The Social Work/Mental Health Boundary: A Qualitative Exploration

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Declaration

The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to others' work. The candidate also confirms that no text of this thesis has been artificially generated.

Signature:  Date: September 24th, 2026

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List of Abbreviations

ADHD	Attention Deficit and Hyperactivity Disorder
AMHP	Approved Mental Health Professional
APA	American Psychiatric Association
APSW	Association of Psychiatric Social Workers
ASSIA	Applied Social Sciences Index and Abstracts
ASW	Approved Social Worker
BACP	British Association of Counselling and Psychotherapy
BASW	British Association of Social Work
BFSW	British Federation of Social Workers
BIA	Best Interest Assessor
BNF	British National Formulary
BPD	Borderline Personality Disorder
CA	Children Act
CAMHS	Child and Adolescent Mental Health Services
CASP	Critical Appraisal Skills Programme
CBT	Cognitive Behavioural Therapy
CBT T	Cognitive Behavioural Therapy (Ten)
CINAHL	Cumulative Index of Nursing and Allied Health Literature
CMHT	Community Mental Health Team
CQC	Care Quality Commission
CQSW	Certificate of Qualified Social Worker
CSPR	Child Safeguarding Practice Review
DBT	Dialectical Behavioural Therapy
DfE	Department for Education
DSM	Diagnostic and Statistical Manual
ECM	Every Child Matters
EMDR	Eye Movement Desensitisation and Reprocessing
EUPD	Emotionally Unstable Personality Disorder
GALENOS	Global Alliance for Living Evidence on aNxiety, depressiOn and pSychosis
GMC	General Medical Council
GP	General Practitioner
GSCC	General Social Care Council
GT	Grounded Theory
HCPC	Health and Care Professions Council
HMI	His Majesty's Inspectorate
HMPS	His Majesty's Prison Service
ICD	International Classification of Diseases
IFSW	International Federation of Social Workers
IMCA	Independent Mental Capacity Advocate
IMHA	Independent Mental Health Advocate
IPA	Interpretive Phenomenological Analysis

LA	Local Authority
LCSW	Licensed Clinical Social Worker
LSE	London School of Economics
MACPU	Multi-Agency Child Protection Units
MCA	Mental Capacity Act
MHA	Mental Health Act
MHFA	Mental Health First Aid
NASW	National Association of Social Workers
NCPS	National Counselling and Psychotherapy Society
NDLTD	Networked Digital Library of Theses and Dissertations
NDPB	Non-Departmental Public Body
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NMC	Nursing and Midwifery Council
OCD	Obsessive Compulsive Disorder
ODD	Oppositional Defiant Disorder
Ofsted	Standards in Education, Children's Services and Skills
OST	Open Systems Theory
PSW	Psychiatric Social Worker
PTSD	Post Traumatic Stress Disorder
PVI	Private, Voluntary and Independent
RTA	Reflexive Thematic Analysis
SCR	Serious Case Reviews
SDMH	Social Determinants of Mental Health
SIT	Social Identity Theory
SPIDER	Sample, Phenomenon of Interest, Design, Evaluation, Research type
SSD	Social Services Department
ST	Systems Theory
SWE	Social Work England
SWTF	Social Work Task Force
TA	Thematic Analysis
TF CBT	Trauma Focused Cognitive Behavioural Therapy
UKIRO	United Kingdom Research Integrity Office

Abstract

This study qualitatively investigates the conceptual border between social work practice and mental health practice. It explores how social workers experience, interpret and navigate mental health issues that are shaped by power imbalances, managerialism and fragmented inter-professional relationships. Drawing on the theoretical lenses of boundary spanning and the social/medical model debate, the research examines where social work is perceived to end, where mental health care begins, and how social workers operate within this contested space.

Social work and mental health services in the United Kingdom are historically organised within distinct professional, legislative and philosophical silos. Mental health provision is largely situated within the National Health Service and grounded in medicalised models of diagnosis and treatment, while social work practice is embedded within Local Authorities and informed by social, environmental and relational frameworks. Despite these formal boundaries, contemporary social workers increasingly encounter complex and severe mental health issues in routine practice. Global socio-economic pressures, including the 2008 financial crisis and the COVID-19 pandemic have contributed to rising levels of psychological distress. Consequently, social workers are frequently required to respond to poor mental health despite limited training, authority and access to mental health resources. This creates significant professional tension, uncertainty and emotional strain.

An interpretivist research design was adopted to capture the subjective meanings social workers attach to their experiences. Serial, in-depth interviews were conducted with 11 qualified social workers practising in the United Kingdom. Following an initial meeting, participants were interviewed on two occasions. A total of 22 interviews were undertaken. This approach enabled the exploration of participants' reflections, allowing for deeper insight into how experiences of mental health are understood, rationalised and emotionally processed. Interview transcripts were analysed using Reflexive Thematic Analysis (RTA),

resulting in a four-part thematic framework providing an intuitive and theoretically grounded explanation of social workers' experiences.

Findings reveal that social workers routinely engage with severe mental distress while operating without the recognition, resources or legitimacy afforded to medical professionals. Participants described tensions arising from medical dominance, role ambiguity, and limited collaboration with mental health services, alongside feelings of responsibility, frustration and powerlessness. These conditions frequently generated moral distress, contributing to emotional exhaustion. At the same time, social workers demonstrated adaptive strategies consistent with boundary-spanning practice, including negotiation, translation between professions and problem-solving to meet service users' needs.

This thesis makes original contributions to knowledge throughout. In its entirety, it articulates how social workers conceptualise mental health, professional identity and inter-professional boundaries within contemporary UK practice. The literature review concludes by offering a new way of thinking about an existing conceptual construct providing social workers with language to capture possible erroneous assumptions. The recommendations offer a re-conceptualisation of an existing model used to explain complexity in social work and offer suggestions to improve social work education to include mental health knowledge. Lastly, it provides an evidence-based argument for a new socio-therapeutic model of advanced social work practice to better address the overlap between the social and mental health domains, building upon, but conceptually distinct from, existing Advanced Practitioner roles in the UK.

1 Introduction

1.1 Purpose

This research qualitatively explores how UK generic social workers conceptually navigate the boundary between social work and mental health. Social work is a global practice and is informed by cultural, political and economic factors. Because I have had the opportunity to practise social work in three countries and in different contexts, the impetus of this research largely stems from my professional experiences, thoughts and observations.

I received my master's degree in social work in 2002 in America but shortly thereafter moved to the United Kingdom where I practised as a safeguarding social worker for 5 years. I then lived and worked in New Zealand for a further 1.5 years before returning to the United States for a further 10 years. I later returned to the United Kingdom.

To carry the title of "social worker" in the United States, one must have completed a master's degree in social work from an accredited university. These social workers carry out traditional tasks such as care planning and safeguarding. However, after three years of further supervised training and the completion of an exam, one may obtain the Licensed Clinical Social Work (LCSW) qualification. LCSWs are qualified to diagnose and treat a range of mental health disorders and are financially reimbursed by third parties (usually insurance companies) for their work, essentially transforming the social worker into a psychotherapist. I obtained this qualification in 2016.

Shortly after, I moved back to the UK and worked as a social worker in an inpatient Priory Mental Health Hospital primarily with adolescents in the Child and Adolescent Mental Health (CAMH) ward. This gave me the opportunity to begin exploring how social work and mental health worked together in the UK.

The different social work cultures between these countries and my roles as social worker and "mental health social worker" in the UK and in America informed my curiosity concerning where standard social work practice conceptually stops, where mental health skills begin, and how UK social workers psychologically and practically navigate that boundary. This research is an attempt to answer that question.

1.2 Topic and Research Overview

Viewed through the theoretical lenses of boundary spanning and the medical/social model debate, this thesis explores where social work stops, where mental health psychotherapy begins and how social workers navigate the two within the constructs of practice and the structures of the UK helping industries.

The helping professions in the United Kingdom are heavily defined by their siloed boundaries (Heenan, 2018). Mental health services exist, operate and are distributed by the National Health Service (NHS) and its medically trained staff, primarily mental health nurses, general practitioners and psychiatric consultants. Social services are operated by the Local Authority (LA) and are staffed by social workers, family support workers and social care staff. Further, different legislation informs how the respective staff practise; social services use the Care Act 2014 to assess adult needs and the Children Act 1989 to inform safeguarding procedures (Brammer, 2020). Conversely, mental health services typically use the Mental Health Act 1983 to determine risk and eligibility for hospitalisation (ibid). Treatment is also different; framing stress as a social issue, social workers will use a range of support methods typically targeting the environment (Fook, 2016) while medical staff, operating from a medical model, have access to medications and psychotherapeutic modalities. These different philosophies even impact the language used: social workers work with service users; medical staff work with patients.

However, in practice, these boundaries are not so clear. Global events have contributed to an increase in mental illness including economic pressures stemming from the financial crisis of 2008 (Coope et al., 2014), adolescent use of social media (Twenge, 2018) and the COVID-19 pandemic (Al Dhaheri et al., 2021). Social work is one of many professions finding itself

confronted with and being pressured to address serious mental health issues among the general population (Tsirimokou, Kloess and Dhinse, 2023) including severe depression, acute anxiety, psychosis and suicidal ideation. Social work is unique among these professions as it already borrows many ideas from psychology and counselling to inform standard practice (Karban, 2011; Golightley, 2020). Additionally, social workers by the nature of the work, will routinely encounter people struggling in life: domestic violence, substance abuse, poverty, adult and child abuse are all issues easily connected with underlying mental health issues (Worsley et al., 2013). However, like many industries, social work has been impacted by neo-liberalism and managerialism (Belloc and Nicita, 2012; Dustin, 2016) which has shifted social work's emphasis away from direct service user contact to desk-based administration.

Medical staff enjoy a level of authority not seen in social work (Devaney, 2008). Largely drawn from the historical confidence and trust society has placed in medical doctors (Davies, 2014), their diagnoses carry with them access to services, powerful psychotropic medication and the power of sometimes lifelong labels (Mogensen and Mason, 2015). Conversely, social work's relatively late arrival to the helping industry informs its struggle to compete alongside medical certainty (Bamford, 2015). These power imbalances manifest in several complex ways including social workers' conclusions being ignored or medicalised (Hood, 2015). Adding further pressure, social work is legislated to remain involved with adults, children and families long after health has withdrawn due to "disengagement."

Despite routinely engaging with profoundly unwell service users, for a variety of reasons, social work has failed to take the lead concerning the national mental health conversation (Rogers and Pilgrim, 1996; Bamford, 2015). This is reflected in the lack of mental health education social work students receive (Karban, 2003; Galvani, Hutchinson and Dance, 2014), the minimal mental health training available to qualified social workers and the disjointed relationships social workers have with mental health practitioners (Devaney, 2008; Hood, 2015). Social workers are then left to address mental health issues the best they can. Viewed through the lens of moral distress, these experiences leave social workers burned out and physically and mentally unwell as they watch young adults suppress trauma, become labelled with personality disorders and adults receive less than optimum care (Mänttäri-van Der Kuip, 2016; Lev, 2024).

1.3 Research Question, Aim and Objectives

1.3.1 Research Question

The overarching research question guiding this study is:

What is the nature of the boundary between social work and mental health?

1.3.2 Research Aim and Objectives

The aim of this research is to explore the experiences social workers have when confronted with mental health issues in practice. This was addressed through the following research objectives:

1. Develop an understanding of how social workers conceptualise what it means to be a social worker.

2. Evaluate how social workers define and conceptualise mental health.

3. Investigate social workers' experiences when working with mentally distressed service users.

4. Understand the challenges social workers face when interacting with mental health services.

5. Examine how social workers think and feel when reflecting on these experiences.

1.4 Research Design

To facilitate the exploration of social workers' experiences, an interpretivist philosophical position was adopted. The research was advertised nationally via different methods.

Qualified social workers (n=11) working for the Local Authority in either adult or children's teams were recruited from different areas of the UK. To address the research objectives, each participant completed an elicitation meeting and two subsequent interviews. The subsequent transcripts were aggregated and analysed using Reflexive Thematic Analysis (Braun and Clarke, 2021) resulting in an inductive, four-part thematic framework explaining social workers' experiences with the intention to convey an intuitive story of not only how social workers navigate this boundary, but how these experiences change them as professionals.

1.5 Thesis Structure

This thesis is organised into nine chapters. Following this introductory chapter, Chapter 2 provides the background to the research, examining the historical development of social work and mental health, contemporary service structures and professional identities, and the wider social and political context within which the social work/mental health boundary exists. Chapter 3 establishes the theoretical foundations of the thesis, focusing on the social/medical model debate and boundary spanning, including professional roles and identities and the application of boundary-spanning theory to social work and mental health practice. Chapter 4 presents the literature review and thematic synthesis of existing research concerning social workers' experiences of the social work/mental health intersection, culminating in the development of the Endogenic Thinking framework.

Chapter 5 describes the methodology and methods used in the empirical study, including its philosophical foundations, recruitment and sampling, serial interviewing, Reflexive Thematic Analysis, ethical considerations and limitations. Chapter 6 presents the empirical findings through four overarching themes: Being a Social Worker, The Approach, Metamorphosis (Becoming Something More), and Aftermath. Chapter 7 analyses and discusses these findings in relation to the existing literature and theoretical framework, before presenting the study's key knowledge contributions, including Endogenic Thinking, the Social Worker's Transformation, a reconsideration of the Toxic Trio, and the proposed socio-therapist credential. Chapter 8 draws together the findings in relation to the research objectives and

presents the overall conclusions of the thesis. Finally, Chapter 9 sets out recommendations for policy, practice, education and further research.

2 Background

2.1 Introduction

This chapter introduces the background context that anchors the key concerns underpinning this research, including key definitions, history, and practice context. Definitions include a contemporary understanding of social work and mental health, highlight important historical points for both professions and briefly examine times when their interests and practice intersect. The contemporary practice discussions explore themes around the complex nature of social work, the implications of COVID-19, recent child deaths, and the manifestation of neoliberal ideologies in social work.

2.2 Key Concepts and Brief History

The following discussions define key concepts which are used throughout this project. There is a precedent of providing history to inform current definitions, particularly in psychological academic work concerning the "science of emotion" (Feldman Barrett, 2014; Kennedy, 2015). Because this research is concerned with two strongly socially constructed ideas, social work and mental health, defining these phrases requires more than a simple agreement or synthesis from multiple sources. Instead, it's useful to understand the current definitions within the context of their evolved histories.

2.2.1 The Historical Basis of Social Work

Social work, internationally, stems from general charity work (Bamford, 2015). Charities were established to address issues of poverty and were generally seen as sources of temporary financial, material goods, or food support. This was largely in response to the increasing

wealth disparity triggered by an increasingly capitalist society found in Western cultures, specifically during the turn of the 20th century (Burt, 2020). Advocating and caring for the most vulnerable of society was also seen as falling into social work's remit, starting with the most visibly vulnerable (i.e. people with disabilities, orphans) falling into this category. As societies have changed and new vulnerable demographics have been identified (i.e. single mothers, racial minorities) social work has been expected to address discrimination-originated social disparity (Bamford, 2015; Burnham, 2016; Burt, 2020).

Considering social work as a professional or academic discipline, it could be argued that social work's journey toward professional recognition has not been as smooth as other professions, potentially because its historical duties and areas of concern have been quite broad and its current function is relatively new. For example, modern medicine's purpose has been understood since the Renaissance when it moved from Galenic notions of humours to the current scientific paradigm pioneered by the likes of Vesalius and Paracelsus (Bynum, 1997) with UK doctors being recognised as such since the establishment of the Royal College of Physicians in 1518 (ibid). Similarly, professions associated with the legal system, in whatever form it has taken over time, have existed since the Code of Hammurabi was carved into ancient stele in approximately 1750 BCE (Padoa Schioppa, 2017), culminating in the origins of the current UK legal system founded on Common Law from 1066. Ask any child what a doctor or judge does, and one is likely to get a reasonable answer.

