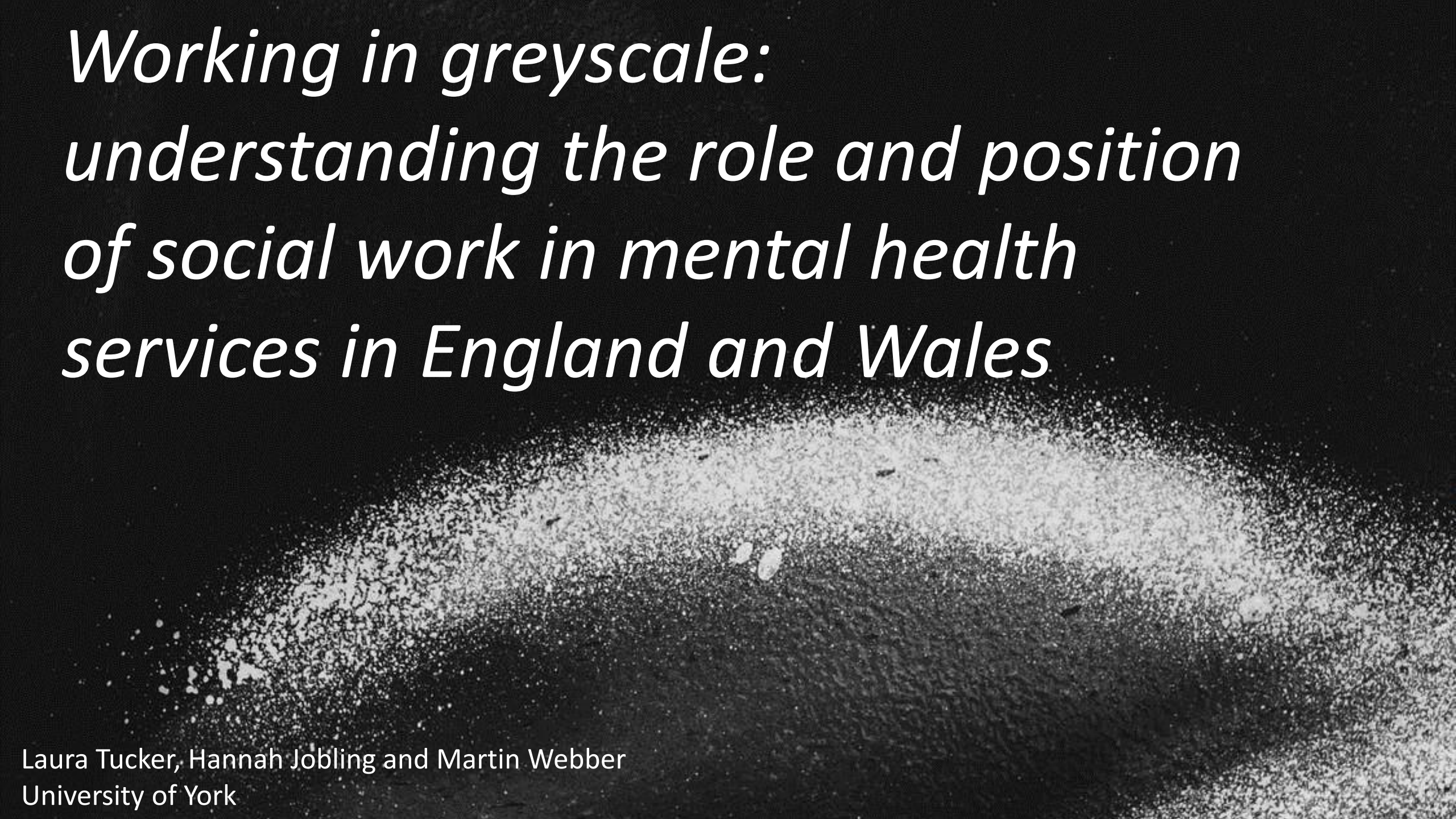
Working in greyscale: understanding the role and position of social work in mental health services in England and Wales



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Mental health social work in England and Wales

Double stranded development of mental health services within the National Health Service and social work services within local councils. Mental health social work straddles this divide

Social work is not the focus in mental health; mental health is not the focus in social work. Rather than a planned implementation, it fits into the gaps…

Why care about mental health social work?

