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Journal of Social Work

Mental health social work in multidisciplinary community teams: An analysis of a national service user survey

Journal:	<i>Journal of Social Work</i>
Manuscript ID	JSW-18-0116.R2
Manuscript Type:	Original Article
Keywords:	Mental health, Community services, Social work values, Social work skills, Social work practice
Abstract:	<p>ABSTRACT</p> <p>Summary: The article addresses the continued lack of clarity about the role of the mental health social worker within CMHTs for working age adults and particularly the limited evidence regarding this from the perspective of service users. It compares findings from the literature, found to originate from a predominantly professional viewpoint, with secondary analysis of a national survey of service users to assess their views.</p> <p>Findings: Three particular aspects of mental health social workers' role identified in the literature were, to some extent, also located within the national survey and can be summarised as: approaches to practice, nature of involvement, and scope of support. The presence of these features was largely not substantiated by the survey results, with few differences evident between service users' experiences of mental health social workers compared with other mental health staff. When nurses and social workers were compared, results were either the same for both professions or favoured nurses. The findings point both to the difficulty of articulating the social work contribution and to the limitations of the secondary data.</p> <p>Application: The findings are a useful benchmark, highlighting the limited evidence base and the need for further research to improve both the understanding of the mental health social work role and how it is experienced by service users. The profession is keen to emphasise its specific contribution. Research evidence is required to underscore this and to ensure that the role is not subsumed within generic practice.</p>

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Table 1: Service user characteristics by professional group

		Social worker n (%)	CMHN n (%)	χ^2	p
Gender	Female	388 (57)	1430 (55)	.403	.544
	Male	294 (43)	1145 (44)		
Respondent	Service User	355 (54)	1685 (68)	63.63	<.001
	A Friend/Relative	174 (26)	419 (17)		
	Service User & Friend/Relative	58 (9)	251 (10)		
	Service User & Professional	66 (10)	124 (5)		
Age	18-35	98 (14)	339 (13)	3.43	.329
	36-50	168 (24)	615 (24)		
	51-65	194 (28)	687 (27)		
	66+	222(33)	934 (37)		
Time in services	< 1 Year	99 (15)	392 (15)	1.48	.686
	1-5 Years	239 (36)	869 (34)		
	6-10 Years	92 (14)	319 (13)		
	10+ Years	237 (35)	943 (37)		
Last seen	< Month	413 (61)	1867 (72)	39.45	<.001
	1-3 Months	156 (23)	443 (17)		
	4-6 Months	82 (12)	202 (8)		
	7-12 Months	31 (4)	63 (2)		
Total		695	2589		

Table 2: Communication

	Social workers n (%)	CMHN n (%)	χ^2	p
Did the person listen carefully to you?				
	n=674	n=2542		
Yes definitely	485 (72)	1983 (78)	10.94	.004
Yes, to some extent	153 (23)	451 (18)		
No	36 (5)	108 (4)		
Were you given enough time to discuss your needs and treatment?				
	n=661	n=2490		
Yes definitely	437 (66)	1809 (73)	11.06	.004
Yes, to some extent	175 (25)	524 (21)		
No	49 (7)	157 (6)		
Did the person or people you saw understand how your mental health needs affect other areas of your life?				
	n=657	n=2478		
Yes definitely	410 (62)	1653 (67)	8.73	.013
Yes, to some extent	177 (27)	643 (26)		
No	70 (11)	182 (7)		

Table 3: Co-production

	Social workers n (%)	CMHN n (%)	χ^2	P
Have you agreed with someone from the NHS mental health service what care you will receive? (N=663/2516)				
Yes definitely	363 (55)	1550 (62)		
Yes, to some extent	227 (34)	788 (3)	15.79	.000
No	73 (11)	178 (7)		
Were you involved as much as you wanted to be in agreeing what care you will receive? (n=577/2315)				
Yes definitely	332 (57)	1459 (63)		
Yes, to some extent	207 (36)	709 (31)	11.98	.007
No, but I wanted to be	26 (4)	125 (5)		
No, but I did not want to be	12 (2)	22 (1)		
Does this agreement on what care you will receive take your personal circumstances into account? (N=581/2294)				
Yes definitely	373 (64)	1540 (67)		
Yes, to some extent	178 (31)	655 (27)	2.04	.361
No	30 (5)	99 (4)		
In the last 12 months have you had a formal meeting with someone from the NHS mental health services to discuss how your care is working? (N=553, N=2066)				
Yes	474 (86)	1752 (85)		
No	79 (14)	314 (15)	0.29	.593
Were you involved as much as you wanted to be in discussing how your care is working? (N=462/1729)				
Yes definitely	289 (63)	1178 (68)		
Yes, to some extent	143 (31)	451 (26)	5.70	.127
No, but I wanted to be	26 (6)	91 (5)		
No, but I did not want to be	4 (1)	9 (1)		
Did you feel the decisions were made together by you and the person you saw during this discussion? (N=456/1716)				
Yes definitely	278 (61)	1138 (66)		
Yes, to some extent	144 (32)	465 (27)	6.53	.088
No, but I wanted to be	27 (6)	100 (6)		
No, but I did not want to be	7 (2)	13 (1)		
Have the NHS mental health services involved a member of your family or someone else close to you as much as you would like? (N=602/2246)				
Yes Definitely	308 (51)	1187 (53)		
Yes, to some extent	126 (21)	400 (18)		
No, not as much as I would like	60 (10)	206 (9)	8.03	.154
No, they have involved them too much	6 (1)	43 (2)		
They did not want to be involved	24 (4)	70 (3)		
I didn't want them involved	78 (13)	340 (15)		