Contrasting these ancient and well-defined professions, Bamford and Bilton (2020) describe social work's first major step toward professional recognition in the UK originating in 1934 with the establishment of the British Federation of Social Workers (BFSW). This organisation was an amalgamation of six other professional associations, two of which were the Association of Mental Health Social Workers and the Association of Psychiatric Social Workers (APSW) discussed in the next paragraph. Not without controversy, two other associations refused to join, stating that social work's "implied definition" was "too wide" (ibid). It would seem that this concern was legitimate, given the broad working environments in which social workers found themselves, and since most were not formally trained at this point (Bamford, 2015) many have been viewed as "helpers" working alongside other more established professions and it was in this context that social work first began establishing itself as a

recognised, distinct profession; the psychiatric social worker. The following discussion is based upon Noel Timms' "Psychiatric Social Work in Great Britain" (1939 – 1962) (Timms, 2014) and David Burnham's "The Social Worker Speaks" (Burnham, 2016).

Relating to this research's topic, it is interesting to note that one of social work's early key functions existed within the context of supporting people with poor mental health. The role of the Psychiatric Social Worker (PSW) and its formation and training are worth deeper exploration since the role represents a key historic overlap of the two broader disciplines.
The title was first used in 1906 at the Boston Psychopathic Hospital in Boston, Massachusetts in the United States. Via some visiting British educators concerned about addressing child delinquency in the UK, the ideas here migrated to the United Kingdom and provided the foundation for education taking place at the London School of Economics (LSE), where the first psychiatric social workers were educated in 1929 and represented the first formal training of any social workers in the UK. Later, other psychiatric social work courses would be developed in Edinburgh (1944), Manchester (1946) and Liverpool (1954) (Henning, 2018). Based on two reports penned in 1947 by Eileen Younghusband, an early pioneer in social work training, the LSE course later evolved to generically train social workers and again, was the first training to do so in the United Kingdom (Bamford, 2015).

Students admitted to the LSE course arrived with a previous social-related degree. Curriculum focused around casework, psychoanalytic theory (the more accepted modality of the time), techniques, and lifespan theory designed to address the needs of adults in mental hospitals or "delinquent children" (Henning, 2018). The focus remained on social and environmental factors which were thought to contribute to poor mental health but also included medically modelled aetiology and diagnostic lectures concerning anxiety, schizophrenia, neuroses and what was known as "mental deficiency" (ibid).

Upon graduation, PSWs usually worked in one of three areas: community care, child guidance clinics or mental hospitals where PSWs worked alongside other professionals and generally took direction from psychiatrists. However, the events and social changes post-World War II greatly impacted the role and many PSWs found themselves working more independently, mostly in newly developed child guidance clinics, the establishment of which was a response

to children separated from parents and families during the London bombings and the Education Act of 1944, which required local authorities to support "maladjusted pupils" (Timms, 2014).

2.2.1.1 Social Work's Emerging Identity Outside the NHS

There is much discussion among seminal writers (Timms, 2014; Bamford, 2015; Burnham, 2016) concerning how PSWs were viewed by generic social workers (or those calling themselves such) and the other professional disciplines with whom they worked. PSWs were seen as a more elite form of practitioner by the non-psychiatrically trained while the psychiatrists with whom the PSW worked viewed them anywhere between auxiliary helpers (much to the PSW's frustration) to clinically qualified professionals who only lacked some form of registration which might allow them to practise "therapy" independently, a theme which will be explored much later.

Further, the Association of Psychiatric Social Workers (APSW), founded in 1930 and comprising only those specifically trained as PSWs, was at a crossroads internally in terms of forming an identity for its members in their different roles. Some felt the role needed to be closely linked with psychiatry (drawing on the medical legitimacy psychiatry itself was struggling to maintain), while others felt the role should be more deeply connected with social work's roots in the social environment. This latter position was also fuelled by the public's growing recognition of social workers in child guidance clinics and community care sectors which contributed to social work's professional legitimacy independent of psychiatry. The issue came to a head during the NHS's embryonic stages, and the association was asked what role it pictured its members playing in the new service. Due to the association's internal strife, to some degree of its own making but exacerbated by the political nature of the decision, the association was never able to formally decide the PSW's role in the NHS and hence was never established. The consequences of this decision remain with us today. PSWs lost their status as such when the APSW was absorbed into the British Association of Social Work (BASW) in 1971. Following the Seebohm Report publication in 1968 and the subsequent Local Authority Social Services Act of 1970, social workers were shortly directed into Social Services Departments (SSD) which advocated that social workers be trained generically and without

specialisation (Bamford, 2015). The generic approach remains and is how social work is currently taught in the UK.

The PSW period represented the most fully connected historical instance of an attempt to blend social work and psychiatry in a way that, working with the best knowledge and tools of the time, aimed to support people within both medical and social frameworks. The following discussion will describe how social work is constructed currently.

2.2.2 Contemporary Social Work

Social work's definition has changed over time and geographically, underpinned by social changes and pressures, legislation and global events (Bamford, 2015). The International Federation of Social Workers (IFSW), the internationally recognised social work association, defines social work as "a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people" (IFSW, 2025). The National Association of Social Workers (NASW), the United States' professional organisation for social workers, defines social work as "a profession focused on improving people's lives through psychosocial services and advocacy, helping them address their needs and overcome challenges" (NASW, 2025b). Lastly, the British Association of Social Workers (BASW), the United Kingdom's professional association for social workers, draws heavily from the IFSW, defining the profession as "a practice-based profession and academic discipline that promotes social change, development, social cohesion, empowerment, and liberation of individuals" (BASW, 2025a). While there are other definitions, these three provide a good definition for this thesis, capturing the idea of assisting marginalised populations towards a goal of improving their lives by addressing social factors.

However, trying to fully and exhaustively define what social workers do is deceptively complex because 1) one can approach it from several directions, and 2) what social workers do is quite complex. A very practical perspective might describe social workers meeting and talking with service users, collaborating with other professionals or writing assessments and court reports (Bamford and Bilton, 2020). Exploring more deeply, social workers could be described as helping to improve people's lives, specifically those of marginalised or oppressed

populations (Thompson, 2016; Dominelli, 2018). Going deeper still, we can diverge into other disciplines: sociologically, social workers help mitigate the effect larger, systemic forces have on these populations, e.g. racism, sexism, ageism, (Thompson, 2016) while if we borrow from psychology, social workers could be seen to help people identify internal barriers which might be preventing them from reaching their potential (Tew, 2005a). Bureaucratically, social workers fulfil the local authority's legislative obligations of protecting vulnerable people like older adults, children or people with learning disabilities (Ferguson, 2016; Hughes and Wearing, 2022). A more philosophical, and one perhaps helpful for this research, comes from Rosenfeld (1983) who defines the social worker's role as filling the gaps, or the "threadbare" areas where other services do not meet people's needs. In short, social workers aim to help and support vulnerable people, irrespective of the sources of that risk or marginalisation, to meet whatever needs they might have to live a safe and satisfying life.

2.2.3 The Historical Basis of Mental Health

Defining mental health proves even more complex and again requires some historical exploration because how we categorise who is mentally unwell and who is not has evolved and changed with the currents and eddies of human history and largely depends on when and where one finds themselves. While not discounting non-colonial perspectives, because this research is concerned with mental health issues in the United Kingdom, this discussion will be limited to a European context.

Before the 15th-century European Renaissance, people who heard voices or hallucinated might be considered either in touch with a spirit world or possessed by a maleficent demon (Bentall and Beck, 2004). The rise of positivism and modern medicine took a more scientifically grounded approach, while social forces of commerce and capitalism identified this population as counter to the new demands of wealth accumulation and economic goals (Foucault, 1988). Jean Étienne-Dominique Esquirol (1772-1840), protégé of Phillipe Pinel (1745-1826), was one of the first medical professionals of the time to consider that "witches" and other criminals might be mentally unwell (Szasz, 1977), introducing the idea that mental illness originated from "within the patient," and hence placing the treatment of the illness firmly within the domain of medical practitioners. These views took the form of social policy

during the industrial revolution, where those who clearly were not able to function (i.e. work and contribute to the economy) were isolated in asylums, one of the first of which was the infamous Bethlem Royal Hospital in London, from which we get the word "bedlam," defined by the Oxford dictionary (Oxford English Dictionary, 2024) as "a scene of extreme noise and confusion, similar to chaos."

It was in these locations that early treatment research took place (Bentall and Beck, 2004). Since mental illness shows no physical indicators, despite the medical professional's attempts to make such connections (the debunked practice of phrenology, for example), explorations for a cure consisted largely of a mass trial-and-error process. Patients were hence exposed to all manner of "treatment" including extreme temperatures, sudden and frightening noises (in hopes of "shocking" the patient back to a normal state) and optical treatments such as flashing strobes and "colour therapy." The creative limits of these treatments were the doctor's own imagination, drawing serious questions as to what the treatments were designed to address- the patient's condition or the doctor's amusement (Bentall and Beck, 2004). It was under these unfortunate circumstances that the foundations of modern psychiatry took hold.

Since its inception, psychiatry has been operating under the pretence that mental illness's origins lie within the person and therefore could be treated by administering physical treatments, firmly situating mental health alongside physical health, and hence, should be treated by medical doctors. Reinforcing this notion was the general hierarchy of medical administration within the asylum, specifically placing bed access and control in the hands of the psychiatrist, with nurses, aides and early social workers orbiting around the patient administering psychiatric orders (Rogers and Pilgrim, 1996).

However, psychiatry was still very aware of its own vulnerability and was seeking a scientific basis which would dispel the subjective nature of the illnesses it claimed to treat. Eugenics, the underpinning theory explaining madness at the time, was moving out of fashion. Neuroscience now seemed a more promising field with which to align and was comparable with other medical fields such as cardiology. Therefore legitimising the profession was a high

priority, often underpinning treatment decisions (Bentall and Beck, 2004). This was made more so by the advent of World War I.

Prior to the First World War, mental illness and society's relationship to it were highly influenced by the emerging eugenics movement (Rogers and Pilgrim, 1996). Eugenics is the concept that people, like animals and plants, can be bred for socially desirable characteristics. Underpinned by this highly immoral and discredited theory, mentally unwell people were thought to be so largely due to "poor breeding;" the offspring of intellectually impaired and "degenerate" members of society. Psychiatry grounded much of its legitimacy in treating these members of society, assuming the problems originated within the person, specifically their genes. However, representing a serious threat to this assumption, and hence psychiatry's legitimacy, was the tortured state of many of England's returning service members from European combat fronts such as the Somme, Verdun and Passchendaele. These brave men were far from "degenerate" (to use the eugenic phrase of the time); however, their symptoms were often completely incapacitating and required hospitalisation alongside the "eugenically inferior" (Rogers and Pilgrim, 1996). The concept that one could be mentally incapacitated due to an environmental factor, in this case combat trauma, conflicted with the medical model that lent psychiatry its legitimacy. This presented a very public example of how the environment was considered to be a factor contributing to one's mental health (Kirk, 2004) and presented one of many existential threats to the psychiatric profession.

Scientific and technological advancements often take place within the context of ensuring national security (White, 2005). Mental illness was now considered as such, as it appeared that more soldiers were forced off the battlefield due to what we now understand to be Post Traumatic Stress Disorder (PTSD), but at the time was referred to as "shellshock" (WWI) or "combat fatigue" (WWII). Additionally, adequate draft numbers were also impacted by mental health issues (Horwitz, 2021). Consequently, the United States Army began to develop its own nomenclature to classify mental illness, which heavily influenced the American Psychiatric Association's (APA) later publication of the Diagnostic and Statistical Manual First Edition (DSM I) in 1948, its first attempt to pull together several global nosology tools in use at the time (Bentall and Beck, 2004; Horwitz, 2021).

The idea that mental health concerns were equal to unhappiness took root in post-World War II America with the advent of psychiatrists dispensing low-grade tranquilisers to dissatisfied homemakers (Hirshbein, 2014; Horwitz, 2021), a practice which became more widespread over the following decade. This coincided with the United Kingdom's disbanding and closing its asylum hospitals, resulting in the "care in the community" approach (Scull, 2021). Both transitional periods laid the foundation for debates of what symptoms constituted a mental health concern; general unhappiness, which could be experienced by anyone who experienced environmental stressors, or someone experiencing the effects of a biological disorder?

The DSM series has been a significant driver of the mental health industry with additional disorders added to DSM IV in 1994 and DSM 5 in 2013, reaching the current total of 320 recognised, diagnosable and hypothetically treatable illnesses (American Psychiatric Association, 2013). DSM is now considered the clinical determinant of what is considered a mental disorder and how these are diagnosed. It has been widely argued that the advent of the pharmaceutical industry has played a large role in DSM's expansion, as many of the physicians on the DSM task force, the body of professionals who determined what would be included in DSM (and hence what might be treated with pharmaceuticals), financially benefited from a widened field of disorders (Frances, 2013; Davies, 2014). While the UK does not legally recognise the DSM, the ICD 11 draws largely from it, and many of the diagnoses are quite similar, if not identical, in their diagnostic criteria.

Today, the World Health Organisation (WHO)'s website defines mental health as "a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (WHO, 2025). Some criticism has been levelled at this definition, specifically because of its "demanding positive account" (Murphy, Donovan and Smart, 2020), generalising statements and removing the individual from their environmental context (Galderisi et al., 2015). In 2015, the United Kingdom's National Health Service (NHS) provided new guidance, defining it as "a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment" (NHS

England, 2015). Both definitions imply that mental health is about a sense of happiness and satisfaction with one's life, however the NHS definition discusses the role that environmental factors such as abuse experiences, bullying, or poorly fitted learning environments have on mental health. In short, these sources explain that poor mental health appears to be the experience of feeling unhappy because of environmental issues, however neither speaks to what might be considered "ill mental health," or those who might be experiencing more acute, perhaps psychotic symptoms, because of a biologic disorder, a debate more fully explored in chapter 7.

Defining social work and mental health is not a straightforward task. Both concepts are deeply embedded within history, politics, and culture, and their meanings continue to evolve in response to shifting societal values, professional struggles for legitimacy, and global events. Social work's origins in charitable relief and its professionalisation through psychiatric social work highlight its longstanding tension between social work and medical frameworks, a dynamic that continues to shape the profession's identity today. Similarly, mental health has moved from pre-scientific understandings of "possession," through asylum-based psychiatry, to modern debates over diagnostic classifications and the role of environmental versus biological factors. Contemporary definitions, whether provided by international bodies or national institutions, reveal a shared emphasis on wellbeing, social functioning, and resilience, yet they also expose ongoing tensions between medicalised and socially constructed views. For the purposes of this thesis, it is crucial to hold these definitions as historically contingent and contested, recognising that both social work and mental health are not fixed categories, but evolving constructs shaped by wider ideological, professional, and societal forces.

2.3 Current Social Work and Mental Health Services in the United Kingdom

The following discussions provide an overview of the social work and mental health professions as they exist in the United Kingdom. They will briefly explore their respective education requirements, the organisations which employ their staff, some of the legislation used and the quality assurance organisations which govern and accredit their professions. It

will also include brief descriptions of current social work roles informing the mental health industry.

2.3.1 Services, Structure, Multi-Disciplinary/Interprofessional Practice and Mental Health Overlap

This section outlines how social work services are structured in the UK and explores the different employment arrangements commonly found in the social work/mental health industries and overall helping professions. It provides some definitional clarification as well as exploring some areas of interest where social work and mental health routinely overlap. This section will provide further practice and systemic context and foundation upon which later chapters will build because understanding how social work is practised and structured in the United Kingdom is pivotal to appreciating the experiences participants describe in later chapters.

