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Social Workers as Members of Community Mental Health Teams for Older People: What Is the Added Value?

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Abstract

Social workers have worked with older people with mental ill health in multidisciplinary teams for many years. Research regarding their contribution is nevertheless sparse. This article addresses this gap. Qualitative data from semi-structured staff interviews were drawn from a multiple case study of community mental health teams (CMHTs) for older people, some with and others without social worker members. Interviews included questions about team roles and the impact of the presence or absence of social workers on team functioning. A grounded theory approach was adopted to analyse the data, enabling issues of importance to interviewees to emerge. Non-social work CMHT staff were found to place a high value on social worker team membership due to their specific skills, knowledge and values, and with regard to communication pathways. Social workers and other team members' views were found to differ regarding whether social workers within CMHTs should operate as generalists or specialists. The findings suggest the need for formal structures extending beyond the co-location of multidisciplinary staff; appropriate and sufficient supervision for social work team members; and the development of more workable and direct referral systems between CMHTs and social services adult social work teams.

Keywords: Social workers, multidisciplinary teams, older people, mental health

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Introduction

Social workers operate in a range of settings, both specialist and generic, within single and multidisciplinary teams, in hospitals and in the community. Articulating the social work role, however, is acknowledged to be challenging (Social Work Task Force, 2009; Allen, 2014). The international definition, currently under review in Britain, describes it as an 'interrelated system of values, theory and practice', with values based on 'respect for the equality, worth and dignity of all people'; theories relating to individual behaviour and wider social systems; and practices in keeping with a 'holistic focus' (IFSW, 2002). More specifically, in relation to adults with mental health needs, The College of Social Work have recently noted the crucial role of social workers in promoting recovery, supporting self-directed change and balancing rights against protection (Allen, 2014). Research evidence identifying how these roles are manifested in practice, especially in relation to older people with mental ill health, is, nevertheless, limited.

Using interview data from a multiple case study of community mental health teams (CMHTs) for older people, some with and others without social worker members, this article seeks to address this gap. It focuses on three themes: the range of skills, knowledge and qualities that social workers bring to their work in CMHTs; how social workers are used within CMHTs—particularly in relation to their specialist knowledge; and issues of interdisciplinary communication—both inside and outside teams. This is preceded by a brief overview of two areas relevant to this study: the development of CMHTs; and multidisciplinary team working and the place of social workers in this.

CMHTs: origins and development

Whilst social workers have worked with older people with mental ill health in hospital settings from the 1950s, it was the closure of mental hospitals from the 1960s and the consequent need to provide care and support in the community that precipitated the development of a new type of service in which the role of social workers was recognised as being crucial (Nolan, 1993). The emerging community services, spearheaded by consultant psychiatrists (Ministry of Health, 1962; Hilton, 2008), were, accordingly, characterised by multidisciplinary membership, including increasing numbers of social workers, from the start (Wattis *et al.*, 1999). Professionals' roles and tasks within these services were clearly demarcated, with psychiatrists, for example, undertaking all assessments. In other ways, too, the new community facing services continued to operate along traditional medical lines being hospital-based, led by medics and only accepting referrals from other doctors. A new type of team began to appear from the early 1980s, with a number of defining features which challenged traditional attitudes and practices. These included

the introduction of team managers, the acceptance of referrals from social services and the public alongside doctors, and the undertaking of initial assessments by all professional team members. This, its advocates argued, resulted in a more efficient use of staff time and resources (Collighan *et al.*, 1993).

The need for a comprehensive specialist mental health service for older people was formally recognised in government policy for the first time in 2001 (Department of Health, 2001). CMHTs have since become the acknowledged cornerstone of this service (Department of Health and CSIP, 2005), numbering over 400 in England in 2009 (Wilberforce *et al.*, 2011). Their key features include a multidisciplinary membership, ideally including mental health nurses, consultant psychiatrists, social workers, occupational therapists, psychologists and support workers (Department of Health, 2001); a single point of access; and a focus on supporting people with complex and/or severe mental health difficulties (Ovretveit, 1993; Department of Health, 2001; Onyett, 2003). Although social workers were included in the earliest CMHTs (Macdonald, 1991), surveys in the early years of the twenty-first century found them in only half of teams (Challis *et al.*, 2002; Tucker *et al.*, 2007), rising to two-thirds by 2009 (Wilberforce *et al.*, 2011).

