**Mapping the matrix: understanding the structure and position of social work in mental health services in England and Wales**

*Abstract*

Social work is one of the core professions within mental health services in the UK, though its position as local authority ‘outsider’ excludes it from health-based workforce planning, leaving the exact national composition of mental health social work shrouded in mystery. In the context of increasing demand and limited resources, this lack of clarity precludes effective use of the mental health workforce. This study aimed to map the provision of mental health social work across England and Wales. A cross-sectional design was used, with brief surveys issued to all local authorities and NHS trusts responsible for providing social work or mental health services. These surveys collected the number of mental health social workers in each agency and their employment contexts for subsequent descriptive statistical analysis. Responses were received from 96.6% of agencies, employing 6,584 social workers. Findings indicated that mental health social work varies widely across both nations, with little clear rationale for, or consistency in, how social work is structured within mental health services. While these findings establish the first robust framework for understanding the size and scope of mental health social work provision, further research is required to establish temporal and contextual understandings to inform future service planning.

*Keywords*

mental health, social work, workforce

*Subject Categories*

Social work workforce

*Teaser Text*

Social workers are one of the main professional groups working in mental health services in the UK. However, social workers are often employed by local councils rather than the National Health Service. This means that there is no central record of how many social workers work in mental health services, or where they are based. Mental health services work with limited resources to respond to large amounts of mental health need and knowing what staff are available to do this work is important. This study looked at how many mental health social workers there were across England and Wales and where they worked. All organisations providing social work or mental health services were surveyed to collect this information. 96.6% of organisations replied, who employed 6,584 mental health social workers. Where and how social workers worked in mental health was very different across both countries, and there was no consistent approach. These findings are useful, because they set out for the first time how mental health social work is provided in England and Wales, but more research is needed to see how this changes with time or based on location to help with planning for mental health services in the future.

*Main Article*

**Introduction**

Despite occupying a key position within formalised mental health care from its inception, mental health social work in England and Wales has become amorphous and ill-defined (Wilson et al, 2011). Social workers in these contexts are employed predominantly within local authorities, and secondarily within the National Health Service (NHS), with their key roles and responsibilities deriving from the obligations of these organisations rather than from a clear professional objective. In recent years, there has been an increased awareness of mental health social work, led in part by promotion from within the profession (Allen, 2014), but reinforced through a governmental commitment to the ongoing training of specialised mental health social workers above and beyond the legislative role outlined in the Mental Health Act 1983 (HM Government, 2017) and the adoption of profession-defined key roles into national policy (Allen et al, 2016). Despite this, more general policy direction around modern mental health services is non-specific about the discipline-specific contribution and understanding the social work position within mental health has remained challenging.

This lack of clear direction is less than ideal. Mental health services in England and Wales face increasing levels of demand. Need across countries is reported to be growing (Mental Health Foundation, 2016; Welsh Government, 2019, British Medical Association, 2020), with approximately 318,000 referrals per month and 1.4 million people in contact with mental health services in England alone as at January 2021 (NHS Digital, 2021). This represents a 21% increase in demand since 2016 (British Medical Association, 2019). Although the coronavirus disease (Covid-19) pandemic initially saw demand for services overall drop by as much as 40% in the early months of 2020 (NHS Confederation, 2020), early data indicates an increase in overall psychological distress in the population (Pierce et al, 2020; Pieh et al, 2021) and future need is predicted to increase across adults and young people, with an anticipated 8.5 million adults and 1.5 million young people requiring new or additional support with their mental health as a direct consequence of the pandemic (O’Shea, 2020).

The anticipated need is expected to include a strong social work element, arising from prolonged isolation, family change and bereavement, and loss of employment and financial security (O’Shea, 2020). Effective use of the mental health workforce in this context is critical. While demand for services is increasing, service provision appears to remain static while entrants to social work are reducing, although qualification from specialist mental health programmes remains stable (Skills for Care, 2021a). Despite commitments to increase the mental health workforce to meet the aspirations of the *Five Year Forward View for Mental Health* (Health Education England, 2017), NHS staffing has remained stagnant or decreased over the last decade (British Medical Association, 2019). Potential capacity issues are likely to be compounded in the Covid-era, with infection control and social distancing measures anticipated to reduce capacity by up to 30% (NHS Confederation, 2020).