Table 4: Finance and employment advice

	Social workers n (%)	CMHN n (%)	χ^2	p
In the last 12 months, did the NHS mental health services give you any help or advice finding support for financial advice or benefits?				
	N=648	N=2467		
Yes definitely	208 (46)	682 (48)	2.7 4	.254
Yes, to some extent	137 (30)	371 (26)		
No, but I would have liked help	107 (24)	356 (25)		
In the last 12 months, did the NHS mental health services give you any help or advice with finding support for finding or keeping work?				
	N=361	N=1332		
Yes definitely	83 (40)	254 (41)	1.5 1	.470
Yes, to some extent	74 (36)	197 (31)		
No, but I would have liked help	51 (24)	175 (28)		

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Mental health social work in multidisciplinary community teams: An analysis of a national service user survey

For Peer Review

Introduction

Social workers have played a major role in the development of community mental health services for adults in England. Deinstitutionalisation policies from the mid-20th Century demanded enhanced community support services (Department of Health [DH], 1962; Mental Health Act, 1959), which in turn drew on key social work values linking successful support with the need for understanding of the dynamics between patients, their families, communities and wider social forces. Additionally, social work's long history of individual casework orientated to people in their own homes and communities naturally lent itself to the needs of new services. More specifically, the 1959 Mental Health Act gave additional responsibilities to social workers including post hospital discharge support (Burns, 2014). A decade later, the Medical-Psychological Association (1969) recommended that a new body of mental health social workers with additional training was now required to support the growing numbers of people with profound and complex mental health needs living in the community (Godin, 1996). The introduction of the Approved Social Worker in 1983 (MHA, 1983) conferred on this group of staff further duties and responsibilities to conduct assessments where formal detention was considered. Within this role their duty included investigating the feasibility of community alternatives to avoid hospital admission (Rapaport, 2005). These factors reinforced the shift away from genericism in the social work role (Challis & Ferlie, 1987, 1988). Furthermore, government policies which sought to reorient mental health services towards care in the community often included an enhanced role for social workers within integrated services (e.g. DH, 1975, 1989, 1990, 1995, 1998; Health Act, 1999).

New approaches to support involved multidisciplinary services and focused on early intervention and the maintenance of independence (Anthony, 1993; Hibbard & Gilbert, 2014). Today such services are the norm, with social work joining psychiatry, nursing, psychology and occupational therapy in a spectrum of specialist community teams (Malone, Marriott, Newton-Howes, Simmonds & Tyrer, 2007). Such teams are increasingly prevalent across Europe, North America, and Australasia (Draper & Anderson, 2010; Evans et al., 2012; Ng, Herrman & Chiu, 2009). These multi-disciplinary teams encompass the early assessment and diagnosis of psychiatric conditions and the coordination of long-term support and care to meet specific needs.

However, as social workers have been included within the wider mental health system, boundaries between professionals have blurred with a 'creeping genericism' gradually eroding traditional roles (Brown, Crawford & Darongkamas, 2000, p426). Role blurring and the

erosion of traditional professional practices have become a salient issue for many practitioners (Jones, 2014). This is evidenced, for example, by clinical psychologists helping to organise accommodation for service users, and social workers implementing psychotherapeutic interventions (Abendstern et al., 2014; Brown et al., 2000; Wall, 1998). The increasing pressure on social workers and other members of community mental health teams (CMHTs) for adults to move towards more generic roles has furthered a lack of clarity regarding what social workers should do compared to other professionals, whilst roles that were specific to them historically, such as the approved social work role, have been opened up to others (Bailey & Liyanage, 2012). Social work has long been recognised as difficult to define (Allen, 2014; Howe, 1979; Rode, 2017) and more recently role blurring has added to the challenge of articulating its unique contribution to mental health.