Multidisciplinary team working and the role of the social worker

Although research on the specific effects of multidisciplinary team working in CMHTs for older people is sparse, evidence regarding the concept of multidisciplinary team working that includes both health and social care staff more generally suggests that this model can meet the needs of people with long-term conditions or complex needs more effectively than single disciplinary teams (Franx *et al.*, 2008; West *et al.*, 2012). Reasons for this include the delivery of support via a more holistic process (Bailey and Liyanage, 2012) and improved communication and understanding between different disciplines leading to more timely assessments when compared with single discipline teams (Brown *et al.*, 2003). Structural factors have also been highlighted as creating barriers to effective multidisciplinary working where professionals are not based in the same team. These include a lack of coterminous boundaries, a lack of inter-agency protocols and 'little sense of a shared legal responsibility' (Macdonald *et al.*, 2007, p. 1374). In contrast, Norman and Peck (1999) found that most members of multidisciplinary CMHTs for working-age adults (eighteen to sixty-five years) regarded interprofessional working as beneficial, expanding the range of skills available within the team, leading to a 'creative tension' that was a 'spur' to innovative practice (p. 221). This is not to deny the complexities of multidisciplinary team work, acknowledged by earlier research to include both cross-disciplinary management and role blurring (Ovretveit, 1993; Brown *et al.*, 2000).

One recent study (Evans *et al*., 2012) noted that social workers in CMHTs for working-age adults were called upon where statutory intervention was required, where high levels of social deprivation existed and where social inclusion was being promoted, suggesting the recognition of both a specific social work role and acknowledged set of skills. However, the same study found that the rationale for employing social workers within these teams was influenced more by historical precedent and financial considerations than by recognition of their particular value (Evans *et al*., 2012). This might throw some light on evidence, found consistently over time and between settings, that social workers experience poorer well-being and less satisfaction than other professions when working in multidisciplinary teams (Wilberforce *et al*., 2013). The belief that their contribution is regarded as less important than that of other team members, a perceived lack of understanding of their role, role conflict and role ambiguity have all been cited as reasons for this (Siefert *et al*., 1991; Peck and Norman, 1999; Brown *et al*., 2000; Carpenter *et al*., 2003; Huxley *et al*., 2005; Onyett, 2011).

A number of studies have suggested that the position of social work with older people has 'lost its way' since the introduction of the community care legislation of the early 1990s, with excessive emphasis on assessment procedures and short-term interventions at the expense of monitoring and longer-term support (Lymbery *et al*., 2007). Social workers working with older people are said to spend too much time on routine work that could be undertaken by others, with a loss of defined role and purpose (Phillips *et al*., 2006; Lymbery *et al*., 2007; Manthorpe *et al*., 2008). For example, the time required to develop a trusting relationship, something valued by older people themselves (Phillips and Waterson, 2002; Manthorpe *et al*., 2008) and necessary to the production of effective assessments, was found to be largely absent from practice (Gorman and Postle, 2003; Lymbery *et al*., 2007). Although one recent report touched on the role of the social worker in CMHTs for older people (HC, 2009), robust evidence on this issue remains limited.

Method

The work reported in this article formed part of a wider study of the factors that make for effective working of CMHTs for older adults (sixty-five plus). This had three main strands: a literature review which identified variations in CMHTs' structures and processes (Abendstern *et al*., 2012); a national survey that assessed services against key policy goals in service delivery and integration; and a multiple case study which investigated the characteristics and outcomes of service users and the experiences of staff working in variously organised CMHTs (Wilberforce *et al*., 2011, 2014; Tucker *et al*., 2014). The findings reported in this paper are drawn from the qualitative element of the latter strand.

Table 1. Team types

Team types	Team attributes	Individual teams
Non-integrated	Co-located multidisciplinary health team	E, F, G, H, I
Hybrid	Co-located but separately managed health and social work team	B
Integrated	Co-located multidisciplinary health and social work team with single manager	A, C, D

Multiple case study analysis enabled the performance of social workers to be examined within diverse contexts (Stake, 2006). The nine teams involved were located in separate Mental Health Trusts in England and covered a variety of urban/rural/mixed communities, affluent and deprived populations. All teams were co-located. Three distinct team types were identified (see Table 1): those with social workers (three integrated teams), those without social workers (five non-integrated teams) and one with social workers but separate health and social care management (one hybrid team).

Qualitative data collection and analysis

Semi-structured interviews were conducted with forty-two staff. On average, five members of each team were interviewed including the team manager in all cases and the consultant psychiatrist and a nurse in most. Four social workers were interviewed in total, one from each of the integrated teams and one from the hybrid team. A breakdown of team membership can be found in Table 2 where shaded text indicates that a member from this staff group was interviewed. Team G was disbanded during the period of the research and consequently only a manager from this team was interviewed.

A broad thematic framework was developed to provide a structure for the interviews whilst also allowing other topics of importance to interviewees to emerge. Questions focused on the individual's role within the team and the make-up of their caseload; their views of other professionals within their team; the extent of role blurring and their views on this; and, in particular, what the presence or absence of social workers meant to them and to how their team functioned. Interviews were undertaken between January and August 2011. Each interview was recorded and professionally transcribed.

