Liverpool John Moores University

Faculty of Health and Applied Social Sciences

MA in Social Work

7008SWMAP: Dissertation Module

Title

Exploring social workers' perceptions of their role and duties within community mental health teams: A qualitative study using semi-structured interviews.

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December 2012

This dissertation is submitted to the Faculty of Health and Applied Social Sciences as part of the degree requirements for the MA in Social Work at Liverpool John Moores University.

Statement of Consent

I have the consent of the participants and the organisations concerned for open access to the present research, and thus, I give my consent to this dissertation being read by other people (i.e. not for the purposes of examination).

Please note that in order to respect confidentiality and protect the identity of the participants, no real names have been used during this dissertation. The initials used are not the participants' real initials, while the names of work places, locations and the organisations concerned are not included.

Name: Georgios Chatziroufas   Date: December 2012

Acknowledgements

This dissertation would not have been possible without the contribution, support and encouragement of a variety of people.

Thus I would like to thank all the participating social workers who volunteered and gave up their time in order to take part in this study. I would also like to thank their work place organisations for consenting to the study. The participants' honest and open description of their working experiences, duties and responsibilities made this research study possible: thank you.

I would also like to thank my tutor and supervisor, Echo Yeung, for her support and guidance during the past two years of my studies and for encouraging me to continue until the completion of my dissertation. Thank you as well to Oliver Hughes for his contribution as a student peer reviewer during the data coding process.

And a final thank you to my wife, Aleasha, my family and friends for their continued support and encouragement and for not letting me give up when the task ahead felt overwhelming: thank you.

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Title

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Abstract

Social workers, employed by Local Authorities and seconded to work in Mental Health NHS Trusts, have been working in the multidisciplinary environment of integrated community mental health teams over the past decade. In the past year however, mainly due to budget cuts, some Local Authorities decided to withdraw social workers from those integrated teams, transferred them back to adult social services departments and thus started the disintegration process of multidisciplinary health and social care working in mental health. Given the above context and from a social work perspective, the aim of this study was to explore social workers' views and opinions regarding their role, duties and responsibilities within integrated community mental health teams. This was a qualitative study that utilised a phenomenological research approach, as social work theory and practice were considered, and semi-structured interviews with seven participants, recruited with a mixture of convenience and snowball sampling strategies, were conducted. All the participants were qualified social workers in integrated community mental health teams and members of an Approved Mental Health Professionals Forum. The transcribed interviews were analysed and coded utilising thematic analysis and the data analysis process was facilitated by the use of the NVivo computer software programme. The findings included both facilitating and inhibiting factors for the integrated multidisciplinary model of community mental health teams. Participants considered as facilitating factors: the communication and the cooperation between the different professionals; as well as their shared values in working with, and supporting, service users. Participants regarded as inhibiting factors: the perceived isolation and alienation from the Local Authority that employed them; and the lack of recognition and appreciation for the complexities of their dual social work role, as they carried out statutory duties as well as care programme approach tasks, by their health managers and other mental health professionals. Overall the integrated multidisciplinary environment of community mental health teams was supported by participants, while suggestions to improve integrated working included: appropriate social work supervision; peer support; and continuous dialogue with other mental health professionals regarding role integration issues and the complexities and duality of the mental health social work role.

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Chapter 1: Introduction

According to the definitions of health and mental health agreed on and utilised by the World Health Organization (WHO), health for more than sixty years has been defined as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (World Health Organisation, 2006, p.1). While mental health is described as *"a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"* (World Health Organisation, 2001a, p.1).

It was estimated that at some point in their lifetime, one in four (25%) of the world's population would experience a mental health problem (World Health Organisation, 2001b). In the UK, for any given year, it was estimated that around one in four adults (25%) would experience a mental health issue (Office for National Statistics, 2001). In another report (Joseph Rowntree Foundation, 2010) the risk of experiencing a mental health problem in the UK, for the adult population, was estimated to be around 15% for women and 10% for men. That risk was significantly increased to around 24% for women and 20% for men, when issues of low income, poverty and social exclusion were taken into consideration (Joseph Rowntree Foundation, 2010).

The experience of a mental health problem was a major contributing aspect to poverty, social isolation and social exclusion (Gould, 2010; Joseph Rowntree Foundation, 2010). A person who experienced a mental health problem was at risk of experiencing social problems as well due to the impact of the mental health issue on the person's ability to work, socialise, interact with family members, participate and get involved in the social and cultural life (Gould, 2010; Joseph Rowntree Foundation, 2010). It was also argued that there was a link between poverty, mental health issues and unequal societies, where more inequality existed within the same society, then there was more poverty and the risk of experiencing a mental health issue was increased (Wilkinson and Picket, 2010).

Taking into consideration the above, it can be argued that mental health is an extremely important factor in human life experience (World Health Organisation, 2001a), whilst experiencing a mental health problem is an equally serious issue that can have a significant impact on a person's life and is linked to social exclusion (Gould, 2010; Joseph Rowntree Foundation, 2010).

In order to support people who have experienced mental health problems at some point in their lifetime, societies and governments have established various national and international policy responses to mental health issues with appropriate service provisions and interventions by statutory organisations and voluntary agencies (Gould, 2010; World Health Organisation, 2001b). The aim of mental health policy and services, both on an individual and community level, is to address mental health problems, promote mental health recovery, address issues of social isolation and social exclusion, taking into account the financial and economic costs of mental health problems to societies (Centre for Social Justice 2011; Gould, 2010; Pilgrim, 2009; World Health Organisation, 2001b).

In the UK, the mental health policy is implemented on a governmental level through legislation with various acts of parliament, statutory regulations, statutory guidance, governmental departments' procedures and code of practice guidelines (Brayne and Carr, 2010; Department of Health, 2002; Department of Health, 2008a; Department of Health, 2008b; Mental Health Act 1983 as amended by the Mental Health Act 2007). Thus in UK, the mental health policy provides the legal framework within which mental health services, both community and hospital based services, operate and are commissioned to deliver service provisions to the relevant population who require those services due to experiencing various levels of mental health issues and problems (Bogg, 2008; Brayne and Carr, 2010; Department of Health, 2008a; Gould, 2010; Lester and Glasby, 2010; Pilgrim, 2009).

As the present research dissertation study formed part of the degree requirements for the MA in Social Work at Liverpool John Moores University, it focused on mental health social work in the UK, and more specifically, in community mental health teams and the integration of adult health and social care services in delivering service provisions (Bogg, 2008). The interest of the student researcher in the topic derived from a social work student placement experience within a community mental health team (CMHT) in a regional Mental Health National Health Service (NHS) Trust. The aim of the research study was to explore social workers' views and opinions regarding their duties, tasks and responsibilities in community mental health teams, by utilising qualitative research approach and methods to conduct semi-structured interviews with a sufficient number of participating social workers (Carey, 2009). The present research study also aimed to concentrate and explore social work perspectives as it was argued that, in the past, research into community mental health teams focused mainly on health care perspectives (Bogg, 2008).

Many different names and labels have been used to describe people in contact with and in receipt of care services such as: "*'client', 'patient', 'customer', 'consumer', 'expert by experience', 'service user'*" (McLaughlin, 2009, p.1101). The use of those words was critically explored and it was claimed that the label *"service user"* although described people by only one characteristic of their lives, it was *"the most popular term at present"* (McLaughlin, 2009, p.1101) in explaining the relationship between provider and recipient of social care services. The present research study acknowledged the limitations of the term service user (McLaughlin, 2009). However the student researcher utilised the term service users to describe people who have experienced mental health issues and are, or have been, in contact with health and social care services, as it was consistent with the terminology commonly utilised in the field of mental health social work (Bogg, 2008; Department of Health, 2008b; Gould, 2010; Pilgrim, 2009).

Social workers working in community mental health teams have a complex employment status as they are employed by a local authority and then are seconded to work for a Mental Health NHS Trust as care coordinators in integrated community mental health teams (Bogg, 2008; Gould, 2010). In those teams, social workers are part of a multidisciplinary setting working together with other professionals such as; community psychiatric nurses, occupational therapists, psychiatrists and psychologists (Bogg, 2008; Department of Health, 2002; Gould, 2010). Some of the challenges for social workers in integrated community mental health teams are to balance the social model of care and practice with the medical model and to support

service users whilst balancing the social and health care requirements of the local authority and the NHS (Bogg, 2008; Gould, 2010).

Social workers have to utilise, combine and integrate two different approaches; the social care led care management and the health care led care programme approach (Carpenter et al., 2004; Gould 2010; Payne, 2009) in order to support service users who receive an enhanced care package due to experiencing *“severe and enduring mental health problems”* (Carpenter et al., 2004, p.313). Thus social workers apply social work theory and practice (Howe, 2009) in order to work together with service users and promote anti-oppressive practice (Clifford and Burke, 2009; Wilson et al., 2008), supporting human rights, advocate for service users and address issues of power, oppression and social exclusion (Coppock and Dunn, 2010; Gould, 2010)

Chapter 2: Literature Review

The literature review for this study was conducted by utilising the university's library, the electronic resources, journals and electronic database search engines, where the key words of; social work, mental health and community mental health team were entered and the appropriate results in terms of articles and journals were reviewed (Carey, 2009; Whittaker, 2009).

This literature review explored the role and challenges of social workers working in integrated community mental health teams by considering: the role of social work and the development of relevant mental health legislation and guidance within a brief historical perspective (Brayne and Carr, 2010; Payne, 2005); the role and duties of social workers in the integrated community mental health teams (Bogg, 2008; Gould, 2010); the care and control elements of mental health social work and the role of anti-oppressive practice in supporting service users (Wilson et al., 2008); issues around social work specialisation and genericism (Wilson et al., 2008); social exclusion of service users and the supportive role of mental health social work (Gould, 2010; Pilgrim, 2009); whilst relevant research and the aims and objectives of the present research study were discussed (Carey, 2009; Whittaker, 2009).

Brief History of Social Work and Legislation in relation to Mental Health Care

It was argued (Payne, 2005; Wilson et al., 2008) that the industrial revolution, the development of cities, the emergence of a working class, the issues around poverty and laws for the poor people of society, the influence of humanistic ideas and charitable organisations in western societies, the sense of a need to do something about the above issues, all had an impact and contributed to the development of social work. The parliamentary UK legislation, that established and provided social workers with a recognised professional role, which is still valid in the modern world, and that assigned social workers some of their statutory requirements, duties, obligations, powers and roles, was the Local Authority (Social Services) Act 1970 (Brammer, 2010; Brayne and Carr, 2010).

It was also claimed that the establishment of the professional role of social workers through an act of parliament was a natural progression and consequence of the National Assistance Act 1948 (Brammer, 2010; Brayne and Carr, 2010; Payne, 2005; Wilson et al., 2008) as the formation, emergence and development of the welfare state and the National Health Service that provided free health and welfare services to every UK citizen, including the poorest and socially excluded members of the society, facilitated the role of social work (Brayne and Carr, 2010; Payne, 2005; Wilson et al., 2008).

The relationship between health and social care also started at around the same time (British Association of Social Workers, 2010) and over the years the need for cooperation between health care and social care services, and in particular in the field of mental health care, grew stronger as new legislation and acts of parliament

were passed, such as the National Health Service Act 1973, the Mental Health Act 1983, and the National Health Service and Community Care Act 1990 (Brammer, 2010; Brayne and Carr, 2010; British Association of Social Workers, 2010; Coppock and Dunn, 2010; Lester and Glasby, 2010). The Mental Health Act 1983 established the role of approved social worker in a coordinating and facilitating role in Mental Health Act assessments in decisions regarding the compulsory admission to hospital of people experiencing mental health problems whilst also exploring alternative social perspectives to issues of mental distress (Brammer, 2010; Brayne and Carr, 2010; Gould, 2010; Gregor, 2010; Hatfield, 2008). The Mental Health Act 1983 was amended by the Mental Health Act 2007 and the role of the approved social worker was replaced by the role of the approved mental health professional and social workers as well as health professionals can now train for the role (Brammer, 2010; Brayne and Carr, 2010; Gould, 2010; Gregor, 2010).

The National Health Service and Community Care Act 1990 (Brammer, 2010; Brayne and Carr, 2010) provided the legislative framework for care of people in the community including people with mental health needs (Coppock and Dunn, 2010; Gould, 2010; Lester and Glasby, 2010). Furthermore the process of closing down the centuries old mental health institutions and asylums due to a variety of reasons: better treatment options, human rights of mental health service users, social perspectives of mental distress challenging medical model, outdated systems of managing mental health problems and cost effectiveness issues (Barnes and Bowl, 2001; Coppock and Hopton, 2000; Fawcett and Karban, 2005; Goodwin, 1997) increased the needs of care in the community options for mental health service users and also increased the need for policy responses on a governmental level (Coppock and Dunn, 2010; Gould, 2010; Lester and Glasby, 2010). In order to address the above issues, various UK governments responded by implementing policies and guidance such as: the health care oriented care programme approach, which was introduced in the early 1990s (Department of Health 2008b; Payne, 2009); the National Service Framework for Mental Health (Department of Health, 1999); the Community Mental Health Teams policy guide (Department of Health, 2002); and the New Ways of Working for Everyone (Department of Health, 2007).

Although the student researcher acknowledged that the above history of events was a crude attempt to briefly describe complex issues around mental health policy and that many important events and policies were omitted, nevertheless, it can be argued that the above issues, policy responses and legislation provided the foundation for the emergence of the health and social care integrated model of community mental health teams (Bogg, 2010; Coppock and Dunn, 2010; Gould, 2010; Lester and Glasby, 2010).

<u>Social Work Role in Integrated Community Mental Health Teams: Care Programme Approach; Care Management and Local Authority Statutory Social Work Duties</u>

The role of social work, in terms of practice and theoretical application, within mental health settings in the UK and, in particular, the role of social workers, their practice, duties and tasks, within community mental health teams, has been explored by a number of authors (Bogg, 2008; Coppock and Dunn, 2010; Gould, 2010; Pilgrim, 2009; Wilson et al., 2008). Social workers in integrated teams utilise social theory, social perspectives and social models of care (Gould 2010; Howe, 2009; Pilgrim, 2009) in their social work practice (Coulshed and Orme, 2006) in order to support service users who have experienced mental distress and mental health problems (Gould, 2010; Pilgrim, 2009).

Since the cooperation of health and social care services in community mental health teams and within the past decade, social workers' employment conditions have changed as they are employed by Local Authorities but they are seconded to work in Mental Health National Health Service Trusts (Bogg, 2008; Gould, 2010). Social workers' role and duties have also changed and include: the health care tasks of the care programme approach; and the social care tasks of care management as well as the statutory social work duties (Bogg, 2008; Gould, 2010; Payne, 2009).

Thus social workers in integrated teams work with a variety of other mental health professionals in a multidisciplinary environment (Bogg, 2008; Coppock and Dunn, 2010; Department of Health, 2002; Gould, 2010). The different professionals in the current integrated community mental health teams in the UK include: psychiatrists, community psychiatric nurses, occupational therapists, psychologists and social workers (Bogg, 2008; Department of Health, 2002; Gould 2010). The members of the team work together to support service users who experience *"severe and enduring mental health problems"* (Carpenter et al., 2004, p.313). The role of the multidisciplinary team is to work with adults in their communities and provide support and to promote service users' recovery, offer relapse prevention advice, support independence and social inclusion, respecting service users' dignity and human rights (Bogg, 2008; Department of Health, 2002; Department of Health, 2008b; Gould, 2010).

The health oriented care programme approach has different levels of care and when a service user has an enhanced care package, this care package consists of a multidisciplinary team with a consultant psychiatrist and a care coordinator, who can be a community psychiatric nurse, a social worker or an occupational therapist (Bogg, 2008; Carpenter et al., 2004; Department of Health, 2008b; Gould, 2010). In the care programme approach the needs of service users and the clinical risks are assessed and reviewed in order to support them and promote their mental health recovery (Bogg, 2008; Department of Health, 2008b; Gould, 2010).

Furthermore as social workers in the integrated community mental health teams are employed by a Local Authority, they are also required to perform specific statutory duties and obligations on behalf of that Local Authority (Brammer, 2010; Brayne and Carr, 2010). A specific and very important social work statutory duty that was described earlier is the role of approved mental health professionals, who are responsible in coordinating and organising Mental Health Act assessments

according to the Mental Health Act 1983 as amended by the Mental Health Act 2007, regarding the admission of service users to hospital for assessment and/or treatment of mental health issues, if and when necessary and when alternative options for treatment in the community have not worked (Bogg, 2008; Brayne and Carr, 2010; Department of Health, 2008a; Mental Health Act 1983 as amended by Mental Health Act 2007).

In the past, the role of the approved mental health professional was an exclusive statutory duty of social workers and those social workers with the relevant training were known as approved social workers (Bogg, 2008; Brayne and Carr, 2010). The change in the mental health legislation enabled other professionals working in mental health settings, for example community psychiatric nurses and occupational therapists, to train as approved mental health professionals (Brayne and Carr, 2010; Bogg, 2008; Coppock and Dunn, 2010; Gould, 2010). This significant change, which affected a statutory duty traditionally seen as a social work role, had its critics as it was viewed as a reduction in the responsibilities of social workers working in mental health, however it was also interpreted as an opportunity for social workers to adapt, change and expand their role within community mental health teams due to the integration of the services (Bogg, 2008; Coppock and Dunn, 2010; Gould, 2010, Pilgrim, 2009).

Other social work statutory duties derive from the Mental Capacity Act 2005 (Brayne and Carr, 2010; Department for Constitutional Affairs, 2007) as social workers undertake best interests assessments under the Deprivation of Liberty Safeguards (Ministry of Justice, 2008). Social workers are also required to carry out vulnerable adult safeguarding investigations under the No Secrets guidelines (Department of Health and Home Office, 2000) and the Safeguarding Vulnerable Groups Act 2006 (Brayne and Carr, 2010) in order to safeguard vulnerable adults against significant harm, exploitation and abuse. A vulnerable adult *“is a person aged 18 years or over who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation”* (Department of Health and Home Office, 2000, p. 8-9). Finally care management tasks include the assessments of service users’ needs and social care funding applications that are carried out by social workers, on behalf of Local Authorities, in order to meet the needs of service users by providing various care support packages (Payne, 2009; Wilson et al., 2008).

Care and Control Debate and Anti-oppressive Practice in Mental Health Social Work

Within the history and foundations of social work, the way that social work practice is seen and the role that social workers are required to perform by governments and authorities, there are elements of social control, state intervention and protectionism (Brayne and Carr, 2010; Wilson et al., 2008). The same elements of social control may also be found in the provision and delivery of mental health services (Coppock and Hopton, 2000; Pilgrim, 2009). Hence it can be claimed that in mental health social work there is an ethical debate and a discussion regarding the responsibility, task and place of social work, its theory and its practice in modern society (Banks, 2006; Coulshed and Orme, 2006; Howe, 2009). Whether the function of mental health social work is about caring, advocating and empowering people by working anti-oppressively and exploring service users' perspectives or it is about controlling and making individuals compliant (Banks, 2006; Brayne and Carr, 2010; Clifford and Burke, 2009; Coppock and Dunn, 2010; Gould, 2010; Pilgrim, 2009; Rogers and Pilgrim, 2005).

The above care and control analysis and arguments in social work practice are very relevant in mental health legislation and acts, as it can be claimed that the laws around mental health are among the most interventionist, coercive, restrictive and oppressive, when compared to the other UK legislation, in terms of their interference in the private lives, private affairs, human rights and liberty of UK citizens (Brammer, 2010; Brayne and Carr, 2010). Subsequently, the social care and social control debate can be utilised in arguments concerning the role of mental health social workers in: supporting the interests and human rights of adults with mental health issues, protecting people with mental health problems from harming themselves and protecting the general public, safeguarding their wellbeing, welfare and safety, as individuals with mental health problems in contact with services are regarded as vulnerable adult service users (Brammer, 2010; Brayne and Carr, 2010; Coppock and Dunn, 2010; Wilson et al., 2008).

It was argued that the political emphasis on individuality rather than communities, capitalism, privatisation and free market economy, targets and management of resources had an impact on the social work training provided (Dominelli, 1996). The above process would lead in a situation where the modern social worker was becoming detached from critical analysis regarding such issues as the influence of social, economic, political factors on the exclusion and oppression of service users (Dominelli, 1996). The end result would be that a de-skilled professional practitioner would have a negative impact on the empowerment of service users and on working anti-oppressively with service users (Dominelli, 1996).

Thus the role of a mental health social worker is to understand the issues around the care and control debate (Brayne and Carr, 2010; Coppock and Dunn, 2010; Gould, 2010), support service users by working with an anti-oppressive practice (Clifford and Burke, 2009), utilise appropriate social work supervision to reflect on issues of professional practice (Noble and Irwin, 2009), whilst also being aware that at times and on an organisational level, anti-oppressive practice can be used as an excuse to endorse the exercise of oppression by that powerful agency (McLaughlin, 2008; Wilson and Beresford, 2000).

Specialisation and Genericism in Mental Health Social Work

The discussion and arguments regarding the specialisation and genericism debate were reviewed and explored in relation to the issues, problems and complexities that social work practitioners, as a professional entity, had to deal with and confront in trying to create a core generic social work theory and practice which in turn would then be utilised as a framework in order to formulate and inform the specialised social work theory and practice (Stevenson, 2005; Wilson et al., 2008). It was argued that social workers started as generic social work practitioners with core and shared principles, ideas, standards and expertise as they worked in every area of social work: with children and families, with adults, with people with mental health issues, and then those core values and principles would have been utilised as the source and root from which the various specialisations in social work practice would surface (Stevenson, 2005). The above process was compromised due to issues around professional status, influence, power, politics, selectiveness, previous specialisations and exclusivity (Stevenson, 2005). Thus it was claimed that in the modern times social work practice and social workers are divided and spread in a number of various different services, organisations and agencies, working either with children and families, or with adults, or with people with mental health issues, without having the notion of a generic social work practice and a shared knowledge base (Stevenson, 2005). Based on and following from the above arguments (Stevenson, 2005; Wilson et al., 2008) it can be claimed that an issue with specialisation might be that specialist services can become fragmented, isolated without coordination and collaboration with each other, while an issue with genericism might be that generic services, without a core shared knowledge base, might lack the specific knowledge and expertise of the specialist services (Stevenson, 2005; Wilson et al., 2008).

The specialisation and genericism debate (Stevenson, 2005; Wilson et al., 2008) is of importance to mental health social work as social workers who were employed by Local Authorities to work in the specialist area of mental health were seconded to work for the National Health Service in integrated community mental health teams, another specialist field (Bogg, 2008; Gould 2010). Those social workers were then asked and expected to perform the Local Authority statutory duties and care managements tasks as well as the National Health Service's care programme approach care coordination tasks (Bogg, 2008; Department of Health, 2002; Gould 2010). Thus based on the above, it can be argued that mental health social workers become generic workers, but not generic social workers, but rather they became generic mental health practitioners sharing tasks with health professionals, and in a way mental health social workers work in a generic way but within the specialised integrated health and social care model of community mental health teams (Bogg, 2008; Gould 2010).