Mental health need

- 21% increase in demand since 2016 (British Medical Association, 2019)
- Further increase in overall psychological distress in the population linked to Covid-19 (Pierce et al, 2020; Pieh et al, 2021) and the cost of living crisis (Anderson and Reeves, 2022)
- Anticipated strong social need (Christodoulou and Christodoulou, 2013; O'Shea, 2020)

Mental health provision

- Service provision appears to have remained static (Skills for Care, 2021; British Medical Association, 2020)
- Operating with limited resources and under increased pressure (NHS Confederation, 2020)
- Service structure is localised and driven by resource availability (Evans et al, 2012)

Mental health social work

- No overview of provision or structure (Anderson et al, 2021) but a substantial element of the mental health workforce
- No agreed understanding of role or contribution (Tucker and Webber, 2021)

Navigating an understanding of mental health social work is tricky…

- The organic development of mental health social work as an area of practice leading to a wide range of working contexts (Evans et al, 2012; Moriaty et al, 2015; Lilo, 2016)
- The debate between generic and specialist mental health provision (Boland et al, 2019; Aiello and Mellor, 2019)
- The lack of consensus at legislative and policy levels in defining mental health social work (Health Education England, 2017; Allen et al, 2016)
- The lack of consensus in practice in defining mental health social work (Ekeland and Myklbust, 2021; McCrae et al, 2004)
- The lack of consensus in academia about what defines mental health social work: tasks ('social' work versus 'not-health' work), legal responsibilities (AMHP or not), values, positioning (cross-boundary workers) (Tucker and Webber, 2021)
- Mental health social work's nebulous professional status (Weiss-Gal and Welbourne, 2008)

…and context matters

- Understandings of professional identity are linked to self definition and situational definition (Ashforth and Mael, 1985)
- a strong link to statutory obligations which are held by organisations (Wiles, 2017)
- Organisations influence – and their aims are managerial, target driven and authoritative (Evetts, 2013)
- Previous research suggests a split identity between social work, mental health work and mental health social work (MaCrae et al, 2004)

So, professional identity – who we are and what we do in professional spaces – is integrally tied to organisational influence and expectation and workplace culture (Webb, 2017)

How do mental health social workers understand their role within mental health services?

How does employment context impact on that understanding and undertaking of their role?

What we did

Phase One: Understanding the Workforce (2019)

Information requests sent to 173 local authorities responsible for social services and 64 NHS trusts responsible for mental health, asking for:

1. Number of MHSWs employed?
2. How many were AMHPs?
3. Working arrangements?
4. LA and NHS partnership arrangements

Phase Two: The Practitioner Overview (2020)

Online anonymous survey distributed through employers, social media and researcher contacts, asking about:

1. Demographics and context
2. Social work identity and influencers
3. Practice environment

Statistically analysed to look at differences based on employer, workplace and management

Phase Three: Talking to Practitioners (2020-21)

Interviews with a deliberately selected subset of the survey participants, based on demographics, context and scores on social work identity. Interviews asked about:

1. Substantive role
2. Desirable aspects of role
3. Undesirable aspects of role
4. Factors that influenced undertaking role

Analysis looked for recurring themes/ideas across and within different practice contexts

Unweaving the Web:
Key Findings from the Workforce Survey (Phase One)

- ✓ 96.6% of organisations responded (229/237)
- ✓ 6,585 mental health social workers; 67% employed by local authorities
- ✓ 87% of LAs employed social workers: In-house (58.1%) or within the NHS (67%).
- ✓ 89% of English NHS and 71% of Welsh NHS providers also employed social workers directly
- ✓ 55.1% of LAs had formal partnership arrangements with NHS, 13.8% had no working agreements
- ✓ Lack of overall structure or plan: No link between organisational type, organisational location or number of mental health social workers and structure of provision
- ✓ Levels of provision broadly mapped to population size (not need) on a regional basis
- ✓ Varied tapestry of provision: ad-hoc, localised and driven by local resources

Tucker, L., Webber, M. and Jobling, H. (2022) 'Mapping the matrix: understanding the structure and position of social work in mental health services in England and Wales, *British Journal of Social Work,* 52(2), 3210-3229.

The survey participants
(248 respondents)

Aged between 23 and 69 (missing = 4)

Three quarters identified as female (75.4%), with one quarter identifying as male (22.6%). Two preferred to self-identify (missing = 3)

92% identified as White, 3.2% as Black, 1.6% as Asian and 2.4% as from a mixed background (missing = 2)

Social work experience ranged from newly qualified (4) to qualified more than 20 years (51). 52% had more than 10 years qualified experience

Mental health experience ranged from inexperienced (4) to more than 20 years experience (45). 42% had more than 10 years experience in mental health.

69.8% were LA employed, 24.2% NHS employed (but 71.7% were NHS *based* and 22.2% LA *based*)

The interview participants
(30 respondents)

Aged between 24 and 65

21 identified as female and 9 as male.

25 identified as White, 3 as Black, 1 as Indian and 1 as Pakistani

Social work experience ranged from 4 months to 40 years

Mental health experience ranged from 1 year to 30 years

13 were employed by local authorities and 13 by the NHS, plus 2 with dual employment contracts. But 5 worked in local authorities and 23 worked in the NHS.

