Social work, the sociological imagination and the social determinants of mental health: a study of mental health social work practice in multi-disciplinary settings.

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Dedication

This thesis is dedicated to the memory of Uncle Neville, the great encourager!

Summary

This study explored how social workers working within one English NHS trust understood the impact of the social determinants of mental health, and mental health inequalities, on the experiences of service users. The study used the concept of the sociological imagination, developed by C. Wright Mills (1959), to explore participants' ways of thinking about the factors that cause and maintain mental distress.

Early findings about organisational context, role, and the experience of multi-disciplinary working, shaped the focus of data analysis. Social workers who participated in this research were employed in one of two types of organisations: a local authority or an NHS trust. Which organisation employed them, which they worked in day-to-day, and if they were employed as social workers or generic mental health practitioners appeared to influence their identity, practice and experience of multi-disciplinary working.

Cross-sectional research design enabled the collection of detailed qualitative data. Twenty-one social workers participated in semi-structured interviews about their practice. The interviews included participants responding to the circumstances of fictional characters outlined in three textual vignettes. Thematic data analysis was undertaken, and data themes were identified. Theories by Freidson (2001) and Bourdieu (1977) were used, in addition to Mills' (1959) concept of the sociological imagination, to analyse the data.

Participants were aware of the impact of the social determinants of mental health. How participants translated that awareness into their practice appeared to be influenced by the vividness of their essential imaginations, by the mediating impact of their organisational and employment context, and by the role and strength of their professional identity and capital in multi-disciplinary environments.

The study concludes by considering whether the concept of the sociological imagination can be further developed to enable social workers to give a comprehensive sociological explanation about the impact of the social determinants of mental health.

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Chapter 1 Introduction

1.1 Motivation, rationale and context

The gap in life expectancy in the city where I live, between the poorer streets and the richer ones, is about ten years. Ten years more life if you have accumulated the advantages and opportunities that living in a more affluent area often denotes. It is a compact city and a short cycle between the leafy streets and the ones with the pay day lenders and betting shops. When I practised as a mental health social worker, I would cycle between appointments wondering what it was – and where the line was – that made people's experiences of health so different. I thought about what I could do as a social worker for the service users I knew, who often lived in the areas where social and economic disadvantage appeared to translate into poorer physical and mental health. From those early considerations I developed an academic interest in the relationship between social work practice and the social determinants of mental health.

The initial aim of this research study was to explore how mental health social workers were able to use their understanding of the social determinants of mental health, and mental health inequalities, in their work with service users.

Our mental health is as much determined by environmental and social influences as it is by individual biological or genetic disposition (World Health Organisation 2014). Physical and mental health are inversely related to individuals' and communities' economic wealth (Marmot 2010), and differing experiences of the social determinants lead to those health inequalities. The social determinants of health have been characterised as the "causes of the causes" (Marmot 2010, p. 39) and, although they can appear distant from more immediate risk factors, they create the context for poor mental health and mental illness (Compton and Shimm 2015). A social gradient of health inequalities exists and inequalities in physical and mental health are harmful for all members of society whatever their socio-economic status (Wilkinson and Pickett 2010). Social work academics have pressed for a commitment from the profession to tackle both health inequalities in general (Bywaters 2009) and inequalities in mental health in particular (Fish and Karban

2014). Mental health inequalities are in part explained by socio-economic position (in relation to the social determinants of health) and in part by other aspects of people's identities such as ethnicity, gender, and sexuality (Commission for Equality in Mental Health 2020).

Since 2008, and the period of austerity brought about by government welfare funding cuts, there has been a worsening of everyday living conditions for the poorest in UK society (Akhter et al. 2018). This has contributed to increased levels of poor mental health and mental illness (Barr et al. 2015). The Covid-19 pandemic disproportionately impacted members of Black and ethnic minority communities and explanations for this include elements of the social determinants of health (Morales and Ali 2021). Austerity has been characterised as a "cover for welfare transformation and public sector spending reductions" (Lavalette 2017, p. 21) which have resulted in a reduction in mental health service provision (Cummins 2018).

Mental health social workers are engaging with service users who experience the negative effects of social determinants, the impact of inequalities in mental health, and the consequences of austerity on their everyday lives (Mattheys 2015). There is an increasing interest in the social determinants of mental health and of mental health inequalities (McDaid and Kousoulis 2020; Kirkbride et al. 2024). Social workers are well-trained and well-placed to understand the lived experiences that service users have of mental health inequalities (Allen et al. 2016; Abendstern et al. 2021).

This research was partly inspired by C. Wright Mills' concept of the sociological imagination. Mills suggested that individuals' *private troubles* – such as unemployment or poor-quality housing – could only be properly understood in relation to the *public issues* of the day. Knowledge of those social (public) issues, in part the result of the historical development of society, combined with a person's own biography, could, Mills argued, provide the social scientist with a fuller understanding of a person's difficulties. My research explored how social workers appeared to use a sociological imagination to understand the difficulties that service users experienced, in the context of practitioners working within multi-

disciplinary recovery orientated mental health services. I was interested to know what it was like for practitioners working in environments where an imaginative, sociologically informed approach to understanding mental health distress, might compete with other explanations.

The concept of the sociological imagination enabled detailed consideration of social workers' discussions about practice. As I undertook initial data analysis the significance of employment context and the experience of working in multi-disciplinary teams on participants' approach to practice became apparent. This led me to consider how to undertake a richer and more nuanced analysis of the data relating to the influence of employment context and MDT working on social workers' professional identity and practice. Using Freidson's (2001) theory of the organisation of labour helped me to understand the influence of practitioners' professional status and employment context on the strength of their social work identities. The influence of these considerations on how practitioners articulated a sociological imagination and addressed mental health inequalities is discussed. Freidson's focus on theorising how work and labour are organised offered a perspective on the data that Mills' concept did not. In addition, analysis was undertaken using Bourdieu's (1977) concepts of field, habitus and capital. This supported a detailed understanding of how participants talked about the impact of multi-disciplinary team working on their opportunities to articulate and action a sociologically informed understanding of service users' difficulties.

In developing this study, I was particularly influenced by Roslyn Giles' (2009) paper *Developing a Health Equality Imagination*, in which she considered the work of hospital based social workers in Australia. Giles accepts the importance of the critically reflective practitioner in trying to understand the lives and experiences of people. Using Fook and Gardner's (2007) work as a springboard, Giles suggests that:

> Regardless of the context of practice, social work can develop a health equality imagination in order that in both direct practice and in education social workers are continuing to promote the growth of equality in health and well-being and not further contributing to inequality (Giles 2009, p. 530).

Giles writes that the acknowledged relationship between social factors and people's health, provides challenges and opportunities for social work. The profession, she argues, should continue to try to promote the "common goals of reductions in poverty, the alleviation of oppression and enhanced social equality: that is, the development in each practitioner of a health equality imagination that inspires action" (Giles 2009, p. 530).

This research study developed the work of Giles (2009) to consider the experiences of social workers in multi-disciplinary environments, within recovery focused mental health services. The research was focused on developing knowledge about how social workers understood and worked with the social determinants of mental health, which in turn contribute to mental health inequalities. I explored the extent to which mental health social workers understood and incorporated the impact of factors such as housing, education and community resources, in their understanding of the difficulties people experience. The study also considered how social workers brought this knowledge to bear within the context of multi-disciplinary teams within statutory mental health services. In addition, my research identified the conditions that hinder or promote the use of a sociological imagination by social workers. This research focus is largely absent from the literature and so, this study – using the sociological imagination as its inspiration and primary organising concept - makes a unique contribution to social work research knowledge.

At the point of research design, the study's initial overarching question considered how mental health social workers articulated a sociological imagination when considering the social determinants of mental health. As noted, during the initial data collection and analysis, it became apparent it was important to reflect the significance of social workers' employment context and professional identity in the study's main research question. The overarching research question is therefore:

How do social workers, working in different organisations, roles and teams, articulate a sociological imagination when considering the social determinants of mental health?

1.2 Context for study

The research project focused on finding out about the day-to-day practice of mental health social workers, working for or within, an English NHS trust. The study took place in a trust that covered a large geographical area within which there were several local authorities; together they served a population of over 1.8 million people. Within the trust area were large multi-cultural regional cities, affluent market towns, extensive rural areas, and coastal communities. The trust employed many people including approximately 130 registered social workers. A slightly smaller number of social workers employed by local authorities also worked within the trust via partnership agreements. During the study 21 social workers were interviewed. The social workers mainly worked within multi-disciplinary teams and predominantly within the recovery focused services. Some interviews took place face-to-face on trust premises, and some took place online.

1.3 Thesis structure

Chapter 2 - Literature review, discusses C. Wright Mills' (1959) concept of the sociological imagination, its origin and application in sociology. The link between the sociological imagination and critical reflective practice is considered, and the possibility of the concept's extension is debated. The chapter then turns to discussing the definition and features of the social determinants of health and mental health inequalities, and their relevance to understanding the experience of mental health service users. The history of mental health social work in the UK is considered in relation to the focus of this thesis and the recovery approach to mental health is reviewed. The chapter concludes by setting out the study's research questions.

Chapter 3 - Research design and methodology, explains the theoretical frameworks that underpin the study's design and data analysis: principally the work of Mills (1959), Freidson (2001) and Bourdieu (1977). The overall research process is discussed including the study's setting, access to the field, eligibility criteria, as well as sampling, recruitment, and the consent of participants. Ontological and epistemological considerations are highlighted, and research methods reviewed, including researcher identity and bias, and data collection using semi-structured

interviews and textual vignettes. Consideration is given to the recording and transcription of interviews, and subsequent thematic data analysis (Braun and Clarke 2006). The chapter also summarises the research and ethics permissions gained to undertake this study.

Chapter 4 – Pure or diluted: the shifting identity and location of social work, focuses on considering the influence of the employment context of the study's participants. Participants were either employed by a local authority or the NHS trust and employed as social workers or generic mental health practitioners. The chapter uses Freidson's (2001) theory of the organisation of labour to support data analysis and to explore the impact of these different employment contexts on participants' social work identity and practice.

Chapter 5 – Imagination, wisdom and empathy: thinking like a social worker, thematically analyses the data collected from participants' discussions about the difficulties faced by three fictional vignette characters: Amira, Akiel and Jack. The vignette stories contained differing elements of the social determinants of mental health and so were used to prompt discussion about their impact on the characters' situations. C Wright Mills' (1959) sociological imagination was central to analysing the data because the vignettes also signalled to participants circumstances that, in analysis, could be considered private troubles or public issues.

Chapter 6 - Identity, capital and influence: multi-disciplinary team working, thematically analyses research data about participants' accounts of working with colleagues from different professions within the same service or team. Participants' experiences varied depending on their role, employer and the location of their work. Analysis of the data, while continuing to be informed by insights gained from the sociological imagination, is primarily undertaken using Bourdieu's (1977) concepts of field, habitus and capital.

Finally, in Chapter 7 - Discussion and conclusions, the culmination of this three-year part-time research project is reviewed. The findings of the three data analysis chapters (4, 5 and 6) are synthesised to consider the principal outcomes of the research. The chapter concludes by discussing how mental health social workers do

articulate a sociological imagination when considering the social determinants of health. The study's contribution to the literature is considered, and recommendations for policy and practice made.

Chapter 2 Literature review

2.1 Introduction and strategy

Four fields of study were considered to complete the literature review. Firstly, literature related to C. Wright Mills' (1959) concept of the sociological imagination. Secondly, literature related to the social determinants of health and mental health inequalities. Thirdly, literature related to the recent history, and contemporary context, of mental health social work. Finally, literature about the recovery approach is discussed. This literature review presents findings from all four areas of investigation, in the sections that follow. First though, the literature search strategy is discussed.

To support a search of academic papers, information from background literature was gathered to map the policy landscape. Documents were identified from organisations, including the World Health Organisation (WHO), the Centre for Mental Health and The King's Fund. Cardiff University's library online search engines enabled straightforward use of Boolean operators and search terms. The terms included 'mental health', 'health inequalities', 'mental health inequalities', 'social determinants of health', and 'social determinants of mental health'. Databases searched included *Social Policy and Practice, Social Services Abstract, Social Care Online (SCIE), Medline*, *Sociological Abstracts, Applied Social Sciences Index and Abstracts (ASSIA).* For example: in *Medline*, searching the title field from the year 2000, the term 'mental health' yielded 44,267 results, adding the Boolean operator - OR - with additional search term 'social determinants' resulted in a further 1705 results. Combining those two search terms with the Boolean operator - AND - produced 34 results. The titles and abstracts of the 34 papers were screened: excluded were four repeat papers from a search of a different database, one duplicate paper within the *Medline* search, and 15 papers were assessed as not relevant to this study. The remaining 14 papers were reviewed in full, and six were excluded because of limited relevance to this study's aims. The remaining eight papers were included in the preparation of this literature review. Following a similar process, a further five papers were identified from *Social Policy and Practice,* two from *Social Services Abstract,* and seven through *SCIE*.

The search results included qualitative and quantitative research papers but also links to relevant academic books and other literature. The snowball/ bibliographic review technique was used to search the reference lists of papers identified through the database searches, to identify subsequent research papers (Aveyard et al. 2021). This was an exciting way to discover new researchers and their work. The process of undertaking the literature review was also supported by my work as a senior lecturer in social work where I routinely engage with research papers, academic writing, and policy documents.

2.2 The Sociological Imagination

This research uses C. Wright Mills' (1959) concept of the sociological imagination as an analytical lens through which to explore social workers' practice. Mills suggested the essential value of sociology was to make links between 'private troubles' and 'public issues' (Orgad 2020). That is, to examine how structural factors within society affect the experience of the individual:

> You can never really understand an individual unless you also understand the society, the historical time period in which they live, personal troubles, and social issues…The sociological imagination enables us to grasp history and biography and the relations between the two within society. That is its task and its promise (Mills 1959, p. 11-12).

To exercise a sociological imagination is to understand individuals' experiences (private troubles), in the context of the society and period of history in which they live, as well as appreciating the impact of social (public) issues within that society on individuals. This research explores whether practitioners exercise or adopt their own sociological imagination in their identification of, and explanation for, service users' situations. That is, are the social determinants of mental health and mental health inequalities identified and addressed through practice.

The sociological imagination is a way of thinking, or a quality of mind, that enables individuals to make links between social structure, history, and personal biography (Solis-Gadea 2005). Mills' promise is both to academia- offering a better way of understanding society - and to society itself, offering the hope of better insights

into its citizens' lives (Mjøset 2014). To exercise a sociological imagination is to see the links in a person's circumstances between the "most intimate features of the human self [and the] most impersonal and remote transformations" (Mills 1959, p. 7) in society. It enables a more detailed understanding of an individual's circumstance (personal troubles) but also leads to the identification of contributory social (public) issues (Edmiston 2017). From an academic perspective, Mills' vision of sociology was of "an essentially political task to try to make a difference to, and where possible, improve the lives of ordinary men and women" (Brewer 2014, p. 219). The solutions to some of the personal troubles that are also public issues is then political (Brox 2014). The sociological imagination is relevant to social work because the profession is (perhaps) uniquely concerned, as an academic discipline and as practice, with both individuals and society (Payne 2006): it occupies a contested space within society, it is an inherently political role (Gray and Webb 2013) and it seeks to tackle structural social injustice (Jones 2014).

Mills was writing in the context of post war American capitalism and Soviet communism when sociology was a developing academic discipline. Mills' book *The Sociological Imagination* (1959) challenged his contemporaries' vision for sociology. In considering how to understand how society worked, Mills largely rejected the theories and approaches of both abstracted empiricism (focused on the use of quantitative data) typified by the work of Paul Lazarsfeld (1968), and he rejected the Grand Theories – such as functionalism - of Talcott Parsons (1952). Mills was scathing about the direction in which sociology was developing, and he was radical in his own counter approach (Mjøset 2014). Mills suggested the discipline, and the craft of sociology, should be concerned with developing an empirical understanding of society and with developing a critical sensibility "which seeks to link the most intimate personal experiences to wider social forces, and seeks out the public issue or problem contained in the private trouble" (Gane and Back 2012, p. 405). This was the unique perspective that Mills advocated and, in part, perhaps explains the enduring popularity and relevance of the concept of the sociological imagination.

The decision to explore Mills' concept is partly a response to how his impression of the practice of social workers (of his day) contributed to the development of the concept of the sociological imagination. Mills lamented the lack of abstraction in professionals' writings and commented that both judges and social workers appeared to be trained to only think in terms of the individual 'case' and not to think more broadly (Mills 1943). Mills asserted that problems should not be defined by individuals deviating from the norm, but by analysis of causation that would promote action at a structural level. I was curious to explore whether mental health social workers considered and articulated the wider structural factors impacting on service users' lives. Practitioners' professional socialisation coupled with the culture and focus of their organisations, influences their practice focus (Wiles 2013; Webb 2017).

The Sociological Imagination, published in 1959, has several significant omissions. Mills makes no reference to civil rights, race, or gender equality (Geary 2009, cited in Mjøset 2014, p. 76). This may not be surprising given the period, but their omission as explanatory factors is both ironic and illustrative of the evolution of sociology. The text also assumes that the starting point for analysis is the personal trouble, and that personal biography is then understood in terms of social history (Platt 2014). Equally though, the focus of analysis could be the reverse: how important societal developments come to impact individuals.

Nevertheless, in two ways, Mills does advocate the importance of values and connection that are relevant to my research. Firstly, it is important to understand the values that are being threatened by people experiencing personal troubles, for example the values of independence and choice that are at risk for a person who loses their job. Secondly, it is important to understand the values that drive structural changes in society and that cause the public issues of the day. For example, the values of capitalism that underpin neoliberal policy making, and result in a residual welfare state (Horton 2018). Consideration of underpinning values is the common connector between private troubles and public issues, and their consideration by the sociologist makes the concept a powerful analytical tool.

Thinking in a sociologically imaginative way is different to individually articulating the relevance of analytically separate social, structural, or historical factors, in isolation from one another. To actively think in a way that is cognizant of the values that drive individual behaviours – as well as societal trends – and that figuratively draws the connecting lines between people's individual troubles, society, and the historical time in which troubles and issues are unfolding, is to use a sociologically imaginative approach to understanding others. This "relationality is considered the bridge between the individual and society" (Rogers and Pilgrim 2024, p. 97).

This is the power of Mills' concept; it fuses together potentially separate areas of academic and practice focus to challenge our curiosity to recognise, understand and then stress the importance of the connectivity between aspects of life that impact on individuals, families, and communities. VanderPlaat (2016) writes about how the concept promotes the shift in gaze from the individual to the social context, and that it "requires us to recognize adversity as a collective condition that is socially structured" (VanderPlaat 2016, p. 197). The emphasis on the collective cause and experience of aspects of adversity is a particular quality of Mills' concept that contrasts with the individual focus of the biopsychosocial model of health (Engel 1977), discussed in Subsection 2.5 below.

The data analysis presented in subsequent chapters uses Mills' relational perspective as a lens through which to understand participants' approaches to social work practice. This is undertaken in Chapter 4 where participants' employment context is considered, in Chapter 5 where participants responses to three fictious practice vignettes are analysed, and in Chapter 6 where the experiences of participants in multi-disciplinary settings are explored.

The concept of the sociological imagination has been used in a wide variety of disciplines. This includes the treatment of problem gamblers (Bernhard 2007), sociology teaching (Scanlan and Grauerholz 2009; Garoutte 2018), the study of delinquency (Singer 2014; Cullen 2017), globalisation and spatialization of sociological concerns (Shields 2017), educational technology (Selwyn 2017), and the effectiveness of political messaging during political campaigns (Curtis 2020). The

concept continues to influence contemporary social science research. Power (2008) encouraged the development of a 'professional imagination' so individual professionals could understand their own positions in increasingly managerial environments. Power suggested professionals could then avoid overly individualised or deterministic interpretations of the challenges they faced.

Two studies are particularly relevant to my research. Edmiston (2017), researching welfare policies in the UK and New Zealand, used the concept of the sociological imagination to consider how individuals' experiences of relative deprivation, or affluence, appeared to influence their explanations about why people access welfare services. Edmiston found that people who had not experienced hardship found it difficult to access a sociological imagination. They struggled to attribute reasons for an individual's difficulties outside of that person's immediate decisions and actions. This finding is relevant to my study because it suggests that a person's own experiences influence the type of explanations they might ascribe to another person's situation. Knowledge gained through social workers' professional education may influence their understanding and attitude towards service users, but social workers' own experiences may also contribute to how easily they access a sociological imagination.

Orgad (2020) argues that the sociological imagination is important in the study of media and communications in neoliberal societies, where, in the context of deepening inequalities, the 'message' is often of individual responsibility detached from its structural context. Orgad and other sociologists assert that the critical sensibility of the sociological imagination is vital because the neoliberal world "seeks to tear asunder private troubles from public issues, and thereby turn social uncertainty into personal failure that is divorced from any collective cause or remedy" (Gane and Back 2012, p. 405). Social work practice in the UK takes place within a neoliberal context where political discourse characterises many service users in positions of dependency and personal failings (Garrett 2015; Hyslop 2018). Orgad's contextual argument is relevant because this study aims to understand how social workers use a sociological imagination to understand service users'

experiences, which take place within the neoliberal organisation of society's welfare services.

The research of Edmiston (2017) and Orgad (2020) can therefore be linked to the focus of this research. Whether something is a private trouble or a public issue remains a core question in relation to the appropriate focus of social work practice (Shaw 2017). Troubles are to do with "an individual's character and with those limited areas of social life of which he is directly and personally aware" (Mills 1959, p. 15). A trouble is then, a private matter, and the state intervenes only when invited or if there is a legal requirement to do so: in social work this is in relation to the statutory duties concerning the lives of children and adults at risk. Some issues though are thought of as wider concerns and so relate to the connection and organisation of many milieus:

> An issue is a public matter: values cherished by publics are felt to be threatened… it is the very nature of an issue, unlike even widespread trouble, that it cannot very well be defined in terms of the everyday environments of ordinary people (Mills 1959, p. 15).

Critical social work practice, with its focus on social justice and human rights, is concerned with challenging the ways in which policies and practices, often in relation to public issues, are presented and implemented (Payne 2021). Social work practitioners have a role to play in understanding and responding to some public issues. The intervention of a social worker though, does not necessarily mean a private trouble is, or becomes, a public issue.

Fook (2019) has linked the sociological imagination with theorizing about practice wisdom and critical reflection. Practice wisdom, defined by O'Sullivan (2005) as the "ability to base sound judgements on deep understanding in conditions of uncertainty" (p. 222) suggests there is an accumulation of knowledge through experience (Samson 2015; Johnson 2017). Social workers may develop practice wisdom through critical reflection, but Fook argues, if they do not have an awareness of the link between personal troubles and wider public issues, then those reflections will remain focused on individualized, and already familiar, points

of reference. Fook suggests practitioners find it hardest to understand the links between events, rather than just the identification of individualised understandings of events and wider structural explanations.

This observation points towards consideration of the knowledge base of the profession. Often referred to as eclectic, social work has long drawn on theoretical knowledge from sociology (Shaw 2021) and psychology to understand people, situations, and events (Trevithick 2008). Sociology looks to society for its explanations of people's experiences, psychology more typically to their inner lives. It is the links between events in people's lives and structural explanations that is at the centre of much of the research about health inequalities and social determinants. Adopting a sociological imagination involves both sociological education and a disposition or deliberate effort to try to identify wider, structural, aspects of society impacting on individuals. The conscious use of a sociological imagination, through the process of "deep critical reflection" (Fook 2019, p. 104), can help practitioners to understand the links between private troubles and public issues. This in turn may enable them to make better decisions about how to help service users, through interventions that aim to alleviate immediate and individual difficulties.

As discussed in Chapter 1, social work academics have previously extended the concept of the sociological imagination to suggest that social work practitioners should adopt a 'health equality imagination'; whereby practitioners continue to "promote the growth of equality in health and well-being and not further contributing to inequality" (Giles 2009, p. 530). Some of the benefits of doing so might be to ensure that broader understandings of health inequalities are represented in core assessment processes, and to ensure a critical perspective is adopted in hypothesising and problematising the experiences of service users (Pocket and Beddoe 2017). The following section explores the relationship between the social factors, or determinants, that people experience and the health inequalities that may arise from them.

2.3 Social determinants of health and health inequalities

The social determinants of physical and mental health are the "conditions in which people are born, grow, live, work and age, and inequities in power, money, and resources" (Marmot 2020, p. 1). Social determinants include factors such as socio-economic position, housing, education, and environmental conditions (WHO 2008). It is these social determinants that in part give rise to *health inequalities*, which "are avoidable, unfair and systematic differences in health between different groups of people" (The King's Fund 2020). Inequalities in health arise from the inequalities in society (Marmot 2010). More specifically, some authors refer to health inequities as differences in health between groups of people that are predominantly the result of unjust social policies and practices (Kirkbride et al. 2024; Public Health Scotland 2021). The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries (WHO 2014). This research uses the term health inequality to encompass differences in physical *and* mental health that are in part the result of social determinants, including social determinants resulting from socially unjust policies or practice. The term mental health inequality is used when referring predominantly to the experience of service users in relation to their mental health.

Contemporary social epidemiology employs an eco-social approach to understand and interpret the pattern and distribution of illness (Krieger 1994). The approach seeks to answer the fundamental question "who and what drives the current and changing pattern of social inequalities in health" (Krieger 2001, p. 672). Key tenets include an emphasis on the pathways that lead to a person's embodiment of their health and illness; the effects of cumulative interactions between susceptibility, resistance and exposure; and accountability and agency for the causal patterns of inequality at all levels.

The eco-social model helps explain why different individuals, groups and communities have different experiences of good and poor mental health (Kreiger 2005). A *social gradient* has been identified in health inequality research (Marmot and Bell 2010). That is, "differences in access to opportunity, power, and resources as well as varying exposure to stressors and social protective factors." (WHO 2008,

p. 26). Mirroring the multifactorial nature of physical health inequalities, mental health inequalities can also, in part, be explained in terms of the conditions in which people are born, live, work and age. The Commission for Equality in Mental Health (2020) state that *mental health inequalities* take three forms:

- Social inequalities that lead to poor mental health: the social determinants.
- Inequality of access to mental health services.
- Inequality of outcome from accessing those services.

The mental health inequalities that some people experience are in part explained by socio-economic position (in relation to the social determinants of health) and in part explained by other aspects of identity such as race, gender, and sexuality (Commission for Equality in Mental Health 2020). While the role of genetic inheritance and familial patterns of health are important, mental health is as much determined by environmental and social influences as it is by biological or genetic disposition (WHO 2014). Some life experiences may be positive and protective, for example experiencing good parenting or social support. Others may be negative. Risk factors present in people's lives will impact on how their mental health develops across the life course as well as in relation to discreet events of good or poor mental health (Stansfield and Bell 2019).

Advocates of a social determinants approach focus on the interaction between the identity characteristics of individuals and communities with the social circumstances and characteristics of people's lives. The social groupings that individuals belong to, or aspects of their identities – such as identifying as gay or being from a Black and minority ethnic community – may not in of themselves increase the risk of poor mental health. However, it is the social experiences of people in those groups, of having particular identities, that leads to an increased likelihood of events, situations, or experiences happening that might provoke episodes of poor mental health. For example, the impact of being a victim of racism or homophobia (Walters et al. 2020) is only likely to have occurred for people who are from minoritized ethnicities or who identify as gay or non-binary.

Therefore, the factors that protect or expose people to risk are not evenly distributed between individuals, families and communities. Some people will be at far higher risk of poor mental health, or experiencing mental illness, than others. Embodiment is literal and our minds and bodies experience the changing patterns of health in society and our bodies tell the stories that cannot be separated from the conditions in which we live (Kreiger 2005). In Beck's (1992) book *Risk Society*, and the concept of the same name, the difficulties that people experience, in a neoliberal context, are framed as the result of individual choice and behaviour. Neoliberalism promotes the virtuous resilience of individuals and families, while the impact of social injustice and structural barriers are minimised (Garrett 2016). In contrast, a social determinants approach acknowledges the importance of structural and societal factors on individuals: "Social injustice is killing people on a grand scale" (WHO 2008, p. 26).

Our understanding of the causal mechanism between the interaction of identity characteristics, subsequent experiences and people's social and economic circumstances is tentative and not generalisable (Trygg et al. 2019). The subjective nature of many mental health difficulties, in contrast to a firmer symptom-based diagnostic system in physical health, may make it more challenging to identify the underlying structural determinants of people's difficulties (Todman and Diaz 2014). The complexity and the quest to identify causation can lead to the creation of "false dichotomies" between different causal factors (Compton and Shim 2015, p. 8) but complexity also offers the possibility of a more sophisticated understanding of causation. The social determinants approach may also seem to absolve individuals of responsibility or agency in terms of explaining the risk, or development, of poor mental health. This again is complex, for example a person's choice of a poor diet, may result from factors beyond their control, such as the availability of affordable food in their community (Compton and Shim 2015).

Sometimes, inequality in mental health is referred to as inequality in the *experience* of good or poor mental health; or differences in the likelihood of developing a more severe mental illness (Thomas et al. 2018). In other writings, inequalities in mental health relate to the inequality of access to, and outcome from, mental health

services. For example, access to counselling (Beck and Naz 2019). The literature appears unanimous though in agreeing that people's mental health, and many common mental health problems, are influenced by the different economic, social, and environmental factors that create the context for people's lives (Allen et al. 2014; Cross-Denny and Robinson 2017; Compton et al. 2020).

Poorer people suffer disproportionately from common mental health problems and while low income is an important correlate, so is low educational attainment, poor material environment and unemployment. A social gradient in mental health means the lower a person's socio-economic position in society the worse their mental health is likely to be, with those in higher positions enjoying better mental and physical health outcomes (Fisher and Baum 2010). The role of accumulated stress through the life course appears clear and links with the concept of allostatic load (McEwen 1998) – a biological marker of physical and mental wear and tear - evidenced in several studies of health inequalities (Cowley et al. 2016; Kelly-Irving 2019; Ribeiro et al. 2019).

In a full text review of 150 studies accessed through *PubMed* and *Web of Science,* Silva et al. (2016), identified 78 papers where there was an association between sociodemographic and economic factors, and population mental health. Silva et al. (2016) identified key *individual* factors associated with worsening mental health – low income, living alone, poor social support, being female, low levels of education, unemployment, financial strain, and perceived discrimination. *Area level* factors – such as neighbourhood socioeconomic conditions, social capital, built environment, and neighbourhood problems – were associated with worsening mental health in 69 out of the 78 studies reviewed. Some factors appeared more significant in initiating worsening mental health, such as the association between men becoming unemployed and suicidal ideation, while other factors like poor neighbourhood environment contributed to the continuation of a person's difficulties. Silva et al. (2016) noted that having trust in people, feeling safe in your community, and having good social connections were associated with a lower risk of developing mental health problems. Other research has also identified positive correlates with good mental health, including rural living (Riva et al. 2010), urban regeneration

(Candy et al. 2007), and ageing in place for older adults (Cross-Denny and Robinson 2017).

Marmot (2010, p. 39) and others have used the phrase "the causes of the causes" to explain the complexity of social determinants. If proximal risk factors – such as poor diet, insecure employment, unsafe neighbourhoods – are factors that might lead to mental health difficulties, then it is the distal upstream environment and contextual factors that give rise and shape to those risk factors (Compton and Shim 2015). These can therefore be considered the causes of the causes. If the upstream factors are the "fundamental causes of disease" (Link and Phelan 1995, p. 81) then they must be addressed, otherwise even if proximal causes are ameliorated, then the circumstances that give rise to people's difficulties will return. To understand the complexity in the linkages involved, poor mental health should not be identified and constructed only as an illness burdening the individual, requiring individual solutions, but as an experience that must be explained by incorporating the political and policy processes, often in sectors outside health and social care systems, that partially give rise to its occurrence (Das and Rao 2012).