This poses distinct challenges for the practice and organisation of mental health social work. First, service users may be unclear about the roles and remit of social work in their mental health care, which may undermine confidence and impede the contribution that social workers can then make (ComRes, 2017). Second, repeated studies have found that mental health social work staff in multidisciplinary environments have relatively poor job satisfaction and face significant risk of stress (Evans et al., 2005; Onyett 2011). This is empirically linked to social worker perceptions that their core skills and knowledge are not well matched with those demanded in their role (Wilberforce et al., 2013). Third, there appears to be a growing trend towards the removal of mental health social workers from multidisciplinary environments, at least based on anecdotal reports (ADASS 2018; Lilo 2016; McNicoll, 2016), for fears that social workers are not being utilised appropriately. Such decisions are (inevitably) being taken without appropriate evidence asserting their unique role.

This article aims to articulate the unique contribution of the social work role in mental health through a synthesis of two processes. First a focussed review of the literature was undertaken to identify the features of the social worker role in mental health care. Second, a new analysis of nationally collected data from the Care Quality Commission (CQC) was employed to identify service user perspectives of social work in mental health. These data enabled a comparison to be made between the experiences of service users supported by social workers and those supported by other professionals.

Methods

Review of literature

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5 This review sought to identify and synthesise the literature on the distinct contribution of the
6 social work role in mental health. It was designed to serve the needs of a wider research
7 study investigating the contribution of social work in community mental health teams
8 (underway at the time of writing, and which required the collation of a list of attributes to
9 incorporate into data collection tools). 'Contribution' was defined by the research team as
10 including both 'what' they do and 'how' they do it, acknowledging that social workers may do
11 similar tasks to other professions, but in a different way. The pragmatic aims meant there was
12 no requirement for the review to be exhaustive. Nevertheless good practice in literature
13 reviewing was followed drawing upon rapid review methods as a means of expediting the
14 identification and synthesis of existing literature. Whilst no formal definition for a rapid review
15 exists, the process adopted used Tricco and colleagues (2015) working definition which states
16 that they are "a type of knowledge synthesis in which components of the systematic review
17 process are simplified or omitted to produce information in a short period of time" (Tricco et
18 al., 2015, p225). In line with this this, they tend to be characterised by a restriction of searches
19 to one or two databases, limiting search terms, and a presentation of results within a narrative
20 summary with no quality appraisal.
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31 Three different sources of literature were reviewed. The first identified six authoritative
32 textbooks which described mental health practice and generic social work (Briar & Miller, 1971;
33 Davies, 2012; Goldstein, 1973; Golightley & Geomans, 2014; Moxley, 1989; Raiff & Shore,
34 1993). These texts were selected by two of the authors (DE, JH), with professional social work
35 qualifications and the most extensive experience from within the research team, making a
36 pragmatic choice from existing textbooks known to them. The second consisted of existing
37 research and practice documents known to the authors to be closely aligned to the intent of
38 the present review, that is, the nature of social work practice today (e.g. All Party Parliamentary
39 Group 2016; Moriarty & Manthorpe, 2016). Finally a bespoke literature search of two
40 databases was undertaken (Web of Science and PsychInfo) using the search terms "social
41 work*" AND (role OR function) AND "community mental health", restricted to the period 1999
42 to 2017. Broad inclusion criteria enabled the capture of evidence of social work attributes
43 within both generic and specialist mental health social work. All included texts were required
44 to include descriptions of one or more social work attribute, in line with the aim of the review
45 which sought to collate a list of such features. This yielded 85 references after duplicates were
46 removed. Titles and abstracts were reviewed by all the research team and any abstract
47 identified as relevant by any member (n=44) were obtained, bar five items that could not be
48 sourced. Those with exclusive focus on older adults services were also excluded (n=2).
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3 For each included source, a short summary narrative of social workers' contributions was
4 produced and entered into MS Excel (RP). These were then discussed by the wider authorship
5 group who, through an iterative process, identified three broad areas under which the findings
6 were collated: 'approaches to practice'; 'nature of involvement'; and 'scope of support'. Within
7 these headings, RP and MW jointly devised sub-themes by reviewing all Excel entries, revising
8 and updating these as the analysis progressed. The final step involved providing a narrative
9 commentary of each theme and sub-theme, with an example of social work practice illustrating
10 each in practice. The aim was to draw out distinctions where possible. Decisions were
11 pragmatic rather than definitive with overlap acknowledged, indicative of the characteristics of
12 social work practice.
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21 **Secondary data: Community Mental Health Service User Survey 2016**