Compounding this potential lack of capacity is a lack of understanding of the structure and provision of the social work workforce itself (Health Education England, 2017). While the components of the NHS workforce are well-documented, a similar overview of mental health social work on a national scale is lacking (Anderson et al, 2021).

This lack of awareness of how social work ‘fits’ within the mental health service structure may relate to the organic nature of its development. Establishing a history of mental health social work is by no means simple. Existing historical accounts primarily focus on either a generic history of social work (see, for example, Woodroofe, 1962; Seed, 1973; Younghusband; 1981; Payne, 2005; Bamford, 2015) or a generic history of mental health services (see, for example, Jones, 1960; Freeman, 1998; Rogers and Pilgrim, 2001; Glasby and Tew, 2015) Comprehensive accounts which address both are limited, leading to a social work history dominated by an emphasis on work with children and families, and a focus on child abuse (Dickens, 2011) and a mental health history told from a legislative and medical standpoint, where the social work perspective is marginalised and silenced.

Where the two elements to this history are combined, the professional role of the Psychiatric Social Worker (PSW) has been more easily delineated and documented (see, for example, Timms, 1964; Henning, 2018) than its less formalised counterpart. Burnham (2011) argues that this disregards the pre-existing arrangement and parallel development of local authority provisions which have invariably influenced the current composition of the mental health social worker. While the PSW role is more fully understood, the piecemeal understanding of mental health social work relies on contemporaneous narrative accounts from individual practitioners rather than an overall conception (Burnham, 2011). This limited understanding has resulted in a profession whose development is shrouded and unclear, and whose contribution to service provision is more reactive and responsive than intentional. Consequently, mental health social work has been driven by organisations and fashioned by legislative and policy provisions and despite recent work to define its contribution more concretely (Allen, 2014), space to implement such definitions is limited by the existing needs of wider health and social care structures. The preferrable approach of a profession-led development of role has been neglected.

As a result, understanding the position of social work within adult mental health services presumes that there is a degree of intentional oversight associated with the development of these services. Evidence suggests, however, that the practice reality is far less structured than this. Although teams are generally structured from a range of allied professionals, including nurses, psychologists, psychiatrists, occupational therapists, and social workers, with these latter often seconded from local authorities (Gould, 2010), the actual team structure and composition varies by area (Freeman and Peck, 2009).

The rationale for this variation is unclear, although the move toward and then away from integration may offer some explanation. Integrated and multi-professional care has purportedly been a long-standing objective of mental health care. The *National Service Framework for Mental Health* (1999) prioritised linking skills mixes and staffing profiles to local need and projected future demand, placed high value on multi-disciplinary assessments to ensure a holistic approach (Gibb et al, 2002. Underpinned by a legislative framework including the Health Act 1999 and the National Health Service Act 2006 which enabled multi-agency budgetary planning, delegation of organisational responsibilities and staff sharing (Gibb et al, 2002), mental health services were positioned to lead the field in integration (Lilo 2016). While the focus on the professional skills mix has fluctuated, a retained focus on partnership working within the NHS Plan (Duggan et al, 2002), and the core principle of working across organisational boundaries enshrined within the current *No Health without Mental Health* (2011) policy has informed mental health service delivery.

