



BASW Policy on Social Work in Multi Disciplinary Mental Health Teams

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Social Work in Multi Disciplinary Mental Health Teams

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1. Introduction

This paper was written in order to develop a BASW position on the role of social workers in multi disciplinary mental health teams in England and to make recommendations regarding the structures that are essential to enable social workers to effectively deliver services to people with mental health problems. The paper also has relevance for social workers and social work managers who are working in other multi disciplinary teams.

The rationale for the paper was to respond to the concerns of a significant number of social workers who work in Community Mental health teams (CMHTs).

Wider issues of the future role of social work in developing mental health services are referenced, however the primary product is a series of recommendations of a set of principles and standards for the effective deployment of social workers in CMHTs. The paper takes in to account a number of significant changes that are occurring in mental health services at the moment. Some are of immediate practical concern and some more developmental. Immediate concerns include the impact of the “Payment by Results” (PbR) funding mechanisms and the personalisation agenda. Another immediate issue is reports of a degree of disaggregation occurring in some CMHTs and some very concerning reports that CMHTs are disappearing. Developmental issues include the work coming out of “New Horizons” (DH 2009) and the Government response to New Horizons August 2010,(DH 2010) which makes strongly the welcome recognition that mental health is everyone’s concern and that a strategic approach to mental well being in communities is very important. Brief mention is also made on the potential impact on the new health white paper Equity and Excellence: Liberating the NHS (DH July 2010).

The social perspective in mental health has been at the forefront of the development of user engagement and empowerment, with social workers promoting this philosophy strongly within mental health settings, which have been traditionally dominated by the medical model of mental illness. Service users stress strongly that they want support across the whole spectrum of their

lives, with particular emphasis on over coming the social barriers to their recovery and well being. The user voice, which has been strongly supported by social workers, is in great danger of being lost, or at least diluted with the pending structural and financial changes in mental health services. Social work training has been at the forefront in engaging with service users and carers, which has been carried forward by social workers in practice. This philosophy has greatly influenced practice in some CMHTs. Poor implementation of multi disciplinary working, or the removal of social workers from CMHTs would have a real detrimental impact on the lives of service users.

The methodology to develop the paper included a literature search, discussions with social workers and managers working in Community Mental Health Teams (CMHTs) and community mental health services, the views of the inaugural meeting of the BASW mental health committee. This meeting was attended by 80 mental health social workers. The paper has also been informed by the views of the BASW mental health policy steering group. Many of the social workers questioned on the issues expressed concern about their roles in mental health trusts. They felt that managers and practitioners from other disciplines do not always value a social care model or the skills and expertise of mental health social workers. Seminar attendees also felt that there are gaps and fissures developing in partnerships that are challenging integration, regardless of whether staff are co located or are fully integrated. The paper refers to the background to multi disciplinary working, summarises research findings, and explores terminology and theoretical issues concerning role, identity and role dissonance. Definitions of social work are detailed.

The research found that some social workers are very positive about working in multi disciplinary teams, but others are far from content. Those who are positive feel that the social work role is making a real difference to service users and that the role of social work is understood and valued by CMHT members. Some social workers felt that the opportunities to improve services, for example by embracing the personalisation agenda and the wider context of mental health, as described in New Horizons, offers a great opportunity for social work. Others describe that disintegration is already occurring as tensions between health and social care are exposed. The differences between social work in CMHTs focusing on the needs of older service users and those working with adults of working age are noted.

2.0 Background

2.1 Roles of Social Workers

Much work has recently taken place on the role of social workers in adults services. A joint statement on the roles of social workers, supported by BASW includes the following definitions of social work:

“Social work’s distinct contribution is to make sure that services are personalised and that human rights are safeguarded through:

- building professional relationships and empowering people as individuals in their families and in communities;
- working through conflict and supporting people to manage their own risks;
- knowing and applying legislation;
- accessing practical support and services;
- and working with other professionals to achieve best outcomes for people”. (DH March 2010)

The Social Work Task Force implementation plan defined social work as:

“Social work helps adults and children to be safe, so that they can cope and take control of their lives again. Social workers [can] make life better for people in crisis who are struggling to cope, feel alone and cannot sort out their problems unaided”. (HM Govt. 2010)

The International Federation of Social Work defines social work as:

“The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.” (IASSW and IFSW)

The Social Care Strategic Network for Mental Health (SCSN) states that:

“Social work is rooted in empowering and supporting people within their social contexts and promoting access to citizen entitlements. It should play a vital role in driving whole persons, whole systems approaches” (SCSN 2010).¹

The mental health development group of BASW has endorsed the following definition:

“Working with users and carers, social workers promote an unique holistic, recovery orientated, values based, social care/social inclusion model” (NIMHE April 2006)

Section 6 details the roles of social workers in CMHTs and explores further definitions of social work.

2.2 Partnership working between health and social care

Partnership between health and social care has been sought for decades and although there are lots of positives and successful partnerships the relationship has never been problem free. The time line of major changes affecting social workers is as follows:

- 1948. NHS employed hospital social workers.
- 1973. Hospital social workers employed by local authorities. Local authority health staff transferred to NHS.
- Mental Health Act 1983 – which provided a very clear role of Approved Social Work Practitioners
- NSF Mental Health (1999) (DH 1999) really pushed multi disciplinary teams to provide a more integrated service for service users.
- 2000 onwards Mental Health Trusts

¹ This vision of mental health services – seeing good mental health as rooted in positive ordinary relationships and as a right for all for all citizens - is essentially socially driven. It draws upon the theory and practice bases that have been traditionally most developed in the social science underpinnings of social work.