Service Users, Social Exclusion and the role of Mental Health Social Work

The issues of poverty, social exclusion, stigma, oppression and their impact on mental health and on service users, as well as the role of social workers in supporting service users with mental health issues have been identified by a number of authors (Coppock and Dunn, 2010; Gould, 2010; Pilgrim, 2009). A number of studies were reviewed exploring the issues around poverty, welfare benefits and the experiences of service users with mental health issues (Davis, 1999). A cooperative approach with social work involvement and awareness of service users' perspectives and their needs was proposed in order to develop a mental health social work practice that can address issues of social exclusion and poverty (Davis, 1999). It was also argued that the political motivation to modernise service provisions in mental health with the integrated model of community mental health teams, provided social workers with an opportunity to utilise their skills and social perspectives in order to address issues of poverty and social exclusion and thus support the social inclusion of service users (Gould, 2006).

Social workers in the integrated community mental health teams have a number of statutory responses and policy responses, through legislation and governmental documents, available for guidance in supporting service users to address issues around social exclusion, poverty and discrimination (Brayne and Carr, 2010; Department of Health, 2008a; Department of Health 2008b; Gould, 2010; Mental Health Act 1983 as amended by the Mental Health Act 2007). For example section 117 of the Mental Health Act 1983 as amended by the Mental Health Act 2007, provides the right to free social and health aftercare for service users who are discharged from section 3 of the act following a hospital admission that can last up to six months (Brayne and Carr, 2010; Department of Health, 2008a). It is the responsibility of the relevant mental health services and the social workers working within those services to implement a poverty aware practice, provide support around social inclusion and advocate for the rights of service users at a very vulnerable stage of their lives following a lengthy hospital admission (Brayne and Carr, 2010; Carpenter, et al. 2004; Department of Health 2002; Department of Health 2008a; Department of Health 2008b).

Another statutory legislation that social workers utilise to support service users is the Mental Capacity Act 2005 with its Code of Practice (Brayne and Carr, 2010; Department for Constitutional Affairs, 2007) where further protection is provided to service users who lack the mental capacity to make decisions in particular areas, for example to manage their financial affairs. Social workers provide assistance and statutory support by employing the use of agencies and procedures such as the Court of Protection, appointments of Deputies and Independent Mental Capacity Advocates in order to safeguard service users from financial exploitation and monitor the implementation of care packages that would enhance social inclusion (Brayne and Carr, 2010; Department for Constitutional Affairs, 2007; Gould 2010; Payne, 2009). A step forward towards addressing social exclusion (Gould, 2010; Pilgrim, 2009) was made with the Equality Act 2010 (Government Equalities Office, 2010) as the law made illegal for employers and organisations to discriminate against a person because of their physical and/or mental health. Thus this explicit declaration against discrimination and in favour of equality could provide, in theory, employment opportunities for people who in the past were excluded and faced discrimination

because of mental health issues (Gould, 2010; Government Equalities Office, 2010; Joseph Rowntree Foundation, 2010; Pilgrim, 2009). It is worth noting that all the above statutory legislation and policies were implemented in accordance to the Human Rights Act 1998 (Brayne and Carr, 2010), which provided the benchmark and protects the human rights of every person in this country.

The policy issues around poverty, inequality and social exclusion that affect service users experiencing mental health problems have been explored by UK governments (HM Government, 2009; HM Government, 2011) and by social policy organisations (Centre for Social Justice 2011; Joseph Rowntree Foundation, 2010). By reviewing the above policy responses to social exclusion and mental health, it can be argued that they share common themes regarding the need for a united approach and strategy, a joint partnership working within multidisciplinary settings, in order to address those issues, while it can also be claimed that they differ in the fact that different governments with different agendas have commissioned different strategies in order to serve their own political aims and objectives as the issues were already identified but the policy responses have been delayed (Centre for Social Justice 2011; HM Government, 2009; HM Government, 2011; Joseph Rowntree Foundation, 2010; McLaughlin, 2008). Social workers working in community mental health teams are then caught in the middle as they try to balance the various governmental changes regarding the policies and responses to social exclusion and mental health (Department 2008b; HM Government, 2009; HM Government, 2011) whilst supporting service users to address their needs (Coppock and Hopton, 2000; Gould, 2006; Gould, 2010; McLaughlin, 2008)

Relevant Research in Integrated Community Mental Health Teams

A number of studies researched the multidisciplinary working environments of integrated community mental health teams, exploring the views, experiences and opinions of the various health and social care professionals regarding the impact of integration on their professional roles, their identity and on issues of professional cooperation (Bailey and Liyanage, 2012; Brown et al., 2000; Carpenter et al., 2003; Gibb et al., 2002; Hannigan and Allen, 2011; Norman and Peck, 1999; Peck and Norman, 1999; Rees et al., 2004). The majority of the above studies were conducted from a health care perspective, utilised various qualitative research approaches, and examined issues around professional roles, boundaries and potential conflicts in integrated community mental health teams (Brown et al., 2000; Hannigan and Allen, 2011; Norman and Peck, 1999; Peck and Norman, 1999; Rees et al., 2004). Whilst a couple of studies employed a social work perspective (Bailey and Liyanage, 2012; Carpenter et al., 2003) as they explored mental health social workers' views as well as the views of health professionals in integrated teams.

A number of studies were reviewed (Bogg, 2008) regarding multidisciplinary working within an integrated mental health and social care approach and some common factors and obstacles to integration were identified. Thus it was argued that the various different professionals within community mental health teams were confronted with issues around: *"role ambiguity and conflict"*; *"communication difficulties"*; *"development of a shared philosophy"*; and *"lack of faith in management understanding and effectiveness"* (Bogg, 2008, p. 37) and those issues were seen as inhibiting to integration.

A report on the role of social workers within integrated community mental health teams by the British Association of Social Workers (2010) argued that within UK various Local Authorities and National Health Service Mental Health Trusts have implemented integration at varied and different levels while those services that supported all different professionals in terms of their identities and roles were seen as more successful. The report supported that social workers should maintain their role identity, valued the holistic approach and the use of social perspectives by social workers in those integrated teams and acknowledged the benefits of multidisciplinary working for service users (British Association of Social Workers, 2010).

The study by Carpenter et al. (2003) explored the multidisciplinary team structure within community mental health teams across four districts in relation to the level of health and social care collaboration and integration and then examined the effects of service integration on the different professionals of those teams, while the teams differed on their level of integration as social workers in some of the teams performed social work tasks only, while in other teams they performed both statutory social work and care coordination tasks. The study employed a quantitative research approach with questionnaires and had a qualitative element as participants, mainly community psychiatric nurses and social workers, could write some comments, as issues around: professional identity, roles and team integration were explored (Carpenter et al., 2003). It was argued that when the level of health and social care cooperation was increased, then there was a better performance indicator favouring the more integrated services, whilst issues around professional identity and *"role clarity"* were also identified as social workers reported more concerns around *"role*

conflict” and experienced more stress and less *“job satisfaction”* than community psychiatric nurses and other health professionals (Carpenter et al., 2003, p.1082). The issues of stress and job satisfaction as factors negatively affecting social workers working in mental health settings was replicated by a number of other studies (Evans et al., 2005; Evans et al., 2006; Huxley et al., 2005).

In another study by Carpenter et al. (2004) a quantitative approach with questionnaires was utilised in order to explore service users’ perspectives regarding service provisions from community mental health teams that had different levels of health and social care integration, whilst the same questionnaires were administered to the same participants after six months. It was claimed that participating service users showed a preference for service integration (Carpenter et al., 2004).

In the study by Bailey and Liyanage (2012) the role of social work within integrated community mental health teams was explored by utilising an ethnographic approach which was a mixture of participant observations and semi-structured interviews in order to ascertain the views and opinions of all the various health and social care professionals working in four different community mental health teams. It was argued that participants, mainly community psychiatric nurses and social workers, valued the integrated health and social care model of community mental health teams, whilst they acknowledged the existence of separate health and social care funding packages (Bailey and Liyanage, 2012). The contribution of social workers and social perspectives in the integrated community mental health teams was also seen as positive and complementary to the medical model by participants, whilst it was accepted that health care dominated the integrated services and participating social workers reported that they felt isolated from the Local Authority that employed them (Bailey and Liyanage, 2012).

Aims, Objectives and Relevance of Present Research Study

The aim of the present study was to utilise a social work perspective in order to explore the views and opinions of a number of social workers working within integrated community mental health teams, regarding their perceptions of their role and duties, their responsibilities and tasks and to provide an opportunity for their suggestions and comments.

The objectives of the present research study are to explore social workers':

- views regarding their social work role and statutory duties
- experiences of cooperative and collaborative work
- experiences of support received by social work and mental health managers
- views on the role of anti-oppressive practices in mental health social work
- views of multidisciplinary team structures in relation to social work identity
- opinions regarding the role of the approved mental health professional

The present study utilised a qualitative approach to explore the research questions (Carey, 2009; Robson, 2011; Whittaker, 2009) and this approach was consisted with other relevant studies in the field of mental health social work, which produced either qualitative research data (Bailey and Liyanage, 2012) or quantitative data with some qualitative elements regarding participants' comments (Carpenter et al., 2003).

This study was relevant for a social work practice perspective as it attempted to explore the views and opinions of social workers, who were working in community mental health teams, about cooperative working within an integrated health and social care multidisciplinary team model (Bogg, 2008; Gould, 2010). The views of social workers were significant as the research study was conducted within a political climate where certain Local Authorities within UK had decided, or considered, to remove social workers from community mental health teams and relocate them to social services departments (Community Care, 2011) and hence start a process of disintegration by separating mental health social work from the National Health Service mental health provisions (Community Care, 2011). Thus the student researcher argued that given the above potential change in working practice and procedures (Community Care, 2011), the present study was significant for social work practice as it explored the contemporary views and opinions of social workers regarding best practice, multidisciplinary working and the proposed changes (Bogg, 2008; Community Care, 2011; Gould, 2010).

Chapter 3: Methodology

Design

This study utilised a qualitative research approach instead of a quantitative approach (Carey, 2009; Robson, 2011; Whittaker, 2009) due to the nature of the study's questions and the stated aims and objectives to explore social workers' views and opinions in relation to their working experiences, their role, duties, responsibilities and tasks in multidisciplinary team environments of community mental health teams (Bogg, 2008). A qualitative approach with semi-structured interviews as its research method was the best way to capture the experience of social workers as it enabled to explore and interpret participants' views and opinions in a more meaningful way than a quantitative research approach would (Carey, 2009; Robson, 2011; Whittaker, 2009). A quantitative approach would have attempted to measure and statistically quantify participants' opinions rather than understanding and interpreting those opinions as did the qualitative approach used in this study (Carey, 2009; Robson, 2011; Whittaker, 2009).

The present qualitative research study utilised, as its design, a phenomenological approach (De Witt and Ploeg, 2006; Dowling, 2007; Porter, 2008; Robson, 2011; Whittaker, 2009; Yeung et al., 2012) in order to explore, understand and interpret participants' opinions about their working experiences and their role within their multidisciplinary working environment. Specifically an interpretive phenomenological approach (De Witt and Ploeg, 2006; Dowling, 2007; Robson, 2011; Yeung et al., 2012) was used, within a social work theoretical and practical framework (Coulshed and Orme, 2006; Howe, 2009); where the researcher's own working experiences as a social work student in a community mental health team are acknowledged and accepted as a fact of life (De Witt and Ploeg, 2006; Dowling, 2007; Robson, 2011; Yeung et al., 2012), whilst the student researcher's past ideas, presumptions and practical knowledge gained in the field of mental health social work are not expected to be dismissed, ignored or marginalised, they are rather described, assimilated and rationalised as they form part of the researcher's interpretation and understanding of participants' views and opinions (De Witt and Ploeg, 2006; Dowling, 2007; Robson, 2011). The notion that phenomenological approaches in health and social care research are utilised at times without fully comprehending the theory and philosophical framework of phenomenology (Porter, 2008) is also acknowledged by the student researcher.

Recruitment of Participants & Sampling Strategies

Participation in the study was voluntary, while potential participants were approached and recruited via a forum for professionals utilising a mixture of convenience and snowball sampling strategies (Noy, 2008; Robson, 2011; Whittaker, 2009) due to issues of availability, access, opportunity, time constraints, nature of the professional forum's meetings and in order to recruit a meaningful number of participants. Furthermore, the convenience and snowball sampling strategies were chosen as those strategies were consistent with the research study's qualitative approach and the use of semi-structured interviews (Robson, 2011; Whittaker, 2009).

Convenience sampling *"simply means selecting participants based upon the relative ease with which they can be contacted"* (Whittaker, 2009, p.35). Whilst snowball sampling *"is a technique where the researcher selects a small number of participants and asks them to recommend other suitable people who may be willing to participate in the study"* (Whittaker, 2009, p.35).

All the study's participants were qualified social workers, members of the Approved Mental Health Professionals (AMHP) Forum, and they were working within the city's various community mental health teams. Participant eligibility and inclusion criteria also depended on their consent for the audio recording of the interviews.

The student researcher had liaised with the Forum's Facilitator and had obtained consent (Appendix 5: Confirmation of Gatekeeper Consent) to attend one of the bimonthly AMHP Forum meetings. At that particular meeting, the student researcher addressed the members of the Forum that were present at that time and explained the aims and objectives of this study, whilst the Participant Information Sheet (Appendix 2) and Participant Consent Form (Appendix 3) were distributed. Social workers who were interested in participating were recruited, via informed consent and convenient interview appointment times and locations were offered and agreed with participants.

The student researcher utilised a convenience sampling strategy (Robson, 2011; Whittaker, 2009) by attending and addressing the readily available members of the AMHP Forum that were present at that meeting at that particular date, as potential participants were in attendance and were conveniently contacted and recruited for the study.

The student researcher also utilised a snowball sampling strategy (Noy, 2008; Robson, 2011; Whittaker, 2009) to recruit participants as the members of the Forum in attendance were asked to suggest and discuss the study with their colleagues who were not present at that particular meeting and who might have been interested in taking part in the study.

Research Method & Data Collection

The research method utilised for the present qualitative study was semi-structured interviews (Carey, 2009; Robson, 2011; Whittaker, 2009), as interviews are considered an appropriate, prevalent and accepted way for collecting meaningful data and information from participants in studies utilising qualitative research approaches (Bailey and Liyanage, 2012; Carey, 2009; Robson, 2011; Whittaker, 2009; Yeung et al., 2012).

Thus following the recruitment of participants that met the inclusion criteria, convenient appointment times were agreed at locations where participants felt comfortable to be interviewed. At the scheduled appointments for the interviews, the Participant Information Sheet (Appendix 2) was provided again and it was explained that participants had the right to withdraw at any stage of the interview process without providing any explanation for doing so. Informed written consent was sought via the Participant Consent Form (Appendix 3) as participants were asked to sign the form. An opportunity for participants' questions prior to the recorded interview and for feedback after the interview was also provided. All the interviews were recorded with a digital audio recorder and then transcribed. Participants' anonymity and confidentiality was protected as any details or characteristics that could potentially identify the names of participants, their employers or any service users were neither asked nor recorded during the interview process

The use of semi-structured interviews with open-ended questions enabled the student researcher to administer a flexible Participant Interview Schedule (Appendix 4) that took into consideration the participants' flow of answers and deviations from the order of the interview schedule (Robson, 2011; Whittaker, 2009).

Qualitative Data Analysis

The semi-structured interviews (Appendix 4: Participant Interview Schedule) with all the participants were transcribed (Appendix 6: Examples of Interview Transcripts with Participants). The transcribed interviews were then analysed with the process of thematic analysis (Braun and Clarke, 2006; Carey, 2009; Robson, 2011; Smith and Firth, 2008; Whittaker, 2009) which was facilitated by the use of QSR NVivo 10 (NVivo), a computer software programme designed to assist in the analysis of qualitative data (Robson, 2011; Whittaker, 2009).

Thematic analysis is *"a method for identifying, analysing and reporting patterns (themes) within data"* (Braun and Clarke, 2006, p.79). Thus the student researcher utilised the software programme (QSR NVivo 10) to process, scrutinise, classify and organise the data by spotting and connecting common patterns and codes within the data and grouping the common codes together (Braun and Clarke, 2006; Carey, 2009; Robson, 2011; Whittaker, 2009). The coding process was then repeated (Appendix 7: Audit Trail of Thematic Analysis Coding using NVivo) until higher level themes and their sub-themes emerged and were identified by the researcher (Braun and Clarke, 2006; Carey, 2009; Robson, 2011; Whittaker, 2009).

Thematic analysis can be utilised as an inductive approach to data analysis (Braun and Clarke, 2006; Elo and Kyngas, 2007) which is *"independent of theory and epistemology, and can be applied across a range of theoretical and epistemological approaches"* (Braun and Clarke, 2006, p. 78) thus enabling the researcher to draw conclusions and findings from observing and analysing the data (Braun and Clarke, 2006; Elo and Kyngas, 2007). Thematic analysis can also be utilised within a theoretical and philosophical approach which *"would tend to be driven by the researcher's theoretical or analytic interest in the area"* (Braun and Clarke, 2006, p. 84). Hence it could be argued that thematic analysis (Braun and Clarke, 2006) is compatible with the theoretical assumptions of an interpretive phenomenological research approach (De Witt and Ploeg, 2006; Dowling, 2007; Porter, 2008; Robson, 2011) as the interview data analysed were based on an interview schedule and questions, that were developed from research aims and objectives, that in turn were evolved from the student researcher's social work placement experiences within a community mental health team, where social work theory and practice were linked (Coulshed and Orme, 2006; Howe, 2009).

By utilising the QSR NVivo 10 computer programme, it was possible to represent the main themes (*"tree nodes"*) and their sub-themes (*"free nodes"*) graphically into *"tree map of nodes"* which depicted the *"nodes compared by number of items coded."* Thus the largest sections of the generated figures represented the most common and most frequent sub-themes of that particular theme. A computer programme (QSR NVivo 10) was utilised to assist in the data analysis instead of a paper trail transcript process due to availability of the programme, time consumption from using paper trail, convenience of storing all the data under one place and ability to review and connect data quickly, whilst acknowledging that the computer programme is a medium in assisting the data analysis and could not replace the interpretive, analytical skills of the researcher (Robson, 2011).

Issues of Methodological Rigour & Bias

The issues of rigour and bias in qualitative research (Robson, 2011) and reflexivity (Guillemin and Gillam, 2004; Whittaker, 2009) were considered in order to address the study's standing and integrity and protect against subjectivity (Robson, 2011).

Reflexivity refers to the process of recognising and acknowledging that the researcher's presumptions, subjectivity and ideas impact on the research study and influence the researcher's decisions about the study and the interaction with participants (Guillemin and Gillam, 2004; Shaw, 2010; Whittaker, 2009). Thus it could be argued that reflexivity (Guillemin and Gillam, 2004; Shaw, 2010; Whittaker, 2009) and a phenomenological research approach (De Witt and Ploeg, 2006; Dowling, 2007; Robson, 2011) are complementary and interlinked as they acknowledge the issues of researcher's bias, subjectivity and prior knowledge (Shaw, 2010) and that reflexivity *"offers a mechanism for identifying and managing issues arising from the fusion of horizons we encounter as people researching people"* (Shaw, 2010, p.240). Thus the researcher acknowledged that as a social work student on a placement experience had formed views and ideas about integrated community mental health teams from social work theory and practice (Coulshed and Orme, 2006; Howe, 2009) and from interacting with social workers; those views were also influenced by the views of social workers who provided guidance to the student researcher, who in turn utilised the knowledge gained to construct the research questions; whilst interaction with participants was also affected due to power issues (Clifford and Burke, 2009) between the student researcher and participants who were qualified social workers. The student researcher reflected on those issues and utilised tutorial sessions with the dissertation supervisor in order to discuss those issues (Guillemin and Gillam, 2004; Whittaker, 2009).

In order to increase the study's rigour (Robson, 2011) the Audit Trail of Thematic Analysis Coding using NVivo (Appendix 7) was included for reasons of transparency, and openness and hence the process could be reviewed. Furthermore triangulation (Robson, 2011) was achieved as the data coding process was reviewed during tutorial sessions with the student researcher's dissertation supervisor, whilst a fellow social work student peer reviewed part of the data coding process; both the student researcher and the peer reviewer independently coded an interview transcript and then reviewed the coding process to compare and discuss whether similar codes were identified (Robson, 2011).

The issue of participant feedback in phenomenological research approaches was explored and it was argued that seeking participant feedback was appropriate within phenomenological approaches and that the feedback increased rigour (Bradbury-Jones et al., 2010). Due to this study's time constraints it was not possible to provide participants with a summary of the interview transcripts and ask them whether they agreed or disagreed with the transcribed interviews. Participant feedback (Bradbury-Jones et al., 2010) was sought by providing participants with an anonymous summary of the study's main themes and findings. Participants were asked for feedback and were given the opportunity to comment and state their opinion about the findings (Appendix 8: Draft Summary of Main Findings sent to Participants).

Ethical Issues & Considerations

This study obtained Ethical Approval by Liverpool John Moores University Research Ethics Committee (Appendix 1) following a successful submission and acceptance of the Research Ethics Committee Application Form (Appendix 9) which was supported by a research proposal and various other documents (Appendix 2; 3; 4; 5).

When the ethical approval (Appendix 1) for the study was obtained, the student researcher commenced the process of data collection by attending the Approved Mental Health Professionals Forum, where participants were recruited and interview arrangements were made. The extremely significant issue of ethics in qualitative research studies was explored (Guillemin and Gillam, 2004) and it was argued that there are two different important aspects of ethics: *"procedural ethics and 'ethics in practice'"* (Guillemin and Gillam, 2004, p.262) with the former dealing with issues around application for the study's ethical approval and the latter dealing with practical issues arising from contact with participants.

The present study considered both *"procedural ethics and 'ethics in practice'"* (Guillemin and Gillam, 2004, p.262) as it complied with Liverpool John Moores University's (2011) ethical guidelines regarding the use of participants in research studies, with the General Social Care Council's (2010) Codes of Practice and the British Association of Social Workers' (2012) Code of Ethics. Whilst the description of the processes of participant recruitment, sampling strategies, interviewing and data collection and the consideration to issues regarding written informed consent, participants' rights, confidentiality and anonymity intended to provide an account of the ethical considerations and the ways they were managed by the student researcher (Guillemin and Gillam, 2004).

Thus in the participant information sheet that was provided, participants' right to withdraw at any stage of the interview process without giving any explanation for doing so was explained and written informed consent was sought. Participants were given the opportunity to ask questions about the study before the interview whilst feedback was provided following the interview.

In order to ensure data protection and confidentiality of personal data (Brayne and Carr, 2010; Liverpool John Moores University, 2011) the participants' signed consent forms were kept in a locked cabinet, the digital audio recorder for the interviews was kept in another, separate, locked cabinet, whilst the interviews were copied and transcribed from the digital recorder to the researcher's laptop where they were kept under a password protected file.

Chapter 4: Findings & Analysis/Discussion

Theme 1: Participants' Characteristics

Participants

In total seven (7) participants were interviewed for this research study; four (4) were female and three (3) were male. All participants were qualified social workers and they were working in community mental health teams at the time when the interviews took place. Following discussion with the dissertation supervisor and taking into consideration the nature of the research study, the time constraints and resource limitations, the above number of participants was considered sufficient for the study's aims and objectives (Whittaker, 2009).