Data analysis adopted a grounded theory approach and utilised a systematic process to ensure that subjective interpretations were visible and thus open to challenge. Basic codes were initially produced from a priori concepts used to frame the interview guides. Close reading of a small number of transcripts led to the identification of further themes which were then used to categorise the full set of transcripts. Individual codes were organised into 'families' as a tool for making links between concepts and of moving between empirical description and a more theoretical understanding of

Table 2. Team membership and interviewees

	Teams									
	Non-integrated					Hybrid	Integrated			
	E	F	G	H	I	B	A	C	D	Total
Team manager	1	1	2	1	2*	2	2*	1	1	13
Consultant psychiatrist	3	2	1	1	1	1	2	1	1	13
Other doctor	0	2	1	1	1	0	1	0	1	7
Nurse	2	5	9	5	9	5	9	4	4	52
Occupational therapist	2	1	3	1	2	1	3	1	1	15
Clinical psychologist	0	1	0**	0	1	1	0	1	0	4
Social worker	0	0	0	0	0	5	2	3	3	13
Support worker/equivalent	1	2	5	2	2	2	3	2	2	21
Other professional	0	0	1	1	1	0	2	0	0	5
Total team size (wte)	8	***	***	9.5	14.5	15	17	12	12	83
Total interviewed	5	5	1	5	5	6	5	5	5	42

*Job share; **post vacant; ***data not available. Shaded text = one staff member from this occupation interviewed, except in team B, where both managers were interviewed.

the data. Three members of the research team were involved in coding and analysis to ensure the reliability of decisions.

Ethical approval was granted for the study by the Cambridgeshire Research Ethics Committee in August 2010 (Reference: 10/H0306/43). Interviewees were approached in the following way. Team managers were asked to supply a list of their team members by occupation. The researcher then 'randomly' chose three, usually one from each staff group, who were asked by their managers if they would be interested in being interviewed. If they agreed, they were sent an information sheet including consent details and an interview topic list. This was followed by a telephone call to arrange the interview. Immediately prior to the interview, they were given a consent form to read and sign, and were also told that they could withdraw consent at any time.

Findings from the interviews

Three main themes emerged from the interview data, as noted in the introduction. Each of these is explored below.

Social work skills, knowledge and qualities

Many respondents made reference to the specific knowledge base and skills of social workers working in CMHTs. One area highlighted concerned their expertise and understanding of mental health issues and legislation. CMHT social workers were recognised as having undergone a degree of specialist training which those outside the teams tended not to have had. As one

social worker put it, her 'skills and knowledge base' was 'more specialised' than that of a generic social worker (Social worker, team C). Another noted that:

> Guardianships . . . mental health assessments and . . . reviewing people under the Mental Health Act . . . it is a very important part of our work (Social worker, team D).

The impact of this was summed up by a consultant from an integrated team who noted:

> A striking difference in the knowledge and understanding of the mental health condition . . . . With all respect to my social worker colleagues coming from outside the CMHT . . . you may have to have more deliberations . . . . When you have the team social worker . . . you don't need to (Consultant, team D).

Reflecting on the same issue, a team manager from a non-integrated team commented that they found that the social workers they accessed outside the team 'sometimes . . . don't quite understand mental health' (team G). This could result in frustration for CMHT staff members and to the person in need of a service not getting one. This concern and opinion was shared by CMHT social workers, one commenting that:

> There's a real tendency unfortunately in social care teams . . . that if someone says 'no I don't want that service', then people just go away . . . sometimes a person who doesn't have full insight into their own needs might disqualify themselves from the service by simply refusing at the first hurdle . . . . We're able to . . . work alongside people who can be quite difficult to engage with and find ways to help them to accept a service (Social worker, team A).

A second area of specialist social work knowledge and expertise, highlighted by staff, related to social services processes and resources. Members of non-integrated teams commented on their lack of awareness of these whilst staff from both integrated and hybrid teams spoke of how social work membership led to a greater awareness of social services resources and processes amongst all team members. Whilst social workers reported that they still carried out most social care functions, the fact that non-social work staff were more aware of what social workers could and could not achieve was regarded positively by the social workers interviewed:

> Keeping my colleagues aware of things like the principles of fair access to social care so that they are not expecting something that's not going to happen (Social worker, team A).

Social workers were also described as bringing a 'different dimension' (Consultant, team C) to team discussions that supported a person-centred perspective. As one social worker put it, the profession uses a 'social care model of illness and recovery', focused on 'people's strengths and the strengths of their own community networks' operating from an 'ethic of social justice' and 'widen[ing] the perspective from . . . a medical model' (Social worker, team A). This was

something non-integrated teams recognised they lacked. As one psychologist put it, 'I think it [would] be very useful ... having another voice to balance out the medical model' (team F), whilst the importance of 'the social component' in the care of older people with dementia was further stressed by the consultant from team D who stated that 'If you call to see a client with dementia ... it is inevitable that there will be social issues and if we are not addressing that, we are not giving the complete care to our patients'.

Generic or specialist workers

The three social workers interviewed from the integrated teams described their role within the CMHT as having expanded to incorporate both traditional social work features and a range of other responsibilities and functions. For example:

> The role as it stands now ... is much more inclusive and blurry around the edges with CPNs ... where initially it was about procurement and care management, now it's much more inclusive, much more key worker, and monitoring through peoples mental health, looking at medications (Social worker, team C).

