**The position of the social worker in community mental health teams in England: findings from a national survey.**

**ABSTRACT**

**Summary**: Social workers are integral to community mental health teams, bringing skills and approaches to supporting people, promoting multidisciplinary working and holistic practice. However, a combination of factors have resulted in the removal of social workers from CMHTs in some areas. This study presents findings from a national survey of CMHT team managers (44% response rate), conducted in 2018, to understand the current position of the social worker within CMHTs in England. Analyses focussed on membership, roles and tasks, and change within the previous 12 months. Descriptive statistics were used to analyse the quantitative data and content analysis to interpret free text comments.

**Findings**: Although social workers undertook a variety of generic roles and tasks they were reported to do so proportionally less often than nurses. Results indicated that in over one-fifth of team managers thought they had too few social workers. Managers described the removal of social workers from their teams as having a negative effect on overall service delivery.

**Applications:**These findings are concerning given recent international recognition and support for the social model of mental health to be given parity with the biomedical approach. They suggest that the removal of social workers may undermine important aspects of the delivery of a comprehensive mental health service.

**Key words:** CMHT, mental health, social work, integration,

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**Introduction**

There is growing recognition internationally of the social determinants of mental health and of how social inequalities leave those with the least social and economic agency at most risk of mental disorders (World Health Organisation [WHO], 2014). A comprehensive mental health service is consequently required to provide support that goes beyond medical treatment to consider the whole person in their environment. Social workers are integral to this process. Within multidisciplinary teams they have been reported to support the delivery of timely and holistic services that place the service user and their network at the heart of practice, providing non-judgemental, strengths-based input that promotes self-determination and long-term recovery (Abendstern et al. 2016, 2020; Allen 2014; All Party Parliamentary Group [APPG], 2016). Evidence from service users suggests that they value social workers for their ability to see them ‘in the round’, to work in partnership with them, and to provide clear communication (Kam, 2019; Vicary and Bailey, 2018; Wilberforce et al. 2019). When compared with their health colleagues, service users have reported that social workers deliver more person-centred support (Boland et al 2019). Despite such endorsement, the social work membership of community mental health teams (CMHTs), the cornerstone of mental health services in England, appears under threat (Association of Directors of Adult Social Care [ADASS], 2018; Lilo & Vose, 2016; McNicoll, 2016). This paper provides new empirical evidence and reflects on what the findings mean for the quality of CMHT service provision. Its aims are:

* To investigate the position of the social worker within CMHTs in England in terms of membership and roles undertaken and
* To compare social workers’ roles with those other CMHT members.

The article begins by providing some background to the development of CMHTs and the social workl role within them in order to place the current findings in context.

**Background**

Adult mental health services have been primarily located within community-based provision across the UK, Western Europe, and elsewhere for many years following a de-institutionalisation process. In England this dates back to the 1959 Mental Health Act which declared the community as the most appropriate setting to support people with mental ill health, although large scale hospital closures were only evident from the 1980s (Gilburt et al. 2014). From this time, community services for people with severe and enduring mental ill health have been largely provided by CMHTs (Rapaport, 2005) with variation in focus over time reflecting shifts in policy and practice developments about the optimal way of providing support (Department of Health [DH], 1999; Royal College of Psychiatry, 2018). Two key CMHT features have persisted. First, a responsibility for the delivery of specialised community-based support for specific groups of people. This encompasses assessment and diagnosis, coordination, including within the framework of the Care Programme Approach (CPA), a form of case management introduced to improve care in the community for people with severe mental ill health (DH, 1990, 1995), and provision of a range of therapies, advice and support regarding health and wider social issues. Second, multidisciplinary membership including medical, health, allied health and social care, and social work staff (Carpenter et al. 2003). Membership has expanded over time with the introduction of new roles following policy reforms (DH, 2007) leading to increases in the employment of clinical psychologists, mental health nurses and psychiatrists and to the introduction of support workers, a wide ranging staff group without professional registration and including peer support workers (Wilberforce et al. 2017). Social workers have been members of CMHTs from the outset and regarded as core members since the 1990s (Onyett, 2003). Evidence suggests that the social work membership of CMHTs has been rising with an average of 3.4 per team in 2007 compared with 1.9 in 1994, although social workers remain a much smaller percentage of these teams compared with mental health nurses (Evans et al. 2012; Onyett & Hepplestone, 1994).