2.3. Relations between health and social care services.

Repeated reforms and reconfigurations have not eliminated the tensions between the health and social care perspective. Tensions include: financial, power and authority in multi disciplinary teams, the support that various professionals receive, issues to do with lack of clarity of role and diversity in terms and conditions of employment.

There is however a danger that a focus on the perspectives of professionals can diminish the purpose of CMHTs – providing high quality services to people with mental health problems. There is also a danger by focusing on problems that there is a failure to acknowledge that a lot of good work takes place, which is of real benefit to service users / patients. Tensions between professions can be healthy, particularly tensions over the rights and responsibilities of patients / service users. Within social work, as one would expect, there is strong support for the role of social work as a clear and strong profession, which provides a valuable perspective on the needs of users of mental health services and a range of intervention tools. There is also frequently support for the role of social work from other professionals. This support appears to be particularly prevalent in mental health services for older people. Tensions and conflicts are not only about different perspectives; they can also be about resource issues. Depending on the financial arrangements between the two main funders of mental health services – PCTs and Councils - tensions can and do occur in spite of joint budgets, pooled budgets, integrated budgets and the funding of preventive services in the community.

3.0 Legislative and policy framework.

3.1 The legislative and policy framework makes many references to multi agency working, working together, partnerships, integration. The following are pertinent:

- National Health Service Act. 1973.
- The NHS and Community Care Act. 1990
- Health Act. 1999 enabling pooling of funds and delegation of functions between health and social care
- National Service Frameworks (Sheppard M.)
- Section 75 of NHS Act 2006 (Pooled resources) - or aligning budgets (Community Care March 2010)
- Mental Capacity Act (2006)
- Mental Health Act 2007 – AMHP's (Community Care (June 2008)
- Putting People First (DH 2006)
- New Horizons (DH 2009) –
- Revised NHS Operating Framework 2010/11 (June 2010)²

² As an example of latest “health direction” p6 “The arrangements for joint planning between the NHS and social care must remain,..... Joint working and commissioning between PCTs and Local Authorities will be of increased importance in order to deliver better outcomes for patients, service users and their carers”.

3.2 Mental health social work prior to CMHTs

Prior to the development of multi disciplinary teams mental health social workers, particularly Approved Social Workers (ASWs) were often based within the local authority. This had the disadvantage of knowledge and information being difficult to share with health professionals, but the advantage that there was a degree of independence as a result of employment and location by another organisation. ASWs “..were well placed to protect rights of vulnerable people counter balancing orthodox psychiatric view with holistic social care view”. (New Ways of Working 2005).

However research indicates that there was consistent unevenness of ASW practice and questions about how protective of service users rights it was (Campbell, J. 2010). The presence of mental health social workers and ASWs in area based social work teams also meant that the expertise of mental health social work was more easily shared within social work and social care teams within the local authority. A large proportion of families seen by children and family social workers have a significant element of mental health aspect.³

3.3 Variance in how the role of social work developed

Just as there was an unevenness of practice of social work and ASWs when they were not part of multi disciplinary teams there appears to be variance in how the role of social work has developed. The development of multi disciplinary teams in some places appears to have enhanced the role of social workers, however in others multi disciplinary working has undermined the independence of the social workers. Which of these two directions – enhancement, or undermining seems to depend on a number of key factors. These factors are detailed in section 7.1. Prior to an exploration of these factors the concept of role identity is explored in section 4.0 as a background to the issues of role uncertainty for social workers in multi disciplinary teams.

3.4 Current policy. Early intervention and re-ablement

The social care policy agenda, as articulated in New Horizons (DH 2009) Department of Health. (2010) and the revised FACS guidance (DH Feb2010) articulates the importance of early intervention and re-ablement. Social workers and managers are reporting that this is creating tensions in developing a shared agenda with health. It is reported that although PCTs are accepting joint responsibility for community mental health and well being, there is still a major commissioning emphasis within health on secondary and / or specialist mental health services. This is creating a tension regarding resources and a tension in relation to user led and co – produced services, running parallel with the personalisation agenda. (LKM 2009). The work of the LKM project identified that a number of local authorities were withdrawing from integrated partnerships and are indeed de-integrating taking back direct management of social care staff and resources due to concerns about the prompt and effective use of social work resources.

4.0 Role identity

Human beings in work and social settings need to feel that they are understood and that their roles are clear and valued by others. Without such role clarity people can feel dissatisfied and undervalued. Multi disciplinary working can be beset by problems of individual staff, or groups of staff feeling the malcontent of role confusion. In a social work context role adequacy (feeling knowledgeable about ones work) and role legitimacy – believing that one has the right to address certain client issues is very important for professionals, and particularly important for social workers who can be perceived as suffering from a lack of clarity regarding their role. Feelings of role adequacy and role legitimacy appears to be variable depending upon the particular team, its make up, supervision and support, the degree of isolation and degree of training, knowledge, specialisation, leadership and the degree that other professionals

³ It also needs to be noted that in many local authorities where there was a hospital with mental health provision that some social workers were physically based in the hospitals and in practice worked very closely with multi disciplinary teams. It was always contentious as to whether these social workers should be ASWs because of the lack of distance between them and health. Some argued that it was best to be at the table to influence practice, others

understand the role of social work (Loughran et al 2010). In recent years the concept of the social model of care, compared with a medical model has gained increasing currency. The social model developed from the disability rights movement and has been supported by a large tranche of the social work profession. It does need to be noted however that the success of the spread of the social model to mental health care has meant that other professions, including nursing and professions allied to medicine have increasingly taken on board some or parts of the model. Whilst this is to be celebrated it also means that the social work role of propagating the social model within a medical model environment has been in some places reduced. Holding strongly to the social model did enforce role clarity among social workers and other social care staff, the spreading of the model to a other professions has meant that for some social workers that role ambiguity may have increased.