A united front?

Key Findings from the Practitioner Survey

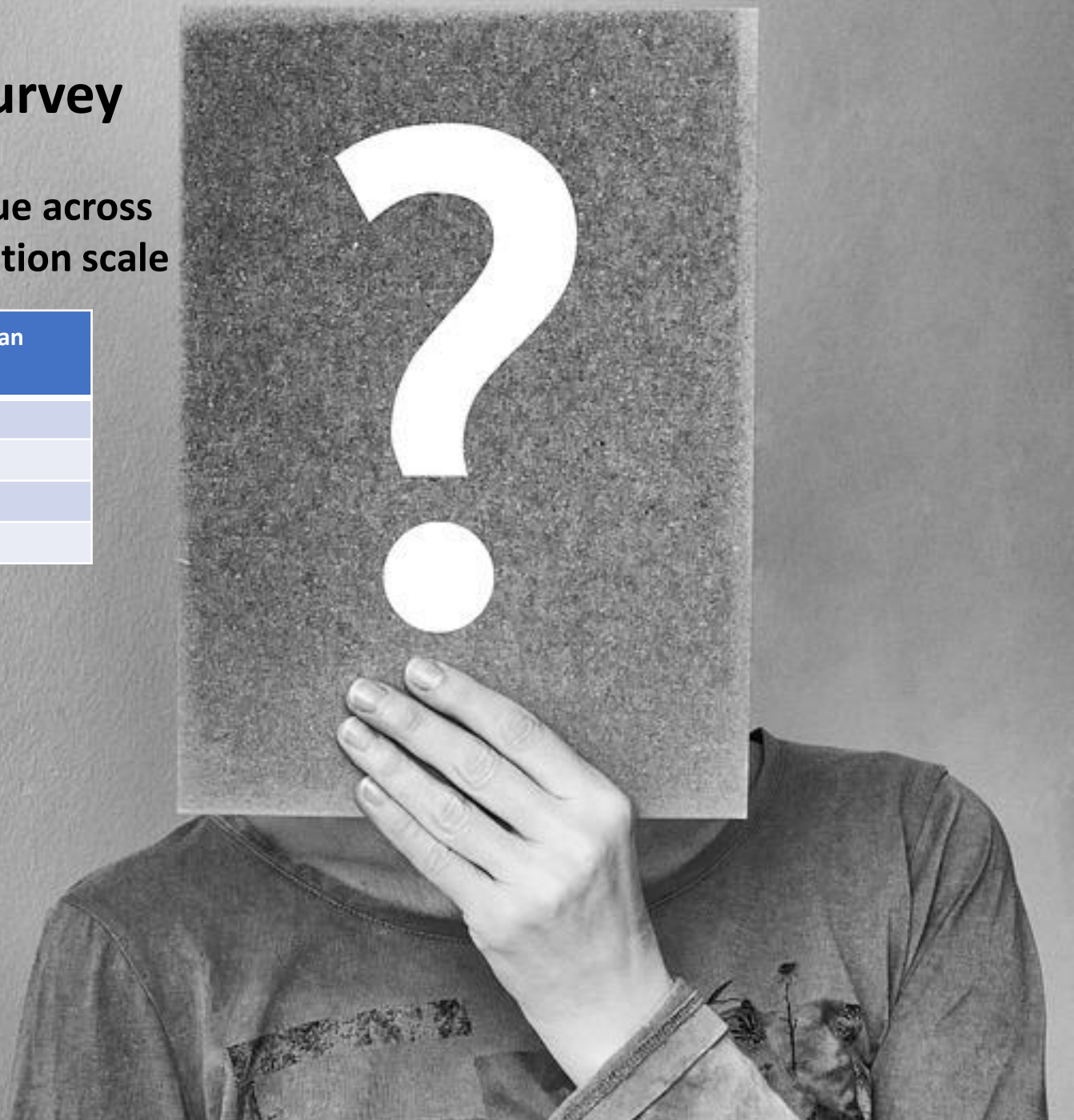
- Strong sense of professional identity, which held true across practice contexts, using Single Item Social Identification scale

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

- Hybrid identities: 14.9% scored all three categories at the maximum 7

- LA-based participants rated the social worker identity more highly than NHS-based participants.

- Strongest influencers on identity were internal (values, role, education), weakest influencers were external (organisation, professional bodies, public views)



A united front?