Years Social Work Service	**14.3 years** On Average	**3 - 27 years** Range
Years SW Mental Health Service	**11.6 years** On Average	**3 - 23 years** Range

Table 1

Participants' Years of Service in Social Work and in Mental Health Social Work

Years of Social Work Service

The participants' working experience and years of service as qualified social workers varied; four (4) participants had over ten (10) years of social work experience and three (3) participants had under ten (10) years of experience. Participants' years of social work service ranged from 3 to 27 years, with an arithmetic mean of 14.3 years.

Years of Social Work Mental Health Service

The participants' experience working as qualified social workers within mental health settings also varied; three (3) participants had worked in the mental health field since they qualified as social workers while four (4) participants had worked in other fields of social work (children and families; adults) before working in mental health. Participants' years of social work mental health service ranged from 3 to 23 years, with an arithmetic mean of 11.6 years.

Employment Status

All seven (7) participants were employed by the same Local Authority and were seconded to work for the same regional Mental Health NHS Trust, in three different community mental health teams, under an operational agreement between the two organisations as part of the integration of health and care services in mental health settings (Bogg, 2008).

Structure of Community Mental Health Teams (CMHTs)

The seven (7) participants worked in three (3) different community mental health teams (CMHTs) and all those teams were part of the same regional Mental Health NHS Trust. Those CMHTs had a similar structure in terms of the various different professionals that formed the respective multidisciplinary teams (MDTs) of each community mental health team.

According to a participant the team they worked in consisted of:

> *"It's quite complicated really, it's basically one big team but it's split into sub-teams so each of those teams has a consultant psychiatrist at the head of it and then you have community nurses, social workers, occupational therapists working in each of those sub-teams and then in addition to that we have housing officers and psychologists that come in and work across all of those different sub-teams."*
>
> (Transcript of Interview 7, Mr FF, 19/04/2012, 41m58s; Appendix 6)

The above description of various professionals was fairly typical of the structure of multidisciplinary community mental health teams (Bogg, 2008; Department of Health, 2002).

Professional Background of NHS and Local Authority Managers

All seven (7) participants reported that the managers in the three (3) community mental health teams they worked for had a health care professional background, as did the majority of the deputy managers, whilst some deputy managers had a social work background.

Participants reported that they were either not sure who their Local Authority line manager was, or they were not aware whether a Local Authority line manager existed, in terms of support, accountability and supervision. Thus according to the account given by one participant:

> *"Not that I know of. There is...who is kind of a [Local Authority] senior manager, but in terms of accountability no not really. Not that I'm aware of anyway."*
>
> (Transcript of Interview 4, Ms EE, 19/03/2012, 21m03s; Appendix 6)

Theme 2: Social Workers' Role, Duties and Tasks within Integrated CMHTs

Working in the health and social care integrated community mental health teams meant that social workers have duties and tasks that derived from their respective health and social care agencies and hence they have to utilise two different approaches; the Local Authority statutory duties with the care management tasks and the NHS care programme approach tasks (Carpenter et al., 2004; Gould 2010; Payne, 2009). The main theme and its sub-themes are presented below.

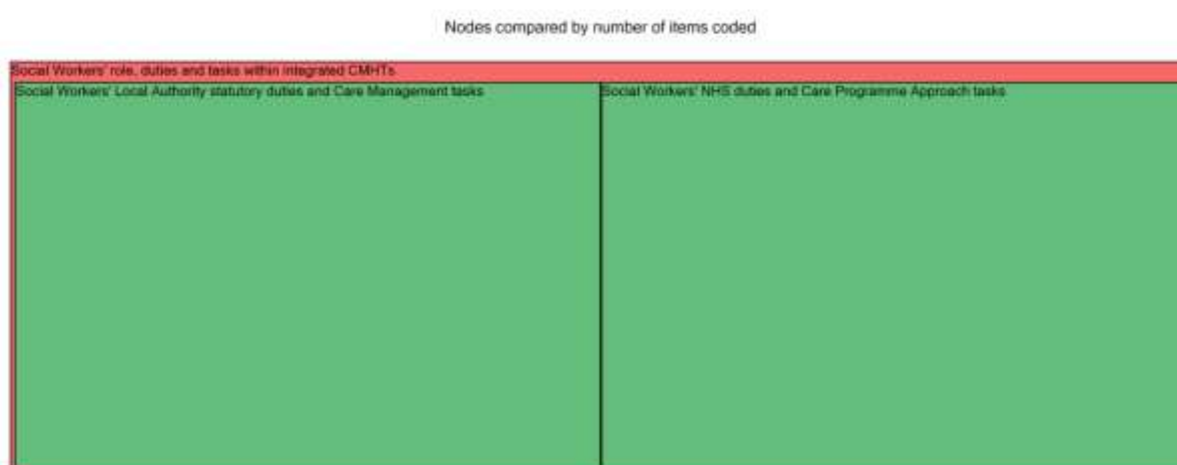

Figure 2

Visual representation of Theme 2 (Social Workers' Role, Duties and Tasks) with its two (2) sub-themes, which were equally referenced within the main theme

Social Workers' Local Authority Statutory Duties and Care Management Tasks

The statutory duties of the Local Authority along with the social work care management tasks were explained by one of the participants as:

> *"We also still carry out our duties as statutory social workers which would involve care management around commissioning and it would also involve safeguarding, we carry out the AMHP role in relation to the Mental Health Act assessments that are still with social workers at the moment. We also have an exclusive role of social supervisor, and the Section 117 reviews, we ensure that aftercare is monitored and reviewed."*
>
> (Transcript of Interview 1, Ms CC, 01/03/2012, 46m55s; Appendix 6)

The above description was consistent with the typical social work statutory duties and care management tasks (Bogg, 2008; Brammer, 2010; Brayne and Carr, 2010; Gould, 2010; Payne, 2009).

Social Workers' NHS Duties and Care Programme Approach Tasks

According to a participant, the health oriented duties and care programme approach tasks were described as:

> *"Well we became care coordinators and we're involved in all of the care coordination tasks on the Care Programme Approach pathway, along with our colleagues we are responsible for monitoring mental health patients in the community and monitoring medication, ensuring review..."*
>
> (Transcript of Interview 1, Ms CC, 01/03/2012, 46m55s; Appendix 6)

Another participant explained their health oriented care programme approach tasks as:

> *"...Ok, basically I act as a care coordinator for part of my job which is a similar role to CPN [community psychiatric nurse] in terms of mental health monitoring, risk management, clinical risk management, risk assessment, assessment of need..."*
>
> (Transcript of Interview 4, Ms EE, 19/03/2012, 21m03s; Appendix 6)

Again participants' accounts were consistent with the service user needs assessment and risk management rationale of the care programme approach (Gould, 2010; Payne, 2009).

Theme 3: Social Work Identity within Integrated CMHTs

The issues of professional identity and thus social work identity within the field of mental health was explored by a number of authors (Bogg, 2008; British Association of Social Workers, 2010; Brown et al., 2000; Coppock and Dunn, 2010; Gould, 2010; Hannigan and Allen, 2011; Huxley et al., 2005; Nathan and Webber, 2010). Participants' responses showed that they valued their social work identity within integrated community mental health teams. The main theme and its sub-themes are presented below.

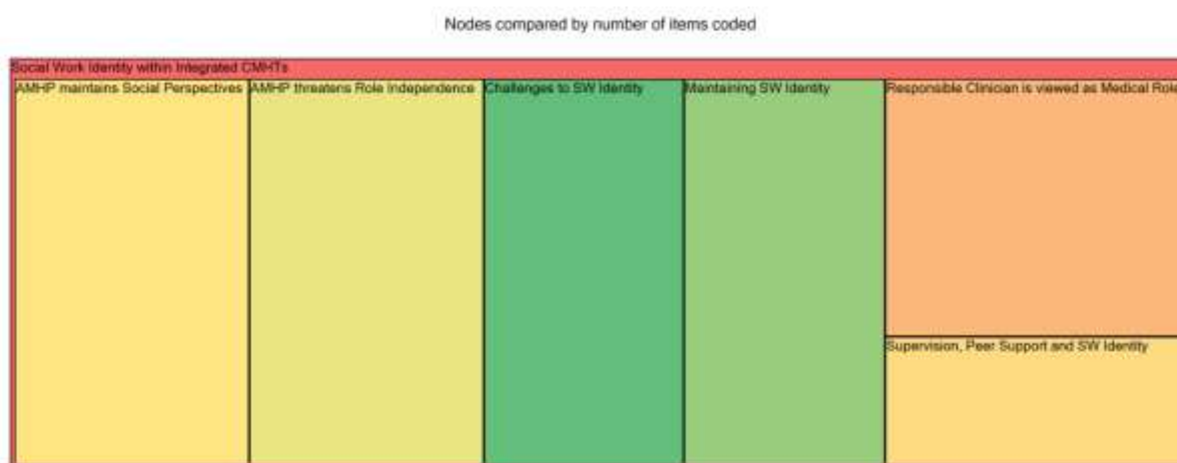

Figure 3

Visual representation of Theme 3 (Social Work Identity within CMHTs) with its six (6) sub-themes, where the largest sections showed the most referenced sub-themes

Perception that AMHP role should maintain Social Perspectives

The fact that the statutory role of the Approved Social Worker (ASW) had been replaced by the statutory role of the Approved Mental Health Professional (AMHP) and the new role was expanded to include other professionals (Bogg, 2008; Brayne and Carr, 2010; Mental Health Act 1983 as amended by the Mental Health Act 2007) was explored with participants and the discussion revealed an ambivalence regarding the issue.

Participants thought that the Approved Mental Health Professional (AMHP) role and training maintained, and should continue to do so, an emphasis on social perspectives and they recognised that those social perspectives were, or started to be, integrated in the other professionals' approaches.

Hence according to one participant:

> *"Basically...in the AMHP course it's about 20% nurses which is quite high actually, which I mean I think this is maybe sort of inevitable I mean in the long term, in the argument that you mentioned before that the social or the psychosocial model is more accepted by nurses and doctors, and it is because they don't see it as the enemy camp, the social workers don't see them as the enemy and over the years I think the doctors have integrated a bit more of an social work approach to their work…"*
>
> (Transcript of Interview 6, Mr BB, 23/03/2012, 51m51s; Appendix 6)

While another participant mentioned that:

> *"But I also think it's a good thing if the nurses and occupational therapists are educated the right way [in the AMHP training] and if they are coming from a social model, biopsychosocial model, they will be able to support the social side of the Mental Health Act assessment, and give that perspective... I think that it highlights the importance of the social perspective and the independent view, and as long as the nurses and the occupational therapists that are on the [AMHP] course are taken account for that then I can't see why it wouldn't work."*
>
> (Transcript of Interview 3, Ms GG, 19/03/2012, 22m09s; Appendix 6)

Participants also argued that the approved mental health professional role is a complex role that took priority over other professional duties within community mental health teams, that professionals in that role need to be able to adapt and be flexible when working as an AMHP and suggested appropriate supervision, managerial structure and dedicated staff as ways to maintain an effective service. The above issues also highlighted the argument that statutory duties created extra pressures to social workers in comparison to social workers performing non statutory roles (Evans, et al., 2005) and thus, with the expansion of the AMHP role, it could be argued that other professionals might experience similar pressures.

Perception that AMHP expansion might threaten Independence of that Role

Participants thought that the expansion of the Approved Mental Health Professional (AMHP) role to include other health professionals (Bogg, 2008; Gould 2010) might pose a threat to the independence of the statutory role and to the social perspective, as well as to the social work role and identity, due to the influence, dominance and hierarchical structure of the medical model. Participants also felt that as social workers in the AMHP role, they were more independent from the NHS mental health service, in comparison to their health care colleagues employed by that NHS service, and thus felt that they could challenge medical and psychiatric decisions with confidence. The above points were consistent with views and opinions expressed by some authors in the mental health social work field (Bogg, 2008; British Association of Social Workers, 2006; Evans et al., 2005; Gould 2010).

Thus one participant viewed the expansion of the AMHP role as:

> *"...I mean one of the biggest changes is that the role of the ASW and the CPNs, and the psychologists, are allowed now to go in for, to do the AMHP role. I found that really hard to swallow at first because I thought they'll take over our jobs, but not many have applied to do the AMHP course as far as I'm aware. But, I think it's important that as a social worker I am independent from the hospital and I feel that that they are not so independent because we can say no to someone that we feel that that isn't detainable, will they be able to do the same?"*
>
> (Transcript of Interview 2, Ms AA, 13/03/2012, 19m42s; Appendix 6)

The above points were also supported by another participant, who reported that:

> *"I think I'd really rather it [AMHP role expansion] just stayed with the social workers really. The other professionals are employed by the NHS for one thing and they're not that kind of used to challenging doctors for example, whereas, even though we work together it's easier for maybe for us to challenge a medical view or perspective, because we're not employed by the same body. I think that social workers maybe are just maybe happier to challenge those viewpoints really than maybe the nurses would be. Nursing tends to be a very hierarchical sort of structure, whereas social work isn't like that at all, so it enables you to challenge doctors, which the nurses by and large wouldn't do really, and advocate for something else."*
>
> (Transcript of Interview 7, Mr FF, 19/04/2012, 41m58s; Appendix 6)

However some participants challenged the idea that social workers in approved mental health professionals' roles would always have the confidence to challenge medical decisions and argued that confidence was also gained by experience and by individuals' professional development and values.

Developing and maintaining a Social Work identity within CMHTs

Participants provided suggestions and commented on ways to develop and maintain their social work identity within the multidisciplinary working environments of community mental health teams, taking into consideration their years of experience as qualified social works.

According to one participant, with under ten (10) years of social work experience:

> *"I suppose this is a difficult one as well for me, because I have only actually worked in the NHS. I've never actually worked in a social work team...but I do also recognise that it would be more beneficial to my development if we had a social work manager as well. Because, maybe some of the supervisions and the guidance that I may need in terms of the social work elements of the role cannot really be, sort of, you know, can be discussed, but it's more difficult to get direction if the manager hasn't got a social work background... But seeing that the team I am in at the moment has two quite experienced social workers, I feel that I can look to them for peer support."*
>
> (Transcript of Interview 3, Ms GG, 19/03/2012, 22m09s; Appendix 6)

Another participant, with over ten (10) years of social work experience, made the following suggestions regarding developing and maintaining a social work identity within multidisciplinary teams:

> *"Well, good point. One, I could say that they [newly qualified social workers] could benefit from doing some of their work within the Social Services Department before they came over. Two, is that at least for a number of years now they're going to have people who are experienced within the team so they're not likely to be on their own. Three, they could still benefit from the occasional social work meetings or going to the AMHP forums, those kinds of things. But four, I think that maybe they're the modern social worker, they're the new social workers. They're the future in which, they're less entrenched in the past. You need to be with the future...It's not like someone like me...who worked with attitudes of social work or what social work should be, that were prevalent in the 80s, 90s, they're too old fashioned so I think the other aspect I would say is that it might be beneficial for new social workers to be less influenced by that. Be aware of it but not be dogged down by it..."*
>
> (Transcript of Interview 6, Mr BB, 23/03/2012, 51m51s; Appendix 6)

Participants also argued that it was the responsibility of social workers to retain their identity by personal and professional development as a potential threat to social work identity was identified when seconded to the National Health Service by a Local Authority (Bogg, 2008) was the only working experience for a social worker. The above arguments were consistent with arguments regarding the importance of developing and maintaining a social work identity within multidisciplinary teams (British Association of Social Workers, 2010).

Social Work Identity and the Role of Supervision and Peer Support in CMHTs

In the multidisciplinary working environment of the integrated community mental health teams, the importance of social work supervision and of peer support in developing and maintaining a social work identity was recognised and appreciated by participants.

The significance of social work supervision and peer support was highlighted by one participant:

> *"...when I first moved here to this [CMHT] team there was a social work manager, so I had supervision with Local Authority manager, which I found really helpful...But seeing that the team I am in at the moment has two quite experienced social workers, I feel that I can look to them for peer support."*
>
> (Transcript of Interview 3, Ms GG, 19/03/2012, 22m09s; Appendix 6)

Another participant acknowledged the importance of social work peer support and of individual perseverance to a person's continuous social work professional development:

> *"...and I think you have to sort of have to have a lot of contact with the social workers just to have that kind of dialogue and conversation to help you retain your identity really and I think by reading that's how you help yourself, you help yourself by reading and you can continue with your knowledge base really."*
>
> (Transcript of Interview 4, Ms EE, 19/03/2012, 21m03s; Appendix 6)

The importance of social work supervision by managers with social work background was acknowledged by participants and that opinion was consistent with arguments about the role of supervision in forming a professional identity (British Association of Social Workers, 2010; Carpenter et al., 2003). Participants also criticised the fact that modern managerial supervision is target driven, a challenge also acknowledged by research (Noble and Irwin, 2009).

Perceived Challenges to Social Work Identity and Duties from Integration

Participants acknowledged that integration of mental health social work into community mental health teams might challenge and threaten their role due to sharing duties with health professionals. Those concerns were also expressed and reported in the past due to the expansion of the approved mental health professional role (British Association of Social Workers, 2006). It could be argued that if social workers are worried about their roles and identity, then those concerns could also lead to decreased job satisfaction due to experiences of stress (Carpenter et al., 2003; Evans et al., 2006).

Thus according to the opinion of a participant:

> *"But I do also worry that we are sort of losing our role, really, by the nurses, and occupational therapists being able to do our job. We could come to a point where we are not actually needed in the teams...I think that we are sort of on the path of destruction in terms of our identity because if the nurses are going to be able to do all the things that we have and traditionally done within the teams, then there is going to come a time when we are not needed."*
>
> (Transcript of Interview 3, Ms GG, 19/03/2012, 22m09s; Appendix 6)

Perception that Responsible Clinician is a Medical Role

The roles of the approved clinician and responsible clinician which were also open to registered social workers (Mental Health Act 1983 as amended by the Mental Health Act 2007; National Institute of Mental Health in England, 2008) were discussed and those roles were viewed as clinical, medical roles by participants.

According to one participant:

> *"No, I'm against that, I'm against that really because by the very nature of the term 'Responsible Clinician' implies a clinical view of mental distress and I don't think social workers would sit happily within that sort of domain really to be honest."*
>
> (Transcript of Interview 4, Ms EE, 19/03/2012, 21m03s; Appendix 6)

While another participant thought that:

> *"Generally speaking I would say I wouldn't be in favour of it, no matter what you say there's still a medical aspect of what the approach of helping people and their mental health problems so therefore there should be some sort of medical side to the supervision. In a way we do hold cases where doctors are not involved but that's more to do with the care management stuff, I think maybe it would depend on the system and how the structure was set up and it's possible for people with the lower level mental health problems, you could be the Responsible Clinician. I'm not quite sure what the benefit would be to be honest."*
>
> (Transcript of Interview 6, Mr BB, 23/03/2012, 51m51s; Appendix 6)

Theme 4: Facilitating Factors for Integration in CMHTs

Participants recognised and attributed certain aspects, within the multidisciplinary working environment, as significant facilitating and supporting features for the successful integration of community mental health teams. Those factors are presented below.

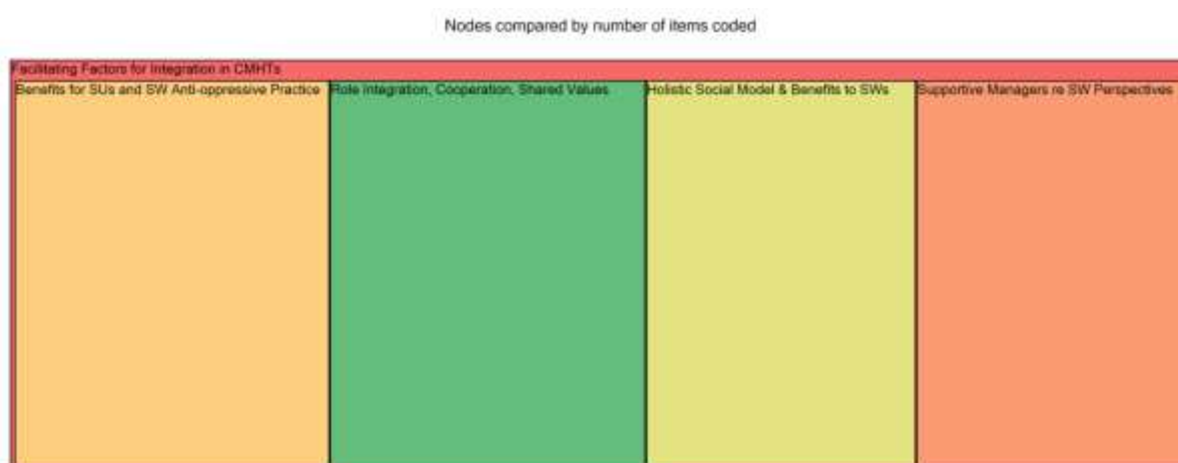

Figure 4

Visual representation of Theme 4 (Facilitating Factors for Integration) with its four (4) sub-themes, the largest sections showed the most referenced sub-themes

Role Integration, Interprofessional Cooperation and Shared Values

Participants appreciated the importance of communication, support and cooperation within the multidisciplinary team structure and recognised that they shared some common values with the various professionals within the community mental health teams. Participants also acknowledged that in an integrated team, professional roles were also integrated towards a generic mental health professional.

One participant reported about role integration and cooperation that:

> *"I think that the role of social worker is going towards more of a mental health practitioner role so it is becoming more generic...I think that it is really important to have an MDT style of working, and think that you gain a lot of experience from the other disciplines, and you are able to look at them for bits which you are not so sure on and they do the same to you."*
>
> (Transcript of Interview 3, Ms GG, 19/03/2012, 22m09s; Appendix 6)

Another participant gave the following example of cooperation and communication:

> *"Yes, obviously we do cooperate with our medical colleagues, we have to, in terms of, sometimes we do joint work for example so there might be someone who is on a depot injection and the CMHN will conduct that role and I as the social worker would conduct the social care needs role side of it, as well as mental health monitoring and we often collaborate on and discuss cases together and offer different perspectives and come at it from multi perspectives. We also cooperate on the MDTs we make decisions jointly. So there are lots of opportunities for cooperation and sometimes it works really well."*
>
> (Transcript of Interview 4, Ms EE, 19/03/2012, 21m03s; Appendix 6)

As for the shared values, one participant viewed them in relation to the service users:

> *"Common values, the good of the people we are working for. Helping and enabling."*
>
> (Transcript of Interview 2, Ms AA, 13/03/2012, 19m42s; Appendix 6)

The above findings were consistent with some findings from previous research (Bailey and Liyanage, 2012; Gibb et al., 2002; Rees et al., 2004) regarding the acknowledgement by social workers and health care professionals of the benefits of integration around sharing experiences and knowledge from different perspectives as the various professionals and perspectives complemented each other for the shared aim of supporting service users.

<u>Holistic Approach of Social Model and Integration Benefits for Social Workers</u>

Participants perceived that they utilised a holistic approach when working with service users, that the value of the social model of care in mental health is respected and that their knowledge as social workers was enhanced due to the integration and the multidisciplinary way of working within the community mental health teams.