5.0 Terminology and concepts of integration / partnership

This section touches on the various models that are employed, or are evolving in working across and removing organisational boundaries. Various terms are used to describe organisations working together and the use of the terms appears to be rather loose and need to be considered carefully as interpretations can lead to significant misunderstandings.

5.1 Organisational models

Terminology needs to be handled with great care – different terms can mean different things to different organisations. There is generally perceived to be a continuum of integration and collaboration as illustrated in diagram 1 ⁴

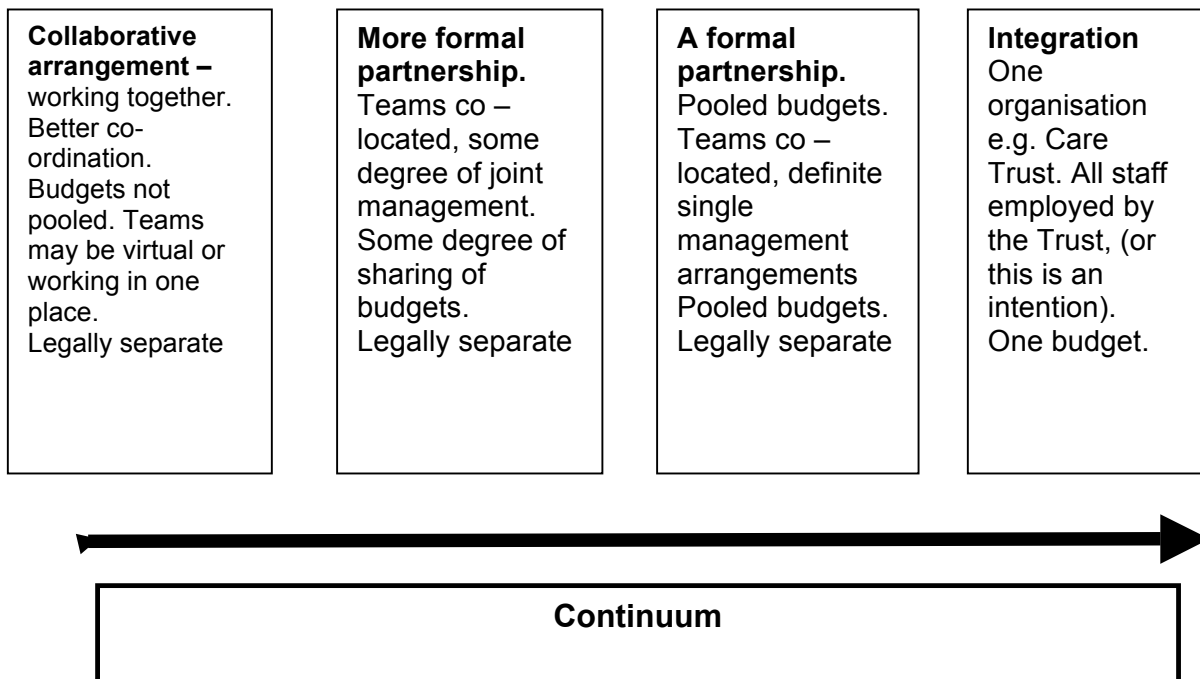


Diagram 1

It should be noted that better co-ordination, while not the same as integration, can also result in gains for service users. The Integrated Care Network report that better co-ordination “has palpable merits: It can deliver many, if not most, of the benefits to users of an integrated system (and) it can be a positive, facilitating step towards an integrated system” (Integrated Care Network). The Integrated Care Network also report that a more integrated approach “..is most needed and works best when it focuses on a specifiable group of people with complex needs, and where the system is clear and readily understood by service users (and preferably designed with them as full partners).The converse of this is also important: The vast majority of people with non-complex needs will continue to be well served by services acting more or less independently. The degree of complexity of individual needs should determine the requirement and context for integration.

Multidisciplinary teams are often discussed in the same context as joint working, interagency work and partnership working. The logic behind multi disciplinary teams is that there are service users / patients who require the help of more than one kind of professional. Elderly people, people with mental health problems, disabled people, troubled teenagers, families in crisis... all require more expertise than one kind of professional can offer (Foster J, 2005). Multi disciplinary teams, whether part of a partnership, or organisationally integrated are also deemed to be clearer for and better understood by the service user(Integrated Care Network)

5.2 The pros and cons of adult care Trusts

A recent article commented on the pros and cons of adult social care trusts. This is reference to the creation of adult social care Trusts, as an addition to Mental Health Trusts. (Community Care March 2010). The direction of Government Policy has certainly been to implement Care Trusts, in practice however there has been no rush by the main players to create such trusts.