Austerity and budgetary reductions within public services have undermined this integrationist approach, however. Cummins (2019) argues that the disproportionate impacts of austerity, combined with anticipated future high costs (Rummery, 2009) necessitates that the ideals of policy are met by a conventional and rote response. With services expected to do more with less, the space for non-essential intervention is small and, in services dominated by a bio-medical focus under a legislative framework which prioritises compulsion (Wilson and Daly, 2007), there is little room for innovative social responses. Combined with the impact of local authority budget cuts, social work within the NHS has reduced (King’s Fund, 2015), with some provision withdrawn to core local authority roles (McNicholl, 2016) in the context of no clear rationale to maintain social work specifically within NHS settings. The debate around the separation and integration of services is extensive and longstanding (see, for example, Gibb et al, 2002; Aiello and Mellor, 2019) and beyond the scope of this paper to explore in full; however, the lack of consistency in approach does highlight a disconnect between policy rhetoric and practice realities which is realised through variations in provision.

Indeed, poor workforce planning is endemic (Evans et al, 2012; Anderson et al, 2021), with teams built pragmatically and without recourse to a theoretical or empirical rationale (Burns & Lloyd, 2004). Instead, team structure is based primarily upon either local convention (Duggan et al, 2002) or the practical availability of staff (Beinecke and Huxley, 2009). Variation has become non-purposive in terms of maximising service delivery and instead exists by rote (Wilberforce et al, 2015). Evans et al (2012) highlighted the impact of poor overall workforce planning, establishing the extent to which compliance with expectation, historical arrangements, and lack of communication between health and social care determined team structures, with less than 10% of services built around a multidisciplinary model. Services are structured around the convenience and expectation of what is available, rather than around need, despite an identified requirement to reflect the nature and scope of local demand (Wilberforce et al, 2015).

Cataloguing mental health social work in its range of integrated and non-integrated contexts is challenging. The localised nature of service provision and recordkeeping precludes gathering an overall picture of the workforce. Even the exact number of mental health social workers is unclear; although Approved Mental Health Professional (AMHP) provision is well documented (Skills for Care, 2021b), no central record exists for the overall mental health social worker workforce, with informal estimates from the Department of Health and Social Care ranging between 4,300 and 8,000 within local authorities, and between 900 and 3,000 within the NHS (Trewin, 2019).

This study therefore intended to meet the following aims:

* To establish a more robust estimate of the number of mental health social workers currently employed in England and Wales
* To establish where this social work provision is positioned within NHS and local authority settings.

**Methodology**

A cross-sectional survey was issued to 173 Local Authorities responsible for delivering social work services and to 54 Mental Health Trusts and 7 Local Health Boards responsible for delivering mental health services in England and Wales. Collection of data was restricted to these two regions of the UK due to the substantially different legislative frameworks in both Northern Ireland and Scotland, which rendered the basis for comparison invalid (Wilson and Daly, 2007; Mackay, 2012). Data was collected via a brief questionnaire due to the low demand this placed on service providers and the numerical nature of the required data (Liu, 2008). This questionnaire was reviewed both within and external to the research team to ensure congruence between communicated meaning and intended meaning (Hakim, 2000).

Composition of the survey was different for local authorities and NHS providers to acknowledge their varying priorities and responsibilities in the provision of mental health care. In both cases, surveys were restricted to four questions to minimise the burden of providing the information and to maximise responses (Robson, 2011). Questions covered the following key areas:

1. Number of social workers working primarily with mental health needs directly employed by the organisation
2. Proportion of these social workers operating as part of the AMHP workforce
3. Positioning of these social workers within services
4. Details of any social work services commissioned from external providers.

The standardised format of the questions was intended to maximise reliability and validity (Sapsford, 1999) and to ensure transparency and facilitate replication (Hakim, 2000), with questions formulated to minimise double counting, given the potential for local authority social workers to be working directly within NHS settings. Inclusive definitions of ‘mental health service’ and ‘mental health social worker’ were also used. While acknowledging that such standardised definitions can limit understanding, the targeted broad scope aimed to minimise the influence of interpretive bias, acknowledging both the socially constructed nature of survey responses (O’Connell Davidson and Layder, 1994; Williams and May, 1996) and the relationship between meaning and social conventions (Marsh, 1982).

*Ethics*

Ethical approval was obtained from the University of York. The Health Research Authority confirmed that further approval was not needed, as the proposed data collection did not meet their criteria for research.