Despite their core membership and unlike their health, allied health and medical colleagues, CMHT social workers have traditionally remained employees of local government (Local authorities (LAs)) social services departments, seconded to NHS trusts (). This organisational separation is a legacy of social policy from the 1970s in the UK which saw the introduction of L.A. Social Service Departments (Seebohm, 1968; Local authority Social Services Act, 1970) which became the main employer of social workers from this time. Greater integration between health and social care services within mental health, as well as in other areas, has been a consistent theme and key policy goal of UK governments ever since (Cameron et al. 2012; Heenan & Birrell, 2017). Integrated systems and practices are believed to improve the quality of care and enhance efficiency (refs). Some evidence exists to support these views, particularly where individuals have multiple, complex and long-term needs (refs).

 Achieving integration has been demonstrated to be challenging (). A recent report described 39 per cent of mental health services in England as fully integrated, a similar number as partially integrated with 22 per cent as not integrated at all. Only 70 per cent of CMHTs included co-located staff from both health and social care sectors (ADASS, 2018). To be successful integration needs to be embedded at a range of levels including both organisational and cultural (Reilly et al. 2007; Pearson and Watson, 2018). The 21st century has seen a series of measures aimed at overcoming organisational barriers to integrated health and social care and support. One response to this separation has been the introduction of ‘Section 75 Agreements’ (NHS Act, 2006) that enabled the pooling of health and social care budgets and integration of management structures and functions to enhance service delivery. More recently the Care Act (2014) in England placed a duty on L.As to promote such integration whilst 2016 saw the introduction of sustainability and transformation partnerships, some of which developed into Integrated Care Systems, place-based partnerships with control over local funding and services (The Kings Fund, 2018). Previous research has indicated that structural merger of health and social care agencies, such as in Northern Ireland and more recently in Scotland, have the capacity to improve the experiences of support, particularly where they have complex needs, but are not sufficient to produce integrated working (Onyett, 2003; Pearson and Watson, 2018; Reilley et al. 2006). Integrated joint boards in Scotland (Public bodies (joint working) Scotland Act, 2014), for example have, to date, been unable to produce integrated culture and practice and that where such practice did emerge it was said to rely on individual ‘boundary spanners’ (Williams, 2002) who were committed to new ways of working (Pearson and Watson, 2018). Early research into integrated care systems in England indicates their potential to bring about positive change although barriers to sustained and effective integration, including the legislative context, a legacy of competitive behaviours, non-aligned regulation, competing demands and funding pressures, remain (The Kings Fund, 2018). Other research has commented on the need for a cultural shift within professional attitudes away from traditional identities and for the need for more boundary spanning roles (Ref?).

. Role clarity has been a concern of social workers and other members of multidisciplinary teams for many years (Culverhouse and Bibby, 2008; Morriss, 2017; Peck and Norman; 1999; Simpson, 2005) and has emerged as a response to calls for greater role flexibility and the introduction of generic roles from policy makers who argue that such an approach puts the service user at the centre of practice rather than the professional (ref?). Evidence of the effectiveness of this approach is mixed (ref?). Social work responses have also been mixed with some research reporting that social workers are more concerned with getting the job done than with professional boundaries (Hannigan and Allen, 2011) and others noting a move towards boundary demarcation in the light of the expectation of generic roles (Brown et al. 2000; Vicary and Bailey, 2018). The argument for the latter revolves around their specialist knowledge and skills and the importance of ensuring that these are recognised and consequently utilised appropriately. Reference to social workers’ involvement in work requiring statutory intervention, where there are high levels of social deprivation and complex family relationships highlight some aspects of these (Evans et al. 2012; Abendstern et al. 2020). Recent research has linked role clarity for mental health social workers with successful integration, putting “effective mental health social work”, achieved through role clarity, professional development and high quality leadership, at the heart of successful integration due to social workers’ ability to coordinate care and engage with communities (Vicary and Bailey, 2018, p78).