In terms of actions to ameliorate the impact and accumulation of negative social determinants through the life course, Allen et al. (2014) restates the importance of proportionate universalism (Marmot 2010). That is, intervention is needed throughout the life course, all the way along the social gradient in mental health inequalities between different socio-economic groups, proportionate to the level of disadvantage/inequality found. The fundamental causes, or the "causes of the causes", can only effectively be challenged through political will and policy interventions.

2.4 Social work and the social determinants of mental health

Social work, as a global profession, places an emphasis on social justice and human rights, as the universal values that underpin practice (IFSW 2014). In UK social work, the code of ethics stresses the values of respecting the essential rights and dignity of people, championing social justice and acting with professional integrity (BASW 2021). Social work is often described as a values-based profession (Banks

2012). Working towards ameliorating the social injustice and inequity that creates health inequalities should be the concern of the profession and its practitioners.

There is a relative abundance of research about social workers' practice and physical health inequalities in hospital social work settings (Craig et al.2013; Muskat et al. 2017). Additionally, substantial research has been undertaken to understand the impact of aspects of health inequalities on the lives of children (Gupta 2017; Morris et al. 2018) and their relation to the frequency of statutory childcare social work interventions (Bywaters et al. 2020; Webb et al. 2021). Research about social workers addressing the social determinants of mental health, or mental health inequalities, however, is less evident in the literature. This might be because some of the health inequalities research incorporates both physical and mental health concerns, for example O'Brien's (2019) review of screening tools used in healthcare settings. It may also be because much of the existing research has taken place in the context of social workers based in hospitals, settings concerned mainly with physical health conditions.

Fish and Karban (2014) have suggested that a health inequalities approach should be at the centre of the social work training curriculum, and Karban (2017) argues for a health inequalities approach specifically in mental health practice:

> [Social work] has the potential to offer a unique approach, drawing on a social perspective that complements and supports the need to address health inequalities and promotes positive mental health within an approach grounded in social justice and human rights (Karban 2017, p. 889).

This is an important agenda, and Karban advocates improving the overall health of mental health service users with rather than making a distinction between addressing the social determinants of mental or physical health.

Social work research that considerss the impact of some of the *specific* social determinants of mental health inequalities can be located in the literature. For example, poverty is a key social determinant, and the research identifies the challenges for practitioners in this area. Hyslop and Keddell (2018) challenge

neoliberal doctrine regarding individual responsibility and poverty to highlight the impact of structural discrimination and oppression. Social work is concerned with both the actions of individuals and the social context which shapes those actions (Hyslop and Keddell 2018). Gupta (2017, p.21) characterises poverty as the "elephant in the room" that is insufficiently acknowledged as a cause of service users' difficulties, while Feldman (2019) discusses a relational approach between the elements that perpetuate poverty, and social workers' contributions to alleviating its presence. Krumer-Nevo (2016) promotes poverty aware social work practice, as does the British Association of Social Workers (2019). Giles' (2009) conception of a health equality imagination calls on all social workers to be cognisant that poverty is a central cause of health inequalities. Other areas of research in relation to social work practice and specific social determinants of health, include housing (Hicks and Lewis, 2019; Tseris et al. 2023) and the impact of loneliness (Hagan 2021).

While research has been undertaken into the experiences of social workers in mental health services (Bailey and Liyanage 2012; Morriss 2017; Tucker et al. 2020, Bark et al. 2023) there does not appear to be any research specifically investigating the challenges and opportunities for social workers to incorporate their understanding of the social determinants of mental health into their practice. This study and thesis aim to begin to fill that research gap.

It is important to do so for several reasons. Firstly, if our understanding of the development of poor or good mental health is based on an interactionalist perspective between the individual and their environment, then it is important to understand the influence and causation between the two. Secondly, there is a moral duty to attend to the social determinants of mental health because they are responsible for the development of avoidable mental health inequalities (Shim et al. 2015). Therefore, if we accept the moral argument for promoting a fair and equal society, then there is a strong argument for understanding and addressing the social determinants. Thirdly, the individual treatments for many mental health difficulties are not wholly successful; if the medication and the counselling do not work, then an impetus is created to find additional ways to help. This impetus

involves moving beyond biopsychosocial models to embrace the wide variety of models and theories used to understand mental health (Richter and Dixon 2022).

2.5 Mental health social work

To be able to consider whether social workers exercise a sociological imagination, and in doing so the extent to which they address the social determinants of mental health, it is useful to briefly review the history of mental health social work[1]. Of particular interest is the changing focus between generic or specialist mental health social work practice; the impact of where and for whom mental health practice takes place, and consideration of the impact of the social model of disability (Oliver 1983).

In the early 1900s, social work was an emerging profession, its origins in the UK often located in the work of the Charity Organisation Society and the Settlement Movement (Horsley et al. 2020). Social work activity had a moralistic and philanthropic focus (Bamford 2015). The interwar years saw increasing recognition of both the impact of social conditions on people's mental health and a rising interest in psychological approaches, as society began to understand the trauma of war and 'shell shock' (Rogers and Pilgrim 2001). In hospitals almoners began to receive training, and the specialist role of the psychiatric social worker developed, with the first training course provided by the London School of Economics in 1929 (Burt 2008). At the same time local authority functions, such as those of Duly Authorised Officers to arrange for people's admission to psychiatric hospital, continued. After the establishment of the welfare state in the 1940s those functions were undertaken within Mental Welfare Departments of local authorities.

Two strands of specialist or particular 'mental health social work' therefore existed by the time of the 1968 Seebohm Report that had recommended the creation of generic local authority social services departments (Dickens 2011). The resulting

[1] This account focuses on the development of policy and legislation in relation to social work in England. Some of the account is relevant to the history of social work in the devolved nations of the UK but at times different policies, practices and legislation developed.

Local Authority and Social Services Act 1970 arguably marked the beginning of the bureaucratisation of the social work function (Harris 2008), the creation of a strong link between social work and local authorities, and a move to generic practice and training. In due course the role of the psychiatric social worker diminished, and its professional association was absorbed into the British Association of Social Workers in 1971 (Goodwin 1990 cited Tucker 2022).

Generic professional training was introduced by the Central Council for Education in Social Work, established via the Local Authority Social Services Act 1970 (The Health Foundation 2024a). In the subsequent decades social work sort to develop its professional status but debates about its legitimacy, knowledge base, skills and purpose have continued (Horner 2019). The creation of the Approved Social Worker (ASW) role through the passing of the Mental Health Act 1983 was perhaps the clearest example of a specialist mental health social work role since the advent of the psychiatric social worker. The impetus for the ASW role from service users and the profession, partly informed by the growth of the anti-psychiatry movement, was that social workers would be well placed to advocate for service users and promote alternatives to hospital treatment (Prior 1992). An implication was that ASWs' training focused on legal knowledge, advocacy and appreciation of alternative (social) explanations for mental distress. The ASW role was replaced in 2007 by the Approved Mental Health Professional (AMHP) role[2], one that retained a focus on community alternatives to admission to hospital (Bailey and Liyanage 2012).

It is also important to note the impact of the social model of disability (Oliver 1983) on practitioners' perspectives of mental health. Originating in the 1970s as a response to the individualised way social workers engaged with disabled people – based on their impairment - it suggested practitioners should reorient themselves to working within a framework of a social model of disability. That is, to understand and challenge the disabling nature of the society and environments within which

[2] The reform of the Mental Health Act 1983 in 2007 enabled nurses, occupational therapists and psychologists to train to be Approved Mental Health Professionals. See Stone et al. 2020.

people lived and worked. The adoption of a social model of disability was part of a wider change to the predominant knowledge base of (mental health) social work. Whereas psychodynamic and psychoanalytical theories had informed the initial training of social workers in the 1970s, there was now a shift towards more critical and radical approaches that sort to challenge society's assumptions and the treatment of users of social work services (Jones 2020).

Oliver (2013a) later noted the model's limitations, for example its minimal impact on challenging barriers to employment for disabled people. It has nevertheless been very influential in social work, and advocates suggest its use beyond its initial focus on the barriers to inclusion in society for disabled people (Levitt 2017). The argument for the use of the social model of disability within mental health care has been less clearly made by service users and has been critiqued by academics (Beresford et al. 2010; Tew 2015). While some find the model useful, others have disliked the concept of impairment that informs it, and do not see a clear mapping with their experiences of poor mental health (Beresford et al. 2016).

From a practitioner perspective, the biopsychosocial model of mental health (Engel 1977) is one of the most prevalent (Richter and Dixon 2022). The model stresses the interaction of biological, psychological, and social factors to explain the development and continuation of mental health problems. Despite its ubiquity in mental health services in general, this model has also been critiqued for its limited relevance to social work (Ashcroft and Van Katwyk 2016), and its limited consideration of political or economic factors (Pilgrim 2015). Nevertheless, in some studies of multi-disciplinary working the adoption of a broadly holistic social approach, or social model, has been identified as a distinctive feature of social work practice (Abendstern et al. 2021; Wilberforce et al. 2020). Someservice users, though, sometimes appear less certain of social workers' distinctive roles (Boland et al. 2021).

The NHS and Community Care Act 1990 marked a sea change in the provision of health and social care services, with a new focus on a mixed economy of care. The long-stated intention to reduce the use of psychiatric hospitals, since the 1962

Hospital Plan for England and Wales, finally gained momentum and many people with serious mental health issues were resettled in community or residential settings (Murphy 1991; The Health Foundation 2024b). In response, as local authorities also contended with their varied welfare statutory duties e.g. the Children Act 1989, social work departments started to move away from generic approaches to delivering social work services.

A parallel drive, from central government, towards the integration of health and social care, also took place. Legislation, such as the Health Act 1999, permitted pooled budgets (Tucker 2022). Government policies, such as the National Service Framework (Department of Health 1999), promoted the importance of mental health social work and integrated working (Woodbridge-Dodd 2017). Social workers, generically trained, began joining health based multi-disciplinary teams (MDTs), and were soon recognised as key members of community mental health teams (CMHTs) (Abendstern 2020).

By the early 2000s, many practitioners were either seconded or transferred to the NHS and mental health social work practice once again became increasingly specialist – or at least separate - from other areas of social work practice. In 2014, *Think Ahead*, a dedicated training route for would be mental health social workers began (Smith 2023). However, the role of social workers in CMHTs, often in a minority position, was not straightforward. Social workers reported a lack of role clarity, low status relative to colleagues, and isolation from their employing local authority (Bailey and Liyanage 2012). Joint working between health and social care has been promoted in policy and legislation but differences in professional and organisational cultural have complicated the integration project (Cameron 2016). Research has continued to identify this complex experience for mental health social workers.

The social work role in mental health services is most often discussed in terms of demanding statutory duties (Evans et al. 2005) and stress or burnout (Huxley et al. 2005; Evans et al. 2006). Drawing on the work of Pithouse (1987), Morriss (2017) suggested there was an invisibility to contemporary mental health social work, that

workers were isolated with poorly defined roles, and that they struggled to make the values of a social perspective visible. More broadly, social workers have continued to be characterised as street level bureaucrats (Lipsky 1980), able to have a degree of discretion in their interpretation of policy and actions of everyday practice, for example, in mental health street triage (Bell and Hill 2023). Evans (2011) argues that Lipsky's theory does not sufficiently account for how professionalism influences social workers' decisions, as opposed to a self-serving "client processing mentality" (Lipsky 1980, p. 140). Equally, the distinction that Lipsky makes between managers and front-line practitioners is more permeable and complex than he envisaged (Evans 2011).

Throughout the first two decades of the twenty first century, social works' professional bodies have sought to clarify the role of mental health social work through strategic statements (Allen 2014), as have the governments of the day (Department of Health 2015; Allen et al. 2016; Bayliss-Pratt 2019). Practitioners though, often have a limited knowledge of the priorities contained in policy documents (Tucker and Webber 2020). As specialists, AMHPs report that aspects of this role are valued and (relatively) prestigious e.g. having advanced legal knowledge, but less desirable aspects have been sociologically described as "dirty work" (Morriss 2016, p. 704). Even this specialist role has sometimes been characterised as a 'jack of all trades', linked academically to the notion of the hybrid professional (Noordegraaf 2015), rather than solely as a specialist practitioner (Leah 2020).

This recent history is relevant to this study because it highlights two ongoing debates about mental health social work. Firstly, whether training and practice should be specialist (Narey 2014) or generic (Croisdale Appleby 2014). Qualifying training in the UK has been generic for over thirty years, but the development of the training programmes *Step Up to Social Work* in 2010, and *Frontline* in 2014, both focused on childcare (Scourfield et al. 2023), along with the *Think Ahead* programme in 2014, focused on mental health (Smith et al. 2019), has challenged the profession's commitment to genericism.

A second debate is about whether service users are best served by specific professional groups, or whether that is less important than working with practitioners (from any relevant profession) who have the right skills, motivation and attitude. The *New Ways of Working* (Department of Health 2007) policy promoted roles within mental health crossing traditional professional boundaries (Stone et al. 2020). Both *the NHS Five Year Forward View* (NHS England 2014) and *The NHS Long Term Plan* (2019) promote generic practitioners delivering a range of specific mental health interventions. Yet independent experts in mental health, advising the government, continue to promote mental health social work as distinct profession e.g., *The Five Year Forward View for Mental health* (Independent Mental Health Task Force 2016).

Therefore, while social work remains a generic profession at the point of qualification, practitioners in the statutory sector are increasingly working in specialist areas and organisations (Social Work England 2023). An increasingnumber of social workers will have studied training programmes focused on childcare or mental health. There has been an increase in the number of social workers employed directly by NHS mental health trusts (Health Education England 2020; NHS Benchmarking Network 2023), and while practitioners sometimes occupy specific social work posts, often they are employed in generic mental health practitioner roles. The experience and impact of these developments on social workers' opportunities to bring a sociologically informed approach to their practice is considered in this research (see Chapters 4, 6 and 7). A further aspect of mental health social work's evolution is the emergence of the recovery approach as a significant development in the understanding of service users' experiences and the organisation of services to support them; this is considered in the following section.

2.6 The Recovery Approach

This section explores the features of the recovery approach, its place in UK mental health services, and its usefulness in addressing the social determinants of mental health. The recovery approach originated in the psychiatric rehabilitation movement (Anthony 1993; Deegan 1998) and the psychiatric survivor movement (Cleary and Dowling 2009). The approach advocates a move away from a traditional

medical/clinical concept of recovery - cure and the absence of illness symptoms - towards an approach that focuses on broader ideas of social or life recovery that can encompass living with symptoms. The recovery approach has been defined as:

> A deeply personal, unique process of changing one's attitudes, values, feelings, goals and/or role. It is a way of living a satisfying, hopeful and contributing life, even with limitations caused by illness (Anthony 1993, p. 527).

The approach does not mean someone must be symptom free to have recovered, and a distinction is sometimes made between clinical recovery and personal recovery, the latter involving social reengagement leading to a person finding a meaningful "place in the world" (Bradshaw et al. 2007, p. 27). Common aspects of the recovery approach include people being empowered to reclaim control over their lives, the importance of building positive personal and social identities (including tackling discrimination and stigma), connectedness, hope for the future, and finding meaning and purpose in life (Leamy et al. 2011).

Recovery orientated care is now embedded in the UK mental health system (Holley et al. 2016) and internationally (Khoury and del Barrio 2015; Karpetis 2020; WHO 2013). The term 'recovery' is contested (McCabe et al. 2018), and for some it has been co-opted by mental health services (Slade and Longden 2015). Ramon et al. (2009) though, noted an affinity between "social work values and practice and the principles of recovery, such as the focus on the self-agency of the service users" (p. 122). While some social work professional standards (Social Work England 2021) do broadly support Ramon's assertions, the role of mental health social workers is inconsistent (Tucker et al. 2021) and generalisations about compatibility cannot easily be made. Some practice, such as social work in forensic settings (Mann et al. 2014), or social workers undertaking the AMHP role, creates tensions with a recovery-based approach (Karban et al. 2021).

Some interpretations of the recovery approach offer an acknowledgement that an individual psychiatric biomedical perspective can only ever lead to a partial resolution of a person's distress (Slade and Longden 2015). However, the collective and structural experiences contributing to mental distress have been insufficiently

addressed by the dominant interpretation of the recovery approach (Thomson et al. 2018), with its emphasis on individual difficulties and biomedical interventions (Williams et al. 2015; Davidson et al. 2016). There has also been resistance to the concept by some service users, such as the Recovery in the Bin Collective (2016), who argue the approach insufficiently addresses issues of social and class injustice. McWade (2016) characterises this individual responsibilization process as "neoliberal state making" (p. 62), with the state redirecting responsibility to the citizen (Howell and Voronka 2012); a process that has galvanised some practitioners to resist, through their direct practice with service users (Hyslop 2018).

Karadzhov (2021) writes that the relationship between many of the macro factors that make up the social determinants of mental health (such as poor housing or experiences of discrimination) and individuals' abilities to recover, are therefore under researched and under theorized. Without proper consideration of the environment within which people live, then personal recovery is decontextualized. Therefore:

> Situating personal recovery within individuals' socio-structural contexts is instrumental in challenging the reductionist notions that recovery is merely an intrapsychic atomised faculty of the individual (Karadzhov 2021, p. 175).

Karadzhov's assertions mirror Weisser et al.'s (2011) observations that the predominant approaches to recovery, which take the individual service user as their focus, tend to examine the internal rather than the external factors that might contribute to recovery.

Optimistically, Tew (2012) suggests a paradigm for social workers that is concerned with supporting service users to develop personal efficacy and social capability in recovering from mental health problems, in a way that is contextualised, and sustainable through the life course. The approach – recovery capital - offers a holistic way of considering a person's situation. Recovery, for Tew, means "finding ways of reclaiming forms of power and control, reconnecting social relationships and finding positive and socially valued identities" (Tew 2012, p. 363). On a

personal level this might mean finding a sense of self efficacy and confidence, on a social level it might involve achieving "a position of capability" (Tew 2012, p. 363).

Tew writes about how four forms of capital –personal resources and strengths – can support people to move towards recovery. These are *economic capital* such as access to money and employment; *social capital* which is concerned with people's networks and sense of belonging; *relationship capital* focusing on potentially beneficial personal and family relationships; and *personal capital* – an individual's capacity for coping with challenging life events. The four forms of capital consider both an individual's own internal strengths and capabilities, but also their networks and resources: the latter encompassing some of the social determinants of mental health. Tew suggests that taking the four types of capital together, along with consideration of the nature of individual motivation, can be conceptualized as one paradigmatic recovery capital:

> Instead of an individualizing focus on personal pathology, it offers a paradigm for social work practice that both provides a systematic mapping of people's existing strengths and resources, and a focus on what needs to be done in order to enhance their efficacy and social capabilities (Tew 2012, p. 370).

Tew's approach can be linked with C. Wright Mills' (1959) concept of the sociological imagination: to understand the extent to which a person can access recovery capital it is essential to know about a person's history, their biography, their current context, and to consider their personal troubles and the impact of social (public) issues.

2.7 Conclusion and research questions

This literature review considered how C. Wright Mills' (1959) concept of the sociological imagination can be used to analyse and inform how social workers understand the difficulties service users experience. Many of the private troubles that service users encounter can often be attributed to wider public issues. The literature relating to the social determinants of health and health inequalities suggests this is a perspective relevant to a sociologically informed understanding of mental health. The recent history of mental health social work suggests social

workers practising in multi-disciplinary environments are well placed to adopt a social model of mental distress and to understand the importance of the social determinants of mental health. The recovery approach, and Tew's (2012) concept of recovery capital, are both relevant to considering of the approaches social workers adopt in their practice.

Giles (2009), in an extension of the sociological imagination, encouraged practitioners to adopt a health equality imagination to try to consider and address the social determinants and health inequalities. In this research I aimed to develop the use of the concept a step further: to promote recognition *specifically* of the social determinants of mental health and mental health inequalities.

This study therefore aimed to answer the following research questions:

1. How does a sociological imagination feature in social workers' accounts of the impact of the social determinants of mental health inequalities?

2. How does working in multi-disciplinary environments shape social workers' responses to the impact of mental health inequalities?

3. Can social workers develop a 'Mental Health Equality Imagination' to enhance their practice?

Chapter 3 Research design and methodology

3.1 Introduction

This chapter outlines the research design and methodology used in my research. I first explain its theoretical underpinnings, noting ontological and epistemological considerations. The subsequent section gives a summary of the methodology and research design. I then consider the research process discussing access to the field, eligibility criteria, sampling strategy, and participant recruitment. The penultimate section outlines the principal research methods, noting the importance of researcher identity, before considering the use of semi-structured interviews and vignettes. Data transcription and subsequent thematic analysis is also discussed. The final section of the chapter discusses the ethical, risk and data protection considerations pertaining to the study.

3.2 Theoretical frameworks

3.2.1 Wright Mills, Freidson and Bourdieu

The primary theoretical concept that inspired this thesis was C. Wright Mills' (1959) sociological imagination, expounded in his book of the same name. In addition to being a springboard for the study's initial focus and design, the concept is used in two main ways. Firstly, it is positioned as a positive, aspirational concept. The ways of thinking Mills advocates are presented as desirable traits or practices for social workers to have. Secondly, the concept is used as a lens through which to analyse the data. That is, how do participants, through discussing their work, demonstrate thinking in ways suggestive of accessing a sociologically imaginative approach to practice. The thesis uses this concept to explore and understand participants' accounts of their practice in relation to the social determinants of mental health, mental health inequalities, and multi-disciplinary team working.

This research then refers to the concept of the health equality imagination (Giles 2009), an extension of Mills' concept, to discuss whether data from this study suggests that a further development of this idea could happen. That is, could social workers develop a Mental Health Equality Imagination to promote recognition of

the social determinants of mental health and mental health inequalities in the context of MDT environments and recovery-based services?

In the initial research design, and framing of the research questions, my practice experience informed my decision to explore the organisational context of participants' experiences of working in local authorities, NHS trusts, and within recovery-based services. I was interested to find out not only if participants appeared to exercise a sociological imagination, or how they talked about their understanding of the social determinants of mental health, but also about the social context in which that knowledge was constructed, bounded and operationalised. As part of the inductive nature of this study I realised that other theories, in addition to Mills' work, would help me to undertake a more detailed analysis of the data. Additional theories would help me to understand what conditions and factors shaped participants' opportunities to exercise a sociological imagination. To support me to do this, the work of two additional theorists were used.

Firstly, Freidson's (2001) theory of the organisation of labour and the nature of professions places participants' employment status and location in the context of the market, bureaucracy and the profession. This is discussed in Chapter 4. Freidson's theories helped me to consider how participants' employment context, role and location appeared to influence their professional identity, and the extent to which they could express a sociologically informed account of their practice and understanding of the service user's world.

Secondly, Bourdieu's (1977; 1984) concepts of field, habitus and capital are discussed in Chapter 6 to enable a theoretical interpretation of participants' experiences of working in MDTs. The concepts support a detailed analysis of how relationships between MDT members - in terms of identity, status and capital - may appear to support or hinder them to articulate and action a sociologically informed understanding of the social determinants of mental health and mental health inequalities.

In combination, the three main theoretical approaches – Mills, Freidson and Bourdieu – facilitated a methodical analysis and theorisation of the data with the prospect of the study research questions being answered.

3.2.2 Ontological and epistemological considerations

Ontology is an aspect of philosophy concerned with the nature of reality and social entities (Bryman 2016). Two key ontological approaches are objectivism and constructionism**.** I adopted a constructionist approach which emphasises that social phenomena and their meanings are forever being cultivated or accomplished by the social actors involved. Strauss's (1964) classic study of psychiatric hospitals resonates: the organisations' processes and outcomes are "accomplished in everyday interaction, though this is not to say the formal properties have no element of constraint on individuals." (Bryman 2016, p. 31). Symbolic interactionism is a related theoretical position, that views social interaction "as taking place in terms of the meaning actors attached to actions or things" (Bryman 2016, p. 697). This meaning can be communicated to others through language, and the analysis of language is an important way in which the social construction of meaning can be understood. Similarly, Becker (1982) suggests culture is constantly evolving and it is the interaction of people, in this case practitioners and service users, that contributes to the form and culture of professional practice. Reality in the social world is therefore subjective and ever changing.

Epistemology is an aspect of philosophy concerned with the nature and sources of knowledge (Bryman 2016). I adopted an interpretivist epistemological approach, in the hermeneutic-phenomenological tradition (Bryman 2016). That is, knowledge about the experiences of social workers is gained and created through the research process. Social workers' practice is viewed from the premise that their actions take place in particular situations which are in part defined by them. Therefore, practitioners will have interpreted, defined, and now recall, moments in their practice in a particular way. As the researcher, I am the instrument of data collection (Padgett 2017), and participants define their understanding of their practice to me; participants construct accounts of meaning from their experiences. Their accounts of their experiences were accessible to me through qualitative

interviewing and subsequent data analysis. Consideration of the language used during the interview, and its transcription, was important in understanding the conversations that took place. Ideas from discourse analysis, such as the importance of context within speech and understanding the social organisation of "accounts" (Antaki 1994) assisted with the data analysis. How respondents gave meaning and constructed answers to the interview questions was the basis on which I analysed the data to understand the individual and collective experience.

3.3 Methodology and research design

This research was undertaken in the qualitative tradition, concerned with understanding participants' professional practice through listening to their accounts of their everyday work and exploring their thinking processes. Research design provides a framework for collecting and analysing data (Bryman 2016). Design is not static but iterative, and research questions and methods may be – and were - revised during the research process (Shaw and Holland 2014).

In its essential design though, this research adopted a cross-sectional approach: my research sought to capture the 'snapshot' of participant experience, highlighted by Flick (2018a) as the hallmark of qualitative cross-sectional design, from social workers across multiple teams, roles, and employment contexts. Data was collected over a relatively short period of time - six-months – in line with this key feature of cross-sectional design approaches (Silverman 2022). The research was not a detailed case study of the trust, or of one of its teams or locations over a longer period.

The research was both a study of how practitioners understood service users' experiences, and a study of practitioners' experiences of working with one NHS trust, either as direct employees or through employer partnership arrangements with local authorities. The participant sample was therefore drawn from one primary organisation but also from other organisations. The sample and data collected were, arguably, biased towards the experiences generated by working with the trust. This is both a legitimate characteristic, and a limitation, of my research. The results of this qualitative research are not generalisable, but readers

can contrast their own knowledge and understanding with the study's participants' experiences, and they may find they resonate. While qualitative cross-sectional design does not create generalisable research data, it does allow detailed data to be collected efficiently over a short period of time. The study's three research questions make the link between social workers' understandings of service users' experiences and how their organisational environment influences their practice. The idiographic inductive approach to theorising, that qualitative methods promote, was supported by using this cross-sectional research design.

3.4 Research process

3.4.1 Study setting and eligibility criteria

The study took place in a large NHS mental health trust. The trust covered an area that encompassed several local authorities in England. Participants were in teams across the trust and Interviews took place either face-to-face or online. The trust was an appropriate research site because it had a relevant research population to sample. The trust directly employed approximately 130 social workers and had approximately an additional 80 social workers working within the trust, via partnership arrangements with local authorities. The contrast in employment status between trust and local authority social workers was of interest and is analysed in Chapter 4.

To take part, participants had to be social workers registered with Social Work England, and employed by the trust, or work within the trust as a result of a partnership agreement with their local authority. A proportion of participants' regular duties also had to be in direct practice with adult service users. Potential participants self-selected and this eligibility criteria was used to determine if they could be included in the sample.

3.4.2 Access, sampling, recruitment and consent

The research adopted a purposive sampling strategy where participants were drawn from a relevant population with the aim of being able to answer the research questions (Bryman 2016). Social workers within the trust typically worked in multi-disciplinary teams where the assessment of service users' difficulties

included exploration of the social and economic aspects of their circumstances. This meant that participants would most likely have experiences to discuss in relation to the research themes.

The Head of Social Care and Social Work for the trust acted as gatekeeper to the research site. They assisted in identifying potential participants, whom they invited by email to take part. The gatekeeper did not line manage any of the participants which reduced the likelihood of participants having felt obligated to take part. The research was also advertised via internal trust communication e.g., newsletters. The gatekeeper cascaded information to team managers and practitioners, and also identified the number of social workers either employed by, or working within, the trust. Social workers employed by the trust had permission to participate as part of their standard working hours. Social workers employed by local authorities, who may also have had line managers external to the trust, had to ensure they had permission to participate. I confirmed with the Association of Directors of Adults Social Services (ADASS) that I did not need to seek their additional approval to undertake this research involving local authority staff (Lomax 2021).

The email sent to potential participants included an attachment of the participant information sheet (Appendix A) and consent form (Appendix B). Obtaining informed consent is a key research principle (de Vaus 2001). I felt confident potential participants would understand the nature of the research and the implications of taking part. Potential participants were asked to contact me if they would like to take part, and to express a preference for a face-to-face, or online interview.

Participants were given at least five working days 'cooling off' time between agreeing to be interviewed and the interview date. This gave them time to reflect on their decision, consider the focus of the research, and to form any questions they might have. No participant withdrew from the research after expressing their initial interest. I subsequently obtained consent from all participants before their interview began. If the interview was face-to-face, participants were asked to sign the consent form when we met. If the interview was online, participants emailed me a signed consent form in advance.

In qualitative research in particular, the topic of how many interviews to undertake is of perennial interest (Guest et al. 2006; Francis et al. 2010, Baker and Edwards 2012; Hennink et al. 2016). My research design did not require an exact number of participants to be identified in advance. Discussion with my supervisors concluded I was unlikely to undertake more than 25 interviews and ethics approval for this upper limit was given. 21 interviews subsequently took place, 10 were face-to-face, 11 were online. In deciding how many interviews was sufficient I, like most researchers (Jackson et al. 2015), referred to the methodological literature regarding saturation and adequacy, as well as considering the scope of the study, the nature of the topic, the quality of the data and the study design (Morse 2000). There were also practical and financial considerations that impacted on my research design (Braun and Clarke 2022). As I approached nearly 20 interviews the data appeared to give sufficient scope to answer the research questions and replication of some characteristics of interviewees' responses was becoming apparent during the concurrent analysis.

Table 1 summarises the information collected about the sample, which broadly reflects the gender mix of social workers in England (Social Work England 2023) but with a higher percentage of male participants (33.3%) than the percentage of registered male social workers (16.9%). Participants' ethnicity was recorded using the census ethnicity group classifications (Office for National Statistics 2021) and the sample distribution broadly reflects the UK ethnicity data, which records over 81.7% of the population identifying as White (Office for National Statistics 2022). The average age of a social worker in England is 46, and less than 2% of social workers are under 25 years of age (Social Work England 2023). The average age of participants in this research was not recorded but five were aged 41 to 50 years of age, and only one participant was under 25 years of age. The average time spent in frontline practice is eight years (Curtis et al. 2010) but some participants in this study had substantially extended their contribution with seven people recording over ten years of experience, and four of those people had 20 or more years' experience.

Table 1 Participant data

Employer				
Trust	14			
Local authority	7			
Gender				
Female	12			
Male	7			
Not stated	2			
Ethnicity				
Asian British	1		White Irish	2
Black British	1		White Other	2
White English	13		Not stated	2
Age Range				
21-25	1		46-50	3
26-30	4		51-55	0
31-35	3		56-60	3
36-40	2		61-65	1
41-45	2		Not stated	2
AMHP Status				
AMHP	8			
Non AMHP	13			
Practice Experience (Years)				
1-5	8		21-24	1
6-10	4		25-30	2
11-14	2		31-34	1
15-20	3			
Team Type				
Recovery	4		Primary Care Liaison	1
Early Intervention	3		Primary Care (GP)	1
AMHP	2		Personality Disorder	1
Recovery & Assessment	2		Autism	1
Forensic Services	1		Adult Community Services	2
Perinatal	1		Complex Treatment	2

3.5 Research methods

3.5.1 Researcher identity

This research is not an ethnographic undertaking, but my academic practice has been influenced by the study of ethnography. Ethnographers consider whether they are 'insiders' or 'outsiders' (Dwyer and Buckle 2009) in relation to the field. In some respects, I felt an outsider. I am a university academic as well as a student. I do not work at the local authorities or the trust. In other respects, though, I felt an insider. I am a registered social worker specialising in mental health. As a practitioner and educator, I have been involved with the trust, to the extent that I could access a conversational shorthand about buildings, places and people, that facilitated engagement. This made my access to the field easier as I knew some of the key gatekeepers.