5.3 Defining attributes of successful partnerships

The creation of organisational partnerships or integrated services does not automatically lead to improved services. There are whole hosts of issues that need to be tackled in order to lead to better services. These include managing the process of change and extensive work with teams and individuals.

Issues that need to be tackled include:

- Trust between partners – there will almost always be a history that needs exploring and issues from that history need to be tackled
- Respect for partners. Respect implies an attitude of equality between partners
- Joint working of cases – all the relationship issues between organisational partners applies at the level of professionals working together at the case level
- Teamwork. Individuals in teams can co-operate, but there can still be dysfunction in teams, including professional clashes
- *“Integration only gets you a ticket to the game! The hard work starts from there”*(Social Perspectives Network Paper 6)
- Roles and responsibilities of staff are clear and understood and management accountability is clearly delineated and professional support is in place (Integrated Care Network)

5.4 Core characteristics of integrated organisations

Glendenning (2008) describes some core characteristics of integrated organisations. Integration is more likely when several of the following are evident:

- joint goals
- very close-knit and highly connected networks of professionals
- little concern about reciprocation, underpinned by a mutual and diffuse sense of long-term obligation
- high degrees of mutual trust
- joint arrangements which are ‘core business’ rather than marginal
- joint arrangements covering operational and strategic issues
- shared or single management arrangements
- joint commissioning at macro- and micro- levels.

6.0 The role of social work in CMHTs

One of the challenges of social work is that it can be difficult to define what the contribution of social work is and this does pose problems for social workers in multi disciplinary teams.

Broader definitions of social work were raised in section 2. This section will concentrate on the more specific attributes of social work in CMHTs

Until recently social workers in CMHTs, whatever else they did, had a monopoly of role in relation to the Approved Social Worker role, (albeit the role of ASW was poorly understood by the Crisis Resolution and Home Treatment Teams (Furminger, E. 2009). However the uniqueness of the ASW role is now under challenge following the introduction of the Approved Mental Health Professional role (AMHP).

If social work in CMHTs and other multi disciplinary teams are to have professional confidence there does need to be a much wider justification for existence than the limited legislative role. The following touch on the wider role of social work as practiced over the last thirty years or more:

- Social Work was practising social inclusion before it has been invented (Community Care (Community Care July 2006)
- Social work propagated the concept and practice of service user involvement. From “doing to” people, to “doing for” people, to “doing with” people, to being alongside people as an ally, advocate and assistant (Community Care March 2010). Social work has an understanding of how systems work and the cultural and other barriers that need to be overcome to promote multi disciplinary work or integration (IDEA)
- “Social work brings something distinctive to mental health. Articulating it is more difficult. It is a constellation of values, commitment to social justice and partnership with users and carers”. (Community Care July 2006)
- Working with users and carers, social workers promote a unique holistic recovery orientated values based social care / social inclusion model that is able to challenge the dominant task orientated medical model and this is reflected in the competences that are required. (CSIP 2006)
- The SCIE Research briefing 26: Mental health and social work provides a wealth of discussion and evidence on current social work practice in relation to mental health. The following is a brief citation⁵:

“The core values of social work practice directly support the principles underpinning self-directed support and the independent living movement. (Similarly, analysis of the ‘essential capabilities’ required to practice in mental health also emphasizes the importance of a professional value base which promotes dignity, human worth and social justice, and includes a commitment to the principles and social perspectives of the recovery model. (33) Research exploring community care practices (34) Hardiker, P. and Barker, M. (1999) ‘Early steps in implementing the new community care: the role of social work practice’, Health & Social Care in the Community, 7 (6), pp. 417-426. found that social workers frequently identified empowerment as a fundamental principle in their practice, both as a goal and as an underpinning value. There is also widespread agreement among people who use services, practitioners and researchers that service developments such as mental health promotion, crisis resolution, and the implementation of support based on the principles of recovery, must be explicitly underpinned by social perspectives. (35, 36) Hope, R. (2004). The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce, London, NIMHE/SCMH Joint Workforce Support.) These perspectives can help promote access for people susceptible to discriminatory institutional practices, including people from black and minority ethnic communities. (37) ⁶

According to Peter Gilbert in his latest book “Social Work and Mental Health: the Value of Everything” social workers are “ideally placed to act as trailblazers in bringing to the fore the contribution of social care to the wider determinants of mental health and well being” (Gilbert, P. et al 2010 p108). Gilbert and his fellow authors firmly set social work as one of the most vital components in a truly whole-person and whole systems approach to mental health.

⁵ Since the SCIE report the work of the Social Work Reform Board has been published Along with a clear statement of the role of social work.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_114572.pd

⁶ The numbers in the citation refer to references in the original article. They can be accessed by reading this article

Michelle Rowett, former Chief Executive, Manic Depressive Fellowship, 2003 makes the following point: “Mental distress may be caused or compounded by poor living conditions and difficult personal circumstances. The role played by social workers can therefore be crucial to recovery from mental illness precisely because their focus is personal, giving practical support and help to resolve problems of living that might otherwise appear insurmountable to someone who is also trying to deal with his/her mental distress. This type of support not only contributes to recovery from a period of illness, it can also help reduce the likelihood of a further episode recurring. (quoted from Gilbert, Peter et al 2010 p141)

