trained as AMHPs and why some AMHPs are leaving the profession and going back to practice as generic social workers. Without doing this it seems likely that it will continue to be difficult to increase the number of AMHPs, which is a burning issue for the CMHTs currently.

In addressing the issue of recruiting a sufficient number of AMHPs, as Blinkhorn (2004:19) reveals, “The need for this matter to be reviewed in a whole systems approach both within Authorities own Mental Health Workforce plans and through the wider National Service Framework (NSF) Local Implementation teams (LITs) Workforce Development plans”.

7.6 Original Contribution to Knowledge

Despite the fact that social model of care is considered as playing a vital role in the provision of mental health care, there is a lack of published research focusing on social work professionals’ roles in health and social services integrated CMHTs. This study aimed to increase the body of knowledge in this area by gathering evidence of MHSWs’ and AMHPs’ experiences, together with the experiences of other mental health professionals working in these CMHTs and the experiences of users of these CMHTs’ services, about the role and contribution of AMHPs and MHSWs.

Unlike a number of preceding studies on mental health social work, this study was completed at a time when the CMHTs were fully integrated, functioning under the New Ways of Working policy and the new community mental health services, like AOTs, CRHTs and EIP, were in full operation. The fieldwork period was also a transitional period for the two CMHTs, because the 2007 MHA was introduced during this time and the two teams were reconfigured into four specialist teams. This had resulted in many changes inside the teams and I believe that this study is the first to research the working of the new psychosis disorders and affective disorders specialist teams. This can be considered as an advantage of this research and it has helped to expand the existing knowledge and generate fresh knowledge in the field. This new knowledge, I believe provides evidence to inform future developments in policy and good practice in the field of mental health service provision.

A review of the literature showed that other studies have not specifically addressed the views of MHSWs and AMHPs and the views of other mental health professionals and service users, about the role and contribution of social work professionals. In contrast, it was a specific objective of this study, to gather an overall perspective on the social work professionals' roles in the CMHTs, as these professionals are a part of a team rather than individual professionals working separately. As a result, the findings of this study offer a holistic understanding of MHSWs' and AMHPs' contribution to multidisciplinary CMHTs, rather than just the views of a specific professional group.

This was the first time Bronfenbrenner's Ecology of Human Development Theory (1977) has been used as the conceptual and theoretical framework, to understand the social work professionals' roles and contribution in the CMHTs. This framework allowed me to consider the social work professionals' place in a nested system and to look at their role overall, from the perspectives of these interacting systems. This subsequently helped to clarify the relationship between each system that social work professionals are interacting with, and how each of these systems impact in shaping their roles. As a result the knowledge generated through this study clearly indicates how and where each system can mediate in improving the MHSWs and AMHPs roles, which will hopefully lead to better mental health service provision.

As a concluding remark it is important to state that social work intervention in the mental health field, has moved from specialist to generic and then back to specialist, influenced by changes in the profession. In the modern teams social workers find themselves distanced from the communities they were employed to serve. This situation has to be changed alongside the New Ways of Working and also within the integrated setting.

Finally, as Duggan *et al* (2002:17) emphasise: "The critical question is whether the promotion of the social model requires the continued existence of social work as a discipline". The answer generated for this question through this study is a definite 'yes' as the evidence clearly indicates the unique social model contribution that social workers can bring into practice.

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Appendices

1. Flyer
2. Information Sheet for Service Users
3. Information Sheet for Staff Members
4. Invitation Letter
5. Letter to GPs
6. Consent Form for Service Users
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8. Interview Guide for Mental Health Professionals
9. Interview Guide for Social Work Professionals
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Appendix -1 Flyer
Social work intervention in
Community Mental Health Teams

About me

I'm Lakshika Liyanage a PhD student at Durham University. I'm carrying out an individual research in the Community Mental Health Teams in and to collect data for my PhD.

What are my aims and objectives?