In contrast, the social worker interviewed from the hybrid team stated that, although most of her cases were jointly worked with a member of the co-located health team:

> My roles within that are very different from the CPN. My role within that is around self-directed support ... looking at support needs and how a person's going to manage the budgets in order to meet their support needs. The health side is a different focus (Social worker, team B).

A range of views were reported by social workers in relation to this issue. Variation of opinion appeared to be related to the nature of integrated practice within the team as well as the profession of the team manager. Two of the integrated teams had nurse managers. Within these teams, social workers reported a degree of role blurring that appeared to them to be one-sided. For example:

> The expectation is that social workers will kind of blur ... for instance medication, all the kind of mental health professional skills whereas ... there's a lot of reluctance within the rest of the team to take on the social care roles (Social worker, team A).

The third integrated team was managed by a social worker. Here, role blurring was experienced by the social worker to be more evenly balanced. Commenting on the fact that the care coordinator could be from any profession within the team, she noted that:

> CPNs, OTs, can ... put in packages of care and ... likewise we can go and review and monitor people and see how their mental health is being affected by changes in medication (Social worker, team D).

In teams A and C, although CPNs, occupational therapists and social workers could also be care coordinators, it was only the latter who arranged social care packages. In relation to monitoring medication, the social worker from team D felt that she was protected by her manager from taking on more than was appropriate in a way the social workers in the other two integrated teams did not and where the emphasis was more on the self-management of these boundaries. The two quotations below illustrate the different experiences:

> Our manager is from a social work background, so she knows what our limitations are . . . . So . . . you wouldn't necessarily be taking on something that you wouldn't be trained to do (Social worker, team D).
>
> There's a scary boundary that I feel that I should be very, very careful not to cross (Social worker, team A).

No such role blurring took place in team B, where a service user typically had both a nurse care coordinator and a social work care manager who conducted separate assessments. The social worker interviewed was critical of this duplication and thought the team would offer a more 'direct service' if they were more integrated.

There was a generally held view that social workers took on the most complex cases, where the Mental Health Act or safeguarding issues were involved, making their membership 'imperative' (Consultant, team C) in the eyes of many. Social workers themselves, including the social work manager of team D noted that, whereas in generic social work teams, the social work role had become dominated by arranging care packages, there was still an expectation of and time to undertake 'proper social work' in CMHTs:

> Where you get to know the person and that's where we're lucky . . . . You have that time, you do see somebody through . . . . Unfortunately social work in patch teams . . . they don't get that opportunity . . . . It's too short term (Team manager, team D).

Even within the integrated teams, not all cases requiring social care input were dealt with by CMHT social workers. Two distinct views emerged regarding this: one from social workers themselves and another from other team members. Formal agreements existed in the three integrated teams which resulted in CMHT social workers taking *only* the most complex cases requiring social care input, as defined above. The social workers interviewed wanted to retain this distinction as they believed that this meant that they were able to use their expertise effectively. This demarcation was less clear cut in team C, where the agreement was that if someone was admitted to the acute psychiatric ward and they did not already have a generic social worker involved, then the CMHT social worker was expected to take the case regardless of its complexity:

> It means that we get referrals that ordinarily we wouldn't think would need to come to us, something quite basic . . . that could easily be done on a generic team . . . it's frustrating (Social worker, team C).

In comparison, all non-social work staff interviewed thought that it would be preferable if all CMHT cases requiring input from a social worker could be supported within them as the difference in service when this was not the case was thought to be pronounced both in terms of timeliness and quality. Although the social work interviewees did not necessary agree with this solution, they did recognise that having to refer to another team for social work input was not operating satisfactorily, as seen in the section below.

Communication pathways

A recognised advantage of social work team membership was the ability to refer directly to social workers where social care input was indicated. Such direct access meant both a faster referral to and response from social workers. Even though health and social care staff in the hybrid team were not jointly managed, they were co-located and operated a direct referral system between them. The manager of the health staff from this team commented that:

> You are referring to a colleague, which is a lot quicker because you are not sending it out of the office, onto a waiting list.

A social worker from an integrated team described the benefits for both service users and staff:

> I think the integration for the service user has possibly made it quicker . . . for different disciplines to become involved . . . because we haven't got an external referral system . . .. You can come back and you can have the discussion . . . so that process has quickened up now because it's all within the team (Social worker, team C).

In contrast, in the non-integrated teams, respondents spoke of referring to a central number, of not being able to talk to social workers directly and of having to overstate the needs of the service user in order to have a referral accepted. Thinking about what it would be like if they had social workers in their team, a nurse from one of the non-integrated teams commented:

> I think it would be a lot better . . . it makes access to that service so much better, and as well you've got the social workers understanding and knowing the patient prior to so you're not fighting for service . . . you're not having to state your case and really having to fluff it up . . . just to get them to respond (Nurse, team F).