Delamont (2012) notes researchers risk being so familiar with the field of study that they fail to 'see' – and so record– what is happening, and therefore need strategies to "make the familiar strange" (Delamont and Atkinson 1995, p. 3). White (2002) recounts an internal dialogue between her own identities as a researcher and practitioner, and how this helped her to identify underlying assumptions about her work. I tried to replicate that dialogue and use my knowledge of the field to understand participants' experiences but not to make assumptions. This links with the concept of 'bracketing': consciously putting aside preconceptions about the field and participants (Tufford and Newman 2012). I kept a reflective diary during data collection to help me with this process.

The permissive subjectivity, at the centre of ethnography, is relevant to my research. Although subjectivity has been critiqued as a methodological weakness (Gray 2018), it is a distinct feature of qualitative research, where language and interpretation contribute to understanding. The qualitative approach allows for the possibility that my own previous experience and identities can positively contribute to data collection and interpretation. In the tradition of Schön (1984), I was aware of the importance of reflection in and on action; to ensure a critical distance was created between those experiences/ identities and my practice as a researcher. That is, I needed to develop strategies to "make the familiar strange" (Delamont

and Atkinson 1995, p. 3). I employed a strategy of conscious, deliberate observation and reflection when I attended an interview site. I thought about my previous associations with the building, the team, the locality. I tried to make links between those thoughts and how I was feeling at that moment – sometimes relaxed, sometimes anxious or ambivalent – and then tried to ensure that when I met participants, I had put those feelings aside. Afterwards, I wrote reflective fieldnotes to capture how I felt about each interview, including references to how my previous associations had manifested themselves. On reflection, I feel I came to occupy a position between the two polarities, becoming what Dwyer and Buckler (2009, p. 54) called an "Insider-Outsider"; a challenging identity to Merton's (1972) original dual delineation.

3.5.2 Semi-structured interviews

Semi-structured interviews were the primary method of data collection. As a part time student, but full-time academic, I needed a flexible and efficient method of data collection. As Bryman (2016) notes interviews, transcription and analysis are time consuming activities, but they can be accommodated into other aspects of working life. This was a pragmatic decision, and my study would have yielded additional data had other methods, such as participant observation, been possible.

Whittaker (2012) notes that semi structured interviews provide flexibility for the interviewer to explore participants' responses to the questions asked, but that the structure of an interview schedule enables efficient data analysis. In contrast to structured interviews in quantitative research, the semi structured format enabled me to find out what interviewees thought was relevant and important in relation to my research questions (Bryman 2016). I devised a semi structured interview schedule (Appendix C) used to prompt participants to discuss aspects of their practice which I anticipated would provide fruitful data for analysis.

Semi-structured interviews are extensively used in qualitative research (Roulston 2010) and located within the narrative tradition (Gudmundsdottir 1996). The method is appropriate where the essential research objectives are concerned with understanding experiences and perspectives (Gray 2018). Epistemologically, this

locates the research within an interpretive social science paradigm, with the researcher engaged in a process of co-construction of knowledge: “in the social sciences there is only interpretation, nothing speaks for itself” (Denzin 1994, cited in Shaw and Holland 2014, p. 206). Flick (2018a) also suggests that the semi-structured interview enables the researcher to focus explicitly on the underlying knowledge that informs the interview’s planned form. This study’s interviews focused on participants’ social work practice and their knowledge of the social determinants of mental health. It is through my knowledge of social work, mental health, and the social determinants of health, that I could explore those interview topics. This was an exploratory research study – rather than being primarily evaluative, explanatory or comparative – and the flexibility of the method was well suited to this focus.

The interviews either took place face-to-face or online. I attended to the practical issues such as identifying a venue or setting up recording equipment, without difficulty. I was flexible with the date and times of meetings to increase the chances of participant engagement with the study. I was interested in undertaking some of the interviews on trust premises to gain a sense of participants’ working environments. It was important the venue was comfortable, and free from interruption or distractions. I estimated the interviews would last an hour to an hour and a half but researchers must also allow set up and debrief time to make reflective notes (Wengraf 2001). Therefore, I allocated two hours to undertake each interview.

I undertook a pilot interview with a social worker introduced to me by a colleague. They were an employee of the trust and met the study’s inclusion criteria. The pilot interview helped me to reflect on my role as a research interviewer, refine the interview schedule, consider which theories might be useful for data analysis, revise the research questions, and consider the nature of the interview encounter itself. Braun and Clarke (2013) refer to the importance of piloting vignettes too, to ensure they appear authentic to participants and target the issues of interest. Prior to undertaking the pilot interview, I read extensively about how to undertake

qualitative interviewing (Healey-Etten and Sharp 2010). Nevertheless, at first, I did find interviewing a challenging experience.

As an experienced social worker, I have worked with many service users and carers. I had some baseline interview skills, but the research interview process felt very different. Roulston's (2022) emphasis on the importance of being a reflexive interviewer was familiar to me, but I was interviewing people who, in a different context, would typically be colleagues not service users. The power and role dynamics were different to those I had previously experienced. I also had to learn *how* to do a research interview, rather than an assessment or counselling interview. Some aspects were similar – engagement, asking open questions, probing – while other aspects were different, such as using vignettes. The experience also contributed to my own self dialogue, and conversations in academic supervision, about my identity as an insider or outsider. I felt I used my social work identity, and knowledge of the trust, to easily establish a rapport with participants. I also felt though, that I had to deliberately establish the purpose of the interview and my role as a researcher. At first, I found shifting between these two foci quite difficult but as the interviews progressed, I became more confident.

I undertook some interviews with participants I had known when I worked within the trust over ten years ago. It was great to be reacquainted with former colleagues and I felt confident that none of the people felt obliged to take part. I was also contacted by people who are part of my current professional network as a university lecturer. The participation of both groups of people did though, give me cause to reflect further on my identity and practice as a researcher.

Space, language, role and trust must be considered in all interviews, but particularly with peers (Quinney et al. 2016). Hammersley and Atkinson (2019) emphasise that an inter-personal distance between researcher and interviewee is required to meet the aim of the interview: data collection. I felt though that knowing participants brought advantages in terms of an established level of trust and accelerated rapport building (McConnell-Henry et al. 2010). I was mindful not to be too informal or stray from the focus of the interview. The confidentiality requirements, and the

possibility of that commitment being overridden by safeguarding or professional practice concerns, were the same as for all participants.

For participants with whom I had current contact with through my academic role, I made sure the interview was focused on generating new knowledge and that it was not a conversation about other aspects of our working lives. Recording data is a form of social interaction and is "an inherently subjective endeavour" (Jenks 2018, p. 4) and, from an ontological perspective, qualitative interviews are not a pure or unfiltered window into participants' thoughts. There will always be a level of performativity and co-construction of knowledge through the narrative created in the interview encounter. Silverman (2010) notes the legitimacy of a constructivist approach to knowledge creation through the interview process, alongside other theoretical interpretations of the interview encounter. As the researcher, I will have influenced the progress of the interview conversations. The ethics approval for this study was for the collection of new data based on interview process, not the use of my pre-existing knowledge of some participants to help me answer my research questions. Equally, it was discussions in the interview that led to the production of the transcript for analysis. My prior knowledge of the person, at some level, influenced the questions I asked, and my interpretation of the responses given.

Online interviewing seemed a logical step when I was planning my research during the Covid-19 pandemic. The early use of synchronous online qualitative interviews was broadly positive (Deakin and Wakefield 2014) but much of the literature exploring this method e.g., James and Busher (2012), now feels quite dated. The coronavirus pandemic increased rate and use of different online technologies for research activities (Lobe et al. 2020; Howlett 2021), along with the everyday use of video conferencing technology. I found it straightforward to establish a rapport with participants and was able to use a common semi-structured interview schedule for both online and face-to-face interviews. Online interviewing has some advantages including straightforward scheduling and ease of data capture with automated recording and transcription (Hanna and Mwale 2017). Using Microsoft Teams also enabled me to interview participants over a wide geographical area, at low cost, sustainably, and to make appointment times convenient for them.

My data collection began just after the end of public health restrictions when Covid rates remained high, and people were deciding the extent of their in-person contact. I therefore gave participants the choice of whether to meet face-to-face or online. The social workers demonstrated a high level of commitment to undertake the interviews for both modes of participation, with all participants bar one keeping the originally agreed interview time. Online interviewing provided me with an alternative means of data collection and interviewees with choice about how to participate. Participants emailed me a completed consent form before the interview began and they viewed the vignettes via screenshare. Data security was ensured by using the Cardiff University Microsoft Teams application and storing the recording and transcript of the interview with the university OneDrive account.

I was surprised how many participants requested online interviews and I think this reflected people's familiarity with Microsoft Teams and the ease of arranging a suitable time. It did not feel like a compromise or second best. As other researchers have reported, digitally engaged participants respond well to online interviews and vignettes can be successfully transposed to this medium (McInroy et al. 2022).

3.5.3 Vignettes

Within the practical limitations of a professional doctorate study, I wanted to explore different methods. I wanted to use a tool to help me talk with participants and stimulate discussion; vignettes can be used for this purpose (Queiroz de Macedo et al. 2015). The three vignettes used are reproduced in Appendix D. Vignettes are "short stories about hypothetical characters in hypothetical circumstances, to whose situation the interviewee is invited to respond" (Finch 1987, p. 105). Vignettes are a practical, low cost and ethical method of generating data (Hughes and Huby 2002): they tell "stories about individuals and situations which make reference to important points in the study of perceptions, beliefs and attitudes" (Hughes 1998, p. 381). Gray (2017) highlights that vignettes focus on participants' perceptions rather than on their actions. Authenticity, in terms of the situation depicted, is key to writing useful vignettes (Neff 1979, cited Hughes 1998, p. 385). Vignettes have the advantage of allowing exploration of participants'

responses without the researcher overtly imposing their understanding of the research topic through the data collection process (Holley and Gillard 2017).

Vignettes have been used in a variety of social science research to explore participants' views of service users' circumstances (Holley and Gillard 2017); research the experiences of service users (Hughes 1998; Queiroz de Macedo et al. 2015; Barter and Renold 2000; O'Dell et al. 2012); and understand the experiences and needs of social workers (Wilks 2004; Galvani et al. 2013; Harris et al. 2023). Vignettes are not used to mirror real life experience per se, but to provide an interpretation of aspects of real life which then provides a context and a stimulus to which participants can respond (Hughes 1998). In this research, by using vignettes that outlined mental health service users' situations, social workers' explanations for the cause and course of those difficulties and circumstances could be explored.

The use of vignettes can act as a prompt for a wider conversation about a participant's approach to their practice and afford subsequent analysis of the language used to identify with the characters portrayed in the vignette (O'Dell et al. 2012). The vignettes were used, as Jenkins et al (2020) suggested, as an analytic technique to prompt participants to reflect, and be reflexive, about their own views of the characters' lives. The vignettes asked participants not to say, "What would you do next?" but to talk about "What do you see as significant in the story you have read, and why?". I also wanted to introduce some element of standardization in the interview process so that in data analysis there would be a common point of reference against which to compare participants' responses.

There were several factors to consider when writing the vignettes. Hughes and Huby (2004) highlight the influence of the *research topic, internal validity*, the significance of *relevance and realism*, and the nature of the *participants.* The *research topic* of social determinants of mental health is multi-factorial and complex. I felt textual vignettes could succinctly convey that level of complexity to participants and so prompt an opening "it depends" (Barter and Renold 2000, p.309) conversation that facilitates further exploration. I attempted to ensure *internal validity* by writing vignettes that, to a greater or lesser extent, reflected the

presence of factors in the characters' lives that could be identified as being social determinants of mental health. The social determinants of mental health were drawn from the variables identified by Silva et al. (2016). The vignettes appeared plausible and real and so contained sufficient information for participants to understand the situation. The vignettes also aimed to be inconclusive and uncertain enough to encourage participants to discuss additional factors that might be important to think about in relation to the topic (Barter and Reynolds 1999).

Through personal experience, and my practice as a social worker, I understand some of the hardships people experience, and I was to be able to write vignettes that had the degree of *relevance and realism* required for them to be effective. Spalding and Phillips (2007) note the need for vignettes to be trustworthy in their depictions and have a capacity to generate or surface thoughts and feelings in the research participants. I reviewed draft vignettes with social work colleagues and with my social work qualified academic supervisors as part of the writing process.

Each vignette character had a real-world name to make the character's situation more authentic and concrete (Queiroz de Macedo et al. 2015). The first vignette, Amira's story, reflects the possible impact of female gender, a lack of social support, migration, social isolation and limited social capital, on her mental health experiences. Akiel's situation, that features in the second vignette, reflects the likely impact of not living with a partner, being from a minority ethnic background, having limited family support, experiencing racism, and living on a low income. The third vignette, featuring Jack, was written to be a counterpoint to the first two: it does not include any specific negative social determinants.

The *participants* for this research were all professional social workers and so were used to reading and reflecting on the paper presentation of service users' difficulties. Three vignettes were enough to prompt discussion without being repetitive. I wrote vignettes that did not include professional characters e.g., a social worker or a doctor. This was so participants would be more likely to give a personal response -what they thought – rather than being diverted to give a hypothetical response of what they anticipated a professional character in the

vignette might have said or done. I used open-ended questions and encouraged participants to respond from their own perspectives as practitioners and from the perspective of each vignette's main character. This potential for switching perspectives is an advantage of this method.

Vignettes can be critiqued as prompting socially desirable answers (Hughes and Huby 2004) and lacking the interaction and feedback that are part of discussing real life (Hughes 1998). I therefore ensured my research interviews also gave participants the opportunity to discuss their own social work practice. This supported me to understand participants' perspectives, and emotional responses, in two different contexts: the hypothetical and selective vignette, and the real and comprehensive context of their own practice. This is important for data collection and analysis. Vignettes must generate data that reflect the complexity of the researched area (Wilks 2004) but there will always be a distance between the fictional account and social reality (Barter and Renold 2000). Data collected constitutes information related to a hypothetical scenario and a partial representation of life. It's applicability and generalizability to real life is therefore limited. If data is subsequently collected from the same participant about their own practice, then this can be viewed alongside the vignette data. The boundaries between the fictional and the real are softened (Rahman 1996).

3.5.4 Transcription

Characterised as an inevitable and problematic step in qualitative research (Kowal and O'Connell 2014), Shaw and Holland (2014) caution against seeing transcription as a series of technical decisions. The act of transcribing and the resulting transcript are the consequence of decisions about inclusion and exclusion in the process of converting the digital audio recording to text: the fleeting moment becomes fixed on record. Sometimes viewed as an act of reductionism (Jenks 2018), transcription is necessarily selective and at risk of bias through deletions, additions, substitutions and recollections of events (Kowal and O'Connell 2014).

I used an orthographic approach to transcription which centres on transcribing the spoken word from the audio recording. While the clear focus is helpful, the way

words are spoken varies in pace, volume and emphasis which was hard to capture. Transcription is the creation of documentary evidence of a social encounter, and the transformation of that encounter into another (printed) form: “Like the photograph, the transcript capture something, but not everything, ‘out there’. It also alters that something. Its ontology is, therefore, both realist and constructed” (Sandelowski 1994, p. 312).

For face-to-face interviews, the recording made using a handheld digital recorder was subsequently transcribed. For online interviews, the automated recording and transcription affordance of Microsoft Teams was used as a basis for the subsequent final transcription. Padgett (2017, p. 145) notes there is “no substitute for hearing one’s own voice and reliving the interview” through the researcher transcribing the interview. I was able to transcribe some of the interviews but pragmatically, to progress with my studies, I needed to use a university approved third-party service too. This had been agreed as part of my university ethics committee application. The service followed an in-house style - ‘near verbatim’ - which captured all the words spoken plus most of the pauses/repetitions and other sounds e.g., laughter (Transcribe-this 2018). The inhouse style chimed with the principles that transcriptions should be straightforward to write, read, learn and search (Bruce 1992 cited Flick 2018a, p. 439).

For online interviews that I transcribed, I listened back and formatted, anonymised, and amended the automated Microsoft Teams text to create a more accurate and nuanced transcript. At this point, the risks of transcription identified above were present. I produced a transcript in the ‘near verbatim’ style of the transcription service to try to achieve consistency across the data set, a key purpose of transcription conventions (Jenks 2018). Transcribing online interviews “still remains a property of the human transcriber, not of software” (Kowal and O’Connell 2014, p. 76) but I was able to use this technological affordance as a basis to work from.

Where possible I undertook the transcriptions soon after the interview. The recency of the encounter helped me to realise some of the advantages Padgett (2017)

highlights, of being able to fill in unclear moments in the recording, clarify unclear words, and also access a means to reflect on my own interview style:

> the move from text to speech also changes the relationship of discourse to the speaker. Asking what a text means is not the same as asking what the speaker meant. The said now comes to matter more than what the author [speaker] meant to say (Shaw and Holland 2014, p. 215).

The raw data that transcript becomes is, of course, data that is already "partly cooked" (Sandelowski 1994, p. 312) through the process of transcription itself. To ensure quality and consistency in transcription, Padgett (2017) suggests checking transcripts randomly against the original recording is a constructive compromise for researchers unable to transcribe all the interviews. I followed this suggestion for recordings I did not transcribe and identified a high level of fidelity to the original recordings.

3.5.5 Thematic analysis

Lofland and Lofland (2006) advise beginning data analysis during data collection to avoid the monumental task once all the interviews have taken place. I heeded this advice. Doing so helped me to identify areas of interest in the data, realise the usefulness of using additional theories, and hone my interviewing skills.

The qualitative research paradigm suggests a panoply of different research methods. Analysis may, at one end of the spectrum be descriptive, and towards the other end much more interpretative. Thematic analysis, as described by two of its proponents (Braun and Clarke 2006), is a foundational and flexible approach accessible to new scholars. They suggest thematic analysis is "more akin to a method (a transtheoretical tool or technique) than a methodology (a theoretically informed framework for research)" (Braun and Clarke 2022, p. 1). Thematic analysis has less emphasis on interpretation than some approaches e.g., Interpretative Phenomenological Analysis, but it does retain an essential 'double hermeneutic' whereby I have been making sense of what participants tell me, about how they, make sense of their (social work) world (Smith et al. 2022a).

Thematic analysis has advantages: it is flexible in terms of how data is collected, it is relatively straightforward to learn, and the results are hopefully straightforward to understand for a wider audience. Its limited theoretical underpinnings, in contrast to grounded theory or interpretative phenomenological approaches, means it can be regarded as lacking an explicit interpretative mandate or power. This can lead the analysis to essentially consist of (realist) descriptions of participants' reflections. Braun and Clarke (2022) suggest a reflexive approach to thematic analysis can counter this concern.

Bryman (2016) states thematic analysis can be viewed as a generic qualitative analysis approach and refers to the six steps set out by Braun and Clarke (2006, 2022): *1) transcription, reading and familiarisation - taking note of items of potential interest, 2) coding - undertaken across the entire data set, 3) searching for themes, 4) reviewing themes, 5) defining and naming identified themes, and 6) finalising the analysis.* I broadly followed this process. Thematic analysis is a pattern-based approach to qualitative data, where the identification of interesting features of the data, perhaps in prominence or repetition, but also variation and difference, are identified through coding individual transcripts and then brought together into named themes.

Braun and Clarke (2022) suggest a tripartite categorisation of thematic analysis: coding reliability, codebook, or reflexive. The distinction is based on how researchers approach coding, with the first two types focusing on pre-determined themes and inter-coder reliability. The third type – reflexive- is more concerned with the researcher exploring the meaning of what participants say and the social construction of knowledge within the interview process. Of the ten assumptions Braun and Clarke propose for reflexive thematic analysis, the fourth emphasises a dual process of in-depth immersion in the data, along with creating time and space for reflection, ideas and inspiration to develop (Braun and Clarke 2022).

Coding, therefore, is not simply a process of identification, but of interpretation, and my approach to coding developed as I analysed more transcripts. I identified initial codes in relation to some of the underlying ideas that informed my research

design and questions. I then identified themes from the coded data set and subsequent data extracts. In trying to identify themes, I initially looked at whether groups of codes suggested that participants were using a sociological imagination or not. I also looked for groups of codes that could be arranged into themes that would help me answer my research questions, reflecting back and forth in my mind, on the relevance of the theoretical perspectives of Mills, Freidson and Bourdieu. Braun and Clarke (2022) repeatedly remind the researcher that themes are *not* like fossils in a rock waiting to be discovered but are decided upon through the researcher's interpretation of the data. Writing about the data is part of the process of analysis within qualitative research. In thinking about the codes and themes, I considered the language used by participants in the data extracts. I was interested to consider how participants spoke about their experiences: what they talked about and how they expressed themselves.

3.6 Ethics, risk and project management

Research ethics are concerned with protecting the interests and welfare of participants and other people associated with a project (Hugman 2010). Moreover, how any research is conducted and managed is an indication of the overall quality and rigour of that research (Becker et al. 2012). This research has been designed with due regard to the UK policy Framework for Health and Social Care Research (Health Research Authority 2017), and the Cardiff University Research Integrity and Governance Code of Practice (2019). These frameworks, along with my obligations as a registered social worker to comply with the Social Work England Professional Standards (2021), provided the project's overarching principles and values. Banks (2012) emphasises the importance of respect, protection, and honesty. Important areas for ethical standards are informed consent and confidentiality, as well as considering how to ensure participants come to no harm; these aspects of research design are considered below.

3.6.1 Assessment and management of risk

There was a minimal risk that during the interviews participants might have experienced emotional or psychological distress. For example, a participant might revisit difficult practice encounters through the interview discussions, and this type

of risk is a hazard of undertaking qualitative social work research (Shaw and Holland 2014). To respond to this risk, I ensured there was time available after the interview for participants to debrief and for me to be sure they were not likely to experience ongoing distress. Each participant also had my contact details and I offered follow up contact if required. Safeguarding others is a recognised limit of confidentiality within health and social care research (Shaw and Holland 2014). If a participant had disclosed practice that raised safeguarding concerns and/or breached professional standards, I would have discussed this with the gatekeeper.

There was a minimal risk to me, as the researcher, that I might experience emotional or psychological distress through undertaking the research project. If that had occurred, I would have contacted my academic supervisors for support.

3.6.2 Research Ethics Committee, regulatory reviews, training and reports

An application was made to the Cardiff University Social Sciences Research Ethics Committee on September 30th 2021, and a favourable ethical opinion and approval was given on 5th November 2021 [SREC reference: 32]. I undertook the university's Research Integrity Training (Cardiff University 2021) as an element of the requirements for that application.

An application for University Sponsorship was made on 4th October 2021 and approved on 11th November 2021 [SPON 1874-21]. Cardiff University's indemnity policy met the potential legal liability of the sponsor(s) for harm to participants arising from the management, design and conduct of the research.

The site of the research was an NHS trust and so approval by the Health Research Authority (HRA) was required. The study did not require consideration by the HRA Research Ethics Committee, principally because the study was primarily an educational endeavour, did not involve patients or their data, and because of the project's prior approval by Cardiff University's Research Ethics Committee (Health Research Authority 2021). I undertook the Good Clinical Practice (GCP) eLearning training as part of application requirements (NIHR 2021). I also developed a research protocol which formed part of my HRA application. I completed my submission to the HRA on 22nd November 2021 and approval was given on 9th

December 2021 [IRAS project ID: 305930; REC ref: 21/HRA/5203]. I subsequently applied for a Research Passport from the trust on the 28th March 2022 and received the required access letter on 22nd May 2022.

Throughout undertaking this research, I have ensured that I have complied with the requirements of Cardiff University Social Sciences Research Ethics Committee, Cardiff University's Research and Innovation Services requirements for project sponsorship, and of the Health Research Agency's requirements for project approval.

3.6.3 Data protection and confidentiality

The dignity and rights of participants is partly assured through proper attention to confidentiality (Flick 2018a). All data handling, transmission and storage was undertaken in accordance with data protection policies (Cardiff University 2023). Confidentiality was maintained throughout the research process, and I complied with General Data Protection Regulations (GDPR) with regards to the collection, storage, processing and disclosure of personal information and upheld the core GDPR principles (Information Commissioner's Office 2022). This project collected some personal data: participant name, location of team base, email address, phone number, age, and gender.

Anonymisation of data was important so that participants could speak freely and so that service users were not identified. Participants were asked to use pseudonyms when discussing service users and carers, and to make sure other aspects of their situation, e.g., geographical location, were not revealed. At the end of the interview, I checked with the participants that anonymisation was observed. If a participant inadvertently identified a service user or carer by name, then I had planned to ensure that anonymisation took pace during transcription. Fortunately, service user and carer confidentiality was not breached in this way during the interviews.

On two occasions confidentiality may have been breached by participants referring to geographical locations. Post interview I anonymised the two transcripts by substituting the identifying information with fictional information i.e., a fictious

location. Any readily identifiable characteristics (e.g., unique demographic information, details of specific cases/incidents, etc.) were also redacted from transcripts to help promote participants' anonymity and reduce the likelihood of deductive disclosure. I ensured that this was done sensitively so that the original sense/meaning of the information was retained. Personal data will be retained until the project end date – September 2024 - and then for up to 5 years after this.

As Principal Researcher, along with my supervisors, I have access to the data. Some data was shared with a (university approved) transcription service. Data was only shared once I had reviewed that service's information sharing policies. Secure data transfer procedures were followed using Cardiff University's FastFile service (Cardiff University 2024). All data and subsequent transcripts were stored on the Cardiff University network – not standalone computers - using apps within Microsoft Office 365 (Cardiff University account). All applications were password protected. The Chief Investigator is the data custodian for this research.

For all face-to-face interview audio recordings and transcripts were stored using Microsoft OneDrive. Original recordings of face-to-face interviews were made using a digital recorder. Once the MP3 file had been transferred to OneDrive, the original recording was deleted. For all online interviews the recording and transcription affordance of Microsoft Teams was used. The automated transcript was then amended for accuracy. The final transcript was then stored in OneDrive and the original recording deleted from Microsoft Teams.

It is important to disseminate research findings to contribute to the development of professional social work practice. Therefore, participants were informed, and consented to, anonymised excerpts and/or verbatim quotes from interviews being used as part of research publications. Participants also consented to the research findings being presented in this thesis (which will be publicly available after completion) and to findings being published in academic journals and other media. During the process of completing this thesis I was able to present some early findings at the 12th European Conference for Social Work Research (Lomax 2023).

3.7 Conclusion

This chapter has outlined the theoretical and methodological approach to undertaking this cross-sectional research of social workers' practice within an NHS trust. Using semi-structured interviews, and incorporating textual vignettes, enabled detailed exploration of participants' practice. Influenced by the work of ethnographers, I reflected on how my professional identity and career experiences may have influenced data collection. Reflective thematic analysis has been used to identify themes in the data. The theoretical concept of C. Wright Mills' (1959) sociological imagination, alongside Freidson's (2001) theory of professionalism, and Bourdieu's (1977) concepts of habitus, field and capital, are used in subsequent chapters to theorise and analyse the data. The following chapter, the first of three data analyses chapters, introduces the study's participants and discusses the significance of their employment context and role on their professional identity.

Chapter 4 Pure or diluted: the shifting identity and location of social work

4.1 Introduction

Mental health social workers practise in a range of settings and this study's participants' experience reflected those variety of locations. This first analysis chapter introduces some of the study's participants and their experiences of being employed either by a local authority or the NHS trust. The chapter first briefly discusses social work's status as a profession and the relevance of this consideration to this research. The second section provides an overview of the professional characteristics of the participants and where they worked. The three main employment contexts of participants are: social workers employed by a local authority and working within the trust; social workers employed by a local authority undertaking the AMHP role, and social workers employed by the trust. Finally, the chapter considers the experience of participants employed by the trust in generic mental health practitioner posts rather than dedicated social work roles. In addition to using C. Wright Mills' (1959) sociological imagination to help understand participants' perspectives of their roles, Freidson's (2001) theory of professionalism is used to discuss the differing strength of participants' professional identity and the relationship between their practice, their employer and their team's location. It is argued that social workers' professional identity shifts in different employment and practice contexts, and that participants are not fully in control of the focus and remit of their work. Organisational context appears to influence social workers' perception of the purity or dilution of their professional identity and role.

4.2 Social work: professional logic

Recent social work history in the UK includes the professionalisation of the activity of social work through the introduction of requisite qualifications in 1962, the formation of a national association in 1970, the requirement to register to practice since 2001, and the protection of the title of social worker in law since 2005 (McLaughlin et al. 2016). Although Moriarty et al. (2015) note that definitions of

social work are contested and evolving, perhaps a useful way to assess the 'strength' of the profession is to consider how its work is organised and undertaken.

Freidson's (2001) book *Professionalism: The Third Logic* suggests work can be organised through the market, through bureaucracy or by profession. From the logic of the profession, an important organisational characteristic is that the profession has control over the nature of work undertaken (rather than being predominantly influenced by the consumer in the marketplace or the manager in the bureaucracy). If social work is a strong profession, then it follows it should have control over the nature of the work its members undertake. However, in the context of new public management and the neoliberalism, the logic of the market and the manager do impact on social workers' experiences (Nathan and Webber 2010). The distinction between manager and practitioner is also less clear than either Freidson (2001), or Lipsky (1980) in his classic study of street-level bureaucrats, implies (Evans 2015). The rise of managerialism within public services has impacted on social workers' roles and professional discretion can take many forms within practice (Evans and Harris 2004; Matarese and Caswell 2018).

As is discussed below, participants' sense of professional identity and strength was consistently affected by the organisation they worked for, the context or location in which they worked, and the tasks they undertook. Participants' abilities to bring a sociological perspective, or sociological imagination to their work, sometimes appeared to be a secondary consideration in light of the challenges of their role and location.

4.3 Social work participants: overview

Participants were based in a variety of different settings. These included early intervention, primary care, and recovery teams. Fourteen participants were employed by the NHS trust, and seven by one of three local authorities with which the trust had partnership arrangements[3]. Pseudonyms have been used throughout data analysis and presentation. Some local authority participants worked within

[3] The National Health Service Act 2006 enabled local authorities and NHS trusts to enter 'section 75' partnership arrangements to facilitate joint working.

multi-disciplinary teams organised by the trust, such as Michael, a practitioner of 20 years' experience who worked in a community assessment and treatment team. Other participants worked in local authority teams that were co-located in the same building as trust mental health teams. For example, Sarah, an experienced manager in a local authority mental health team.

Participants employed directly by the trust often viewed the experience positively, especially regarding training opportunities. Sometimes though those participants felt isolated or marginalised; these experiences are discussed below. Working for the trust meant that participants were often employed in roles that could be undertaken by other professionals, such as nurses or occupational therapists.

Eight participants were social workers who were AMHPs, undertaking assessments under the Mental Health Act 1983. All AMHP qualified participants were employed directly by a local authority, except one – Jane – who was employed by the trust. Two social workers – Louis and Darren – worked full time in a dedicated AMHP service. The other six AMHPs worked in different types of community teams, for example Clare, who worked in a recovery team.

When participants spoke about the specialist services they worked in, they were often enthusiastic and motivated about their work. John, a local authority social worker with 20 years' practice experience, worked within the trust in a specialist autism team. His language conveys the energy and commitment he brings to advocating for service users:

> I look at the needs of the population that I work with, and I propose strategies and ideas to meet those needs. So, I do a lot of work on benefit acquisition, a lot of signposting. I consider myself as an insider, both in the NHS and the council, so what I try to do is rally services to support the people I work with. I've come to learn that if you're going to design a disability to fall through the cracks of health services out there, you cannot design a better disability than autism in order for people to say, sorry, that's not my job, that's not my role. And so I'm constantly trying to bend other

> services, or you know, work with criteria of other services in order to meet the needs of the people that I work with.