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24 The CQC (2016) annual Community Mental Health Survey data were selected for analysis, as
25 a standardised survey with national coverage. Its primary aim is to find out what service users
26 think about the NHS healthcare services they use, to highlight good care and to identify the
27 potential risks to the quality of services. The survey consists of 47 questions with 41 of these
28 asking about the service user's specific experience of the care they receive. Twelve of these
29 questions were analysed, being those most relevant to the core aim of the article: to articulate
30 the social work role within these services (see Tables 2-4 for details). These were organised
31 according to the literature review themes: approaches to practice (n=3); nature of involvement
32 (n=7); and scope of support (n=2). The responses are collected using Likert-type categories.
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34 The survey also asks who is the main person organising the service user's care, providing an
35 opportunity for comparison between social workers and community mental health nurses
36 (CMHNs) as care coordinators.
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45 **Settings:** All Trusts providing community mental health services in England were eligible to
46 take part in the survey. Fifty eight providers of NHS mental health services in England,
47 including combined mental health and social care trusts, foundation trusts and community
48 healthcare social enterprises commissioned by Trusts, provided mental health services.
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50 Fieldwork for the survey took place between February and June 2016.
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54 **Respondents:** Each NHS Trust providing or commissioning mental health services drew a
55 random sample from their records of 850 people receiving services. Service users were
56 eligible to complete the Community Mental Health User Survey if they were over 18 years of
57 age and had received specialist care or treatment for a mental health condition from a
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3 community-based treatment or care service, delivered through a Mental Health Trust during
4 the sampling period. This also included those who received care under the Care Programme
5 Approach (CPA). Several exclusions were applied by the authors, including specialist services
6 for people with learning disabilities, drug and alcohol problems, and forensic psychiatry.
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8 Further, those only seen for assessment; those who were inpatients at the time of the survey;
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10 and people seen exclusively by Improving Access to Psychological Therapies services were
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12 excluded. Full details are provided in CQC (2016).
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17 The CQC dataset comprised 12,522 people who had seen a mental health practitioner in the
18 previous 12 months; 2,739 of whom were care coordinated by a CMHN and 802 by a social
19 worker. Some respondents perceived that more than one professional acted as care
20 coordinator and were removed from the analysis. The final sample comprised 2,575 and 682
21 people whose care was coordinated by a CMHN and social worker respectively.
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27 **Analysis:** Data analysis on the selected CQC questions, which were grouped into three
28 themes, was conducted using SPSS statistical software. Effect sizes were also calculated,
29 however, only as a guide since the data were categorical not continuous. This permitted
30 quantification of the difference between two groups, and is helpful in large samples where
31 small differences may be statistically significant. The effect size is the standardised mean
32 difference between the two groups. By convention, an effect size of 0.2 or less is 'small'
33 (Cohen, 1977).
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40 **Results**

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42 Following a description of the characteristics of the literature and survey sample, the results
43 are described under three sub-headings, each of which contains findings from the literature
44 followed by the results of the secondary data analysis of the related survey questions. A final
45 section about overall satisfaction contains survey data only.
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50 ***Literature characteristics***

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52 Together the three sources produced 59 articles and books published between 1971 and
53 2016. The majority (n=32) came from the UK with a substantial number (n=17) being published
54 in the US. A smaller amount came from a range of European countries (n=10). The
55 descriptions of social worker contributions were organised under the three interlinked themes
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3 already noted. The CQC data was then also arranged under those headings. Each theme
4 contained a number of sub-themes which are outlined below. The included literature was
5 dominated by non-empirical texts in the form of published books and articles (n=28) and grey
6 literature (n=11). Twenty empirical research articles were included of which 13 reported data
7 collected from social workers. Only three reported the perspectives of service users. Unless
8 otherwise stated, the data reflects a mix of empirical research and opinion from social work
9 experts within academia and/or policy environments.
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16 ***Survey sample characteristics***

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19 Service user characteristics are displayed in Table 1. There were no significant differences
20 between the two groups (those supported by a social worker and those supported by a CMHN)
21 with regard to gender, age or time spent in services. However, on average service users on
22 CMHN caseloads had been seen more recently compared to service users on social worker's
23 caseloads. Also significantly more service users on CMHN caseloads had completed the
24 questionnaire themselves, compared to service users on social workers caseloads.
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30 <Insert Table 1 about here >
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33 ***Approaches to practice***

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36 ***The literature:*** Three areas were identified within the literature on this theme: that social work
37 theory and practice is situated within an understanding of society as socially biased against
38 the vulnerable; starts from a holistic perspective; and prioritises good working relationships
39 with individuals to support positive change.
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44 Social work practice in mental health and other services was reported to be intentionally non-
45 neutral; framed by an assumption that people with mental health problems are vulnerable to
46 abuses of their human rights (Ife, 2012) and face greater difficulties in accessing health and
47 welfare services, education and training, employment, housing, and participation in civic
48 society (Ahmedani, 2011). Further, discrimination due to mental health was recognised in
49 social work texts as inseparable from other forms of injustice, for example with regards to
50 ethnicity and culture or sexual and gender identities (Allen, 2014; Faust, 2008; Golightley &
51 Geomans, 2014; Ramon, 2010).
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58 Social workers were also said to be guided by an awareness and understanding of how
59 individual wellbeing is inextricably linked to their social environment (Goldstein, 1973; Raiff &
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3 Shore, 1993). As a consequence social work has been identified as being cautious about the
4 medical model of psychiatry, as insufficient to explain causes and consequences of mental
5 health problems (Carpenter, Schneider, Brandon & Wooff, 2003), described as impeding
6 mental health recovery due to an overriding focus on deficits' alone (Davies, 2012; Ramon,
7 2010; Stanley et al., 2003; Stromwall & Hurdle, 2003). A holistic approach that takes into
8 account a persons' wider needs and social context was said to be valued by service users
9 (Beresford, 2007).