According to one participant the social model of care was seen as:

> *"Yeah I think so, yeah. And I think also it has permeated into the language as well, I mean even if staff, non-social work colleagues, might not even recognise it sometimes, but some of the language being used on the training courses and the way that they look at mental health now is a lot more holistic than it would have been twenty or thirty years ago. So there is a lot of recognition that the social model and the social way of looking at things have got a greater validity and respect now than they would have had in the past and recognition that people's environments and social situations have a big impact on mental state, it's not just about dopamine levels or medical treatment for mental health, there's a long way to go I think but these things do take time to shift."*
>
> (Transcript of Interview 7, Mr FF, 19/04/2012, 41m58s; Appendix 6)

Another participant valued the knowledge gained from the skills, experience and qualities of the various different professionals within the integrated teams:

> *"I think it's about the best sort of approach for working with other professionals who have got different experience, different qualities, different skills, you are able to learn off those people, you are able to go out with a nurse if there is medication issues, and work as a team, and everybody's skills are used to the best advantage of the service user..."*
>
> (Transcript of Interview 3, Ms GG, 19/03/2012, 22m09s; Appendix 6)

This finding was consistent with the theme of *"disciplinary contribution"* reported by Bailey and Liyanage (2012, p.1126) where it was argued that *"an approach combining the medical and social models underpinned best practice"* (Bailey and Liyanage, 2012, p.1127) and was also beneficial to service users.

Social Work Anti-oppressive Practice and Service Users

Participants also viewed their role as supporting and advocating for service users, promoting anti-oppressive practice within the integrated community mental health teams. Thus according to the description of one participant regarding anti-oppressive practice whilst working with service users:

> *"Well, I see the role as you know as optimally as sort of enabling service users to make their own decisions and I think that social workers can come from a different perspective. We come from the perspective that service users are capable of making their own decisions and should be enabled and facilitated, it's not so much about doing what we think is best, I think that's more of a sort of medical view of how to manage people's distress. I think we come from the position of that we are enabling or helping people to make their own decisions and be more autonomous and those things are anti-oppressive for me. And seeing distress in a more social context, that mental distress is something that is common to all human beings basically and it's on a spectrum. I think those ideas are really important to retain and the sort of anti-stigma for you know, your work, that you might do all of those things for me are the anti-oppressive work really, so that's sort of contrary to some of the ways that CMHTs work sometimes."*
>
> (Transcript of Interview 4, Ms EE, 19/03/2012, 21m03s; Appendix 6)

Participants also agreed that the integrated multidisciplinary working environment of community mental health teams was beneficial to service users due to issues around continuity of care and interaction of health and social care professionals. This view was consistent with the opinion of service users regarding integrated working which was reported in a study by Carpenter et al. (2004) and with findings by Bailey and Liyanage (2012).

Supportive Managers with understanding of Social Work Perspectives

A supportive manager, irrespective of professional background but with a good understanding of social work and other professionals' perspectives, was perceived as another facilitating factor for a successful integrated community mental health team. The above was described by a participant who reported that:

> *"...at the moment we've got a mental health manager in the CMHT I work in, with health background, and no disrespect to any other non-social work managers I've had before, but the current one just seems to be reasonably able to take the social work perspective and reason that way. I had a similar experience, years ago, with a social work manager, with a strong social work background, who managed social workers and nurses and I said how do you do it and he said I had to understand what the nurses themselves do, the integration process is very difficult for them because of this, this and this. It seemed more difficult for them than the social workers and so he was saying he tried to understand things from the nurses' perspective and he said to me as well it doesn't matter if your manager is a social worker, you can get bad ones as well. And I think nursing managers are the same you get good and bad or you can get ones that are more responsive to needs [of social workers]..."*
>
> (Transcript of Interview 6, Mr BB, 23/03/2012, 51m51s; Appendix 6)

The importance of supervision in creating a good working environment was also reported in previous studies (British Association of Social Workers, 2010; Carpenter et al., 2003).

Theme 5: Inhibiting Factors for Integration in CMHTs

Participants also acknowledged that certain issues and certain aspects, within the multidisciplinary working environment, were perceived as inhibiting factors for the successful integration of community mental health teams due to unresolved issues between the health and social care services, the relevant NHS and Local Authority respectively. Those factors are presented below.

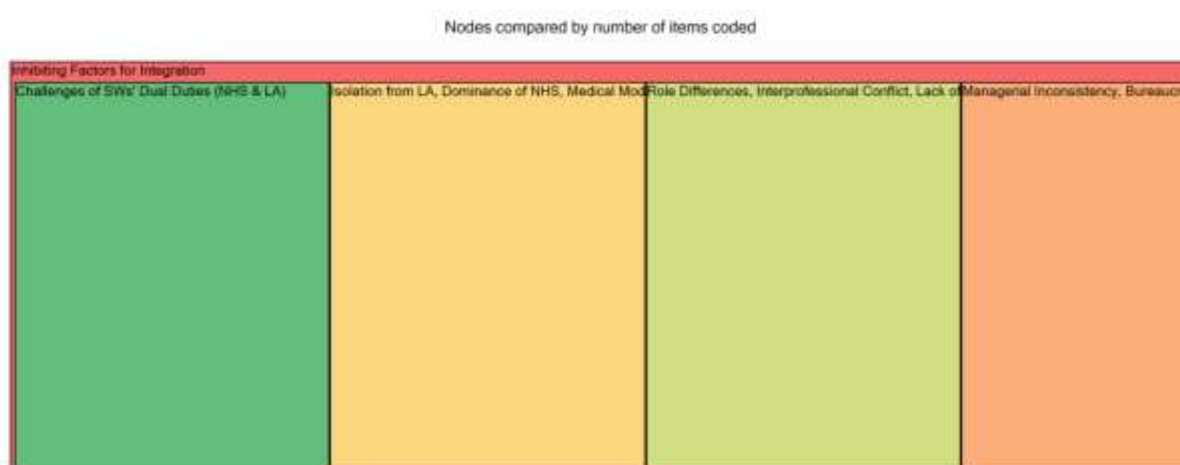

Figure 5

Visual representation of Theme 5 (Inhibiting Factors for Integration) with its four (4) sub-themes, the largest sections showed the most referenced sub-themes

Challenges for Social Workers due to their Dual Duties (NHS & Local Authority)

Participants reported that due to their employment status and the integration agreement between Local Authorities and the National Health Service, they had dual duties and responsibilities within community mental health teams. Thus participants reported that they had to fulfil both the health oriented care programme approach duties and the Local Authority care management tasks and statutory duties and viewed the above situation as an important challenge, as they perceived that their dual role was not fully acknowledged by their managers and their health professionals in the community mental health teams. Participants argued that their ability to complete both their tasks effectively and efficiently was affected by the unpredictable nature of statutory duties, which had specific time frames for completion, but they were not acknowledged in their caseload. The above arguments were consistent with the views expressed by other authors in the field of mental health social work regarding difficulties in interprofessional understanding (Bogg, 2008; British Association of Social Workers, 2010; Gould, 2010). The potential risk of experiencing stress due to the above issues should be considered as it was pointed out by a number of studies (Carpenter et al., 2003; Evans et al., 2005; Evans et al., 2006; Huxley et al., 2005).

According to an account by a participant, the above challenge was described as:

> *"Well we became care coordinators and we're involved in all of the care coordination tasks on the Care Programme Approach pathway, along with our colleagues we are responsible for monitoring mental health patients in the community and monitoring medication, ensuring review. We still retain our care management, our social work statutory duties. I think because of the amount of work that we actually do it's difficult to carry out two roles I think effectively with this time constraint, the caseload constraints I think it's difficult to carry out the two simultaneously...Those statutory duties [AMHP assessments, safeguarding adults investigations], mostly come unexpectedly, they're unpredictable they can come, they can be referred to us by our health colleagues who don't carry out those roles and they are additional to the care coordinator role in terms of our CMHT work....would trump all of the planned work for that day or* even week, for however long it takes, we have to ensure that it's carried out."
>
> (Transcript of Interview 1, Ms CC, 01/03/2012, 46m55s; Appendix 6)

Another participant reported that the Local Authority social work statutory duties were not recognised by the NHS recording system and thus were not taken into consideration in their caseloads:

> *"Well I think sometimes it's difficult because; there's capacity issues for social workers in mental health teams, because quite often, this is my opinion and I think it's possibly shared by some of the social workers, is that the role of the social worker for the Local Authority is not recognised so much. It's not recorded on the NHS system, so* it's almost like invisible work sometimes. So capacity issues are one issue..."
>
> (Transcript of Interview 4, Ms EE, 19/03/2012, 21m03s; Appendix 6)

Role Differences, Interprofessional Conflict and Lack of Role Clarity

Following from the dual function of social workers in community mental health teams, it can be argued that the perceived role differences between social workers and health professionals, the lack of role clarity and the different degrees of integration within different community mental health teams inhibit successful integration and create conflict. This finding was consistent with findings from a number of studies that also reported concerns around role clarity and issues around communication (Bogg, 2008; Brown et al., 2000; Carpenter et al., 2003; Hannigan and Allen, 2011; Peck and Norman, 1999).

Thus according to one participant regarding the perceived conflict:

> *"Yes [statutory duties]. On top of your caseload. So it does need to show in a reduction of your CPA so that you can manage everything. And that's where, I think, some of the conflict arises, because the nurses often look and think, well they haven't got as many people on their caseload, what are they actually doing, when they don't take into consideration that we have a lot of other things that we have to do, that they don't always have to do... I suppose you could say that if a social worker was allocated a piece of work commissioning and they actually have got a nurse care coordinator who knows them a lot better, but the social worker has been asked to do the assessment; I suppose you've got a question who's the more appropriate person to do the assessment. I would argue that possibly it would be the person who knows that person the best and sometimes that's not happening. And social workers are being asked to do work of commissioning when they haven't had any previous knowledge. Same with what used to be with social circumstances report which has got a lot better now with nurses doing their own."*
>
> (Transcript of Interview 3, Ms GG, 19/03/2012, 22m09s; Appendix 6)

Following on from the above reported issues, it could be argued that the needs for continuous interprofessional dialogue and training have been identified in order for better understanding of the various professionals' roles and duties within integrated community mental health teams.

Feeling Isolated from Local Authority and Dominance of the NHS

Participants felt that in the integrated community mental health teams, the National Health Service was the dominant organisation and reported that they felt isolated, abandoned and alienated by the Local Authority and isolated from their social work colleagues working for the Local Authority. Those findings were consistent with the findings reported by Bailey and Liyanage (2012) regarding the *"organisational dominance"* (p.1120) of the Mental Health NHS Trust and the social workers' perception of *"abandonment by the LA"* (p.1124) the Local Authority that employs them and that is responsible for the statutory duties performed by those social workers.

Those feelings were described by one participant as:

> *"The Local Authority has more or less cut us adrift and left us under the management of NHS. The Local Authority has got no expectations and they don't seem to remember that we exist. So all the other social workers in other parts of the City Council went through a long process of being trained, some people would say brainwashed, into something called the City way; which was kind of a `this is how we do things in this City`. The mental health teams weren't even included in that. So even though we are employed by the Local Authority we have more or less been abandoned by them. Although we are fulfilling statutory criteria for their duties to provide mental health social work assessments, or AMHP assessments as it is now."*
>
> (Transcript of Interview 5, Mr DD, 19/03/2012, 26m11s; Appendix 6)

Another participant reported that:

> *"But what tends to happen most of the time is you'd just go with the dominant model, which is the NHS, so I was supervised by my manager who was from the NHS, so she would just use whatever documentation or whatever that she has, simply because it's probably the most convenient way to do it, but I think you do lose a lot really, you're not working for your employer really, it's strange to be employed by somebody, but to hardly ever have contact with them apart from a couple of email systems sometimes, so I think you do lose out sometimes through that."*
>
> (Transcript of Interview 7, Mr FF, 19/04/2012, 41m58s; Appendix 6)

Thus it could be argued that the need for better communication and cooperation between the health and social care services, the Mental Health NHS Trust and the Local Authority was identified, as well as the need for the Local Authority to engage again, develop and maintain a working relationship with the social workers it employs.

Managerial Inconsistency and Systemic Bureaucracy

Participants also viewed issues of systemic differences, bureaucracy and lack of managerial consistency as inhibiting factors for a successful integration.

According to one participant who raised issues of managerial inconsistency:

> *"Yes a more consistent approach would be really important. I think the difficulty is that we've had quite a few managers in this team and they all have different ways of doing thinks. And I think that we've moved some way forward with the last manager about the nurses doing more of the roles. And then new managers come along and their way of doing things is different. So I think the team needs consistency and a consistent approach throughout."*
>
> (Transcript of Interview 3, Ms GG, 19/03/2012, 22m09s; Appendix 6)

Whilst another participant highlighted the systemic differences and issues of bureaucracy between the Local Authority and the NHS:

> *"I find that, there's quite a bit of confusion because we've got two different policies to abide to, Social Services policies and NHS policies and basically it's a bit, there're not the same so it's quite confusing really. For example, NHS policy is you can't take any children in your car, whereas with Social Services as long as you have a safety chair that is recognised by a safety organisations you could take, I mean sometimes when someone has children and they have to go to an outpatients appointment they have to get child care and if they can't get child care they won't go to their appointments. It can be quite difficult; I mean that's just a basic example. That's just the first thing that came to my head."*
>
> (Transcript of Interview 2, Ms AA, 13/03/2012, 19m42s; Appendix 6)

Thus the need for cooperation on a managerial and organisational level was identified which was consistent with the findings of a study by Rees et al. (2004) where it was argued that those issues caused conflict.

Theme 6: Supporting Integration, Ideas for Improvement, Alternative Options

The reported decision by some Local Authorities to withdraw social workers from the integrated community mental health teams (Community Care, 2011) and thus disintegrate the operational agreement model of cooperation and integration between Local Authority social care and the NHS health care regarding mental health service provisions in the community (Bogg, 2008; Lester and Glasby, 2010) was discussed with the participating social workers. Participants expressed their support for the integrated model acknowledging that many aspects of the integration required improvement, suggested ideas for improvement and discussed the impact of withdrawing social workers from community mental health teams. A couple of participants provided an alternative option, in case social workers were withdrawn from the integrated teams, the creation of discrete social work mental health teams. Participants acknowledged, however, the budgetary restraints and financial implications on Local Authorities of such a move and were not optimistic about the reasons behind such a move.

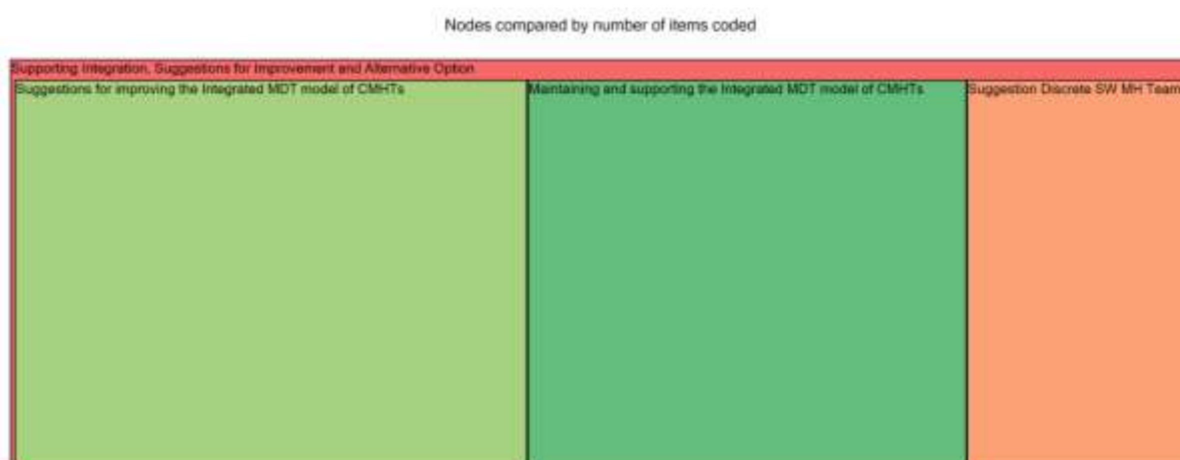

Figure 6

Visual representation of Theme 6 (Supporting CMHTs, Ideas and Options) with its three (3) sub-themes, the largest sections showed the most referenced sub-themes

Maintaining and Supporting the Integrated model of CMHTs

Participants supported the continuation of the integrated multidisciplinary working environment of the community mental health teams and viewed plans to withdraw social workers from those teams as a step backwards.

Thus according to the views of some participants regarding the issue:

> *"I think that it is really important to have an MDT [multidisciplinary team] style of working...There are already rumours that the social workers are going to be pulled out of the mental health teams that they are going to be in separate teams on their own. That for me, will be step back because I think that multidisciplinary team working is really, really important...I think it's really important to continue MDT work, and I think if we were outside of the team just doing the care packages we would learn a lot less about diagnosis, about the running of the mental health team, much more separate from the nurses, and I don't think it would be a very good way of promoting working with other professions...I think that the medical model seems to still rule the majority of cases, but that it's getting better, and that a lot of nurses are becoming more holistic in their approach, and I think that social workers bring that social model to mental health care, that needs to remain."*
>
> (Transcript of Interview 3, Ms GG, 19/03/2012, 22m09s; Appendix 6)

> *"...it was a different world then, it was a different world, and they got over that [health and social care divisions], integrated it, begin to understand one another and now they want to pull it apart, if that's what they're going to do, it's not good…"*
>
> (Transcript of Interview 6, Mr BB, 23/03/2012, 51m51s; Appendix 6)

> *"... but you're sort of going backwards really in many ways [if social workers are withdrawn from CMHTs], and the whole idea is trying to work together and then you're pulling people out..."*
>
> (Transcript of Interview 7, Mr FF, 19/04/2012, 41m58s; Appendix 6)

That finding is consistent with other findings (Bailey and Liyanage, 2012; Rees et al., 2004) where participants supported the benefits of integrated working whilst acknowledging the problems due to disagreements on a systemic level.

Suggestions for Improving the Integrated model of CMHTs

Participants offered their opinions, ideas and suggestions in order to improve the integrated community mental health teams. Thus participants suggested that:

> *"I think to have a social work line manager is very helpful, that's one thing. Maybe regular meetings amongst social workers, and that needs to be encouraged by senior managers, and maybe a structure put in place for social workers to meet, because at the moment we don't meet apart from the forum, we don't actually meet. Nurses have their own meetings but we don't and it's not encouraged particularly so that would probably help. Maybe more education, I don't know how that would be done, more training perhaps? Better training for nurses and medical staff about perhaps the social work role, social perspectives. I'm sure they get that already to a large extent but maybe more of that."*
>
> (Transcript of Interview 4, Ms EE, 19/03/2012, 21m03s; Appendix 6)

The above quote identified again that social workers felt isolated from Local Authorities, which was reported by Bailey and Liyanage (2012) as well, but also offered useful suggestions around the need for social work supervision and peer support in order to address the feelings of isolation and argued for further training and dialogue regarding social perspectives and their significance in mental health. And those issues were also advocated and supported by the British Association for Social Workers (2010).

Suggestion for Discrete Social Work Mental Health team if CMHTs are disintegrated

A couple of participants suggested the creation of discrete social work teams if the integrated community mental health teams were disintegrated and social workers were withdrawn by the Local Authorities. Thus according to those participants:

> *"Well, I'm not aware of the practicalities of it, but I think the most important thing would be if we got moved out of Community Mental Health Teams and were placed in discrete mental health services within the Local Authority, that might be better. If we are just mixed up with adult social care social workers, without the kind of guidance, and management, and skilled coordination of our work, then we will be no better off, except that we won't be surrounded by nurses who don't care, we will be surrounded by other social workers who are avoiding doing our job, because a lot of people find mental health a little bit frightening, I think."*
>
> (Transcript of Interview 5, Mr DD, 19/03/2012, 26m11s; Appendix 6)

> *"Well, I'm in two minds about it on the one hand I feel it's a shame, it's a step backwards, that social workers are being moved out because then perhaps the medical model will prevail even more. But the other side of it is social workers having their own identity in their group separate from the team may actually strengthen the social model of mental distress and enable social workers to communicate that more effectively and that might be a good counter balance to the medical model. So in other words it's less danger of being 'colonised' if you're separate and I think as a body it probably gives the union of social workers strength so I'm not totally against it to be honest."*
>
> (Transcript of Interview 4, Ms EE, 19/03/2012, 21m03s; Appendix 6)

Other participants, however, were sceptical about the motives behind withdrawing social workers from community mental health teams and thought that such moves were financially driven. As one participant said:

> *"…I think at the moment there's a bit of a tendency towards Local Authorities withdrawing social workers from CMHTs and that's a bit of a worry for us at the moment, I would guess that it is financial. I know in another Local Authority they pulled out all the social workers and put them in one team and I think it's less about, that would be to the detriment of Community Mental Health Teams, I can't see how it wouldn't be, but I think it's probably not the fact that they want to destroy the Community Mental Health Team, but I would guess it's more to do with control over the social workers, whether it's the shortage of money and the shortage to pay them so it's easier to have more than one thing so we can cut one or two off now and everybody has got to do their jobs, as well as that, having more control over the expenditure because you've got nurses and nurse managers agreeing and proposing expenditure that's coming mainly out of Social Services they might, they want to control it."*
>
> (Transcript of Interview 6, Mr BB, 23/03/2012, 51m51s; Appendix 6)

Chapter 5: Conclusion

The present research study had as an aim to explore the views and opinions of social workers within community mental health teams regarding their role, duties and responsibilities. This qualitative study adopted a social work perspective as it attempted to link social work theory and practice (Coulshed and Orme, 2006; Howe, 2009) whilst a phenomenological approach (De Witt and Ploeg, 2006; Dowling, 2007; Robson, 2011) was utilised in order to understand and interpret participants' perceptions and experiences within the multidisciplinary setting of those teams. In order to account for the student researcher's social work student placement experiences in a community mental health team and the potential impact of those experiences, views and gained knowledge on the formation of the research questions and on the understanding and interpretation of participants' opinions, reflective thinking was applied (Guillemin and Gillam, 2004; Whittaker, 2009).

By comparing the stated aims and objectives with the main findings it is argued that this research study achieved its goals, as participants' views and opinions regarding their: social work role and statutory duties; experiences of cooperative and collaborative work; support received by managers; the role of anti-oppressive practice; social work identity within multidisciplinary environments; and the role of the approved mental health professional, were represented in a meaningful way. This study argued that participants valued their social work identity and that regarding the integrated multidisciplinary community mental health teams, there were both facilitating factors, such as: the interprofessional communication and cooperation and the different professionals' shared values in working with, and supporting, service users; and inhibiting factors, such as: the perceived isolation and alienation of participants from the Local Authority that employed them and the lack of recognition and appreciation for the complexities of their dual social work role by their health managers and other mental health professionals.

A strength of this study was that it managed to replicate findings from previous studies and hence its credibility was increased (Robson, 2011). After reviewing previous studies, in the literature review, it could be argued that: at the start of the integration between health and social care in community mental health teams issues and concerns around role clarity and interprofessional communication were reported (Bogg, 2008; Brown et al., 2000; Carpenter et al., 2003; Peck and Norman, 1999); then professional interactions and appreciation of different professions' knowledge and experience started to develop (Gibb et al., 2002) as service users also started to value the integrated service (Carpenter et al., 2004); however issues of role clarity and confusion about tasks and responsibilities remained (Hannigan and Allen, 2011); as health and care professionals acknowledged benefits of integration on a interprofessional level but criticised the obstacles due to systemic level disagreements between National Health Service Mental Health Trusts and Local Authorities (Bailey and Liyanage, 2012; Rees et al., 2004) whilst social workers reported that they felt marginalised from their Local Authority (Bailey and Liyanage, 2012). This study added to and complemented the above arguments as participants acknowledged that integration is beneficial due to interprofessional sharing of knowledge, perspectives and experiences and that there was a shared aim in

supporting service users, whilst participants also reported concerns around role clarity and that they felt isolated from the Local Authority that employed them. Hence it is argued that some of the present study's findings were consistent with and replicated some of the previous studies' findings (Bailey and Liyanage, 2012; Brown et al., 2000; Carpenter et al., 2003; Gibb et al., 2002; Hannigan and Allen, 2011; Peck and Norman, 1999; Rees et al., 2004).