**Method**

The paper reports the results of a national survey, conducted as part of a larger mixed-methods research project. The larger study was designed to explore the contribution of the social work role in CMHTs for working age adults and older people (Challiset al. 2014). It examined the responsibilities, roles and tasks of social workers in CMHTs through a national survey (used here) as well as focus groups with team members (Abendstern et al. 2020); the characteristics of people supported by social workers in CMHTs via a caseload audit; and aspects of CMHT social work practice most valued by service users through face-to-face interviews using a Best-Worst Scaling tool (Wilberforce et al. 2019). Finally, service user and staff experiences were captured via postal surveys (Batool et al. 2020 submitted). The research team included three qualified social workers (MA, JH, DC).

***Locating teams***

To execute a national survey of CMHTs, a complete list of teams had first to be compiled. This involved developing a definition of a CMHT for the study, locating and confirming team names, and contacting the teams themselves. The definition of a CMHT used for this study is a team comprising three or more professions, offering medium to long-term support to either adults of working age or all adults, with a wide range of severe and enduring mental health problems.

A list of mental health trusts (n=54) was obtained from the NHS website: <https://www.nhs.uk/servicedirectories/pages/nhstrustlisting.aspx>. Individual trust websites were then searched and a list of CMHTs operating within them extracted. Research and Development (R&D) teams for each trust were contacted to request confirmation or amendment of these lists in conjunction with our inclusion criteria. In some areas, Clinical Research Networks supporting several trusts were approached. Efforts to contact two trusts failed and two others withdrew due to restructuring or understaffing, reducing our sample to 50. A final list of 421 CMHTs were identified.

***Data collection***

The questionnaire was derived from a previous study (Wilberforce et al. 2011) and elicited information about team structures and processes, emphasising social work membership and role. It consisted largely of closed questions with defined response options. One question, for example, asked the respondent to describe the sufficiency (amount) of the social work contribution to their team as either very poor, poor, adequate, good, or very good. A small number of questions requested free text responses, including a request for further information about the nature of any major change that teams had undergone in the previous 12 months and a box for general comments at the end of the questionnaire.

Paper questionnaires were initially sent out to all teams with information sheets about the study and a link to an online completion option. Teams were contacted between March and September 2018. An initial response rate of 18 per cent was increased to 44 per cent through reminder emails.

***Data analysis***

Data were analysed using SPSS (Version 23) statistical software. A ten per cent validity check was undertaken of all data entry with a one per cent error found. Missing data on key variables (Bannon, 2015), ranging from ten to fifteen per cent, was randomly distributed. Responses to free text questions were post-coded using coding frames prepared from responses, creating new categorical variables. This included, for example, ‘other’ categories relating to types of staff not listed within the questionnaire. Descriptive statistics (frequency distributions, means and standard deviations) were used to explore these data.

Responses to the two open-ended questions were systematically categorised using content analysis (Bowling, 2002). Although the context of what is said can be as important as the number of times a word or phrase is used, the nature of the current data (a large quantity of short statements) indicated that the number of times particular issues were raised was also essential to report as one measure of importance given to them. Text was categorised into discrete ‘content areas’ and then grouped into higher level ‘dimensions’. In a small number of cases, where individual comments related to more than one content area, they were split, to ensure that all issues were included. This task was iterative and undertaken by two researchers working together (MA and RP).

**Results**

A total of 188 team managers returned a questionnaire (44% response rate), spanning the 50 participating Trusts and covering all nine English regions. The spread of responses ranged from 80 per cent in three regions to under 30 per cent in three others. Most (59%) completed paper copies. Quantitative results are reported below in relation to team context, structure and management; membership, and role. The free text findings follow, providing evidence of change experienced by the teams over the previous year and managers’ views regarding this.