2.3.1.1 Education and Professional Accreditation

The title of "social worker" is protected and has been since the formation of the General Social Care Council (GSCC) in 2001 under the Care Standards Act 2000 (Care Standards Act, s. 56-61). Social workers in the UK must be registered with their devolved corresponding accrediting organisation; Social Work England, Social Work Wales, Northern Ireland Social Care Council and the Scottish Social Services Council (BASW, 2025b). A bachelor's or Master's degree in social work from an accredited social work programme is required to become a practising social worker in the United Kingdom. Per the Complete University Guide website (2025), there are currently 159 institutions offering a social work degree course. While the curriculum across these courses varies, they will include legislation, identifying various forms of adult and child abuse, risk assessment skills, theory modules and study and practice skills. The nature of social work education in the UK has gone through some recent changes. Social work degrees can now be obtained via apprenticeship courses for those already practising in a social work team but not holding the social worker title (e.g. support worker, family support worker, etc.). These courses run in addition to the standard BA or MA courses, and in 2022-2023, this was the pathway used by 1,060 social workers (Community Care, 2024).

2.3.1.2 Services and Structure

Statutory social work in the UK is generally operated, managed and funded by the Local Authority (LA). Social work is not to be confused with "social care" which is generally understood to consist of care staff who provide basic care assistance to vulnerable adults. However, these services are directed by care plans which are designed by social workers. Social work in the UK can be divided into two large categories: statutory social work and PVI (private, voluntary and independent) practice. The PVI sector consists of charities, independent care providers, and other non-governmental bodies and these social workers are employed directly by these organisations (Burt, 2020). Statutory social work in the United Kingdom can be further divided into two hemispheres based on the demographic they serve: children and adults. These social workers are employed by one of the 317 Local Authorities in England (Burt, 2020). Children's social work consists of safeguarding (formally child protection), fostering and adoption, looked after children, physical and learning disabilities, and Children in Need. The interactions with these children and their parents and/or family are underpinned by the Children Act 1989. Adult social work consists of adult safeguarding, care needs, physical and learning disabilities, and work concerning the potential deprivation of liberties, all of which is underpinned by the Mental Capacity Act 2005.

Social workers are also employed in mental health trusts (local NHS organisations designed to provide mental health treatment), schools, hospitals, prisons and other governmental organisations which are run and managed by the NHS, HM Prison Service (HMPS) or the Department for Education (DfE) (Burt, 2020), respectively. In schools**,** social workers typically support children and families experiencing safeguarding concerns, emotional distress or social difficulties that may affect educational engagement, often working alongside teachers, educational psychologists and pastoral staff. Within hospital settings, social workers are commonly involved in safeguarding, discharge planning and the coordination of community support services for patients whose health conditions are linked to broader social needs. Social workers working within prison environments frequently support individuals

experiencing complex social and psychological difficulties, including trauma, substance use and mental distress, while also contributing to safeguarding, rehabilitation planning and preparation for release. Across these settings, social workers typically operate within multidisciplinary systems and are often required to address the social circumstances that contribute to distress, vulnerability and risk.

Which organisation manages quality assurance depends on the nature of the organisation. School quality assurance is managed by the non-ministerial government department (sometimes referred to as a quango) Standards in Education, Children's Services and Skills (Ofsted). Ofsted also oversees quality assurance for the local authority's children services and are routinely inspected and ranked via a four-point grading system (1) Outstanding, (2) Good, (3) Requires Improvement and (4) Inadequate (Maisuria and Roberts, 2024). Ofsted has come under recent criticism following the suicide of Ruth Perry, the head teacher for Caversham Primary School which Ofsted ranked as "inadequate" (ibid.). Ofsted is currently undergoing substantial reform measures since an inspection found several ways in which the organisation could improve its inspection practices. However, adult local authority social services and hospitals are quality assured by the Care Quality Commission (CQC) while prison oversight is managed by His Majesty's Inspectorate of Prisons (HMI). This somewhat confusing arrangement can make the social worker's role more complex because the same professional, depending on where she is practising, is answering to different quality assurance agencies but still regulated by Social Work England (SWE).

2.3.2 Professional Identity and Multi-Disciplinary Practice

Multi-disciplinary or multi-agency work is defined by one or more agencies working together but located separately from one another. Given the national attention children's social work often gets, usually within the context of a national tragedy, it is not surprising that much of the literature revolves around multi-agency work within this context. Special emphasis directs this work, coming from a number of different directions including specific populations such as children with disabilities (Cigno and Gore, 1999; Abbott, Townsley and Watson, 2005), children with learning needs (Tutt, 2011) or considers the overlapping themes between adults

and children with learning disabilities (Wate and Boulton, 2015). Other special populations, again usually children, concern racial minority children (Thoburn, Chand and Procter, 2005; DeNard, Garcia and Circo, 2017) and how services provide inequitable levels of care across populations. Conceptually, multi-agency work has been considered more broadly with particular emphasis on collaboration within risk mitigation contexts reflecting policy changes and best practice guidelines following the Climbie and Connolly child deaths (Moran et al., 2007; Blyth, 2014; Barton, 2018). These works provide broad strokes, outlining organisational, value and logistical conflicts which contribute to poor outcomes. Other works concern themselves with specific agencies with health driving most of the literature from a medical perspective (De Backer et al., 2025; Wilson et al., 2025), followed by education, particularly post-Covid (Driscoll et al., 2020) highlighting the important roles educational professions play to safeguard children and police response (Martin et al., 2017; McManus, 2023), specifically concerning Child Sexual Exploitation (Pearce, 2014) and criminal county lines drug trafficking (Harvey, Hornsby and Sattar, 2015); issues which tend to draw social work and the police together.

Interprofessional practice is defined by the presence of two or more professions working together within the same organisation or location (Green and Johnson, 2015). Common examples of interprofessional agencies include hospitals, community clinics and local authority services. These professional hubs populate the foundation for a wide-ranging literature base examining how these professionals work together. Providing one of the only comprehensive books on the topic, Klein's (1993) Interdisciplinarity stands as a seminal text, exploring the political, economic and societal structures underpinning these professional relationships. Klein differentiates between "multidisciplinary" (juxtaposing disciplines), 'interdisciplinarity' (integrating knowledge) and "transdisciplinary" (creating a new conceptual framework); all of which will be implicitly present through the course of this study. While Klein does not speak directly to social work or mental health practice, Interprofessional Teamwork for Health and Social Care (Reeves, 2010) draws from empirical work, primarily Hugh Barr who has since written extensively about social work's role in several contexts, including collaboration with other professionals (Davies, 2013) and concerning the global initiative towards integrated care (Barr et al., 2024). As would be expected, social worker interviews contributed to these ideas, albeit from within this integrated context. While many

of the conflicts discussed in this thesis are confirmed by Barr, they are generated from within a different dynamic- social work working directly with other professionals in a shared space and organisational setting. Specifically concerning mental health, integrated care also presents similar challenges as discussed later, specifically hierarchical and professional power differentials explored by Tony Leiba's "Interprofessional Collaboration: Achieving integrated Care in Mental Health Services" (Benamer, 2019). These sentiments are reflected in multiple publications reflecting the push towards integrated care including philosophical and values concerns, (Gerard, 2010) namely the medical/social model debate discussed later.

It makes little sense to discuss social work and mental health without discussing suicide, however the peer-reviewed literature is surprisingly silent on this topic as it relates to social work training to assess risk or even understand some basic models of suicide ideation, intent and planning. However, peer-reviewed work does exist but does not include the views of generic social workers. Awenat *et al*. (2017) explore the views of social workers employed as inpatient staff in a mental health hospital, yet despite the obvious need, these participants describe a lack of any formal training around suicide risk, assessment or training. Given the lack of any other peer-reviewed empirical sources, it stands to reason that generically trained social workers also experience a lack of education and training concerning suicide.

As discussed above, Bailey and Liyanage (2012) refer to social workers working within a larger multi-disciplinary mental health team (suggesting the team defines the role) a notion reflected by Gould (2022) referring to social work being defined by context. Because of the sparse amount of literature concerning this role, more creative ways may be needed to explore the literature. This may be due to the terminology used when the local authority attempts to provide services which border on the NHS's realm (a theme later explored) and therefore resorts to terms such as the "wellbeing" or "early help" teams. For example, the Essex County Council website refers to their "Early Help and Wellbeing Team" as providing services to adults "who are experiencing low-level mental health problems such as anxiety, stress and depression which are causing a social care need" (Essex County Council, 2025). Exploring the literature using the terms "early help" or "wellbeing" when linked with specific local authority social work teams yielded no useful hits, suggesting that little to no substantial research has been completed when exploring these specific roles. However, some other

research makes implicit reference to these professionals. Martins and Tucker's (2023) exploration of working with service users diagnosed with EUPD (discussed in more detail below) makes reference to professionals liaising with a social care "link worker" but they were unable to describe this role. In short, it appears that local authorities have recognised the gap existing between those requiring social work or social care who also need some level of mental health input and given the reluctance participants have experienced in this study of mental health services engagement, these local authorities have created ad hoc mental health teams.

Due to the substantive nature and clear role, the AMHP specialisation is well explored in the literature, most of which seem to revolve around multiple key themes. Matthew Simpson has contributed heavily to discussions around the AMHP role, exploring the decision-making process and professional practice at the point of referral, emphasising early decisions which impact case trajectory (Simpson, 2024) and the moral dilemmas AMHPs commonly face in practice (Simpson, 2020). This last paper, a literature review including empirical work exploring AMHP lived experiences, emphasises that AMHPs routinely act as independent decision makers, providing a key contribution that risk judgements are infused with morality, a theme later echoed in this thesis. These experiential papers include exploring the emotional labour and containment of others' anxiety (Gregor, 2010), the emotional atmosphere of the work (Dwyer, 2012), the emotion of guilt and how it manifests in the role (Morriss, 2016), and fear of decision making and resilience (Stone, Vicary and Spencer-Lane, 2020a). Simpson's conclusions also reflect the moral dilemmas and conflict AMHPs face, informed by Kinney (2009) and Dwyer (2012).

Given the additional powers AMHPs carry, it's not surprising that much of the research revolves around its appropriate use. Their power is influenced by their team members and dynamics and AMHPs find it both liberating and constraining, particularly within a neoliberally driven process (Hemmington, 2023). Personal and professional identity is also explored, informing how the personal use of self impacts professional actions and how the role can recognise human rights and uphold anti-oppressive practice (Stone, Vicary and Spencer-Lane, 2020b)

These papers all touch on themes later discussed in this thesis yet what remains less explored is how generic social workers, operating without the professional training and recognition AMHPs enjoy, navigate these same dilemmas.

Harry Ferguson has written extensively about social work practice and some of this empirical work has focused on social work experience. This work is important and contextualises any other work aiming to describe or analyse social work specific experiences. Ferguson makes good use of ethnographic methods when exploring what social workers do in the real world, specifically while completing child protection tasks (2016); focusing on the space they use (children's bedrooms), tasks they do during a visit (check for food in kitchens) and some of the difficulties encountered (loud televisions on during difficult conversations) and overall organisational and cultural challenges social workers experience on a regular basis (2018b). Social workers are highly reflective professionals and their reflections are often constrained by anxiety, come in episodic and circumstantial contexts and act as "internal supervision" (Ferguson, 2018a) despite the limited amount of time their organisation affords them (Ferguson et al., 2020). Collectively, these papers do more than any others to describe the intimate and challenging nature of social work practice from the social worker's viewpoint.

Other studies qualitatively exploring the social work experience are more eclectic and reflect that specific researcher's personal interests or specific practice context. For example, social work experiences are explored during political conflict in Northern Ireland (J. Campbell et al., 2021) and during the COVID-19 pandemic (Kingstone et al., 2022). Social work identity, touched on later in this research, is explored as social workers see themselves (Cook, Carder and Zschomler, 2025) and how identity is formed via the views of the public and social media (Legood et al., 2016). Supervision is also a theme social workers speak on, specifically newly qualified social workers (Manthorpe et al., 2015), as well as from supervisors themselves (Pitt, Addis and Wilkins, 2022).

2.3.2.1 Parental Mental Health

How social workers engage with parents with mental health issues is also represented in the literature and is explored from several angles. Highlighting the specific challenges personality

disorder can have on working dynamics, the need for social workers to work closely with mental health providers is identified (Martins and Tucker, 2023), however this sample included social workers among several other professions and did not address the social work perspective specifically. Other parental mental health conditions are explored but primarily from the service user perspective (Oakes et al., 2023) via the reports from the professionals interviewed. Again, social work is included in a generic "professional" sample which, while suitable for that paper's research objectives, does not explore the social work role or how the social work identity impacts these dynamics. (Grant *et al.*, 2021) focus on relationship factors and includes a total of 21 social workers among a larger multidisciplinary sample using a Family Focused Practice (FFP) model. While closely related to this research's objectives (there is a clear mental health/social work intersection, and social workers constitute a large portion of the sample) service users' views were also included to better explore the paper's emphasis- the nature of the relationship and what improves it. The findings mirror several themes more deeply explored in this thesis including power dynamics between service users and social workers, organisational pressures and a wide range of confidence and knowledge about mental health among social workers. The social worker's voice is better reflected in this work and their thoughts about working with service user's mental health issues sit at the heart of the relationships explored here. However, as seen with the previous studies, social work identity takes an implicit role and how it informs the mental health/social work boundary is not explicitly explored.

2.3.2.2 Approved Mental Health Professionals

Both children and adults are subject to the Mental Health Act 1983 (albeit under different sections). However, the MHA makes a designation for a specific role, the Approved Mental Health Professional (AMHP), formerly known as an Approved Social Worker (ASW) (Bamford and Bilton, 2020). The Approved Social Worker (ASW) was created under the 1983 Mental Health Act and was a credential specifically for social workers. Per the process outlined under the Act, an ASW in partnership with two doctors completed an assessment to determine the need for detaining and admission into a mental health hospital, commonly referred to as "sectioning." The ASW's role was to determine that the legal criteria had been met for

detainment, all the lesser restrictive alternatives had been explored, complete an application for admission and identify the admitting hospital.

However, the ASW credential changed with the MHA 2007 amendments which allowed other professionals such as occupational therapists, mental health nurses and psychologists to train for, and carry, the newly developed AMHP qualification. This was not a welcome development for social work. Because ASWs were trained by the local authority, social workers were independent of the mental health trust which was perceived as offering a potential ideological social/medical model balance to the process. However, with the 2007 amendments, all members of the MDT could potentially come from the same trust (Bamford, 2015) therefore minimising social work's authority and increasing the likelihood that all members of the assessing team could potentially be practising under a medically-modelled framework.

2.3.2.3 Generic Social Workers / Mental Health Social Workers

Social workers have many roles and therefore it is key to understand that this research is interested in the "generic" social work role; social workers who work directly for a local authority in either a child or adult capacity and who are not linked with a CMHT team or a local authority "mental health" team. However, it is important to clarify these roles to provide a deeper context for future discussions. Multi-disciplinary or multi-agency work is defined by one or more agencies working together but located separately from one another. Interprofessional practice is defined by the presence of two or more professions working together within the same organisation or location (Green and Johnson, 2015). Common examples of interprofessional agencies include hospitals, community clinics and local authority services. While interprofessional collaboration involves mixing professionals from different industries into one organisation, other agencies, namely the local authority, attempt to address integration by identifying one profession as specialising in the realms of another.