Another strength of this study was the fact that a draft summary of the main findings was sent to participants. Thus participants were given the opportunity to comment and provide feedback and that in turn enhanced their participation and involvement in this study, as participant feedback requests were compatible, valued and increased rigour within a phenomenological approach (Bradbury-Jones et al., 2010; Robson, 2011).

Since the interviews with participants took place, and in the past six months, there were news reports suggesting that approximately forty per cent (40%) of Local Authorities in the UK, either had already withdrawn, or were preparing to withdraw social workers from integrated community mental health teams (Community Care, 2012a). It can be argued that, the above news reports combined with some other recent news reports where it was mentioned that governmental funding to Local Authorities for social care and welfare issues would be further reduced for the forthcoming years (Community Care, 2012b), confirmed participants' concerns that the reasons behind Local Authorities' decisions to withdraw social workers from integrated community mental health teams were of a budgetary nature.

The present study, however, was conducted within a multidisciplinary health and social care environment where the Local Authority and the Mental Health NHS Trust remained committed to the integration of services. Furthermore participating social workers acknowledged the benefits of integrated working in community mental health teams and made suggestions to improve and enhance the integration and cooperation between the various professionals for the benefit of service users. Overall the integrated multidisciplinary environment was supported by participants, while suggestions to improve integrated working included: appropriate social work supervision; peer support; and continuous dialogue with other mental health professionals.

This research study's recommendations were based on participants' comments and suggestions and on the student researcher's interpretations, whilst the study's limitations were also acknowledged.

Study's Recommendations

- Commencing dialogue between the different professionals regarding the complexity and duality of mental health social work role.
- Provision of training and shadowing scheme regarding different professionals' roles and tasks.
- Better communication and cooperation at a systemic, organisational and managerial level between the relevant health and social care services; Mental Health NHS Trusts and Local Authorities.
- Need for Local Authorities to re-engage, establish and maintain working relationships with the social workers that are seconded to work for Mental Health NHS Trusts whilst being employed by those Local Authorities.
- Appropriate supervision by social work managers to support mental health social workers in order to develop and maintain their professional identity.
- Development of peer support networks among mental health social workers.
- Managers to undertake management skills training in order to support staff more effectively.
- Further research is needed in reflective thinking and the use of supervision in social work practice. The need was identified by a participant in relation to caseload and time constraints when practising and performing social work tasks:

"...But nevertheless it's nice to have a think about the roles and what you do and take time out from that, sometimes, because you've got a lot of training in the reflective practice and that's drummed in to you a lot, but it's hard to find that time when you're actually doing these jobs, finding time to reflect upon these things so it's quite nice [to be interviewed about those issues], it's been good."

(Transcript of Interview 7, Mr FF, 19/04/2012, 41m58s; Appendix 6)

Study's Limitations

- Generalisation (Robson, 2011; Whittaker, 2009) of findings across different Local Authorities and Mental Health NHS Trusts might be limited, as the study involved seven participants from three different community mental health teams, while all participants were employed by the same Local Authority and were seconded to work to the same Mental Health NHS Trust.
- Although the student researcher reflected on potential bias and accounted for issues of methodological rigour (Robson, 2011), it is acknowledged that the researcher's social work perspective and student placement experiences impacted on the interpretation of the findings.

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Appendices

Please note that in order to respect confidentiality and protect the identity of the participants, no real names have been used during this dissertation. The initials used are not the participants' real initials, while the names of work places, locations and the organisations concerned are not included.

Appendix 1: Ethical Approval by LJMU Research Ethics Committee

Ethical Approval

12/HEA/008, Georgios Chatziroufas, PG (MA), Exploring social workers' perceptions of their role and duties within community mental health teams (Echo Yeung)

Liverpool John Moores University Research Ethics Committee (REC) reviewed the above application and I am happy to inform you the Committee are content to give a favourable ethical opinion and recruitment to the study can now commence.

Approval is given on the understanding that:

- any adverse reactions/events which take place during the course of the project will be reported to the Committee immediately;
- any unforeseen ethical issues arising during the course of the project will be reported to the Committee immediately;
- any substantive amendments to the protocol will be reported to the Committee immediately.
- the LJMU logo is used for all documentation relating to participant recruitment and participation eg poster, information sheets, consent forms, questionnaires. The JMU logo can be accessed at www.ljmu.ac.uk/images/jmulogo

For details on how to report adverse events or amendments please refer to the information provided at http://www.ljmu.ac.uk/RGSO/RGSO_Docs/EC8Adverse.pdf

Please note that ethical approval is given for a period of five years from the date granted and therefore the expiry date for this project will be January 2017. An application for extension of approval must be submitted if the project continues after this date.

Yours sincerely

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Appendix 2: Participant Information Sheet

LIVERPOOL JOHN MOORES UNIVERSITY

PARTICIPANT INFORMATION SHEET

Exploring social workers' perceptions of their role and duties within community mental health teams.

You are being invited to take part in a research study. Before you decide it is important that you understand why the research is being done and what it involves. Please take time to read the following information.
Ask me if there is anything that is not clear or if you would like more information.
Take time to decide if you want to take part or not.

- **What is the purpose of the study?**

This research study is part of my dissertation requirement, as a student for the MA in Social Work postgraduate course, at Liverpool John Moores University.
My interest in this study derived from my social work student placement experience.
Social workers have been integrated into mental health services for around 10 years. Past research into the integration of mental health and social services has concentrated on health perspectives, while this study will examine views and opinions from a social work perspective.
In my study I will interview 6-10 participants, who are qualified social workers, members of the Approved Mental Health Professionals Forum and who are currently working within various community mental health teams.
The aim of my study is to explore your views and opinions, as qualified social workers, examining your perceptions of your role within mental health services in relation to your duties, responsibilities and tasks.

- **Do I have to take part?**

No, as participation in this study is voluntary; it is up to you to decide whether or not to take part. If you do you will be given this information sheet and asked to sign a consent form. You will be provided with copies of these. You are still free to withdraw at any time during the interview process and without giving a reason, while a decision to withdraw will not affect your rights.

- **What will happen to me if I take part?**

If you sign the consent form and decide to take part in this study, a convenient interview appointment time and location will be offered and agreed with you.
Then you will be interviewed once, the interview will last around 40 minutes, it will be anonymous and it will be audio recorded. The interview will be semi-structured and you will be asked about your working experiences in a community mental health team and your role as a social worker within a multidisciplinary environment.
The study will last from February 2012 to August 2012 and the plan is to conduct interviews with 6-10 different participants. The anonymised findings will be used as part of my student dissertation requirements.

- **Are there any risks / benefits involved?**

It is unlikely that your participation in this study will cause any harm to yourself.
No immediate benefits for yourself are expected from your participation in this study. However, as the study will aim to identify some examples of good social work practice models, it may generate discussion and sharing of experiences that might be of interest to you.

- **Will my taking part in the study be kept confidential?**

Yes as in order to ensure confidentiality only I, the researcher, will know your identity, while the information that you will provide during the interview will be anonymous. You will not be asked to provide any details or characteristics that could be used to identify yourself, any service users or your employers, during the interview.
The findings of the study will be anonymous. The anonymised findings will be utilised and published as part of my student dissertation requirements for the MA in Social Work postgraduate course at Liverpool John Moores University and will be disseminated internally amongst supervisors and programme assessment boards.
Potentially a short anonymised summary of findings may be produced and distributed via the Approved Mental Health Professionals Forum, in order to inform social work practice, and so you will have the opportunity to access the anonymised research findings.
All your provided information and data will be safely stored in locked cabinets, they will be kept for 5 years and then all the data will be destroyed.

- **Contact Details of Researcher:**

Please ask me if you have any questions, comments or feedback about the study.
You can contact me at my university's email address:
G.Chatziroufas@2003.ljmu.ac.uk

Appendix 3: Participant Consent Form

LIVERPOOL JOHN MOORES UNIVERSITY
CONSENT FORM

Exploring social workers' perceptions of their role and duties within community mental health teams.

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights. ☐
3. I understand that any personal information collected during the study will be anonymised and remain confidential. ☐
4. I agree to take part in the above study; a semi-structured interview. ☐
5. I understand that the interview will be audio recorded and I am happy to proceed. ☐
6. I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised. ☐

Name of Participant:	Date	Signature
Name of Researcher:	Date	Signature
Name of Person taking consent: *(if different from researcher)*	Date	Signature

Note: When completed 1 copy for participant and 1 copy for researcher

Appendix 4: Participant Interview Schedule

Exploring social workers' perceptions of their role and duties within community mental health teams.

My Interview Schedule

1) Demographic Information about the Participant:
   - Gender:
   - Years qualified as a Social Worker:
   - Years of working experience in Mental Health:
   - Structure of the Community Mental Health Team:
   - Professional background of current managers:
     - Local Authority Manager:
     - Mental Health Manager:

2) How do you see your role as a social worker working in the mental health field?

Prompts to ask if not covered; duties, responsibilities, tasks, statutory duties and anti-oppressive practice.

3) How do you see your role as a social worker within the integrated multidisciplinary structure of the Community Mental Health Team?

Prompts to ask;

- *What do you think about the care coordinating role of the Care Programme Approach, in relation to the care management approach?*
- *The role of anti-oppressive practice in mental health social work?*
- *Can you please tell me about your experiences of cooperation within an integrated mental health working environment?*

4) How do you think other professionals see your role within the Community Mental Health Team?

Prompts to ask; collaborative work, potential conflicts and how do you manage those issues?

5) How do you feel about your social work identity in relation to the other professionals within the multidisciplinary team structure?

Prompts to ask;

- *The medical and social models of care in practice?*
- *How do you feel about the expansion of the statutory role of the approved mental health professional?*
- *what about the option for social worker to take on the role of Responsible Clinician?*

6) What do you think are the common values, if any, that you share with the other professionals within the Community Mental Health Team?

7) What in your opinion are the benefits of multidisciplinary working within the Community Mental Health Team?

Prompts to ask if not covered; specific benefits to; social workers and; service users.

8) What in your opinion are the challenges of multidisciplinary working within the Community Mental Health Team?

Prompts to ask if not covered;

- *specific challenges to; social workers and; service users*
- *the approved mental health professional role;*
- *the withdrawal of social workers from mental health teams by some councils.*

9) What is your experience of working within the National Health Service, seconded by the Local Authority?

Prompts to ask if not covered;

- *How do you manage the different expectations, if any?*
- *What is your experience of the support you receive by your managers; social work and mental health managers?*
- *What would you like to change in relation to the support you receive?*
- *Do you think there are other/better ways to manage this situation?*

10) What do you think will be the ideal situation in order for Social Workers to work effectively within a Community Mental Health Team?

Appendix 5: Confirmation of Gatekeeper Consent

Copy of Email Communication regarding Gatekeeper Consent Confirmation

RE: LJMU MA Social Work Study; Request for Written Consent
From: Chatziroufas, Georgios
Sent:13 December 2011 14:25
To: [.nhs.uk]

Thank you very much

Kind regards
Georgios

From: [mailto: .nhs.uk]
Sent: 13 December 2011 14:00
To: Chatziroufas, Georgios
Subject: RE: LJMU MA Social Work Study; Request for Written Consent

Dear Georgios
I am in support of the research; please attend the next forum on 16th February.

Regards,

Practice Development/Improvement Lead (Social Care)
NHS Trust

Mobile: Fax: .

From: Chatziroufas, Georgios [mailto:G.Chatziroufas@2003.ljmu.ac.uk]
Sent: 13 December 2011 12:53
To:
Subject: LJMU MA Social Work Study; Request for Written Consent
Importance: High

Dear ,
Following on from our conversation yesterday, I am contacting you regarding my research dissertation, as I want to ask your written permission, via email, in order to conduct my proposed study.

I am a Second Year MA in Social Work Student at Liverpool John Moores University. My Supervisor is Echo Yeung, Senior Lecturer on BA & MA Social Work programmes at LJMU. The aim of my study, if approved by the LJMU Ethics Committee, is to explore the views and opinions of a number of social workers, currently working within community mental health teams, regarding their perceptions of their role within mental health services in relation to their duties, responsibilities and tasks. I have attached my Research Proposal, my Interview Schedule and the Participant Consent Form for your information.

In my proposed project, I will conduct semi-structured interviews with 6-10 qualified social workers. The participants will not be asked to produce any details or characteristics that could be used to identify them or any service users or their employers. All the interviews will be recorded with a digital audio recorder and then transcribed. In order to protect participants' anonymity and confidentiality their names will neither be asked nor recorded during the interview process.

I would like to ask your permission as the Approved Mental Health Professionals (AMHP) Forum Facilitator to attend the Forum's next meeting. I would like to discuss the purpose of the study with Forum members in order to explain the aims and objectives of the study, provide relevant information to Forum members, distribute the participant information sheet and recruit potential participants. Forum members will be asked whether they would be interested in participating in the study on a voluntary basis. Interested potential participants will then be recruited, via informed consent, until the target number of participants (6-10 qualified social workers) is reached. Convenient interview appointment times and locations will be offered and agreed with participants.

The anonymised findings of the research study will be utilised and published as part of the dissertation requirements for the MA in Social Work postgraduate course and will be disseminated internally amongst supervisors and programme assessment boards.

Potentially a short anonymised summary of findings may be produced and disseminated via the AMHP Forum, while participants will be asked whether they consent to that.

Please let me know if you require any further information.

I would be very grateful if could confirm, via email, whether I can proceed with my proposed research study.

Kind regards,
Georgios Chatziroufas
Social Work Student,
Liverpool John Moores University

Appendix 6: Examples of Interview Transcripts with Participants

Transcript of Interview 1: Ms CC: 01/03/2012: 46m55s

Participant: *Ms CC:* ***CC*** *Interviewer:* *Student/Researcher:* ***SR***

SR: Thank you for taking part in this study Can you please tell me how many years have you been qualified as a social worker?
CC: .

SR: And how many of those years have you worked in mental health?
CC:

SR: Can you tell me about the structure of the community mental health team?
CC:

SR: Can you please tell me about the professional background of your current manager, your community mental health team manager?
CC: .

SR: Thank you very much, and the professional background of your Local Authority manager?
CC:

SR: And what is your current employment situation?
CC: .

SR: And you're seconded by...
CC: .

SR: You're seconded by the Local Authority, but you don't have any Local Authority line manager?
CC:

SR: Thank you for that. And how do you see your role as a social worker working in the mental health field?
CC:

.

SR: Would you say this role has changed in the eleven years you've been qualified?
CC:

.

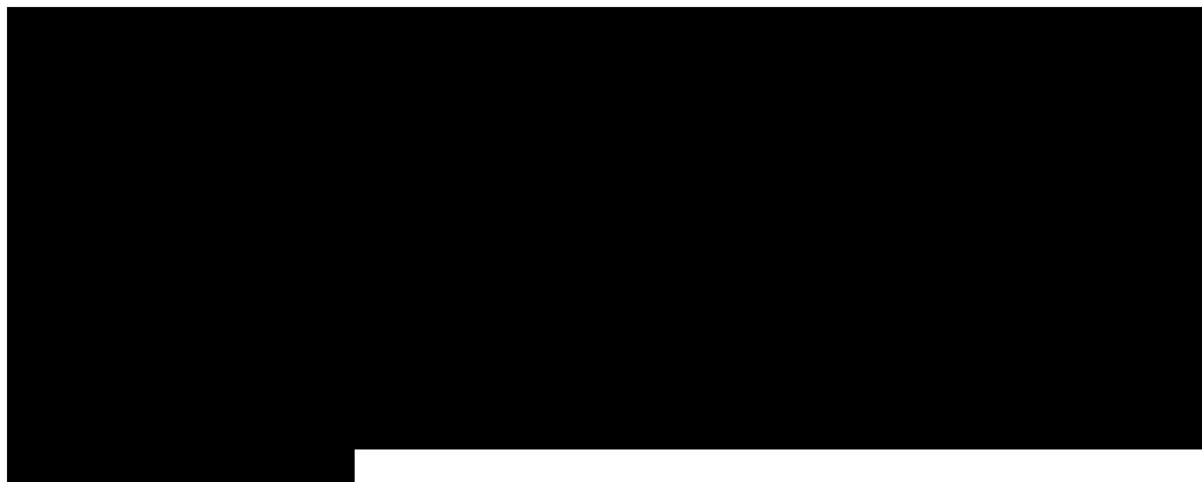
SR: So how do you see your role as a social worker within the integrated MDT, the multi-disciplinary team structure of the community mental health team?
CC:

SR: So the Care Programme Approach is?
CC:

SR: And the Care Management Approach is?
CC:

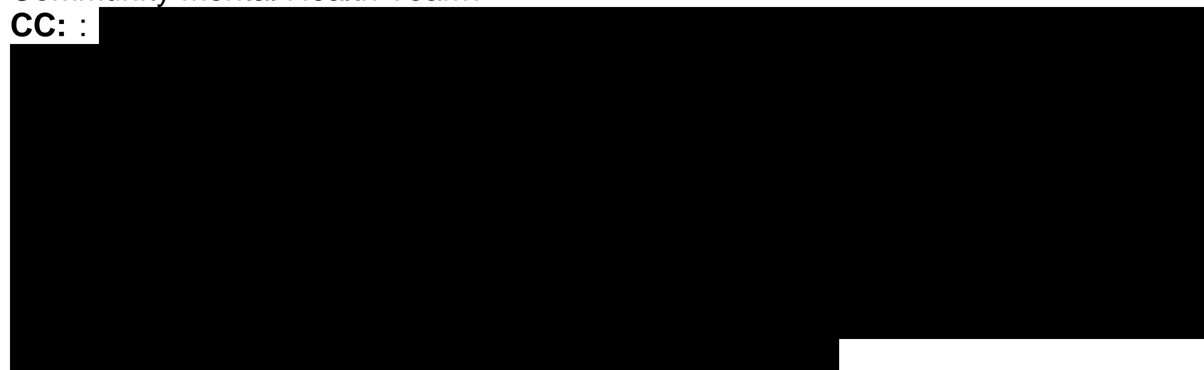
SR: How do you balance the different approaches?
CC:

SR: And can you please tell me about your experiences of cooperation with other professionals within the integrated mental health environment?
CC:



SR: What unpredictable events might happen? What are the statutory duties that you have to do in a day that are unexpected?
CC:

SR: Thank you for that. And how do you feel professionals see your role within the Community Mental Health Team?
CC: :



SR: So you are concentrating on both health and social care needs?
CC:

SR: Do those issues create potential conflicts?
CC:

SR: And how do you manage those potential conflicts?
CC:

SR: How do you feel about your social work identity in relation to the other professionals within the multi-disciplinary team structure?
CC:

SR: And how do you feel the medical and social model of care work in practice?
CC:

SR: So, more provision for social circumstances?
CC:

SR: Thank you for that and how do you feel about the expansion of the statutory role of Approved Mental Health Professionals that changed in the last couple of years and replaced the Approved Social Worker?
CC:

SR: Thank you. And what about the option for social workers to take on the role of Responsible Clinician?
CC:

SR: So, there are other people who are getting paid for that responsibility?

CC:

SR: Thank you. And what about the role of anti-oppressive practice in mental health social work?
CC:

SR: And is it because of the social care model the social workers operate in, in comparison to the medical model?
CC:

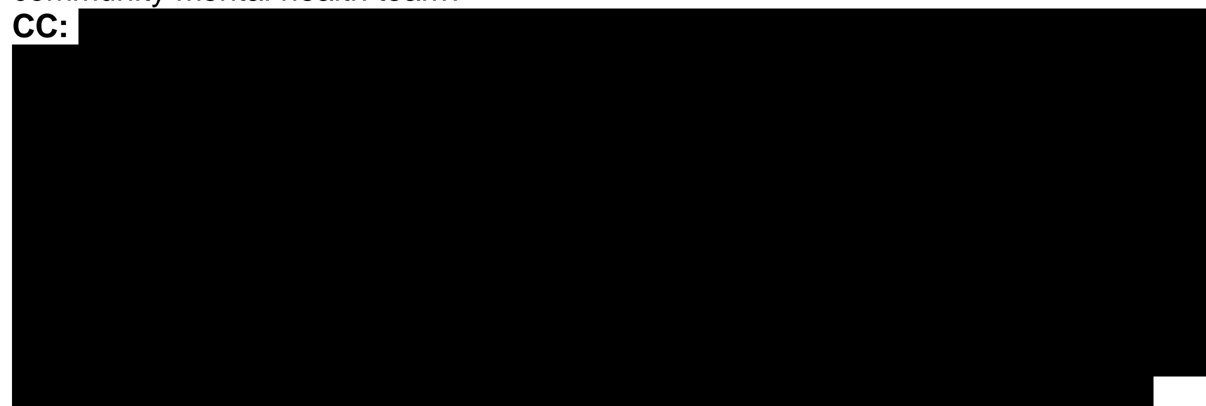
SR: And do you think this is due to training?
CC:

SR: And what do you think are the common values, if any, that you share within the community mental health team?
CC:

SR: So they are common values?
CC: .

SR: And what about the common values between the social workers and nurses? You mentioned earlier about human rights and capacity.
CC:

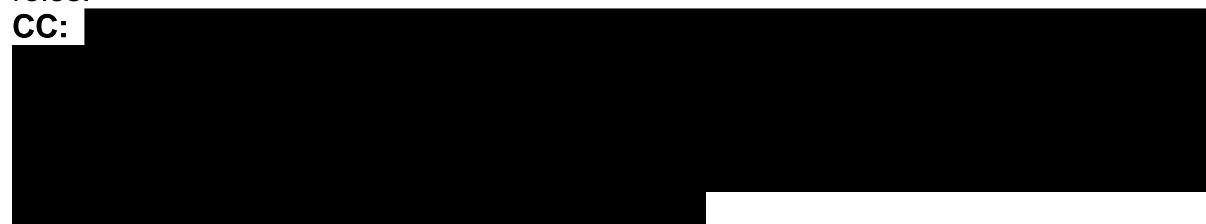
SR: And what in your opinion are the benefits of multi-disciplinary work within the community mental health team?
CC:



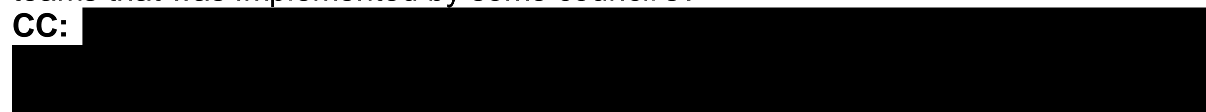
SR: And what would be the benefits to service users?
CC:

SR: Thank you for that. What in your opinion are the challenges of multi-disciplinary working within the community mental health team?
CC:

SR: Like you mentioned earlier about the care coordinating or the care management roles.
CC:



SR: And what do you think about the withdrawal of social workers from mental health teams that was implemented by some council's?
CC:



SR: So you would prefer which of the models?
CC:

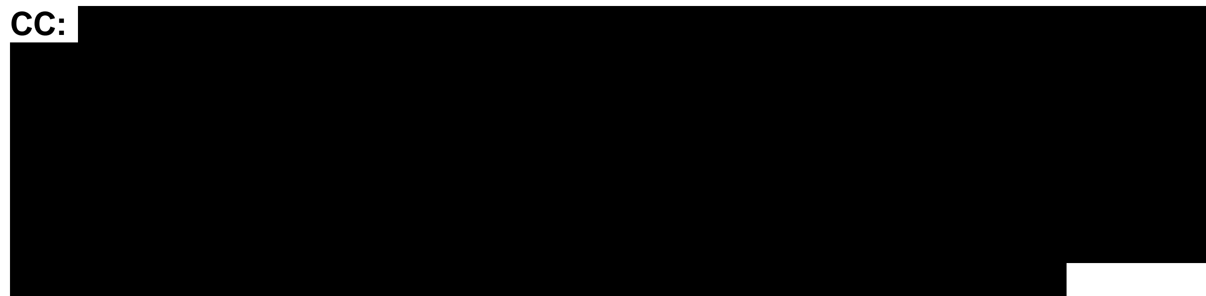
SR: Thank you for that. And what is your experience of working within the National Health Service seconded by the Local Authority?
CC:

SR: So what's your experience of the support you received by your managers, your social work and mental health managers. You mentioned that Local Authorities, you don't have line management.
CC:

SR: And what would you like to change in relation to the support you receive?
CC:

SR: Thank you for giving some solutions to how to manage the situation. What do you think will be the ideal situation in order for social workers to work effectively within the community mental health team?
CC:

SR: So it's a better balance between care management, statutory duties and care coordination?