***Team context, structure and management***

Teams most frequently served mixed urban and rural communities (53%) with over a third describing their area as urban only (37%). Almost 80 per cent were described as regularly working with one Clinical Commissioning Group (78%) and one LA (79%): bodies with separate or integrated responsibility for commissioning health and/or social care services at a local level. The salary source for core team members came from a mix of NHS and LA funding in the majority of teams (58%) with the remainder solely funded by the NHS. Most CMHTs in the survey responses had access to a range of specialist services within their locality including a home treatment team (96%) a substance misuse team (89%) and a crisis intervention team (86%). Just over a third could access an assertive outreach team (36%). Most CMHTs operated a single point of access (92%) and received a large proportion of their referrals form GPs (78%), followed by mental health wards (59%) and psychological services (31%). Eighty-three per cent of respondents stated that all or most service users had a single care coordinator with 71 per cent reporting that this person coordinated support provided by both team members and services outside the team.

Almost two-thirds of teams (64%) had a single manager with just 22 per cent reporting two and 14 per cent more than two. One-fifth (n=12) of those respondents with more than one manager also reported two different professional backgrounds. The majority of managers were nurses by profession and most nurse members were managed within the team. This was less often the case for social workers and other staff (Table 1).

*<Table 1 about here>*

***Team size and membership***

All teams included a team manager, nurses and one or more consultant psychiatrist. Just over 80 per cent of teams included social workers with 87 per cent reporting occupational therapist (OT) membership. As shown in Table 2, mean team size was 25.6. Almost all staff, regardless of profession, were classed as core team members. The largest single group were nurses (37%, mean = 10.4) with social workers (14%, mean = 4) comprising the second largest group. Support workers, albeit incorporating a range of job titles, had only a slightly lower mean than social workers, whilst psychologists had a higher mean membership than OTs.

*<Table 2 about here>*

Over half of respondents described the sufficiency or amount of the social work contribution to their team as being either ‘good’ or ‘very good’. Just over one-fifth (22%) described it as ‘poor’ or ‘very poor’ with the same amount describing it as ‘adequate’. Just over half (55%) also reported gaining one or more social workers over the previous 12 months with just under half (47%) reporting social work losses. Those team managers’ reporting poor or very poor sufficiency of the social work contribution to their team also tended to report social work losses in the last 12 months (and to comment negatively on this issue when describing change). Sufficiency ratings were also positively related to the number of social workers reported to be core team members with those reporting good or very good sufficiency having a higher number of social workers in their teams than those reporting sufficiency as adequate, poor or very poor.

***Team roles and tasks***

Analysis of data on team roles and tasks (Table 3) revealed a high level of generic practice across professions with nurses, OTs and social workers undertaking a range of roles in the majority of teams. These included acting as care coordinator or enhanced CPA coordinator, and undertaking ‘duty’ work. These professional groups also undertook tasks such as conducting initial assessments, in over 60 per cent of teams. The percentage of nurses undertaking these roles and tasks was substantially higher (between 88% and 97%) than for social workers (or any other team member) who were reported to undertake the same roles and tasks by fewer than 70 per cent of respondents.

Roles and tasks traditionally associated with particular professions were still largely undertaken by them. For example, in 92 per cent of teams psychiatrists prescribed or administered medication compared to nurses who did this in 64 per cent, and social workers and OTs in four and two per cent of teams respectively. Social workers were the largest group to have the task of authorising services funded by local authorities and were Approved Mental Health Professionals (AMHPs), additionally qualified professionals undertaking a range of statutory roles, in 59 per cent of teams compared with nurses, psychiatrists and OTs in 15, ten, and four per cent of teams respectively. Finally, nurses monitored medication in almost all teams compared with social workers who undertook this task in just over two-fifths and OTs in just over one-third of teams. Social workers were found to conduct psychosocial interventions with individuals in fewer teams than psychologists, nurses and OTs and to be routinely involved in the supervision of Compulsory Treatment Orders less often than nurses although more frequently than other professional groups. Comparing nurses and social workers overall, nurses were reported to be more frequently involved in almost all the roles and tasks listed, than were social workers, the exceptions undertaking the AMHP role and the task of authorising LA funded services.