John is describing how he uses his access to both the trust and the council to work for the benefit of service users. John's use of the phrase "I consider myself an insider" suggests special access, contacts or information, which he can use to get his job done well. Perhaps "insider" also means spy: John using his knowledge gained from one organisation to covertly work to his advantage in the other. John uses the phrase "bend other services" to encapsulate the challenge he faces in trying to negotiate access to resources to support a service user group that he notes are often excluded.

All participants were working in services that had integrated health and social care functions, and all participants were working within multi-disciplinary teams or environments. Participants full time equivalent practice experience varied. Eight participants had between one and five years of experience, a further four participants had between six and ten years of experience. Five participants had between 11 and 20 years of experience, four participants had between 21 and 35 years of experience. Louis, a local authority employed social worker, typifies this breadth of experience:

> I went pretty much within three months of qualifying [in 1997] into a mental health team and I've done that ever since. Since I've been in mental health, there's been a variety of iterations of how the service works. The council used to be alongside the trust and now the idea is that we are integrated. We were in, what they called, community mental health teams and then I moved to an outreach team. And then I moved back to the new version of a community mental health team, which is a recovery team because if you change the language, it's a better service! And now I've moved over to this team, to just the AMHP service.

While Louis has consistently practised as a social worker for over 20 years, the organisational environment in which he has worked has changed. Louis expresses cynicism about the nature of organisational change in mental health, adding: "if you

change the language, it's a better service". Louis has been part of the iterative development, redefinition and relocation of mental health social work throughout his career, but it is not clear how much influence or control he has had over this.

The location, role and employment context information was summarised in Table 1 Participant Data, in the preceding chapter. The table also summarised additional characteristics of the sample including participants' gender, age, ethnicity and length of practice experience. This chapter now discusses, in more detail, the experiences of participants working for different organisations in different teams and roles.

4.4 Social work from different locations

As outlined, the participants worked for two different types of organisations – a local authority or an NHS trust - and undertook a variety of roles in a range of teams and services. These roles reflect the recent history of mental health social work and mental health services. This section provides an initial discussion of participants' experiences of practising as a social worker in these differing contexts and roles, and considers the strength of social work's professional logic.

The relationship between local authorities and NHS mental health services dates to the early days of community care in the 1980s (Murphy 1991). Successive governments tried to foster closer integration of health and social care services. In mental health care, in the context of new public management reforms (Heffernan 2006), this resulted in partnership arrangements between trusts and local authorities (Moth 2022). In this research, some social workers were employed by local authorities and worked in local authority teams. Most local authority social workers, through partnership arrangements, were working in NHS teams, and some previous local authority workers had been transferred to employment by the NHS via the TUPE process[4]. Most participants were social workers employed directly by the NHS trust, either as social workers or generic mental health practitioners.

[4] TUPED (Transfer of Undertakings [Protection of Employment]). See: https://www.england.nhs.uk/gp/investment/gp-contract/network-contract-directed-enhanced-service-des/enhanced-access-faqs/guidance-relating-to-tupe/

4.4.1 Social workers employed by a local authority and working within the trust

Participants like Clare, a senior practitioner in a recovery team, were employed by a local authority but worked day-to-day in the trust's multi-disciplinary teams (MDTs). Morriss (2017) highlighted that being employed by a local authority but seconded to a trust could be difficult for social workers with "dual pressures" (Morriss 2017, p. 135) impacting from both organisations. Similarly, in this research, Clare comically refers to having "two streams of bosses for a start [laughs]" and outlines what she feels are her responsibilities as a local authority employed social worker:

> I feel that part of my job as a social work senior practitioner is about supporting staff with the more traditional social care agenda. So, Care Act [2014] assessment quality, making sure that people have done the Care Act assessments where it's not just blatantly obvious that someone needs a domiciliary care package, but actually it's a bit more subtle than that, and you're framing conversations within the Care Act framework. Championing direct payments and the good and not so good things about that and the complications that we have… And the social care agenda, the Mental Capacity Act, deprivation of liberty [safeguards], all of those sorts of things.

Clare's description of her role combines elements of leadership and management (supporting staff), advocating for services users' entitlement to services, and using her knowledge of legislation and policy to frame practice. Clare's "championing" of direct payments suggests a degree of discretion in the focus of her work and a decision to advocate for an approach that is underpinned by the social work values of choice and independence. Restricted policy environments that appear to limit discretion but also create uncertainty and ambiguity that require interpretation, can paradoxically, create spaces for discretionary and creative practice (Evans 2020). Allen (2014) identified some of the key aspects of social work as enabling people to access statutory social work services, fulfilling legal duties, and promoting the "personalised social care ethos of the local authority" (Allen 2014, p. 6). In terms of Freidson's (2001) professional logic, it appears that the bureaucracy of local and national government plays a significant part in determining aspects of Clare's day to

day work, and to that extent, has some influence and control over the activities of the profession.

Several participants discussed the advantages of working for a local authority, like Sarah, an AMHP and experienced manager:

> I think it gives us the law and supports us to use the law and to be able to work defensively and be able to justify why we did this capacity assessment, and they [the local authority] show us how to do a capacity assessment and what it relates to, and I think there's a lot of training around how to evidence our thinking: if it's not written down, it didn't happen. Our health colleagues don't always put the law into practice, I think the medical way in which they work overrides, or they don't take into account, the law.

Sarah, like Clare, privileges legal and procedural knowledge and the application of the law as important aspects of her practice and locates the support for its use within the local authority (see Chapter 6). Sarah's articulation of the local authority enabling her to "work defensively" is interesting as organisations can support practitioners to manage risk (Stanford 2010). Sarah appears to use a professional imagination (Power 2008) to help make sense of her employment context and role. Both the organisation and the law appear to define Sarah's professional practice, within which she can exercise professional discretion, while simultaneously providing her with some protection for the decisions that she makes. This perception is reflected in the literature (Tucker and Webber 2020; Bark et al. 2023) and Trevithick (2008) notes the law is part of the factual knowledge base of the social work profession. Sarah emphasises what she considered to be good (social work) practice by contrasting her actions with the different emphasis of (medical) colleagues.

The sense that the type of organisation i.e., the local authority, and the identity of the social work profession are closely entwined, was evident in other participants' comments, too. Darren, a local authority social worker and AMHP whose council owned office also hosts various teams from the trust, highlights the value he sees of being organisationally separate and independent of the trust:

> [Working for a local authority] makes me feel more like a social worker, for sure. When people are employed in that multi-disciplinary team, I wonder if there's a merging of roles in that you could easily lose that social perspective a little bit. I've never had that, you know, I'm a pureblood social worker. I feel much more comfortable to say no, I have more ownership over my work because I'm like, "Hey…" you know, "I'm employed here" [the council] and I can feel much more independent.

Darren identifies that somehow – perhaps through extensive socialisation (Webb 2015) - working for a local authority makes him feel "more like a social worker" and he detects a risk in multi-disciplinary working and the merging of roles. In terms of Freidson's professional logic, Darren's local authority employment appears to embolden his sense of being a professional with the autonomy and discretion to form judgements and make decisions. Darren's stated independence perhaps indicates a level of discretion in his practice that he values and that is important to his social work identity. That discretion and independence may link with the ability to exercise a sociological imagination.

Darren's sense that he could lose his social perspective and independence by working in a trust MDT accord with the findings of other related research (Bailey and Liyanage 2012; Yip 2004). While the 'social perspective' may be differently defined (Beresford et al. 2016), analysis in the following chapters suggests that this perspective is closely aligned to practitioners being able to use a sociological imagination. By using the word "pureblood", Darren makes an analogy between ancestral lineage and social work lineage: the implication being that a local authority social worker is superior by dint of being untainted or unmixed with other professionals. Location within the local authority is perceived to be a pure location where Darren's social work identity can thrive.

In contrast to Sarah and Clare, the use and promotion of Darren's social perspective does appear linked to his employment, location, and identity as a local authority social worker. The social perspective is perhaps what defines the purity of Darren's professional identity:

> I guess I'm more drawn to the family's social picture. I'm not sure we should call that a systems approach. I know [the local authority area] really well. I grew up in this area, I've always worked in this area. Even little jobs, like shop jobs and factory jobs, I've worked in this area, so I'm always interested in how people fit in. So, I know all the nooks and crannies and I'm always interested in what part you are in, how that impacts you, or the family you have around you.

Darren demonstrates, through revealing an aspect of his own biography, how he thinks it is important to understand the "social picture" of the families he works with; the phrase "nooks and crannies" suggestive of a detailed understanding of the interaction of geography, social circumstances and mental health. In the following chapters, Darren's – and other participants' - understanding of service users' experiences, and practitioners' roles within MDTs, suggests articulating a social perspective is indicative of reflexive practitioners using a sociological imagination in their practice. Darren's knowledge and professional autonomy appear to enable him to use his sociological imagination.

The experience of being employed by a local authority but working within a trust is not always straightforward:

> Clare: I've always been employed by a local authority and seconded to [the trust] so this is my third local authority I've worked for. That position of one foot in one camp and another in another is familiar to me. I'm comfortable with the awkwardness of that in some respects. I don't know if that's a good thing or not, but it's familiar to me so that's where we are. I also feel that it's important for me to be employed by the local authority as a social worker and have that identity. But I also need to move with the times a bit as well, and I feel that that's a little bit old-fashioned.

Clare appears so familiar with the situation of being employed by one organisation but working within another, that she uses the contradictory phrase "comfortable with the awkwardness" to express this familiarity. Clare expresses a long-held belief in the importance of the social work profession being rooted within a local authority.

While Clare is not sure if being comfortable with the awkwardness "is a good thing", Oliver (2013b, p. 774) argues that social workers' values and skills makes them well-placed to work across organisations in interprofessional settings as "boundary spanners". Working across these boundaries is a feature of social workers' practice in integrated mental health settings (Tucker and Webber 2020), and Clare appears to be confident in negotiating this: she uses her own biography to question whether her attachment to being employed by a local authority is now, in some way, out of step with contemporary practice. While Darren was concerned that any association or link with the trust was a threat to his "pure" local authority social work identity, Clare appears to have risked diluting or mixing her professional identity over several years. Both social workers appear to consider their professional identity and position in a way that accords with Power's (2008) notion of the professional imagination. They are then, able to be imaginative about both their own role and identity, and about the experiences of the service users they work with.

This section has considered the experience of participants who were employed as local authority social workers. Most participants valued the strong identification they felt with their local authority employer; it appeared to facilitate a confident sense of professional social work identity and enabled them to express a sociological perspective about service users' situations. Social workers valued being employed by their local authority even though, for some, their day-to-day work was undertaken within the trust. This dual association appeared to create tensions for some participants. The following section explores a subset of this participant group: the local authority employed Approved Mental Health Professionals (AMHPs).

4.4.2 Social workers employed by a local authority undertaking the AMHP role

The AMHP role remains rooted in local authority social work and eight of the study's participants were AMHPs, working in a variety of different teams. The role is intended to act as a counterbalance to the power and medical perspective of psychiatry (Stone et al. 2020). Section 13 of the Mental Health Act requires AMHPs to consider "relevant circumstances" (Mental Health Act 1983) and the Mental Health Act Code of Practice states that AMHPs should bring a "social perspective to bear on their decision" (Department of Health 2015, p. 122). A social perspective,

that considers aspects of a person's situation beyond a medical interpretation will include elements of the social determinants of mental health and, most likely, requires an AMHP to engage their sociological imagination to understand a person's situation. As Darren, reflecting on working as an AMHP, notes:

> [Working for a local authority] sort of keeps up my social perspective, I guess, like, I'm purely from that and I'm still that. And just coming over from the trust in general and coming into an AMHP role specifically where people are like 'And who are you?' [laughs] Because we don't know you, you're not part of the trust, where have you come from!

The phrase "keeps up" suggests that having a social perspective is something that needs to be maintained and supported, otherwise it is diluted or lost. Social work's strength as a profession, and the ability of its members to express a social perspective, appears linked to the context in which it operates. The local authority context appears facilitative and supportive to mental health social workers, as it does for adult care social workers in hospital settings (Burrows 2020). Fish (2022) has argued that an AMHP's ability to apply a social perspective is sometimes lost or muted by wider structural and systemic factors. In the context of multi-disciplinary working, Darren uses his employment as a local authority social worker as a means of challenging the wider systemic factors that could impact on his ability to maintain a social perspective. Karban et al. (2021) noted AMHPs have differing understandings of the term social perspective but that there is often an underlying creative effort to ensure a social perspective is represented in their work. The benefit of organisational distance for the AMHP role was also apparent in conversations with Louis:

> I think it's actually still important being plugged into the local authority and not kind of completely subsumed into the trust. There is still very much a sense of encouraging and validating choice, which, it's not that it's not there at all [in health], but there's more of an emphasis on it with social work. You know, [in health] it seems to me that there's more of a sense of, we need to take charge of this whereas with social care, it's more like we need to try and

> either work with what you wanna do or facilitate your choices a bit more, or tolerate your choices a bit more. I think it's more like that.

Louis uses the phrase “plugged into” to denote a connection with the local authority that enables him to promote what he sees as the primarily social work values of choice and autonomy; historically an important aspect of the ASW/AMHP role (Gregor 2010). Social work has features associated with the organisation of labour through the structure of professions, e.g. discretion and autonomy, and in the context of the local authority, Louis appears able to challenge a health based/medical approach. Participants’ accounts suggested social work is also partially reliant on the bureaucracy of the local authority to create or permit the conditions for social workers to feel confident to express those professional features in their role and identity. Through organisational distance from the trust, Louis feels he can retain and assert his social work perspective and values in relation to service user choice. Louis concludes: “There is still something about being a social worker working in a mental health trust, which is, it's not quite… it's not quite a comfortable fit. It’s like you can't quite get comfortable in your seat, so to speak”.

This section has explored the experience of local authority employed social work AMHPs. The importance of maintaining a degree of organisational distance and separation from the trust is evident from participants’ accounts and accords with the original intention of the AMHP role to provide a counterbalance to the medical perspective. In terms of Freidson’s professional logic, while the AMHP role is defined by the law and its associated bureaucracy, it also requires independent individual decision making by the professional (Leah 2019).

4.4.3 Social workers employed by the trust

All participants employed by the trust were contracted by virtue of being qualified and registered social workers. Some participants were employed by the trust as social workers i.e., to roles/posts titled social worker. For example, Peter who worked in a primary liaison team. Other participants were employed, not to be social workers, but to occupy one of a variety of differently titled mental health practitioner posts; this experience is discussed separately in the next subsection.

This subsection focuses on the experience of being employed by the trust in either role.

Participants, especially those who had been transferred to the trust from their employing local authority via the TUPE process, sometimes felt ambivalent about their latest employer. Jane, a manager of an early intervention team, notes:

> I worked for decades in the local authority and kind of resisted the whole going to work in the NHS thing, not quite sure why, I'd have to analyse why, but then eventually I got TUPED over in my previous post to the trust. And it just didn't really sit comfortably with me at the time, I suppose I've just got used to it now, but I do sort of feel it would be nicer to work for the local authority and I enjoyed my years with the local authority. I do think, is there a difference? I mean we're all working to make the lives of service users and their families better. Is there a difference?

Like Louis, Darren and Clare, Jane implicitly expresses her loyalty to working for a local authority. Jane resisted leaving local authority employment but struggles to articulate why and questions if there is a difference between the two employers. This equivocal and ambivalent attitude towards working for the NHS was a theme running through my conversations with participants. Applying Freidson's professional logic (2021), this suggests social work, in mental health care, is quite weak in terms of any claim to be an autonomous profession i.e. the TUPE process – a bureaucratic exercise – was overpowering; social workers did not fully resist becoming employed by the trust. Social work activity in other fields is also frequently reorganised through neoliberal political and organisational change (Jones 2015). If the local authority is key to enabling practitioners to feel confident in their professional identity, and to express a sociological perspective, then this reluctant migration is significant. Alternatively, Ralph a social worker with seven years' experience, now working in an early intervention team, spoke about who he worked for, and questioned whether it made a great deal of difference at all:

> It's funny, I mean, in some ways, it doesn't matter at all, and in some ways, it does. I think in an integrated team, we sort of roughly do the same job

> anyway. So, the social workers in the recovery team care coordinate, and the health roles, the nursing staff can act as sort of care managers under the care act and for the local authority role. So, in a sense, we all do the same job. In other ways it, it can be quite different.

Ralph appears less concerned than Jane about who his employer is and suggests that the roles undertaken by staff of different disciplines are largely interchangeable. This suggests it is the logic of the bureaucracy/organisation that defines roles in the MDT, not professional identity. Ralph's speech "we roughly do the same job anyway" points to professional roles becoming homogenised, possibly because the trust is less permissive of some professions' differing perspectives, knowledge and skills. Some participants discussed the challenges they experienced working for the trust, such as the professional isolation of being the only social worker in a team. Rachel, employed by the trust and working within primary health care[5], notes:

> I think one of the challenges is, I'm not sitting with my colleagues, we all work in different GP surgeries. So, although we have sort of regular Microsoft Teams meetings, I'm very much on my own in the GP surgery, and I'm the only social worker here as well. So it feels very medical model, it feels very primary health care. So even though I sit between the two, I don't really get a lot of the [trust] input either.

Rachel is highlighting her physical and professional isolation from social work colleagues employed by the trust, working in other GP practices. While Rachel may have professional autonomy in this work setting, she finds asserting and maintaining her professional identity challenging as she tries not to succumb to the logic of the (trust) bureaucracy or be dominated by another, stronger, profession such as nursing. Rachel does not appear to feel wholly part of either the primary care team or the trust. Some participants, although employed directly by the trust, felt very

[5] In 2019 primary care networks were able to expand certain professional roles and claim back the cost. See https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-additional-roles-reimbursement-scheme-guidance/

frustrated by the experience. Felicity, a social worker with six years' experience, and now an assessor in an assessment and recovery team, recounts:

> I'm just quite surprised and it annoys me because all the way through the pandemic it was NHS this, NHS that, NHS heroes. And I took the mick. When I left my [local authority] social work team, I was like "Hey, I'm a hero now" but it is a load of bull because I've never worked so hard as I did on that frontline social work job and there's just so much poor organisation here, in the NHS. I'm just quite astounded. I definitely feel like [the trust] doesn't know what to do with social workers. I don't think they utilise us fully. And I think I'm expected to understand an awful lot of medical stuff. And nobody's explained any of that to me. I've not been given any training on that.

Felicity's experience suggests that in moving from the local authority to the trust that she was in some way duped. While the Covid-19 pandemic hero inspired narrative is problematic (Garcia and Qureshi 2022), Felicity contrasts this portrayal of health service staff with how hard she worked in local authority social work and, by inference, the negative media portrayal of her profession (Leedham 2022). Felicity, like Rachel, is describing how on the one hand her knowledge and skills are not understood or used by her team, while on the other she is expected to have medical knowledge outside of her training and experience. The sociological perspective, or imagination, that Darren and Louis express as local authority employed and located social workers, appears quashed or dampened in Felicity and Rachel's accounts. Felicity is quite confident in her professional identity and skills, but the trust context and structures appear to push back and diminish her professional autonomy. Felicity's strength of feeling perhaps reflects her frustration at this predicament.

Other participants reported positive experiences of being employed by the trust. They frequently discussed good access to training, spending time helping service users directly, and being able to work with skilled colleagues. For example, Jenny, a specialist recovery practitioner:

> I feel like the NHS is really invested in keeping us long term, and growing us, and supporting us and so I'm really appreciative of that. Also, because my preference and interest is more around mental health and therapeutic work, there are a lot of opportunities for social workers to develop that here, in a way that I don't think necessarily at the council I would be growing in, like, a different direction. I really appreciate it because I think it frees me up a little bit to grow in the ways that I'm interested in and I'm not necessarily tied to, for example, I'm not super interested in being trained to be an AMHP and I don't have to be. Like I can instead do DBT [Dialectical Behaviour Therapy] training or something like that, and it feels like there is support for growing in the ways that interest you.

Jenny welcomes the positive development opportunities at the trust and takes a broader view of the social work role than her local authority employed counterparts. Jenny does not discuss the law or statutory duties, but highlights a therapeutic role that aligns with her own professional aspirations:

> I think what I draw from most is that person and environment perspective. And so the way that I was trained is in mixed modality mental health work, so drawing on therapeutic interventions but always formulating and understanding people's difficulties and possible interventions, not just based on individual mental health but on a person's place within their family, and community and, the greater societal structures. I think that, to me, that's what sets a social worker apart from those other professions is that it's still therapeutic, clinical mental health work, but it's systems focused.

Jenny, influenced by systems theory, is demonstrating a clear understanding of the importance of a social perspective. Mills' emphasis on thinking about the importance of biography, private troubles and public issues can also be discerned in her speech. Jenny qualified as a social worker outside of the UK and talked about her systemic and therapeutic orientation to practice. Working for the trust, her role appears less bureaucratic and less shaped by legal or statutory tasks and so gives her space to practice in a creative and socially orientated way.

This section has considered the experiences of social workers employed by the trust. Some participants like Jenny reported positive experiences where they could practise social work in a way that was congruent with their aspirations and professional identity. Other participants, like Rachel and Felicity appeared to have found the experience quite abrasive and challenging to their professional knowledge and autonomy. These experiences may have impacted on social workers' motivation and capacity to address the social determinants of mental health and the mental health inequalities that service users experienced. This is discussed further in subsequent chapters. The following section considers the experience of participants employed in the role of mental health practitioner.

4.4.4 Social workers employed by the trust as generic mental health practitioners

Some participants were employed by the trust in mental health practitioner posts: roles that could have been undertaken by other professionals, such as nurses or occupational therapists. Some of those participants continued to describe themselves as social workers, for example, Caroline who worked in an Early Intervention team. Other participants did not use the title social worker, for example Nancy whose job title was Specialist Perinatal Mental Health Practitioner, and Paul whose job title was Specialist Recovery Practitioner. This decision could be viewed as participants rejecting their previous professional identity and embracing an alternative more closely aligned with the expectations of their trust defined roles. It might also be indicative of the limited value and currency that being a social worker had for some participants.

Participants' employment in mental health practitioner roles illustrates the changing nature of mental health services over the past twenty years. A series of policy initiatives including *The National Service Framework for Mental Health* (Department of Health 1999) and *New Horizons: Towards a Shared Vision for Health* (Department of Health 2009), promoted the development of specialist multi-disciplinary teams. *The Ten Essential Shared Capabilities* (Department of Health 2004) policy introduced a framework for the creation of generic mental health posts. It identified common capabilities across professional groups including challenging inequality – which noted the presence of social inequality and social exclusion for service users – and

promoting recovery. The momentum towards organisational integration led, at a service and team level, to the development of multi-disciplinary teams increasingly staffed by generic mental health practitioners. Some participants in mental health practitioner posts, like Jenny, really valued the opportunities afforded to her by her specialist recovery practitioner role:

> I think about the ways that there is a lot that I can do to make my care affirming, and safe and to help connect people to community resources that are incredibly helpful and help people, you know, deal with things like isolation.

Jenny's experience is positive, and it is reasonable to assume that in making those connections for service users she is engaging a social perspective to understand mental health in its broader context (see Chapter 6). In contrast, other participants found working in generic posts frustrating and isolating:

> Rachel: My manager isn't a social worker, but a mental health nurse by background, so I don't get a lot of social work supervision or contact… It doesn't always feel like I'm supported in my role as a social worker, I'm just a mental health practitioner. And I hate that. I hate being called a generic mental health practitioner, because I've done all this training, I'm proud of being a social worker, and I don't always feel like I have the opportunity to use those social work skills.

During the interview Rachel described herself as a mental health social worker and clearly identifies the absence of profession-based supervision or support as a source of frustration. This experience was also identified by Morriss (2017) who discussed how social workers accomplish their social work identity through the supervisory process, and that the absence of a social work supervisor meant this could not be fully achieved. The medicalisation of mental health services (Yip 2004) and the dominance of the biomedical paradigm (Ashcroft and Van Katwyk 2016) in health settings, shows itself. In this study, Rachel's anger at being called a "generic mental health practitioner" appears to relate to a feeling that her social work professional knowledge and skills are not recognised or used in her role. In

discussing her social work knowledge and skills, Rachel goes on to describe what skills she can offer:

> As social workers, we develop a lot of different skills, whether it's like bits of CBT [Cognitive Behaviour Therapy] interventions, or budget planning, or advocacy, or whatever it is, and we have a lot of flexibility to help people and we do that, regardless of Tory government stripping all our funding, we really strive to help people. And I always think about, how much help could we actually do if we had appropriate funding and resources and if we had services that were still available. But yeah, I think we always just try and do our best to, with what we're given.

Rachel's description of her social work skills is quite limited but her commitment to service users is evident, presented through articulating the value of supporting people through their difficulties (personal troubles) despite the difficult political and economic context (public issues, historical time period). The autonomy that Freidson (2021) suggests is the hallmark of how a strong profession organises its work, is largely absent from Rachel's current experience of professional practice. For Rachel, issues of identity and autonomy appear most pressing, rather than a discussion of the social perspective she can bring to her work. Rachel appears constrained by her organisational context and role.

Ralph also describes the complications of generic mental health practitioner roles, such as his care co-ordinator role, and how colleagues from different professional groups often undertake common tasks:

> So, we're arguing at the moment to try and get a [local authority area] council funded post on the team, so we can get some proper social workers, basically, who still remember how to do all the social care stuff. But yes, it's just a kind of complicated thing about integration really. It confuses everyone.

In terms of professional identity, Ralph uses the phrase "proper social workers" to refer to those working in local authorities who have knowledge and skills related to

statutory functions, such as Care Act 2014 assessments: “all the social care stuff”. Although Ralph is a registered social worker, his employment by the trust, his job in early intervention and his location in a trust team, appears to create a distance between his role and focus, and that of local authority colleagues and statutory duties. Ralph, who questioned whether working for the trust “makes any difference at all” seems disconnected from his professional identity.

This section has considered the experience of participants employed by the trust in generic mental health practitioner roles. Their professional identity appeared less stable or consistent than their counterparts employed by the local authority. Some participants found the experience of working as generic practitioners productive and enabling, their social work practice positively impacted by their employment and role. Those participants found a way to assimilate within the trust, as generic practitioners, without feeling that they had compromised their professional identity or values. For other participants their social work identity was compromised by undertaking a role, in an organisation, that did not appear to acknowledge or welcome their professional knowledge or skills. The decision by some participants to no longer refer to themselves as social workers can be viewed as a partial rejection of their professional identity but that does not necessarily mean a rejection of a sociologically informed practice perspective.

4.5 Summary

Freidson (2021) suggested that the strength and confidence of a profession could be assessed through consideration of the extent to which it has control over the nature of the work its professionals undertake. This chapter has introduced the different contexts in which participants worked and considered their experiences. The extent to which participants appeared to have autonomy over their work, and had a clear social work identity, varied. The organisational context in which the participants were employed appeared to have had an important influence on their perception of their role as a social worker and of the potential for them to practise in a way congruent with their training and expectations. In terms of the sociological imagination, pausing for a moment to use the concept to understand participants’ practice context, this can be viewed as occurring at a particular point in the history

of the development of mental health services, grappling with contemporary public issues. Mental health social workers' professional identity and context appears substantially defined by wider organisational (bureaucratic) structures and government policy and intentions. Each participant's experience is told through the prism of their own professional biography, and the private troubles that may be impacting on their work.

For some participants who were employed by a local authority, like Clare and Louis, that association helped them to identify, assert and retain their professional social work identity. That identity included valuing the rights and views of service users, and the statutory aspects of social work practice. Others, like Darren, felt strongly that as a local authority social worker he was able to retain independence and bring forward a strong sociological/social perspective to his practice. This was the case for practitioners working in a dedicated AMHP service and those working in other mental health teams, often located within the trust.

The distinction between working for a local authority and the trust also prompted discussion about ideas of purity and dilution. An aspect of professional strength or identity is that a profession can assert its knowledge base and role. Social workers working for the local authority – both in a standalone AMHP team and in integrated trust teams – appeared to have a stronger sense of belonging to their profession and being able to exercise their knowledge, skills and values. In terms of Freidson's (2001) logic of the profession, if local authority social workers felt confident and purposeful in their role, this appeared – somewhat ironically - to partly derive from them being located within one of society's key bureaucracies i.e., local government.

Participants' employment and management by the trust provoked a greater spectrum of opinion about the fit of being a professional social worker within mental health services. Some, like Jane, had been TUPED from local authorities and expressed feelings of ambivalence and loss at having moved employers. Some participants, like Felicity, disliked working for the trust intensely – seeing it as disorganised and devaluing her social work skills. Others, like Jenny, found the trust to be a supportive and flexible employer whose aims aligned with their own career

aspirations and a broader, therapeutic interpretation of social work. Participants who viewed their role as more therapeutic, and so aligned with a medical or psychological perspective, appeared more content in their roles in the trust. The differences in fit perhaps reflecting the diversity of participants' views about the role of mental health social work and the knowledge and skills needed to support service users.

Trust employed social workers often occupied generic mental health practitioner posts that could have equally been undertaken by colleagues from nursing or occupational therapy. This experience can be characterised as a dilution of the 'pure' social worker role, with participants mixing their own professional knowledge and status with that of different professional groups. While it was participants' professional social work qualification and registration that secured their employment, this did not guarantee a positive experience in post.

Some participants, like Rachel and Felicity, felt isolated from their social work colleagues, and found it hard to assert their professional social work identity in the context of a medical and health-oriented environment. Participants conveyed a sense of loss of professional identity, a lack of recognition of their sociologically informed perspectives, and a lack of autonomy over their work. For those who thrived working for the trust in generic posts, like Ralph and Jenny, it appears it was their role (often working in early intervention or recovery teams) and their team colleagues, that energised them. Their roles appeared to be defined less by statutory or legal knowledge and more by interpersonal and therapeutic aspects.

This chapter has explored the roles undertaken by social workers in mental health services, describing and analysing the variety of contexts and locations in which they were employed, and the impact of this on social work identity and autonomy. Local authority employed social workers appear to have a strong professional identity rooted in the values of their profession and employing organisation. The professional identity of social workers employed by the trust, in a variety of roles, appeared to be more complex and less consistent. The next chapter explores the knowledge and perspectives social workers bring to those different roles and

contexts, by presenting an analysis of data collected through discussions of hypothetical vignettes.

Chapter 5 Imagination, wisdom and empathy: thinking like a social worker

5.1 Introduction

This chapter analyses the data gathered from discussions with participants about three vignette characters: Amira, Akiel, and Jack. Vignettes are short case scenarios useful for eliciting professional values, attitudes and decision-making processes (Bain 2024). The aim of using vignettes was to gather data about participants' practice, through participants "thinking aloud" (McCafferty et al. 2021, p. 2138) about their responses to the three scenarios. The vignettes – see Appendix D - were deliberately constructed to include elements of the social determinants of mental health, and of mental health inequalities. The vignettes also signalled the presence of issues that could be viewed, with reference to C. Wright Mills' (1959) concept of the sociological imagination, as private troubles or public issues, related to individuals' biographies and the times through which they were living.

The first, and overarching, theme from the analysis was *assessment through talk*. Through discussing the vignettes, participants began to assess the experiences of Amira, Akiel and Jack. Assessment is central to the social work role and this focus in practice was mirrored by participants' talk. They combined their empathy and curiosity with an appreciation of how mental health services work, their understanding of society, and what practice interventions might be possible. The analysis also identified three themes about participants' practice*: imagining experiences*, using *knowledge of mental health*, and *reflecting on practice and personal experiences.* These themes are discussed and help to understand how practitioners use a sociological imagination in their practice. The links between sociological imagination, practice wisdom and empathy are also explored.