CC: 

SR: But overall what would be your impression of integrated social workers in community mental health teams? Would you be in favour of this?

CC:

Transcript of Interview 7: Mr FF: 19/04/2012: 41m58s

Participant: *Mr FF:* ***FF*** *Interviewer:* *Student/Researcher:* ***SR***

SR: Thank you very much for taking part in this research study. The first couple of questions are going to be about your social work experience...so how many years have you been qualified as a social worker?
FF:

SR: How many years have you worked in mental health?
FF:

SR: Can you tell me a little bit about the structure of your Community Mental Health Team? In terms of the different professionals that are there, like social workers, what's the structure of your team?
FF:

SR: And do you have family support workers?
FF:

SR: And can you please tell me the professional background of your current manager?
FF:

SR: And what about your deputy manager?
FF:

SR: You are employed by the Local Authority and work for the NHS?
FF:

SR: To your knowledge do you have a direct line manager within the Local Authority?
FF:

SR: Thank you. How do you see your role as a social worker working in the mental health field? In terms of your duties, statutory duties, responsibilities, tasks.
FF: .

SR: Are you an approved mental health professional?

FF:

SR: How do you see your role as a social worker within the integrated multidisciplinary structure of the Community Mental Health Team? Because you mentioned your caseload work, so what do you think about the care coordinating role of the Care Programme Approach and the Care Management Approach?
FF:

SR: How do you balance your work with statutory duties, the Care Programme Approach and the Care Management roles?
FF:

SR: And what is your experience of cooperation within an integrated mental health environment? The cooperation with other professionals, members of the team?
FF:

SR: And how do you feel about that, is it a good thing or a bad thing? In terms of integration?
FF:

SR: Can you please tell me about the role of anti-oppressive practice in mental health social work?
FF:

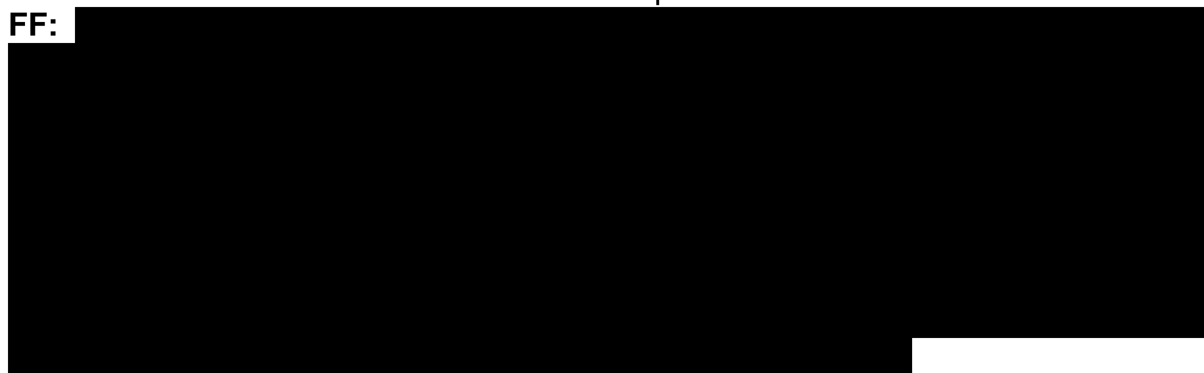
SR: And the stigma…?
FF:

SR: And have you noticed a difference, in the last ten years that you've been working, that service users' perspectives have been listened to more by the system, that they have more ways to ensure that their rights are being respected?
FF:

SR: And you've mentioned the role of the medical model. How do you feel about your social worker identity in relation to professionals within the integrated mental health team?

FF:

SR: Can you please tell me your opinion about the medical and social model of care in practice?
FF:

SR: So how does the social model of care help those service users?
FF:


SR: So the social model tries to do things holistically and complement the medical model…
FF:

SR: How do you feel about the expansion of the statutory role of the approved mental health professionals to professionals like community psychiatric nurses, occupational therapists?
FF:

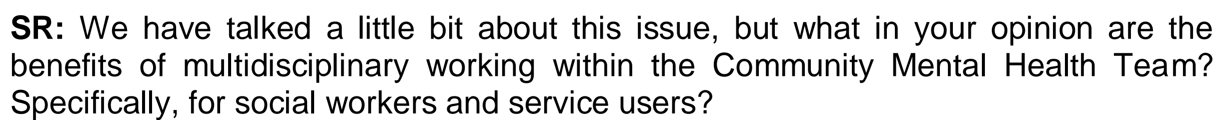
SR: Do you think that the role might lose its independence?
FF:

SR: And what about the option for social workers to take on the role of Responsible Clinician, what is your view about that?
FF:

SR: It's a medical kind of position...
FF:

SR: Thank you. And how do you think other professionals see your role within the Community Mental Health Team? For example, collaborative work, potential conflicts, how do you manage those issues?
FF:

SR: What are the common values, if any, that you share with the other professionals within the Community Mental Health Team?
FF:



SR: We have talked a little bit about this issue, but what in your opinion are the benefits of multidisciplinary working within the Community Mental Health Team? Specifically, for social workers and service users?

FF:

SR: What in your opinion are the challenges of working within a multidisciplinary Community Mental Health Team? Challenges for social workers and service users?

FF:

SR: And what do you think about the withdrawal of social workers from some councils due to budget cuts?
FF:

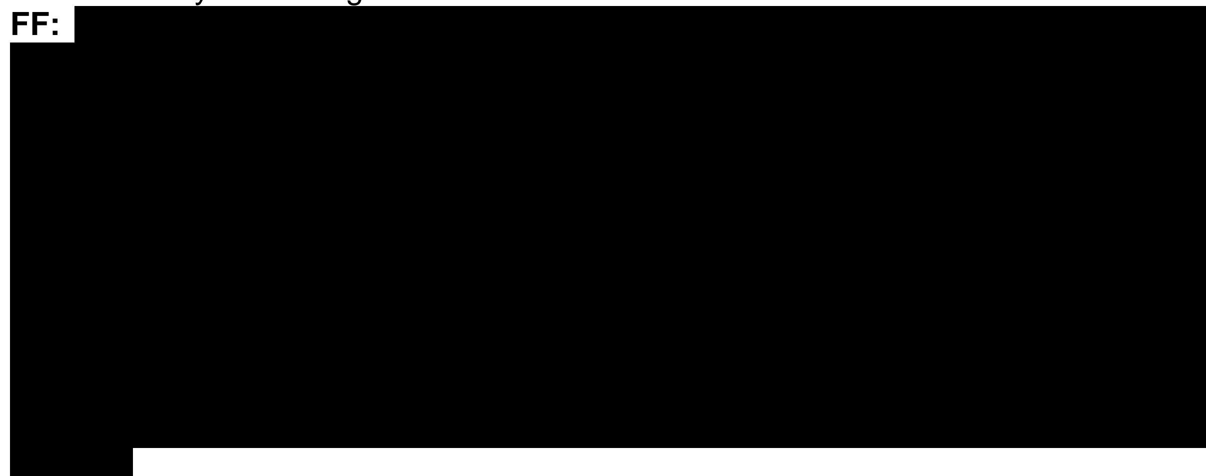
SR: So what do you think about that?
FF:

SR: So what was the reason given for that, was it financial or systemic?
FF:

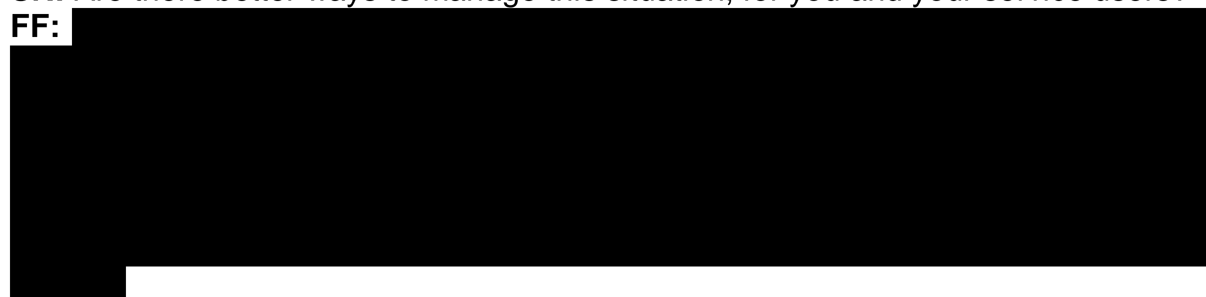
SR: What's your experience of working within the NHS being seconded by the Local Authority, how do you manage the different expectations, if there are any?
FF:

SR: What is your experience of the support you receive from your managers, like mental health managers, Local Authority managers?
FF:

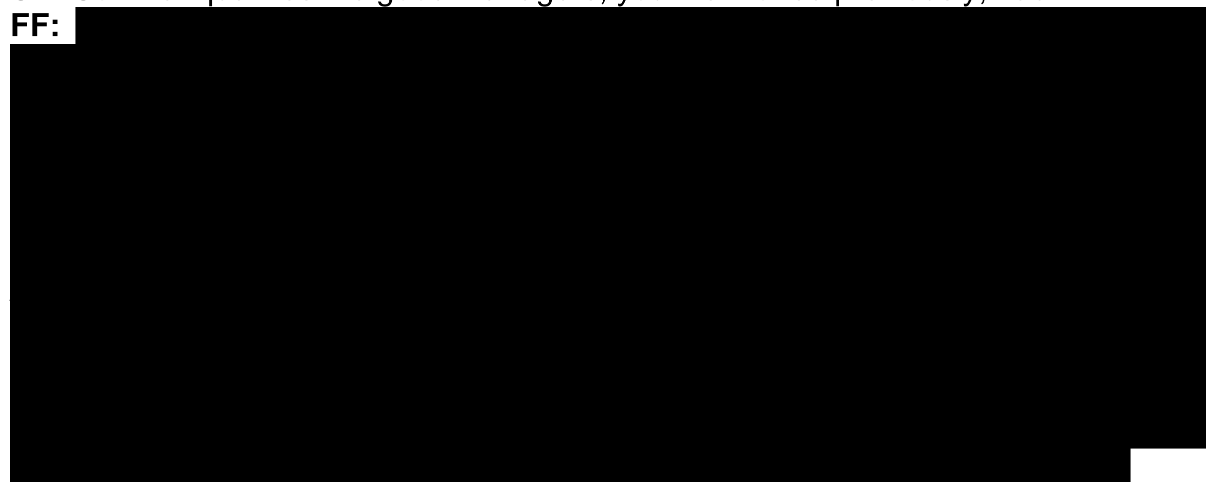
SR: So what would you like to change in relation to the support, supervision, you receive from your managers?
FF:



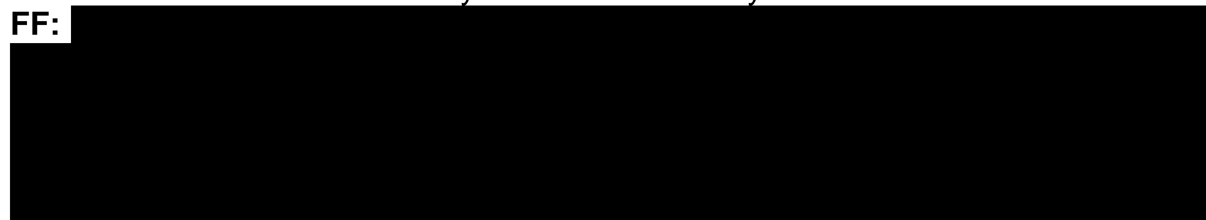
SR: Are there better ways to manage this situation, for you and your service users?
FF:



SR: So what qualities the good managers, you mentioned previously, had?
FF:



SR: My final questions...what do you think will be the ideal situation in order for social workers to work effectively within a Community Mental Health Team?
FF:



SR: So my understanding is that social workers have to be flexible in their work in comparison to other professionals, because of the sometimes unexpected statutory duties that they might have to undertake...

FF:

SR: Basically those were all my questions, I don't know if you want to add anything else?

FF:

SR: Thank you very much.

Appendix 7: Audit Trail of Thematic Analysis Coding using NVivo

Audit Trail: Stages of Thematic Analysis Coding using QSR NVivo 10

Stage 3 - Themes and Tree Nodes

- **Participants' Demographic Information**

➢ Participants’ Gender (Sources: 7; References: 7)
➢ Years of Social Work Service (Sources: 7; References: 7)
➢ Years of Social Work Mental Health Service (Sources: 7; References: 7)
➢ Employment Status (Sources: 7; References: 8)
➢ CMHT Structure (Sources: 7; References: 7)
➢ NHS & Local Authority Managers’ Professional Background (Sources: 7; Ref: 12)

- **Social Workers' Role, Duties and Tasks within Integrated CMHTs**

➢ Social Workers' LA statutory duties and Care Management tasks (Sources: 7; Ref: 19)
➢ Social Workers' NHS duties and Care Programme Approach tasks (Sources: 7; Ref: 19)

- **Social Work Identity within Integrated CMHTs**

➢ Developing and maintaining a Social Work identity within CMHTs (Sources: 6; Ref: 19)
➢ Perceived challenges to Social Work identity and duties from integration (Sources 6; Ref: 23)
➢ Perception that AMHP role maintains social perspectives which are integrated in other professionals' approaches (Sources: 7; Ref: 11)
➢ Perception that expansion of AMHP threatens the role's independent social perspective (Sources: 7; Ref: 13)
➢ Perception that Social Workers should not take on role of Responsible Clinician as is seen as a medical role (Sources: 6; Ref: 7)
➢ Social Work Identity and the role of supervision and peer support in CMHTs (Sources: 3; Ref: 10)

- **Facilitating Factors for Integration**

  - Benefits for SUs and SW Anti-oppressive Practice (Sources: 7; Ref: 20)
  - Role Integration, Interprofessional Cooperation, Shared Values in CMHTs (Sources: 7; Ref: 51)
  - Supportive Managers with understanding of Social Work perspectives (Sources: 6; Ref: 10)
  - Holistic Approach of Social Model of Care and Benefits for SWs (Sources: 6; Ref: 30)

Above Sub-themes were further merged from the sub-themes below:

  - Benefits of integrated MDT model of CMHTs; generic benefits (Sources: 7; Ref: 18)
  - Common values shared by different professionals in CMHTs (Sources: 7; Ref: 10)
  - Interprofessional cooperation, communication and support within CMHTs (Sources: 6; Ref: 13)
  - Positive contribution of SWs' holistic approach and of social model in CMHTs (Sources: 6; Ref: 22)
  - Positive perceptions and benefits of integration for SWs (Sources: 3; Ref:8)
  - Role Integration; from SWs and CPNs to Mental Health Professionals (Sources: 5; Ref: 14)
  - Service Users and integrated model of CMHTs (Sources: 5; Ref: 11)
  - Social Workers' role in promoting anti-oppressive practice in CMHTs (Sources: 7; Ref: 10)
  - Supportive Managers with understanding of Social Work perspectives (Sources: 6; Ref: 10)

- **Inhibiting Factors for Integration**

  - Isolation from LA and Dominance of NHS and Medical Model (Sources: 7; Ref: 25)
  - Role Differences, Interprofessional Conflict and Lack of Role Clarity (Sources: 7; Ref: 39)
  - Challenges of SWs' Dual Role and Duties (NHS & LA) (Sources: 7; Ref: 60)
  - Managerial Inconsistency and Bureaucracy (Sources: 5; Ref: 16)

Above Sub-themes were further merged from the sub-themes below:

  - Challenges due to Integrated MDT model of CMHTs; generic challenges (Sources: 7; Ref: 24)
  - Challenges for SWs due to bureaucracy and dual operating systems (NHS & LA) (Sources: 3; Ref: 10)
  - Challenges for SWs in CMHTs due to their dual role; CPA tasks (NHS) and statutory duties (LA) (Sources: 7; Ref: 37)
  - Challenges to integration by lack of managerial consistency and awareness of Social Work perspectives (Sources: 4; Ref: 6)

- Interprofessional conflict due to lack of role clarity in CMHTs (Sources: 6; Ref: 18)
- Perceived dominance of medical model in CMHTs and criticisms of that model (Sources: 6; Ref: 9)
- Perceived Role Differences between SWs and CPNs within CMHTs (Sources: 7; Ref: 26)
- Perception that SWs in CMHTs are isolated from Local Authority and the rest of SWs due to their employment status (Sources: 6; Ref: 9)
- Perception that SWs' Local Authority statutory duties are not recognised in their CMHT caseload (Sources: 3; Ref: 8)

- **Supporting Integration, Suggestions for Improvement and Alternative Options**

- Maintaining and supporting the Integrated MDT model of CMHTs (Sources: 6; Ref: 23)
- Suggestions for improving the Integrated MDT model of CMHTs (Sources: 7; Ref: 18)
- Suggestions to create discrete SW Mental Health teams if SWs are withdrawn from CMHTs and MDT model is disintegrated (Sources: 3; Ref: 5)

Stage 2 - Merging Free Nodes: Thematic Analysis Coding using QSR NVivo 10

1. Benefits of integrated MDT working
2. Challenges for SWs in CMHTs due to their dual role; CPA (NHS) and CMA (LA)
3. Challenges of bureaucracy and dual systems (NHS &LA) on SW duties
4. Challenges of integrated MDT working
5. Challenges to integration by lack of managerial consistency and awareness of Social Work perspectives
6. CMHT Structure
7. Common values shared by professionals
8. Developing and maintaining a Social Work identity within CMHTs
9. Employment Status
10. Interprofessional conflict due to lack of role clarity in CMHTs
11. Interprofessional cooperation, communication and support within CMHTs
12. Maintaining and supporting the NHS & LA integrated CMHT model
13. NHS & LA Managers
14. Participant
15. Participants' Demographic Information
16. Perceived challenges to Social Work identity and duties from integration
17. Perceived dominance and criticisms of medical model
18. Perceived Role Differences between SWs and CPNs within CMHTs
19. Perception that AMHP role maintains social perspectives which are integrated in other professionals' approaches
20. Perception that expansion of AMHP threatens the role's independent social perspective
21. Perception that Social Workers should not take on role of Responsible Clinician as is seen as a medical role
22. Perception that SWs are isolated from LA due to working for NHS whilst seconded by LA
23. Perception that SWs' LA statutory duties are not recognised in their CMHT caseload
24. Positive contribution of SWs' holistic approach and of social model on medical model in CMHTs
25. Positive perceptions and benefits of integration for SWs
26. Role Integration; SWs and CPNs to be Mental Health Professionals
27. Service Users' rights, anti-oppressive practice and integration
28. Social Work Identity and the role of supervision and peer support
29. Social Work identity within integrated CMHT
30. Social Workers' Local Authority statutory duties and Care Management tasks
31. Social Workers' NHS duties and CPA tasks
32. Social Workers' role in AOP and supporting service users
33. Social Workers' role, duties and tasks within CMHTs; CPA (NHS) & CMA (LA)
34. Suggestions for improving the Integrated MDT CMHT
35. Suggestions to create discrete SW Mental Health teams if SWs are withdrawn and MDT is disintegrated
36. Supporting Integration, Suggestions for Improvement and Alternative Options
37. Supportive Managers with understanding of Social Work perspectives
38. Years of SW MH Service
39. Years of SW service

Stage 1 - Free Nodes: Thematic Analysis Coding using QSR NVivo 10

1. Accepting current situation and trying to work within that
2. Opinion that MDT working has positive aspects
3. Role Integration is seen as beneficial to SWs
4. Negative opinion about some LAs decision to pull out SWs from CMHTs
5. SWs being pulled out of CMHTs; it may actually strengthen the social work model
6. SWs being pulled out of CMHTs; it is a step backwards as medical model will prevail even more
7. Anti-oppressive practice has increased in comparison to the past
8. Argument supporting an integration of professional roles; SWs and CPNs to have same tasks and responsibilities
9. Argument supporting further integration towards CPNs and SWs becoming Mental Health Practitioners and opinion that objections are due to each profession's self interests
10. Argument that even though professional roles are not integrated there are still benefits to CMHT MDT working model
11. Arguments in support of integrated mental health model of CMHT and MDT with historical perspective
12. Available Resources
13. Benefits and positive experiences of cooperation within integrated CMHT MDT; communication, proximity, case discussions
14. Benefits from working within CMHT as medical and social models are represented and different points of view are heard
15. Benefits of AOP to Service Users' rights, community integration
16. Benefits of CPA and continuity of care
17. Benefits of MDT work if CMHTs worked as a team
18. Benefits of MDT working model for SWs
19. Benefits of MDT working to Service Users
20. Benefits of MDT working; continuity of care for service users
21. Benefits of MDT working; exploring different perspectives
22. Benefits of MDT working; interprofessional knowledge
23. Benefits of SW peer group support in CMHT
24. Care Programme Approach Duties-NHS
25. Challenges and problems of CPA; bureaucracy and systemic issues
26. Challenges for SWs as they have to follow CPA (NHS) and CMA (LA) systems in their role within CMHTs
27. Challenges for SWs in CMHTs due to CPA and care management duties; threat to SWs role in CMHT from other professionals
28. Challenges for SWs in CMHTs; they get the Care Management LA tasks from the CPNs on top of their workload (CPA & CMA)
29. Challenges of CMHT working and criticism of attitudes of SWs who protect their own professional interests
30. Challenges of MDT working
31. Challenges of MDT working affect service users
32. Challenges of MDT working due to workload, different tasks and different employment conditions (NHS vs LA)
33. Challenges of MDT working for SWs and social perspectives
34. Challenges of MDT working re expectations