Sir William Utting, former Chief Social Worker Officer, DHSS adds the view “I do not expect social work to be popular. It deals with people society would usually prefer to forget: unwanted, stigmatized, dependent. It does not do so quietly, but acts an irritant by standing up for their rights and needs” (quoted from Gilbert, Peter et al 2010 p153)

6.1 The role of social work in relation to self directed support

Government policy is to increase the number of service users controlling and commissioning their own support services. (DH 2007) (DH March 2010). To date the number of service users with mental health problems utilising personal budgets has been relatively small. (Community Care May 2010). If there is to be a significant increase in take up of personal budgets by service users this will have significant implications for the role and functions of mental health social workers. For all social workers there would still need to be a role of safeguarding, risk management.⁷ Social workers within CMHTs, if there are the necessary strong links with local authorities, will be in a key position to advise service users and other professionals. Mental Health Social Workers also need to work with commissioners of services, service users and providers / facilitators of personal budget services to ensure that the support systems are in place to support service users who opt for this model of service. The drive for the application of personal budgets has come from people with a physical disability and whilst many aspects of the personal budget systems that have been established would translate to support people with mental health problems, there needs to be a specific approach to supporting people with mental health problems. The impact of the Payment by Results (PbR) is also relevant. There is a real danger that two separate systems of assessment and accounting will be operating in parallel, or indeed in conflict. This is explored further in section 10.

One very important role of mental health social workers is of actually providing a direct service to service users – a therapeutic role.

6.2 The therapeutic role of mental health social work.

Mental health professionals from whatever background are required and want to put service user needs at the centre of care planning and ensure that they receive the support and care that meets these needs. This includes providing evidenced based interventions, Nice guidelines, recovery based approaches and supporting users of services as experts by experience. While the needs and views of different professions are important we must keep what works for service users at the centre sharing skills and expertise to make a real difference to their lives. Through the long history of mental health social work, social workers in mental health have had considerable skills based training. They are “more than care co-ordinators”. Many social workers have had psycho social intervention training and many have had specialist intervention training according to personal interest e.g. in working with personality disorders, family therapy solution based therapy or working with survivors of abuse. This therapeutic context to social work has been reinforced and developed by access to multi disciplinary peer support groups, joint workshops, case discussions and extra professional supervision on individual cases. Most mental health social workers operate psycho educational approaches, systematic family work, coping strategy enhancement in managing symptoms, monitoring medication side effects,

⁷ The role of social workers as experts in mental health law and their role in protecting the individual and society is also relevant, which enables them to manage high risk cases and grapple with the autonomy versus social control continuum.

assertive and proactive engagement, use of cognitive and behavioural approaches, planned and structured work on life goals etc. The intensity and frequency of such work is constrained chiefly in the demands of large and diverse case loads by the care co-ordination system and the expectation for workers to be “all things to all people”. (Wilson, C. 2008)

According to Bates the marketing of such a non-statutory role of social care within mental health services has been largely invisible and yet the “stickability” of the social work approach is evident with practitioners working quietly and reliably behind the headlines to provide a consistent and recovery-based service for people who use mental services (Gilbert, Peter et al 2010).

6.1 Integration does not mean assimilation.

Assimilation needs to be avoid(ed) like the plague any talk of turning everyone into some strange homogenous beast. Integrated services need diversity” (Social Care Perspectives Network). Tony Gardener states that integration should not be an end in itself and that integration is not about assimilation – “We don’t want an homogeneous beast”. In other words at both the organisational level and the practitioner level there needs to be, where appropriate, continued separation of roles and professional skills and perspectives.

The issue of workforce redesign is an area that has led to confusion; there have been a number of new roles created in CMHTs, including some hybrid roles. This issue is expanded on in Section 9 on workforce redesign.

6.2 The benefits and challenges of joint working

Joint-working between health and social care can benefit service users and the public purse but an Audit Commission study, reviewed by Jill Manthorpe, found that it is under-used in the adults’ sector. (Community Care March 2010). Integration in health and social care is seen to improve the efficiency, quality and continuity of service delivery, thus leading to improved service user experiences and outcomes. This is because integration recognises that health and social care outcomes are interdependent, in addition it also recognised the provision of integrated care can provide financial benefits.

A review by Turning Point found that there were potentially substantial benefits in integrating services. The report states that people with a range of health and social care problems require services that are easy to understand and access. Integrated health and social care support allows patient journeys to be simplified prevents the needs for individuals to repeat their stories to a range of professionals, Integrating services can improve efficiency and help organizations meet the growing demands for health and social care services. They argued the economic case for integration. (Turning Point 2010).

A report from the Chief Executive of the Cornwall Mental Health Trust, which is an integrated Health and Social Care states that the Berlin Wall between Health and Social Care has been broken down successfully. <http://www.spn.org.uk/> He states that success includes ensuring that the social perspectives will not be lost; and a determination that local authorities will not forget about their responsibilities to promote mental well-being; and to continue relationships with child-care, older persons and learning disability teams in social services. He states that “people who use services, their carers and staff want to see one care system and not two. That one care system can challenge traditional assumptions about choices and services and recognise that people want ‘Whole System’ solutions to problems which don’t see people having to accept treatment or services that do not best suit their individual needs and wishes”. He also stresses that integration is not about assimilation.