I need to explore what unique contribution mental health social work makes to contemporary mental health care. To explore this issue, I want to understand the individual social worker's contribution in Community Mental Health Team functioning and how this role is perceived by others in the team and by people who use the service.

What will I be doing with your team?

I will spend over a three month period in your team, observing individual and team behaviour. I will ask questions to clarify my understanding of what's being observed and will take part in informal discussions. I will also conduct some semi-structured interviews with the staff members of the team including social workers and with some people who use this service. I will not have any case responsibility in your team.

What will you gain from this?

I hope that this study will explore ways of improving the quality of social work support within contemporary mental health services and improve outcome for people who use this service, carers and communities. I also expect that these findings will contribute to the development and profile of mental health social workers as a professional group.

Want to know more?

Contact

Lakshika Liyanage (PhD student – Durham University)
07735534209
l.s.liyanage@durham.ac.uk

or

Ms.Di Bailey (MSW Programme Director and Social Care Lead for the Mental Health Research Network)
School of Applied Social Sciences, Elvet Riverside ii, New Elvet, Durham, DH1 3JT
0191 3341478
di.bailey@durham.ac.uk

or

Mrs XY
Research & Development Manager (Acting)
..... NHS Foundation Trust

or

PALS Team
Free Phone
0800 _ _ _ _ _

Appendix – 2 Information Sheet 1

Information Sheet to Service users

Social Work Intervention in Community Mental Health Teams

About the Study

My name is Lakshika Liyanage and I'm a PhD student at Durham University. I'm carrying out a research in the Community Mental Health Teams in X and Y. This research is supervised by Ms. Di Bailey at School of Applied Social Sciences, Durham University, who is also the Social Care Lead for the Mental Health Research Network.

Purpose of the Research

This research intends to explore what unique contribution mental health social work makes to contemporary mental health care. To explore this issue, I want to understand the individual social worker's contribution in Community Mental Health Team functioning and how this role is perceived by others in the team and by people who use the services of that particular team. I hope that this study will explore ways of improving the quality of social work support within contemporary mental health services and improve outcome for service users, carers and communities. I also expect that these findings will contribute to the development and profile of mental health social workers as a professional group.

My role and Method

During the research I will work mainly with the two teams named above. You have been asked to participate in the research because you are currently using this service or have used this service before. I really value your views and experience as a person who has direct experiences of these services. I would like to conduct a semi-structured interview with you, which will focus on your experience with social workers in your team. This will take around 45-60 minutes and will take place in a confidential place in your Community Mental Health Centre. I will inform your GP/Health Care Professional that you are participating in this research, but will not disclose any details of your responses. There are no known potential risks in this research. However during the course of interview if disclose distressing information you will first get the opportunity to debrief with the researcher and alternatively with your care coordinator. I would be grateful if you could reply to me directly if you wish to participate in this research.

Confidentiality

You do not have to agree to take part in this research and if you decide not to it will not have any effect on your care and treatment. You have the freedom to answer or not to answer any questions asked and you have a right to withdraw from the interview at anytime should you wish to. With your informed consent I will take down notes for my references and will tape record the interviews. All these recordings will be kept locked in a filing cabinet in the researcher's room to which only the researcher has access. Data collected during the interviews will be safely stored with a protective code in a University computer which is subject to the University's procedures in relation to electronic data protection and will only be accessed by myself for the purpose of this study. No further use of data from the research is permitted without your permission. All the data collected including tape recordings will be destroyed 12 months after the study is completed. The analysed data will be presented in my PhD thesis and in some future reports, presentations and publications. The Durham University library will store a copy of the completed PhD theses in perpetuity. Your identity will remain confidential throughout the study. You will not be referred to by your name or any other identifying factor (such as your address) unless you explicitly give consent for a direct quotation to be included that may be attributable to you personally.