35. Challenges of MDT working; bureaucracy, systemic issues, workload, government policies and targets
36. Challenges of MDT working; CPA vs CMA
37. Challenges of MDT working; dominance of medical model
38. Challenges of MDT working; SWs' supervision by Managers with social work background
39. Challenges of MDT working; work is target driven than quality driven (pressure to meet targets whilst quality of work might be ignored)
40. Challenging the idea that SWs have confidence to challenge medical decisions re AMHPs duties
41. Changes Threaten Professionals' Identities
42. Changes Threaten Social Work Roles
43. CMHT MDT working increases SWs' knowledge and access to medical model and professionals
44. CMHT Structure
45. Common Values in relation to service users' wellbeing
46. Common Values re Service Users
47. Common Values that SW share with other professionals
48. Conflict is seen as inevitable part of working
49. Consistent approach was not possible due to changes in CMHT managers
50. CPNs are beginning to do more of the SW roles
51. Criticism of AMHP training
52. Criticism of CMHT integrated model; SWs were asked to cover care coordination gaps due to NHS shortages; systemic problems led to failing system; bureaucracy
53. Criticism of current AMHP duty rota and role of psychiatrists
54. Criticism of medical model and support of social model
55. Criticism of medical model, using social model and advocating for service users
56. Criticism of previous and current LA and NHS models of MH work and suggestion for SWs to be withdrawn from CMHT and work in discrete mental health teams
57. Criticism of supervision received by NHS managers and lack of SW supervision
58. Current Social Work Role in CMHT
59. Differences between SW and CPN re training in human rights and ethical values
60. Differences re caseloads between SWs and CPNs in CMHT
61. Difficulties for SW managing working for NHS whilst seconded by the LA
62. Difficulties for SWs working for NHS seconded by LA; line management; professional development; service agreements
63. Difficulty in balancing the Dual Social Work Role in CMHT
64. Discrepancy of how SW and medical professionals see social impact on MH
65. Discussing discrepancies between reasons of wanting to be a SW in MH and realities of system
66. Dynamics between SW and CPN due to different roles and workload
67. Employment Status
68. Experiences of working with various managers
69. Perception isolated and abandoned by LA to the NHS despite the fact that SWs in CMHTs fulfil statutory LA duties

70. Perception isolated from rest of SWs with current employment status (NHS seconded by LA)
71. Perception overloaded re amount of duties and roles (NHS and LA) in CMHT
72. Perception that AMHP role is a complex role that take priority over other SWs' CMHT duties
73. Perception that AMHP role is same as ASW but resources seem to be significantly less
74. Perception that AMHP role is seen as a stepping stone for career development and not as a functional role
75. Perception that AOP has enhanced service users' rights and offered more options to challenge authorities
76. Perception that CMHT working threatens SW role in MH
77. Perception that CPNs might not want to do SWs' roles
78. Perception that current CMHT manager can understand social work perspective
79. Perception that current CMHT MDT model is not integrated due to interprofessional conflict and confusion about responsibilities
80. Perception that current MDT working model is not fully integrated due to professionals' interests to protect their own roles
81. Perception that employment status (working for NHS seconded by LA) is complicated as SWs have to operate in two different systems
82. Perception that expansion of AMHP will have negative impact on role independence
83. Perception that is vital for AMHP role to maintain social perspective
84. Perception that MDT integrated model of working and medical model threaten SW identity
85. Perception that Medical Model is dominant since integration of SW in CMHT
86. Perception that NHS is the dominant model in the employment status and SWs follow NHS procedures
87. Perception that on an individual basis professionals are more aware of AOP
88. Perception that on an institutional level AOP did not make a positive difference as same issues as in the past remain
89. Perception that other CMHTs are more integrated than present in terms of roles
90. Perception that other professionals see SWs' role as fulfilling both CPA and LA CMA tasks
91. Perception that professionals share Common Values which include AOP and working to support service users
92. Perception that Role Integration threatens SW identity
93. Perception that social model will have positive influence to other professionals trained as AMHPs
94. Perception that SW identity is diluted in an integrated CMHT MDT
95. Perception that SWs' and CPNs' roles are overlapping, and there is lack of clarity at CMHTs
96. Perception that SWs are expected to fulfil range of tasks within CMHTs due to lack of cooperation from other professionals
97. Perception that SWs have already too many duties and responsibilities and are not encouraged to take on role of Responsible Clinician
98. Perception that SWs' LA care management role is not recognised so much as MDT CMHT is using NHS recording systems

99. Perception that SWs' role complexity (LA and NHS) is not considered in caseload allocation
100. Perception that SWs' role within CMHT is misunderstood by other health professionals
101. Perception that SWs' work re LA statutory duties is not recognised and taken into consideration in their CMHT caseload
102. Perception that there is lack of support and supervision from LA managers to SWs in CMHTs
103. Perception that there is more awareness of mental health than in the past
104. Perception that there is share understanding between SWs and CPNs re AOP but with different emphasis that SW
105. Perceptions re AMHP training and role expansion
106. Perceptions that expansion of AMHP training threatens SW role
107. Good working relationship with CPNs in the team
108. Holistic Social Work Approach
109. Impact of changes on SW roles
110. Impact of role integration on SWs and conflict potential
111. Impact of working for NHS but employed by LA; pay differences and impact on integration
112. Importance of being able to adapt and be flexible when working as an AMHP
113. Importance of consistency on Role Integration within CMHTs
114. Importance of consistent approach and good management for effective CMHT MDT working
115. Importance of consistent approach in MDT working
116. Importance of MDT integrated working
117. Importance of reflective practice, workload and impact on reflection
118. Important qualities of a SW in a CMHT; flexibility and adaptability due to dual role (statutory tasks and CPA caseload)
119. Interprofessional communication is improved in MDT
120. Interprofessional conflict due to CPNs' perception that SW have smaller caseloads
121. Interprofessional jealousy
122. Interprofessional roles and tasks within CMHTs are not consistently defined; conflict potential
123. Loss of Independent social aspect with expansion of AMHP role
124. Loss of SW identity due to role integration
125. Managerial changes impact on Role Integration and consistency
126. Managing conflicts by concentrating on own job, role, tasks
127. MDT working and challenges of CPA vs Care Management Approach; who is responsible for which task and how it affects SUs
128. MDT working promotes interprofessional knowledge
129. Medical Model Criticism
130. More information required re withdrawal of SW from CMHT by some LA
131. Need for Medical & Social Model to Complement Each Other
132. Need was identified about clarifying what the different professionals' roles are in CMHT

133. Negative experiences of cooperation; professionals stay within their boundaries and do not work together
134. Negative perceptions about current way that SW are managed by LA and NHS; duplication and bureaucracy
135. Negative Perceptions about Professional Cooperation
136. Negative perceptions about SW taking on role of Responsible Clinician
137. Negative perceptions about SWs taking on role of Responsible Clinician due to medical aspect in Mental Health; recognising differences between social and medical model
138. Negative Perceptions about the Dual Social Work Role in CMHT
139. Negative perceptions and frustration about bureaucracy and paperwork in terms of some LA SW duties; funding application forms
140. Negative perceptions re experience of working within NHS seconded by LA
141. Negative perceptions that changes have reduced SW role in favour of CPN
142. Negative perceptions that current MDT working is oppressive to SW
143. Negative perceptions that MDT CMHT working has isolated SW from their other LA SW colleagues
144. Negative perceptions that MDT work requirements have a negative impact on SW role and identity
145. Negative opinion about expansion of AMHP role as SWs are more likely to challenge medical model and psychiatrists
146. Negative perception about psychologists' role within MDT
147. Neutral perceptions about SWs taking on Responsible Clinician role; another career improvement option
148. NHS & LA Managers
149. Not receiving supervision for SW statutory duties by LA manager
150. Not sure about the impact of decision by some LAs to withdraw SWs from CMHTs
151. Not thinking about different roles (CPA vs CMA); I just do what I've got to do
152. Opinion about qualities of a good manager; supportive and looking after wellbeing of staff
153. Opinion of ideal situation of integrated CMHT; care coordinators (SWs and CPNs) take on social and psychosocial aspect of role
154. Opinion re qualities of a good manager; ability to understand different perspectives irrespective of professional background
155. Opinion that AMHP training is influenced by social perspectives
156. Opinion that approaches used by SWs are valuable within resource limited CMHT
157. Opinion that bureaucratic system meant less time to work directly with service users
158. Opinion that CMHT integration relates to different professionals being in the same team but there is role separation between SWs and CPNs
159. Opinion that CMHT managers should recognise and value SWs' dual role within the team (statutory duties and CPA caseload)
160. Opinion that CMHT MDT model is a grey area as integration threatens SWs' role in CMHT

161. Opinion that CMHTs should serve best interests of service users but that sometimes does not happen due to interprofessional conflict
162. Opinion that CPA take more of SWs working time than LA duties as they work for CMHTs run by the NHS
163. Opinion that current CMHTs are not fully integrated but there are still benefits of having different professionals in the same MDT
164. Opinion that current system that SWs operated in (NHS-CPA, LA-CMA and statutory duties) is bureaucratic
165. Opinion that if LA withdraw SWs from CMHT then best option would be creation of discrete mental health services within the Local Authority
166. Opinion that if SWs are withdrawn from CMHTs then it will be a step backwards as idea of integration is to work together
167. Opinion that if SWs are withdrawn from CMHTs then it will be a step backwards as SWs will have more bureaucracy, less time with service users and will be de-skilled in mental health issues
168. Opinion that in CMHTs medical model is dominant due to severity of mental health issues and social perspectives are more difficult to be implemented
169. Opinion that in current system health and social care services (NHS and LA) have budgetary differences
170. Opinion that integrated approach increases knowledge for SWs
171. Opinion that managing workload is straight forward as statutory duties take priority over everything else
172. Opinion that most SWs come into their job to work with and support people instead of meeting targets and ticking boxes
173. Opinion that old fashioned views of SWs and CPNs about their professional identities might be in the way of integration within CMHTs and optimism about the future
174. Opinion that professionals' (SWs and CPNs) roles and identities have been diluted in the integrated CMHT
175. Opinion that service user representation and perspectives have been acknowledged more so than in the past
176. Opinion that service users need respect, dignity and good treatment
177. Opinion that service users will lose benefits of MDT if LAs withdraw SWs from CMHTs
178. Opinion that social model has influenced medical model
179. Opinion that social model has influenced medical model to the benefit of service users
180. Opinion that social model has positive influence on medical model to view mental health more holistically
181. Opinion that some LAs are withdrawing SWs from CMHTs due to resources and financial reasons and that would be detrimental to CMHTs
182. Opinion that some LAs withdrew SWs from CMHTs due to disagreements between NHS and LAs
183. Opinion that SW and CPN should utilise different but complementary approaches in CMHT work
184. Opinion that SW CMHT role is becoming more generic MH Practitioner
185. Opinion that SWs are not trained to do clinical risk management, CPNs' role

186. Opinion that SWs' LA statutory duties could be done by other health professionals as well
187. Opinion that SWs working in CMHT MDTs have specific MH skills than those working in LAs and those skills will be lost
188. Opinion that the lack of integrating the systems and approaches of NHS (CPA) and LA (Care Management Approach) reflect the divisions within health and social care
189. Opinion that there are financial reasons for some LAs decision to withdraw SWs from CMHT
190. Opinion that there is supervision and support available for SW tasks by approaching appropriate nominated NHS & LA managers
191. Opinion that when a team is bigger then the distance between staff and manager is greater
192. Opportunity to reflect and explore issues around SW identity
193. Opposing the idea of LA withdrawing SW from CMHT
194. Optimistic about the future of SW as NQSW might be free from past attitudes and dogma
195. Option was given to have social work supervision
196. Other professionals in CMHT appreciate SWs' role, but not fully
197. Participant
198. Passing on SW identity and social model of care to next SW generation
199. Past Social Work Role in Mental Health
200. Peer SW support within CMHT available
201. Perception of how Nurses see Role of Social Workers
202. Perception of own role as SW in CMHT; support service users, reduce stigma of diagnoses, explore social perspectives
203. Perception of role of social model in CMHT; advocacy and support for service users
204. Perception that AMHP role will threaten future SW MH role even more
205. Perception that anti-oppressive practice is SW led
206. Perception that changes affect SW in a negative way
207. Perception that is difficult to maintain SW perspective in MDT working due to dominance of medical model
208. Perception that medical model is dominant in CMHT
209. Perception that other professionals are confused about SWs' role and tasks in CMHT MDT working
210. Perception that prior to CMHT MDT working model SWs had stronger SW identity
211. Perception that role differences (SWs and CPNs) within integrated MDT are recognised and respected
212. Perception that social model utilised by SWs is more holistic than the medical model used by other professionals
213. Perception that SW role and tasks are not clear to other professionals in MDT
214. Perceptions of how Social Workers see their Role in relation to other Professionals
215. Perceptions of Role Differences between Social Workers and Nurses
216. Positive current and past experiences of working in integrated CMHTs
217. Positive experiences of interprofessional respect and contribution within CMHT

218. Positive perception about MDT working
219. Positive perception re support received by CMHT Manager
220. Positive perceptions about CPA role
221. Positive perceptions about current CMHT working re caseload work
222. Positive perceptions about expansion of AMHP role as social model has been accepted and integrated by health professionals
223. Positive Perceptions about Interpersonal Working Relationships
224. Positive perceptions about MDT of CMHT; quite bonded
225. Positive perceptions about MDT working in terms of interprofessional cooperation for the SUs' benefits
226. Positive Perceptions about Role Changes
227. Positive perceptions about Role Integration
228. Positive Perceptions about Social Work Identity
229. Positive perceptions about SW and anti-oppressive practice
230. Positive perceptions about SWs' use of social model in CMHTs
231. Positive perceptions and experiences of working with other MDT professionals
232. Positive perceptions and experiences re cooperation within CMHT
233. Positive perceptions of CMHT MDT working; communication and proximity
234. Positive perceptions of cooperation and support within integrated CMHT
235. Positive perceptions of MDT working in terms of SW and CPN role complementing each other
236. Positive influence of social model of care on the medical model and positive role of SWs in CMHT
237. Positive influence of SWs in CMHTs adopting a holistic approach
238. Positive Opinion about MDT working and need to keep integrated model
239. Potential threat to SW identity when NHS is the only working experience of a SW
240. Pragmatic approach about situation regarding meeting targets in CMHTs; government driven
241. Preference for an integrated model re management and SW supervision by CMHT manager with SW background
242. Preference for Integrated Model of Care
243. Preference for integrated model re supervision by CMHT manager with SW background rather that SW supervision by LA manager
244. Preference for working as a SW for the NHS than being withdrawn from CMHT by LA
245. Preference for working as a SW in CMHT MDTs than LAs due to professional diversity
246. Preference of Integrated Model of Care with suggestions for improvement
247. Rationalisation of Cooperation Differences between Social Workers and Nurses
248. Reasons for Role Integration
249. Recognition of positive aspect of MDT under certain provisions
250. Recognition of role differences within CMHT (SWs, AMHPs, CPNs)
251. Recognition that a SW Manager would be helpful to SW's CPD

252. Recognition that in CMHT there is openness to accept different opinions
253. Recognition that individual professionals practice anti-oppressively
254. Recognition that SWs and social model influence medical model and CPNs to a holistic approach
255. Reflecting on past antagonism between health and social care (SWs and psychiatry) and supportive of integrated CMHT MDT models as interprofessional understanding re MH is enhanced
256. Reflecting on past SW practice and supporting integrated approach
257. Reflecting on the way workload is prioritised as a SW in CMHT and perceptions about ways of working
258. Reflecting that statutory duties mean that a SW might not have as much time to do CPA tasks
259. Reluctantly positive position re SW working in integrated CMHT
260. Resistance and reluctance to work for NHS seconded by the LA
261. Resisting integrated MDT CMHT working
262. Respect for service users
263. Respecting work colleagues and creating a good working environment
264. Role Changes
265. Role Conflicts
266. Role Confusion and Role Blurring
267. Role confusion as perception that in current CMHT there is an expectation for CPNs to take on social roles
268. Role differences within MDT due to professional roles
269. Role Integration and Benefits to Service Users
270. Role Integration; Nurses do Social Workers' Tasks
271. Role of AOP in SW mental health
272. Role of Manager in Reducing Conflict
273. Role specificity and MDT
274. Rumours that SWs will be pulled out of CMHT and perception that change will be negative
275. Service users benefit from interprofessional communication in MDT
276. Service users benefit from MDT working
277. Social Work Statutory Duties & Care Management-LA
278. Social Work Supervision helpful
279. Strong SW identity
280. Strong SW identity supporting integrated approach
281. Suggested change; more social work managers in CMHTs
282. Suggestion for a more integrated approach within CMHTs with a discussion of roles between NHS and LA
283. Suggestion for change in order for SWs to work effectively in CMHTs; SW line manager, regular SWs meetings, peer support, education and training other professionals about SWs' role
284. Suggestion for CMHTs to work effectively; recognition of SWs' statutory duties on top of their caseload work
285. Suggestion for SWs to work effectively within CMHTs; recognition of discrete SW MH tasks reflected on caseload and appropriate supervision
286. Suggestion of how Medical and Social Model should work together in MH

287. Suggestion of how to improve AMHP role; supervision, managerial structure and dedicated staff
288. Suggestion of how to make the system of CPA & CMA tasks within CMHTs less bureaucratic
289. Suggestion that managers should have better training in management skills in order to better support their staff
290. Suggestion to change integrated CMHT MDT model; SWs to be withdrawn and work separately in MH with clearly defined roles and strong SW identity
291. Suggestion to improve bureaucracy and paperwork; introduction of experts in a particular field that can support other SWs
292. Suggestions for change re SW to work effectively within CMHTs
293. Suggestions for different work approach within CMHTs
294. Suggestions of how a NQSW can develop a SW identity within LA & NHS
295. Suggestions of how SWs working in CMHT MDT can maintain their SW identity
296. Support for CMHT integrated model and suggestion for more integration
297. Support for CMHT MDT model of working as SWs gain knowledge of medical model and interprofessional working is promoted
298. Support for MDT integrated model of working
299. Support of integrated approach re SWs in MH due to negative past working experiences as LA SW in MH
300. Supporting and seeing CMHT SW role as integrated
301. Supportive CMHT manager and rest of managers
302. Supportive of AMHP role expansion provided that SW and Social perspective are maintained
303. Supportive of integrated MDT working model despite opinion that professionals' roles have been diluted due to integration
304. SW experiences working for the NHS seconded by the LA; experience of only working for the NHS
305. SW identity and perception that SW are more independent than other medical professionals
306. SW identity in relation to experience as a SW
307. SW role in AOP and supporting service users
308. SW role in CMHT; Care Management tasks
309. SW role in CMHT; CPA tasks
310. SW role, AOP theory and practice and lack of reflection when working
311. SW vs CPN re AOP
312. SW vs CPN re Training, AOP, social approach to MH
313. SWs have smaller caseloads than CPNs due to extra duties
314. SWs in CMHTs have dual role; statutory duties (LA) and their caseload (CPA)
315. SWs' responsibility to retain their identity by personal and professional development
316. Uncertainty about SWs and CPNs roles and tasks within CMHT
317. Withdrawal of SWs from CMHTs; disagreement between health and social care (NHS and LA)

318. Working within MDT enhances interprofessional experiences and learning
319. Working within NHS seconded by LA; concentrating on CMHT duties on a daily basis and being reminded of LAs specific duties when referrals arrive
320. Working within NHS seconded by LA; operating in two systems and choosing the NHS as majority of work is there
321. Worried about the fact that some LAs are withdrawing SWs from CMHTs
322. Worry that Role Integration will threaten SW CMHT role
323. Years of SW MH Service
324. Years of SW service

Appendix 8: Draft Summary of Main Findings sent to Participants

Copy of Email Communication regarding Draft Summary of Main Findings that was sent individually to each Participant

From: Chatziroufas, Georgios
Sent: 31 October 2012 15:37
To: [redacted].nhs.uk

Hi

thank you for participating in my research project "Exploring social workers' perceptions of their role and duties within Community Mental Health Teams."

I am sending an anonymous summary of my main themes and findings from analysing all the interviews, for your information, and ask for an optional task!

I would like to ask you for any feedback and/or comments regarding the findings (whether our discussion is represented within the main themes).

Thank you

Georgios Chatziroufas
MA Social Work Student at LJMU

Draft Summary of Main Themes and Findings

1. Participants' Demographic Information

Ø CMHT Structure
Ø Employment Status
Ø NHS & LA Managers
Ø Participants' Gender
Ø Years of SW Mental Health Service
Ø Years of SW Service

2. Social Workers' role, duties and tasks within integrated CMHTs

Ø Social Workers' Local Authority statutory duties and Care Management tasks
Ø Social Workers' NHS duties and CPA tasks

3. Social Work identity within integrated CMHT

Ø Developing and maintaining a Social Work identity within CMHTs
Ø Perceived challenges to Social Work identity and duties from integration
Ø Perception that AMHP role maintains social perspectives which are integrated in other professionals' approaches
Ø Perception that expansion of AMHP threatens the role's independent social perspective
Ø Perception that Social Workers should not take on role of Responsible Clinician as is seen as a medical role
Ø Social Work Identity and the role of supervision and peer support

4. Facilitating Factors for Integration

Ø Benefits of integrated MDT working
Ø Common values shared by professionals
Ø Interprofessional cooperation, communication and support within CMHTs
Ø Positive contribution of SWs' holistic approach and of social model on medical model in CMHTs
Ø Positive feelings and benefits of integration for SWs
Ø Role Integration; SWs and CPNs to be Mental Health Professionals
Ø Service Users' rights, anti-oppressive practice and integration
Ø Social Workers' role in AOP and supporting service users
Ø Supportive Managers with understanding of Social Work perspectives

5. Inhibiting Factors for Integration

Ø Challenges for SWs in CMHTs due to their dual role; CPA (NHS) and CMA (LA)
Ø Challenges of bureaucracy and dual systems (NHS & LA) on SW duties
Ø Challenges of integrated MDT working
Ø Challenges to integration by lack of managerial consistency and awareness of Social Work perspectives
Ø Interprofessional conflict due to lack of role clarity in CMHTs
Ø Perceived dominance and criticisms of medical model
Ø Perceived Role Differences between SWs and CPNs within CMHTs
Ø Perception that SWs are isolated from LA due to working for NHS whilst seconded by LA
Ø Perception that SWs' LA statutory duties are not recognised in their CMHT caseload

6. Supporting Integration, Suggestions for Improvement and Alternative Options

Ø Maintaining and supporting the NHS & LA integrated CMHT model
Ø Suggestions for improving the Integrated MDT CMHT
Ø Suggestions to create discrete SW Mental Health teams if SWs are withdrawn and MDT is disintegrated

Appendix 9: Research Ethics Committee Application Form

Date received	Initials	LJMU REC Ref

Research Ethics Committee Application

Application for Ethical Approval of Undergraduate, Postgraduate or Staff Research involving Human Participants or the Use of Personal Data

Where research involving human participants or databases of personal information is being conducted by a member of staff or student LJMU Research Ethics Committee (REC) considers and advises researchers on the ethical implications of their study.

No research must be started without full, unconditional ethical approval.

Applications must be made using this form and must be typed. Please note that the only valid version of this application form is the current version found online. Previous versions will not be accepted.