As such, the role of the "mental health social worker" function will now be explored, however for reasons discussed shortly, there is little if any empirical research concerning these social workers. The term "mental health social worker" can be deceiving as it can refer to social

workers working in an NHS mental health clinic (presumably performing social work duties for "patients" receiving services) or social workers working in a local authority whose caseloads consist entirely of "service users" previously diagnosed with a mental health disorder. The previous discussion concerned the former, therefore this discussion explores the latter. It is important to consider this category because several participants discussed the "mental health team" as a source of ongoing frustration, lacking a clear function or goal. While this differentiation seems quite clear, the literature reflects an ongoing confusion between the roles and seems to provide no insight into the role these participants describe.

The final setting worth exploring is that of social workers working directly within a mental health hospital. Priory Hospitals are part of the larger Priory Group, a privately owned chain of psychiatric hospitals in Britain, and currently employ social workers to work in their multi-disciplinary teams (MDT). Priory hospitals offer different services, including 28-day drug and alcohol treatment, Children and Adolescent Mental Health Service (CAMHS) and adult inpatient and outpatient services. In 2017 and 2018, I worked in one of these hospitals, primarily with the CAMHS and the adult eating disorder units. The role consisted of several tasks including liaising with the local authority (usually related to post-discharge services) and the patient's family members. The role was not well defined at the time of my arrival, and those interviewing me were generally unclear as to what a social worker did and how one could inform the Priory's mission. Therefore, the job description was quite flexible, and I found myself routinely invited to MDT meetings, discharge planning meetings and mental health review tribunals (hearings where patients formally appeal their detainment under the Mental Health Act 1983). I often played dual roles: working with the medically modelled team and speaking diagnostic language while also advocating that the environment played a large role in a patient's "diagnosis." Further, I routinely educated the MDT about the local authority's role and the different legislation to which social workers were bound. Outside these clinical settings, I liaised with social services which often included educating social workers around some of the terminology the clinical staff were using. In short, I attempted to bridge the gap between the two services: provide a mental health perspective to social workers while providing a social work perspective to mental health staff.

2.3.2.4 Self-neglect

Self-neglect is unhelpfully and loosely defined in the Care Act 2014 as covering a "wide-range of behaviours neglecting to care for one's health, hygiene, or surroundings, and includes behaviours such as hoarding" (DHSC, 2024, para. 14.17). Since 2014, when self-neglect was brought into scope for safeguarding in England (Orr, Nasrawy and Morrison, 2025), several papers have explored this very complex and challenging phenomenon. Firstly, the reasons behind why people self-neglect is up for heavy debate, as noted by Day et al. (2012) who cite literature describing it as a distinct syndrome while others link it to several syndromes underpinned by mental health and cognitive issues. It can also be viewed as socially constructed, thereby completely removing it from the mental health realm all together. It can encompass several psychosocial, contextual, behaviour or cultural factors, or be associated with social isolation or grief and loss, abuse or exploitation. For this reason, self-neglect has not been included in the literature review chapter, because doing so might suggest the unjustifiable argument that self-neglect is *always* underpinned by a mental health issue. However, as mentioned, it would be incomplete to not include self-neglect into this discussion, not just due to its contemporary nature, but to acknowledge the ongoing debate that mental health factors can contribute to it.

Self-neglect does, however, highlight points discussed earlier in the literature and elsewhere in this project- that of multi-agency collaboration. The unclear aetiology of self-neglect makes it a contentious issue for services and professionals who view the issue completely differently, and within an austerity driven context, provides plenty of room for organisations and services to argue that specific cases, for various reasons, do not meet their eligibility criteria (Orr et al., 2025; Orr, Nasrawy and Morrison, 2025), a challenge further explored using the theoretical framework of "Logics of Appropriateness" (Mason and Evans, 2020). How social workers conceptualise risk when working with two fictional vignettes is explored (Harris et al., 2023). For those working directly with self-neglect adults, the issue is mined with debates and conflicts around self-autonomy and risk (Day, McCarthy and Leahy-Warren, 2012) which touch upon value concerns and practice dilemmas- themes present in this thesis as well.

This section has explored some of the social work background information necessary to contextualise this thesis. The next section will repeat this process but from the mental health perspective.

2.3.3 The Mental Health Industry in the UK

2.3.3.1 Service, Structure and Employment

Mental health services in the United Kingdom are primarily managed and funded by the NHS. Patients can encounter services in a variety of ways. Roughly 90% of those with mental health difficulties will be in contact with their primary General Practitioner (GP), but only 10% of those will be referred on for specialist services (Pilgrim, 2020). This is a point of contention within psychiatric circles because specialists feel that GPs are not trained well enough to diagnose patients, yet this does not stop the pharmaceutical industry from heavily marketing psychotropic drugs to GPs to prescribe to patients (ibid). Consequently, and contradictorily, at this point many patients are treated medically for what Chew-Graham et al. (2002) refer to as "common mental health problems." Of the mentioned 10% who are referred on, post-COVID -19 figures indicate they may experience a wait time of up to 1 year, despite the NHS's goal of referrals being completed within 18 weeks (The King's Fund, 2025). Consequently, many patients find their way to services via acute, crisis-led processes through the Mental Health Act 1983, either by contact with the police (Sec. 136 MHA) or by way of urgent referral from other professionals or those in contact with the person. Non-urgent patients are generally seen by a mental health nurse practitioner or consultant in a Community Mental Health Team (CMHT) facility and will undergo talk therapy, medication or usually a combination of both.

If determined to present a risk to themselves or others and meeting the relevant criteria under the Mental Health Act, patients may be detained in hospital under Section 2 for assessment for up to 28 days, or under Section 3 for treatment, initially for up to six months (Jones, 2011). Patients may also be admitted voluntarily as informal patients where they recognise the need for inpatient treatment and agree to admission. The type of inpatient service required is determined by the individual's clinical presentation and level of risk rather than simply by the section of the Mental Health Act under which they are detained.

Acute mental health inpatient wards provide care for people experiencing severe mental health difficulties that cannot safely or effectively be managed within the community. Where a patient requires a greater degree of observation, containment and clinical intervention, admission to a Psychiatric Intensive Care Unit (PICU) may be required. These environments employ increased safety and risk-management measures, including secure access, management of potential ligature risks and levels of observation appropriate to the individual patient. Staff-to-patient ratios and observation levels consequently vary according to individual need, ranging from general observation to continuous one-to-one or, in exceptional circumstances, higher levels of supervision.

Where the level of risk cannot be safely managed within acute inpatient or psychiatric intensive care services, patients may require admission to secure mental health services. These are differentiated according to low, medium and high levels of security, with placement determined by the nature and severity of the risks presented and the degree of physical, procedural and relational security required to manage them. Low-secure services provide care for patients requiring a level of security beyond that available within general mental health services, while medium-secure services provide greater levels of security for patients presenting more substantial risks. High-secure services represent the highest level of secure psychiatric provision and are reserved for patients whose risks cannot safely be managed within lower levels of security. In England, high-secure psychiatric care is provided at Broadmoor, Ashworth and Rampton hospitals. Length of admission varies considerably according to clinical need, risk and progression through treatment, and patients may subsequently move between different levels of security as their needs and risks change.

During their treatment, patients can appeal against their involuntary hospitalisation under the MHA with the assistance of a solicitor or Independent Mental Health Advocate (IMHA) whereby a tribunal is held. This procedure is adjudicated by a panel of three independent people (a judge, a doctor and a lay person) and a determination is made if it is appropriate for the patient to remain. Roughly 10% of patients requesting a tribunal are discharged under the process (Care Quality Commission (CQC), 2022).

Under Sec 117 of the MHA, patients are entitled to community care which is a joint statutory duty arising after qualifying detention and continues until the responsible bodies are satisfied the person no longer needs those services. Under sec 117, patients can receive specialist housing, help with work/education, social care, free psychotropic medication and therapy. As some of the findings will discuss, some participants found this legislation helpful because it aided professionals in understanding their boundaries and duties when collaborating.

Other patients who don't require emergency services can access community mental health services via their local CMHT. It should be noted that some patients can financially afford mental health services privately, however for most patients, this is not the case. Therefore, when referring to mental health services throughout this thesis, the discussion primarily concerns NHS-funded provisions unless otherwise stated.

2.3.3.2 Education and Professional Accreditation

Most patients getting mental health services through the NHS will work primarily with a Master's-level mental health nurse practitioner (NHS England, 2023). Nurses are required to hold at least a bachelor's degree in nursing from an accredited university and are required to be registered with the Nursing and Midwifery Council (NMC). Psychiatric consultants undergo standard doctoral-level medical training before specialising in psychiatry. They are required to be registered under the General Medical Council (GMC).

These discussions have provided the context in which the following chapters should be read. Participants refer to these processes and professional differences throughout the remainder of the thesis. The following discussion will explore some of the global and national events which have changed social work practice in the UK.

2.3.4 Global and National Events, Social Movements and Tragedy

The following discussions describe global and national events which contribute to the complex landscape in which social work is practised in the United Kingdom including distinct events such as the COVID-19 pandemic and the 2008 economic recession but also the societal

movements of neoliberalism and the influences of corporate philosophy on social work practice. Notable child deaths which have fuelled political agendas are also explored. Global events such as the COVID-19 pandemic have impacted the very way in which social work is practised and have spawned entirely new research areas such as the efficiency of tele-health and have highlighted, in tragic ways, the important role social workers play to protect vulnerable people. The 2008 recession, also on a global scale, has placed the profession in an entirely new economic landscape where previously threadbare resources are even more pronounced, and families are struggling to survive in the face of higher unemployment, lower wages and fewer benefit structures to support them. Both events have occurred within an ethos of expanding neoliberal philosophy which informs how local authorities fund, quality assess and structure social work services. Lastly, highly publicised child deaths put pressure on social work, and are unfortunately usually the only times the national media acknowledges social workers or their practice. These events structure the context of current social work practice and are important to remember when considering the social worker's experience of navigating the boundary between social work and mental health.

2.3.4.1 Neo-liberalism

Neo-liberalism is often characterised as an ideology reflecting complex notions around market-based and economic priorities such as cost-benefit, efficiency and market competition (Mudge, 2008; Scull, 2021; Hughes and Wearing, 2022). Neo-liberal practices and philosophy, based on western ideas of individualism and independence from the state, are often seen as a result of a revolution against the ideas of "classical liberalism" rooted in more collectivist attitudes commonly found in eastern and communist-based governments (Becchio and Leghissa, 2016). Neo-liberal attitudes inform corporate practices to, theoretically, help insulate a profit-driven entity from bankruptcy and failure and gain a larger claim on a target market. Both the UK and the United States governments, most notably since the Thatcher-Reagan era, have adopted these philosophies to "shrink" government and make it more efficient (Mudge, 2008; Belloc and Nicita, 2012; Pettit, 2019). Politically driven "cost-saving" notions hold considerable appeal to fiscally minded politicians appeasing to their constituency, usually within the context of securing future elections on a "tax-cutting" campaign platform.

Neo-liberalist practices manifest in social work in several ways. For example, contracting residential care staff mirror the capitalist-Darwinism philosophy of market competition (Dustin, 2016). Technological tools imbedded within children and adult social work teams help quantify "output," justifying staff numbers, maintaining professional credibility and meeting set criteria by the Office for Standards in Education, Children's Services and Skills (Ofsted). These are examples of an underlying shift towards a capitalist, market-driven ethos underpinning social work practice which emphasises cost savings and efficiency over quality services. For caring and compassionate staff, this creates tension which will be more fully explored later in the thesis.

If neo-liberalism is the underpinning philosophy informing many of our corporate and public services, then managerialism is the practical and physical manifestation of those ideas. Sometimes considered a separate ideology, managerialism can be thought of as a set of business and organisational practices which, if correctly implemented, are thought to ensure the success and smooth running of any organisation, public or private (Doran, 2016; Klikauer, 2025). Managerialism endorses the idea of "Taylorism," the idea that an effective manager can manage staff and bureaucratic processes irrespective of the goals, values or end-product of any organisation (Hughes and Wearing, 2022). As such, some local authorities have appointed management staff with non-social work backgrounds to oversee adult and children services in an attempt to promote smooth and efficient operations (Dustin, 2016).

Taking this cost-saving and efficiency practice to its logical conclusion results in the mechanisation and de-humanisation of services. Sometimes referred to as "McDonaldisation," this hyper-efficient production model aims to maximise profit (Ritzer, 2013) by turning human interactions into machine-like stages of production commonly found when building a product, (in this case a hamburger) as quickly and efficiently as possible. Based on postmodern ideas of Fordism, this approach is evident in social work practice when social workers are required to evidence "output" of non-tangible products (Dustin, 2016) via embedded, quantifying computer systems which categorise families and needs, measure the start and end date of work completed and calculate cost of services provided. Often marketed as time-saving tools to the overly administratively burdened social worker, these

tools may also de-skill social workers while simultaneously providing statistics evidencing time and cost efficiency to budget holders. As will be discussed in later chapters, these quantity performance measurements, while necessary to ensure adequate service funding, do little to evidence quality of service, a metric more important to the practitioner.

The above processes have, over time, limited social workers' functions to a highly bureaucratic role of resource distribution, thus aligning more closely with notions of street-level bureaucracy (Lipsky, 1983), discussed in a later chapter. This has the consequence of turning service users into "consumers" of services, removing the value-driven, people-oriented nature of social work and replacing it with a corporate, cost-efficient relationship, characterised by brief interactions, data gathering and success defined by quantifiable "quantity" and "speed" and less by intangible notions of "relationship" or "life improvement" (Dustin, 2016). These philosophies do not just inform procedural practices or how services are measured but have acted as catalysts for changing well-established therapy modalities and justified the creation of entirely new services, two examples of which will now be explored.

Cognitive Behavioural Therapy (CBT) is a modality of therapy designed to help patients identify links between their thoughts and emotions (Freeman and Freeman, 2005). While it has a range of uses including treating Obsessive Compulsive Disorder (OCD) (Abramowitz, Brigidi and Roche, 2001) and adolescent autism (Walters, Loades and Russell, 2016), it was primarily used to treat panic disorders and anxiety (Davies, 2014). CBT is a relatively structured tool in that it follows a process of stress inoculation techniques whereby a therapist guides a patient through a series of mindfulness and breathing exercises aimed to help him/her manage stress responses to specific stimuli (Freeman and Freeman, 2005). The process then progresses to real world situations where the exercises are repeated to the point that the patient can tolerate the stimuli and no longer experiences disability anxiety. CBT is most effective when treating specific phobias, e.g. arachnophobia, aviophobia, or claustrophobia (Maxmen and Ward, 1995). CBT can also be used to address anger management issues by helping the patient become more aware of his/her emotions and behavioural outbursts (Ali et al., 2015)

In 2005, research from Sheffield University, Cambridge and NICE (National Institute for Clinical Excellence) (Lovell and Bee, 2011; Davies, 2021) identified CBT, specifically CBT- T (the "T" stands for "ten" sessions) as a very attractive form of therapy to the Labour government, primarily due to the brevity and low-cost nature of treatment compared to other forms of talking therapy, e.g. psychodynamic therapy, and relative ease of quantifying success rates. CBT is now considered the "gold standard" of therapy (David, Cristea and Hofmann, 2018) and ideologically aligns with the current target and outcome-driven neoliberal agenda (Davies, 2021). However, this "gold standard" and default nature of CBT within the NHS has come under considerable criticism. Firstly, CBT has now become an "umbrella" term to capture various other modalities, not all of which are considered effective using the previously evidenced NICE guidelines (Fairfax, 2008). Secondly, CBT is not the only modality available to treat underlying and unresolved childhood abuse, neglect or sexual trauma (Maxmen and Ward, 1995), yet NHS patients are misled to believe that a form of CBT, Trauma-Focused Cognitive Behavioural Therapy (TF CBT) is the only option. When these patients find CBT unhelpful, they then conclude that all therapy is ineffective (Haller, Besson and Watzke, 2019; Davies, 2021; Scott, 2021, 2024) withdraw, and go untreated. Despite these concerns, CBT and its derivative modalities remain the primary option on the "Talking Therapies" NHS menu, driven by the need to provide a "cost-effective" treatment, irrespective of the clinical limitations and research which supports its plaster-like results.