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16 More generally, the social worker's approach was described as prioritising a positive working
17 relationship with clients and their families built on compassion (Ramon, 2010), trust and clear,
18 uncomplicated, communication (Allen, 2014; Golightley & Geomans, 2014; Hardiker & Barker,
19 1999; Herman, 2014; Peck & Norman, 1999). Mental health social work training has long-
20 included relationship work as one component of their duties (Perlman, 1979). More recently,
21 this has received attention as part of recovery principles, allied with concepts of 'hope',
22 'strengths' and 'control' to improve social functioning and promote engagement in the wider
23 community (Allen, 2014; Pahwa, Smith, McCullagh, Hoe & Brekke, 2016). An emphasis
24 on self-awareness including limited self-disclosure (Golightley & Geomans, 2014) and the
25 ability to actively listen and empathise with service users (Faust, 2008; Penhale & Young,
26 2015) were also skills acknowledged to be required to build positive working relationships.
27 Two publications which focussed on users' views stressed that the social worker's approach
28 to practice, including kindness, sensitivity, reliability and a non-judgemental attitude, was
29 paramount to service users' satisfaction with social work (Beresford, 2007; Penhale & Young,
30 2015).

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41 **The secondary data:** The three questions within this theme spanned careful listening,
42 whether service users were given enough time, and how well they thought they were
43 understood by their key worker. Descriptive statistics for these questions are displayed in
44 Table 2. There were significant differences for all three questions, with respondents in the
45 CMHN group answering more positively compared to those in the social worker group,
46 although the effect sizes were small (all $d \leq 0.13$).

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52 <insert table 2 about here>

53 54 55 56 **Nature of involvement**

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3 **The literature:** This theme includes the sub-themes of advocacy; anti-oppressive practice;
4 and the exercise of care coordination. Advocacy has been described as a routine element of
5 social work ensuring that service users' rights are upheld and respected (Cummings & Cassie,
6 2015; Davis & Jung, 2012; Manktelow et al., 2002). Social workers were characterised in the
7 literature as promoting social justice, giving the powerless a voice (Faust, 2008) and
8 supporting people to express themselves so that they could be "recognised on equal terms
9 with others" (Parrott, 2014: p105). Anti-oppressive practice in social work, linked to
10 challenging discrimination along all lines of difference (Beresford, 2007) has emerged from
11 social work training that articulated theories and practices related to resolving differential
12 power relationships within families, social networks, public services, and communities.
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21 One of the key vehicles through which social workers engage service users and their social
22 networks in promoting self-determination is through their involvement in care coordination,
23 which in social work is also geared towards changing the power balance between the
24 supported and those supporting them (Herman, 2014; Penhale & Young, 2015; Ring, 2001).
25 In terms of assessment activity, social workers were found to make key links between
26 psychiatric, psychological and social functioning together with reviewing risk and physical
27 health needs (Aschbrenner et al., 2015; DH, 1999). In relation to care planning and
28 coordination, social workers play a key role in creating comprehensive and personalised care
29 plans which reflect an individual's needs, preferences and strengths and enable individuals to
30 live more independently (Allen, 2014; Raiff & Shore, 1993). This role is reported to involve
31 arranging, purchasing and monitoring social care packages and referrals (Marshall, Lockwood
32 & Gath, 1995; Moxley, 1989) and therefore involves liaising, mediating and negotiating with
33 other professionals and agencies to ensure continuation of care (Cummings & Cassie, 2015;
34 Janlov et al., 2015). Social workers were also reported to liaise closely with nurses, care
35 agencies and voluntary organisations, GPs and hospitals, and specialist psychological support
36 services (Golightley & Geomans, 2014) to coordinate care and ensure service users' and
37 carers' needs are appropriately met (Hardiker & Barker, 1999).
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49 Mulhall (2000) found that service users wanted to be treated with respect, to be involved in
50 planning their own care and to be listened to, all of which have been identified as core skills
51 of social workers. Additionally, Beresford (2007) reported that service users valued social
52 workers for their focus on supporting independence and participation rather than dependence.
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57 **The secondary data:** Seven questions were linked to the theme of coproduction covering the
58 level of involvement of the service user and their wider network in planning and reviewing their
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3 care. The questions focused on the extent of involvement in discussions about care needs,
4 formulating plans, and agreeing decisions. Descriptive statistics are displayed in Table 3.
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8 Significant differences emerged in relation to the level of involvement in agreeing the care the
9 service user would receive, with service users on the CMHN caseload seeming more satisfied,
10 although effect sizes were small ($d_s \leq 0.12$). No other significant differences were found
11 within this theme, suggesting that both CMHNs and social workers involved the service users
12 and their wider networks in decisions surrounding their care to the same extent.
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21 ***The scope of social work support***