As the intention was to comprehensively map social work provision nationally, the target response rate was 100% to minimise misrepresentation (O’Connell Davidson and Layder, 1994). However, response rates for surveys generally fall significantly short of this (de Vaus, 2014). To counteract this, the initial research design used the Freedom of Information Act 2000 (FOI), which creates a general right of access to information held by public authorities and, by extension, places a legal duty upon such authorities to provide this information on request. The FOI covers all public authorities in England and Wales, including local authorities and NHS trusts, which positioned it as a useful resource for a comprehensive, exploratory enquiry of this nature (Bows, 2017). However, although some have lauded FOI approaches as a valuable new methodological tool within the social sciences (Lee, 2005; Atkinson et al, 2019), FOI requests have been a source of significant academic debate. Proponents highlight positive co-production potential (Bourke et al, 2012) and transparency (Hammond et al, 2017), formalising critical research access to large-scale public sector data (Savage and Hyde, 2014). Critics, however, have highlighted how the coercive nature of FOI requests potentially damages research relationships (Lee, 2005; Bows, 2017) and creates burdens in time and financial costs (Breathnach et al, 2011; Independent Commission on Freedom of Information, 2016) which exponentially increase when requests are made to multiple authorities, as in this study’s design (Fowler et al, 2013).

The ongoing debate has not yet led to an agreed approach (Bows, 2017). In the absence of formal guidance, requests for information were sent informally and without recourse to the legislative framework. Instead, a cost-benefit approach was adopted; public bodies were offered access to the findings of the survey (Dillman et al, 2014) and the research purposes explained to ensure an understanding of relevance (Savage and Hyde, 2014). However, FOI does not require the requester to specify that their request is made under the provisions of the Act (Freedom of Information Act, 2000). Instead, responsibility to decide applicability rests with the public authority (Fowler et al, 2013; Bows, 2017). Despite the researcher’s intentions, requests were without exception treated as being made under the legislative provisions. Due to the potential to sour research relationships for both this and future studies (Hughes et al, 2000), although two follow up requests were sent, no formal process was undertaken to pursue non-responders (Hammond et al, 2017).

*Data Analysis*

Descriptive statistical analysis was undertaken using SPSS (version 25) to explore the characteristics of the dataset and to develop a framework which could adequately demonstrate the structure of provision. To enable understanding, additional data fields which were not direct questions on the survey were added to ensure clarity and reflect the complexity of the survey responses. These included:

* *External AMHP workforce:* This identified where the reported AMHP figures included workers based outside of mental health services. These most frequently related to AMHPs employed to work exclusively within generic Emergency Duty Teams
* *Hybrid working arrangements:* This identified local authorities who reported a range of working arrangements for social work staff (namely a mixture of staff based within both local authority and NHS teams).

Further statistical exploration investigated any links between organisational characteristics and the structure of their mental health social work provision. The nature of the data, as assessed using Shapiro-Wilk’s tests, and a visual inspection of box plots, precluded the use of parametric tests of association, and number of social workers was analysed according to whether organisations employed above or below the arithmetic mean for the full sample. Due to the subsequent categorical nature of the variables, Chi square tests were used where expected frequencies were sufficient to render the test valid and where variables were deemed to be suitably independent (Field, 2013), with Cramer’s V tests undertaken to check the strength of any association.

**Results**

*Response rates*

Surveys were issued between February and May 2019, and responses returned between March and September 2019. Requests were sent to a total of 237 public authorities, including 173 local authorities, 57 NHS trusts and 7 Local Health Boards. Response rates were very high, overall 96.6%. Responses were not received from six local authorities and from two NHS trusts (table 1).

Local authority structure across England and Wales is non-uniform and local authority responses were classified by their authority sub-type in addition to being recorded as local authorities. 100% response rates were achieved from County Councils and Metropolitan Borough Councils. Unitary Councils had a response rate of 96.4%, London Borough Councils had a response rate of 93.9% and Welsh Councils had a response rate of 90.5% (table 2).