The team manager from another non-integrated team stated that an additional difficulty for them was that the central number to which they had to refer cases was staffed by people without mental health experience who operated a 'tick-box' system, and appeared to only accept referrals of people who required 'help with washing and dressing'.

Once they had referred to social services, members of non-integrated teams also complained of a lack of feedback:

> We make the referral to [a central number] . . . and then that tends to sit on a waiting list . . . we don't even know when it happens unless we actually keep checking (Nurse, team H).

Where members of integrated teams had to refer outside the team for social work input, their experience was similar to that of the non-integrated teams—explaining why they wanted to keep cases within the team. Some differentiation was noted within the external referral systems of two non-integrated teams where formal arrangements between the CMHT and specialist mental health social work teams were reported to work well for specific types of referrals: emergencies and safeguarding. For example:

> We've . . . got very good relations with a group of mental health social workers for older people, and if it's urgent, we can . . . bring them directly . . . [and] get it done on the day. But when you're just looking at a care package . . . you've got to go through the right channels (Team manager, team E).

Social work team membership or the lack of it also made a difference to the nature and extent of joint working that was reported to be achievable. The informal access and communication that social work membership enabled meant that discussions could take place at an early stage rather than only at the time when decisions needed to be made. This was reported as promoting reflective practice and aiding decision making. In relation to working with an approved mental health professional, one consultant from an integrated team commented that it was:

> . . . very useful in having some of the discussions about at what stage would we need to think about using the Mental Health Act for somebody in the community who has dementia . . . to have that sort of conversation is invaluable (Consultant, team A).

In comparison, members of non-integrated teams described a culture of 'referring on' rather than joint working. Team H were particularly aware of the change regarding this since moving away from the co-located office that they had shared with the social work team. Their team manager commented:

> Where we would have jointly worked . . . [now] they are . . . asking for our involvement . . .. The minute . . . we've got it on our caseload they close it . . .. No joint working.

Similarly, a member of another non-integrated team commented:

> We refer people . . . and they don't tell you when they are doing something, so you don't know whether they've done it . . .. It would be better if they were here and we could have those conversations more quickly . . .. It's just a matter of calling them and then they are out of the office, and then they call [and] you're not in . . ., days can go by before you talk to them about something that's really urgent. Or you don't know if it's urgent or not because you don't know what the outcome of their meeting was (Psychologist, team F).

A number of respondents from non-integrated teams noted the disjointed nature of the work where separate health and social work teams were involved, resulting in a fragmented service that service users found difficult to understand. In contrast, within the integrated teams, the work was said to 'flow much better' and that 'the person in the middle knows exactly where they are' (Social worker, team D).

Such ready access could, however, increase pressure on social work caseloads. For example, one social worker from an integrated team noted that there was:

> No such thing as full up. We don't have a waiting list . . . I think that the new revised caseload weighting tool shows that we were far exceeding the expectations of what we should be doing . . . but . . . we just take it (Social worker, team C).

Discussion

At a time at which the importance placed on multidisciplinary working has perhaps never been greater (Department of Health, 2013; Department of Health and Concordat Signatories, 2014), this article provides a unique picture of the value of social workers in CMHTs for older people. It offers a range of insights into the skills and knowledge such staff offer, the extent to which they have maintained a specialist social work focus and the difference their presence within the team makes to interprofessional communication. Below, we explore the implications of these findings for service users and CMHT members, and consider what they tell us about the relative strengths and weaknesses of different team structures, and the conditions necessary to optimise the contribution of social work staff in CMHTs.

Implications for service users

Although UK policy has long stressed the importance of involving service users in service planning and development (Cabinet Office, 1998; Department of Health, 2001; Audit Commission, 2004), few studies have explored what older people want from specialist mental health services, or the benefits they perceive from different service models (Age Concern, 2006). What evidence there is suggests that older people with mental health problems value services that are timely, accessible, personalised and coordinated (Department of Health, 2001; Age Concern, 2006). Furthermore, many of the outcomes they aspire to (including access to social contact, a good home environment, and getting out and about) relate to their social care needs (Joint Commissioning Panel for Mental Health, 2013).

Respondents within the current study strongly believed that such outcomes were advanced by the inclusion of social workers in CMHTs. Mirroring the findings of a previous report (HC, 2009), social work membership

was said to promote faster, more responsive access to social care resources, whilst the contribution of social workers, with their social orientation to needs assessment and care planning, was thought to support a more holistic, person-centred approach. Indeed, the presence of professionals from both health and social care backgrounds, with their complementary skills and experience, was said to have what Bailey and Liyanage (2012) have called a 'multiplicative effect', such that together they were able to offer a higher standard of care and greater range of services than when accessed via separate services.