Mental Health First Aid (MHFA) is the second resource serving a neoliberal agenda (DeFehr, 2016; Cosgrove and Karter, 2018; Davies, 2021) and is worth examining. MHFA is a purchasable training course which prepares corporate employees to provide frontline mental health support to colleagues and signpost them to support in the hope of reducing sick leave and improving employee productivity. Since its inception in 2007, over 8 million people have been MHFA trained globally, 800,000 of whom, employed by 20,000 organisations, are in the UK (Our history, MHFA, 2025). Mental Health First Aiders are trained to look for the signs of poor mental health and make suggestions aimed to help, e.g. go for a walk, take a bath, buy something. They are not overly concerned with the stressor (e.g. an environmental issue like an increased workload) as much as they are about where to send them (to someone who can prescribe medication to treat the internal "disorder" within the employee if the walking, bathing or buying doesn't help), with the agenda, according to James Davies (2022), of

keeping them at work, productive and contributing to a profit-driven, capitalist society. While there is evidence to suggest that MHFA improves mental health literacy (Morgan, Ross and Reavley, 2018) there is little to suggest it is particularly effective in addressing sick leave or the prevalence of mental health difficulties (Forthal et al., 2022).

While the list of ways in which neoliberal values have infiltrated social work and mental health is long and beyond the scope of this discussion, both CBT and MHFA are pertinent to this research because they are relatively new ways of treating mental health issues within the current neoliberal ethos in which social work and the mental health industry exist. Further, participants speak about CBT and MHFA as options available to service users and describe their interactions and thoughts of both.

2.3.4.2 Austerity and the 2008 Recession

This argument is not suggesting that the industry fails to care about service users/patients. Instead, it should be recognised that these modalities do not exist in a vacuum but are instead products of the current global drift towards the philosophical conservative right whereby governments believe helping and supporting business interests will indirectly help private citizens (Andersen, 2021), an idea founded on the Regan-era economic plan called "supply side" economics, or more commonly referred to as "trickle-down" economics. These philosophies have pushed the wealth distribution towards an imbalance not seen since the early 19th century (ibid), resulting in governments placing austerity measures around public services and welfare benefits. The term "austerity" refers to a series of measures and policies implemented by the Conservative-Liberal Democrat Coalition government as a response to the global economic crisis of 2007-2008, sometimes referred to as the Great Recession. This crisis originated from multiple factors including an unregulated home mortgage market in the United States and the failure of the United States federal government and Federal Reserve to manage these risks (Pajarskas and Jočienė, 2015). In the United States, this resulted in approximately 40% of homeowners being affected by foreclosure proceedings. This had global economic impacts and resulted in the UK's debt to increase from £208 billion in 1993 to 1.04 trillion in 2013 (De Koning, Kees, 2013). As a response, the UK austerity measures were designed to eliminate an approximate £75 billion deficit and consisted of an increase in

taxes and a reduction of public funding, the majority of which were targeted towards local government and social security (Irving, 2021). The extent of the global impact the recession had is hard to understate and is too broad for this discussion. However, how it affected local authorities and their ability to deliver services to vulnerable people in the UK is relevant and needs to be explored.

As a result of austerity measures, between June 2010 and September 2012, there were over 500,00 public sector job losses in the UK, the majority of which occurred in the North resulting in a 20% increase in suicide in this region (Stuckler et al., 2017). Homelessness also increased resulting in an increase in emergency housing aid (Loopstra et al., 2016) as did the demand for emergency food assistance. These services continue to see annual increases, the latest of which were reported to be 3.1 million emergency food parcels delivered between April 2023 and March 2024, an increase of 94% compared to the previous five years (Trussell Trust, 2025). All of these factors have impacted global mental health quality (Stuckler et al., 2017) which in turn has increased the demand on social and mental health services (Cummins, 2018) including an increase in use of the compulsory measures of the MHA, police responses to those in a mental health crisis and an ongoing "bed" crisis (lack of inpatient services) (Sweeney et al., 2016).

In relation to child and adult safeguarding, austerity measures impacted these populations in two ways: Firstly, the services which scaffolded vulnerable families and provided early support or social interactions were removed, pushing otherwise safe families into risk (Webb, Bennett and Bywaters, 2024); Secondly, constrained resources and an emphasis on budget management and fiscal accountability measures altered social work practice dynamics, limiting social workers' time and abilities to address risk and prevent harm (Murphy, 2023; Webb, Bennett and Bywaters, 2024). The combination of underlying neo-liberal and private market philosophies of the 1980's and 1990's in conjunction with the more recent austerity measures implemented in the 2000's has eroded the resources needed to address a widening need across the UK and globally. In short, social workers found themselves with an increased workload because of the first issue with less time and resources to manage it because of the second. This equation provides the foundation for stress in social work practice, more specifically, the inability to practise social work in an ethical and moral way; the perfect recipe

for causing professional moral distress, discussed in section 6.5.2. However, more tragically, some of these measures have been identified as contributing to the high-profile child deaths; events which frustratingly are catalysts for the public's rare acknowledgement of social work or social workers and subsequent criticism and policy changes. (Bamford, 2015; Bamford and Bilton, 2020)

2.3.4.3 Nationally Impacted Child Deaths

The cycle between scandal, the media, politics and policy change is well documented (Butler and Drakeford, 2003; Bamford and Bilton, 2020; Purcell and Ennals, 2020): a child death or other scandal occurs, the media reports it, public outrage ensues which in turn pressures politicians to be seen to do something which in variably results in some sort of social work policy change or reform. Three events will be briefly discussed with an explanation of how the cycle has influenced contemporary social work practice.

Victoria Climbié was residing with her great aunt and her boyfriend in London before she died, age 8, on February 25th, 2000. Due to the horrific extent of her injuries and the numerous missed safeguarding opportunities, a public inquiry was arranged and headed by a former social worker, Lord Laming. While there was significant media coverage around this case, the evidence of this inquiry was planned to be used to make extensive operational and systemic changes to child safeguarding which the Labour government at the time had already been planning prior to the Laming publication (Purcell and Ennals, 2020). The report concluded with 108 recommendations aimed to address failings, not only of social services, but also policing and the medical professions. Several significant changes were made to the social work profession, including the introduction of the 3-year social work degree requirement, the 2004 Every Child Matters (ECM) reform (which required social services and education professionals to work more closely together) and the introduction of more closely monitored performance targets by different organisational entities (Purcell and Ennals, 2020). These performance targets, and the individual social worker's increasing requirements to evidence timely work, have come under considerable criticism, as meeting targets now appears more of a priority than quality engagement with families and relationship development (Ferguson, 2016) which link closely with the neoliberal agenda previously described.

Peter Connolly (aka “Baby P”), age 17 months, was murdered in 2007 by his mother, father and uncle. This tragedy occurred within the context of the new ECM reforms which emphasised closer safeguarding working relationships between agencies. Revisiting the cycle described above, this case made national headlines due to the similarities between it and the Climbié case, including the irony of them both occurring within the London Borough of Haringey. This proved a difficult time for social work as the Sun newspaper launched what it called a “campaign for justice” shortly after the murder convictions. This was heavily critical of Haringey Social Services, particularly the individual social workers and their Director of Children’s Services who was later publicly pressured to resign. It appeared later that this was intentional, as David Cameron intended to use struggling social services as a platform on which to launch his eventually successful pursuit of a Conservative Party takeover (Purcell and Ennals, 2020). This crisis led to the creation of the Social Work Task Force (SWTF) which in turn recommended creating the College of Social Work aimed to elevate the social work profession. However, despite high hopes, the College of Social Work was abandoned in 2015 due to financial problems and social work would remain regulated by the Health and Care and Professions Council (HCPC) until 2017 when Social Work England (SWE) took over this role. SWE remains social work’s regulatory non-departmental public body (NDPB) at the time of this writing; however the British Association of Social Work (BASW) remains social work’s professional association, despite having no regulatory or educational oversight. This is a clear case of a crisis-led change to the nature of social work in the UK and creates the climate and ethos under which social workers practise today.

Like all aspects of life, COVID-19 impacted social work practice. In March 2020, because of the UK government’s concern over the spread of SARS COVID-19, the entire United Kingdom was placed into “lockdown” (GOV.UK, 2022). Households were not allowed to visit others (including close family), children did not attend school, and health visitors did not see families; interactions which historically decreased risk to vulnerable children and adults (Drane, Vernon and O’Shea, 2021). For social work staff, this also limited home visits, in-person child protection checks (Arnold et al., 2022) and meaningful meetings with other professionals. Face-to-face meetings with service users and professionals, a staple of pre-pandemic social work practice, transitioned to virtual meetings using unfamiliar, commercially-based

technological communication platforms such as Microsoft Teams and Zoom which created new risks around rights and privacy (Eubanks, 2017) with little time to consider other, perhaps more critically considered, options. Consequently, and continuing the "crisis" theme above, the pandemic and its limitations on individual personal contact were identified as contributing factors in two more high-profile child deaths: Arthur Labinjo-Hughes and Star Hobson.

Six-year-old Arthur Labinjo-Hughes was killed by his father Thomas Hughes and his partner, Emma Tustin in June, 2020, three months after the first national lockdown (Buckler, 2023). Emma Tustin had significant mental health issues and was known to the police, community mental health services and other agencies and herself had come from a domestic abuse background as both victim and perpetrator (GOV.UK, 2022). Arthur's mother, Olivia Labinjo-Hughes, with whom Arthur did not live, had been imprisoned for manslaughter of her previous partner with whom she had had a relationship impacted by alcoholism and domestic abuse.

One year-old Star Hobson was killed in September of the same year at the hands of her mother Frankie Smith and her partner, Savannah Brockhill. Frankie Smith, while not diagnosed, was identified as a vulnerable young person when she gave birth to Star at age 17. Star's biological father, Jordan Hobson, was a care leaver and was described as having a low IQ or learning difficulties. Savannah Brockhill also had a history of domestic abuse, as a victim and perpetrator, and was described as controlling and coercive in her relationship with Frankie (GOV.UK, 2022).

Both cases highlighted how the COVID-19 pandemic impacted social workers' ability to complete safeguarding tasks and simultaneously identified the important role social work plays in protecting the vulnerable. Additionally, these events provided further evidence to the growing discourse around the need for organisations to improve inter-agency communication. Further, research recommended developing Multi-Agency Child Protection Units (MACPU) and developing evidence-based National Standards for supporting children (Cocker, Holmes and Cooper, 2024).

2.3.4.4 COVID-19 Impacts and Gen Z

Irrespective of the conditions the pandemic lockdown presented, several other practice issues were later identified as contributing to these deaths. Despite both Arthur and Star being known to children's services for several years, some professionals failed to consider Arthur's needs and relied too much on the views of his parents. Further, and echoing the Climbié death, information was not adequately shared between professionals involved in these children's lives, opportunities to escalate their cases to statutory-level were missed, and a lack of leadership within the respective local authorities were identified as contributing factors to their murders (GOV.UK, 2022).

Both cases exemplify the intersection of mental health issues with social work practice, a complex web exacerbated by the limitations imposed by the COVID-19 social restrictions. Further, both cases evidence the "toxic trio" or "trio of vulnerabilities," (the presence of domestic violence, substance abuse and mental health concerns), a concept which will be explored in section 7.7.3.

However, social work and supportive agencies have seen significant changes, both in practice and organisationally, since the lockdown. The virtual solutions which accompanied the lockdown highlighted cost-cutting and efficiency measures which neo-liberal-minded managers have adopted on a full-time, post-lockdown basis. The ability to virtually connect has manifested itself in several ways. For example, mental health services have implemented remote assessment practices either via videocall or telephone call, referred to as "tele-health," negating the need to see a patient in person in their environment (Haque, 2021). The results of this practice are not entirely clear, as different studies have identified different results. For example, there appeared to be a 1% drop in suicidality among American Veterans as a result of better access to services as a result of telehealth (Tenso et al., 2024) while other studies found challenges from both service users and practitioner perspectives (Bornheimer et al., 2022). Practitioners have also found that virtual working has changed their working environment, specifically the need to work together in-person as a physical team located in one area. Post-pandemic, workers are finding that they are working more from home, sometimes called "hybrid working," and if they require a physical space away from home, can

book a space anywhere in the organisation's network (Schölin et al., 2021). While the overall impacts of the pandemic are beyond the scope of this study, it's clear that the helping professions have been permanently altered by the pandemic, most notably the mainstreaming of some of the emerging technological tools that previously had only been used by some of the younger generations. The COVID-19 lockdown accelerated the use of communication technology, the advancement of which had already infiltrated every corner of social life within the last 20 years (Kumar, 2025). These advances have had a profound impact on those born into such a connected world, and therefore when exploring the current social work landscape, it seems reasonable to explore some of the generational characteristics young people are demonstrating which present unique challenges to the social work profession.

Defined as those born roughly between 1995 and 2012, (Twenge, 2024) generation Z (also known as "Zoomers" or "Gen Z") have never known a non-digital, globally connected world. Popularised by the iPhone released by Apple in 2007, smart mobile phones (defined as phones with touch screens which easily interact with the internet) are an integral part of the Gen Z experience (ibid). It is the medium through which they virtually conduct all aspects of their lives: social interactions with friends and family, studying, accessing information, applying for jobs, listening to music or any other daily activity (Twenge, 2018). Whereas previous generations relied on non-digital means to conduct their lives (using the telephone, travelling to meet friends and date, accessing physical learning materials like books and newspapers) Gen Z has entered adulthood with the means to complete these tasks from their homes and their bedrooms. Gen Z has been identified as struggling more with real-time, face-to-face encounters which bring them the subtleties of eye contact, body language, tone of voice and other meta-communication mediums pre-Gen Z members take for granted on an unconscious level. Further, these lack of human, face-to-face interactions has been identified as a key contributor to overall unhappiness, anxiety and depression (ibid.) More concerning and darkly are the impacts social media has had on this generation's overall mental health. Cyber-bullying, digital predators and the insidious ways some social media platforms are designed, not to better connect people but to encourage further usage (thus generating profit for the platform designers) have challenged this generation in ways unseen in the pre-smartphone era (O'Reilly, Michelle, 2021). Consequently, Gen Z confronts two social concerns stemming

from smartphone usage during the COVID-19 pandemic: an exponentially more difficult adolescence and the lack of opportunity to develop social skills needed to operate in a workforce largely designed, managed and supervised by previous generations (Twenge, 2018; O'Reilly, Michelle, 2021; Becker, 2022), factors that have all been identified as contributors to the global increase in accessing mental health services (O'Reilly, 2021; Balamurali, 2025).

Generation Alpha have been identified as those born between 2010 and 2024. This generation is experiencing all the stresses Gen Z is. However, one key difference is that Gen Alpha has been interacting with digital devices from birth, prior to language development (Danilova, 2023) and it's understood this will have a profound impact on how this generation learns and processes information, the long-term results of which only time will tell. Gen Alpha has also been described as more emotionally excitable and egotistic than Gen Z. How this generation negotiates adolescence, at the time of this writing, is being observed and will undoubtedly produce new literature providing insights into how the recent technological advances of artificial intelligence impact Gen Alpha's socialisation and entrance into the labour market. Social work will, no doubt, confront service users impacted by these technological advances and the mental stresses which come with them.

