**‘Maybe a maverick, maybe a parent, but definitely *not* an honorary nurse’: Social worker perspectives on the role and nature of social work in mental health care**

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*Abstract*

In many places in the UK, social work is integral to mental health service delivery. Significant role erosion, however, has left the profession unclear about where it fits within modern mental health services. The 2016 *Social Work for Better Mental Health* initiative outlines five key mental health roles and has been adopted into national policy in England to combat this uncertainty, but the influence of this has not been explored.

This study aimed to develop an understanding of how mental health social workers perceive and explain their role. Semi-structured interviews were undertaken with seven social workers based within one English NHS mental health trust covering a large geographical area and their responses analysed using Spencer, Ritchie and O’Connor’s Framework thematic model.

Findings indicated that social workers only superficially engaged with the aspirational policy roles, instead presenting their own framework for what makes mental health social work distinctive. This was constructed around the context and intentions of practice, rather than around proscribed tasks and responsibilities. This study has significance for individual social workers and for organisations providing and planning mental health services in the UK and beyond, given the influence that practitioner perceptions can have on how they undertake their roles.

*Keywords*

mental health, professional identity, role, social work

**Introduction**

Social work in the UK is long established in mental health services (Timms, 1964; Burnham, 2012), with mental health social workers (MHSWs) holding distinct roles focused on the social and relational components of an individual’s experience (Long, 2011) and carrying specific legislative responsibilities, such as arranging assessments under the Mental Health Act 1983. However, in recent years, that distinctiveness has been sharply eroded in England with the introduction of more generic approaches relevant to all mental health professionals. The Care Programme Approach aims to standardise and rationalise service provision (Wilson et al., 2011), reduce duplication (Bogg, 2008) and minimise oversight and service shortfalls (Gould, 2010). Ostensibly, this co-ordinated approach should ensure the most appropriate professionals undertake identified roles. However, policy moves toward service integration, leading with *New Ways of Working in Mental Health* (NIMHE, 2007)*,* have emphasised generic practitioners who can operate across professional boundaries (Department of Health, 2008).

Understanding the contribution of MHSWs to multidisciplinary care is critical in ensuring effective,consistent practice. However, role definitions range widely, with MHSWs alternately defined by their tasks (Morgan, 2004; Dwyer, 2005) and legislative duties (McLaughlin, 2010; Vicary et al, 2019); by their specialist knowledgeof social care resources (Abendstern et al., 2016); by their independent positioning outside of the health system and their autonomic aspirations (Author’s own, 2010), and by their cultural identity and values base (Peck and Norman, 1999; Social Care Strategic Network for Mental Health, 2010).

Exploring this range of perspectives in detail is beyond the scope of this study, however the potential for conflict and confusion is high. Task and knowledge-based definitions delineate quantifiable contributions for MHSWs to the multi-disciplinary setting but disregard the experiential practice knowledge needed to apply such technical approaches effectively (Author’s own, 2013). Similarly, viewing MHSWs as individual actors socially placed across and between services (Evans et al, 2012), while in keeping with the ideal of a values-based approach, presumes an autonomy that is potentially undermined by local authority and National Health Service (NHS) priorities (Murphy et al, 2013; Lilo, 2016).

Legislative and policy frameworks offer an alternative perspective for conceptualising MHSWs. However, mental health services in the UK are led by health priorities rather than social care and Author’s own (2010) argue that the erosion of MHSW is part of a wider “bureau-medicalisation” within the NHSIn this conceptualisation, professional roles become bureaucratised and proceduralised within a dominant medical hierarchy. Policies are tied to medicine (Beresford, 2002) and underpinned by notions of diagnosis and predictability (Davidson, Brophy and Campbell, 2016). This emphasis, with an associated shift towards proceduralised genericism, potentially ignores social work’s unique social history and core principles of empowerment and disregards calls from the service user movement for more socially-minded services (Beresford, 2019) and, arguably, limits MHSWs distinctive contribution (Author’s own, 2010).

This generic shift has been replicated in legislation and impacts on service structure. The Mental Health Act 2007 replaced the Approved Social Worker with the Approved Mental Health Professional (AMHP), opening the role to other professionals, potentially minimising the social emphasis and defining roles irrespective of professional status (Mackay, 2012). Compounding this, poor workforce planning is endemic in health and social care (Evans et al., 2012) and, with minimal policy guidance, team structures are based on historical precedence (Duggan et al., 2002) or practitioner availability in the local area (Beinecke and Huxley, 2009), rather than assessed need or professional input. Although MHSWs are present, the rationale for their inclusion is unclear.