5.2 Assessment through talk

The 'snapshot' vignettes, perhaps akin to a referral to a mental health team, appeared to prompt participants to assess the situations presented to them. The theory and practice of assessment is debated (Parker 2021) and assessment is a central aspect of practice in mental health settings (Boland et al. 2021).

Assessment in social work involves understanding a situation in a holistic way, including environmental, social and interpersonal aspects. While social workers are sometimes unsure about aspects of their role in mental health care (Smith et al. 2022b), studies indicate they are clear about the importance of bringing social perspectives to their practice (Bark et al. 2023). Participants showed curiosity, compassion, and empathy in their discussions. In doing so, they demonstrated an appreciation of the need to know more, in order to contextualise the experiences of Amira, Akiel and Jack.

The *first vignette* (Amira) focused on the character's experience of fleeing war in Syria and then encountering challenges living in the UK. The vignette reflects elements of the social determinants of mental health: female gender, a lack of social support, migration, social isolation, and limited social capital (Silva et al. 2016). In terms of the sociological imagination, private troubles linked to Amira's biography were characterised by anxiety, loneliness, loss, dislocation, trauma, and low income. The public issues linked most readily with the current point in history were the treatment of asylum seekers, the immigration system, community relations, and the Syrian civil war.

Participants, as part of their assessment through talk, identified aspects of the situation they needed to know more about:

> Jackie: What I would like to know more about is her [Amira's] confidence in the English language and whether she's able to access services through that, and whether that's actually more difficult for her because of her mental health and symptoms. What people don't see is how difficult it is to even just initially access services being an asylum seeker. She's been granted indefinite leave to remain but the path to get there is very difficult.

Jackie demonstrates the way in which participants typically began to assess the characters' experience: she is curious and empathetic. The phrase "What people don't see is how difficult it is" illustrates Jackie's empathy for Amira and is also a knowledge claim about Jackie's existing skills and understanding of similar

situations. Social workers are curious because finding out more information enables them to better understand people's circumstances, history and context.

The *second vignette*, Akiel, reflects the likely impact on his mental health of several social determinants: not living with a partner, being from a minority ethnic background, having limited family support, experiencing racism, and living on a low income (Silva et al. 2016). Private troubles linked to Akiel's biography are characterised by the presence of serious mental health issues, multiple hospital admissions, a lack of money, poor accommodation, and a limited network of family and friends. The public issues represented in the vignette include immigration, racism and discrimination, the disproportionate number of formal admissions to psychiatric hospital for people from Black and minority ethnic communities, and the nature of welfare support.

Participants were attuned to the issues presented in the second vignette, and began to show curiosity and empathy as they responded to Akiel's story:

> Jenny: I'm interested in his experience of mental health and of treatment as, I don't know, but he's possibly more likely to be criminalised than someone else is. I'm also interested in this last sentence about how the mental health team tried to engage him, but he won't see staff, he's reluctant to take medication. I'm curious about whether his views about medical and mental health professionals are based on his experiences and maybe family or community experiences. So, is there a reason why he's reluctant to engage or trust the people that are trying to engage him? Are they offering something that he wants? What are his concerns around medication?

Jenny refers to Akiel being "more likely to be criminalised", probably a reference to research that evidences people from Black and other minority ethnic groups are more likely to enter mental health services via a criminal justice route (Ghali 2013). Jenny identifies the intersection of the Akiel's private troubles with the wider public issue of the experiences of racism and discrimination that Black people and people from other minority groups experience within society (Bécares et al. 2024). Jenny demonstrates her professional expertise through rhetorically stating that she knows

that further information is required to inform an assessment, and that she knows the likely types of information needed.

The intersectionality of the vignette characters' identity with other factors in their situations was discussed by participants. For example, with reference to Akiel, Clare highlights the link between the internal world of a person experiencing psychosis – what it might be like and how it might influence behaviour – with the hostility of the external world:

> It sounds like connections in the local area are hostile rather than supportive, and then feeling… well, some people could just feel under constant threat. So, it's almost like you've got an internalised threat with the psychosis, and then you've got an actual physical threat, so no wonder you're feeling threatened all of the time, because that's your experience of feeling threatened. Being verbally abused, feeling like people are watching you, well possibly people are watching you. That's not necessarily psychosis.

Talking in the second person, Clare places herself in Akiel's situation and acknowledges the multiple pressures he faces by using the phrase "so no wonder you're feeling threatened". Clare's approach is to try to identify the social aspects of Akiel's situation and detach them from any biopsychological factors. Therefore, Clare concludes, Akiel's behaviour might not only be the result of psychosis if the community around him is hostile: the experience of people who have psychosis and mania can be complex and disturbing (Clare 2022).

Another participant, Rachel, discusses the intersection of Akiel's ethnicity, psychosis, and the impact of racism within his community:

> I would definitely say the other factors are a big part of this, you know, there's the verbal racist abuse that he's experiencing, he worries that people are watching him, which could generally be a part of that racism if he's living in an area that's predominantly white, or if he's living in an area that unfortunately is very racist, people will be watching you. And that's such a big part of it, because it's going to be amplifying any worries that he's

> experiencing about that, and about his safety, and then adding to that paranoia and to the psychosis as well, and you know, there's been loads of studies that say that stigma from mental health contributes, but also that racism plays a massive part in it too.

Rachel – as other social workers have discussed - brings the impact of Akiel's difficulties back to his identity and security as a person. The interaction between Akiel's illness – his psychosis, paranoia, anxiety – and the racism and hostility he experiences is made clear.

Participants discussed the *third vignette,* which is about a young man – Jack – who is experiencing mental health difficulties, but whose social and environmental situation would be conducive to good mental health. This vignette is a counterpoint to the first two: it does not include any specific negative social determinants of mental health. It does though have some elements linked to private troubles such as Jack's disrupted education, low mood, and self-harm/suicidal thoughts. Public issues are represented through drug misuse (Holland et al. 2023) and the issue of high male suicide rates in the UK (Ward et al. 2024). Typically, participants responded to this vignette by talking about what factors were *not* in the scenario that might well be relevant to their assessment:

> Louis: Quite often we'll have referrals like this to work with people, and you think, well, kind of where's the issue. Where's the trauma? Where's the terrible incident that's undermined this guy? And you think, well, I'm not sure, there's nothing obviously here.

Louis, at first is quite dismissive in tone, but then reveals how in the absence of any obvious indication of why Jack is experiencing difficulties, draws on a range of possible explanations that might not have yet been considered:

> But that either suggests that there's something that you've not been told, or there's something he is unaware of that is unsettling to him. You know, there's got to be a bit more history here in terms of bereavements, in terms of losses, in terms of like, does he have any siblings and what's his

> relationship with his siblings? Where's the wider family? You know, are there any debt issues? Like, what is going on?

Louis's inquisitiveness, like other participants, is not uninformed or unguided curiosity, but instead a rapid and methodical listing of additional information needed to be able to assess Jack's situation. Louis, from a sociological imagination perspective, turned to Jack's biography to try and locate information that might begin to explain the reason for his difficulties. Louis's analysis starts with the individual by trying to locate a private trouble that may not yet have been revealed. Louis's professional knowledge base – informed by sociology and psychology – will have helped him to identify aspects of Jack's biography that might be relevant to his current difficulties.

This section has highlighted that participants' responses to the vignettes were, through talk, to begin to assess the situations of Amira, Akiel and Jack. Participants wanted to know more information because it would enable a better understanding of the characters' circumstances. Participants were curious about the lives of the vignette characters; they were also immediately empathetic to the impact of those experiences. Assessment is a key aspect of social work practice and the participants demonstrated this in their responses.

The analysis now turns to discuss how participants' assessments through talk, were informed by three sense-making actions: imagining experiences, employing knowledge of mental health, and reflecting on their own personal and practice experiences to understand the characters' situations.

5.3 Imagining experiences

Understanding C. Wright Mills' ambition for the sociological imagination involves appreciating the intersection and interaction of four elements: private troubles, public issues, biography and historical time period. Imagination requires a flexibility of mind to see how these elements interact and, in doing so, gain a more complete understanding of someone's situation. Participants' overarching responses to the vignettes were to try to assess the characters' situations, as a means of understanding. As a central function of social work, this assessment response is a

readily understandable professional action. The curiosity and empathy that participants demonstrated through talk also suggested that they were making sense of the vignettes by imagining the lived experiences of the characters. That imagination went beyond, for example, simply "thinking what it would be like to lose your home", to empathising at a much deeper level about the impact of a given experience. Participants also demonstrated the use of a sociological imagination by appreciating the impact of the public, private, biographical and temporal elements of the characters' experiences. The activation of the sociological imagination appears linked to the ability to empathise.

Empathy is an important aspect of social work education and practice (Eriksson and Englander 2017) but lacks a common definition or understanding for the process of its feeling or demonstration (Gerdes 2011). Often referred to as walking a mile in another person's shoes (Gair 2011), Segal et al. (2012, p. 541) propose empathy is the ability to "understand people from different socio-economic classes and racial/ethnic backgrounds within the context of institutionalised inequalities and disparities". This definition fits well with this study's focus and points towards empathy being a necessary quality for an active sociological imagination. Different writers view empathy as a process of cognitive simulation, perspective taking, or a direct emotional response resulting from social perception of others' situations (Eriksson and Englander 2017). The extensive literature about the resilience of social work practitioners (Collins 2007; Frost et al. 2017) notes the importance of empathy and emotional literacy for practitioners who work in stressful situations (Grant and Kinman 2014). It is important that workers can express appropriate empathy: that they can be deeply moved by the events they encounter but are not overwhelmed by them (Collins 2017).

An illustration of participants' use of their sociological imagination and empathy is how they spoke about the impact of trauma. Trauma informed approaches in mental health care have gained prominence in professional practice (Sweeney and Taggart 2018). Amira's experience of the Syrian civil war, was identified by many participants as an 'obvious' traumatic experience:

> Jackie: So, I would say that's [Amira's difficulties] due to her experiences in Syria, being exposed to trauma through civil war, … exploring what she's experienced during that time but also being removed from her home, her community, her livelihood.

Jackie empathises with the way many people will have been affected by the war but then focuses on Amira: a direct line is made between the public issue and the individual experience that forms part of a private trouble. Darren, in contrast to Jackie's rhetorical listing of the elements of trauma, discusses the impact of trauma in terms of unfairness:

> Typically, with things related to trauma, quite often I think you haven't, you know, you're certainly not the cause of the difficulties you're facing. But at the same time, you're sort of the only person who can really deal with them. It's almost like the ball is in your court quite unfairly.

Darren removes Amira from having responsibility for the impact of the traumatic events but then empathises with the unfairness of her (perhaps) being the only person who can really resolve those impacts:

> In this case, it's hard to see how she could possibly deal with the ball being in her court when she is so isolated. You know, let's say she was engaged in some sort of therapy… therapy to sort of get back to a life but then there's… she doesn't seem to have a life to get back to.

Darren highlights the negative impact of social isolation on Amira's mental health and on her motivation to try to recover. Past trauma is identified as the cause of Amira's difficulties, but the impact of that trauma is mediated through current factors and events. Many of the participants appeared to understand the vignette characters' (mental health) difficulties as a response to the ongoing impact of past traumatic events combined with current difficulties of living. Participants therefore make a link between the impact of past private troubles (and other elements of biography) and current private troubles and public issues on people's recovery from mental health difficulties.

Trauma in Akiel's situation is not identified as a single event but through repeated intersecting experiences during his life:

> Jane: So, I mean I'm making an assumption, but most people like Akiel that I would meet have probably experienced horrible, horrendous racist abuse as a child, maybe not, but there's a lot of people who have. I just continue, even now, after all these years, I continue to be horribly shocked by the things that people tell me about what they've experienced at school and in the community. So, you know, that's trauma, and it's alienating and isolating.

Jane, a white social worker, uses her imagination to empathise with the impact of the trauma Akiel might have experienced. Jane uses the phrase "after all these years" to emphasise the emotion of shock she still feels despite a long career in social work and so legitimises her knowledge claim. Jane then identifies the impact of racism as "alienating and isolating", accessing non-medical explanations of Akiel's difficulties. Jane appears to be using her sociological imagination to connect with, and better understand, Akiel's situation. In social work practice, this way of thinking might enable her to engage and work effectively with service users.

In imagining the experiences of Akiel, and the other vignette characters, participants at times spoke in the first person, as if to emphasise their identification and understanding of their predicaments:

> Clare: It's problematic because if you're saying people are watching you, that's not necessarily psychosis, people probably are. If you're being subjected to verbal abuse then people are going to be potentially in an agitated state and feeling like they need to protect themselves, and then it's hard to engage with other people, to trust people. You've got a doctor or a nurse knocking on your door asking you to take medication when potentially you're saying well, I actually feel like I'm being watched and I'm not having a very good time, and you're asking me to take medication?

At first Clare uses the second person to discuss Akiel's situation but then moves to further warrant her explanation by adopting the position of Akiel and talking in the first person. By doing so Clare is actively imagining the emotion being felt and asserting why Akiel's behaviour and responses might be understandable. The implication being that professionals might need to reassess their interpretation of the situation and try to engage with Akiel in a different way. Clare's interpretation of the vignette points to her appreciation of the wider context that impacts on service users and the importance of factoring in this knowledge into practice assessments and interventions.

The final vignette, Jack, presents a scenario without any significant obvious trauma, but this lack of apparent difficulties, leads participants to hypothesise (to imagine) whether there is a traumatic event in Jack's history that has not yet been identified:

> Jane: Well, I suppose it's like anyone, you do an assessment and there may be stuff there that he hasn't said to his GP. You know maybe no one's actually said to him, "Has anyone ever, you know, abused you?" Maybe he has got a massive trauma in his past that he's never told anyone. Maybe his mum and dad argue all the time, maybe his mum drinks alcohol? There's always stuff, isn't there, in people's pasts? There's often a trauma of some kind, but not always.

Jane notes the frequency with which trauma is encountered in working in mental health services: "it's like anyone". She outlines her view that people do not always disclose information to their GP and so is stating a claim to specialist skills and knowledge to find out information. It is a private trouble, as an aspect of Jack's biography that Jane is trying to uncover/imagine, with the knowledge that she already has about public issues affecting people of Jack's generation and situation in society.

This section has discussed how participants informed their own assessment of the vignette characters' circumstances by imagining what elements of their experience might be like, but also taking that understanding and combining it with an analytic perspective that appreciates the interaction of personal troubles, public issues,

biography and the period in which the scenarios are located. Participants demonstrated empathy in their understanding of the characters' difficulties, and these are sometimes discussed in the first person and often presented as a combination of past trauma, combined with current difficulties in living. To have an active sociological imagination, therefore, appears to require both the ability to link individual events with wider issues, and the presence of affect: an emotional identification with service users. In the discussion of hypothetical vignettes, the sociological imagination is guided or informed by emotion. The analysis now turns to discuss how participants used their knowledge of mental health inequalities and mental health care to inform their overarching assessment talk.

5.4 Knowledge of mental health

As well as using their imagination to be curious and have empathy for the vignette characters, participants also made sense of the vignettes through using their knowledge about the social determinants of mental health, mental health inequalities, and the recovery approach in mental health care. The literature makes explicit the interconnected nature of social, political and environmental factors that positively and negatively contribute to people's mental health (Stansfield and Bell 2019). Participants recognised the importance of the *interconnectedness* of the factors that impact on Amira, Akiel and Jack's situations:

> Clare: That she's a woman and living on her own, that she's Muslim, and those three things for her, from what she's describing is that where she's living, that potentially is a challenge for her. Her neighbours next door, she's saying that her sense is that they resent her for living next door so in terms of her connecting to people that she may feel are like her, it doesn't seem like there's any opportunities for that and therefore she's saying that she's not leaving her flat and her mood is low.

Clare clearly identifies gender, accommodation, and faith as important interconnected factors that, from a systemic perspective, influence Amira's situation. Clare continues:

> So, no wonder your mood would be low if you're living alone in a flat, not feeling connected and then you've got the overlay of PTSD. That would be difficult for anyone, let alone somebody moving here and then not having any social contact. Then she's experiencing PTSD and high levels of anxiety and other things that come with that really. She's lost family members in the civil war. So really alone and isolated, and that's the main thing that comes out for me really, and just not having any connections at all.

Clare then uses the phrases "no wonder" and "let alone" to imagine the Amira's emotional state and to emphasise that those factors would be sufficient to contribute to someone's mental health difficulties before considering other factors. Clare uses her knowledge of mental health and the recovery approach to pinpoint elements of Amira's identity and biography – a woman, a Muslim – that create a challenge for her in the wider context of living her life at this point in history affected by substantial public issues. For example, media reporting and public attitudes towards asylum seekers (Griffiths 2022). Clare's speech again conveys the empathy expressed by other participants, and her concluding comment emphasises the loneliness that she imagines Amira is experiencing; it is Amira's lack of social connections that are highlighted as the most pertinent factors to consider (Poole and Huxley 2023). There is thus an interconnectedness between the societal factors that contribute to people's mental health difficulties and an essential need for people to be connected to others in society. This demonstrates an understanding of Tew's (2012) approach to recovery capital. Similarly, Jenny notes several factors, and makes the connection between the experience of trauma and Amira's social isolation:

> The cause of her mental health difficulties at the moment? Okay. Well, her diagnosis of PTSD. I mean, she's a refugee, she's lived through war, and she's lost loved ones. And so I think about her experience of trauma. But then it sounds like things are also sort of exacerbated by her current social situation. So she's quite isolated. And we don't know too much about what she's doing with her days but it doesn't particularly sound like she has social or other things that occupy her time that are enjoyable or meaningful, from

> what we know. So, I guess I'd say her experience of trauma but then the precipitating factors are her social situation at the moment.

Jenny's speech shows great compassion for Amira. Jenny uses the phrase "I mean" to appeal to me, the researcher, as if to say, "it's obvious, isn't it?" but then balances this by highlighting the need to "think about her experiences of trauma" and tempers her assertions by noting "from what we know". Jenny's speech suggests that Amira's lived experiences are at the same time obviously traumatising but will also have particular and individual impacts, that a social worker might need to investigate in more depth. Jenny hints at the importance of activity and focus as ways that Amira might be able to manage her anxiety.

Jenny and Clare's responses describe an overlaying of different interconnected factors to explain Amira's situation. Clare used the phrase "overlay of PTSD", and other participants used the metaphor of layers or levels to describe how they approached understanding the different vignette scenarios. For example, talking about Amira, Felicity notes "They've just lost so much, haven't they? There're so many multiple layers of loss". Similarly, Stephanie said:

> It just sounds like *layers on layers* of difficult things that happened over a period of time that have been really traumatic. So, you've got, what she's experiencing in terms of anxiety, the flashbacks and the nightmares. She doesn't get respite even when she's sleeping because her sleep is disturbed.

And discussing Akiel's situation, Clare notes:

> I mean it's hard enough for people without a diagnosis if you haven't got those other resources and other things that you might need in an emergency or just if you're struggling. So again, it's that *layering* isn't it. The *layering* of all these different things contributing to you know, that's kind of typical of the things that we would see in our service really.

The repeated use of this phrasing by different participants suggests an appreciation of the interconnectedness of factors in trying to understand Amira's difficulties and how deeply the individual can be affected. Knowledge of this interconnectedness is

important for practitioners in how they then approach assessing and working with service users in the context of MDTs in recovery orientated services. It might constitute a particular, even unique, aspect of social workers' knowledge base.

Another aspect of the *knowledge about mental health* theme, identified in the data, was participants' knowledge of why *engagement with services* may not be straightforward for some people. Successful engagement with services and professionals is key to working with mental health service users (Katz et al. 2021) but people from Black and minority ethnic backgrounds are less likely to engage with services (Sainsbury Centre for Mental Health 2002; Memon et al. 2016; Degnan et al. 2022). Participants were aware of the contested and insecure spaces that the social work profession and mental health services occupy in some communities (Gould 2022), and of the challenges professionals face (Codjoe et al. 2019; Keating 2021). In relation to Akiel, participants were very attuned to the issues related to ethnicity, racism and mental health services:

> Ralph: He spent time in and out of psychiatric hospitals, like all of that kind of ups his risk of suicide. He's not engaging well with the local mental health team. Yeah, he's poorly engaged with the local mental health team… I wonder what he's worried will happen if he engages. Maybe he's been sectioned a couple of times, it's not going to make him like us. Do you know what I mean, it's not gonna make him want to talk to us?

Ralph's speech combines elements of familiarity with the scenario with a compassion, curiosity and empathy for Akiel's specific situation. The negative perception of mental health services and the anticipated racism contributes to social exclusion, which in turn reproduces mental health inequalities (McClean et al. 2003). Ralph acknowledges the negative impact of repeated hospital admissions and the negative effect of being detained under the Mental Health Act on future engagement with services (Blakley et al. 2022). It is well-established that people from Black and minority ethnic backgrounds are more likely to be detained under the Mental Health Act 1983 (Barnett et al. 2019) and report experiencing abuse and racism while in hospital (Chambers et al. 2014; Solanki et al. 2023). In implicitly

acknowledging this, Ralph is demonstrating that social work's knowledge base includes an understanding of the iatrogenic risks of service users engaging with services, and of the impact of the wider social (public) issues on individuals' mental distress. Jane, similarly, uses her knowledge of public services to contextualise Akiel's experiences of mental health services:

> Maybe he's avoiding services because he's had negative experiences from different sorts of public sector agencies, whatever they may be, housing or money agencies. So how do you explain it? I don't know. It's got to be something wrong with society, hasn't it?... it's about how he's alienated, he's had negative experiences, he's still getting verbal racist abuse, it's just horrendous.

Jane uses the rhetorical question – "so how do you explain it?" – to emphasise the irrationality of services ostensibly created to help people, being unapproachable and unhelpful for some. Jane hypothesises that Akiel's experience is part of a wider picture of minority groups experiencing racism, discrimination and negative outcomes from public services. Jane shares responsibility for these experiences by using the plural "we" to refer to discriminatory practices and the negative outcomes. Jane places the responsibility for engagement with services, and agreement to take medication, not solely with Akiel, but with services too:

> Often, he won't see staff. So, what's that about? So, is it because people aren't taking time to, to work with him, to engage and to work alongside him? I'm guessing he's had difficult experiences in the past when he's been detained. Reluctant to take medication. So, is he asked why? Is he getting unwanted effects from his medication? Has he been getting reviews of it or trying other ways to help his mental distress? Has he been offered therapy? Has he been offered counselling?

Jane connects with Akiel's experience and adopts a very active approach to demonstrate the good practice she thinks should take place to find out why Akiel is not engaging with services. A critique of the recovery approach is that services' standardised care does not reflect the different experiences some people or groups

may have of trying to access them (Brown 2021; McWade 2016). To this extent Jane is challenging the responsibilization of individuals' patterns of accessing and accepting help from services. The voice of service users, and the importance of their explanation, experience and expertise in mental health, is a key tenet of good social work practice (Beresford et al. 2010; Wilberforce et al. 2020). Jane alludes to the iatrogenic risks of psychopharmacological treatment (Alshaikhmubarak et al. 2023) and is aware that service users are sometimes fearful of taking medication (Morant et al. 2018; Keogh et al 2022). People from Black and minority ethnic backgrounds are more likely to be prescribed anti-psychotic medication and less likely to receive talking therapies (Das-Munshi et al. 2008).

Ralph and Jane both demonstrate a knowledge base that is beyond a purely medical explanation for Akiel's situation. Both embrace some of the nomenclature and aspects of medical psychiatric practice – risk, medication, treatment, hospitals – but are not restricted by this. Both go beyond a medical perspective to ask questions predicated on a knowledge base that suggests an understanding of the wide variety of theoretical approaches available that could provide additional or alternative explanations for Akiel's experiences and behaviour.

The third vignette (Jack) does not include any experiences that are obviously linked with racism or discrimination. Participants did discuss the advantages of Jack's white ethnicity, in terms of access to, and attitudes towards, services.

> Ralph: The flip side of that is if you already have experience of services before that, or you did well at school, so you like the teachers, or like maybe mum and dad had a private therapist or something, you're much more likely to see that as a really positive thing, and you're much more likely to seek help. It's not saying people are less deserving, like Jack sounds like he needs help. But he will probably want help more than the others would, I guess as well.

Ralph having previously noted the impact of poverty and negative attitudes towards services, talked about Jack's affluent socio-economic position. He explains how it may have shaped his attitudes and so helped engender some protective

factors for Jack's mental health. Ralph therefore demonstrates an understanding of how mental health inequalities can be reinforced by advantage as well as disadvantage.

This section has highlighted the way in which participants used their knowledge of the social determinants of mental health, mental health inequalities, and the nature of mental health care, to inform their understanding of the vignette characters' situations. Participants recognised the importance of the interconnectedness of the factors in each situation, and used specific knowledge about patterns of, and barriers to, engagement with services: for example, the experience of racism and the impact of repeated detention in hospital. Participants' responses to the three vignettes were also influenced by reflections on their own personal and professional experiences, which are analysed below.

5.5 Reflecting on practice and personal experiences

The conversations that took place with the participants demonstrated the importance of assessment through talk, with participants using their imaginations to be able to show curiosity about, and empathy for, the vignette characters. Participants' knowledge, related to aspects of mental health, was one source of knowledge that informed their discussions. Another source of knowledge was participants' use of reflections on practice and personal experiences. The use of practice experience can be related to the concept of practice wisdom. Practice wisdom is variously defined and debated, with Cheung (2017) emphasising that it is intuitive in nature, an embodied wisdom and understanding attained by experienced practitioners. For others, it is the bridge over the divide between practice and theory that has existed since the professionalisation of social work (Samson 2015). The use of practice wisdom involves critical reflection, which is central to social work practice (Fook and Gardiner 2007). Fook (2019) argues that practitioners' critical reflections can usefully be developed through their engagement with their sociological imagination. Fook suggests that practice wisdom offers a legitimate source of knowledge (in addition to formal theory) but that it is limited in its usefulness *unless* critical reflection also takes place. That reflection must address the values that are being challenged in the private troubles

and public issues being considered. That is, practitioners should engage their sociological imagination to inform their critical reflections on their practice. The analysis below discusses how participants reflected on their practice experience, and personal experiences, to inform their responses to the vignette characters' situations.

5.5.1 Practice experiences

Participants often reflected on their professional practice experience to make sense of the vignette scenarios. For example, Jenny invoked her professional role to support her knowledge claim about how mental health is best understood:

> Sort of like, is it an individual mental health problem or is it connected to her broader context? I would say the latter, but I think that's my view as a social worker, that individual mental health is almost always only understood within the broader context.

By using the phrase "my view as a social worker", Jenny is distinguishing her professional view from views that other professionals or lay people might hold. Jenny is suggesting her professional knowledge base and experience gives her some claim to a different or better understanding of Amira's situation. Geetika, who works in forensic services, makes a similar reference to her own community social work practice to demonstrate her understanding of Amira's situation:

> She's a refugee, that just, the whole change from leaving what she's grown up in and known as normal. I actually had a family who I was working with in [location] who were a Syrian family, who I put in contact with services to have support, to help this lady who had lost her husband in the war and fled with all her children, to make friends and to become more integrated into the community.

Geetika, supports her knowledge claim to understand Amira's situation by then recalling what the family experienced:

> it's similar to [location], if I can say that, that the area, it was a very white area in which she said, you know, "I don't feel comfortable, I don't feel that

> anybody around here looks like me. I go to the shopping centre…" which was Tescos… "… it doesn't have the ingredients that I'm used to cooking with, it doesn't have anything that I'm used to."

Geetika is using her social work knowledge and experience to convey the importance of people feeling connected to their communities, and in this case, to highlight the isolation that Amira feels. Participants also drew on recent statutory social work experience in their responses. John uses his AMHP practice to articulate the iatrogenic risks that service users can face, highlighting the role of the police in contributing to the negative experience Black people may have of the mental health system. John begins by talking about his professional experience to support the knowledge claim that follows:

> You know, before I was doing this, I used to work for the Youth Offending Team. So, I've worked in prisons. So, I've got a lot of experience with that as well. And I, you know, I think Black and ethnic minority people, there, there still is sort of an endemic fear and distrust they will have with, with the legal system and the with the system of detention, with the Mental Health Act as well.

John then relays some specific details of recent assessments to support his knowledge claim:

> Interestingly enough, I've been doing two Mental Health Act assessments on the same day, two Black people, both in police cells, one in [location 1], one in [location 2], and both had been, one had been tasered and one had been pepper sprayed by the police. So the risks of Black people being unwell, I think they are more at risk of a heavy-handed approach by the police.

John links his recent practice encounters with his professional knowledge, and so uses practice wisdom to highlight the connections between a variety of factors, including the risks associated with being Black and being mentally unwell, which can lead to a further risk of a heavy-handed response by services, which in turn exposes a further risk of deteriorating mental health:

> And I think that will also then increase the trauma, increase the unwellness if somebody is vulnerable, due to stressors, environmental stressors, and if they're being treated heavy-handedly by the police, there are more likely to be physical interventions that involve harming the person, spraying them or tasering them than, than if somebody were white and say, diminutive, so, you know, those risks are very much there and they very much create a situation, that will contribute to people being very unwell.

The participants in the study therefore used a range of practice experiences and knowledge to support their understanding of the experiences of Amira, Akiel and Jack. Participants appeared to be able to access their sociological imagination and how they constructed their understanding of the characters' situations can be understood in terms of practice wisdom. Participants personal experiences also influenced their use of self in responding to the vignettes and this is now discussed.

5.5.2 Personal experiences

Some participants used their own personal experiences to inform their responses to the vignettes. Personal experience is used as legitimate knowledge to inform the participants' professional role and understanding. Participants spoke less about the influence of personal experiences, than they did about professional experiences. When they did talk about the influence of personal experiences, it had the effect of adding validity and authenticity to their views. For example, Louis talking about Amira:

> I mean so personally, I grew up in Northern Ireland and, honestly, it's taken me years to realise that my experience wasn't quite normal [laughter]. You know, the being afraid. You know, not having it at the forefront of your head but just constantly being fearful that you might get killed today does make you very different. Your much more sort of hyper alert, you're much more aware of lethal risks, or you're thinking about lethal risks to yourself. So, I would imagine somebody who's grown up in a… you know, lived through the Syrian civil war is gonna be having the same sort of experience, which is,

> you’re hyper alert and you're not quite sure why you don't quite fit in with everybody else.

Louis uses his childhood experience growing up during The Troubles in Northern Ireland to provide insight into Amira’s situation. Louis has direct experience of this crucial public issue – armed conflict - and he uses laughter to help convey the gap between his own experience and a ‘normal’ childhood. Louis uses the phrase “So I would imagine” to demonstrate the transposition of his experiences to Amira’s, and to then empathise with her difficulties settling into a new country. The phrase “you’re not quite sure why you don’t quite fit in” points to unease and anxiety that he experienced and which Amira is experiencing now. As Mills noted, public issues – like conflict – “cannot very well be defined in terms of the everyday environments of ordinary people” (Mills 1959, p. 15).

Another participant, Alice, empathises with Amira through invoking her own experience of having been an asylum seeker:

> Obviously, she applied for asylum, because she escaped from the war, so there will definitely be a lot of trauma from that. So, for me, in this scenario, I come from a similar kind of situation. I come from a country that is unsettled, politically unsettled. And I've come here, the same way. I applied for asylum. When I first got here, and I was obviously alone, on my own, isolated, not knowing anything around yourself, and I was pregnant at the time, which didn't really help.