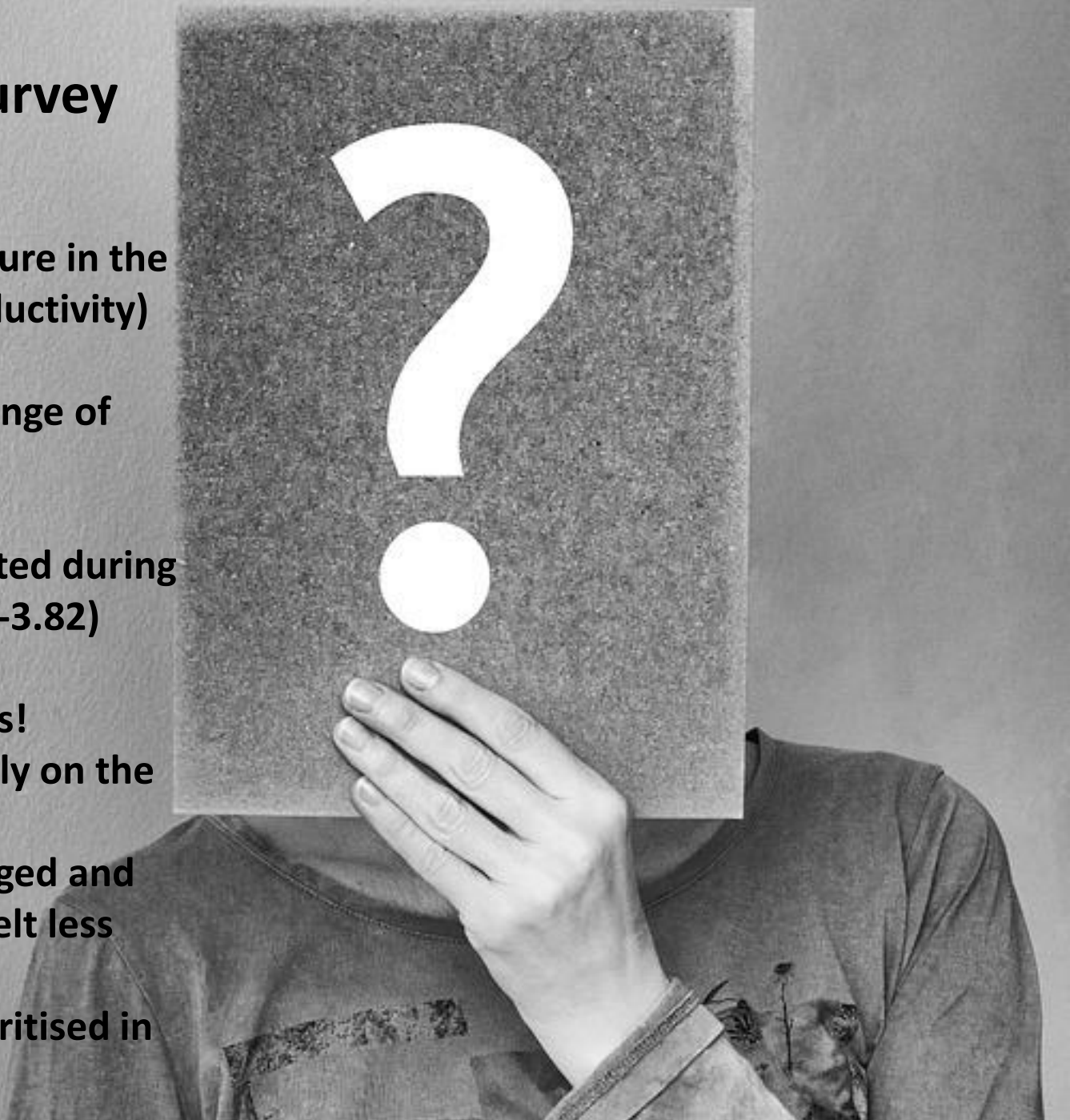
Key Findings from the Practitioner Survey

- PES-NWI (how the practice environment facilitates professional practice) and CoCB (organisational culture in the context of staff commitment, engagement and productivity)

- Overall 'favourable' scores on the PES-NWI: 2.76 (range of 2.62-2.85) – but interpret with caution!

- Scores on the CoCB were in line with those anticipated during development of the instrument: 3.58 (range of 3.44-3.82)

- High congruence but some key statistical differences!
  - LA-managed participants scored more highly on the CoCB than their NHS counterparts
  - NHS-employed participants felt more engaged and informed, but NHS-managed participants felt less involved and influential
  - Health relationships were more highly prioritised in health contexts



Digging into the detail: Social Work Roles

Task-based

Organisational agent

Statutory agent

Collaborative agent

the CPNs have their medication, the OTs have their, like, OT assessments I don't think we have anything uniquely like that - ours, like, apart from using legislation

Values-based

Holistic practitioner

Person-centred practitioner

Challenge agent

Social justice advocate

if a patient needs it, I think it's my job

Knowledge-based

Knowledge specialist

Educator

Discourse challenger

sorry, but you've got a responsibility to the social role as well as the medical role

Task-based roles

(what social workers do)

Organisational agent

- What social workers do – their substantive employment role
- Tasks fell into gatekeeping and access roles, service provision roles and background structural roles
- NHS participants more likely to do service provision roles

Statutory agent

- Disagreement between views of statutory work as social work or as LA work
- Strongly linked to social work identity
- NHS participants more likely (but not exclusively!) to distance themselves from statutory work

Collaborative agent

- Working both within teams and across team and organisational boundaries
- External collaboration (across teams/organisations) and internal collaboration (across professions)
- LA participants work more externally; NHS participants work more internally.