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25 ***The literature:*** The literature described three elements of support provided by social workers:
26 knowledge of and ability to access a broad range of resources; direct interventions; and
27 statutory roles requiring specific knowledge and skills.
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31 A central contribution of social work to mental health care, as noted above, is its wide frame
32 of reference compared to a more medicalised model: if a person is to be viewed holistically,
33 then the range of support must not be constrained to clinical resources. Social workers were
34 found to be knowledgeable about services available through the local authority, including
35 social care and housing (Mitchell & Patience, 2002). King and colleagues' (2002) survey
36 comparing different professionals in community mental health services found social workers
37 to have significantly greater knowledge of employment support than other staff. Social workers
38 were also found to routinely liaise with wider groups including the police and offenders'
39 services, immigration, jobcentres, benefits support and local community support groups
40 spanning a range of potential needs (Allen, 2014; Stromwall & Hurdle, 2003). Outreach work
41 took social workers into hospitals, jails, and communities where long-term goals were created
42 based on the individual's stage of readiness (Dumaine, 2003). To this end, social workers
43 were reported to be adept at multidisciplinary working, and to offer unified and integrated
44 services that enable individuals with mental health needs to improve their social and
45 community functioning (All Party Parliamentary Group, 2013; Stromwall & Hurdle, 2003).
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56 Social workers were reported to implement a spectrum of interventions (All Party
57 Parliamentary Group, 2016). Practical interventions dominated accounts in the literature, such
58 as Priebe and colleagues' (2005) who found that 82 per cent of social workers in London
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3 reported that support in, and training of, daily living skills was one of their main roles. Other
4 interventions targeted social functioning with the aim of improving engagement in the
5 community and enabling individuals to enter meaningful vocations (Pahwa et al., 2016;
6 Ramon, 2010; Stromwall & Hurdle, 2003). Social workers used psychological interventions
7 (Davis & Jung, 2012), including counselling (Beresford, 2007; Lang et al., 2011; Peck &
8 Norman, 1999), psycho-education around medication effectiveness and side effects (Davies,
9 2012; Pahwa et al., 2016), and emotional support to individuals in crisis (Marshall et al., 1995;
10 Raiif & Shore, 1993).

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17 The literature also described the statutory roles of social workers within mental health
18 (Golightley & Geomans, 2014; Ramon, 2010). It illustrated how social workers exercised
19 professional judgement over ethical dilemmas and risk when supporting individuals and
20 families with the most serious needs, spanning safeguarding, domestic abuse, child
21 protection, criminality, homelessness and substance use issues (Goldstein, 1973; Gould,
22 2016; Rubin & Parrish, 2012). Social workers were reported to require assessment and
23 decision making skills under circumstances where full information was either not available,
24 was uncertain, and/or within fast-moving and volatile situations (Davies, 2012).

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32 One study by Cree and Davis (2007) highlighted service users' views on the scope of mental
33 health support from social workers. The authors conducted four service user and two carer
34 interviews about the social worker input into their care. They found that both the service users
35 and carers identified that social workers liaised with other services on their behalf, introduced
36 other treatment options, for example, Cognitive Behavioural Therapy, and involved family
37 members where appropriate

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42 **The secondary data:** This theme was limited to two questions regarding the scope of support
43 service users received in relation to financial and employment advice. Descriptive statistics
44 can be found in Table 4. For both questions, no significant differences emerged, ($ds \leq 0.02$),
45 suggesting both social workers and CMHNs provided the same level of support.

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50 **Overall Satisfaction:** The CQC questionnaire also included a question about service users'
51 overall satisfaction with their experience of NHS mental health services, using a 10 point Likert
52 scale ranging from 0 (I had a very poor experience) to 10 (I had a very good experience). A t
53 test revealed a significant difference between CMHNs and social workers $t(3048) = 3.75, p <$
54 $.001$. Service users on CMHN caseloads rated their experience as significantly higher than
55 service users on social workers' caseloads.