7.0 What is happening in practice re organisational integration / partnership in CMHTs?

Detailed comment on what is happening to partnerships is beyond the scope of this report. It should be noted however that The Social Care Perspectives Network is monitoring the situation⁸⁾ and a review of partnership working in Lincolnshire, which included research into mental

⁸ The Social Perspectives Network is monitoring the effects of changes, such as the creation of Health Trusts, with

health partnerships in other parts of the country found that there is major disquiet from social care commissioners and some evidence of drawing back from partnerships. (KLM 2009). Section 10 explores the issues in relation to partnerships with the introduction of PbR.

7.1 Literature reports of the experiences of social workers in CMHTs

Various reports highlight the following issues:

- Isolation in MDT (New Ways of Working for Social Workers 2005) particularly if employed or seconded to a NHS Trust
- Lack of job satisfaction, not feeling valued, (Huxley et.al (2006)
- Concern about the erosion of the social work role with the creating of new roles (DH May 2006)
- Stress and burn out of ASW's (Huxley et al (2006)

7.2 Experiences of practitioners and managers.

As stated in the introduction this paper resulted from a BASW seminar of 80 mental health social workers in 2009 and has subsequently been followed up by a series of interviews with practitioners and managers. The paper was also subject to comment from the BASW Mental Health Advisory Group.

A very variable picture of the experiences of social workers has been found. One social worker (and this was not an isolated example) had been the only social worker in a team, which included 17 nurses.⁹ She said that she had felt very isolated, was not treated with respect by other members of the multi disciplinary team and basically was used for her statutory role in relation to her AMHP status. (She reported that nurses were not wanting to take on this role). Social work supervision was confined to an occasional session with a Team Manager from an area team, which was not satisfactory. Line management was from a nurse and indeed all the managers were from a nursing background. Senior managers from Social Services did not appear interested and she had nowhere to take her concerns.

By contrast other social workers reported that their experiences were almost the opposite of the above. Examples were given of teams that contained several social workers, professional supervision was provided regularly from an experienced mental health social worker (in line with the clinical supervision that the nurses received). Social services senior management remained interested and involved. They felt that they received support as social workers.

The head of social care in a Metropolitan Authority reported that considerable effort goes into supporting social workers in CMHTs.¹⁰ Policies included:

- Professional supervision within the team from an experienced social worker
- Support for the experienced social worker from an external mentor
- Assistant Director membership of both operational and Board meetings
- A strong emphasis on training and development for social workers
- A mental health social work practitioners forum
- Access to and support from social services training and access to Council information systems, such as intranet.

A number of social workers who were positive about their work situation felt that the social model of community and family engagement was the dominant philosophy in the teams where they worked, which although to be celebrated lead to role ambiguity and uncertainty for them. One social worker worked in an older people's team and she felt that she and her social work colleagues were respected and valued as team members. In her view the positive attitudes of

<http://www.spn.org.uk/>

http://www.spn.org.uk/fileadmin/SPN_uploads/Documents/Papers/SPN_Papers/SPN_paper_6_1_.doc

⁹ She had recently resigned because of the isolation that she felt.

¹⁰ This organization was a formal Trust with pooled Section 75 budgets. However staff were still seconded and

the medical consultants was vital in generating this respect. A knowledge and understanding of community services and planning of discharge services contributed to the respect, as well as a respect for statutory safeguarding and civil liberties issues.

One social worker reported that she had worked in two CMHTs in the same area and one had been an entirely positive experience, with a lot of support regarding the social work role and perspective and respect from other professionals. However the other experience was very poor and was basically caused by the control and inappropriate operating of authority by the consultant psychiatrist. In that setting social work and the social perspective was marginalised and indeed looked down on. In the other setting the Consultant Psychiatrist had taken a very inclusive view of professions and treated all members of the multi disciplinary team with respect. The experience of social workers, anecdotally, did not seem to reflect the degree of organisational integration. In other words there did not appear to be a correlation between social workers feeling more valued and the particular organisational arrangements, such as whether they were employed by Health Trusts, or were seconded, whether there was full organisational integration, or a partnership. What was very important was the arrangements for support that social workers received and the degree of respect that other professionals, particularly psychiatrists had about social workers. Inevitably where there was only one social worker placed in a team of other professionals the social worker was likely to feel isolated. The extreme case of one social worker working alongside 17 nurses has been cited.

The issue of individual budgets and resource allocation and the role of the social worker was raised by all participants. Social workers generally were seen as gate keepers to social care resources to support people in the community, although the social workers themselves felt that they were not the gate keepers, but the resource allocation panels were. There were concerns about the changes in the role of care management, from one where social workers had an ongoing role to support service users to a role where the on going support and management of community care packages had or was moving to a diversity of new professionals – brokers, advocates etc. (DH Adult Social Care Workforce Strategy 2009)

8.0 Workforce re design

A considerable amount of work has taken place in the last decade to consider whether the traditional roles within the workforce are can be improved on, or whether there are gaps that could be filled. One of the overriding objectives has been the attempt to improve the experience of the service user. Service users frequently claim that they do not understand all the differentiation of professional roles and also that they want a reduction in roles. In mental health settings these issues have been tackled by identifying which professional is the most suitable to undertake the role of key worker for a particular service user. This has led to some over lap of former roles – for example nurses taking on the service brokerage or service arranger role. An example of a new role is the role of Support Time and Recovery Workers. These STR workers can take on a therapeutic role, working with families as well as supporting service users in practical ways in the community. Social workers do not oppose the development of new roles and welcome the empowerment of service users, indeed social workers have been initiators and drivers of much of the development of service user led services. Social workers therefore welcome the development of new roles where the new roles enhance outcomes for service users. The social model of disability is central to social work training and understanding. Social workers are therefore one of the keys to development of service user lead services and the effective development of new roles. It is recommended that shared workforce priorities focused on service users, but maintain professional identities.(JIT 2009)