*The Mental Health Social Work Workforce*

The total number of social workers working directly in mental health provision was 6,584.82, across 228 organisations. Of this total, 1,536.77 (23.3%) were identified as specifically working with adults and 435.90 (6.6%) as specifically working with children. For the remaining 4,612.15 (70.1%), the client group was not identified (table 3).

The minimum number of social workers employed within a single organisation was 0 (n=30) and the maximum number was 147 (n=1). Distribution of social work employment was positively skewed. 66.6% (n=4,387.22) of social workers were employed by local authorities, 32.5% (n=2,144.10) by NHS trusts, and 0.8% (n=53.50) by Local Health Boards.

The total reported number of AMHPs was 3,215.60. This number included AMHPs who were employed outside of direct mental health provision (most commonly with generic Emergency Duty Teams), with 34.5% (n=79) of organisations giving AMHP figures including those based outside mental health provision. The vast majority of these cases were local authorities, including only one NHS trust. 92.4% of AMHPs were employed by local authorities, 7.35% by NHS trusts, and 0.25% by Local Health Boards.

*Mental Health Social Work Providers*

Local Authorities

Social workers were employed to work directly in mental health settings by 86.8% (n=145) of local authorities. For the remaining local authorities, provision in mental health settings was outsourced to an outside organisation (n=1), to the NHS (n=15) or service provision within the authority included no mental health specialism (n=6).

Over half of local authorities reported having social workers in-house (58.1%, n=97) and approximately two thirds reported employing social workers based in NHS teams either with local authority oversight (36.5%, n=61) or without local authority oversight (31.1%, n=52). 30.5% (n=51) of local authorities employed social workers in a mix of different settings within both the NHS and the local authority. This division generally related to different arrangements for the AMHP workforce as opposed to their general mental health workforce.

Local authorities had varied working relationships with NHS partners. The most common arrangement was a formal working agreement (55.1%, n=92), of which 35.3% (n=59) were specifically identified as ‘Section 75’ arrangements (Health Act 2006). 28.1% (n=37) of local authorities reported an informal working arrangement, most often based on working practices or co-location of non-integrated staff. 3% (n=5) of local authorities reported a hybrid arrangement, with different agreements across different service areas and 13.8% (n=23) reported no working agreements in place.

NHS and Local Health Boards

Social workers were employed directly in mental health settings in 89.1% (n=49) of NHS trusts and in 71.4% (n=5) of Local Health Boards.

NHS trusts and Local Health Boards employed social workers across the full range of service provision. Organisations were most likely to employ social workers in crisis services, with 59.7% (n=47) employing in this capacity. However, the largest number of social workers were employed in working age adult services (n=536). Inpatient services were both the least common base for social workers, with only 41.9% (n=26) of NHS trusts and no Local Health Boards employing staff in this area, and the area with the fewest number of social workers employed (n=46). Social workers employed in other areas included management and commissioning roles, specialist services (such as substance misuse), Assertive Outreach, Liaison services, Perinatal services, and social care specific roles (table 4).

With the exception of three local authorities who outsourced their social work provision entirely to community interest companies, neither NHS trusts nor local authorities externally commissioned mental health social work services.

Mental Health Social Work by Location

Geographic location was considered by regions, as the highest level of bureaucratic structuring within the country. Local authorities were congruent with these regional boundaries. Where this was not the case for NHS organisations, each was assigned to an area based on where it operated most prominently. Where this was unclear, organisations were allocated based on the location of their head offices.

Social workers were employed in all areas of England and Wales, with the highest number of employing agencies in London (n=40) and the lowest in the East Midlands (n=13) (table 5).

The area employing the highest number of social workers was London (n=1099.13) and the lowest was Wales (n=335.7). Broadly, social worker numbers correlated to population figures for the local areas, with the exception of Yorkshire & the Humber (ranked 4 for social workers and 7 for population) and East (ranked 7 for social workers and 4 for population) regions (table 6).