Alice describes some of the risks apparent in her situation and then discloses she was pregnant when she arrived in the UK, and so raises the researcher’s appreciation of the risks she faced. Alice appears very certain why Amira might feel so socially isolated and find it difficult to make connections:

> Yeah, you've got that feeling of not belonging, first of all, not belonging somewhere. When you come in somewhere, you feel that judgement, you feel that rejection, you don't feel you belong, you are anxious to go out, because you don't know how you're going to be perceived. When I was first

> here, pregnant on my own, I would go out and get eggs thrown at me. You know? Oh, yeah. So, you don't want to be, on top of everything you're experiencing in terms of your PTSD, you don't want to aggravate that by putting yourself out there. There is that lack of confidence that is really driving your life. So, you want to just stay somewhere you're safe, which is in the comfort of your home, and know you're safe, not out there to be hurt even more.

Alice describes her feelings and gives an example of harassment to validate her account of how she felt and how Amira might be feeling. Alice has lived experience of significant public issues – hostile immigration policies, treatment of asylum seekers, war - and through her speech articulates her sociological imagination to describe the intersection of recent world history, her own biography, the impact of public issues on her. By talking in the second person, Alice asserts her understanding and rationalisation of Amira's social isolation. Alice is almost giving retrospective permission to Amira to not go out and encounter the risks inherent in the community.

Participants, then, used reflections on both their professional practice experience and their personal experiences to help them understand some aspects of Amira, Akiel and Jack's situations. These reflections appear to enable them to access a sociological imagination to understand and offer explanations for the vignette characters' experiences. This finding accords with the outcomes of Edmiston's (2017) research, highlighted in Chapter 2. Participants appear to use empathy, practice wisdom and critical reflection to make sense of the vignette scenarios and to inform their responses.

5.6 Conclusion

This chapter has reviewed social workers' accounts of three vignettes. Using vignettes gives "an insight into the social components of the participant's interpretative framework and perceptual processes" (Jenkins et al. 2010 p. 178). Participants' responses related to many elements of the social determinants of mental health and the public issues and private troubles suggested by C. Wright

Mills (1959). The concepts of empathy and practice wisdom were also evident in the data. Using vignettes worked well: amongst participants, there were some similar responses to the scenarios and some that were particularly striking. Responding to the vignettes, in the context of a research interview is a performative exercise. Some participants seemed to view the vignette as a test of their skills and were keen to demonstrate their professional knowledge through idealised answers. One participant, Sarah, commented: "It feels like a job interview and I'm like, oh no, I should have done a bit of research!". Listening to participants responding to the unseen vignettes, it was apparent they were "thinking aloud" (McCafferty et al. 2021, p. 2138) in talking through their answers. Participants whose own background or circumstance was reflected in the characters' stories often gave emotional responses full of empathy and understanding. Some very experienced social workers, while recognising the familiar elements of the stories, demonstrated their continuing ability to emotionally connect with each character as an individual with a unique life experience.

The first, and overarching, theme identified from the data was *assessment through talk.* The participants were all practising social workers and so it was not surprising that their responses were often akin in style and content to an assessment they might make at work. The participants' inquisitiveness about the lives and experiences of the characters suggested that a curiosity and imagination is employed to try to understand other peoples' experiences. Perhaps freed from the constraints and pressures of day-to-day practice, participants appeared able to think imaginatively about the lives of Amira, Akiel and Jack. Participants combined how they imagined the situation with an analytic perspective that articulated the interaction of personal troubles, public issues, biography and the period in which the scenarios were located.

The second theme identified was *imagining experiences.* Participants recognised the importance of connections between people and their environments, in trying to understand the origin and course of the vignette characters' mental health experiences. The third theme identified was *knowledge of mental health*, focusing on the importance of *interconnectedness of impacting factors* and *engagement*

with services. Participants used their knowledge of the social determinants of mental health, mental health inequalities, and the recovery approach in mental health care, to inform their understanding of the vignette characters' situations. Two of the vignette characters were from Black or minority ethnic groups and participants were alert to the impact of this identity characteristic. Participants explored in detail the impact of ethnicity, culture and racism on the characters' experiences of accessing mental health services, receiving treatment and experiencing racism.

The fourth theme, *reflecting on practice and personal experiences* was evident in discussions of all three vignettes. Social work is a profession based on values and relationships. Practitioners readily used their practice experiences – often drawn from service users with comparable experiences to the vignette characters - to help make sense of the scenarios. Similarly, some participants by dint of their own identities and life events were able to explore the characters' situations through the lens of their own lives.

Throughout the analysis of the vignette data, it was evident that participants' talk combined their knowledge about mental health with the articulation of reflective and imaginative insights. Participants took the opportunity to think aloud (McCafferty et al. 2021). The expression of those thoughts was often imbued with emotion, primarily expressed through the demonstration of empathy. The exercise of the imagination was not a single or one-way cognitive exercise. Participants were not only bringing their knowledge and understanding of mental health – characterised as practice wisdom - to identify with the experiences of the vignette characters. In addition, participants were engaging in a "double hermeneutic" (Giddens 1987, p. 18) process. That is, they were combining their own understanding people and society, with their known and imagined understanding of how people – in this case fictious people – would make sense *of their* situation and place in society. This is an inherently imaginative, interpretative and speculative activity and one that participants readily engaged with.

This chapter has considered how social workers think and draw upon the sociological imagination to understand the experiences of three vignette characters, using empathy and practice wisdom to do so. Assessment through talk was an overarching analysis theme, along with recognising the way in which participants used their imaginations, knowledge and reflective skills, to respond to the vignettes. Chapter 6 moves the analysis from fictional vignettes to real life experiences. The chapter analyses participants' accounts of their work in multi-disciplinary teams to further understand how social workers can address the social determinants of mental health within recovery-based services.

Chapter 6 Identity, capital and influence: multi-disciplinary team working

6.1 Introduction

This chapter presents an analysis of the data collected through conversations with participants about their own practice experiences. C. Wright Mills wrote that a person exercising their sociological imagination will "often come to feel that they can now provide themselves with adequate summations, cohesive assessments, comprehensive orientations" (1959, p. 14). I was interested to know how participants viewed their practice, in relation to team working, to help me understand how they worked with the recovery approach and tried to address the social determinants of mental health. There were challenges in working with colleagues from other disciplines, but participants also spoke positively about their practice within multi-disciplinary teams (MDTs). Three themes were identified from the data. Firstly, capital: the challenges of MDT practice. Secondly, collaboration: the positive aspects of MDT practice; and thirdly, identity: sociological and legal knowledge in MDT practice. As well as using C. Wright Mills' (1959) concept to interpret the data I also used Bourdieu's (1977) concepts of field, habitus and capital. This enabled me to extend the analysis beyond identifying if social workers appeared to be using a sociological imagination, to consider how the impact of accessing that imagination is enabled or bounded by multi-disciplinary working. Beddoe's (2011) concept of professional capital, an extension of Bourdieu's original concept of symbolic capital, offered an additional way of understanding the strength of social workers' contributions to MDT practice.

6.2 Bourdieu: field, capital and habitus

Pierre Bourdieu is one of the most significant sociologists of modern times (Wolniak and Houston 2023), and whose work has influenced social work scholarship (Emirbayer and Williams 2005; Garrett 2018). Bourdieu's output was prodigious, varied, and often written in extended prose, sometimes making it challenging to understand. His concern with the oppressive nature of the state, bureaucracy and the misuse of power, align with social work's values and international definitions

(Garrett 2007a). Although Bourdieu's lack of engagement with, and scepticism of, the concepts of multi-culturalism and ethnicity, continue to be critiqued (Garrett 2007b) he was a sociologist, like Mills (1959), who also wrote specifically about social work. Mills thought individual social workers "tend to have an occupationally trained incapacity to rise above a series of 'cases'" (Mills 1943, p. 171), while Bourdieu thought social work (as a collective activity) would struggle to achieve any of its emancipatory aims for those it sought to help. This was because social workers were agents of the state, and "shot through with the contradictions of the state" (Bourdieu 1999, p. 184).

Bourdieu's main theoretical concepts supported a detailed analysis of participants' conversations about their interactions and relationships with other professionals in MDTs. This enabled consideration of the circumstances that appeared to support or hinder social workers expressing a strong professional identity, and using their sociological imagination. The concepts used were *habitus, field and capital. Habitus* is concerned with how people act, feel, think and be (Maton 2014). Habitus has been considered "a concept that orientates our ways of constructing objects of study, highlighting issues of significance and providing a means of thinking relationally about those issues" (Maton 2014, p. 49). Habitus was defined by Bourdieu as "a system of durable, transposable dispositions, structured structures predisposed to function as structuring structures" (Bourdieu 1977, p. 72). At first this definition appears contradictory, but it is not. Bourdieu is arguing that how people act - and feel - is determined by society, and people in turn determine the nature and character of that society. Some theorists argue that Bourdieu's habitus is too deterministic (Lane 2000) or static (Garrett 2007b) but Houston and Swords (2022) suggest habitus can change through reflection, a concept that is of course central to social work theory and practice. Consideration of the habitus of social workers, particularly in relation to their work with service users, provides insights into their practice (Garrett 2007a). In this research considering habitus supports theorising about what influences social workers' capacity to respond to the social determinants of health in MDT settings.

The *field* is Bourdieu's second key concept: it is a social space where people engage in daily actions. The field is structured by the habitus of its participants, and in turn participants' habitus may be modified by interactions in the field. The field is an analogy or scholarly device used to try to understand the observed or reported behaviours. A field is not a physical place – although Bourdieu sometimes wrote in language analogous to a battlefield (Wiegmann 2017) - but a "space of relations which is just as real as a geographical space" (Bourdieu 1991, p. 232). While the field might be imagined as a boundaried space, like a football field, it can also be considered a 'force field' where different forces push against each other (Thomson 2014). There are different types of field – such as political, cultural, educational or economic – and people compete in the field to secure their positions and relationships through the acquisition of different kinds of capital. Bourdieu conceptualised a hierarchy of fields, with the broadest being society itself through to much smaller fields, or subfields, such as family or religion. The field is not concrete entity but an object within a relational system (Emirbayer and Williams 2005). Whether social work practice itself can be conceptualised as a field has been debated, often in relation to social work's links with the state, its professional status, and social workers' relationships with service users (Wiegmann 2017). As a continuation of social work scholarship that does conceptualise social work as a field of practice (Houston 2002; Garrett 2007a; Papadopoulos and Egan 2023), this research accords with that view.

Bourdieu's third key concept is *capital,* which is a resource that supports an individual to participate in a given field. Bourdieu wrote about actors, through their habitus and appreciation of the relationships within the field, of having a "a feel for the game" (Bourdieu 1994, p. 9) and that the competitive game being played is the accumulation of different types of capital. Bourdieu (1977) first wrote about economic capital, noting its concern with self-interest and profit. He also considered it a concept that could be extended to other spheres. Bourdieu discussed cultural capital (such as academic qualifications), social capital (such as contacts or friendships) and symbolic capital: "commonly called prestige, reputation, fame etc… is the form assumed by these different kinds of capital when they are perceived and

recognised as legitimate (Bourdieu 1991, p. 230). Symbolic capital only has value when it is recognised as such by participants in the field (Noordegraaf and Schinkel 2011). Beddoe (2011), in social work research, drew on Bourdieu's (1984) concept of the distinctive space, as well as symbolic capital, to articulate the concept of *professional capital.* This form of capital, in addition to the contribution of educational qualifications and achieving the economic rewards gained from occupational closure, notes the importance of 'social distinction' within health and social care services i.e. having a distinct identity or contribution.

Bourdieu cited by Maton (2014, p. 50) suggested that practice is the result of the relationship between a person's dispositions (habitus) and their position in the field (i.e. the extent and nature of their capital), placed within the broader social arena (field). This is formulated as:

[(habitus)(capital)] + field = practice

The field, in this research, can be identified as social work practice, the relationships between actors that make up the activities of that field take place in several sites or locations. One of those locations is the multi-disciplinary mental health team. MDT practice has interested researchers over many years (Peck and Norman 1999; Boland et al. 2021), and all participants bring their habitus and symbolic capital to the field. Bourdieu's key concepts are used in this chapter to analyse the three main themes identified from the data: capital, collaboration and identity. The analysis suggests that social workers' capacity to adopt a praxis founded upon a knowledge of the social determinants of mental health, and accessing a sociological imagination, is critically influenced by the nature of relationships between professionals within the MDT.

6.3 Capital: the challenges of MDT practice

During the semi-structured interviews, participants spoke of their practice in ways that suggested they had accumulated an effective degree of symbolic and professional capital in relation to their colleagues. That capital, from a Bourdieusian perspective, afforded them a degree of symbolic power, and the impact of this is discussed in sections 6.4 and 6.5. There were though, as reflected in the literature

(Tucker and Webber 2020; Bark et al. 2023), challenges in working with colleagues whose knowledge base, values, position and power differed at times to social workers. This section discusses those challenges.

At the centre of Bourdieu's theory of practice is the concept of power; the material power derived from economic capital, and the symbolic power derived from cultural, social and symbolic capital. Symbolic capital and power only arise through recognition in the field of the legitimacy and value of actors' cultural and social capital in relation to other actors (Christensen 2023). Bourdieu (1990) wrote that habitus is "a realistic relation to what is possible, founded on and therefore limited by power" (Bourdieu 1990, p. 65). Data analysis indicates that participants did experience limited power in relation to some of their colleagues, experiencing some feelings of marginalisation, and this manifested itself in several challenges.

The first challenge was that participants sometimes experienced *a lack of recognition, or misrecognition, of the social work role* within MDT practice. Nancy, in practice for four years, typifies this experience:

> I've had to work quite hard to, not to educate, but to put the social work voice out there in the team. I think especially because I was the only one when I first joined the team and now, we've got three social workers, including me. Our manager last year, was a social worker so that was really beneficial having her as the team leader in the service, and bringing those discussions back to the social aspects in our MDT meetings. But yeah, it's not as clear, definitely not as clear cut as other disciplines. Well, perhaps comparable to the OT role maybe.

Other professionals in the field may have accumulated more cultural and symbolic capital that enabled them to have stronger voices within the team. That it was hard to "put the social work identity out there" could be a function of being in a minority position, but Nancy's view that the social work identity is "not as clear cut as other disciplines" is reflected in the literature (Vicary and Bailey 2018). Other professionals may not automatically appreciate social workers' expertise or value, and deliberate approaches to informing colleagues may be needed (Ambrose-Miller

and Ashcroft 2016). If professional identity is in part determined by access to an identified and exclusive knowledge base (Nuttman-Shwartz 2017) then the ongoing debate about social work's knowledge base and professional status (Hannan and Teater 2023) could be reflected in how confident participants felt in asserting their professional views. This was evident in the interviews. A further layer of frustration was experienced by participants undertaking generic mental health practitioner posts**.** Quite often their professional qualification and role was not acknowledged by other members of the team. Rachel, in practice for three years, and employed by the trust at a GP surgery, notes:

> They don't really know, the difference between me and the mental health nurses. So, they already had some mental health nurses here. The amount of times I get called a nurse, like every day. When I first joined my badge said mental health nurse, so I had to get that changed. The amount of times they introduced me to service users as a nurse, which is fine, but I'm not a nurse!

Rachel's use of humour to describe her experiences most likely belies the frustration she feels. The experience, of being misrecognised as a nurse, or the social work role being perceived as synonymous with the nursing role, was common amongst participants undertaking generic practitioner posts. Rachel being presented with a name badge that wrongly identifies her profession, and then being introduced – repeatedly – as a member of that profession, establishes a pattern of behaviour that could diminish her cultural and symbolic capital, and that of her profession.

Honneth (2012) theorises the human need for recognition and validation, and how this is sought in three spheres: private, legal and solidarity. The solidarity sphere includes work environments, and in this study a further aspect of the experience of misrecognition, was that participants often needed to explain to colleagues the skills and roles of a social worker. June, a social worker of 15 years' experience and now working in a recovery and assessment team, described one of the most frequent examples given of this experience: the assumption that social workers

would be involved in supervising service users' medication.

> We do get trainee GPs come in, and I might do a joint meeting, someone's reviewing their medication and they can't see people on their own. And a GP trainee will automatically think that… or I've even had it said in front of the person, "Oh June will sort out your medication", and I thought, will she?! [laughter]. It can be difficult in situations where I don't feel like my expertise is necessarily welcome in the room.

June makes light of the assumptions made about her knowledge and skills. Her humour belies feelings of marginalisation that her expertise is not "necessarily welcome in the room". The trainee GP – a person yet to fully qualify for their profession– still has sufficient symbolic and professional capital to be able to assert themselves through their habitus. The power relationships in the field are often the "result of past struggles for cultural capital" (Christensen 2023, p. 5), and this example perhaps reflects social work's long campaign for recognition (Jones 2020). The trainee's misrecognition of June's role, maybe through ignorance rather than malice, diminishes the cultural capital and symbolic capital she has to exercise in the field. The sense of skills and expertise being marginalised or obscured was echoed by Alice:

> I think, sometimes, as part of the integrated team, social workers often find, I'm talking about myself here, barriers to the best use of my skills. So as a care coordinator, for example, you will be required to undertake some generic tasks that you're not really trained to do. When I was in the recovery team, I felt out of place at times, because as a social worker you are supposed to undertake local authority or, social work tasks, but you are met with tasks like advising on medication, which I had no clue about.

Alice roots her social work practice in her local authority but discusses how working within the trust presents a barrier to using her skills. The health dominated trust environment appears to have tasks and processes more appropriate to other professions, such as nursing, and Alice's social work knowledge and skills appear not to be recognised or valued. At an organisational and team level other actors in the

field appear to have power to assert their professional capital to a greater extent. The lived experienced of feeling that there are barriers to being able to practice effectively, to feel out of place in the team in which you work, and to be asked to do tasks for which you are not trained, is demoralising (Bark et al. 2023). In the circumstances June and Alice describe, with colleagues not understanding their role or seemingly not valuing their contribution, then it will perhaps have been difficult for them to be able to exercise a sociological imagination in their practice. A further implication is that service user needs may only be partially met if other professionals, who have not benefited from the focus of social work training, undertake social work tasks poorly or not at all.

The second challenge of MDT practice was that participants sometimes found it difficult having *different professional perspectives and priorities to colleagues*. The negotiation and resolution of difference between colleagues is the operation of the power relationships within the field. Peter, qualified for 11 years and working in a primary care liaison team, notes the tension that can arise between colleagues:

> I don't know, whether it's being flexible or not, but different colleagues have different thresholds, different views, so it can be difficult. So, while the conversations are pretty robust, it still makes a difference that you can put your point of view. For example, like that chap on the PICU [Psychiatric Intensive Care Unit], and the nursing staff keep saying he's sleeping all the time. The man is a small man, and he's in his 50s, and he's on a raft of medication, so it's lucky the man ever wakes up at all. [Laughter]. And it's described as sleeping!

Peter gives legitimacy to the different professional perspectives by referencing flexibility and thresholds as possible positive behaviours or judgements that might create different views amongst colleagues. Peter is also clear that there is a need for him to assert his views and that this is worth doing. The differences in interpretation of a service user's behaviour – "sleeping" – is recounted with humour. He locates the difficulty externally to the service user i.e. the medication given by the nurses and doctors. The nurses locate the problem internally to the behaviour of the man.

Peter is an experienced social worker and felt able to challenge his colleagues, and advocacy is an established aspect of social work practice (Dalrymple and Boylan 2013). This type of encounter was often described by others in positive terms, as an action a practitioner could be proud of:

> Geetika: It was quite early on in my role actually and I'm quite proud of the fact that I was able to challenge the OTs and the nurses in the rehab ward to say, well actually I've now met this gentleman on several occasions, and we've had conversations around a specific issue about how much support he wants. And he doesn't want 24- hour care, he does not want it and you're saying you will only discharge him on that basis.

Geetika, like Peter, suggests that challenging her colleagues is a necessary part of her role to secure the best services and outcome for the service user. Here the analogy of a battlefield appears apt; the field is a battleground between colleagues with different levels of professional capital and differing habitus characteristics. That Geetika characterises her challenge as something to be proud of, suggests that she may routinely lack power and professional capital to confidently assume her views would be heard by her MDT colleagues from different professions.

Participants also discussed having different professional priorities to their colleagues. Social workers explained how they had to try to exert their professional power, derived from their cultural, symbolic and professional capital, to assert what they felt was a priority during MDT discussions. For example, Nancy, working in perinatal mental health services, highlights the tension between safeguarding responsibilities and the therapeutic relationship:

> I often think the safeguarding discussions can be quite difficult in the team if we're discussing symptoms of mental illness and the impact on the child or the unborn. That's probably the biggest one that I would say causes a divide sometimes, is discussions around safeguarding and whether to refer to children's services. And often the worry is about breaking, or losing that therapeutic relationship with the client if we need to refer to children's services.

Different actors in the field will have a different habitus in relation to the centrality of the therapeutic relationship with service users. Nancy is describing her social work priorities informed by her professional values and an awareness of statutory responsibilities: these can clash with the values held by colleagues from other disciplines. While safeguarding is everybody's business and sociologically a clear public issue (Jones 2014), the MDT conversations about when to involve safeguarding services will have reflected the relative symbolic and professional power of the different professionals involved. To be in a numerically smaller profession than your multi-disciplinary peers (NHS Benchmarking Network 2023), and to have to continue to advocate for an alternative, appropriate action, is difficult.

This section has discussed the theme of capital and the challenges of MDT practice. Bourdieu's theory of practice is essentially one of relations between different actors. Social workers negotiated differing power relations within the field, and this sometimes made collaborative work difficult. Some participants experienced misrecognition of their professional roles at an interpersonal and organisational level. An implication is that service users might have been negatively impacted and that the social workers' sociologically informed perspective of mental health may have been edged out. The tensions experienced were sometimes expressed through participants having different perspectives and priorities to their colleagues, but participants were proud to assert the importance of the social work role.

6.4 Collaboration: the positive aspects of MDT practice

While there were challenges in MDT practice, social workers were also able to discuss ways in which the experience was positive. The theme of collaboration explores positive examples of MDT practice in relation to ideas of *respecting the expertise of colleagues,* and *shared endeavour*. Beddoe (2011) suggested that professional and symbolic capital can be identified in a variety of ways, including the presence of mutually rewarding relationships with other professional groups. Participants' knowledge claims regarding sociological and legal knowledge are characterised as tentative (see Section 6.5) but practitioners were nevertheless sufficiently confident to work with their colleagues positively and cooperatively. The

challenge of MDT practice though, in Bourdieusian terms, is that actors in the field working together will also be trying to promote and claim their own professional and symbolic capital through these relations. As previously noted, the field both structures habitus and is structured by the prevailing habitus (Bourdieu 1977). The data analysis below discusses this interdependency.

Analysis revealed that participants understood that different professions use different models of mental health to inform their practice (Richter and Dixon 2023). This understanding extended to social workers *respecting the knowledge and expertise of colleagues* from health-based professions:

> Louis: Generally, there's that sense of respect within a service, and a service that gets that sense of focus on let's all help this person. You know, that can work well, just in terms of whatever it is; medication, support with getting employment, vocational support, just that psychological work. You know, like I say, working in the community mental health teams and recovery teams, it's just that sense of everybody pulling together in the same way.

Louis references a "sense of the respect" to emphasise the importance of shared values within MDT practice as a necessary quality amongst professionals if the public issues (of unemployment) and private troubles (of mental distress and access to therapy) are to be addressed. It is by evoking an image of dedicated people working together, that Louis suggests the combined efforts of team members can best help people. From a Bourdieusian perspective, Louis appears to value the contribution of his colleagues, even as they assert their symbolic and professional capital, and views this as beneficial. As an experienced social worker, he will be aware of, and have strategies to challenge, the inequities in the team power relationships (Abramson and Mizrahi 1996). Yet, according to Beddoe (2011), this positive team working could also be an example of a mature expression of professional capital through the confident and established habitus of professionals within the field.

Other participants also had the capital and confidence to invite professionals in the field to support their practice. Jackie highlights this aspect of the data:

> I think particularly in my current role in the prison, it is about having different interpretations, and not only understanding the current situation but the background psychological views on people's upbringing, particularly when it comes to medication and how that impacts somebody's presentation now. We invite professionals that work with the service user, not just from our service but from around the prison. So, from the primary mental health team, the perinatal mental health service, our own prison psychologists, and officers, to just get a really good understanding of somebody, their experiences, their presentation and how best to manage and work and create a treatment plan, or a release plan.

In her practice Jackie is collaborative and welcomes the expertise from other disciplines. The phrase "we invite professionals" suggests a confidence that enables her to work with other professions and services. Jackie justifies her positive view of MDT practice by highlighting the valuable contributions of other professionals to help her "get a really good understanding". Jackie uses the term "presentation" from the medical lexicon, symbolic of its influence in MDT practice. While Jackie is asserting her own symbolic and professional capital, she is also sufficiently confident to be able to work with the agendas of other actors in the field. In sociological imagination terms, Jackie's consideration of treatment and release plans reflects not only her immediate professional responsibilities, and concern for prisoners' private troubles, but also the public issues of how to rehabilitate offenders and the intersection of criminal behaviours and mental illness.

Service users value the contribution of social workers who can attend to "my whole life, not just my illness" (Wilberforce et al. 2020, p. 1337). For social workers to be able to make that contribution in an MDT setting it is important that colleagues can work well together. Analysis of the data suggested other participants, like Louis and Jackie above, emphasised the importance of *respect and shared endeavour*:

> Jenny: In terms of times when it's gone well, I think it's when there's more coordination and respect for each other's expertise and perspective. I think this was a really difficult multi-disciplinary problem, but we ended up using

> everything at our disposal. So there was a team formulation, there was a risk review, there was a risk panel that management were involved in, and I think it ended up working out really well because everyone's perspectives were heard.

Although Jenny alludes to times when MDT practice has not been productive, here she discusses how colleagues are able to use the knowledge and expertise that underpins their professional capital to work well together. Jenny uses an extreme case formulation (Pomerantz 1986) – "everything at our disposal" - to suggest both that the problem the team faced was of the most difficult kind, and that even the combined skills and resources of the MDT were only just able to find a solution. At a time of stress Jenny suggests that respect and cooperation prevailed. As an aspect of their habitus, individuals within a field "think, feel and act in determinant ways" (Wacquant 2006, p. 316). In this example team members are using the resources, systems and structures of the MDT to solve a difficult problem. Jenny's account emphasises shared values and context amongst colleagues from different disciplines. She describes shared team processes to support her knowledge claim that MDT practice goes well when team members' work is coordinated and respected.

Participants spoke about the good work that was undertaken through discussions in MDTs and the positive outcomes that could be achieved for service users. There was repeated reference to better outcomes being achieved by team members working well together. Jane, managing an early intervention service, comments:

> We work very tightly as a team. You know, we've got social workers, nurses, doctors, community mental health workers. In the past we've had OTs. I suppose everyone has a view. But this one particular person [service user], we just kept persisting with him and he ended up getting some treatment which worked and he's so much better. But in terms of how the MDT was responsible, I don't think it would have happened if it was just one person working with him.

Jane identifies a key quality from team working – persistence – that individual workers alone may not have been able to maintain. Here, a habitus that includes the value and action of persistence, is operating in the field. Professionals appear prepared to use their respective professional and symbolic capital collaboratively, while no doubt, also trying to ensure their own presence and influence in the field. Jane, like Jackie, justifies her positive statements about MDT practice by noting the contributions of different disciplines and, so in turn, their different views. Decision making in social work is often complex (Hood 2018) and Jane's speech reflects the need to have different views and skills, and a persistent attitude, to achieve positive outcomes. Like Louis's reference to "pulling together", Jane uses the phrase "we work very tightly" to evoke the proximity and purposefulness of team members' combined actions. Participants often commented on the expertise of their colleagues and the importance of different perspectives. Jane's further reflection was typical:

> It's a different perspective on things, you know. Somebody might be thinking a lot about medication, somebody else might be thinking a lot about what their home environment was like, or somebody might be thinking about, well they need to be physically active and get out in the community, which no one person could hold all the views, but I think it's just important to always be questioning each other and thinking about different approaches really. I don't pretend to have the answer to everything at all, I'm always asking my team for advice about stuff.

In Jane's account she is emphasising questioning and thinking, as both important aspects of individual practice, and as a benefit of the resourcefulness and creativity of working as part of an MDT. Jane's phrase "no one person could hold all the views" suggests problem solving and decision making is a process of synthesis and creativity, rather than the actions of one person or profession: a contrast to the challenges of MDT working identified in the previous section.

Critical thinking is a key part of reflective social work practice and Fook (2019) highlighted the importance of deep reflection, using a sociological imagination, to

help practitioners challenge their own familiar perception of the context in which they work. Jane is open in her approach to help from other professionals. Jane also repeatedly emphasises the importance of "thinking about" an aspect of the situation and notes the importance of questioning and considering alternatives. All three aspects are elements of good reflective practice within team working (Thompson and Thompson 2023), and all three are indicative of an active sociological imagination. From a Bourdieusian perspective, Jane – an AMHP qualified manager in an early intervention team –has sufficient symbolic and professional capital to be able to orchestrate working with other actors in the field. Jane's practice appears confident, not defensive: a sign of a stable habitus and developed levels of professional capital.

This section has discussed the second theme identified through data analysis: collaboration and the positive aspects of MDT practice. Participants had sufficiently developed symbolic and professional capital to give them the confidence and maturity to work collaboratively within the field. Participants highlighted a habitus that promoted mutual respect and a focus on supporting service users. Participants who brought a habitus that accepted and valued MDT practice to the field consequently influenced the prevailing custom and practices of that field, which in turn reinforced and influenced the habitus of other actors. The presence of different professionals with different knowledge and skills was viewed positively by participants. A key benefit of working collaboratively was that it enabled interventions to take place over longer periods of time, that would be difficult for one professional to sustain. Concerns about social workers in MDT settings feeling marginalised (Peck and Norman 1999; Evans et al. 2006) were not strongly evident in this study's data.

Practitioners return to the field of MDT working daily and must negotiate their relationships with colleagues to undertake their work. The power relationships and challenges of MDT working identified in the previous section, centred on concepts of recognition and differing perspectives, and how this may create tensions that impede effective social work practice. Those tensions risk diminishing the potential benefits for service users and practitioners offered by the positive aspects of MDT

practice identified in this section. A well-functioning team, where its management and members value the different knowledge and skills colleagues can contribute, will work to accommodate differences in professional knowledge, roles and perspectives, to embrace the potential of MDT working.

Within the positive aspects of collaboration, and the challenges of differing power relationships in the field, social workers were able to establish aspects of their social work identity: these are discussed in the following section.

6.5 Identity: sociological and legal knowledge in MDT practice

Data analysis suggested that participants promoted and negotiated their professional identity through repeated and varied articulations of their distinct knowledge contribution to MDT practice. Social workers' participation in the field, through habitus, contributed to the development of their professional identity. Professional identity is not a stable entity and results from this ongoing professional socialisation (Webb 2017). Professional identity can therefore be viewed as an aspect of cultural or professional capital (Beddoe 2011), with actors who have a stronger sense of professional identity likely to demonstrate higher levels of cultural or professional capital. The articulation of professional identity in this study took two main forms: firstly, participants brought *knowledge of a social perspective*, and secondly participants brought *legal and statutory knowledge* to the field. The social perspective was vividly expressed by Stephanie:

> I think in a wider MDT context, as a social worker, I might see things - and it depends on the clinicians – but as a social worker, I might see things as more of a social problem than a mental illness that needs treatment with medication, because you could have all of the medication and all the CBT in the world but if you're living in a poor social situation, CBT and medication are only going to do so much, really.

Stephanie, a social worker in a recovery team, defines her own position in relation to other professionals in the field, and through this contrast, highlights her focus on the "social problem" rather than the "mental illness". Addressing a person's social situation is arguably more effective than "all the CBT in the world" because distress

is a situated phenomenon. Stephanie's account challenges MDT colleagues whose own position and professional capital might be constituted in part through a belief in the efficacy of medication and therapy. If the field is "a space of relations which is just as real as a geographical space" (Bourdieu 1991, p. 232) then Stephanie is challenging the methods and perspectives, the symbolic capital, of her MDT colleagues. Stephanie is suggesting that an understanding of the social situation is what might be most important to effectively help service users, to help them to develop their recovery capital (Tew 2012), and, that it is the social worker who understands this fact. Stephanie's phrase "I might see things more of a social problem" is quite tentative though, suggesting limited professional capital and some equivocation about her knowledge claim. Stephanie's account reflects findings about the social work role and the centrality of the recovery approach in mental health care. For example, Abendstern et al. (2021 p. 779) discussed how social workers "distinguished themselves from their [MDT] colleagues in terms of their understanding of the social determinants of mental ill health and their approaches to overcoming these".