Values-based roles

(how social workers do what they do)

Holistic practitioner

- Working with clients accounting for their wider social circumstances
- Adaptable and flexible approaches to practice seen as essential
- Acknowledged need to guard against paternalism

Person-centered practitioner

- Viewing clients as more than a presenting mental health need
- Humanising, respectful and empowering. Relationship focused.
- Going beyond prescribed role to work in partnership with clients

Challenge agent

- Questioning the status quo
- Focused primarily on 'the organisation' (mostly NHS) and other professionals
- Organisational challenges linked to role expectations; professional challenges linked to client needs AND role expectations
- Linked to power relationships, particularly for NHS staff

Social justice advocate

- Similar to the Challenge agent, but aimed at wider social structures and contexts
- Difficult to change underlying injustices, but focused on awareness raising and smaller, localised changes

Knowledge-based roles

(what social workers know)

Knowledge specialist

- Mental health specialist (in LA settings)
- Social work specialist (in NHS settings)
- Social determinant specialist (but not always acknowledged)

Educator

- Formal educator (but very rarely, outside of practice education)
- Informal educator, sharing knowledge ad hoc with colleagues. More commonly in non-LA settings

Discourse challenger

- Adding in social perspectives on mental health (to complement, not replace medical models)
- Occurs almost exclusively in NHS and health settings
- Frequently challenged (and defended)

Understanding the setting: Roles in context

Relational

Clients in context

Interprofessional relationships

they're not really clear about what social care is meant to do or what a social care intervention would actually achieve for someone

Locational

Physicality

Organisational influence

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

Structural

Formal frameworks

Professional skills and knowledge

Support and development

I think it is really, I think this is what keeps the professional, that golden thread of the professional, alive, is having that contact directly with a social worker

Relational factors

(the impact of other people)

Clients in context

- Understanding clients in their individual, family/community and wider societal contexts
- Directly relevant to practice holistically and in a person-centered way
- Beyond diagnosis and beyond legislative responsibility

Interprofessional relationships

- Characterised as co-operative, conflicted or misunderstood
- Positive when informed by shared understandings and objectives
- Frequent misunderstandings from external teams and other professions about the social work role, leading to unrealistic expectations
- Health dominated (or, in forensic settings, criminal justice dominated), sometimes leaving social work 'invisible'
- Conflict linked to different professional priorities
  - Staying within self-defined professional remits
  - Rejecting the social perspective
- Challenging to effective collaborative work

Locational factors

(the impact of place and space)

Organisational influence

- When organisations worked well together, not a big influencer on social work practice
- But often a practical and ideological split between NHS and LA settings
- Unclear service structures and confusion about how different teams operate prohibited effective collaborative working
- Too much bureaucracy impacting on client time (especially for integrated participants)
- Resource limitations a barrier to values-based practice

Physicality

- Location linked to a sense of connection – ‘the office’ as a social work resource
- Medically dominated settings could threaten social work distinctiveness… but separation heightened misunderstandings
- Rural versus urban settings required adaptability
- Responses to physical location showcased participants as holistic and person-centered

Structural factors

(the bedrock of social work practice)

Formal frameworks

- Firmly rooted within legislation (but which legislation mattered most was dictated by role)
- The law is pertinent but policy less directly relevant to practice
- Local policy and guidelines prioritised for practice relevance

Professional knowledge and skills

- Social work skills and competencies prioritised over specific theories
- Strongly linked to social work values
- Professional training generally insufficient for mental health practice; value of practice and experience-based learning

Support and development

- Strong support for reflective versus managerial supervision, but ambivalence around group and peer support
- More challenging to access social work supervision in NHS settings
- Minimal opportunities for social work progression (what more than AMHP?), with general disinterest in management
- Opportunities for training and development very organisation specific – no sense of an overall plan!

Social workers in mental health have three key types of role: **task-based roles**, **values-based roles** and **knowledge-based roles**

Task-based roles are about what social workers *do* and are very dependent on context. They are most likely to be influenced heavily by practice setting

Values-based roles are about *how* social workers approach their work – holistic and person-centred with a social justice focus. They are less influenced by practice setting, although how these roles can be seen to be done *are* dependent on context

Apart from some subtle statutory differences, **Welsh** and **English** participants had very similar experiences and views. Mental health social work roles, and how these were influenced by setting, crossed national borders.