*Mental Health Social Work Provision*

Organisation type and numbers of social workers

There was no statistically significant difference between the number of social work staff employed by a local authority or NHS trust (Local Health Boards were incorporated into NHS figures due to the low numbers involved) (x2(2)=2.000, p=0.382)

Organisation location and numbers of social workers

There was no statistically significant association between geographic location and the number of social workers employed (x2(18)=22.233, p=0.221). Across the whole population, 13.2% (n=30) of organisations employed no social workers, 50.4% (n=115) employed below the mean average and 36.4% (n=83) employed above the mean average, with organisations in the East most likely to employ above the mean average (n=7, 46.7%) and organisations in Wales most likely to employ below the mean average (n=21, 80.8%).

Local authority sub-type and numbers of social workers

There was a moderately weak, but highly significant association between the sub-type of local authority and the number of social workers employed (x2(8)=29.932, p=<0.001, Cramer’s V=.300). 53% (n=88) of local authorities employed below the mean average and 33.7% (n=56) employed above the mean average.

Local authority sub-type and relationship with NHS

There was a moderately weak but highly significant association between the sub-type of local authority and the nature of the relationship with NHS partners (x2(8)=29.912, p=<0.001, Cramer’s V=.294). Formal relationships were the dominant relationship type for all sub-types of local authority except for the Welsh Local Authorities, where informal relationships were predominant (table 7).

Number of social workers and relationship with NHS

There was a weak but significant association between the number of social workers employed and the nature of the relationship between local authorities and their NHS partners (x2(8)=9.974, p=<0.041, Cramer’s V=.173). Formal relationships were the dominant relationship type regardless of the number of social workers employed.

**Discussion**

Previous estimates of the mental health social work workforce have been incomplete and broad-ranging, making understanding how it can be used effectively in service provision challenging (Trewin, 2019). The high response rate here provides a more robust understanding of how this professional group is composed, supporting workforce planning aspirations more widely than at a local level. Subsequent work by NHS Benchmarking (2020) addressing a similar question returned consistent findings in terms of the NHS-employed social work workforce, although the impact of the Covid-19 pandemic precluded similar comparative work with local authorities, suggesting that these findings reflect the practice realities in mental health social work.

The lack of overarching structure to service provision evident in previous research is similarly reflected here (Burn and Lloyd,2004; Wilberforce et al, 2015). Social workers were widely employed within both local authority and NHS settings, with no clear preferred model of practice emerging, reinforcing assertions that provision is ad hoc, driven by local priorities, relationships, and conventions rather than by a more comprehensive plan (Evans et al, 2012) and reinforcing perceptions that workforce planning is health focused to the exclusion of social work (Anderson et al, 2021). Indeed, it could be suggested that austerity drivers, and the removal of social workers from NHS contexts (King’s Fund, 2015) may be an influential factor in the increasing number of social workers being employed within the NHS rather than their traditional local authority settings, but these changes are not consistent on a national scale. Instead, provision appears haphazard, rather than being driven by any informed concept of the social work contribution (Allen et al, 2016). This risks a ‘postcode lottery’ provision, where service user experience is dictated more by location than identified or personalised need, running directly contrary to current mental health policy (HM Government, 2011) and the personalisation agenda which underpins social work (HM Government, 2007).

This risk is evident in the disparity in volume of mental health social workers in relation to the general population, with provision in the North East almost twice as high than in the East Midlands. Although the most robust pattern to the provision of mental health social work did appear to relate to the corresponding population, there was no significant association identified between the two, and the rationale for provision remains unclear. However, such observations should be treated with caution, as general population figures do not necessarily correspond to the regional level of mental health need (Wilkinson et al, 2007; Pieh et al, 2021). Although data at a regional level is not routinely available, local need appears both variable over time, and across regions; however, these variations do not correspond to the variation in provision demonstrated here (Wilkinson et al, 2007; Baker, 2020; Pieh et al, 2021).