*<Table 3 about here>*

***Experience of change***

Over half the sample (59%) reported undergoing major changes in the last 12 months with fifty-four per cent (n=102)of respondents providing comments describing these changes. Nineteen per cent of respondents (n=36) also left comments at the end of the questionnaire. The profession of the team managers supplying comments aligned with the overall sample reported above. These data are considered together below. Comments clustered around five broad dimensions: general restructuring, integration between health and social care, general staff presence/loss, social work presence/loss, and role change, demonstrating contiguity with the examples provided in the questionnaire, as previously noted. Each contained more detailed ‘content areas’, summarised in Table 4.

Approximately half the comments to the question about change in the last 12 months were general statements relating to a change in team focus and/or management structures. The remainder related more specifically to integration with the separation of health and social care and particularly the extent of the social work contribution, being the most numerous. Most comments at the end of the questionnaire also focused on issues of integration and concerns about the loss of social workers to their teams. A small number referenced how they related to a range of specialist services in their locality with this information linked to the previous question in the survey. The text below focuses on topics relating to the position of the social worker within the CMHT (in bold text in Table 4) which accounted for 46 per cent of comments overall.

*<Table 4 about here>*

***The changing position of the social worker in the CMHT***

Changes relating to the position of the social worker in the CMHT were described in terms of causes, substance, and impact. The former consisted of the ending of Section 75 agreements and additional local authority duties such as statutory assessments, delegated to social workers, following the introduction of the Care Act 2014. Substance included the removal of social workers from CMHTs in some trusts and a curtailment to the work they did within the teams, in particular a move away from generic roles and tasks (e.g. care coordination or CPA) in others. Impact was described in terms of a reduction of integrated approaches resulting in more limited communication and collaboration; loss of experience and knowledge; increased workloads and types of tasks and roles taken on by other CMHT staff; and the larger negative impact on staff and service user experience and service delivery. Commentary noted, for example, the “detrimental effect on the care we provide across localities” due to the loss of social workers (17.1) and to the “unnecessarily fractured care provision” (12.2) it resulted in. Another commented that

Since social workers were removed from joint working the care/support to service users I feel has been negatively impacted. I feel collaborative approach benefited both service users and the decision making and support for all professionals disciplines (17.5)

Their loss to the team meant a loss of easy and informal access to their *“*specialist skills and knowledge within mental health” (37.2) and to a collaborative approach that benefited all.

In the coming weeks the role of the social workers will change within the CMHT … we will no longer offer a holistic care coordination approach but instead a fragmented health/social work divided approach with the social work staff offering ‘Care Act’ work with mental health populations only … This is due to a focus on finances over client need (13.2)

Others described the positive impact of the integrated practices that they had lost, when social workers were removed, which had produced:

Supportive working relationships with social work colleagues with enhanced and more informed level of care able to be offered from shared resources being within team (21.2)

Social work team members were described as having “benefited service users and provided support for all professionals’ disciplines” and that since they “were removed … the care/support to service users I feel has been negatively impacted” (17.3). Another respondent commented on the range of interventions undertaken by social workers, stating that these were “often the most effective intervention for service users who are unable to tolerate therapy or group work” (19.4). In contrast to these concerns about the negative impact of the loss of social work input into CMHT practice, were others who suggested that the social work role itself had been diluted as a result of integration with a focus on “social workers facilitate[ing] care packages”, linking this with poor social work recruitment and retention (4.1).

Overall, managers’ remarks indicated that social workers were valued by them both as an extra pair of hands when undertaking generic work (e.g. “additional social workers can offer a lot of generic working … now required (27.4)) and for their specialist contribution, including “skilled risk assessments, assessments of mental capacity [and] focussed social work interventions” (19.4) which enabled CMHTs to offer comprehensive and holistic support. Their loss to the team meant a loss of easy and informal access to their *“*specialist skills and knowledge within mental health” (37.2) and to a collaborative approach that benefited all.