2.3.4.5 Contemporary Policy Drivers: Integration of Health and Social Care

Contemporary social work practice is also shaped by national policy intended to increase integration between health, social care and other public services. The *NHS Long Term Plan* (NHS England, 2019) placed considerable emphasis on reducing organisational fragmentation and developing more integrated forms of community-based care. Within mental health provision, this included expanding community mental health services and developing models intended to bring together primary care, specialist mental health provision, local authorities and the voluntary sector. Although primarily an NHS policy, these ambitions have implications for social work because many of the social and environmental needs accompanying mental distress fall within local authority responsibilities and require practitioners to work across organisational boundaries.

This direction was subsequently formalised through the *Health and Care Act 2022*, which established Integrated Care Systems (ICSs) on a statutory basis. These structures were intended to strengthen collaboration between NHS organisations, local authorities and other agencies and to enable services to respond collectively to population needs. The policy direction is therefore towards reducing organisational separation between health and social care, despite the professions themselves retaining different statutory responsibilities, organisational structures and forms of professional authority.

Policy concerning children and young people's mental health is particularly relevant to this research. The *NHS Long Term Plan* (NHS, 2019) committed to substantially expanding access to mental health support for children and young people, while subsequent planning guidance continued this expansion through 2024/25. This included increasing access to NHS-funded mental health services and extending Mental Health Support Teams within schools and colleges. Such developments place children's mental health within a broader network involving the NHS, education, local authorities and other agencies rather than locating responsibility solely within specialist Child and Adolescent Mental Health Services.

These policy developments are significant to the present research because they provide a formal context in which social work and mental health are increasingly expected to intersect. Policy promotes collaboration and integration across organisational boundaries while social workers remain professionally regulated, trained and employed within structures distinct from those governing most specialist mental health practitioners. The policy landscape therefore creates an interesting tension: organisational boundaries are increasingly expected to become permeable while professional responsibilities and authority remain differentiated. It is within this contemporary policy environment that the social work/mental health boundary explored throughout this thesis is situated.

2.4 Conclusion

Social work does not happen in a vacuum. Social workers exist, on all levels, against the backdrop of society including macro factors such as global pandemics (John et al., 2020),

economic recessions (Reibling et al., 2017) and national tragedies (Cocker, Holmes and Cooper, 2024). Their work is measured by an industry informed by economic philosophy and their success or failure against standards which may not fit within their values or align with the very reasons they entered social work in the first place (Dustin, 2016). To fully understand the social work experience requires understanding the factors over which they have no control but which they must still navigate: a pandemic which, at the time, limited how they could communicate with service users but which still echoes into present practice; a near economic meltdown which limited resources available to support an already struggling working class, and national conversations about vulnerable children and social work's shortcomings. These events inform and provide the context underpinning the following chapters: the nature of social work practice participants discuss in interviews, how the data was thematically organised and how this practice landscape shapes recommendations for the future.

This chapter has outlined the practice context in which social workers exist in the UK. To appreciate the full depth of participants' experiences, it is important to understand how they practise, the stresses they experience and the education and training they receive. However, it is also important to consider how theory has informed this research. The following chapter will explicitly define the theoretical lenses through which practice was explored.

3 Theoretical Foundations: The Social/Medical Debate and Boundary Spanning

3.1 Introduction

This chapter will define and explore two theories which underpin this research project: the Social/Medical Model Debate and Boundary Spanning. Both theories operated either implicitly or explicitly throughout the project. For example, the social/medical model debate helped frame interview questions while Boundary Spanning aided the analysis and make sense of how participants viewed their experiences. In short, the data will show *what* happened, whereas the theories explain *why* and help to understand events and experiences likely occurring outside of this project's small sample size. Lastly, these theories help transition experiences outside of this group and relate phenomena to larger structures like professions, systems and institutions while also incorporating less tangible ideas such as power and agency.

Social research is underpinned by "orienting concepts," forms of explanation which are relevant to the research question (Layder, 1998) and can be used creatively to see what they can offer to help make sense of social phenomenon. In social work research, they function not only as intellectual frameworks but also as practical tools for interrogating the everyday realities of practice (Punch, 2014; Clark et al., 2021). These frameworks were chosen because of their dual capacity to illuminate both the structural and relational dimensions of social work practice within mental health contexts. The chapter argues that when combined, the two theories create a robust foundation for exploring how social workers understand and negotiate the professional and conceptual boundaries between their field and that of mental health.

The debate between the social and medical models has been central to academic, professional, and policy discourses concerning health, illness, and disability for several decades (Goering, 2015; Hogan, 2019). At its core lies the question of whether illness and

distress are located primarily within the individual, as suggested by the medical model, or within broader social, cultural, and environmental conditions, as emphasised by the social model. This binary, although often critiqued for oversimplification, remains influential in shaping how needs are assessed, how services are organised, and how professional responsibilities are allocated. In a social work context, it provides a useful orienting concept for understanding how practitioners make sense of their role in supporting individuals whose difficulties may be defined as medical, social, or some intersection of both. For the purposes of this research, the medical/social debate functions as a lens through which the conceptual foundations of practice are examined, with attention to the implications of adopting one perspective over the other.

Boundary spanning offers a complementary but distinct angle. First developed in organisational theory, the concept refers to the processes by which workers cross professional, institutional, or conceptual borders to address complex or "wicked" problems (Aldrich and Herker, 1977; Williams, 2002). Social workers are frequently engaged in such work, as their practice often positions them in the intersection between agencies, disciplines, and systems. In the context of mental health, this boundary work becomes especially pronounced, as social workers encounter situations that require them to adopt perspectives and interventions outside the traditional parameters of their role (Oliver, 2013). Boundary spanning, therefore, provides a vocabulary and conceptual framework for analysing the ways in which practitioners extend, adapt, and negotiate their professional identities to meet the demands of practice.

By integrating these two frameworks, this chapter establishes the theoretical foundation for this research project in a way that captures both the "what" and "how" of social workers' engagement with mental health. The social/medical model clarifies the assumptions that underpin how problems are defined, while boundary spanning illuminates the processes and experiences involved in crossing professional lines. In doing so, these perspectives provide the interpretive resources necessary to understand participants' accounts of their practice, the challenges they face, and the strategies they employ. The remainder of this chapter explores each framework in detail, highlighting its relevance and application to the research questions.

3.2 The Medical vs. Social Model Debate

The social work and mental health industries provide a myriad of theoretical frameworks, any one or two of which might be useful when making sense of how the social work/mental health boundary is negotiated. For example, when examining how social workers think of mental health, a pharmacological approach could be considered. This would assume that mental health issues are caused by chemical imbalances and best addressed by medications (Healy, 2000). As discussed in the background chapter, continuing this line of thought further approaches a more radical conclusion; that the pharmaceutical industry has helped engineer how we define mental illness with the aim of maximising profits (Frances, 2013; Davies, 2014). However, for the purposes of this research, focusing on the pharmaceutical dimension could potentially limit the scope of how social workers think about mental health, artificially narrowing the analysis of what is potentially a larger issue than the purely chemical argument. Further, this lens could unintentionally imply that medication has no role when addressing issues such as depression and/or anxiety. This is not accurate, nor is it this research's intention to discount the role the medical industry plays when helping people in acute crisis or suffering from disabling conditions.

Other approaches assume the opposite approach, namely the social context model which argues that purely biological mental health conditions do not really exist but are instead products of the environment, i.e. poor neighbourhood conditions, poverty or crime and would be addressed by social agents such as political and social overhaul (Davies, 2021; Kirmayer, 2025). While these ideas have relevance here and are discussed below, adopting a purely social context as a theoretical lens could again potentially narrow the scope of this research and assume, again incorrectly, that the aetiological pendulum swings to the other extreme. By not advocating for a purely social context approach, the research aims to explore all aetiological avenues available to the generic social worker, including biological sources, as she feels they play a role in her practice.

Another approach could be to question the very nature of medical and social power and the assumed constructs by which we define who is mentally unwell and who is not (Scull, 1977; Foucault, 1988; Bynum, Porter and Shepherd, 2004). These discussions lead to highly critical

arguments around the role of psychiatry, again already briefly explored within the necessary scope of this research. These Foucauldian arguments could again potentially dismiss the role psychiatry plays, discounting the millions of people who have benefitted from their skills and services as well as unnecessarily misdirect participants towards a line of thinking which misses the mark of exploring their own experiences. Additionally, a strong focus on the underpinning philosophy of power could de-emphasise the practical or pragmatic experiences social workers describe.

By adopting the more generic or broader social/medical model debate, participants had the option of choosing any number of theoretical constructs, consciously or unconsciously, to help them understand their personal understanding of the boundary between social work and mental health and their relationship with it. Further, the framework does not require any "work" on the participants' part, in that she will come to the research already well informed of the model and have an intuitive grasp of its underlying principles. Lastly, the framework provides a point of common ground between the participant and researcher and allows for a shared language as a foundation over which more complex ideas can be explored during interviews. In short, the medical/social model provides a specific enough framework to start discussions with participants, frame the research questions, and understand and thematically arrange the data without unnecessarily narrowing the theoretical approach and risk missing interesting points, insights or observations.

How we determine the causes of illness and their origins sits at the core of this research. The much documented medical and social model frameworks need to be solidly and securely anchored, as it is around this binary assumption that many discussions throughout this work revolve, including the literature review, findings and discussion chapters. The debate of whether a stressor is caused by a service user's biology (medical) or his/her environment (social) forms not only how participants consider the social work/mental health boundary, but also how services triage cases and which professional ultimately holds responsibility for their care. The following discussion explores this topic within the boundaries needed for this project.

The medical model assumes that lack of optimal functioning, physical or mental, is a result of a physical deficit, or something within the person that requires *fixing* (Haegele and Hodge, 2016; Hogan, 2019). This fixing requires the expertise of a medical professional, historically and culturally, considered to be a distinguished and trust-worthy professional and as such, holds great power over the patient, the subject of which has spawned entire bodies of research, philosophy and cultural commentary since the dawn of modern medicine (Busfield, 1986; Shorter, 1997; Bentall and Beck, 2004). Noted limitations of the medical model include its use of language by defining the person by their limitation via the use of medical diagnosis and the impact this label has on access to resources, services (Humpage, 2007) and equal opportunities towards basic social institutions such as employment and education (Thompson, 2018). Further, this labelling process has been identified as highly de-individualising, in that it does not take into consideration the patient's wishes, skills or resources or specific circumstances.

The social model contrasts with the medical model and is commonly used when discussing disability, hence the phrase "social model of disability" (Shakespeare, 2004). While the medical model locates the deficit *within the person*, the social model locates it *within society* and the infrastructure which limits everyone from fully accessing it. Therefore, the aforementioned "*fixing"* needs to be done to the wider environment, not to the person, including political, social and cultural change. Further, the social limitations are not limited to observable physical issues such as wheelchair accessible lifts or street crossings made safe for the visually impaired (Haegele and Hodge, 2016) but can also include educational and employment structures and informational ableist assumptions such as how public information is organised and presented (Thompson, 2016). The social model is also not without limitations, most notably its assumptions when categorising disability, because how one's disability manifests in their life is as unique as the person. Further to this point, the model discounts ideas of intersectionality; the idea that oppression can occur due to multiple individual characteristics vis-a-vis other social constructions such as racism, sexism, or other marginalising mechanisms (Oliver and Barnes, 2012).

If one moves away from the disability context (physical or mental), the social model can also be applicable when considering the possibility that one's stress resides within their personal

environment. Borrowing from Bronfenbrenner's social ecosystems theory (Payne, 1997), these issues could include stresses within one's local microsystem (e.g. family, friends), larger mezzo system (e.g. lack of community resources) or cultural macrosystem (e.g. institutional racism). One need not be physically disabled to be impacted by these issues, yet as we shall see in later chapters, these issues are still medicalised via a labelling diagnosis and physical treatment, i.e. psychotropic medication, despite their endogenic sources.

There are several different versions of the social model, including a version in the United States (social constructionist version), the impairment model, the post-modern version and a United Kingdom model (Mitra, 2006) and the differences between them are not great enough to warrant further exploration. Philosophically, the UK model is very similar to the others and only its political contextual differences substantially separate it from the group (Haegele and Hodge, 2016). For clarity purposes, the United Kingdom model will be used when referring to the social model as this is where the research for this project takes place.

The medical/social model debate underpins this research project because of the nature in which people's needs are met in UK society; if someone has a medical condition, they go to a doctor who is employed by the NHS. If someone is experiencing a social ailment, e.g. abuse, unemployment, they may receive services from a social worker who is most likely employed by a Local Authority (LA). However, the world is not so binarily or neatly structured. The NHS medically treats people suffering from depression or anxiety, conditions which can be argued to originate from their environment, and which will be explored more deeply later. In the natural course of practice, social workers will work with mentally unwell service users, diagnosed or not, and therefore are migrating into the realm of mental health, the topic of this research. The medical/social model provides the basic framework around how these professionals think about the origins of stress and, therefore, how they might practise. These are key research objectives for this project.

The social model has gained a reputation among the social work community as "better" than the other (Rosa et al., 2016). However, each model is needed depending on the circumstances. The confusion arises when the ailment and its point of origin are confused or matched with the incorrect model (Goering, 2015). Much more has been written about

medicalising social problems than socialising medical ones, i.e., there seems to be little debate justifying a doctor performing a family assessment on a patient writhing in pain from a broken leg, while a great deal has been written about mood altering medications prescribed to grieving spouses (Bandini, 2015; Gurley-Green et al., 2025). As such, mental illness has been seen as a medical problem since the popularisation of the Diagnostic and Statistical Manual (DSM), specifically since the publication of the 4th edition, or DSM IV, which introduced vast psychological terms, phrases and concepts into the general American public (Horwitz, 2021) and then, via cultural migration, to the rest of the Western world. Framing mental illness as a medically treatable condition has given rise to exponential profits for the pharmaceutical industry and solidified poor mental health as a disease with behavioural symptoms (allowing for diagnosis) rather than a symptom of underpinning environmental stressors (Frances, 2013; Davies, 2014, 2021). Consequently, there has been a push back against this thinking, with more literature reflecting the social elements impacting mental health, sometimes referred to as social determinants of mental health (SDMH).

As the name implies, SDMH are social or environmental factors, or those outside of oneself, which impact mental health and functioning (Alegría et al., 2018). Low socio-economic status, poverty, loss of employment or under-employment have all been evidenced to impact mental health, particularly over long time frames (Marmot and Bell, 2016; Brydsten, 2018), with increased frequency post the 2008 housing crisis discussed in the previous chapter. Discrimination related to ethnicity, sexual orientation, gender or other marginalising characteristics has repeatedly been linked to increased poor mental health (Benoit, McCarthy and Jansson, 2015; Berger and Sarnyai, 2015). Negative family relationships or family disharmony has strong linkages with poor mental health (Han and Lee, 2015), particularly for young people who, due to the extreme physical changes they experience during adolescence, social pressures, exposure to social media, and higher likelihood of drug use present their own risks for poor mental health (Bruffaerts et al., 2018; Albaugh et al., 2021; Alsarrani et al., 2022). Lastly, but not exhaustively, poor neighbourhood conditions and dense urban living environments have been linked to lower mental health quality (Robinson et al., 2017).

While slightly outside the scope of this research, it's important to recognise that the pathway reverses, in that mental health difficulties contribute to poor employment, homelessness,

relationship difficulties and substance use (Hjorth et al., 2016), making it difficult for clinicians to know which issue to address. Hence, we see a shift away from a dichotomous, rather simplistic framework of "this or that" or a *post hoc ergo propter hoc* logical fallacy, bringing with it the temptation to simplify the complex. Despite this, attempts have been made to organise, link, and in some cases, (e.g. "the toxic trio" discussed in section 7.7.3), imply that a combination of specific factors can be used to help professionals identify risk.