Role clarity increases opportunities for collaboration (Sheppard, 1992) and genuinely multidisciplinary perspectives have an “enhanced multiplicative effect” (Bailey and Liyanage, 2012, p.1122); however, policy-driven integration and role erosion prompt defensive “jurisdictional claims” (Hannigan and Allen, 2011, p.6). The College of Social Work presented such a claim for MHSWs, comprising; statutory duties, recovery, working with complexity, working with communities and leading the AMHP workforce (Allen, 2014).

Critically, these criteria have been adopted into *Social Work for Better Mental Health: A Strategic Statement* (Allen et al, 2016) and offer the only operational definition for MHSWs in England, using a framework comprised of aspirational aims and statutory obligations. However, the *Strategic Statement’s* impact has been unclear, while the focus on statutory duties arguably supports concerns, mirrored elsewhere, that MHSWs are being underused as generic service brokers and care co-ordinators (All-Party Parliamentary Group on Social Work, 2016).

Largely absent from the discussion has been MHSWs themselves. Studies have focused on the perspective of associated professionals (McRae et al 2004; 2005; Abenstern et al, 2016), on Community Psychiatric Nurses (see, for example, Crawford, Brown and Majomi, 2008; Hannigan and Allen, 2013) or on comparing professions within the field (see, for example, Sheppard, 1992; Peck and Norman, 1999; Bressington, Wells and Graham, 2011; Beinecke and Huxley, 2009). Social work studies have concentrated on the AMHP workforce (see, for example, Gregor, 2010; O’Hare et al., 2013; Buckland, 2016; Morriss, 2016) or on a comparison with nurse AMHPs (Bressington et al., 2011). However, the AMHP role is unique in being both explicitly legislatively defined (Gregor, 2010) and distinguished by its practitioners as fundamentally different to general MHSWx (Buckland, 2016).

Three studies are worth noting, however. Peck and Norman’s (1999) comparative study of roles found that MHSWs offered a distinctive perspective which was reflective, values driven and derived from the context of practice. They adopted a stance which prioritised *where* and *why* they practiced, although the ambiguity of this raised challenge from other professionals. While this view represents a single, consensus perspective from one group of MHSWs two decades ago, it provides some insight into the potentially esoteric self-identification of MHSWs.

Bailey and Liyanage’s (2012) participant observation with MHSWs in the context of the generic care co-ordinator role found conflict between the generic approach and the benefits of drawing on diverse professional viewpoints. However, the emphasis was on role perspectives in the context of integration and care co-ordination, rather than exploring themes common to MHSW understandings of their role across organisational boundaries.

Finally, Woodbridge-Dodd’s (2017) discourse analysis into how MHSWs construct their professional selves identified six key subject positions; care co-ordinator, advocate, therapist, knower of local authority duties, professional and AMHP. However, while this represented self-definition, the identified roles were more reflective of the positions available to MHSWs within mental health discourses. These typologies therefore represent how MHSWs position themselves in relation to the tasks they are undertaking at any given time, rather than offering an overarching definition of professional self.

While the empirical work undertaken thus far contributes to the overall understanding of MHSWs, this is far from fully developed. Competing academic debate around practical and abstracted definitions of MHSWs, complemented by a framework for genericism and a lack of clarity from within the profession, suggest that the MHSW role remains unclearly defined. In the context of resource-limited services, with local authorities withdrawing from integrated services to prioritise their own statutory obligations (Lilo, 2016) and acknowledging social work activity is influenced by role expectation (Moriarty et al., 2015) there is a need for clarification. However, this cannot exist solely at a policy level but needs to be both reflected in and reflective of how MHSWs understand and undertake their role.

The study therefore intended to answer the following question: How do MHSWs perceive and understand their role in mental health services?

**Methodology**

A multi-setting comparative qualitative approach was adopted, using in-depth interviews with MHSWs. The strength of qualitative interviewing lies in depth (Hakim, 2000), enabling engagement with subjective meanings (O'Connell Davidson and Layder, 1994). A relatively small sample also enabled sufficient analytic depth to explore complex social ideas around role (Orford, 1996).