Organisation-as-setting and **professional relationships** are the biggest external influences on how social workers undertake their roles – it is the *where* and the *who* that make the difference

Knowledge-based roles focus on social worker's specialist knowledge in social work and in mental health. Practice setting can influence specialism, but which knowledge is seen as specialist depends entirely on practice context.

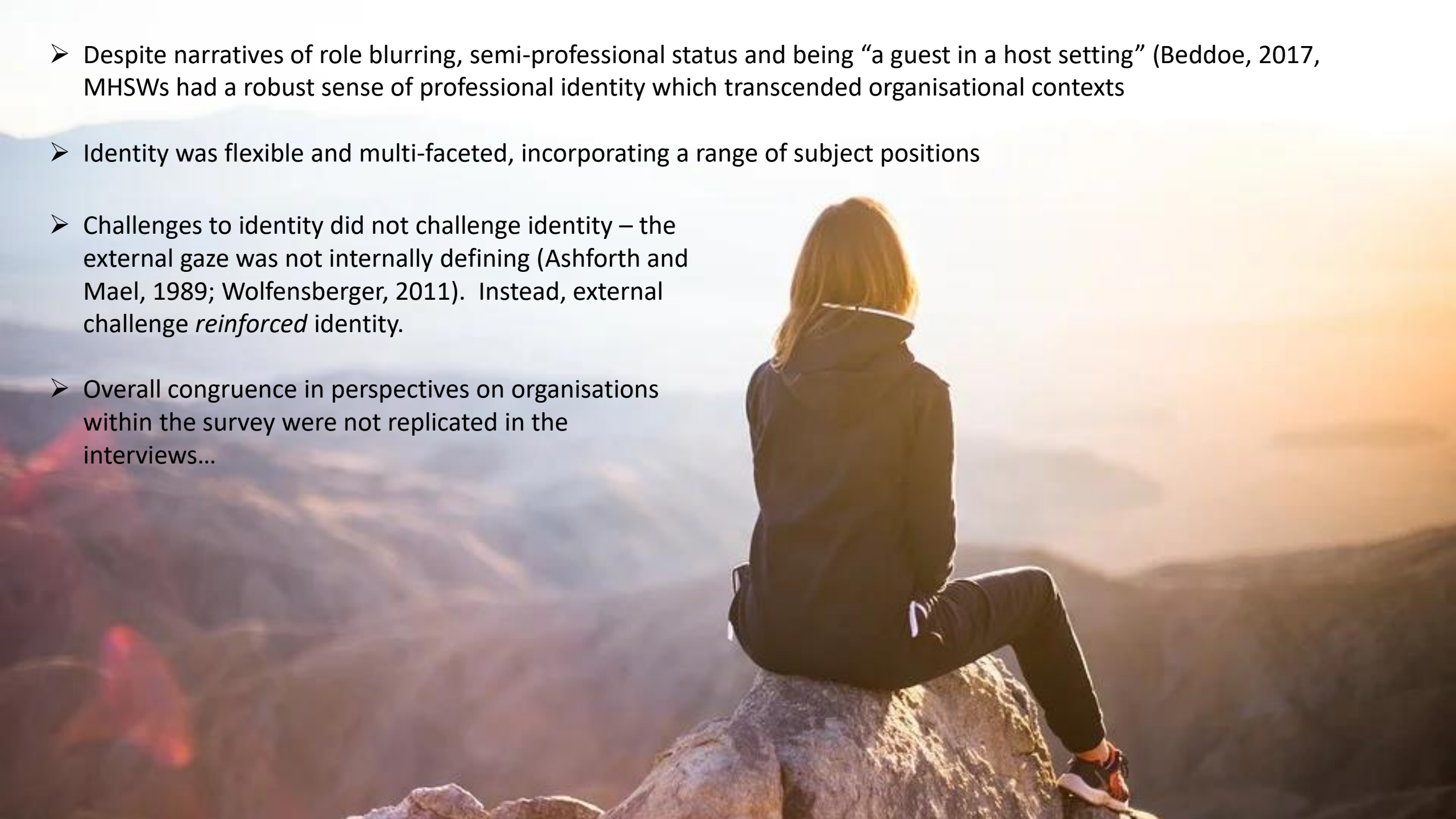
So, how does this all fit together?