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6 **Discussion**

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9 Despite decades of debate about the importance of social work in mental health, the
10 profession appears to have made little progress in establishing a clear evidence-base for its
11 role. This article reviewed literature on the mental health social work role and provided a new
12 analysis of secondary data on service user perceptions thereof. The discussion considers the
13 implications of the findings for mental health social work going forward, focusing on the
14 importance of developing a clearer role definition which can be understood by all, including
15 service users, alongside a fuller comprehension of the service user perspective of this. The
16 strengths and limitations of the data used for this study are also explored.
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23 ***Social work today and the service user voice***

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26 The review of the literature undertaken for this study indicated that social workers operated
27 within a value-based approach recognising societal influences on the individual; perceived the
28 promotion of self-determination of vulnerable individuals as central to their work; and
29 undertook a broad range of support including advocacy; direct interventions and the ability to
30 access others, alongside statutory responsibilities. Social workers were found to recognise
31 the importance of the individual participating as fully as possible in decision-making (Golightley
32 & Geomans, 2014; Herman, 2014; Penhale & Young, 2015; Ring, 2001); to play a key role in
33 creating comprehensive and personalised care plans, reflecting individuals' needs and
34 preferences (Allen, 2014; Raiff & Shore, 1993); and to understand the need to develop trusting
35 relationships to support these ends (e.g. Allen, 2014; Beresford, 2007).
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44 These principles are the foundations of current social work training in England, with the
45 ThinkAhead initiative being one example of the drive to promote graduate entry to mental
46 health specialist training (Clifton & Thorley, 2014). Its publicity highlights key features of social
47 work including building relationships with people, providing guidance and therapy, arranging
48 support and care, ensuring people's safety, standing up for people's rights, and improving
49 community services. They describe the role of a mental health social worker as someone who
50 empowers individuals through therapy, support and advocacy, building resilience in
51 individuals, their networks, and their communities, thus transforming people's wellbeing and
52 improving our society and economy (ThinkAhead.org, 2018).
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3 The evidence presented in this article identifies that within the literature whilst social workers,
4 educators and other professionals are (broadly) able to discern the unique contribution social
5 work provides as part of community teams (see also ADASS 2018), there is a surprising lack
6 of testimony or articulation of the service user perspective in relation to their role in mental
7 health care. Interestingly, even the Barclay Report of the 1980s on Social Workers' Roles and
8 Tasks (Barclay, 1982) makes no mention of mental health care in their chapter on views of
9 social work. Given the profession's position as advocating for, and empowering, the service
10 user, these findings are puzzling. This is not unique to mental health. Penhale and Young's
11 (2015) review of research spanning service user views of social work in general found a
12 paucity of such evidence but it was notable that evidence specific to mental health services
13 was even scarcer. Two reports that did focus on users' views, although not on mental health
14 services specifically, recorded a range of attributes that service users valued and which they
15 identified with social workers (Beresford, 2007; Penhale & Young, 2015). These studies, which
16 are by no means definitive, mirrored the professional perspective of the social worker's unique
17 contribution and included recognising and respecting diversity; seeing the client as a unique
18 individual with unique needs; being non-judgemental; and being trustworthy and honest.

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Despite the paucity of service user-based research, there is also an argument that existing
data is not used to its full capability. In this article, secondary analysis of the CQC Community
Mental Health Survey data was undertaken, in part to redress the imbalance found in the
literature. It enabled a comparison of those supported by a social worker with those supported
by a mental health nurse. Perhaps surprisingly, minimal evidence was found to support the
views identified in the literature and noted above as being particular to social workers. Indeed,
where differences between mental health nurses approaches and those of social workers did
emerge, they largely favoured nurses. This merits some reflection: why does the unique
contribution of social work articulated in the literature not percolate through to evidence of
service user experiences? What is obscuring its visibility?

First, there continues to be widespread misunderstanding of the social work role which may
influence service user expectations. For example, ThinkAhead recently commissioned the
polling company ComRes to find out what the public thought social workers did. They
interviewed 2,033 adults online across Great Britain, in March 2017. Key findings included that
only 41 per cent thought that social workers were an important provider of mental health
support, that the most likely type of support provided by social workers to people with mental
health conditions was to assess practical needs (65%); and that only 33 per cent thought that
social workers were involved in the detention of individuals under the Mental Health Act
(ComRes, 2017). This is not a new debate: that social work struggles to make clear its

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3 purpose to the general public has been discussed at length, both at home and abroad
4 (Barclay, 1982; LeCroy & Stinson, 2004). However the implications may be profound. Service
5 user misunderstanding can undermine confidence that social workers can help them; can
6 affect the social worker's own belief in their capacity to make a difference; and together form
7 a self-fulfilling prophecy (Legood et al., 2016).
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12 A second reason may be that social work in community mental health is culturally and
13 numerically subsumed within a health-dominated framework. Mental health social workers
14 remain a minority within a medically dominated workforce (Evans et al., 2012) meaning that
15 when teams and services are faced with managing crises in an increasingly austere
16 environment it might become more difficult for social workers to "argue the importance of ... a
17 person's right to accommodation, building social networks and buffers, or the use of social
18 interventions" (Woodbridge-Dodd 2017, p3). This view is also supported by evidence from
19 social workers themselves who have described themselves as being isolated within NHS
20 Trusts (Morriss, 2016). The same study found that those who did not have social worker
21 managers were described as being unable to make their contribution visible through
22 supervision. This was corroborated by earlier research, albeit with CMHTs for older people,
23 where social workers supervised and managed by non-social workers were reported to feel
24 less well understood and their contribution less valued and supported when compared with
25 those managed and supervised by social workers (Abendstern et al., 2014).
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36 Evidence also suggests that within multidisciplinary teams social workers are increasingly
37 seen as generic mental health professionals whose roles overlap with other professionals
38 more than in the past (Wilberforce et al., 2013). These trends are exemplified in legislative
39 changes, whereby approved mental health professionals (AMHPs) have replaced the
40 approved social worker role, although in practice 95 per cent remain social workers (ADASS,
41 2018). Interestingly, Beresford (2007) reported an expression of concern from service users
42 regarding a possible reduction in the helpful practice provided by social workers in this field
43 with the ending of the approved social worker role. This provides some evidence or suggestion
44 of service user recognition of difference between the approaches taken and roles of different
45 professional groups and a preference for those of social workers.
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54 ***Study limitations***