Seven participants were drawn from multiple sites across one NHS mental health trust, incorporating four local authorities with both integrated and non-integrated working arrangements, to mitigate against the potential bias of a single site focus. Participants were recruited on a volunteer basis, with all eligible staff informed about the study through NHS gatekeepers. Participants were required to be qualified social workers practicing within mental health. In order to elicit views from different perspectives (Peters, 2010), no further inclusion or exclusion criteria were applied. Eight participants initially volunteered, with seven progressing to interview.

Semi-structured interviews were undertaken during June and July 2017 and lasted 50-60 minutes, to allow time for essential rapport-building (O'Connell Davidson and Layder, 1994) without becoming burdensome to busy MHSWs (Arksey and Knight, 1999). To maximise focus on participants and enable fluid discussion, while also retaining the integrity of participants verbatim accounts, interviews were recorded with participants’ consent (Noaks and Wincup, 2004). Field notes were taken, and key impressions and thoughts were recorded in situ to ensure these were not lost to the subsequent analytic process (Kalof, Dan and Dietz, 2008).

A topic guide based upon the *Strategic Statement* was used to ensure relevance. Key questions were contextualised to individual participants to root the discussion within their experience. Follow up questions placed individual experiences into the broader context, allowing for smooth transition between each area (Rubin and Rubin, 1995). The range of topics was kept to a minimum to allow for depth without becoming overwhelming. Participants were made aware of the researcher’s social work background, both to prove worth (Arksey and Knight, 1999) and to establish shared understanding.

Data analysis was undertaken using the Framework approach (Ritchie, Spencer and O'Connor, 2003), using a matrix structure both to manage overwhelming amounts of data (Good and Watts, 1996) and to preserve the link between raw data and interpretation. Transcriptions were pseudonymised to protect confidentiality whilst also maintaining this connection. Brief intervals were allowed between interviews, transcription and analysis. While not as immersive as would have been ideal, these delays acknowledged the interpretive nature of transcription and allowed themes to emerge as part of a cogitative process (Gillham, 2005). Data was initially coded using the *Strategic Statement* as an a priori framework, and then recoded iteratively to ensure completeness. Coded data was also cross-referenced to raw data within the matrix to ensure that the context of key points could be re-examined, and that identified themes represented the whole sample. Coding was initially analysed in the context of five pre-existing themes; statutory duties, recovery, working with complexity, working with communities and leading the AMHP workforce. Iterative analysis identified three additional themes; working across boundaries; providing a holistic perspective; prioritising client needs.

Ethical approval was granted by the University of York, with regulatory oversight from the Health Research Authority.

**Results**

*Sample characteristics*

Participants were all female, perhaps reflecting the uneven gender distribution within the profession nationally (Sheldon and Macdonald, 2009), and had been qualified between 22 months and 36 years. Participants had worked in mental health for between 7 months and 37 years, with three participants having spent some of this time in unqualified roles.

Four participants were employed by the NHS and three by local authorities. None of the participants were currently AMHPs, although two had previously worked as AMHPs within local authorities.

Four participants held generic roles, with the remaining three in specialist roles. For the purposes of this study, those in ‘generic roles’ undertook general mental health duties, while ‘specialist roles’ worked with specific aspects of mental health care, such as housing. Three participants had managerial experience, and three had experience in other social work disciplines.

***Perceptions of MHSW within the Strategic Statement framework***

*Statutory Duties and Personalisation*

Statutory duties were a source of some conflict. Social care legislation, and MHSW familiarity with this, was seen as both specialist knowledge and an integral element of the work MHSWs were doing with clients. However, *where* the responsibility for these duties lay was a universal theme. Participants distinguished between social work duties and local authority duties and saw these as distinct from one another, albeit potentially interrelated depending on where the MHSW was employed; as one local authority participant commented “*it’s a duty placed on the local authority, so it’s a social work role”* (Generic MHSW).

There was a clear delineation between participants employed directly by the NHS and those seconded from the local authority. For the former, mental health and mental capacity legislation were seen as more pertinent that wider social care legislation, although for those in specialist roles, this was supplemented by legislation with context-specific relevance. In relation to general social care legislation, particularly the Care Act (2014), NHS-employed participants saw their role as signposting to and co-working with local authority colleagues, as illustrated below:

“*you might be contributing to working within statutory legislation but you are not leading on it”* (Specialist MHSW)

*“we’re not allowed to do them, because it’s a statutory duty of the local authority”* (Specialist MHSW).