The relationship between the field and habitus is one of mutual influence. The field is structured, in part, through the behaviour (habitus) of its participants, and participants' behaviours are in part influenced by the structure of the field (Thomson 2014). As Maton (2014, p. 51) notes, "Simply put, habitus focuses on our ways of acting, feeling, thinking and being". Participants, asserting their identity through discussion of their knowledge of a social perspective, frequently described aspects of their habitus; how they went about their work, and how they felt they brought different knowledge and skills to other members of the MDT. Nancy articulates specific aspects of her work:

> I think about other people in the household. I think we've got better at that, thinking about partners, or carers in the client's network. Thinking about safeguarding the children, safeguarding adults. We've done quite a lot of work around domestic abuse, because in the perinatal period domestic abuse does increase, the risk of domestic abuse increases in pregnancy and postnatally. So, we've done quite a lot of work around safeguarding adults.

> And then also, in general, when we're discussing cases and assessments, thinking about asking, well, where do they live, you know, what's their cultural background?

Nancy's professional capital is created and predicated on her knowledge and skills of working with a wide range of people within the service users' network. Nancy pinpoints her contribution as thinking more widely – the essence of the sociological imagination - to understand service users' situations, considering aspects of the household, network, community and culture; all in the context of safeguarding responsibilities. Nancy's practice is a challenge to Mills' (1943) assertion about social workers failing to rise above the case. Nancy's habitus appears to include using research knowledge about the occurrence of domestic abuse, to inform her understanding. Both Stephanie and Nancy demonstrate the importance of thinking about service users' social, community and family context: a social perspective. Their professional identity and capital are in part constructed through a knowledge claim to understand service users' difficulties in a wider social context, that includes aspects of the social determinants of mental health. Both are also thinking in ways that can be viewed as using elements of the sociological imagination – biography, historical time, private troubles and public issues – to make sense of service users' situations.

The second way participants asserted their professional identity and negotiated their professional capital in the field, was through discussion of their *legal and statutory knowledge*. Bourdieu used the analogy of the 'game' to describe habitus (Maton 2014). Actors (participants) are not necessarily fully aware of all the rules or the current states of play, but "enjoy a particular point of view on proceedings based on their positions, and they come to acquire a sense of the tempo, rhythms and unwritten rules of the game through time and experiences" (Maton 2014, p. 53). Clare, whose strong identification with working for a local authority was discussed in Chapter 4, notes:

> You should be trying to use the Care Act criteria as a way of prompting your discussion and to frame what someone's outcomes are. You can then record

> their goals in a way that might give access to resources and services. I feel like it is a challenge in integrated teams because not all health colleagues feel like they've got the experience or expertise. Some of them have blatantly said they don't want to do it. It's not my job. That's a challenge because you are in an integrated team, so it is *your* job. Form filling is really boring, we know that, but that's what we've got to do.

Clare appears to have developed professional capital and an understanding of the MDT 'game': she is confident in asserting her expertise and the importance of working with legislation as part of MDT practice. Clare tries to influence colleagues' habitus by educating and (ostensibly) encouraging them to integrate working with legislation as part of their practice.

Clare's frustration with her colleagues is evident in her talk about their shortcomings in experience, expertise and attitude of her colleagues. The 'rules of the game' in the field are interesting: some colleagues avoid or resist an aspect of MDT practice – perhaps their professional capital is secured through other knowledge domains and activities – but Clare appeals to the collective responsibility of the team: "that's what we've got to do". Yet, this phrase also suggests a lack of autonomy in Clare's practice. It appears in part determined by process and structure, rather than independent judgement that can be regarded as a hallmark of professional practice (Freidson 2001). Stephanie, also referred to legislation and the bureaucratic processes its use entails:

> I suppose with a social work background, we look at legislation and then make sure that's met one way or another, and I probably know a little bit more about, you know, writing plans of care, kind of making sure boxes are – I know it's a social work stereotype – but making sure boxes are ticked, but actually checking those boxes in one way is quite important.

Stephanie locates her practice within the bureaucracy of the state and derives some professional capital from her commitment to the processes of the state. Stephanie appears to be fulfilling the role of the Street-level bureaucrat (Lipsky 1980). In referring to her professional background, Stephanie is most likely referencing her

qualifying training and previous social work experience. Social work education plays an important part in producing and reproducing the level of professional capital and identity that practitioners acquire (Wiles 2013). Legal knowledge and experience of undertaking statutory tasks is a core part of qualifying social work training (Social Work England 2021). Stephanie equates legal knowledge with bureaucracy but values this as part of her role. The phrase 'one way or another' suggests the exercise of professional discretion as she tries to fulfil her role.

Social work practice has become more bureaucratic, and that is often resented by practitioners (Pascoe et al. 2023). Stephanie though, emphasises its value by referring to "making sure boxes are ticked", a rewording of the colloquial refrain "ticking the boxes", sometimes used to devalue or trivialise bureaucratic processes. Stephanie is claiming a role within the MDT that she is best qualified to undertake – "I probably know a little bit more" – but her knowledge claim is quite tentative, perhaps illustrative of relatively low professional capital and she ultimately concludes her specialist contribution is only "quite important". Perhaps other members of the MDT have similar knowledge given the growing number of generic mental practitioner posts.

The AMHP role can be viewed as having heightened levels of professional and symbolic capital because of the specialist training and legal knowledge required to undertake it. The role, although open to some other professions, is predominantly undertaken by social workers (Skills for Care 2024). Created by legislation, the role confers on practitioners, in terms of title, status, powers and specialist knowledge, substantial professional capital. Louis, in the context of considering a request for a Mental Health Act 1983 assessment, demonstrates his use of this symbolic and professional capital through a discussion about the importance of human rights and civil liberties:

> Does the risk or the concerns in the situation, does it meet our [legal] threshold? I just had this conversation today with the consultant [psychiatrist]. I'd say, yeah, okay, you have got concerns but do they warrant me depriving this person of their liberty? It's trying to convey to people we

> do have to think about a person's liberty and their entitlement not to be bothered by services. You know? You just want me to go and deprive this person of their liberty straightaway on your [the psychiatrist's] hunch? We need a bit more than a hunch.

Louis asks a rhetorical question to expose his scepticism about the appropriateness of the psychiatrist's approach. He is using his specialist legal knowledge to challenge the psychiatrist's view, and in doing so he is symbolically defending the liberty of the service user, as well as challenging the dominance of psychiatry and the medical model of mental health (Huda 2021). Louis is asserting, through habitus, his professional capital. Louis's phrasing and request for evidence – "more than a hunch" - is an expression of his professional values, legal knowledge and confidence. Louis has sufficient professional capital to challenge the power of his medical colleague.

Bourdieu was concerned with how economic capital reproduces inequalities in society (Moore 2014), and how symbolic capital seeks to reproduce the inequalities of power in a given field. In mental health care, psychiatry has traditionally been the dominant profession, with its members having high levels of professional capital, exercised in the maintenance of their position within the MDT. Louis, equipped with his legal knowledge and status conferred by his AMHP role, can challenge that orthodoxy to present a different interpretation of the situation, a finding reflected in the wider research about the AMHP role (Abbott 2022; Karban et al. 2021). This type of account, of social workers using the power derived from their professional capital and role, to counter the assumptions and intentions of a medical perspective of situations, featured frequently in the data.

This chapter section has discussed how participants articulated their professional capital and identity in two main ways: through bringing a social perspective to their MDT work, and by having a particular legal and statutory knowledge to contribute to MDT practice. Beddoe's (2011) concept of professional capital, an extension of Bourdieu's conceptions of capital, has been useful in considering the identification of participants' unique contribution to MDT practice. What is striking is that while

participants can articulate a distinct contribution, they appear to lack some confidence in doing so. This suggests that the extent to which, through their habitus, they can influence MDT practice may be limited at times.

6.6 Conclusion

To analyse the data fully, with the aim of understanding how MDT working impacts on social workers' praxis, I used elements of Bourdieu's theory of practice. Doing so, in addition to using Mills' concepts, helped to make sense of social workers' experiences. Bourdieu's concepts supported an analysis of how participants spoke about their interactions and relationships with other professionals in the MDT, in a way that Mills' concept did not. This enabled analytical themes to be identified in the data.

Power relations within the field, identified in the first theme -*capital* - sometimes made collaborative work difficult. Participants experienced misrecognition and marginalisation, where their professional qualifications and role were repeatedly misidentified and devalued. When participants expressed different perspectives and priorities to their MDT colleagues, tensions sometimes arose. Despite this, *collaboration* - theme two - was viewed as a positive aspect of MDT practice, and one that often transcended interprofessional tensions. Collaboration through combined knowledge and expertise of professionals is an established rationale for multi-disciplinary working (Evans et al. 2012). While social workers' symbolic and professional capital may not always have been definite and secure, it was sufficient for participants to engage in the field through this common element of actors' habitus. Mutual respect for other professionals and a shared endeavour to support service users appeared to reassure social workers of their value. MDT practice appeared to engender a persistence amongst team members to work through complex situations which for individual practitioners may have been difficult to sustain.

Beddoe's (2011) extension of symbolic capital helped define professional capital and suggested that professions can occupy a distinctive space in relation to the field. Data analysis indicated a third theme: *identity*. Participants could identify their

specific contributions to MDT working and articulated their professional capital and identity in two main ways. Firstly, through bringing a *social perspective*, and secondly, through having particular *legal and statutory knowledge* to contribute. Sometimes these knowledge claims were tentatively expressed, perhaps suggestive of a lack of personal confidence in their own, or collective, cultural, symbolic and professional capital.

Therefore, social work identity appeared to be influenced by, but independent of, the team. Professional capital, although sometimes hesitantly asserted, was often sufficient for social workers to contribute a distinct social perspective to MDT working. Social workers exercise a sociological imagination, by providing a social perspective to the MDT, but this can only take place when they accrue sufficient professional capital to gain confidence and influence in the field. When a strong professional identity had enabled social workers to claim space to exercise their values and autonomy, then workers' sociological imaginations were apparent and articulated in the data. A central function of social workers in MDTs was to bring a sociologically imaginative approach to practice.

Chapter 7 Discussion and conclusions

7.1 Introduction and overarching research question

The initial aim of this study was to gain an insight into how mental health social workers understood the origin, presence, and impact of the social determinants of mental health, and mental health inequalities, on their work with service users. The sociological concept that inspired this study was C. Wright Mills' (1959) sociological imagination. Mills sought to enhance sociology's understanding of peoples' lives by advocating an approach that considered biography, the time and society in which people lived, and the interaction of these considerations with their personal troubles and social (public) issues.

The inductive nature of this study soon influenced how the research developed. During initial data collection and analysis, the importance of employment context and professional identity were findings that had greater significance than anticipated on the presence or absence of social workers' sociological imaginations. Early analysis indicated that whether practitioners were employed by a local authority or by the trust, and as social workers or generic mental health practitioners, influenced their sense of professional identity and experience of MDT working. Moreover, while I was initially considering how social workers thought about their work, the interview and data analysis process prompted me to consider social workers' praxis; that is, how their theoretical understandings of the social determinants of mental health and mental health inequalities, are operationalised in practice. These considerations informed the study's overarching research question:

How do social workers, working in different organisations, roles and teams, articulate a sociological imagination when considering the social determinants of mental health?

This final thesis chapter discusses the extent to which analysis of the data has enabled the research aims to be met. The chapter first summarises the research findings. The implications of those findings are then discussed, considering the three subordinate research questions outlined in Chapter 2. The limitations of the

study are then noted, followed by suggestions for future research. The study's contribution to the literature is reviewed and recommendations for policy and practice offered.

7.2 Summary of findings

Throughout this research, influenced by my own background as a former local authority social worker who practiced within an NHS trust, I have been curious to know how current social workers view the influence of their employment context on their individual practice. To recap, for each participant, data collection took place through one face-to-face or online interview. The semi-structured interview had two parts: firstly, participants responded to three textual vignettes, and secondly participants discussed their practice, with a focus on multi-disciplinary working and the recovery approach. The analysis of the data has been presented in Chapters 4, 5 and 6, and is summarised below.

Firstly, Chapter 4 analysed the data with the aim of understanding the influence of participants' employment context on their professional social work identity and approach to practice, taking as a starting point whether participants were employed by a local authority or the trust. Using Freidson's (2001) theory to consider the logic of the organisation of labour (via bureaucratic, market, or professional groupings), and noting the role of discretion in professionals' work (Evans and Hupe 2020), I considered the strength and characteristics of participants' social work identity.

Participants worked in a range of teams and settings which were summarised as: social workers employed by a local authority and working within the NHS trust; social workers employed by a local authority undertaking the AMHP role, and social workers employed by the trust as social workers or generic mental health practitioners. Working for a local authority, whether based day-to-day within the authority or the trust, gave participants confidence to locate, assert and retain their professional social work identity. Identity characteristics included valuing the statutory aspects of social work practice, such as using the Care Act 2014 or the Mental Health Act 1983; and retaining a strong sociological/social practice perspective; especially important for AMHPs and social workers within the trust. For

some participants employment by the local authority was central to their identity and prompted discussion of ideas of purity and dilution in relation to working with, or within, the trust. The strength of feeling participants expressed about working for a local authority was not something I had fully anticipated despite my own experience of working for similar authorities.

Participants employed directly by the NHS trust as social workers expressed a range of views about their employment context. Some were ambivalent about their employer, with it making little reported difference to their practice, while some felt positive about the opportunities the trust offered to develop their careers and practice skills. Some participants disliked the trust and felt the organisation did not understand their social work values and skills. At times social workers employed by the trust as generic mental health practitioners reported feeling isolated, had difficulties asserting their professional identity and autonomy, as well as experiencing a lack of recognition of their sociologically informed perspectives. This is not surprising given their minority position in relation to other professional groups in mental health services who undertake that role. On occasion though, the specialist teams that practitioners worked in appeared to compensate for this compromise in identity because the work was interesting, practitioners had supportive colleagues from different disciplines, and there was scope to pursue interesting career opportunities.

Therefore, social workers were working in a variety of contexts with differing experiences. Social workers who were secure in their professional identity, were able to practice in accordance with their professional values, and those who enjoyed a degree of autonomy and discretion in their roles were well placed to bring a social/sociological perspective to their practice. Those social workers were predominantly employed by local authorities and working as social workers rather than employed by the trust as generic mental health practitioners.

Secondly, Chapter 5 discussed participants' responses to three vignettes that featured the characters Amira, Akiel and Jack. The vignettes were written to include elements of the social determinants of mental health, and of mental health inequalities (Silva et al. 2016). C. Wright Mills' (1959) sociological imagination was

central to data analysis because the vignettes also signalled to participants circumstances that could be considered private troubles or public issues. Immediately evident from data analysis was the style in which participants discussed the vignettes: it was akin to them undertaking a social work assessment as part of their routine practice. This *assessment through talk* was identified as the overarching theme from this section of the data analysis.

The vignettes elicited curious, compassionate and empathetic responses from participants towards the challenges faced by Amira, Akiel and Jack. Analysing the data prompted consideration of the link between the sociological imagination, empathy, and practice wisdom. The prominence of empathy in participants' responses was notable and led me to consider what processes contribute to thinking in a sociologically imaginative way; this is discussed in the next chapter section. A further three themes about participants' practice were identified*:* *Imagining experiences*, using *knowledge of mental health*, and *reflecting on practice and personal experiences*. The overarching theme, and three subordinate themes, suggested participants were identifying elements of the social determinants of mental health, and public issues and private troubles. Participants appreciated the impact for service users of the social determinants of mental health inequalities, and issues relating to access and outcomes from services (Commission for Mental Health 2020).

Lastly, Chapter 6 analysed data from discussions with participants about their own practice experiences in multi-disciplinary teams and environments. Participants worked in a wide variety of specialist recovery practice settings including perinatal services, services for people with autism, forensic services, and early intervention in psychosis teams. The analysis, in tandem with using the sociological imagination, also used concepts from Bourdieu's theory of practice: habitus, field and capital, and Beddoe's (2011) concept of professional capital. I identified three themes. The first theme discussed *capital* and the power relationships in multi-disciplinary working and noted the challenges that can bring for practitioners working collaboratively with colleagues from different professions. Identifying that theme emphasised to me the emotional impact on practitioners of being in a minority

position and of, at times, experiencing the partial devaluing of their professional identity, skills and perspective.

The second theme identified *collaboration* as a positive aspect of multi-disciplinary practice including the benefits of shared knowledge and expertise from different professionals. The valuing of mutual respect and shared endeavour was also evident in participants' discussions. Finally, in the third theme, participants identified and articulated their *professional identity* through bringing a social perspective, and specialist legal and statutory knowledge, to their work. This finding mirrored the insights gained into participants' employment, status and location, discussed in Chapter 4. Sometimes though, the knowledge claims made by participants appeared tentative and perhaps that limited social workers' influence in their teams.

Social workers who participated in this research were therefore employed in one of two types of organisations: a local authority or an NHS trust. Which organisation employed them, which they worked in day-to-day, and if they were employed as social workers or generic mental health practitioners appeared to influence their identity, practice and experience of multi-disciplinary working. There were a variety of responses to these experiences, and data analysis has enabled the identification of the research themes discussed above. Linking those research themes together suggests all participants were primarily concerned for the welfare of the service users. Participants were aware of the impact of the social determinants of mental health on service users' circumstances and the mental health inequalities they experienced. How participants translated that awareness into their professional practice appeared to be influenced not only by the presence or vividness of their essential imaginations but also by the mediating impact of their organisational and employment context, and by the strength of their professional identity and capital in multi-disciplinary environments. This research has provided useful data about the experience of mental health social workers, the importance of participants feeling connected to the organisation they work within, and their approach to working with colleagues from different professions. The following section expands upon these insights.

7.3 Social work, mental health inequalities and the sociological imagination

This chapter now discusses the extent to which the analysis in the three preceding chapters, and the summary above, has enabled me to answer the three research questions set out in Chapter 2. It is evident from data analysis that participants did have knowledge about the social determinants of mental health and mental health inequalities that they could discuss in relation to fictional vignettes and conversations about their practice. It is also apparent that participants exercised a sociological imagination in relation to their work. How that knowledge and imagination was expressed appears partly dependent on the organisational context of social workers' employment and practice. That context had a significant impact on participants' professional identity, autonomy and professional capital. This in turn, as is discussed below, impacted on social workers' capacity to translate insights from their sociological imaginations into practice. Social workers use important knowledge and skills in their practice. They require facilitative employers, with roles and practice environments created, that support the accumulation of professional capital, so that their knowledge and skills can be used. Each research question is now considered in turn, and finally the overarching research question is addressed.

The first research question asked: *how does a sociological imagination feature in social workers' accounts of the impact of the social determinants of mental health inequalities?* Mills suggested that "the first fruit", and the first lesson, of the sociological imagination was that an individual "can understand his own experience and gauge his own fate only by locating himself within his period, that he can know his own chances in life only by becoming aware of those of all individuals in his circumstances" (Mills 1959, p. 11). If this primary benefit of accessing a sociological imagination is transposed from a person understanding their own situation to a social worker assessing a service user's situation, then the relevance of Mills' concept to social work is clear. Practitioners will only understand a service user's situation if they are able to locate that person within their current social, political, economic and environmental context, and to use their knowledge about people in similar circumstances to inform their assessment and interventions. The positive

and negative impact of the social determinants of mental health are of course fundamentally influenced by decisions made by society's citizens and its politicians.

Participants in this study, responding to the three vignettes, all identified and talked about the social determinants of mental health that were present in the scenarios of Amira and Akiel, and noted their absence from the final vignette about Jack. They demonstrated an appreciation of the nature of the social determinants of mental health, identified their possible impact on the lives of the vignette characters and were able to do this through accessing knowledge about people in similar circumstances. This can be interpreted to signify that participants were cognizant of the importance of a broad, holistic approach to assessment; one that looks beyond a predominately medical/psychiatric explanation for people's difficulties. That is, they were able to look both ways, upstream to broad social determinants of mental health and downstream to the impact of those determinants on people's lives and mental health, including the challenges of poverty, racism, and isolation.

That participants were able to think in this way when responding to the vignettes is interesting. Wilks (2004) notes when researching social work, vignettes create a distance from actual practice that renders them less threatening to participants' own actions or abilities. This hopefully encourages free and authentic responses. In designing a research study in a way that enabled me to ask participants to consider fictious vignettes, I had created a space where they could respond freely, reducing any concerns that their answers could reflect negatively on their decision making in practice. Participants were not encumbered by the complexities of practice within MDT environments. They were not asked what they would do, or how difficult it would be to do something, but simply what did they see, what did they imagine.

As indicated by the research themes identified in Chapter 5, knowledge was developed and used by practitioners in several ways. These included participants appreciating the importance of assessment (through talk), augmenting new information with their existing knowledge about mental health, and by reflecting on personal and practice experience. In Chapter 4 and 6 practitioners again articulated how a social perspective was important in understanding service users' difficulties.

Edmiston's (2017) research, highlighted in Chapter 2, concluded people who had experienced personal hardships tended to have greater empathy and an openness to alternative explanations to understand the situations of welfare claimants. Participants in my research appeared to also access a sociological imagination quite readily when they used their own personal and practice experiences to empathise with service users' situations. Empathy appears to be an important aspect of accessing a sociological imagination; it is the affective component of thinking that establishes a connection between the participants and the experiences of others.

Orgad's (2020) research, also highlighted in Chapter 2, noted the message in neoliberal societies is one of individual responsibility detached from its structural context. While the concept of the social determinants of health has been critiqued for failing to sufficiently acknowledge the issues of power, politics and social action (Krieger 2001), Marmot's (2010) definition does note the influence of power, money and resources. Participants in this study often pushed back against the individual responsibilization of service users and appeared to understand that people's difficulties are contextualized, and often directly impacted by the public (social) issues that Mills suggested. In responding to service users' situations, participants also talked in ways that suggested their roles involved judgements, discretion and advocacy: features of Street-level bureaucrats (Lipsky 1980). The inter-connected nature of the social determinants of mental health is key to understanding why the sociological imagination is so important. If the cause and effect of the social determinants are to be properly understood then a sophisticated and deep understanding of their impact, and the interconnected nature of these difficulties is required from practitioners. Use of a sociological imagination may support practitioners to ward against the risks of dichotomous thinking that Karban (2017) critiqued, where people's difficulties are seen as either physical or mental, social or individual.

One of the ways in which practitioners can achieve this synthesis in their understanding is through combining their practice wisdom – the accumulation of knowledge through experience (Samson 2015; Johnson 2017) -, and empathy towards service users (Eriksson and Englander 2017), with a commitment to critical

reflection. Fook has consistently argued for the incorporation of critical reflection in social work practice (Fook and Gardiner 2007). Latterly, as noted in Chapter 2 and 5, Fook has discussed how critical reflection – itself a conscious endeavour to look again at explanations for practice scenarios, including the influence of the practitioners themselves – can be enhanced further by social workers adopting a sociological imagination (Fook 2019). That is, practitioners should engage their sociological imagination to inform their critical reflections to move away from familiar or restricted conceptualisations of events or circumstances.

The clear message from my research is that social workers are aware of the importance of a social/sociological perspective in trying to understand the origin and nature of people's mental health difficulties. However, data analysis also suggests the extent to which participants can articulate and act upon a sociologically informed perspective is contingent not only on accessing a sociological imagination. It is also contingent on how participants negotiate their professional identities in the context of working for either a local authority or a trust, whether they are employed in social work roles or risking devaluation or misrecognition in generic mental health practitioner posts, and whether they are confident and successful in asserting their professional capital in the context of multi-disciplinary environments and recovery-based services. These are additional and significant factors that promote or impede participants' expression of a sociological imagination.

The second research question asked: *how does working in multi-disciplinary environments shape social workers' responses to the impact of mental health inequalities?* Analysis in Chapter 6 indicated that social workers appear to be able to access a sociological imagination and, in doing so, readily identify and appreciate the impact on people, families and communities, of the social determinants of mental health and mental health inequalities. Participants' capacity to translate this understanding into practice is mediated by their organisational context. Moreover, it became evident during data analysis that the inter-professional relationships within the MDT, along with the influence of wider organisational structures, was as

important in determining participants' ability to respond to the impact of social determinants of mental health, as their accessing a sociological imagination.

Freidson (2001) noted a profession's confidence and strength could be evaluated through considering the level of control its members have to undertake their roles. An aspect of that control can be professionals having the autonomy to exercise discretion in the interpretation of policy in their direct work with service users (Evans 2011). The MDT structure creates the framework for working with colleagues from different disciplines and in doing so can facilitate access to a range of expertise. Professionals undertake their roles with a degree of autonomy but are also influenced by the policy, processes and structures of their team and agency. Social workers exercise a degree of discretion in their practice as they respond to service users' needs and negotiate the professional relationships within the MDT. Participants in services and teams that recognised the value of the social work contribution, had a greater opportunity to practice in accordance with their professional values and to bring a social perspective to the teams' work. That is, a positive team environment appeared to influence the confidence of social work members to work in ways that were congruent with their training, knowledge and values. The social work identity was secured and enhanced by positive and mature team functioning.

Participants also had the opportunity to influence the practice of other team members. Social workers, employed by a local authority, seemed to have a strong sociological/social perspective, which was apparent when working in multi-disciplinary environments. It appears that employment by the local authority increased the sense of certainty and control social workers had about their role. This might be because of the long-established link between the profession and local government, and between local government and the statutory duties it is bound to meet. Conversely social workers employed by the trust – a predominately medical environment- indicated they had less control over the focus of their work, and less certainty about their role, maybe because of the blurring of boundaries between the different professions in health-based MDTs.

Participants who worked in well-functioning teams within the trust talked very positively about opportunities for joint working. This created the possibility of some of the impacts of the social determinants that contribute to mental health inequalities, such as poverty or homelessness, being addressed at a service user/team level. Conversely a minority of participants who reported negative experiences of MDT working found that their ability to respond to service users' issues, that were often related to mental health inequalities, was curtailed. Sometimes social workers experienced misrecognition (as being nurses) and the consequent devaluation and marginalisation of their role, knowledge and skills.

Some participants employed by the trust, often as social workers, were able to articulate a social perspective, and gave examples of how they tried to address the impact of mental health inequalities. Others found the isolation of working in the trust as a generic practitioner diminished their confidence in their social work perspective and limited the opportunities to express it. The frustration and disempowerment those participants experienced may have ultimately impacted negatively on the range and extent of their interventions. The decision to work as a generic practitioner, and for some participants not to use their professional social work title, was not necessarily a rejection of a sociologically informed practice perspective. It seems likely that a participant's ability to act on the insights gained through accessing their sociological imagination was reduced when they had limited confidence in the value their team gave to their social work role, knowledge and skills.

In Bourdieusian terms, multi-disciplinary work is a location of activity within the field of social work and, as the literature and this research demonstrates, it is a dynamic and interactive experience in which actors negotiate their power and position. The MDT is a site of relations between competing actors (colleagues), who are paradoxically, tasked with working together for the benefit of others. Therefore, the way in which working in multi-disciplinary environments shapes social workers' responses to the impact of social determinants and inequalities is not a neutral, passive, static, or a one-way experience. Social workers are seeking to influence the practice of different disciplines and challenge more medical interpretations of

mental distress (Willis et al. 2022). Social workers' responses to the impact of mental health inequalities are both independent of the multi-disciplinary environment – in terms of professional values, knowledge and skills - but also mediated by it, as they try to assert their symbolic/professional capital, in contest with other team members. The response is dynamic, and varies between different social workers in different settings, and depends in part on the strength of their symbolic and professional capital relative to the other actors in the field.

The range of participants in this study – in terms of years in practice, and varied practice experience - will have contributed to the evolution of their habitus and the accumulation of different levels of professional and symbolic capital. Analysis suggested participants sometimes seemed tentative in their knowledge claims and so perhaps had more limited symbolic capital than some of their colleagues from other disciplines. In contrast to participants' responses to the vignette scenarios in Chapter 4, this tentativeness may have reflected their knowledge of the realities of practice. These include having to practice in MDT environments where they may be in a minority position, working with a predominately medically orientated approach to mental health, and by simply being aware of the difficulties in trying to effect change for service users.

The organisation participants worked for was influential in how they constructed their professional identity. Participants who worked for a local authority appeared to have a stronger social work identity, rooted in a link with their employing organisation and a commitment to bringing a social perspective to their work. "Pureblood" was how one participant, Darren, described the strength of the connection between his social work identity and employment by his local authority. The consequent views, assessments and decisions that resulted from those participants accessing a sociological imagination, were supported by the professional logic of the authority. The social work identity of participants who worked for the trust was less stable and visible. Some participants were employed as generic mental health practitioners and had stopped referring to themselves as social workers, while others objected if they were not referred to by their professional title. If social workers lack control or influence over their individual

professional identity – literally what they are called at work – and in their profession's overall identity in an organisation, then asserting the knowledge, skills and values that underpin being a professional social worker will be difficult. This will include challenges in articulating a social perspective, developed through exercising a sociological imagination.

Social workers' experiences of multi-disciplinary working are important in shaping their responses to mental health inequalities, but it is not the only factor. Marmot et al. (2010, p. 39) referred to the "causes of the causes" of health inequalities and discussed the metaphor of contributory upstream and downstream factors. The upstream (distal) environmental and contextual factors often give rise to the downstream factors. It is those proximal risk factors – such as insecure employment or unsafe neighbourhoods –that contribute to the experience of mental health inequalities (Compton and Shim 2015). That some social determinants of mental health are remote and structural in nature makes them difficult to change or influence at a practitioner level. Beyond attending to the immediate needs of individual service users it is difficult for a practitioner to address, for example, poor housing or access to education at a policy or structural level. This challenge has led to calls for policy practice, to facilitate practitioners advocating for, or challenging policy developments, to be a core aspect of social work education and practice (Evans 2021).

There is then a difference between recognising the importance of the social determinants of mental health, working to limit their impact, and being able to address their ultimate cause. Working in multi-disciplinary environments influenced the extent to which participants could bring a social perspective to their work, and therefore advocate for a team-wide appreciation of how important it is to address the impacts of the social factors contributing to mental distress. Even for the most confident social workers in well-functioning teams, the scope to impact upstream social determinants may have been limited. The use of critical reflection at least offers a route to practitioners being able to analyse the impact of policies on practice, and to be aware of the need for societal and structural factors to be addressed (Fook 2019; Evans 2021).

Participants were, in C. Wright Mills' (1943) terms, concerned with the 'case' i.e. working with individuals or families addressing specific issues being experienced at that time. However, the data suggests participants challenged C. Wright Mills' (1943) view that social workers found it difficult to "rise above a series of 'cases'" (Mills 1943, p. 171). Social workers were able to appreciate the broader picture and the influence of public issues on individuals' personal circumstances. Participants brought a social perspective to their practice, along with specific statutory and legal knowledge. Their ability to address the impact of mental health inequalities was shaped, along with the multi-disciplinary environment, by wider contextual issues. These included the priority given by their organisation to addressing social determinants, and the limitations created by participants' own downstream location in relation to the fundamental causes of inequalities.