Guidance on completing this form can be found at http://www.ljmu.ac.uk/RGSO/93717.htm

Applications, inclusive of specified attachments, can be emailed to LJMU REC via researchethics@ljmu.ac.uk. A paper copy of the signature page only must also be sent to the Research Ethics Administrator, Research Support Office, Rodney House. Applications must be received by the submission dates published on the RSO website.
Where a University research project is to be undertaken using NHS patients, staff or resources or
the work must undergo ethical review via the National Research Ethics Service (NRES). University staff or students undertaking such research need not complete this form but **must** submit a completed LJMU Research Governance Proforma and provide LJMU REC with written evidence of full, unconditional ethical approval from NRES prior to commencing their research. On receiving confirmation of NRES ethical approval formal notification of LJMU REC approval will be issued via Chair's action.
Where teaching practices involve invasive (psychological or physiological) procedures on human participants staff should refer to the guidance provided at http://www.ljmu.ac.uk/RGSO/93087.htm regarding the development of departmental/faculty codes of practice. Codes of Practice will receive blanket approval for a period of 5 years from LJMU REC.

Potential participants must not be contacted until written approval has been received from the LJMU REC.

Application for Ethical Approval of Research Involving Human Participants

Research Mode

- ☐ Undergraduate – specify course
- ☑ Postgraduate
  - ☐ MRes,
  - ☐ MPhil,
  - ☐ PhD
  - ☐ Prof Doc
  - ☑ Other – please specify

    MA in Social Work (Year 2)
- ☐ Postdoctoral
- ☐ Staff project
- ☐ Other – please specify

Has this application previously been submitted to the University REC for review? Yes / **No**

If yes please state the original REC Ref Number [ ] and,

the date of the REC meeting at which it was last [ ] reviewed.

Section A – The Applicant

A1a. Title of the Research

Exploring social workers' perceptions of their role and duties within community mental health teams.

A2. Principal Investigator (PI) *(Note that the in the case of postgraduate or undergraduate research the student is designated the PI. For research undertaken by staff inclusive of postdoctoral researchers and research assistants the staff member conducting the research is designated the PI.)*

Title **Mr** Forename **Georgios** Surname **Chatziroufas**

Post **Social Work Postgraduate Student**

Department / School / Faculty **Faculty of Health and Applied Social Sciences**

Email **G.Chatziroufas@2003.ljmu.ac.uk** Telephone **079 1937 8600**

Relevant experience / Qualifications

10/1997 - 07/2000; University of Essex; BSc with Honours in Psychology (2:1); (full-time). My final year project explored the phonological working memory where the participants, who were university students, were asked to recall visually presented words.

09/2003 - 05/2005; Liverpool John Moores University; Postgraduate Diploma in Drug Use and Addiction (part-time), awarded in 09/2008.
I produced a report for the ███ Primary Care Trust and Drug and Alcohol Action Team regarding harm reduction and syringe exchange services for injecting drug users.

12/2005 - 07/2010; Substance Misuse Worker for (12/2005 - 09/2009) and then for (09/2009 - 07/2010); substance misuse services for adults; full-time employment.
Part of my responsibilities was to manage the Needle and Syringe Exchange Programme. My role, in that annual report, was to assist in the study by recruiting participants , by administering and collecting the questionnaires and then returning them to the Health Protection Agency for analysis.

A3. Co-applicants *(including student supervisors)*

Co-applicant 1

Title **Ms** Forename **Echo** Surname **Yeung**

Post **Senior Lecturer, teaching on BA/MA Social Work Programmes**

Department / School / Faculty **Faculty of Health and Applied Social Sciences**

Email **Y.Yeung@ljmu.ac.uk** Telephone **0151 231 4097**

Relevant experience / Qualifications

Echo qualified as a social worked in 1989, started her teaching career in Liverpool Community College in 2002 and then took up a teaching post at Liverpool John Moores University in 2007.
Teaching Interests; Social Work: International and Comparative Studies; Mental Health and in particular Chinese Mental Health.
Research Interests; Health and social care of minority ethnic groups. Echo conducted a number of studies to explore different ways to involve service users and carers from minority ethnic communities in the training of social work students. Echo is currently undertaking a PhD studying the pathway to mental health care of Chinese people suffering from severe mental illness in England.
Echo has extensive experience as a dissertation supervisor for postgraduate Social Work students.

SECTION B – PROJECT DETAILS

B1. Proposed Study Dates

Start Date	**16 February 2012**
End Date	**20 August 2012**

B2. Scientific Justification. State the background and why this is an important area for research *(Note this must be completed in language comprehensible to a lay person. Do not simply refer to the protocol. Maximum length – 1 side of A4)*

For the past decade social workers have been a part of community mental health teams, working within the National Health Service, being employed by Social Services Departments of Local Authorities and accessing both health and social care funds. Social workers in community mental health teams work with a variety of other mental health professionals (psychiatrists, community psychiatric nurses, occupational therapists, psychologists), in a multidisciplinary environment, in order to implement the care programme approach pathway and support service users who experience "severe and enduring mental health problems."

Social workers working in mental health settings have specific statutory duties and obligations to perform as they work within specific statutory legislation such as the Mental Health Act 1983, as amended by the Mental Health Act 2007, and the Mental Capacity Act 2005, while they also have to implement various policies and procedures such as the Care Programme Approach and the Safeguarding Vulnerable Adults guidelines. In the past, the role of the approved mental health professional was an exclusive statutory duty of social workers and those social workers with the relevant training were known as approved social workers. The change in the mental health legislation enabled other professionals working in mental health settings, for example community psychiatric nurses and occupational therapists, to train as approved mental health professionals. This significant change, which affected a statutory duty traditionally seen as a social work role, had its criticisms as it was viewed as a reduction in the responsibilities of social workers working in mental health; however it was also interpreted as an opportunity for social workers to adapt, change and expand their role within community mental health teams due to the integration of the services provided by the National Health Service and by Social Services Departments of Local Authorities.

A community mental health team is regarded as a multidisciplinary setting with an integrated mental health and social care approach. A number of studies have explored the strengths, challenges and issues for the various professionals working within multidisciplinary teams and the following themes have been identified:

- "role ambiguity and conflict"
- "communication difficulties"
- "development of a shared philosophy"
- "lack of faith in management understanding and effectiveness"
- "power and hierarchy/uni-professional cultures"
- "perspective and hierarchy conflicts"

However, most of these studies reported the experiences from the perspectives of health workers. Little is known about social work perspectives, where issues around "role identity" and "job clarity" have been identified by past research.

The aim of the present study is to explore the views and opinions of a number of social workers, currently working within community mental health teams, regarding their perceptions of their role within mental health services in relation to their duties, responsibilities and tasks.
The objectives of the present research study are to explore social workers':

- views regarding their social work role and statutory duties
- experiences of cooperative and collaborative work
- experiences of support received by social work and mental health managers
- views on the role of anti-oppressive practices in mental health social work
- views of multidisciplinary team structures in relation to social work identity
- opinions regarding the role of the approved mental health professional
- views regarding the medical and social models of care
- views regarding their care management and care coordinating roles

My interest in this topic derived from my social work placement experience.
The present study will explore participants' views and opinions from a social work perspective. Furthermore, this research study will be conducted in a period where some Local Authorities within the UK are considering separating social work from mental health practice, due to resource constraints, by removing social workers from community mental health teams and relocating them to social services departments. Thus, it can be argued that given this potential change in working practice and procedures, the present study is significant for social work practice as it will explore the current views and opinions of social workers regarding best practice, multidisciplinary working and the proposed changes.

B3. Give a summary of the purpose, design and methodology of the planned research

(Note this must be completed in language comprehensible to a lay person. Do not simply refer to the protocol. Maximum length – 1 side of A4)

A qualitative research approach will be utilised due to the nature of the study's questions and the stated aim and objectives to explore social workers' views and opinions in relation to their working experiences. A qualitative research approach will enable to explore participants' views and opinions in a more meaningful way. The study will comply with Liverpool John Moores University's ethical guidelines regarding the use of participants in research studies, with the General Social Care Council's Codes of Practice and the British Association of Social Workers' Code of Ethics.

In this study, semi-structured interviews, with open-ended questions, will be conducted with 6-10 social workers who work in the city's various community mental health teams. The participating social workers will be recruited based on convenience sampling, via the researcher's contacts with the Approved Mental Health Professionals (AMHP) Forum. The use of semi-structured interviews with open-ended questions will enable the researcher to administer the same questions to the participants, while the participants will have the opportunity to elaborate on their answers and include their own comments. All the interviews will be recorded with a digital audio recorder and then transcribed. In order to protect participants' anonymity and confidentiality their names will neither be asked nor recorded during the interview process. As the interviews will be recorded, a requirement of the study will be for participants to consent to the recording, they will be

informed of that requirement in advance. The participants will not be asked to produce any details or characteristics that could be used to identify any service users or their employers. The researcher will not take any written notes during the recorded interviews. The research methods of thematic analysis will be utilised to analyse the data from the recorded interviews. The transcripts with the participants' responses to the research questions will be processed, scrutinised, analysed and coded in order for shared "common themes" to be identified. This process of the management and analysis of the anonymised qualitative data will be assisted by the use of Nvivo, a computer software programme for qualitative data analysis.

Proposed timetable for the stages of the research study:

- From 15/12/2011: Concentrate on; Introduction, Literature Review, Methodology
- 05/01/2012: Send all the parts of the study's application Form to Ethics Committee
- 19/01/2012: Ethics Committee Meeting
- 26/01/2012: Ethics Committee decision. Make the necessary amendments, if required. Wait for final ethical approval for study
- 10/02/2012 - 30/04/2012: Conduct interviews with 6-10 participants and arrange regular meetings with supervisor regarding data analysis
- 01/05/2012 - 30/06/2012: Review thematic coding analysis and complete the coding. Begin the process of writing the Findings Section and arrange meeting with Supervisor regarding findings
- 01/07/2012 - 31/07/2012: Complete the Findings Section. Start and Complete the Analysis/Discussion and Conclusion Sections. Arrange meetings with supervisor. Revisit and Complete the Introduction Section.
- 01/08/2012 - 10/08/2012: Make Final amendments
- 20/08/2012: Hand-in the Dissertation

B4. State the principal research question

The aim of the present study is to explore the views and opinions of social workers, working in community mental health teams, regarding their perceptions of their role, duties, responsibilities and tasks.

B5a. Give details of the intervention(s) or procedure(s) to be received by participants *(including psychological or physical interventions, interviews, observations or questionnaires)*

Intervention	Numbers per individual participant	Avg. Time / Intervention / participant	Is this a novel procedure?
Interviews	1 Interview	40 minutes	No

B5b. Where questionnaires are to be used have these previously been validated?

☐ Yes ☐ No ☑ **Not Applicable**

If yes, state by whom and when. If no, you must append copies of the questionnaire to this application.

Not applicable.

B5c. Where interviews (structured or semi-structured) are proposed you must append an outline of the interview schedule to this application.

Please refer to the Study's Interview Schedule.

B6. Will individual or group interviews/questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting or is it possible that criminal or other disclosures requiring action could take place during the study? (e.g during interviews or focus groups)

☐ Yes ☑ **No** ☐ Not Applicable

If yes give details of procedures in place to deal with these issues. Information given to participants should make it clear under what circumstances action may be taken

B7. Where will the intervention take place? *(ie LJMU premises, participants' homes, public places etc)*

In order to create a safe environment that will enable recording of the interview and that will ensure participant confidentiality, all the interviews will be conducted at a mutually agreed location, where participants find it convenient and comfortable to be interviewed.

B8. How will the findings of the research be disseminated?

The findings of the research study will be utilised and published as part of the dissertation requirements for the MA in Social Work postgraduate course and will be disseminated internally amongst supervisors and programme assessment boards.
Potentially a short anonymised summary of findings may be produced and disseminated via the Approved Mental Health Professionals (AMHP) Forum, in order to inform social work practice, and thus participants will have the opportunity to access the anonymised research findings.

SECTION C – THE PARTICIPANTS

C1a. Identify the participants for the study *(LJMU staff, LJMU students, members of the public, other please specify)*

All the study's participants will be qualified social workers, members of the Approved Mental Health Professionals (AMHP) Forum, currently working within the city's various community mental health teams.

C1b. How will the participants been selected, approached and recruited? If participants are to be approached by letter/email please append a copy of the letter/email.

Participation in the study will be voluntary. Potential participants will be selected, approached and recruited via the Approved Mental Health Professionals (AMHP) Forum. Most of the members of the Forum are social workers; some AMHP of health care backgrounds also attend the Forum. The Forum is open to anyone with an interest in mental health and the application of mental health law, while students can attend. The Forum has a Facilitator, a social worker, while the members who are social workers might be employed by various organisations (Local Authorities and National Health Service Trusts) and might have various different line managers.
The researcher was considered as a student member of the Forum and in the past, as a social work student on a community mental health team placement, has attended and participated on the AMHP Forum meetings.
The researcher has liaised with the Forum's Facilitator about the proposed study and has obtained consent to attend the Forum's next meeting, to be held on the 16th of February 2012, in order to discuss the purpose of the study with Forum members.
Thus, provided that the study has obtained ethical approval, the researcher will attend the Forum, explain the aims and objectives of the study, provide relevant information to Forum members, distribute the participant information sheet and recruit potential participants from the population of Forum members.
A convenience sampling technique will be utilised and Forum members will be asked whether they would be interested in participating in the study on a voluntary basis. Interested potential participants will then be recruited, via informed consent, until the target number of participants is reached. Convenient interview appointment times and locations will be offered and agreed with participants.

C2a. What is the total number of participants?

6 - 10

C2b. How was this number decided?

Due to the time constraints and resource limitations of the study, a sample of 6-10 participants should provide enough meaningful findings for a qualitative data analysis.
Taking into consideration the nature of the research study, this number of participants is consistent with similar small scale studies.

C3a. Will any of the participants come from any of the following groups? (Please tick all that apply)

Please note that the Mental Capacity Act 2005 requires that all research involving participation of any adult who lacks the capacity to consent through learning difficulties, brain injury or mental health problems be reviewed by an ethics committee operating under the National Research Ethics Service (NRES). For further information please see http://www.ljmu.ac.uk/RGSO/101579.htm

- ☐ Children under 16
- ☐ Adults with learning disabilities
- ☐ Adults with mental illness (if yes please specify type of illness below)
- ☐ Drug / Substance users
- ☐ Young offenders
- ☐ Those with a dependant relationship with the investigator
- ☐ Other vulnerable groups please specify

Justify their inclusion

Not applicable

C3b. If you are proposing to undertake a research study involving interaction with children do you have current, valid clearance from the Criminal Records Bureau (CRB)

Yes / No / **Not applicable**

C4a. What are the inclusion criteria?

All the study's participants will be qualified social workers, members of the Approved Mental Health Professionals (AMHP) Forum, currently working within the city's various community mental health teams.
Furthermore, only those potential participants who consent to the recording of the interview will be recruited for the study.

C4b. What are the exclusion criteria?

All the qualified social workers who are not currently working in community mental health teams and who are not members of the AMHP Forum.

C5. Will any payments/rewards or out of pocket expenses be made to participants?

☐ Yes ☑ **No**

If yes what or how much?

SECTION D – CONSENT

D1. Will informed consent be obtained from (please tick all that apply)

☑ **The research participants?**
☐ **The research participants, carers or guardians?**
☑ **Gatekeepers to the research participants?**
(ie school authorities, treatment service providers)

D2. Will a signed record of consent be obtained? *Please note that were the study involves the administration of a questionnaire or survey a signed record of consent is not required for completion of the questionnaire as long as it is made clear in the information sheet that completion of the questionnaire is voluntary. Under these circumstances return of the completed questionnaire is taken as implied consent.*

In such cases the REC would expect a statement to be included at the start of the questionnaire where the respondent confirms that they have read the participant information sheet and are happy to complete the questionnaire.

Participation in any other interventions within the same study eg interviews, focus groups must be supported by obtaining appropriate written consent.

☑ **Yes** ☐ No

If no please explain why not

D3. Will participants, and where applicable, carers, guardians or gatekeepers be provided with an information sheet regarding the nature, purpose, risks and benefits of the study?

☑ **Yes** ☐ No

If no please explain why not

D4. Will participants be able to withhold consent or withdraw consent to the procedure?

☑ **Yes** ☐ No

If no please explain why not

SECTION E - RISKS AND BENEFITS (Where risks are identified an LJMU risk assessment form must be completed)

E1. Describe in detail any potential adverse effects, risks or hazards, including any discomfort, distress or inconvenience, of involvement in the study for research participants. *Explain any risk management procedures which will be put in place.*

No potential adverse effects, risks, hazards, discomfort, distress or inconvenience, for the participants are expected from their involvement in this research study. It is unlikely that involvement in this study will cause any harm to the participants. A participant information sheet, explaining the purpose of the study and the participants' right to withdraw at any stage of the interview process without providing any explanation for doing so, will be provided. An opportunity for participants' questions prior to the recorded interview and for feedback after the interview will be provided. Informed consent will be sought via a written consent form and participants will be asked to sign the form.

E2. Explain any potential benefits of the proposed intervention for individual participants.

No immediate benefits to participants are expected from their involvement in the research study. The study will explore the views and opinions of social workers and will aim to identify some examples of good social work practice models, which may generate discussion and sharing of experiences.

E3. Describe in detail any potential adverse effects, risks or hazards (mild, moderate, high or severe) of involvement in the research for the researchers. *Explain any risk management procedures which will be put in place.*

No potential adverse effects, risks or hazards, for the researcher are expected from the researcher's involvement in this study. It is unlikely that involvement in this study will cause any harm to the researcher.

SECTION F – DATA ACCESS AND STORAGE

F1. Will the study involve any of the following activities at any stage (please tick all that apply)

Applicants should note that no personal identifiable information or sensitive information relating to participants should be transferred in or out of the EU without the consent of participants. Similarly where the use of verbatim quotes is proposed in future publications or presentations or it is intended that information is gathered using audio/visual recording devices explicit consent for this must be sought from participants.

- ☑ Electronic transfer of data by magnetic or optical media, email or computer networks
- ☐ Sharing of data with other organisations
- ☐ Export of data outside of the European Union
- ☐ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☑ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☑ Use of audio/visual recording devices

Storage of personal data on any of the following:

- ☐ Manual files
- ☐ Home or personal computers
- ☐ Private company computers
- ☑ Laptop computers

Applicants should note that only in exceptional circumstances will the storage of personal identifiable or sensitive information relating to participants on home or laptop computers or private company computers.

What measures have been put in place to ensure confidentiality of personal data (eg password protected files, encryption or other anonymisation procedures)? If you have checked any of the boxes above please provide justification for such activity.

In order to ensure confidentiality of personal data; the participants' signed consent forms will be kept in a locked cabinet, while their names will neither be asked nor recorded during the interview process; the digital audio recorder for the recorded interviews will be kept in another, separate, locked cabinet; the anonymised interviews will be copied from the digital recorder to the researcher's laptop where they will be kept under a password protected file; then using the researcher's laptop, the interviews will be transcribed to a word document which will be kept under another, different, password protected file. Only the principal investigator (researcher) will know the identity of the participants, the interviews will be anonymous, while the consent forms will be put in random order and kept in a locked cabinet, in a separate area from the recordings and the researcher's laptop computer.

F2. Who will have control of and act as custodian for the data generated during the procedure?

The Principal Investigator; Georgios Chatziroufas; MA Social Work Postgraduate Student.

F3. Who will have access to the data generated?

The Principal Investigator; Georgios Chatziroufas; MA Social Work Postgraduate Student. The Student's Supervisor; Echo Yeung; Senior Lecturer, teaching on BA/MA Social Work Programmes.

F4. For how long will data for the study be stored?

The study is part of the dissertation requirements for the MA in Social Work postgraduate course. The dissertation hand in date is the 20th of August 2012. According to the University's guidelines for assessed work, all assessed work with feedback will be retained in the school office for a period of 4 months from the date of the release of results; after 4 months all work is shredded. According to the Question Specific Guidance for LJMU Research Ethics Committee Application Form, data and information collected as part of a postgraduate research project should be retained for a minimum period of 5 years. Thus all the study's data will be safely stored in locked cabinets and retained for a minimum period of 5 years, and then all the data will be destroyed.

Once you have completed the above application form please submit it electronically to researchethics@ljmu.ac.uk. *If possible please submit your application form and any additional supporting documentation as a single pdf file.*

Both you and you supervisor or school director must sign the signature page below, complete the checklist of documents sent electronically and send a paper copy of the following 2 pages only to the Research Ethics Administrator, Research Support Office, 4th Floor Kingsway House, Hatton Garden, Liverpool L3 2AJ.

Please ensure that you complete the summary project details below to ensure that your signature page can be associated with your electronic submission for approval.

Title of the Research Study

Exploring social workers' perceptions of their role and duties within community mental health teams.

Principal Investigator (PI)

Title	*Mr*	Forename	*Georgios*	Surname	*Chatziroufas*

For RSO use only

Date received	Initials	LJMU REC Ref

DECLARATION OF THE PRINCIPAL INVESTIGATOR / SUPERVISOR / STUDENT

The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
I undertake to abide by the ethical principles underlying the Declaration of Helsinki and LJMU's REC regulations and guidelines together with the codes of practice laid down by any relevant professional or learned society.
If the research is approved I undertake to adhere to the approved study procedures and any conditions set out by the REC in giving its favourable opinion.
I undertake to seek an ethical opinion from LJMU REC before implementing substantial amendments to the approved study plan.
If, in the course of the administering any approved intervention, there are any serious adverse events, I understand that I am responsible for immediately stopping the intervention and alerting LJMU REC.
I am aware of my responsibility to comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
I understand that any records/data may be subject to inspection for audit purposes if required in the future.
I understand that personal data about me as a researcher will be held by the University and this will be managed according to the principals of the Data Protection Act.
I understand that the information contained in this application, any supporting documentation and all correspondence with LJMU REC relating to the application will be subject to the provisions of the Freedom of Information Act. The information may be disclosed in response to requests made under the Act except where statutory exemptions apply.
I understand that all conditions apply to my co-applicants and other researchers involved in the study and that it is my responsibility that they abide by them.

Signature of Principal Investigator

Georgios Chatziroufas

Date

14/12/2011

Print Name

GEORGIOS CHATZIROUFAS

Signature of Supervisor / School Director or nominee

Echo Yeung

Date

14/12/2011

Print Name

ECHO YEUNG

CHECKLIST OF DOCUMENTS SUBMITTED ELECTRONICALLY (Please tick relevant boxes)

☑	Ethics Application Form (MANDATORY)
☑	Protocol (MANDATORY) see note below
	Copies of any recruitment/advertisement material e.g. letters, emails, posters etc.
☑	Participant Information Sheet
	Carer Information Sheet
	Gatekeeper Information Sheet
☑	Participant Consent Form
	Carer Consent Form
	Gatekeeper Consent Form
	Non-validated questionnaires
☑	Interview schedule
	Risk Assessment Form
☑	Other please specify

Email communication with Gatekeeper regarding obtained consent for the study.

Note

A research protocol is a document describing in detail how a research study is to be conducted in practice, including a brief introduction or background to the study, the proposed methodology and a plan for analysing the results. For the purposes of your application for ethical approval it is something which can be presented in a variety of formats dependent on its origin for example:

- *for postgraduate research students it may be the programme of work embedded within their programme registration form (RD9R)*
- *for studies which have obtained external funding it is often the description of what they propose doing which they submitted to the funder*
- *for other students it is the study proposal they have written and had assessed/approved by their supervisor.*