By contrast, the local authority-employed participants saw the local authority’s statutory duties as central to their role. These participants were more likely to describe statutory duties as “*statutory social work stuff”* (Generic MHSW) and, where based in health settings, felt more susceptible to the conflicting demands of working across two services. Where the needs of the NHS restricted their ability to undertake local authority statutory work, they found this concerning.

*Recovery and Social Inclusion*

Recovery and social inclusion did not appear to be part of the ‘language’ of practice, with that ‘type’ of intervention seen as the domain of other team members, such as support workers. There was a sense of this work being devalued and seen as lower status than clinical interventions.

While participants were positive about recovery and social inclusion in principle, they struggled to articulate these as practice concepts. Interpretations were frequently conditional, carrying caveats in relation to risk management and social control, placing MHSW engagement with recovery in the context of wider organisational approaches. Indeed, the only participant who mentioned recovery independently expressed concern that MHSWs had become divorced from this principle.

 *“We know about recovery, that term that was hijacked by the NHS, and until the NHS said it, no-one ever talked about recovery, but we don’t embrace it and that’s our fault”*

(Specialist MHSW)

*Working with complexity, ambiguity and risk*

Working with complexity and risk was identified as a core element of mental health work, rather than being specific to MHSWs. Risk assessment and management was described as integral to mental health teams, although most participants spoke about having technical expertise around safeguarding. Similarly, family complexity was seen by most participants as tied to specific *organisational* rather than professional roles, linked to job description rather than professional background. One participant did feel that *“that lies in the heart of the social worker”* (Specialist MHSW); however, for most participants, there was no professional distinction around who was best placed to undertake complex family work, and those who worked with complex situations linked this to their job specialism rather than social work expertise, as illustrated by this comment:

 *“The ones I get are complex and difficult and not the straightforward ones - the care co-ordinators, the* ***social workers****, they deal with them”* [emphasis added]

(Specialist MHSW)

*Working with local communities*

Community work did not feature prominently in participant’s accounts, and was seen as reactive rather than preventative, with “*the wheeling and dealing of being a social worker”* (Specialist MHSW) to access resources seen as essential. However, this was exclusively described in terms of statutory and third sector services rather than a broader engagement with the community at large.

Participants identified a range of barriers to working with communities. Teams lacked established links with community resources, which were also seen as scarce. Some participants felt the barriers were more ideological than practical, with low organisation-led impetus to establish such relationships; as one participant commented “*we’d like some other connections, but they don’t seem to pick up momentum really”* (Generic MHSW). For most participants stigma and local authority positioning within their communities were seen as limiting factors.

 *“I do think we get tied up in ourselves as a local authority really…whenever we expect the community to join us, in terms of safeguarding, I think we invite them in at that point and then we push them away again”*

(Generic MHSW)

*Leading the AMHP workforce*

None of the participants were practicing AMHP’s and opinions on the AMHP contribution were divided. Positive accounts emphasised the person-centred, rights-based empathic approach, while critical narratives brought to light the more procedural, process-based aspects of the role, placing them *“on the health side and risk side”* (Specialist MHSW).

The separation of the AMHP workforce from mental health services was a source of frustration and anger for most participants experienced in generic roles, who saw such division as damaging and ineffective. One participant spoke particularly emotively about the detrimental impact of this:

 *“We had Approved Social Workers then in the mental health teams and I was around when it was all dismantled and I was part of the angst at that time, which was dreadful. One of the worst times, I think, in my career was watching that happen…and we’ve never recovered, and I don’t think social services has ever recovered in terms of their ability to manage people with mental health problems”*

(Generic MHSW)

Role as inextricably linked to location featured heavily in the discussion around AMHPs. For most participants, the AMHP role was distinct and, due to its placement within local authorities, unattainable. However, for those participants with AMHP experience, that role continued to strongly influence their sense of identity: “*My biggest loss of identity was not being an AMHP and I still feel it now”* (Specialist MHSW).

**Perceptions of MHSW beyond the policy framework**

*Working across boundaries*

Central to participants’ understanding of their role was not *what* tasks they undertook but *where* they operated. Bridging the divide between health and social care was a key concept, even for those participantswithin the NHS who had no specific obligations to the local authority. Participants with a history of working with local authorities spoke about using that experience to bridge divides and offer different interpretations to their medical colleagues.