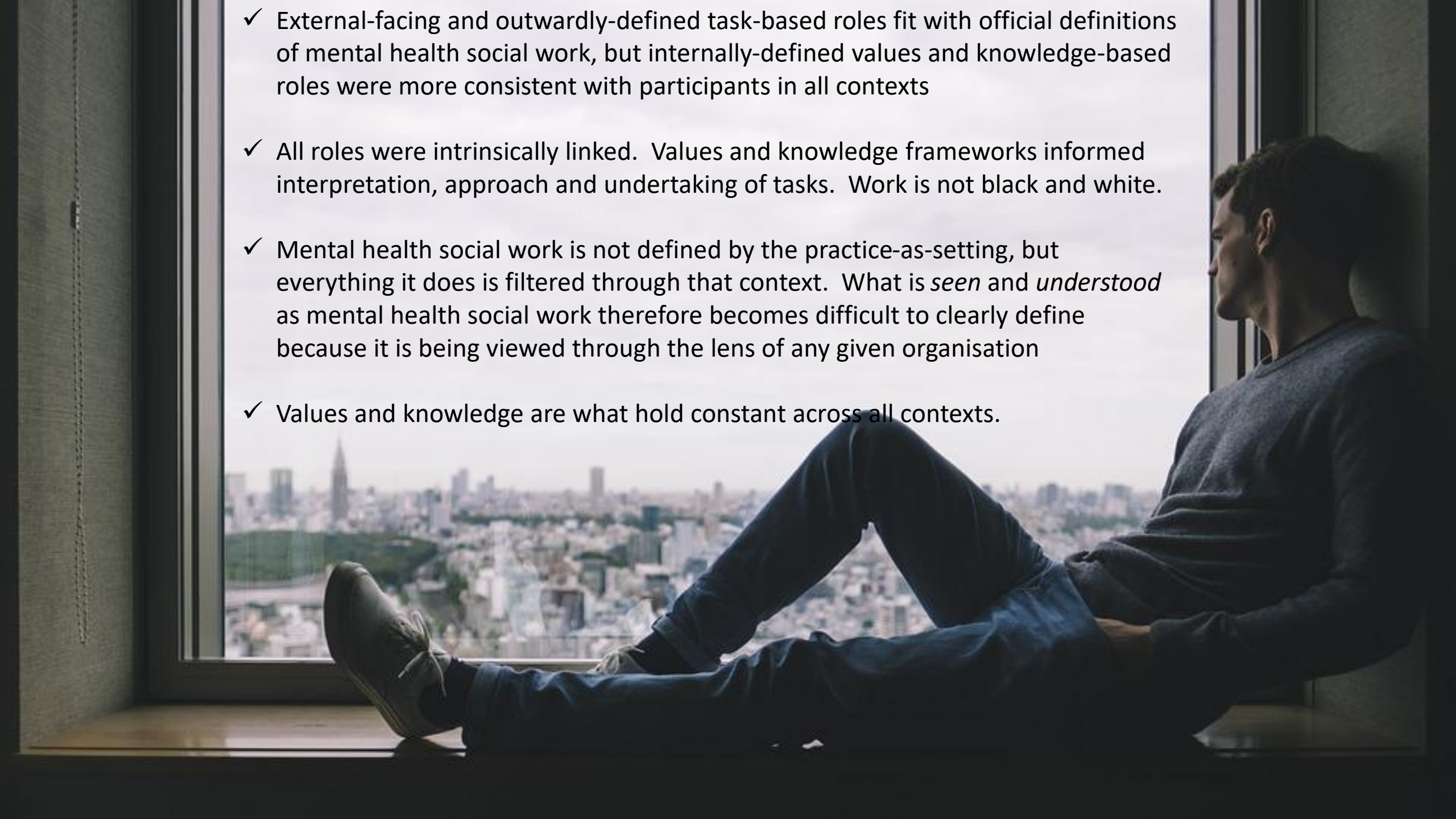
- Despite narratives of role blurring, semi-professional status and being “a guest in a host setting” (Beddoe, 2017, MHSWs had a robust sense of professional identity which transcended organisational contexts

- Identity was flexible and multi-faceted, incorporating a range of subject positions

- Challenges to identity did not challenge identity – the external gaze was not internally defining (Ashforth and Mael, 1989; Wolfensberger, 2011). Instead, external challenge *reinforced* identity.