9.0 Opportunities for social work

The section on workforce re design has created challenges for the roles of social worker, although it can be argued that a holistic understanding of service user behaviour, within the context of the social networks that service users operate in is an area that social work training and practice is best served to inform. Indeed it may be that social workers to some extent are the victims of their own success as the social model of mental health has gained more prominence in mental health settings, although it would appear that there is at best a very patchy. A number of sources state that there is now a great opportunity to spread social care

and the impact on social workers, particularly AMHPs, is being monitored by the Social Perspectives Network <http://www.spn.org.uk/>. Other commentators state:

- Social models of understanding can challenge or complement clinically-oriented medical models of mental illness. (NIMH 2005)
- For those who really are concerned that social care values will somehow become subsumed or colonised by less than progressive conservatism within the health system I believe that there has never been a better moment to grasp some of the values that have been evident in social care for many years. The momentum towards greater social inclusion, recovery, early intervention and choice offers a mental health landscape with more opportunity than before (Gilbert, P.)
- The work of the Social Work Task Force and Reform Board makes this an exciting time in the development of social work. It is also an exciting time in the further deinstitutionalisation of mental health services. SCSN believes that social work – and its values – can become a more powerful force in shaping the mental health landscape. (SCSN 2010)

10.0 The implications for Social Work in CMHTs of the Payment by Results (PbR) system.

Payment by results (PbR) is a concept that is not at all new for Councils, however within the NHS the concept is less well developed. NHS mental health services have been one of the last services within the NHS to go down this road. In order to implement PbR a number of tools have been developed to identify need and to define indicative services to meet the identified needs. A major plank of the approach is the Care Packages and Pathways Project (CPP) which groups similar types and levels of service user's health care needs into 'clusters' to enable delivery of a consistent service response and 'care pathway'. However there is concern that CPP and personalisation initiatives, if developed in isolation from each other, could create a disjointed assessment process with parallel care pathways, and place additional demands on staff, especially in terms of delivering integrated care (ADASS 2009). The ADASS also express concern that the social care aspects of mental wellbeing need to be incorporated into CPP if understanding and choice are not to be restricted. Furthermore:

“There is concern from various stakeholders that the Care Packages and Pathways (CPP) approach is concentrating only health needs, when this seems artificial in the context of mental health and emotional/psychological wellbeing. A number of stakeholders/partners think that the language of CPP, especially the clusters, and the emphasis on treatment and intervention, is overly medical and there is widespread concern that differences between Personalisation and CPP, and the way the two approaches are being introduced, are contributing to disintegration between health and social care MH services”.(ADASS 2009).

More fundamentally if Trusts do not get reassurance from commissioners that under PbR they will be paid if social workers care co-ordinate a “health” case they will be pressurised to move to a more delineated health and social care model.

On personalisation there is a need for Trusts in integrated services to take a position on whether their staff will assess for services that are self directed under the personalisation system, in the same way they previously did in care management, (which varies in extent across partnerships). Personalised budgets are also meant to have the potential to include health funding. If this occurs – the review of the individual budget pilots recorded almost zero activity on this front – then the role of assessment and care co-ordination will take on a new dimension.

Research on the implications of PbR found that health trusts did not fully understand the implications of local authorities pulling out of PbR. (Wilson, C, 2010). Most health trusts will not be able to staff care clusters, without Mental Health Social Workers. (Workers which are seconded, or funded via pooled budgets). In one locality in the North East where mental health

being defined as MH the LA tends to take on costed care and safeguarding and the rest is defined as "health". This will mean that 100's of current cases held by MHSWs which will have to transfer to CPNs.

The development and uptake of individual budgets within mental health services has been relatively slow compared to other service user groups, but there is now evidence that it is increasing a little (MIND 2009). However a report on the introduction of personal budgets and its relationship to CPP expresses a lot of concerns that the two approaches are not being integrated.

"There is an inaccurate impression that personalisation is specifically a social care phenomenon. MH NHS Foundation Trusts in the NE have not thought about personal health budgets, or how they might be factored into CPP". (NEMHDU May 2010).

The North East Mental Health Development Unit (NEMHDU) raise concerns that need urgent attention if personalisation and CPP are to enhance, rather than detract from joint working.

In conclusion there must be considerable concerns for social workers within CMHTs who are trying to implement personalisation, but at the same time are part of the introduction of CPP. Separate assessment systems are in danger of being utilised and there is a real danger that the PbR systems do not sufficiently take into account person centred social care. The unique role of social work in creating a holistic assessment could be compromised to the detriment of the service users, the principles of personalisation and the value base of social work.

11.0 Summary

BASW has found that the experiences of social workers working in CMHTs and mental health services is very variable. The renewed emphasis on prevention and community well being is welcomed by social workers, however the main focus of this paper has been on the experiences of social workers working within the field of severe and enduring mental health. In such specialist mental health teams the challenges of implementing personalisation and individual budgets has been flagged up, particularly with the parallel development of Payment by Results. A number of reports that integrated services being disaggregated are being received. This is not welcomed by BASW, which sees the distinct advantages for service users of integrated services.