The following chapters use the medical/social model both implicitly and explicitly. Participants were asked questions about their practice and experiences, assuming a shared understanding of the framework between her and the interviewer. Using the medical/social framework, these answers were often clarified or gently challenged to better understand the participant's theoretical perception of the social work/mental health boundary and the data was analysed through the medical/social structure to identify how, when and why social workers were navigating mental health issues. In other words, it would be impossible to understand how social workers think of this boundary without first operating from a shared position of how the fields are already separated. Lastly, the final discussion chapter challenges accepted theories and provides new ways of broadening them, all of which are underpinned by the medical/social assumption.

3.3 Boundary Spanning

The following section introduces the idea of boundary spanning, a theory upon which much of this thesis rests. Therefore, it is important at an early stage to anchor a solid definition, operationalise the term and explain its linkages to social work and its boundary with mental health associated tasks.

3.3.1 Definition and Operationalisation

For the purposes of this research, boundary spanning is operationalised as practice in which a social worker moves beyond the conventional knowledge, activities or responsibilities associated with their social work role and engages with those associated with another

professional or organisational domain. Boundary spanning may therefore include negotiating between services, translating between different professional perspectives, drawing upon knowledge or skills associated with another discipline, or undertaking activities which might ordinarily be expected of another professional group. Such movement does not require the social worker to abandon their professional identity or formally assume another professional role. Instead, the boundary is understood as permeable, allowing practitioners to extend their practice into an adjacent professional realm while continuing to identify and operate as social workers (Oliver, 2013).

Within this thesis, boundary spanning into the mental health realm is identified where generic social workers encounter mental health needs which cannot be adequately addressed solely through their established social work role and consequently extend their practice in response. This may involve recognising and assessing mental health need or risk, attempting to secure specialist intervention, using therapeutic or psychologically informed approaches, or otherwise responding to mental health difficulties despite these activities extending beyond what the practitioner understands to be their conventional professional remit. Importantly, boundary spanning is understood here as a process rather than a discrete event. The extent of this movement may vary considerably: some practitioners may briefly cross a professional boundary in response to a particular situation, while repeated exposure to mental health work may result in a more sustained expansion of practice, with implications for professional role and identity.

First coined in the 1970's (Aldrich and Herker, 1977), Boundary Spanning has evolved over time and emerged as a critical concept amongst organisational theory discourse (Williams, 2002) and refers to those who work across hierarchical, geographical or conceptual boundaries. More specifically, it assumes that certain tasks, particularly those within a "wicked" (Ritell & Webber, 1972) context, are best completed via a multi-disciplinary approach. Further, the idea assumes that disciplines do not enjoy clear and opaque boundaries, and that some practitioners find themselves working closely with others or drawing on skillsets outside their own discipline (Sullivan and Skelcher, 2017). The concept is central to this research because the thesis will be arguing that the mental health related tasks social workers undertake is a form of boundary spanning. This discussion will explore

boundary spanning's central and underpinning theory and principles but will be explored later within the context of this research's findings.

Boundary spanning has received more attention within the last 20 years or so due to various governments' attempts to address complex social issues via "joined up" or collaborative work between governmental organisations (Williams, 2002). New Labour's incentive of blending private and public services is a good example and a manifestation of its philosophy of merging the "best" parts of socialism with the "best" parts of capitalism, and these changes brought about further emphasis on more neoliberal practices of performance measurement, consumer choice and private sector management styles previously discussed.

As such, boundary spanning is commonly found in industries designed to address complex social issues, or "wicked" issues e.g. homelessness, poverty, crime or child abuse. It's understood that these issues are a culmination of multiple, overlapping and underpinning social ailments existing on several levels and exhibiting fluid and intermingling relationships. Therefore, it's assumed that no one agency or government entity is equipped to address such issues and instead requires the much-discussed "multi-agency" approach (Bronstein, 2003; Williams, 2012; Noel et al., 2022). Multi-agency working presents a myriad of issues ranging from organisational practice and cultural issues, legislative conflicts, geographical and jurisdictional disagreements and budgetary battles (Klein, 1993; Williams, 2012; Sullivan and Skelcher, 2017). However, how different disciplines approach and conceptualise a social problem, and the kind of people who undertake these roles, are fundamental questions which this thesis addresses. To further anchor this key concept, the below discussions are relevant to how boundary spanning is informing later chapters, in that they will provide insight into the empirical data and subsequent discussion chapter.

3.3.1.1 Tensions and Contradictions

Boundary spanning is often presented as a means of improving collaboration between organisations and professional groups, yet the role is inherently characterised by tension, largely because one is expected to remain sufficiently anchored within their own

professional role. This creates a fundamental contradiction: the boundary spanner must be both connected to, and separate from, the domains she attempts to bridge (Friedman and Podolny, 1992).

Elaborated on more shortly, Williams (2002) similarly conceptualises boundary spanning as an individual-level activity requiring a particular combination of skills and competencies. Boundary spanners must be able to build relationships, communicate between different professional cultures, negotiate competing interests and understand the motivations and constraints of those operating in other organisations. These competencies allow one to work across fragmented service structures, but they also place the boundary spanner in an ambiguous professional position. Effective collaboration requires sufficient flexibility to understand and accommodate alternative perspectives, yet the practitioner must retain enough professional identity and legitimacy to continue representing her own organisation or discipline (ibid). Boundary spanning consequently involves an ongoing negotiation between flexibility and professional containment.

A related tension concerns responsiveness and accountability. Boundary spanners are often expected to respond pragmatically to complex problems which do not fit neatly within the remit of a single service. Boundary spanners are particularly important within public services because many contemporary social problems require inter-organisational responses, referred to as “wicked problems” discussed later. However, the flexibility required to address such problems can conflict with organisational procedures, eligibility criteria, professional standards and statutory responsibilities (Bar-On, 1994; Noordegraaf, 2007; Mannsåker and Vågan, 2024). The boundary spanner may therefore identify an appropriate response to a problem while lacking the formal authority to deliver it. Conversely, she may find herself assuming responsibility for coordinating a response while remaining dependent upon organisations over which she has little direct control.

This highlights another contradiction between responsibility and authority. Boundary spanning can expand the range of issues with which an individual becomes involved without necessarily expanding her formal powers, resources or expertise. She may therefore become increasingly responsible for ensuring that different parts of a system connect while possessing limited authority to compel those parts to cooperate (Nissen, 2010). Within

complex public-service systems, this is particularly significant because organisational boundaries frequently correspond with different legislation, funding arrangements, professional hierarchies and eligibility requirements (Williams, 2002; Oliver, 2013). The boundary spanner may consequently act as an intermediary between systems without occupying an equivalent position of authority within each of them. These issues underpin several discussions related to participant experiences

More recent work has added an important emotional dimension to these organisational tensions. Emotional labour is often a factor when boundary spanning in public services because professionals frequently need to establish trust, manage emotionally complex interactions and negotiate relationships with those whose needs cut across conventional service categories. Needham et al (2013) further distinguish between *explicit* boundary-spanning roles, where working across services is formally recognised, and *emergent* boundary spanning, where individuals find themselves performing this function because circumstances require it. The latter distinction is particularly important because emergent boundary spanners may experience the demands of cross-boundary work without the specialist training, recognition or organisational support associated with a formally designated role. This is more fully reinforced by Leah (2023) whose work exploring the formally recognised AMHP professional role contrasts with the more emergent role of the generic social worker explored in this thesis.

These tensions should not necessarily be regarded as failures of boundary spanning but are instead consequences of occupying a position between systems which retain different purposes, expectations and forms of professional legitimacy. As discussed previously, the ability to tolerate and negotiate such tensions may itself be an important boundary-spanning competency. Further, these contradictions are particularly pertinent to social work (Oliver, 2013; Leah, 2023) because of the myriad of services with whom they work. However, this also raises questions about where legitimate interprofessional working ends and movement into another professional domain begins, a point this thesis explores. Boundary spanning therefore provides not only a framework for understanding how social workers connect fragmented systems, but also a means of examining the professional,

organisational and emotional tensions created when those boundaries become increasingly permeable.

3.3.1.2 Boundary Spanning vs. Boundary Blurring

Having anchored boundary spanning, it is important to contrast it with a similar but fundamentally different idea, that of boundary blurring. Boundary blurring refers to a process through which distinctions between established professional jurisdictions become less clearly demarcated as knowledge, roles and activities increasingly overlap or become hybridised (Liu, 2015). It differs from boundary spanning in an important respect: boundary spanning assumes the continued existence of distinguishable professional boundaries across which practitioners operate, whereas boundary blurring concerns a reduction in the clarity of the boundary itself. In other words, boundary blurring may happen when an exceptional activity (I will do this thing one time) turns into a routine (I am now expected to do this). Boundary blurring erodes the role of each structure, while boundary spanning is more inclined to maintain each role's perimeter. Re-framed another way, boundary spanning is what people do, while boundary blurring may be the result of those actions.

Boundary blurring is particularly pertinent within contemporary health and social care because professional practice increasingly occurs within integrated and multidisciplinary environments. Professionals may draw upon overlapping knowledge, perform similar activities or develop competencies which historically belonged to neighbouring disciplines. Leah's (2020) discussion of AMHPs illustrates this complexity through the concept of hybrid professionalism**.** Drawing particularly upon Noordegraaf (2007; 2015), Leah describes hybrid professionals as occupying complex professional identities and bringing together potentially contradictory bodies of knowledge, values and ideological positions. AMHPs provide a particularly clear example because their practice combines legal, social, psychological and medical perspectives while practitioners may originate from social work, nursing or occupational therapy backgrounds.

Importantly, boundary blurring can occur through apparently pragmatic responses to everyday organisational problems. Leah draws upon Morriss's (2017) research (which also

informs this thesis' literature review) in which a social worker describes their role as "paper[ing] up the gaps" left between other professions, particularly where work is complicated or difficult to allocate. Leah identifies a similar phenomenon within her own research, where an AMHP describes "sweeping up the odds and ends" that fall outside the clearly defined legal role. These examples are important because boundary blurring need not arise from a deliberate attempt to expand professional jurisdiction. It may instead emerge incrementally as practitioners respond pragmatically to work which falls between established professional responsibilities.

This distinction between boundary spanning and blurring is important later when participants discuss an apparent pattern of mental health service deficit. Due to the increasing need for mental health services among service users and declining opportunities to access services, social workers may feel an increase in the requirement to routinely fill this role. However, for the purposes of this discussion, it is sufficient for the moment to introduce and anchor the distinction between boundary spanning and blurring to inform later discussions in Chapter 7.

3.3.1.3 When is Boundary Spanning Successful?

Exploring this question from an organisational perspective, boundary spanning tends to succeed when organisations provide role clarity, sufficient autonomy, managerial and peer support, access to resources, legitimacy, reciprocal relationships with partner organisations, and enough authority or influence to make collaboration meaningful. Although boundary spanning is frequently conceptualised in terms of the skills and characteristics of the individual practitioner, whether it is successful cannot be understood solely as a consequence of individual competency, particularly as boundary spanners operate within organisational environments which may either enable or constrain their capacity to work across professional and organisational divisions. Consequently, while an individual's ability to build relationships, negotiate professional differences and coordinate activity remains important, successful boundary spanning also depends upon organisational conditions which provide sufficient support, legitimacy, resources and clarity for this work to occur (Stamper, 2003; Van Meerkerk and Edelenbos, 2018; Collien, 2021; Satheesh et al., 2024).

This places some responsibility for successful boundary spanning not simply with the individual attempting to negotiate the boundary, but with the organisational systems within which that activity takes place.

One important organisational characteristic concerns clarity around the boundary-spanning role**,** particularly as practitioners working across organisational divisions may be exposed to expectations from several organisations, professional groups or stakeholders whose priorities are not necessarily compatible. Stamper and Johlke (2003) identify role conflict and role ambiguity as significant sources of stress among boundary-spanning employees, with ambiguity occurring where individuals are unclear about their responsibilities or expectations, while conflict emerges where incompatible demands are placed upon them. Importantly, however, their research suggests that these difficulties are not simply inevitable consequences of working across boundaries, as perceived organisational support was associated with lower levels of both role conflict and role ambiguity. The organisation therefore appears capable of reducing, or alternatively exacerbating, some of the difficulties inherent in occupying a boundary position.

More recent research by Satheesh et al. (2024), examining boundary spanners within public-private collaborations, similarly emphasises the importance of organisational support, distinguishing between support provided by senior management and that provided by colleagues**.** Top-management support was associated with reduced role conflict and role ambiguity, while co-worker support reduced role ambiguity, suggesting that boundary spanners remain dependent upon their home organisation even where much of their activity occurs beyond it. This is important because boundary spanning can otherwise become conceptualised as something undertaken by particularly capable individuals who, through their own interpersonal abilities, are somehow able to negotiate organisational complexity. In practice, managers can provide clarity around priorities, legitimise cross-boundary activity and support practitioners when competing demands arise, while colleagues provide information, advice and practical assistance which may help to make an otherwise ambiguous role more manageable.

Related to this is the degree of discretion and autonomy available to the boundary spanner. Cross-boundary activity is difficult to prescribe entirely through organisational procedures

because it requires practitioners to respond to changing circumstances, different professional actors and sometimes competing organisational priorities. Satheesh et al. (2024) therefore consider autonomy alongside organisational support as a potentially important condition for boundary-spanning activity, although their findings did not demonstrate the anticipated direct effects and some caution is therefore necessary. Nevertheless, this does not necessarily diminish the importance of discretion, but instead suggests that autonomy cannot be separated from the wider organisational environment in which it is exercised. Indeed, autonomy without sufficient clarity, support or resources may simply leave the boundary spanner with greater responsibility for resolving organisational problems, without providing the structures necessary to assist them in doing so.

Successful boundary spanning is also dependent upon relationships across organisational boundaries, given that practitioners cannot meaningfully connect organisations where opportunities for interaction are limited or collaborative relationships remain poorly developed. van Meerkerk and Edelenbos (2018) argue that boundary-spanning behaviour is influenced by facilitating conditions within governance networks and, importantly, boundary spanning is fundamentally relational, requiring access to individuals on either side of the boundary and relationships through which information, perspectives and resources can be exchanged. Organisations which expect practitioners to work collaboratively must therefore provide opportunities for interaction and information exchange, rather than assuming that individual boundary spanners can compensate for systems which remain structurally disconnected.

Closely related to these relationships is trust, particularly as boundary spanners frequently possess little direct authority over individuals working outside their own organisation and must therefore rely upon others being willing to communicate, exchange information and cooperate. Trust, from this perspective, is not simply an interpersonal characteristic but something which can be facilitated or inhibited by organisational arrangements. Stable inter-organisational relationships and repeated opportunities for interaction may allow trust to develop, while fragmented systems, professional competition or conflicting organisational priorities may make this considerably more difficult. The capacity of the

individual boundary spanner to establish productive relationships is therefore inevitably influenced by the relationship which already exists between the organisations themselves.

This leads to the related issue of legitimacy, influence and power**,** which Collien (2021) argues have received insufficient attention within accounts of boundary spanning that predominantly emphasise cooperation. Boundary spanners do not operate within politically neutral environments and, given that organisations and professional groups possess different levels of resources, professional status and decision-making authority, these inequalities inevitably influence what the practitioner is able to accomplish. Collien (2021) suggests that power may enable, broaden or constrain boundary-spanning activity, while legitimate authority, recognised expertise and other sources of influence may be necessary if boundary spanners are to persuade other actors, mobilise resources or facilitate change.

The issue of legitimacy is particularly significant because responsibility for coordinating across a boundary does not necessarily provide authority over it**.** An organisation may expect an individual to coordinate with external professionals or agencies while providing them with very little influence over the decisions subsequently made by those actors. There must therefore be some relationship between the responsibility allocated to the boundary spanner and the authority, resources or legitimacy available to fulfil it, although this does not imply that formal hierarchical authority over partner organisations is necessary or even possible. Rather, boundary spanners require sufficient organisational backing and professional legitimacy for those operating across the boundary to regard their contribution as credible and consequential. Without this, responsibility may be transferred to the practitioner without providing any meaningful capacity to influence the outcome for which they have become responsible.