In the coming weeks the role of the social workers will change within the CMHT … we will no longer offer a holistic care coordination approach but instead a fragmented health/social work divided approach with the social work staff offering ‘Care Act’ work with mental health populations only … This is due to a focus on finances over client need (13.2)

I believe that social care and CMHT need to be fully integrated … We need to work together to promote seamless care for our patients (4.3)

**Discussion**

These findings provide up to date evidence regarding the position of the social worker within CMHTs, particularly in relation to their numbers and unique contribution, in 2018. The implications of each is considered in turn below, although it is acknowledged that in practice these two dimensions cannot be neatly separated, the number of a particular staff group within teams being a factor likely to influence their own and others’ functions.

*Team membership*

Findings from this study are in line with a trend towards larger teams over the last 25 years (Onyett et al. 1994, Boardman & Parsonage, 2005; Huxley et al. 2011). Previous surveys of CMHTs for working age adults and for older people both reported smaller mean team size than the current study (Huxley et al. 2011; Wilberforce et al. 2013). The relationship between overall team size and social work membership is not, however, the same thing. A comparison of the current findings on social work team membership with those from previous studies, suggests a slight upward shift in mean numbers per team alongside social workers representing a smaller percentage of the whole: 14 per cent compared with 19 per cent in 2007 (Huxley et al. 2011). The same study reported that nurses made up 33 per cent of team membership in 2007, compared with 36 per cent in the current study. These comparisons suggest that CMHTs have grown due to increasing numbers of non-social work staff, particularly mental health nurses. Other evidence supports this. A recent social care workforce study (NHS Digital, 2019) reported that social workers and OTs, part of the same “professional job group”, employed by LA social services departments, from where social workers in CMHTs are often seconded, had increased in size by only 700 between 2011 and 2018. In contrast, between 2014 and 2019 the Care Quality Commission (2019) reported an increase of 15 per cent in mental health nursing numbers from a larger baseline. This discrepancy between social worker and nurse numbers in CMHTs found in earlier studies has continued despite guidance issued at the start of the century that indicated the need for a ratio of three social workers to every four nurses (DH, 2001). Looking to the future, this gap seems likely to continue with NHS England (2019) recently committing to recruit an additional 1,540 nurses and just 360 social workers to adult community mental health services over the next five years.

Compared with earlier research findings, the mean number of psychologists per team was higher in this study (e.g. Huxley et al. 2011). The impact of the growth of other staff groups, including psychologists, is unclear. Whilst psychologists may share certain values and approaches there are also important differences between them and social workers. These include the social worker’s statutory knowledge and function and their more informal relational approach (Folgheraiter, 2007) compared with the formal counselling provided by psychologists, something that, as noted by one respondent in open text, was more suitable for some service users with chaotic lives.

Overall, the quantitative data demonstrated similar rates of flux in relation to teams gaining and losing social workers, in line with NHS Digital data (2019). However, these figures started from a position of insufficient social worker contribution in many teams. Free text comments also indicated that shortages of social workers created difficulties for the team, resulting in the provision of more limited functions by them jeopardising their ability to support people holistically. Finally, the turnover of staff, as noted in other studies, may have resulted in a loss of expertise as long-serving staff move on and are replaced by newly qualified personnel who are cheaper to employ (Hanley et al. 2017).

*Social work contribution to CMHTs*

How social workers and others CMHT members are utilised: as either generic practitioners carrying out roles and tasks that are also undertaken by others, or as specialists focussing on areas that require their particular expertise, has long been debated (e.g. Peck & Norman, 1999; Brown et al. 2000; Hannigan & Allen, 2011). Central to these debates are issues of effective multidisciplinary team working and how to optimise professional specialisms within integrated practice. Some research suggests that social workers have faced particular challenges in relation to these issues, being minority members of health dominated CMHTs (Morriss, 2017), whilst other research indicates similar issues for OTs (Reeves & Mann, 2004) and psychologists (Anciano & Kirkpatrick, 1990; Holmes, 2001). Similarly, some reports have noted that where social workers were used generically, their skills were wasted, disadvantaging service users (e.g. Lilo & Vose, 2016) whilst others suggest that social workers are more concerned to do what needs to be done rather than stick to their professional role (Hannigan & Allen, 2011).