In spite of the above challenges and opportunities BASW is supportive of the role of social workers as full members of CMHTs, providing that a good level of support is provided and providing that the issues of PbR and the roles within personalisation can be agreed upon. Details of what is necessary in terms of support is detailed in section 12.

Inter agency and multi disciplinary work is not new, in mental health services the model – at least at the level of a degree of service integration or partnership working – is fairly well developed. What is not well developed is a set of standards for employers of social workers and other social care professionals who work in CMHTs. Standards that recognise the importance of social work and detail the support systems that need to be in place to ensure that social workers thrive and are able to deliver a good social work service. The experience of social workers is that strikingly different experiences occur. Some social workers feel that they are valued and that they have good support structures in place to support them as individuals and as social work professionals. Others felt very isolated, disempowered and under valued, with the bigger concern that the independent social care perspective of social work was not being heard in multi disciplinary teams. There is evidence that the social work role in CMHTs working with older people is better established and valued compared with social work in CMHTs working with adults of working age.

12.0 Recommendations

12.1 Principles to support social workers working in CMHTs and community mental health services

It is recommended that the following measures are adopted. The measures all refer to principles and ethics that are captured in the BASW code of ethics¹¹:

- The BASW Code of Ethics is adopted by Health Trusts and Social Service Partners to underpin the relationships within and between the partners
- Health managers must recognise that social work is a profession with its own principles and codes of conduct and unique knowledge and skill set. This knowledge and skill set includes safeguarding, the mental health act, case management and personalisation, but also relates to wider knowledge emanating from research and practice. This includes a high level of understanding of the social model of disability.

12.2 Practices and processes adopted in order to achieve the principles

It is recommended that the following practices and processes are adopted in order to ensure that social workers are well supported in community mental health services and that social work continues to make a significant and positive contribution to mental health services:

- That Health Trusts and Social Service Partnerships sign up to the BASW 5 star engagement plan endorsing their commitment to social work
- That the implications of the introduction of PbR are seriously considered by Health Trusts and Social Service Departments in order to avoid the disintegration of multi disciplinary teams
- An interagency group is established specifically to oversee section 75 agreements
- Regular governance meetings at senior management level to monitor partnership arrangements are instituted
- There needs to be social work representation at Trust Board level. A member who clearly owns the local authority social care portfolio
- Social care is recognised as an integral part of a Trust's mission statement
- When the commissioning of mental health services is moved to GP commissioning practices that recognition of the vital role of social care and social work is recognised by commissioners
- There needs to be strong on-going local authority engagement at senior management level with mental health services in order to ensure that the social care model, personalisation and the social work role are effectively embedded in Health Trusts
- Social care models are incorporated into the training of all mental health professionals
- Clear lines of accountability, leadership and support is given to middle managers in taking the social care agenda forward
- The value of the social care workforce is promoted
- Anyone responsible for personnel issues – recruitment, disciplinary, grievance and absence are trained in the requirements of the local authority, Care Quality Commission, Social Work Codes of Practice, Social Work Task Force recommendations
- Social care leaders should ensure that that support services are in place for social workers – IT HR, finance, learning and development. This includes ensuring that

¹¹ For a summary version of the code of ethics see Appendix 1. For a full version please go to <http://www.basw.co.uk/about/codeofethics/>

social workers, whether seconded to Trusts, or directly employed have the tools to engage (such as access to local authority internet and intranet and recording systems) with social service departments)

- Social workers and social work managers should be engaged from the outset in the development of plans to re configure and change services
- Robust arrangements are put in place to ensure that social workers receive good quality supervision from qualified social workers
 - Professional supervision within the team from an experienced social worker
 - Support for the experienced social worker from an external mentor
- There should be an adequate number of social workers in CMHTs
- There should be a social work forum in each locality, that is separate from other professions in order to build and sustain identity
- The issue of unequal terms and conditions of employment between professions needs to be addressed
- Detailed governance arrangements are instituted so that arrangements are not reliant on personalities, or the enthusiasm of particular managers
- Clarity is developed regarding which personnel policies are followed – Trust or Local Authority
- Support for social workers is given to take on leadership roles in mental health trusts
- Support is given to social workers to strengthen capabilities and social workers ability to do their job well.
- Managers in mental health services need to recognise the importance of team working and the value that different professional roles bring to the teams
- Where necessary appropriate development work, involving all members of multi disciplinary teams, takes place to ensure that there is mutual understanding of roles. Relevant toolkits should be used to facilitate this
- That the recommendations of the Social Work Task Force for the profession – including supervision, training and development and qualifications are followed and implemented when they become policy. (DH 2009)

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14.0 Appendix 1

Code of Ethics – summary:

Key principles

Human dignity and worth

- Respect for human dignity, and for individual and cultural diversity
- Value for every human being, their beliefs, goals, preferences and needs
- Respect for human rights and self determination
- Partnership and empowerment with users of services and with carers
- Ensuring protection for vulnerable people

Social justice

- Promoting fair access to resources
- Equal treatment without prejudice or discrimination
- Reducing disadvantage and exclusion
- Challenging the abuse of power

Service

- Helping with personal and social needs
- Enabling people to develop their potential
- Contributing to creating a fairer society

Integrity

- Honesty, reliability and confidentiality

Competence

- Maintaining and expanding competence to provide a quality service