The final research question asked: *Can social workers develop a 'Mental Health Equality Imagination' to enhance their practice?* This research study was in part inspired by Mills (1959) but also by the work of Giles (2009), and I have sought to develop the health equality imagination concept she proposed. Mills suggested that there are three questions social scientists should try to answer. These can be précised as, what is the structure of society, where does this society stand in human history, and what sorts of people live in this society in this period of time? (Mills 1959, p. 13). Power (2008) in advocating for a professional imagination described the questions as relational, temporal and dispositional. Social workers' identity has been conceptualised as part social scientist (Croisdale-Appleby 2014) and Mills suggested that developing a sociological imagination would support the social scientist to answer those three questions. I suggest social workers, by using their sociological imagination, can provide answers to the three questions in relation to their work with service users.

Marmot described the social determinants of health as the "conditions in which people are born, grow, live, work and age, and inequities in power, money, and resources" (Marmot 2020, p. 1). Participants in this study worked for a local authority or a trust, and although some were employed in generic practitioner posts, all were qualified social workers. The themes identified in all three analysis

chapters, such as the importance of a social perspective (Chapter 4 and 6) or reflecting on personal and practice experience (Chapter 5), suggested social workers are interested in understanding how the biographies of service users have been influenced by the factors Marmot identified. Participants demonstrated this in both their response to the vignette characters' circumstances and in subsequent conversations about practising in multi-disciplinary environments.

Health inequalities "are avoidable, unfair and systematic differences in health between different groups of people" (King's fund 2020) and are widely reported to be increasing in the UK (Institute of Health Equity 2024). Social work is based on the values of respecting the essential rights and dignity of people, championing social justice and acting with professional integrity (BASW 2021). The social injustice that is inherent in the existence and perpetuation of (mental) health inequalities is therefore of direct relevance to the central focus of the social work profession. This has led academics to support a more prominent consideration of the relevance of health inequalities in social work nationally and globally (Bywaters 2009; Bywaters et al 2020), and of mental health inequalities in social work education (Fish and Karban 2014) and mental health practice (Karban 2017).

Participants in this study evidenced their understanding of the social determinants of mental health that contribute to mental health inequalities, which they encountered in their own practice. The Commission for Mental Health (2020) used a tripartite definition of mental health inequalities: the social determinants of mental health, access to services and outcomes from services. This research study did not focus on the third aspect of this definition, but it is apparent from the data that participants were very aware of the impact of social determinants and the barriers that some people face in accessing services.

The identity characteristics of some individuals and groups gives rise to a greater risk of them developing mental health difficulties. Participants, particularly in discussing the vignette characters Amira, Akiel and Jack, demonstrated they understood the impact of identity characteristics, such as being an asylum seeker or being from a Black or ethnic minority group, on the likelihood of experiencing mental distress and inequality. The importance of empathy and practice wisdom

was apparent in the data analysis (Chapter 5), and to have an active sociological imagination appeared contingent on the presence of affect: an emotional identification with service users. In the discussion of hypothetical vignettes, the sociological imagination appeared guided or informed by emotion.

Participants demonstrated that they think in ways indicative of exercising a sociological imagination. Participants were interested to understand service users' circumstances and what had happened in their lives to bring them in contact with services. Assessment through talk was a superordinate theme discussed in Chapter 5 and the importance of collaboration to understand, and to help, was identified in Chapter 6. All the social workers I interviewed demonstrated through their conversations with me how they valued the contact they had with service users and sought to promote their human rights and recovery. Participants, in both their responses to the vignette characters, and their discussions of working in MDTs, demonstrated an understanding of the role of private troubles and public (social) issues in the development and maintenance of service users' difficulties. The usefulness of a biopsychosocial model of mental health was evident, but participants understandings and explanations went further. Imagining the experience, a theme identified in Chapter 5, was very important in supporting participants to understand the situations of others. The use of a sociological imagination enabled participants to detect and interpret the interaction between a person's biography and private troubles, the public (social) issues of the day, and the nature of the society in which they lived.

Participants used the sociological imagination for the tasks Mills suggested it was best suited to and fulfilled some of the promise he ascribed to his concept. Returning to Giles (2009), writing about hospital social workers in Australia in her paper *Developing a Health Equality Imagination*, she was confident that practitioners could begin to address health inequalities they encountered in their work. This would be achieved by focusing their practice on promoting equality and by making sure they did not further inequality through their actions. Giles (2009, p. 530) wrote that "regardless of the context of practice" social workers should aim to develop a health equality imagination. This study has demonstrated, in contrast,

that the context of practice *is* critical to answering the question whether social workers can use their sociological imagination and develop a mental health equality imagination.

Practitioners in well-functioning MDT environments, who are secure in their essential professional identity and skills, may be able to consistently practice in ways that are congruent with adopting a sociologically imaginative approach to addressing the mental health inequities in service users' lives. Practitioners in trust MDTs who remain employed by a local authority appear more likely to be able to bring a social perspective, their confidence to do so bolstered by the historic link between the values of their profession and their employing organisation. Social workers' knowledge, power and identity appears therefore, at least partially, contingent on how their employment and working environment is structured. The complexities of working for the trust in an MDT environment, sometimes in generic practitioner roles that obscure or misrecognise social workers' professional backgrounds, can make the expression and application of a sociologically imaginative approach more difficult.

Several features of the health equality imagination Giles (2009) advocated for can be discerned from her writing. Firstly, social workers should develop detailed knowledge about health inequality in addition to their knowledge of other forms of discrimination and injustice. Secondly, practitioners should deliberately promote a social model of health. Thirdly, practitioners should reflect upon how life could be different for the family, individual and community. And fourthly, social workers need to challenge barriers and structural factors to facilitate individual and community access to healthy, active lives. The four proposed features of a health equality imagination are now used as a gauge to discuss whether participants' accounts of their practice appeared to be in accordance with Giles' suggestions.

Firstly, participants had an understanding about the nature of mental health inequalities and the social determinants which they used in tandem with other sources of knowledge and understanding to work with service users. Secondly, the accounts given of social workers' contributions to MDT working, as they sought to assert their professional capital in competition with others in the field, contained

many examples of promoting a social model, or sociologically informed models, of mental health. The relevance of psychological or biological explanations was not discounted or ignored, but the starting point and emphasis of social workers' explanations was about understanding service users' lives in their social context.

Thirdly, the focus on the recovery approach for many participants supported the overall sense that social workers in this study wanted to enable service users to lead meaningful and fulfilling lives. Participants referred to several of Leamy et al.'s (2011) elements of the recovery approach and, in their conversations about their practice, clearly appreciated that recovery "unfolds within a social and interpersonal context" (Topor et al. 2011, p. 90). They were able to envision a life where service users had been able to make choices about the services they received, the options they chose and how they tried to move forward with their lives. Fook's (2019) link between critical reflective practice and the sociological imagination, provides a theoretical underpinning for promoting reflection on how life could be different – better – for the users of mental health services.

The fourth feature, discerned from Giles' writing, to challenge the barriers and structural factors that restrict service users and contribute to the inequity at the core of health inequalities was much more difficult for the practitioner to action. Participants could articulate the societal structures that impacted on service users, but they did not often talk about how they, as practitioners or as members of a team or profession, could tackle them. A renewed focus on policy practice would support a more determined approach from the profession to change this limitation (Evans 2021).

Giles' vision was of a politically active profession pushing to redress current discriminations and social injustice:

> To work in this manner will require all social workers to develop a health equality imagination that restores the link between social justice and health in all areas of practice and education (Giles 2009, p. 535).

This study has demonstrated that social workers can exercise a sociological imagination in the context of multi-disciplinary working, to understand and try to

assist service users. There is potential though to further develop an explicit, deliberate, *mental health equality imagination.* That is, to take the ongoing attention to health inequalities and social determinants in general, but to focus on mental health in particular. This is challenging though, because for practitioners' sociological imaginations to flourish, it is necessary for social workers to feel supported by their employing organisation, have roles which recognise their professional identity as social workers, and accrue sufficient symbolic and professional capital in multi-disciplinary settings. If they achieve this, they will be enabled to assert a perspective that recognises the impact of the social determinants of mental health and the consequent mental health inequalities.

To develop a specific mental health equality imagination practitioners will need to consciously consider how to restore the link, as Giles suggests, between the profession's core value of social justice and its response to the persistence of mental health inequalities. Mills wrote that "Perhaps the most fruitful distinction with which the sociological imagination works, is between 'the personal troubles of milieu' and 'the public issues of social structure'" (Mills 1959, p. 14). Both aspects of service users' lives were apparent to participants, and the development of a mental health equality imagination could help to ensure, that when supporting service users to manage the downstream impacts of inequality, attention and action is also given to addressing upstream structural factors.

7.4 Reflections on, and limitations of, the study

I am a novice researcher, and no doubt made some mistakes: this was the first time I had undertaken primary data collection or analysis. There was no grant, budget or assistant to support me to organise the study. Negotiating access to the NHS was at times labyrinthian, but it feels a great success to have been able to undertake doctoral research within the health service. While my supervisors, and staff from different teams at Cardiff University, have been very supportive, by its very nature the study is limited in scope.

Methodologically, as an example of qualitative research, one of the study's strengths is the collection of accounts of social work practice that have enabled

detailed thematic analysis. My identity as a researcher, and the reflexivity that is part of qualitative research, contributed to the richness of the discussion. The research focus evolved during data analysis, which was a positive development. It was difficult to avoid the risk of desirability bias in the accounts participants gave of their work, but the use of vignettes mitigated, to an extent, against this happening. It is important to acknowledge this limitation and an observational element to future studies might further address this concern. A methodological feature of qualitative research is that findings are not generalisable to other organisations or locations (Bryman 2016). A follow up study at several locations in each of the nations of the UK would raise the confidence in the conclusions of this research study about social work practice.

This study does not systematically consider the socio-economic position or identity characteristics of the service users referred to by participants. Mental health inequalities arise from both people's socio-economic position (in relation to the social determinants of health) and from aspects of identity such as race, gender, and sexuality (Commission for Mental Health 2020). Therefore, the study's conclusions would have been strengthened by a greater level of detail about the situations and identities of the service users discussed.

7.5 Focus for future research

While this study was originally about social work practice and the social determinants of mental health, much of the discussion about the three vignette characters, and of practice, focused on social workers' experiences of multi-disciplinary working. An interesting area for future research would be to expand the study to include professionals from other disciplines. In particular, the Bourdieusian analysis of field, habitus and capital could be more revealing if information was known about how other actors perceived their power and position.

As noted in Chapter 3, I am drawn to ethnography as a method of qualitative inquiry. Future research could incorporate an ethnographic aspect to a study's design by using participant observations. This would extend the existing study beyond firsthand accounts of practice encounters, to observations of those encounters. A further development could then be to triangulate those accounts and

observations by interviewing service users and carers. This would enable knowledge to be created about service user perspectives of their contact with practitioners regarding the social determinants of mental health, and so help to counter the acknowledged absence of service user voice in research (Beresford 2019).

The concept of the sociological imagination has been explored in this small doctoral study. A much larger scale piece of research, taking in practitioners at multiple sites, exploring the usefulness of an assessment tool based on incorporating the concept of a mental health equality imagination, would support the accumulation of further research evidence regarding the concept's usefulness.

7.6 Contribution to the literature and recommendations for policy and practice

This thesis has reviewed the literature related to the sociological imagination, the social determinants of mental health and mental health inequalities. A brief history of mental health social work was discussed to contextualise contemporary multi-disciplinary practice, and the role of the recovery approach in mental health care was highlighted. As part of the literature review, I identified that research had been undertaken into the experiences of social workers in mental health services (Bailey and Liyanage 2012; Morriss 2017; Tucker et al. 2020, Bark et al. 2023), but that there was a lack of research investigating the challenges and opportunities for social workers to incorporate their understanding of the social determinants of mental health into their practice. This thesis has begun to address that research gap.

This study has added to the literature by providing a piece of primary research involving registered social workers in England discussing their understanding of the social determinants of mental health, mental health inequalities, and practice in contemporary mental health care settings. The creative use of textual vignettes to gather data that was then thematically analysed, has contributed to knowledge creation. We now know more about how social workers understand and respond to the role of the social determinants of mental health as contributory explanatory factors for the occurrence and continuation of mental distress. In extending Giles'

(2009) call for social workers to adopt a health equality imagination, to suggest more specifically, that mental health social workers should develop a *mental health equality imagination*, this study has generated new knowledge in support of this proposal. Valuing the sociological imagination, and advocating that practitioners adopt a mental health equality imagination, leads to the development of three policy recommendations for mental health social work.

Firstly, as previously advocated by Karban and Fish (2014), the social work education curriculum should include teaching and learning about the social determinants of health in general, and mental health in particular. Furthermore, the curriculum could incorporate within its sociological teachings C. Wright Mills' (1959) concept of the sociological imagination: its relative simplicity and broad definition make it accessible and applicable to many social work settings. Enhancing the curriculum in this way could support students to make links between the values of the profession and how these can be harnessed if a mental health equality imagination is adopted. As a social work academic, I have begun to introduce teaching about C. Wright Mills' work to undergraduate students.

Secondly, practitioners in multi-disciplinary contexts should be given support to develop their distinct contribution to their teams, based on their insights derived from applying a mental health equality imagination. Adopting this approach may help practitioners to make comprehensive assessments that incorporate an understanding of the social determinants of mental health inequalities. Profession based supervision and ongoing training, which are identified as important aspects of social work practice (Beddoe 2010; Beddoe et al. 2014), would support this focus. In Bourdieusian terms, this could help practitioners to have more influence in the field of mental health care. Their symbolic and professional capital (Beddoe 2011) might have more influence in multi-disciplinary settings, as a result. Post qualifying training for the AMHP role could use the concept of a mental health equality imagination to support practitioners to meet their duty to consider the least restrictive option (Rooke 2020) before making applications for compulsory detention. It may also help AMHPs to articulate and reclaim "the lost social perspective" (Fish 2022, p. 3) in statutory mental health practice.

Thirdly, Chapter 4 highlighted the impact of social workers being employed by either a local authority or the trust, and of working as either social workers or generic mental health practitioners. Further research could be undertaken to understand the experience of social workers in these settings and how best to support their professional development. It took the social work profession in the UK many years to acquire its registered status and protected title. It would be interesting to know more about the circumstances that lead some mental health practitioners to effectively obscure or compromise that professional identity, by being employed as generic practitioners.

7.7 Final remark

It is through our imaginations that we visualise and articulate our hopes and dreams. This thesis has considered whether through accessing a sociological imagination, social workers gain a more complete understanding of service users' lives.

Who participants worked for, what role they had, and how they negotiated relationships with team colleagues, all influenced how their imaginations, empathy and practice wisdom informed their actions. Participants often talked in ways that suggested they could access their sociological imagination, and I believe practitioners should be further guided to do so:

> The sociological imagination is a quality of mind that seems most dramatically to promise an understanding of the intimate realities of ourselves in connection with larger social realities.
>
> (Mills 1959, p. 22)

Appendix A: Participant information sheet

V1.0 12th Nov 2021

IRAS Project ID: 305930

PARTICIPANT INFORMATION SHEET

Social work, mental health inequalities, and the sociological imagination.

You are being invited to take part in a research project. Before you decide whether or not to take part, it is important for you to understand why the research is being undertaken and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish.

Thank you for reading this participant guide.

1. What is the purpose of this research project?

My name is Robert Lomax, and I am a registered social worker, who previously worked in mental health services for about fifteen years. I am now a Senior Lecturer at the University of the West of England, and I am undertaking this project as part of my doctoral studies at Cardiff University.

The project aims to understand aspects of mental health social workers' experiences of working within an NHS mental health Trust. The social determinants of mental health and mental health inequalities are important factors affecting the lives of people who use mental health services. I am interested to understand how social workers are able to use their understanding of mental health inequalities to inform their work with service users.

2. Why have I been invited to take part?

You have been invited because my research is taking place within the [trust]. I am interviewing a number of registered social workers, either employed directly by the Trust, or employed by a local authority but working within integrated mental health services that the trust delivers. The conversations I have with social workers will form the data for my research.

To take part in the study you must be a:

- Social worker registered with Social Work England, *and*
- Be employed by the [trust], *or*
- Be employed by a local authority but work within the [trust] because of a partnership agreement with your employing local authority, *and*
- A proportion of your regular duties must be direct practice with service users over eighteen years of age.

If you a registered social worker employed by the [trust], but your current duties do not involve direct practice with service users, you cannot take part in this study.

3. Do I have to take part?

No, your participation in this research project is entirely voluntary and it is up to you to decide whether or not to take part. If you decide to take part, I will discuss the research project with you and ask you to sign a consent form.

If you decide not to take part, you do not have to explain your reasons and it will not affect your legal rights. Whether you participate, or not, will have no impact on your employment, and your line manager will not be informed whether you have participated or not. You are free to withdraw your consent to participate in the research project during the data collect stage, without giving a reason, even after signing the consent form.

4. What will taking part involve?

You will be asked to participate in a one-to-one interview with me.

The interview may take place either face-to-face at an agreed location, or online via Microsoft Teams or similar application. You can decide whether you would prefer to participate online or face-to-face. The interview is likely to last around 45-60 minutes but please set aside an hour and a half to allow for set up and debrief processes to take place.

The interviews, both face-to-face and online, will be recorded and a transcript subsequently created.

You will be asked to read a number of short vignettes/accounts related to mental health care and then to comment on what you have read.

The interview is semi-structured, meaning that I will have some topic areas that I will want to discuss but that there will also be considerable scope for you to discuss aspects of your own practice.

5. Will I be paid for taking part?

There is no payment for taking part, but you participation is very much appreciated, and it can be undertaken as part of your standard working hours.

6. What are the possible benefits of taking part?

There may be no direct advantages or benefits to you from taking part, but your contribution will help develop my understanding of the nature of contemporary social work practice. The final thesis and future publications that will result from this research will contribute to the knowledge base about social work practice. Other people will hopefully benefit from reading them. It might be that you will feel a benefit from having been able to have an extended conversation about your social work practice.

7. What are the possible risks of taking part?

The risks of participation for most people will be very low. For some though, discussing their professional practice might mean upsetting memories are revisited. This could possibly cause some upset or distress. At the end of each interview there will be an opportunity to talk with the researcher about the experience of participating in the research. Participants can also use their usual supervision processes to reflect on their experience of participating in the research project.

8. Will my taking part in this research project be kept confidential?

All information collected from (or about) you during the research project will ordinarily be kept confidential and any personal information you provide will be managed in accordance with data protection legislation. Please see 'What will happen to my Personal Data?' (below) for further information. Information you discuss will be kept confidential and anonymised for the purpose of the research project. However, as a registered social worker with Social Work England, I am obliged to share information with others if a safeguarding or serious professional practice issue arises.

Therefore, in exceptional cases, the research team may be legally and/or professionally required to over-ride confidentiality and to disclose information obtained from (or about) you to statutory bodies or relevant agencies. Where appropriate, the research team will aim to notify you of the need to break confidentiality (but this may not be appropriate in all cases).

9. What will happen to my Personal Data?

Personal data, according to the General Data Protection Regulation (GDPR) means any information relating to an identifiable living person who can be directly or indirectly identified in particular by reference to an identifier.

This project will be collecting the following personal data:

- Name
- Location of team base
- Email address
- Age
- Gender
- Contact phone number

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. Further information about Data Protection, including:

- your rights
- the legal basis under which Cardiff University processes your personal data for research
- Cardiff University's Data Protection Policy
- how to contact the Cardiff University Data Protection Officer
- how to contact the Information Commissioner's Office

may be found at:

https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection.

Your personal data will be processed over the period spring 2022 to autumn 2023. Within one month the research team will anonymise all the personal data it has collected from, or about, you in connection with this research project, with the exception of your consent form [including details of any other personal data which must be retained]. Your consent form [including details of any other personally identifiable information which must be retained] will be retained for five years after the end of the research project and may be accessed by members of the research team and, where necessary, by members of the University's governance and audit teams or by regulatory authorities. Anonymised information will be kept for a minimum of five years after the end of the research project but may be published in support of the research project and/or retained indefinitely, where it is likely to have continuing value for research purposes.

If you withdraw your consent to participate in the research project during the data gathering stage (January 2022 to January 2023), then your personal data will be deleted.

10. What happens to the data at the end of the research project?

At the end of the research project the data will continue to be stored by secured means. It maybe that the data is used to inform future research projects or publications. The data will not be made publicly available or shared outside of the university in its 'raw form'. Personal data (see above) will be removed before use is made of the overall data set gathered for this research project.

11. What will happen to the results of the research project?

The results of this study are likely to be published from autumn 2023 onwards. It is my intention to publish the results of this research project in academic journals and present findings at conferences. Participants will not be identified in any report, publication or presentation. Anonymised verbatim quotes may be used in any publication or presentation.

12. What if there is a problem?

If you wish to complain or have grounds for concerns about any aspect of the manner in which you have been approached or treated during this research, please contact me, or my supervisors, Dr. Tom Slater (slatertb1@cardiff.ac.uk; Tel: 02920 874155) and/or Dr. Dan Burrows (burrowsdr1@cardiff.ac.uk; Tel: 02920875501), in the first instance. We hope to be able to resolve any issues in a timely and constructive manner. If though, you do not feel your concern has been handled to your satisfaction then you should contact the Chair of the Social Sciences School Research Ethics Committee via socsi-ethics@cardiff.ac.uk.

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, you may have grounds for legal action, but you may have to pay for it.

13. Who is organising and funding this research project?

The research is organised by Robert Lomax (Doctoral Student), Dr. Tom Slater (Supervisor), Dr. Dan Burrows (Supervisor) and the School of Social Sciences in Cardiff University.

14. Who has reviewed this research project?

This research project has been reviewed and given a favourable opinion by the School of Social Science Research Ethics Committee, Cardiff University. Sponsorship for the project has been given by the Research Integrity, Governance and Ethics Team, Cardiff University. Approval for the research to be conducted within the NHS has been given by the Health Research Authority. Approval for the research to take place within the [trust] has been given by the trust's Research and Development office.

15. Further information and contact details

Thanks for reading through this information. If you would like to take part in this research, or if you have any further questions, you can contact me by phone or email. If you do decide to participate, we will make a time to meet up, either face to face or online, to undertake the interview.

Robert Lomax
Principal Researcher
Lomaxr@Cardiff.ac.uk
Telephone: 01173 281678

Thank you for considering taking part in this research project. If you decide to participate, you will be given a copy of this Participant Information Sheet and a signed consent form to keep for your records.

Appendix B: Consent form

V1.2 8TH Dec 2021

IRAS Project ID: 305930

CONSENT FORM

Title of research project: **Social Work, Mental Health Inequalities, and the Sociological Imagination**

SREC reference and committee: 32. SOCSI committee.

Name of Principal Investigator: Mr. Robert Lomax
Email: Lomaxr@cardiff.ac.uk

Academic supervisors: Dr. Dan Burrows and Dr. Tom Slater

	Please initial box
I confirm that I have read the information sheet dated 12th November2021 Version 1.0 for the above research project.	
I confirm that I have understood the information sheet dated 12th November 2021 Version 1.0 for the above research project and that I have had the opportunity to ask questions and that these have been answered satisfactorily.	
I understand that my participation is voluntary, and I am free to withdraw at any time without giving a reason and without any adverse consequences (e.g. to medical care or legal rights, if relevant).	
I understand that data collected during the research project may be looked at by individuals from Cardiff University or from regulatory authorities,	

where it is relevant to my taking part in the research project. I give permission for these individuals to have access to my data.	
I consent to the processing of my personal information [e.g. name, place of work, contact details, etc.] for the purposes explained to me. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence, unless disclosure is required by law or professional obligation.	
I understand who will have access to personal information provided, how the data will be stored and what will happen to the data at the end of the research project.	
I consent to being audio recorded and/or video recorded for the purposes of the research project, and I understand how it will be used in the research. I understand the audio/video recording will be transcribed, either manually or using an automated system, and that this may be undertaken by a professional transcription service in accordance with relevant Cardiff University policies.	
I understand that anonymised excerpts and/or verbatim quotes from my interview may be used as part of the research publication.	
I understand that the findings and results will be presented in a thesis that will be publicly available after it has been completed, and that the researcher may also publish findings through academic journals and other means of publication.	
I agree to take part in this research project.	

Name of participant (print)	Date	Signature

*Please indicate your age category **(optional)**:*

21-25	26-30	31-35	36-40	41-45	46-50
51-55	56-60	61-65	66-70	71-75	75+

*Please indicate your gender **(optional)**:*

Female	Male	Non-binary	Other

Robert Lomax		
Name of person taking consent	Date	Signature

Role of person taking consent: Principal Researcher.

THANK YOU FOR PARTICIPATING IN OUR RESEARCH

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP

Appendix C: Semi-structured interview schedule

v. 5 13th April 2022

Semi-Structured Interview Schedule

Start

1. Thank participant for finding the time to take part in the research.
2. Make sure participant has read the participant information sheet.
3. Make sure participant has read and signed the consent form.
4. Rob to sign the consent form: can this be photocopied on the premises?
5. Remind participant that the interview is being recorded, that participation is voluntary, and that their consent can be withdrawn at any time during the project's data collection stage.
6. Inform participant that they should anonymise the name of any service user or carer they refer to during the interview.

START RECORDING

State date of interview and name of participant

Preamble and opening questions

Thanks for meeting with me it will be really helpful to hear your views today.

I am interested in how social workers understand mental health inequalities and the impact of social factors on peoples' mental health. Examples of social factors are education, housing and employment.

Mental health inequalities are an unfair distribution of factors that influence our mental health, an unfair access to services, and an inequality of outcome from those services.

I want to learn more about how the social determinants of mental health contribute to the mental health inequalities that some people experience.

During the interview today, we are going to review the three short case vignettes but to begin with though, I would like to ask a few general questions about your professional role and background.

- *From our email exchange I know a little bit about your work, but can you tell me about the team you work in, your current role and how long you have been in post?*
    - *Prompt: is it a multi-disciplinary team?*
- *What is it you like best about your current role and what do you find most challenging?*
- *Could you tell me how long you have been qualified as a social worker and outline some of the previous roles you have undertaken?*
- *Are you employed by the trust or a local authority (and which one if it's an authority)?*
- *Are you a qualified AMHP? If not, do you aspire to become one?*

Thank you.

Vignettes

Okay, we are now going to look at three vignettes that feature the characters Amira, Akiel and Jack.

I would like you to read each vignette in turn and then I'll ask you some questions about each one.

So, first of all please just read the first vignette about Amira.

Amira

- Social determinants of mental health elements: female, lack of social support, migration, social isolation, low social capital.
- Private troubles/biography: anxiety, loneliness, loss, dislocation, trauma, income.
- Public issues/history: treatment of asylum seekers, immigration system, community relations Syrian civil war.

- *How would you explain the cause of Amira's mental health difficulties and experiences?*
- *How do you think Amira's experiences have been impacted by social factors?*
- *Do you think the Amira may have experienced the impact of mental health inequalities, either in the likelihood of factors that can cause poor mental health, in accessing services or the outcome of services?*
- *What factors, other than social factors, do you think might have impacted on Amira's mental health?*
- *To what extent do you think Amira's difficulties result from issues related to her as an individual or to factors related to a wider interpretation of her situation?*

Akiel

- Social determinants of mental health elements: not living with a partner, from a BAME background, limited family support, racism, low income.
- Private troubles/biography: serious mental health issues, multiple hospital admissions, lack of money, friends & family.
- Public issues/ history: post ward immigration, racism and discrimination, disproportionate admissions to hospital for people from BAME communities, nature of welfare support (food banks).

- *How would you explain the cause of Akiel's mental health difficulties and experiences?*
- *How do you think Akiel's experiences have been impacted by social factors?*

- *Do you think the Akiel's may have experienced the impact of mental health inequalities, either in the likelihood of factors that can cause poor mental health, in accessing services or the outcome of services?*
- *What factors, other than social factors, do you think might have impacted on Akiel's mental health?*
- *To what extent do you think Akiel's difficulties result from issues related to her as an individual or to factors related to a wider interpretation of her situation?*

Jack

- Social determinants of mental health elements: nil
- Private troubles/biography: low mood, self-harm/suicidal thoughts,
- Public issues/ history: drug misuse, high male suicide rates

- *How would you explain the cause of Jack's mental health difficulties and experiences?*
- *How do you think Jack's experiences have been impacted by social factors?*
- *Do you think the Jack may have experienced the impact of mental health inequalities, either in the likelihood of factors that can cause poor mental health, in accessing services or the outcome of services?*
- *What factors, other than social factors, do you think might have impacted on Jack's mental health?*
- *To what extent do you think Jack's difficulties result from issues related to her as an individual or to factors related to a wider interpretation of her situation?*

Questions about practice

I would like to move on now to ask a few questions about your own social work practice.

- *Can you give me an example of when you have used the recovery model in your own approach to practice?*
    - *Prompt: can you be specific*

- *Can you tell me about a time when your experience of multi-disciplinary working went well?*
    - *Prompt: what do you think of that experience now, when you look back on it?*

- *Can you tell me about a time when your experience of multi-disciplinary working badly?*
    - *Prompt: what do you think of that experience now, when you look back on it?*

- *What knowledge and theory base informs your work as a mental health social worker?*
    - *Prompts: law/psychology/sociology/health.*

- *From your own practice, can you give me an example of when you have been able to address the social determinants or mental health inequalities?*
    - *Prompts: housing/education/social capital/discrimination/income*

- *What is it like being a social worker in an NHS Trust?*
    - *Prompt: and are you employed by LA or the Trust?*
    - *Prompt: How does social work fit with other professions within your team?*

- *What do you think are the strengths and weaknesses of the recovery approach in mental health?*

Ending

Thanks for your time today.

- *Is there anything else you would like to say that I haven't asked about, or you haven't had the opportunity to say?*
- *Do you have any questions for me about the interview process or the project?*

Make sure participant is aware that if undertaking the interview has caused them any difficulties or distress, then I am available now – at the end of the interview – or at a later date, to listen to talk with them. Double check participant has my contact details.

STOP RECORDING

Appendix D: Vignettes

v 5. Participant. 4th April 2022

VIGNETTES

Vignette one: Amira

Amira is a 37-year-old Muslim woman who has a diagnosis of post-traumatic stress disorder. Amira tells her social worker that she experiences very high levels of anxiety, flashbacks and horrible nightmares whenever she manages to sleep. Amira applied for asylum in the UK in 2014, having escaped from the Syrian civil war, and was granted indefinite leave to remain. Having been resettled in a small city she feels isolated. Her neighbours are elderly, and she feels they resent her living in the flat next door. Amira has a very limited social network with no family close by and the city only has a small Muslim community. Amira's anxiety means she does not often leave her flat and her mood is often low too. Amira lost many family members in the Syrian civil war.

Vignette two: Akiel

Akiel is a 47-year-old black English man who has experienced episodes of psychosis. He has been admitted many times to psychiatric hospital, sometimes under a section of the mental health act. Akiel has found it difficult to keep jobs and has not worked for some time. Akiel has lived in a variety of supported living schemes and privately rented rooms, is reliant on benefits, and uses a local foodbank. He has few friends but does have a very loyal brother who tries to help. Akiel has been involved in confrontations with people in his local area, mainly when he is unwell, and says he feels watched. He has been the subject of verbal racist abuse as well as graffiti daubed on the door of his current flat. The local mental health team try to engage Akiel but often he won't see staff and he is reluctant to take medication.

Vignette three: Jack

Jack is a white English 24-year-old man, referred by his GP, for an assessment by secondary mental health services. This followed Jack reporting persistent low mood and the development of some thoughts of self-harm and suicide.

Jack was brought up by his mum and dad, living in a good area of town with lots of opportunities. Jack did well at school and sixth form college. He went away to university to study engineering but found it hard to settle. He became quite isolated and stopped attending lectures. He failed some first-year assessments and had dropped out by Easter.

With his dad's encouragement and guidance, Jack then managed to get an apprenticeship to train to be an electrician which he enjoyed but, around the same time, he was smoking cannabis heavily. This meant Jack started to miss work and eventually he dropped out of his apprenticeship.

Jack has since done various low-skill temporary jobs but has struggled to maintain steady employment. His parents continue to support him, but he is frustrated to still be living at home.

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