Implications for CMHT staff

Non-social work practitioners in CMHTs for older people (with and without social workers) typically believed that social work membership brought multiple benefits to the team. Particular advantages were said to derive from CMHT social workers' specialist mental health knowledge, their awareness of social care resources and the increased ease of multidisciplinary communication. In comparison, generic social workers based outside of teams were reported to lack mental health expertise and understanding and be difficult to access.

Whilst, as above, past research in working-age adult services has tended to suggest that social work staff in CMHTs feel unappreciated and misunderstood (Norman and Peck, 1999), the CMHT social workers in this study were largely positive about their experience, believing that their presence led to greater comprehension of the social work role and perspective. In light of concerns about the state of social work with older people generally (Lymbery *et al*., 2007), it is interesting to note that the social workers employed in CMHTs interviewed here valued the continuing opportunity to undertake 'proper' social work, including relationship building and long-term support, safeguarding and assessing mental capacity (alongside financial assessments and arranging packages of care).

These findings raise questions regarding the extent to which CMHT social workers should be seen as mental health specialists or specialists in social care, and of the nature of role blurring. To take another example, the social worker's role in the integrated teams in this study had typically expanded to include a number of non-traditional elements, such as the monitoring of medication, and, whilst it was generally recognised that some degree of role blurring could support efficiency, there were obvious tensions concerning its extent and nature, and how it was managed. These concerns should not be taken lightly, for some integrated CMHTs have been dissolved over such disputes (Royal College of Psychiatry, 2006), highlighting the need for good clinical and managerial supervision for social workers in multidisciplinary environments as a means of reducing stress and isolation (Lloyd *et al*., 2002).

Implications of different team structures

The research also contributes to continued debate over the most appropriate organisational structure for delivering social work support as part of multidisciplinary mental health care. This comes at an opportune time, given anecdotal reports of social service retrenchment from some integrated service arrangements amid turmoil caused by local authority funding reductions. Furthermore, whilst national and international policy guidance has consistently recommended integrated CMHTs combining social workers with a range of health professionals (World Health Organization and Alzheimer's Disease International, 2012; Department of Health, 1999), there is an acknowledged lack of evidence linking such structures with care outcomes (Abendstern *et al*., 2012; Cameron *et al*., 2014). The case study approach taken here afforded an opportunity to consider different approaches to multidisciplinary team work and, in particular, whether a managerially distinct yet formally co-located mental health social work team could be an effective alternative to a traditional integrated CMHT structure. Hypothetically, such an approach might maintain the service user benefits of integration whilst avoiding the significant cultural and administrative difficulties of merging staff from multiple agencies within a single team (Brown *et al*., 2000; Norman and Peck, 1999).

Though not conclusive, the findings from two teams (B and H) suggest that this approach lacked some of the positive attributes of the integrated teams. Duplication of effort resulting from individual service users having both an NHS care coordinator and a local authority care manager signalled a loss of continuity and efficiency, whilst separate contact arrangements for service users reduced their ease of access. Where no formal structure—to support joint working—existed, such arrangements were found to be precarious. Nevertheless, there were reported benefits of separate co-located mental health social work teams as compared to more generic and segregated support being delivered from local authority settings, typically through a centralised referral system. The implied importance of co-location and building informal relationships in multidisciplinary working supports earlier research, noting that frequent and voluntary interaction was required to overcome the tendency of mixed groups to regard those different to themselves as 'other', impeding their ability to work effectively together (Fay *et al*., 2006; Reynolds, 2007; Belling *et al*., 2011).

Methodological considerations and need for further research

A strength of this research is that the findings are based on the experiences of a range of staff spanning the health and social care spectrum, and included staff working in a range of different types of multidisciplinary teams. A potential weakness, however, was that the boundaries of the research meant that it was not possible to interview social workers working within local authority

settings and their perspectives of working with CMHTs. Furthermore, the service user viewpoint is missing from this account, which will be addressed in future published work.

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References

Abendstern, M., Harrington, V., Brand, C., Tucker, S., Wilberforce, M. and Challis, D. (2012) 'Variations in structures, processes and outcomes of community mental health teams for older people: A systematic review of the literature', *Aging & Mental Health*, **16**(7), pp. 861–73.

Age Concern and Mental Health Foundation (2006) *Promoting Mental Health and Well-being in Later Life*, London, Age Concern and Mental Health Foundation.

Allen, R. (2014) *The Role of the Social Worker in Adult Mental Health Services*, London, The College of Social Work.

Audit Commission (2004) *Older People—Independence and Well-Being: The Challenge for Public Services*, London, Audit Commission.

Bailey, D. and Liyanage, L. (2012) 'The role of the mental health social worker: Political pawns in the reconfiguration of adult health and social care', *British Journal of Social Work*, **42**(6), pp. 1113–31.

Belling, R., Whittock, M., McLaren, S., Burns, T., Catty, J., Rees Jones, I., Rose, D. and Wykes, T. (2011) 'Achieving continuity of care: Facilitators and barriers in community mental health teams', *Implementation Science*, **6**(1), pp. 1–23.