Thank you for your time! For any further questions please contact,

Ms. Di Bailey,

MSW Programme Director and Social Care Lead for the Mental Health Research Network
School of Applied Social Sciences, Elvet Riverside ii, New Elvet, Durham, DH1 3JT
0191 3341478 <http://www.dur.ac.uk/socialsciences.health/>

or

If you wish to speak to someone independently about this piece of research, about the way in which the research has been carried out or about the actions of the researcher please contact:

Mrs. XY

Research & Development Manager (Acting)

or Free Phone - 0800 -----
PALS Team

.....NHS Foundation Trust

Lakshika Liyanage

PhD candidate, Durham University

l.s.liyanage@durham.ac.uk

07735534209

Appendix -3 Information Sheet 2

Information Sheet to Staff Members

Social Work Intervention in Community Mental Health Teams

About the Study

My name is Lakshika Liyanage and I am carrying out a research in the Community Mental Health Teams in X and Y. This is an individual study carried out to collect data for my PhD at Durham University. This study is supervised by Ms.Di Bailey at Department of Applied Social Sciences, Durham University, who is also the Social Care Lead for the Mental Health Research Network. Data collected during the research will be analyzed and presented in my PhD thesis. The research findings will also be produced in report form to the Local Authority Social Services Department and the Mental Health Trust. Further the research findings will be presented in conferences and will be submitted for publications.

Aims and Objectives

This research intends to explore what unique contribution mental health social work makes to contemporary mental health care. To explore this issue, I want to understand the individual social worker's contribution in Community Mental Health Team functioning and how this role is perceived by others in the team and by people who use the services of that particular team. I hope that this study will explore ways of improving the quality of social work support within contemporary mental health services and improve outcome for service users, carers and communities. I also expect that these findings will contribute to the development and profile of mental health social workers as a professional group.

My role and Method

I will immerse myself in your team to collect data for the research and will spend an agreed number of days with you over a three month period, observing individual and team behaviour. I will ask questions to clarify my understanding of what is being observed and will take part in informal discussions. I will also conduct some semi-structured interviews, which will take around 45-60 minutes with the staff members of the team including social workers and with some service users. These interviews will take place inside your CMHC. I will also ask for your help in selecting some service users who can consent for themselves to participate in this study. I will not have any case responsibility in your team. There are no known potential risks in this research. However during the

course of interview if disclose distressing information you will first get the opportunity to debrief with the researcher and alternatively will get the opportunity to debrief with your team manager. At the end of the study the research results will be presented back to the team, to the Local Authority Social Services Department and the Mental Health Trust. Also the full report will be presented to Durham University as a PhD thesis.

Confidentiality

I will to ensure your human rights for privacy, respect, dignity and individuality during the research project. Informed consent will be obtained before each individual interview and I will obtain permission to attend any meeting or any event with the team. You have the freedom to decide whether to answer or not to answer any questions asked and you have a right to withdraw from the interview at anytime should you wish to. With your informed consent I will take down notes for my references and will tape record the interviews. All these recordings will be kept locked in a filing cabinet in the researcher's room to which only the researcher has access. Data collected during the interviews will be safely stored with a protective code in a University computer which is subject to the University's procedures in relation to electronic data protection and will only be accessed by myself for the purpose of this study. No further use of data from the research is permitted without your permission. All the data collected including tape recordings will be destroyed 12 months after the study is completed. The analysed data will be presented in my PhD thesis and in some future reports, presentations and publications. The Durham University library will store a copy of the completed PhD theses in perpetuity. Your identity will remain confidential throughout the study. You will not be referred to by your name or any other identifying factor (such as your position in the CMHT or your address) unless you explicitly give consent for a direct quotation to be included in the thesis and in any future presentations or publications. If you are the only professional holding a certain position within the team then I will ask you for your further permission to include direct quotations from your interview that might be attributable to you personally.