- Overall congruence in perspectives on organisations within the survey were not replicated in the interviews…





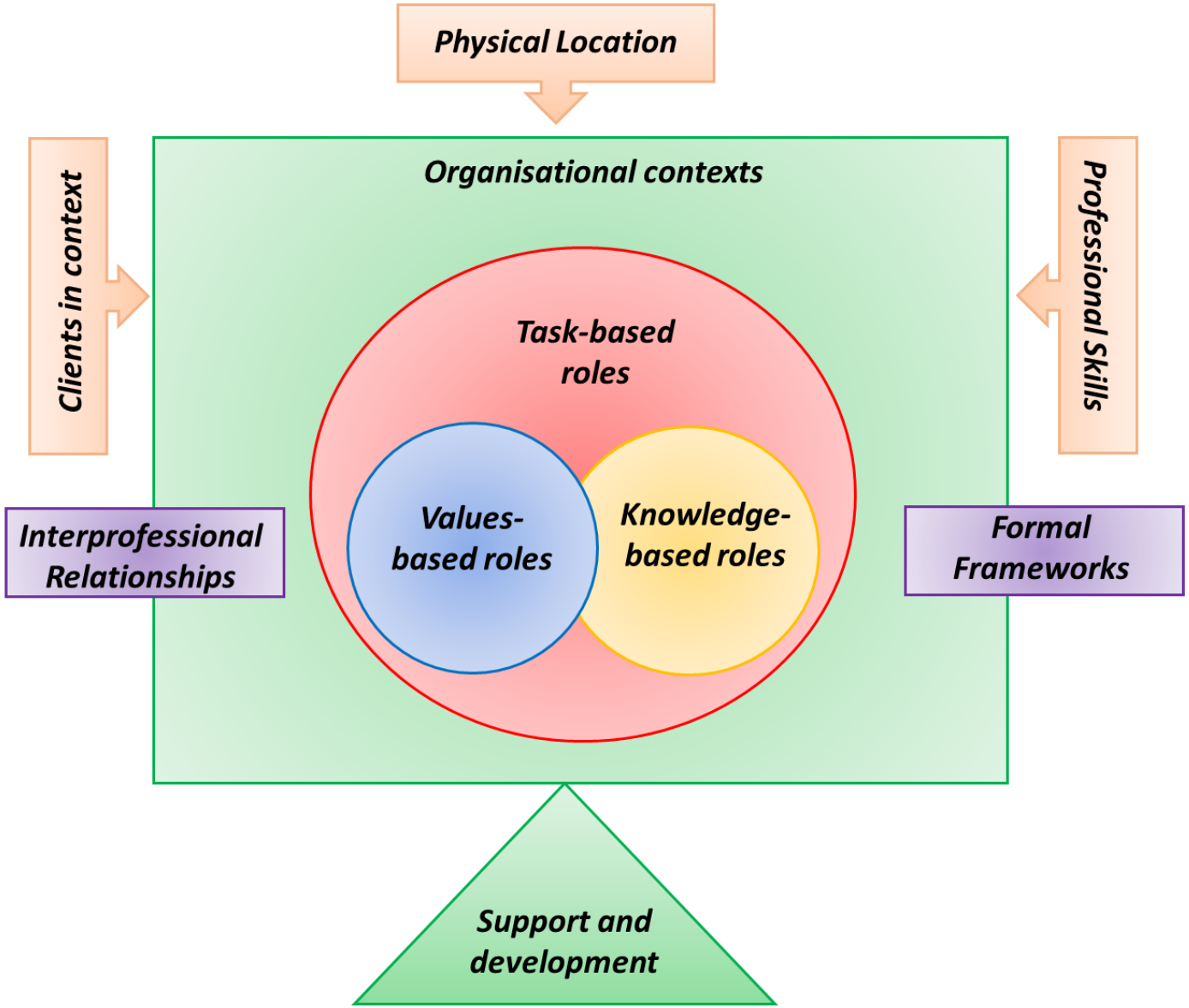
- ✓ External-facing and outwardly-defined task-based roles fit with official definitions of mental health social work, but internally-defined values and knowledge-based roles were more consistent with participants in all contexts

- ✓ All roles were intrinsically linked. Values and knowledge frameworks informed interpretation, approach and undertaking of tasks. Work is not black and white.

- ✓ Mental health social work is not defined by the practice-as-setting, but everything it does is filtered through that context. What is *seen* and *understood* as mental health social work therefore becomes difficult to clearly define because it is being viewed through the lens of any given organisation

- ✓ Values and knowledge are what hold constant across all contexts.

Modelling mental health social work



Implications for practice

- ✓ Rethinking how we see social work in mental health – if social work's defining characteristic is in *how* it contributes, then this gives opportunity to be flexible in what it does.
- ✓ Filling the gaps! Flexibility allows social work to develop in ways which complement and support the health specialisms around it rather than duplicating them
- ✓ A grassroots consideration – a holistic, contextual profession requires a contextual definition. Conceptualising the role needs to be rooted in practice realities rather than definitional tasks.

Limitations

- ✓ A purposive selection… from a self-selecting sample
- ✓ A cross-sectional snapshot of understanding from an unprecedented moment in time

Thank you for listening! Any questions?

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Teaching Partnership Feedback Form - Working in Greyscale Seminar