Brown, B., Crawford, P. and Darongkamas, J. (2000) 'Blurred roles and permeable boundaries: The experience of multidisciplinary working in community mental health', *Health and Social Care in the Community*, **8**(6), pp. 425–35.

Brown, L., Tucker, C. and Domokos, T. (2003) 'Evaluating the impact of integrated health and social care teams on older people living in the community', *Health and Social Care in the Community*, **11**(2), pp. 85–94.

Cabinet Office (1998) *Better Government for Older People Programme*, available online at *http://archive.cabinetoffice.gov.uk/servicefirst/1998/op/newop.htm*.

Cameron, A., Lart, R., Bostock, L. and Coomber, C. (2014) 'Factors that promote and hinder joint and integrated working between health and social care services: A review of research literature', *Health and Social Care in the Community*, **22**(3), pp. 225–33.

Carpenter, J., Schneider, J., Brandon, T. and Wooff, D. (2003) 'Working in multidisciplinary community mental health teams: The impact on social workers and health professionals of integrated mental health', *British Journal of Social Work*, **33**(8), pp. 1081–103.

Challis, D., Reilly, S., Hughes, J., Burns, A., Gilchrist, H. and Wlison, K. (2002) 'Policy, organisation and practice of specialist old age psychiatry in England', *International Journal of Geriatric Psychiatry*, **17**(11), pp. 1018–26.

Collighan, G., Macdonald, A., Herzberg, J., Philpot, M. and Lindesay, J. (1993) 'An evaluation of the multidisciplinary approach to psychiatric diagnosis in elderly people', *British Medical Journal*, **306**(6881), pp. 821–4.

Department of Health (1999) *A National Service Framework for Mental Health*, London, Department of Health.

Department of Health (2001) *National Service Framework for Older People*, London, Department of Health.

Department of Health (2013) *Integrated Care and Support: Our Shared Commitment*, London, National Collaboration for Integrated Care and Support.

Department of Health and Care Services Improvement Partnership (CSIP) (2005) *Everybody's Business: Integrated Mental Health Services for Older Adults—A Service Development Guide*, London, Department of Health.

Department of Health and Concordat Signatories (CS) (2014) *Mental Health Crisis Care Concordat: Improving Outcomes for People Experiencing Mental Health Crisis*, London, Department of Health.

Evans, S., Huxley, P., Baker, C., White, J., Madge, S., Onyett, S. and Gould, N. (2012) 'The social care component of multidisciplinary mental health teams: A review and nation survey', *Journal of Health Services Research and Policy*, **17**(Suppl 2), pp. 23–9.

Fay, D., Borrill, C., Amir, Z., Haward, R. and West, M. (2006) 'Getting the most out of multidisciplinary teams: A multi-sample study of team innovation in health care', *Journal of Occupational and Organisational Psychology*, **79**(4), pp. 553–67.

Franx, G., Kroon, H., Grimshaw, J., Drake, R., Grol, R. and Wensing, M. (2008) 'Organisational change to transfer knowledge and improve quality and outcomes of care for patients with severe mental illness: A systematic overview of reviews', *Canadian Journal of Psychiatry*, **53**(5), pp. 294–305.

Gorman, H. and Postle, K. (2003) *Transforming Community Care: A Distorted Vision?*, Birmingham, Venture Press.

Healthcare Commission (HC) (2009) *Equality in Later Life: A National Study of Older People's Mental Health Services*, London, Healthcare Commission.

Hilton, C. (2008) 'The provision of mental health services in England for people over 65 years of age, 1970–78', *History of Psychiatry*, **19**(3), pp. 297–320.

Huxley, P., Evans, S., Gately, C., Webber, M., Mears, A., Pajak, S., Kendal, T., Medina, J. and Katona, C. (2005) 'Stress and pressures in mental health social work: The worker speaks', *British Journal of Social Work*, **35**(7), pp. 1063–79.

International Federation of Social Work (IFSW) (2002) *Definition of Social Work (in 16 Languages)*, Switzerland, IFSW.

Joint Commissioning Panel for Mental Health (2013) *Guidance for Commissioners of Older People's Mental Health Services*, London, co-chaired by the Royal College of General Practitioners and Royal College of Psychiatrists.

Lloyd, C., King, R. and Chenoweth, L. (2002) 'Social work, stress and burnout: A review', *Journal of Mental Health*, **11**(3), pp. 255–65.

Lymbery, M., Lawson, J., MacCullum, H., McCoy, P., Pidgeon, J. and Wars, K. (2007) 'The social work role with older people', *Practice*, **19**(2), pp. 97–113.

Macdonald, A. (1991) 'Running a team', in J. Lindesay (ed.), *Working Out: Setting Up and Running Community Psychogeriatric Teams*, London, Research and Development for Psychiatry.