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57 A number of study limitations must be acknowledged. The literature review was not fully
58 systematic and its findings must therefore be treated with some caution. In particular, the six
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3 authoritative textbooks were personally selected and others might have been chosen (e.g.
4 Karban, 2011; Tew, 2011). Data extraction was also limited to the collection of social work
5 attributes rather than delineating the voices from whence these data came. The narrative
6 approach to reporting these data, nonetheless, helped to identify particular dimensions of
7 practice for further analysis via the secondary data. These data, however, also had various
8 shortcomings. Firstly, it is possible that service user questionnaires are not sensitive enough
9 to detect experiential differences between being supported by a social worker or other
10 professional. Additionally, the researchers had no control over what questions were asked in
11 the survey and consequentially their mapping to the literature was approximate. The true
12 distinctiveness of social work is perhaps more nuanced than the survey questions would allow.
13 If there is a distinction to be detected, other research methods may be necessary to draw this
14 out. Secondly and more specifically, the CQC questionnaire was not part of a controlled
15 experiment and therefore differences in case mix supported by different professional groups
16 that might impact on the findings could not be measured. For example, other research has
17 demonstrated that social workers often work with different groups to CMHNs, including people
18 with the most complex needs and circumstances (Allen, 2014; Huxley and Kerfoot, 1993;
19 Penhale & Young, 2015). One study found that social workers in CMHTs tend to carry
20 caseloads of those with higher levels of severity of mental illness and impairment than CMHNs
21 (Huxley et al., 1998). This is not inconsistent with the fact that fewer of the social worker
22 supported respondents had self-completed the survey. Such a difference in case mix could
23 affect the perceived satisfaction of service users thereby confounding attempts to compare
24 experiences between respondent groups.
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40 Thirdly, the CQC data also incorporated a range of different services, including crisis teams,
41 recovery teams, and outpatient services. Satisfaction is perhaps more attainable in long-term
42 care, possibly because service users who are involved with a service over a longer period of
43 time develop relationships with their staff enabling them to respond more meaningfully to
44 questions about satisfaction with their input. In the current survey, however, the particular
45 service used by the respondent was not identified. Finally, a significant difference was found
46 between when service users were last seen by a social work compared to a mental health
47 nurse, with those supported by a mental health nurse having been seen more recently.
48 Although it is not clear from the data why this was the case, its occurrence could also have
49 detrimentally affected their satisfaction, whether because they were dissatisfied with the level
50 of contact received or simply because they could not remember the nature of the contact due
51 to the time elapsed since it had occurred.
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Conclusion

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5 The mixed methods approach used for this study had both strengths and weaknesses. The
6 former lies in its ability to access and analyse existing large-scale data that would not
7 otherwise be available. Its limitation, however, is whether the data source was sufficient to
8 illuminate the social work role, which has been shown to be notoriously difficult to articulate.
9 Future research will need to pay heed to these limitations to shed more light on whether there
10 are any true distinctions between the experiences of service users supported by social workers
11 and other professionals. New research funded by the NIHR School for Social Care Research
12 is currently underway which aims to address this through an investigation of service user and
13 staff perspectives of the value of the social work role within Community Mental Health Teams
14 (CMHTs) using a variety of tools and methods. It will be important to identify any distinctions
15 found between service users supported by social workers and other CMHT practitioners and
16 explanations for this. In addition, empirical research to understand the exercise of mental
17 health social work in practice is required to compare with the literature expounding its optimal
18 attributes. Such research might usefully consider the voices of social workers themselves as
19 well as service users and carers. Whilst the focus of this article has been on social work in
20 mental health it is worth commenting that the contribution of social workers for other service
21 users (e.g. older people) and in other settings (e.g. intermediate care) is also difficult to
22 articulate. Thus social work in general as well as mental health social work in particular is in
23 need of research which helps to articulate its role and value.
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