Thank you for your time! For any further questions please contact,

Ms. Di Bailey

MSW Programme Director and Social Care Lead for the Mental Health Research Network,
School of Applied Social Sciences,
Elvet Riverside ij,
New Elvet, Durham,
DH1 3JT,
0191 3341478
<http://www.dur.ac.uk/socialsciences.health/>

or

If you wish to speak to someone independent from this piece of research about the way in which the research has been carried out or about the actions of the researcher please contact:

Mrs XY,

Research & Development Manager (Acting)

or

PALS Team

..... NHS Foundation Trust

Free Phone

0800 -----

Lakshika Liyanage

PhD candidate,

Durham University

l.s.liyanage@durham.ac.uk

07735534209

Appendix - 4 Invitation Letter

Letter of Invitation

Lakshika Liyanage
PhD student,
Durham University.
Date.....

Dear Mr/Ms,

Social Work Intervention in Community Mental Health Teams

As I have stated in the Information sheet provided to you, I am carrying out a research in your Community Mental Health Team. I'm writing this now to ask you whether you wish to participate in this research by attending an interview with me. Your experience as a person who uses this service is very important to this study.

You do not have to compulsorily agree to be interviewed and if you don't agree this will not have any effect on your care and treatment. If you need any help with interpretation I can arrange this service for you. The interview is likely to last around an hour.

As stated in the Information Sheet, I will make sure that your identity remains confidential and you shall not be referred to by name or any other identifying factor such as your address. If you agree I wish to tape record your interview and take down notes as this will help me to remember what we have discussed during the time of the interview. These tape records and notes will be kept locked in a cupboard and destroyed at the end of the study.

If you have any questions or doubts regarding this research, please let me know or you can contact the people given in the Information Sheet. I would be much thankful if you could please let me know within the next two weeks if you agree to participate in the interview.

With best wishes

Lakshika Liyanage
07735534209

Appendix – 5 Letter to GPs

Letter to GPs/Health Care Professionals

Project Title: Social Work Intervention in Community Mental Health Teams

Date:

Dear Dr/Ms/Mr.....,

I am writing to advise you that Mr/Ms. has agreed to take part in a research project on 'Social work intervention in Community Mental Health Teams'. My focus is to understand the views of social workers, mental health professionals and service users about their experiences of social work intervention in their team. I have already provided an information sheet about the research and will explain the study and ask for his/her consent before taking part in the interview. I do not anticipate any risk to the service user from participating in this interview.

This letter is sent for your information only and you are not asked to supply any material for the research. If you want to know anything else please do not hesitate to contact me.

Yours sincerely

Lakshika Liyanage
PhD student
Department of Applied Social Sciences
Durham University
l.s.liyanage@durham.ac.uk
07988166105

Appendix – 6 Consent Form 1

Consent Form for Service Users

Title of Research: Social Work Intervention in Community Mental Health Teams
Name of the Researcher: Lakshika Liyanage
Contact Details: I.s.liyanage@durham.ac.uk / 07735534209

Statement of Interpreter (where appropriate)

I have interpreted the information above to the service user to the best of my ability in a way in which I believe she/he can understand.

Signed: _____ **Name:** _____ **Date:** _____

Statement of the service user

- I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
- I understand that if I agree to tape-recordings being made that they will be kept confidential and destroyed at the end of the study.
- I understand that the researcher will use direct quotations from this interview, will present the analysed data in her PhD thesis and some other future reports and publications, but my anonymity will be safe guarded in any use of the data gathered from the interview.
- I understand that no further use of data from the interview is permitted without my permission.
- I understand that if I disclose any distressing information during this interview, an opportunity to debrief will be made available by the researcher.
- I understand that this information will not be reviewed for audit.
- I agree to my GP being informed of my participation in the study.
- I agree to take part in this interview.