Participants also viewed this ‘bridging’ role as proactive. Building maintaining their understanding of health and social care systems and how they interacted was not only a priority, but also something they felt responsible for:

 *“I’ve never been asked by managers ‘oh, can you set up a meeting with social care’, it’s always been me that’s thought ‘oh, well, we need to have that’”*

(Generic MHSW)

For one participant, there was the uncertainty in this. With the potential for MHSWs to be working across boundaries from both sides of the partnership, this raised concerns that *“maybe the boundaries are going to get blurred”* (Generic MHSW).

*Providing a holistic perspective*

Seeing the bigger picture and acting accordingly was both central anddistinctive as a source of potential conflict with other practitioners, who participants saw as having a narrower focus on medication and therapies.

 *“I know nursing staff do say they come in and look at them* [the wider needs]*, they don’t, they focus on treatment. They’re getting better at it but trying to focus on the needs and looking at the whole situation and the client within their family is - I think that’s a social work approach”*

(Specialist MHSW)

Again, there was a real sense of *where* MHSWs operated being critical, including in taking a socially-based and contextual perspective of the client. Such situational positioning meant that participants saw themselves as responsive. Working with people in context required adaptability to respond to individual circumstances. Participants spoke of working with the person and the situation, rather than despite them:

 *“A patient having money is sometimes more important than them having a therapy session, because you can’t sit in a therapy session with somebody who’s irritated that the staff haven’t had time to go and get their money”*

(Specialist MHSW)

Working holistically and responsively necessitated innovative approaches and participants spoke about stepping outside of perceived job descriptions in order to achieve their role aspirations. This included work with clients which fell outside their remit and undertaking tasks which were not within their service specification, usually practical tasks such as attending appointments. This was generally guided by the view that this would reduce later need, with participants prioritising a preventative focus.

*Prioritising client needs*

Looking *“outside of mental health specific problems”* (Generic MHSW) coalesced concepts of empowerment, social justice and person-centred practice into a theme of prioritising the client. Although not couched in the language of recovery, there was a real sense of working *with* clients, acknowledging the client’s experiential expertise and that *“they always have the answers”* (Generic MHSW). Central to this was a need to adapt strategies to match the capabilities and needs of individuals flexibly:

 *“I’ll probably do a bit more in the background to get him to the point where he’s following processes so he can get somewhere…To me, that’s what social work’s about. A bit like parenting - you’re in there a lot and then you step back”*

(Specialist MHSW)

Processes within teams were seen as secondary to client needs and elicited mixed responses; standardised tools were seen to offer frameworks for relationship-building, but rigid procedures offered only barriers to engagement. For some participants, their role lay in challenging or circumventing these barriers in order to *“make it easier for people* [clients]*, rather than harder”* (Generic MHSW).

Universally, participants were not prepared to work in ways they saw as detrimental. They were critical of slavish adherence to routine practice and service shortages were not seen as a sufficient rationale for compromise in their practice; as one participant emphatically stated *“I don’t bob in and bob out…I normally will spend an hour with each client and I will do something meaningful and purposeful in that time*” (Generic MHSW).

Prioritising the client did not relate to specific measured outcomes, therefore but instead to achieving improvements for the client, both concrete and intangible, through flexible and adaptive practice.

**Discussion**

Throughout their history MHSWs have moved from being specialists to genericists to integrated practitioners, leading to an associated difficulty in articulating their role (Bogg, 2008). The *Strategic Statement* sought to redress that imbalance, providing structure for a profession in danger of being subsumed within a medical hegemony (Author’s own, 2010). However, although the roles were developed in consultation with social workers (Allen, 2014), these findings indicate that the *Strategic Statement* has failed to bridge the policy-practice divide. While participants did not reject any of the proposed roles, they only engaged with them superficially. Half of the participants were not aware of the *Strategic Statement,* and of the remainder, only one had more than a passing familiarity. Perhaps more importantly, when unprompted participants did not frame their contribution within any such task-oriented model.

The *Strategic Statement* assumed a parity of obligation between local authority and NHS employed social workers (Allen, 2014), which was not evident in participants accounts. Within the wider policy context this seems appropriate; integration has been the cornerstone of mental health policy for over 20 years, aimed at standardising mental health service provision (Wilson et al., 2011) and ostensibly supported from both local authority and NHS perspectives (Local Government Association et al., 2016). However, in relation to statutory duties, participants clearly distinguished between the social work role, and the local authority role *as enacted* by social workers. There was a clear divide in how participants viewed the statutory tasks, depending on whether they were employed by the local authority or the NHS, with the latter firmly viewing this asoutside their remit.