Macdonald, A., Ball, C., Burton, S., Herzberg, J., Murphy, E., Philpot, M. and Rao, R. (2007) 'The birth of a specialty: The first ten thousand patients of an old age psychiatry service', *International Psychogeriatrics*, **19**(1), pp. 53–63.

Manthorpe, J., Moriarty, J., Rapaport, J., Clough, R., Cornes, M., Bright, L. and Iliffe, S. and OPRSI (2008) '"There are wonderful social workers but it's a lottery": Older people's views about social workers', *British Journal of Social Work*, **38**(6), pp. 1132–50.

Ministry of Health (1962) *A Hospital Plan for England and Wales*, Cmnd 1604, London, HMSO.

Nolan, P. (1993) *A History of Mental Health Nursing*, London, Chapman and Hall.

Norman, I. and Peck, E. (1999) 'Working together in adult community mental health services: An inter-professional dialogue', *Journal of Mental Health*, **8**(3), pp. 217–30.

Onyett, S. (2003) *Teamworking in Mental Health*, Basingstoke, Palgrave Macmillan.

Onyett, S. (2011) 'Revisiting job satisfaction and burnout in community mental health teams', *Journal of Mental Health*, **20**(2), pp. 198–209.

Ovretveit, J. (1993) *Co-ordinating Community Care: Multidisciplinary Teams and Care Management*, Philadelphia, USA, Open University Press.

Peck, E. and Norman, I. J. (1999) 'Working together in adult community mental health services: Exploring inter-professional role relations', *Journal of Mental Health*, **8**(3), pp. 231–43.

Phillips, J. and Waterson, J. (2002) 'Care management and social work: A case study of the role of social work in hospital discharge to residential or nursing home care', *European Journal of Social Work*, **5**(2), pp. 171–86.

Phillips, J., Ray, M. and Marshall, M. (2006) *Social Work with Older People*, Palgrave, Macmillan.

Reynolds, J. (2007) 'Discourses in inter-professionalism', *British Journal of Social Work*, **37**(3), pp. 441–57.

Royal College of Psychiatry (2006) *Raising the Standard: Specialist Services for Older People with Mental Illness—Report of the Faculty of Old Age Psychiatry*, London, Royal College of Psychiatry.

Siefert, K., Jayaratne, S. and Chess, W. (1991) 'Job satisfaction, burnout, and turnover in health care social workers', *Health & Social Work*, **16**(3), pp. 193–202.

Social Work Task Force (2009) *Building a Safe, Confident Future: Final Report of the Social Work Task Force*, London, Department of Children and Family Services.

Stake, R. (2006) *Multiple Case Study Analysis*, London, The Guildford Press.

Tucker, S., Baldwin, R., Hughes, J., Benbow, S., Barker, A., Burns, A. and Challis, D. (2007) 'Old age mental health services in England: Implementing the National Service Framework for Older People', *International Journal of Geriatric Psychiatry*, **22**(3), pp. 211–17.

Tucker, S., Wilberforce, M., Brand, C., Abendstern, M., Crook, A., Jasper, R., Stewart, K. and Challis, D. (2014) 'Community mental health teams for older people: Variations in case mix and service receipt (I)', *International Journal of Geriatric Psychiatry* Advance Access published September 9, 2014, doi: 10.1002/gps.4191.

Wattis, J., Macdonald, A. and Newton, P. (1999) 'Old age psychiatry: A speciality in transition—results of the 1996 survey', *Psychiatric Bulletin*, **23**, pp. 331–5.

West, M., Alimo-Metcalfe, B., Dawson, J., El Ansari, W., Glasby, J., Hardy, G., Hartley, G., Lyubovnikova, J., Middleton, H., Naylor, P., Onyett, S. and Richter, A. (2012) *Effectiveness of Multi-Professional Team Working in Mental Health Care*, National Institute for Health Research, Service Delivery and Organisation Programme, London, Department of Health.

Wilberforce, M., Harrington, V., Brand, C., Tucker, S., Abendstern, M. and Challis, D. (2011) 'Towards integrated community mental health teams for older people in England: Progress and new insights', *International Journal of Geriatric Psychiatry*, **26**(3), pp. 221–8.

Wilberforce, M., Tucker, S., Abendstern, M., Brand, C., Giebel, C. and Challis, D. (2013) 'Membership and management: Structures of inter-professional working in community mental health teams for older people in England', *International Psychogeriatrics*, **25**(9), pp. 1485–92.

Wilberforce, M., Tucker, S., Brand, C., Abendstern, M., Crook, A., Jasper, R., Stewart, K. and Challis, D. (2014) 'Community mental health teams for older people: Variations in case mix and service receipt (II)', *International Journal of Geriatric Psychiatry* Advance Access published September 9, 2014.

World Health Organization and Alzheimer's Disease International (2012) *Dementia: A Public Health Priority*, Geneva, Switzerland, WHO, available at: http://www.who.int/mental_health/publications/dementia_report_2012/en/. (last accessed 27 October 2014).