Name of the service user

Date

Signature

Name of Person taking consent

Date

Signature

Appendix – 7 Consent Form 2

Consent Form for Staff Members

Title of Research: Social Work Intervention in Community Mental Health Teams
Name of the Researcher: Lakshika Liyanage
Contact Details: I.s.liyanage@durham.ac.uk / 07735534209

Statement of clinician/team member

- I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw from the research at any time, without having to give any reason and without my legal rights being affected.
- I understand that the researcher may be present to observe, without undue interference and judgement, all aspects of my work unless for service user reasons it was deemed to be inappropriate.
- I understand that the researcher may wish to observe and record team meetings in which I am participating.
- I understand that if I agree to tape-recordings being made that they will be kept confidential and destroyed at the end of the study.
- I understand that the researcher will present the analysed data in her PhD thesis and some other future reports and publications, but my anonymity will be safe guarded in any use of this information.
- I understand that no further use of data from the interview is permitted without my permission.
- I understand that the researcher will use direct quotations from this interview, but if there is any possibility of my anonymity to be revealed through these quotations, the researcher will ask for my further consent to use them.
- I understand that if I disclose any distressing information during this interview, an opportunity to debrief will be made available by the researcher.
- I understand that this information will not be reviewed for audit.
- I agree to take part in this interview.

Name of the staff member

Date

Signature

Name of Person taking consent

Date

Signature

Appendix – 8 Interview Guide 1

Semi structured interviews with mental health professionals

Time – 45-60 minutes

General Questions

- How long have you been in the mental health field?
 - How long have you been with this particular team?
 - What professional and academic qualifications do you hold?
 - What is the nature of your work here?
1. What do you consider to be the role of a mental health social worker in terms of
 - Practical and therapeutic role
 - Care management
 - As an ASW/AMPH
 - Advocacy working with individual service users and groups
 - Promoting the social model in mental health care
 2. How do you perceive the status of a mental health social worker?
 - As a mental health professional
 - In the view of service users and carers
 - In the view of the general public
 3. How do you perceive the mental health social workers contribution to the functioning of a multi-disciplinary team in terms of
 - Integration of social work in a joint service
 - Domination by medical model
 - Identification with mental health Trust and Local Authority
 - Overlap with other professions
 4. How do you think Mental Health Social Workers are perceived in relation to
 - Professional Qualifications
 - Academic Qualifications
 5. What do you think are the future issues and challenges for mental health social work in terms of Mental Health Act 2007?
 6. What do you think that will help to improve the mental health social work contribution to new ways of working in Mental Health Services?

Semi structured interviews with social work professionals

Time – 45-60 minutes

General Questions

1. How long have you been in the mental health field?
2. How long have you been with this particular team?
3. What professional and academic qualifications do you hold?
4. What is the nature of your work here?

5. What do you consider to be the role of a mental health social worker in terms of
 - Practical and therapeutic role
 - Care management
 - As an ASW/AMPH
 - Advocacy working with individual service users and groups
 - Promoting the social model in mental health care

6. How do you perceive the status of a mental health social worker?
 - As a mental health social worker
 - In the view of service users and carers
 - In the view of the general public

7. How do you perceive your contribution to the functioning of a multi-disciplinary team in terms of
 - a. Integration of social work in a joint service
 - b. Domination by medical model
 - c. Identification with mental health Trust and Local Authority
 - d. Overlap with other professions

8. What are the barriers to your effective contribution in the team?

9. What do you think are the future issues and challenges for mental health social work in terms of Mental Health Act 2007?

10. What do you think that will help to improve the mental health social work contribution to new ways of working in Mental Health Services?

Appendix – 10 Interview Guide 3

Semi structured interviews with service users

45-60 minutes

1. How long have you been receiving/using the services of the CMHTs?
2. How long have you been with this team?
3. Who in this team get involved in your care and treatment?
4. Do you think different workers in the team connect with each other in preparing services?
5. What has been your experience of this in relation to your care?
6. Do the team members communicate with each other about your care plan?
Can you give an example?
7. Have you ever been involved with the team members in planning care for you?
8. Which service do you find most useful in the team?
9. Do you have a social worker? If so what is his/her role?
10. Have you ever contacted the social workers in the team?
11. How do you find their service in meeting your needs?
12. Have they been engaged in your care plan?
13. Has social work service been useful to you?
14. What do you think are the deficiencies in social work service?
15. Do you see any barriers for their effective contribution to Mental Health Service?
16. What do you think would improve the Social Work Service in the team?