AMHPs were similarly viewed as distinct from MHSWs, driven largely by the loss of co-location and the redeployment of the AMHP workforce. Participants largely spoke about AMHPs in the context of an ‘us’ and ‘them’ discourse - while they often valued the AMHP contribution, contextual removal meant they did not see the AMHP role as integral to their identification as MHSWs. More than this, however, they saw the removal of the AMHPs from mental health services as damaging and detrimental, reflecting Carey’s (2015, p. 2417) assertion that service fragmentation leads to a lack of “consistency, reliability, coherence and focus”. Role clarity alone was seen as insufficient for effective working (Shepperd, 1992); co-location was also seen as integral.

Concepts of recovery and risk are integral to mental health provision. While recovery is articulated in policy (HM Government, 2011), service provision and legislation remain driven by concepts of risk (Davidson et al., 2016) which transcend social work involvement and inform practice across the health professions. Perhaps unsurprisingly, therefore, although risk assessment and safeguarding often represent core social work tasks, participants did not view risk work as specific to MHSWs, but instead positioned this as a core mental health task. Interestingly, concepts of ‘recovery’ and ‘risk’ appeared to have replaced traditional notions of ‘care’ and ‘control’, as the latter seemed absent from participants’ narratives.

Similar ambivalence was seen around concepts of social inclusion and recovery, mirroring service user discontent with these approaches detailed elsewhere (see, for example, Beresford et al, 2010; Peterson et al, 2014). In part this related to the reallocation of socially inclusive activities to non-qualified workers (Author’s own, 2011), reinforcing Bailey and Liyanage’s (2012) assertion that *New Ways of Working* was contributing to the erosion of MHSWs. However, participants also spoke of recovery and social inclusion couched in terms of risk, suggesting that there was also a contextual element to this distancing. Recovery had moved from distinctively social to being core mental health care. *Where* recovery was placed within mental health services was not where participants saw themselves as situated and they did not engage with the recovery terminology. Without unique interventions (McCrae et al., 2004) participants constructed their role in terms of context and location within the intersection of complex systems (Dickens, 2011) rather than as policy-driven interventions.

Perhaps the most controversial aspect of the *Strategic Statement* for participants was around working proactively with local communities. While this was originally positioned as aspirational and supplementary to statutory social work (Allen, 2014), it still featured in the subsequent policy as reflecting both the preventative scope of the Care Act 2014 and the political assertion that “mental health is everyone’s business” (HM Government, 2011, p.5). Participants, however, struggled to link this to their practice and to integrate it within their existing duties. Strategies for this work within existing organisational frameworks which did not compound stigmatisation and social exclusion were minimal, resonating with previous concerns around stigma arising from social work involvement (Bailey and Liyanage, 2012). Arguably, for community work to achieve its aims, MHSWs would need to operate independentlyto enable a genuinely social perspective without compromise (Goemans, 2012) and free from associative service stigma.

While tasks and processes were important to participants, they did not view these as definitional. This may have related to the diverse nature of the social care workforce, even within statutory services (Carey, 2015) – all seven participants worked in different geographical and occupational positions and their prescribed tasks varied widely. Instead, the situated placement of MHSWs was consistently integral to the participants shared understanding, affirming Woodbridge-Dodd’s (2017) claim that MHSWs adapt their professional positioning on a fluid, contextual basis, moving, for example, from advocate to therapist to care co-ordinator depending on the current demands of their role. These findings showed a similarly contextual focus;, participants understood their unique contribution in terms of *where* they operated. This was not related to physical location within teams, but conceptual placements both on the margins and across the boundaries of services and relationships. Mirroring this was a situated understanding of clients which placed individuals in the centre of a complex interaction of circumstances and relationships and attempted to navigate this productively.

Dickens (2011) argues that such positioning is the natural home of social work, with marginalisation providing opportunities for MHSWs to advocate for the individual perspective, challengingthe dominant organisation. However, participants spoke more frequently of mediatiom, acknowledging both perspectives and trying to establish a means of moving forward rather than promoting one over the other, indicating that idealistic, dichotomous arguments had not translated into frontline practice.