Significant associations were noted between local authority sub-types and both the number of social workers employed and the nature of the relationship with NHS partners. While it is beyond the scope of this study to draw conclusions about the nature of this association, local authority sub-types often reflect the local area, with county councils usually covering larger, rural areas while unitary and metropolitan authorities serve smaller, more densely populated communities (Ministry of Housing, Communities and Local Government, 2019). Where there is a larger population to be served, this is likely to impact on staffing provision in a localised service model, potentially indicating the same locally prioritised approach as previously identified (Evans et al, 2012).

Understanding how social work contributes to mental health provision in the context of a unified professional identity is challenging where the rationale for input is unclear. These findings offer a snapshot of provision pre-pandemic but indicate no dominant pattern, suggesting no clear sense of which approach is most effective. This, in turn, limits the optimum use of social work resources to achieve the best outcomes and suggests further investigation is needed. In this context, these findings provide a robust benchmark for understanding provision, with high response rates enabling a reliable estimate of the scope and structure of mental health social work.

**Limitations and potential for further research**

Due to the brief and remote nature of the survey, there was potential for misinterpretation of the questions without opportunity for clarification. This was specifically a concern in distinguishing AMHPs from wider mental health social work. To minimise ambiguity, the survey was reviewed within the research team and externally and revised accordingly prior to being issued.

Cross-sectional studies provide a ‘snapshot’ of a single point in time (Liu, 2008). In the context of a fluid workforce and changing organisational structures, it is noted that the findings from this study will become outdated quickly, as local authority and NHS provision changes. Future research could focus on a more longitudinal understanding, ensuring not only a contemporary view of the workforce, but also an overview of fluctuations over time and how this reflects the broader social and political landscape.

This overview of the structure and provision of mental health social work lacks depth; however, the diversity of approach evident from the results suggests that a more detailed exploration would be beneficial to look at how mental health social work is structured and utilised in these contexts. Furthermore, the lack of correlation between population, need, deprivation and social work provision also suggests that a more detailed exploration to understand the relationship between service provision and local characteristics would be beneficial for future planning and effective use of resources.

**Implications**

Development of the mental health workforce across the health and social care spectrum is currently under governmental scrutiny (NHS Benchmarking, 2020; Health Education England, 2020); however, understanding of the contribution of those professions external to health settings is limited (Health Education England, 2017). In the context of increasing demand and limited resource, even discounting the additional impact of a global pandemic, a comprehensive understanding of mental health service provision not restricted by organisational or professional constraints is essential for future effective service planning. This study complements existing data gathering mechanisms within the NHS, providing a corresponding accounting of social work input into the multidisciplinary environment. This in turn can be used to support the development of a more comprehensive strategy for how mental health services can be structured effectively and efficiently, ensuring optimum use of the full range of professional expertise available. The localised nature of provision has resulted in a shrouded understanding of the position social work occupies within mental health service delivery. By adopting a national perspective, this study has illuminated the current structure, with a view to contributing toward a more cohesive, national plan and setting a reliable benchmark against which further developments can be measured.

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|  |  |  |  |
| --- | --- | --- | --- |
| Organisation type | Total number of requests (%) | Total number of responses (%) | % responses within type |
| NHS Trust | 57 (24%) | 55 (23.2%) | 96.4% |
| Local Health Board | 7 (3%) | 7 (3%) | 100% |
| Local Authority | 173 (73%) | 167 (70.5%) | 96.5% |
| Missing |  | 8 (3.3%) |  |
| **Total** | **237 (100%)** | **237 (100%)** | **96.6%** |

Table 1: Response rates by organisation types

|  |  |  |  |
| --- | --- | --- | --- |
| Local Authority Sub-type | Total number of requests (%) | Total number of responses (%) | % responses within type |
| Unitary | 56 (32.4%) | 54 (31.2%) | 96.4% |
| Metropolitan Borough | 36 (20.8%) | 36 (20.8%) | 100% |
| County | 27 (15.6%) | 27 (15.6%) | 100% |
| London | 33 (19.1%) | 31 (17.9%) | 93.9% |
| Welsh | 21 (12.1%) | 19 (11%) | 90.5% |
| **Total** | **173 (100%)** | **167 (96.5%)** |  |