Qualitative evidence of the social work role within CMHTs for older people (Abendstern et al. 2014; Challis et al. 2014) showed social workers combining generic and specialist functions. These included undertaking initial assessments and care coordination, arranging care packages, conducting financial assessments, and providing expert knowledge of mental health legislation and safeguarding issues. These findings are similar to those within the current study suggesting continuity of role content over time and between settings.

In relation to functions traditionally associated with social workers, it was found that some of these were still largely undertaken by them. This included undertaking the AMHP role, one of five areas of practice areas recently noted by the College of Social Work to be a core function of the mental health social worker (Allen, 2014). However, the percentage of social workers reported to be doing this (59%) was much smaller than that reported by ADASS (2018) who found that only five per cent of the workforce came from professions other than social work despite the role having been open to other professions since 2007 (Mental Health Act). Given the very small proportion of teams indicating that this role was undertaken by other team members in the current sample, it may signify that the ‘shortfall’ is being undertaken by social workers outside CMHTs. This is supported by ADASS (2018) data that noted a range of models of AMHP practice with only 36 per cent operating an approach where most AMHPs are based in CMHTs.

Two additional findings from the current study are noteworthy here. Firstly, that although social workers undertook a range of generic roles and tasks they did so proportionally less often than some other staff. Secondly, that some tasks not typically associated with social workers, such as monitoring medication, were being undertaken by them in a surprisingly high proportion of teams. This finding requires further investigation to understand what this consists of in practice, why it is occurring, and whether social workers, their managers and employers believe this is an appropriate part of multidisciplinary team practice. As noted above, where teams are short-staffed it is more likely that generic practices will increase, as colleagues undertake what needs to be done (Hannigan & Allen, 2011).

Social workers bring a specific set of skills and values to mental health practice that often result in a different perspective on treatment and support than their health and medical colleagues. This has been reported elsewhere, for example, in relation to judgements about case complexity (Cestari et al. 2006), operating least restrictive approaches (Pinfold et al. 2002; Steinert et al. 2005), and placing the person at the heart of practice (Penhale & Young, 2015). Findings from other elements of this study also support this with social workers being described as leaders of the social model, required to ensure that CMHT support was holistic, person-centred, and promoted long-term recovery (Abendstern et al. 2020). The free text data within the current study suggested that where social workers had been removed or had left teams, it had had a negative impact on other staff and service users alike, resulting in a less coordinated and holistic service. Byrne and Onyett (2010) urge team members to work together for the wellbeing of the service user who requires a wide variety of approaches rather than a one-size-fits-all model. They argue instead for integrating models that place the service user at the centre and focus on achieving long-term recovery. Social workers have a key role to play in CMHTs in leading and supporting the whole team in such a joint a mission. These findings chime with the recent English policy and practice context, particularly considering an independent review of the Mental Health Act (DH&SC, 2018) which advocated that mental health social workers play a growing leadership role in psychiatric care.

**Strengths / limitations**

First, the study achieved a respectable response rate (Bowling, 2002) although lower than in previous studies of a similar nature undertaken by this research group. This is in line with other research findings (Cook et al. 2009) and perhaps reflects the pressure that managers are under in the present climate of austerity and service restructuring alongside increasing demands from research itself. Second, it is possible that the language used to describe roles and tasks within the questionnaire was inadvertently linguistically biased towards health care practice resulting in an under-representation of social workers’ roles. The free text data adds weight to this view with comments emphasising roles that are not reflected in the tasks list, suggesting that the results should be treated with caution. On the other hand, these data also point to certain roles, such as care coordination, being undertaken less frequently by social workers, a finding in line with the quantitative evidence.

**Conclusion**

The study provides evidence to support statements from within and beyond the profession (e.g. Allen, 2014; DH, ADASS & Principal Social Work Network, 2017) that social work is integral to the provision of an integrated mental health service. They present a strong argument for social workers remaining or returning to being core members of CMHTs. If a decision is made to remove social workers from a CMHT, important aspects of the delivery of a comprehensive mental health service are likely to be undermined.

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