Indeed, alongside *where*, the findings also illustrated *how* MHSWs operated. Despite their mediatory approach, participants still spoke in terms of challenging professional collusion and “preventing service users’ needs from taking second place to the requirements of institutional and psychiatric hegemony” (Author’s own, 2010, p. 24). However, participants’ holistic perspective often led them to pursue compromise solutions which were acceptable to all parties. Rather than seeing compromise as flawed and collusive with the hegemony (Ramon, 2009; Goemans, 2012), participants frequently posited this as the most effective means of achieving the clients aims.

Interestingly, concepts of recovery, social inclusion and personalisation expressed in the *Strategic Statement*, were implicitly evident in participants understanding of their role, as conceptual themes rather than formalised practices. This reflects two key principles already mentioned in the literature; firstly, that MHSWs extensively use tacit, unspecified knowledge (Author’s own, 2013) rather than explicit theories and models. This helps to explain why MHSWs find it difficult to implement social interventions such as Connecting People, which connects people to resources, networks and activities in their local communities (Author’s own, 2020).

Secondly, Peck and Norman’s (1999) positioning of MHSWs as something more conceptual than practical, built around an ethos rather than a specific contribution, appeared to have been commonly retained. This ambiguity creates difficulties in establishing social work as influential within a field which prioritises evidence-based, clinical practice (Author’s own, 2013).

Despite the evident difficulty in articulating a definition of MHSWs, the three iterative themes did suggest a model for understanding. While each theme appeared distinctively, they were not independent and presented with substantial overlap. *Prioritising the client*, for example, was often informed by *Developing a holistic perspective* and facilitated by *Working across boundaries*. This reflects the diffuse and adaptable nature of MHSWs (Author’s own, 2013) and the messy, complex nature of working across and within individual, organisational and societal frameworks (Dickens, 2011). This overlapping interactional element, perhaps suggests why MHSWs prove so difficult to comprehensively define.

**Limitations and further research**

This was a small-scale qualitative inquiry, undertaken in a single NHS mental health trust covering one geographic area, albeit including both rural and urban settings. While participants were recruited from across different contexts, their small number meant that each represented a unique viewpoint, making it challenging to identify whether responses were specific to role or to participants themselves. Equally, all participants were working within the same organisational framework which has the potential to homogenise responses. Without comparable responses from an alternative context, it is difficult to identify to what extent this has impacted on the findings.

While the sample did include a range of ages and experience, male social workers were conspicuously absent and it is not possible to establish whether gender may have been an influencing factor on perspective (Hammersley, 1995). This holds equally true for ethnicity, as all participants were White British. The timing of the study, which coincided with school holidays may have impacted on response rates (Burgess, 1984), while its nature was likely to attract interest from those with a particular interest in MHSWs, potentially skewing the perspectives offered. Future studies should use a purposive sampling framework, to identify whether similar themes emerge when attempts have been made to mitigate these sources of response bias.

Despite these limitations, the conceptual MHSW as a contextual agent is worthy of further investigation, especially as this differs from the dominant policy discourse orientating MHSWs around specific tasks. The contextual emphasis is especially interesting, given the potentially broad range of organisational arrangements and practice settings. Even within this small-scale study, no two participants shared the same position within mental health services. It is therefore possible that no single definition of MHSWs can be developed, since no such homogenous entity exists. Further research to build an understanding of how MHSWs perceive their role *across* operational contexts could ensure that all emergent explanations are explored and enable a more complete understanding of the MHSW role(s).

**Implications**

MHSWs are currently substantial interest, with direct policy relevance (Allen, 2014; Allen et al., 2016). For employing organisations, especially those NHS trusts employing professionals in generic roles, the disparity between policy definitions and academic explanations of MHSWs, and the explanations of role offered by participants in this study have implications for workforce planning, and not purely in relation to social work. The findings suggest that professional background influences how practitioners operate, and that this can occur regardless of job role or employing agency. How MHSWs undertook their role was informed by the priorities and requirements of the agencies in which they worked and were employed, but not exclusively so - the positioning of professional self transcended, and sometimes supplanted, employer expectations. Workforce planners may need to better consider how MHSWs perceive, and therefore undertake, their role in order to evaluate their contribution more effectively. Further research is required to explore MHSWs perceptions of role in context on a wider scale which mitigates the potential biases of a single site study.

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