Table 2: Local authority response rates by sub-types

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Organisation type | Total number of mental health social workers (MHSWs) | Number of adult MHSWs | Number of children’s MHSWs | Number of AMHPs |
| NHS Trust | 2,144.10 | 1,211.77 | 393.90 | 236 |
| Local Health Board | 53.50 | 19 | 32.50 | 7 |
| Local Authority | 4,387.22 | 306 | 9.50 | 2,972.60 |
| **Total** | 6,584.82 | 1,536.77 | 435.90 | 3,215.60 |

Table 3: Mental health social work numbers (FTE) by organisation type

|  |  |  |  |
| --- | --- | --- | --- |
| Service Type | Number of employing NHS trusts | Number of employing LHBs | Total number of MHSWs |
| Child and Adolescent Mental Health Services | 33 | 2 | 427 |
| Early Intervention in Psychosis | 29 | 1 | 96 |
| Working Age Adults | 35 | 1 | 536 |
| Older Adults | 29 | 1 | 74 |
| Forensics | 31 | 1 | 129 |
| Inpatients | 26 | 0 | 46 |
| Crisis | 33 | 4 | 118 |
| Other | 31 | 3 | 495 |

Table 4: NHS MHSWs by employment type

|  |  |  |  |
| --- | --- | --- | --- |
| Area | Number of employing NHS trusts | Number of employing LAs | Total number of employing agencies |
| East | 4 | 11 | 15 |
| East Midlands | 4 | 9 | 13 |
| London | 9 | 31 | 40 |
| North East | 2 | 12 | 14 |
| North West | 7 | 23 | 30 |
| South East | 8 | 19 | 27 |
| South West | 7 | 14 | 21 |
| Wales | 7 | 19 | 26 |
| Yorkshire & the Humber | 7 | 15 | 22 |

Table 5: MHSW employers by geographic area

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Area | Total number of MHSWs | Mean (compared to national average of 28.8) | Rank by total number employed | Population (rank)\* | Amount of population covered per MHSW |
| East | 526.42 | 39.05 (+10.25) | 7 | 6,130,542 (4) | 11,646 |
| East Midlands | 400.4 | 30.80 (+2) | 8 | 4,724,437 (8) | 11,799 |
| London | 1099.13 | 28.18 (-0.62) | 1 | 8,787,892 (2) | 7,995 |
| North East | 384 | 27.43 (-1.37) | 9 | 2,636,848 (10) | 6,867 |
| North West | 962.5 | 32.08 (+3.28) | 3 | 7,219,623 (3) | 7,501 |
| South East | 975 | 36.11 (+7.31) | 2 | 9,026,297 (1) | 9,258 |
| South West | 606.5 | 28.88 (+0.08) | 5 | 5,515,953 (6) | 9,095 |
| Wales | 335.7 | 12.91 (-15.89) | 10 | 3,113,150 (9) | 9,274 |
| West Midlands | 600.17 | 28.58 (-0.22) | 6 | 5,800,734 (5) | 9,665 |
| Yorkshire & the Humber | 695 | 31.59 (+2.79) | 4 | 5,425,741 (7) | 7,807 |

Table 6: Number of MHSWs (FTE) in comparison to general population by geographic region

\* (Office for National Statistics, 2017)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Number with formal relationships (%) | Number with informal or hybrid relationships (%) | Number with no relationship (%) |
| County | 18 (66.7) | 8 (29.6) | 1 (3.7) |
| Metropolitan | 17 (47.2) | 12 (33.3) | 7 (19.4) |
| London | 23 (74.2) | 2 (6.5) | 6 (19.4) |
| Unitary | 30 (55.6) | 16 (29.6) | 8 (14.8) |
| Welsh | 4 (21.1) | 14 (73.7) | 1 (5.3) |

Table 7: Nature of the organisational relationships with the NHS based on local authority sub-types