Finally, access to resources is important because effective boundary spanning requires time in which relationships can be developed, information exchanged and competing professional priorities negotiated. Organisational endorsement without the practical capacity to undertake this work risks becoming largely symbolic, particularly where practitioners are encouraged to collaborate while simultaneously carrying workloads, procedural requirements or performance expectations which provide little opportunity to do so. Satheesh et al.'s (2024) emphasis upon organisational support and van Meerkerk and

Edelenbos' (2018) consideration of facilitating conditions therefore suggest that boundary spanning should be understood as an organisational investment rather than an additional responsibility which can simply be attached to an existing professional role.

Taken together, these studies suggest that successful boundary spanning depends upon a combination of interconnected organisational conditions. Role clarity provides an understanding of what the boundary spanner is expected to achieve, managerial and collegial support provide organisational backing, discretion permits adaptation to circumstances, resources provide practical capacity, while relationships and trust make cross-boundary collaboration possible. Alongside these, legitimacy and influence provide the means through which other professional actors can be engaged. Importantly, these conditions cannot necessarily compensate for one another; autonomy without support may become isolation, responsibility without legitimacy may become powerlessness, while expectations of collaboration without adequate resources may simply increase role conflict.

Successful boundary spanning should therefore not be understood simply as the product of a particularly skilled or motivated individual, as organisations themselves must provide the conditions within which boundary spanning can succeed. Where practitioners are expected to negotiate professional or organisational boundaries while lacking clarity, support, resources, legitimacy or influence, difficulties cannot necessarily be understood as failures of individual competence. Instead, they may reflect an organisational contradiction in which individuals are required to bridge structural divisions without being provided with the means necessary to bridge them successfully.

3.3.2 Other Theoretical Considerations

When considering how professions overlap, interact or in any other way relate to one another, there again is a range of theoretical lenses from which to choose to help frame this research question. For example, professional role theory, a derivative of social role theory discussed later, concerns how professionals think about their jobs, particularly in a complex network or while undertaking complex tasks. It addresses conflict, particularly when agencies have contrasting goals (Phelan and Kinsella, 2009). It is particularly relevant when

professionals personally identify with their everyday tasks but less so when required to undertake other roles within their organisation. For example, a teacher may closely identify with their pedagogic role but feel resentful or out of place when asked to participate in student recruitment activities. Because of this emphasis on the professional's relationship with their own organisation, role theory may miss opportunities to understand how external organisations impact the professional- one of the key questions concerning this research. One theory which does address this is Open Systems Theory (OST) which examines how organisations act as individual entities but are still open and interact, sometimes very closely, with others within their network (Jung and Vakharia, 2019), arguably changing the employees of each in some way. Open systems theory also considers the larger environment and what external factors may impact on the network (Kanellopoulos, 2024). What open systems theory does not closely consider is how people behave or respond because of these interactions and therefore is not best suited for this project. Occupational identity theory, however, does provide insight into how individuals behave, specifically as it relates to their identity as it relates to the organisation for whom they work (Phelan and Kinsella, 2009). Like street-level bureaucracy which is explored later, occupational identity theory is interested in how individuals express autonomy in the workplace, how the culture and values of the organisation impact this and the individual's emotional response (Maloney, 2023). These theories all orbit the central theme of employee identity impacted by different factors, yet each emphasises one factor within one context. Boundary spanning, however, considers all these factors and has the added benefit of considering the process by which the individual migrates outside their own role as well as exploring personal characteristics which makes this process easier for this kind of professional. Therefore, boundary spanning provides the most suitable lens to help understand what is happening when social workers migrate outside of their role and into another, specifically, into the mental health realm.

Social Identity Theory (SIT) and Systems Theory (ST) are most relevant when understanding how social workers may see themselves as boundary spanners: social identity informs how they see themselves as professionals while systems theory informs how they may operate within the complex system of practice. While both concepts are later explored within the context of the findings, here it is important to establish both theories to better understand

how they will be applied later. Built on theoretical forefathers such as Eric Erikson, SIT suggests that identity is formed through a mental process of assigning ourselves to social groups (Tajfel, 2010; Hogg, 2016). This categorisation brings emotional significance by defining ourselves within the context of that group while simultaneously placing others into other groups (which are not ours). SIT suggests we hold several group memberships at any one time: personal (a role within our family), cultural (nationality, ethnicity, religious system) and professional, with each of these groups corresponding to its own set of values and behavioural expectations (Kroger and Marcia, 2011; Thompson, 2016). SIT provides a lens through which we can understand how social workers identify themselves, as their identity is informed by their professional values, education, and how other professions view them (Oliver, 2013).

ST, in its most basic sense, provides the foundation to understand how different bodies (or organisms) relate to one another within an open or closed system. Since Bertalanffy's original development of general systems theory (GST) within the biologic sciences in the 1930's (Smelser and Baltes, 2001), GST has found countless applications and been adapted to numerous other fields including sociology (Cuff, Sharrock and Francis, 1998), human behaviour (O'Brien, 2020) organisational theory (Hughes and Wearing, 2022) and later Bronfenbrenner's ecological model (Payne, 1997). Here, systems theory underpins boundary spanning because it helps us understand the web of systems in all their complex shapes and forms through and between which professional boundary spanning takes place. In other words, in whatever shape or form the entities within a system take, they create the foundational network through which spanners operate, practise and negotiate. Further, how these systems are constructed and how they relate to one another will define and describe the perimeters that the spanning permeates.

3.3.3 Social Workers as Boundary Spanners

Both Systems and Social Identity theories underpin the social work landscape and experience, creating a complex and dynamic experience. Social work's boundaries are first and foremost defined by the gaps between other, perhaps better defined, structures and services, e.g. education, health, housing, etc., referred to as "threadbare" areas previously discussed. If

social work is defined by the "safety net" analogy (Gustafsson, 1986), then that net's dimension and nature will forever be changing based upon location (regional or national services), time (when resources are either scarce or abundant) and circumstance (the nature of an individual's needs) (Rosenfeld, 1983). The changing nature of this landscape requires a professional who can tolerate fluid and dynamic priorities, evolving and shrinking resources and has the mental flexibility to remain positive and driven in the face of such meandering boundaries and objectives.

Much has been written about the characteristics or personal qualities demonstrated by professionals who routinely span boundaries (Brion et al., 2012; Sullivan and Skelcher, 2017; Foulds, Robison and Schönwälder, 2024): respect for others and their points of view; honest, straight and trustworthy; approachable; diplomatic; positive and enthusiastic; confident and calm (Williams, 2012). These qualities allow the boundary spanner to recognise the needs and perspective of other professionals and the personal fortitude to maintain quality working relationships through systemic or organisational obstacles (ibid.). The boundary spanner is not concerned with myopic targets limited to their own field or organisation but instead remains focused on a shared goal which may exist outside their immediate sphere (a conflict born within the neoliberal nature of practice previously discussed.) It is not difficult to see the parallels between these characteristics and those which make good social workers: empathy; the ability to build trust; navigating complex social situations, and excellent communication skills (Oliver, 2013; Reith-Hall, 2022; Rusanova, 2025). Further, the profession itself is a melding of interventions, programs and functions (Green and McDermott, 2010), drawing from psychotherapy, sociology, psychology, education and medicine (Trevithick, 2006; Bamford, 2015; Fook, 2016). As such, almost by definition, social workers are boundary spanners at the very core of their practice.

3.3.4 Empathy as a Boundary Spanning Mechanism

The question remains as to why a social worker might choose to extend their practice in this way rather than recognise the limits of their professional role and refer the individual elsewhere. One explanation emerging from both the literature and the findings of this research concerns empathy. Briefly mentioned above, empathy is repeatedly identified as an

important characteristic of effective social work practice and has also been associated with effective boundary spanning (Oliver, 2013; Moudatsou *et al.*, 2020). However, within the context of this research, empathy may perform a more active function than simply enabling practitioners to understand the perspectives of other professionals or service users. It may contribute to the decision to cross the boundary itself.

Social workers who recognise the distress or unmet mental health needs of a service user may find it difficult to maintain a rigid distinction between what is and is not formally their professional responsibility. Where an appropriate mental health service is available, empathy can motivate advocacy, referral and collaboration. Where such services are inaccessible, delayed or unwilling to intervene, however, the same empathetic response may encourage the social worker to remain involved and attempt to meet some of that need themselves. Empathy can therefore act as a force towards the professional boundary: the practitioner recognises a need, identifies with the consequences of leaving that need unmet and consequently extends their practice beyond its usual parameters.

Seen in this way, empathy is not necessarily an uncomplicated professional asset. The qualities which enable social workers to establish meaningful relationships with service users may simultaneously make maintaining professional boundaries more difficult when other services fail to respond. Boundary spanning may consequently emerge not only from organisational expectations or formal multidisciplinary arrangements, but from a tension between professional limits and the social worker's reluctance to leave an identified need unaddressed. This raises the possibility that empathy can facilitate effective boundary-spanning practice while also exposing social workers to increasing responsibility, role ambiguity and emotional burden when they repeatedly compensate for gaps elsewhere within the mental health system.

3.3.5 Professional Roles and Professional Identities

Professional identity and professional role are closely connected concepts within social work, although they are not synonymous (Dent, 2017; Webb, 2017; Moorhead *et al.*, 2025). Indeed, distinguishing between the two is important when considering how social workers understand the boundaries of their practice, particularly where the organisational

expectations placed upon them may not necessarily correspond with their understanding of what it means to be a social worker. At its simplest, professional role can be understood as relating to what a social worker does, and is expected to do, within a particular organisational and practice context, whereas professional identity relates more closely to how social workers understand themselves, their profession and the values, knowledge and principles through which their practice is constructed.

Webb (2017) describes professional identity as considerably more complex than simply occupying the occupational category of social worker. Rather, professional identity incorporates the ways in which practitioners understand themselves as social workers through a combination of relationships, beliefs, values and experiences. Professional identity is therefore not something which necessarily follows automatically from qualification or registration, but is constructed and reconstructed through engagement with the profession and the contexts within which practice occurs. As discussed in Chapter 2, social workers operate in different capacities and have held historically different roles and completed different tasks, therefore what connects these practitioners cannot be reduced simply to the performance of a common collection of tasks.

There is consequently potential for tension between professional identity and professional role (Moorhead *et al.*, 2025). Where the two align, the activities expected by the organisation may correspond relatively comfortably with how practitioners understand their professional purpose. However, where they diverge, social workers may find themselves undertaking work which they do not consider consistent with their professional identity or, alternatively, undertaking activities which extend beyond the formal expectations of their role because they nevertheless consider them consistent with being a social worker (Dent, 2017; Wiles, 2017). The latter distinction is particularly significant when considering professional boundaries. It allows for the possibility that movement beyond an established professional role does not necessarily represent movement away from professional identity.

Distinguishing professional identity from professional role therefore provides a means of understanding social work practice as simultaneously professional and organisational. Professional roles locate social workers within particular structures and establish

expectations concerning what practitioners are required, permitted and resourced to do. Professional identity, by contrast, provides a broader and more fluid understanding of what it means to be a social worker and the values, knowledge and purposes through which practice acquires meaning. As Webb (2017), Dent (2017), Wiles (2013; 2017) and Moorhead et al. (2025) collectively demonstrate, this identity is socially constructed and continually negotiated rather than simply acquired through qualification or expressed through the performance of prescribed tasks. The distinction is therefore important when considering professional boundaries because it allows the boundaries of a role to be crossed without necessarily requiring the abandonment of professional identity. Indeed, under some circumstances, it may be professional identity itself which provides the impetus for doing so.

3.3.6 Boundary spanning into the mental health realm

Most of the literature concerning social work boundary spanning with mental health takes the form of exploring the nature of social workers working in a mental health team (based within a local authority) (Karban, 2011), with mental health professionals in a blended team (Batsleer J, Chantler K, and Burman E, 2003; Boahen, 2016a) in an NHS Trust (Morriss, 2017) or working alongside mental health colleagues within a multi-disciplinary context (Hood, 2015; Helm, 2016; Noel et al., 2022). If we consider the "toxic trio" framework (the presence of substance abuse, domestic violence and mental health issues in a family unit), then the spectrum broadens to include social workers working with domestic violence situations (Johnson, 2002; Humphreys, 2007) and substance use (Forrester, 2000; Dance, Galvani and Hutchinson, 2014; Galvani, Hutchinson and Dance, 2014). Williams (2002) observed that, despite increasing interest in collaborative working, the literature provided relatively limited insight into the characteristics and behaviours of individual boundary spanners. While this observation was important in the development of boundary-spanning scholarship, subsequent research has substantially developed understanding of boundary-spanning roles, competencies and professional identities. More recent literature has also applied these ideas specifically within social work and health contexts. Consequently, the relevance of boundary spanning to contemporary social work requires consideration beyond Williams's original formulation. This development is particularly relevant to social work, where practitioners routinely operate between organisations, professional groups and systems of knowledge.

For example, Oliver (2013) explicitly conceptualises social workers as boundary spanners and argues that this offers a useful means of understanding social work professional identity within increasingly interprofessional health and social care environments. Rather than viewing interprofessional activity as something which necessarily weakens professional identity, Oliver suggests that the ability to work between professional domains may itself be understood as characteristic of social work. This is particularly pertinent given social work's historically broad knowledge base and its position between individuals, families, communities and multiple statutory and voluntary organisations. Boundary spanning from this perspective is therefore not simply movement beyond an established social work role, but may constitute part of the role itself. It allows social workers to retain a recognisable professional identity while simultaneously working across disciplinary and organisational divisions.

This interpretation is supported by more recent empirical research. Grell (2022), examining personal social services, distinguishes between formal and informal forms of boundary spanning. Formal boundary spanning can occur where practitioners have recognised responsibilities for coordinating services or participating in established multi-agency arrangements. However, boundary spanning also occurs informally through everyday consultation, information exchange, negotiation and coordination between practitioners and organisations. Grell (2022) identifies different approaches towards this work, describing formalist, specialist, pragmatist and idealist orientations towards organisational boundaries. This is significant because it demonstrates that practitioners do not necessarily encounter or negotiate professional boundaries in the same way. Boundary spanning is consequently better understood as variable professional behaviour rather than a uniform role performed identically by different practitioners.

The competencies required to undertake such work have also received increasing attention. Mannsåker and Vågan (2024) in their study of hospital social workers, locate boundary spanning within activities such as advocacy, facilitation and communication between patients, families, healthcare professionals and communities. Their work emphasises that boundary spanning involves more than simply being present within multidisciplinary

systems; it requires practitioners to coordinate, convey and translate information between different parties and strengthen relationships across professional and organisational divisions. Boundary spanning therefore involves relational and communicative competencies that allow practitioners to understand different perspectives and negotiate between them. This supports earlier associations between effective boundary spanning and qualities such as trust, communication, diplomacy and empathy, while placing these characteristics within observable professional activity.

Developments within the wider literature on professionalism provide a further means of understanding these processes. Noordegraaf (2007) challenges traditional conceptions of professions as clearly bounded occupational territories possessing distinctive bodies of expertise and relatively autonomous forms of practice. Within increasingly complex public services, he argues that such 'pure' forms of professionalism are becoming more difficult to sustain. Instead, professionals operate within ambiguous environments in which occupational, organisational and managerial demands intersect. Noordegraaf (2015) develops this argument further, describing forms of hybrid professionalism in which apparently contrasting professional and organisational principles become combined within everyday practice. From this perspective, crossing or negotiating professional boundaries does not necessarily represent an exceptional departure from professional practice but may increasingly be characteristic of contemporary public-sector professionalism.

This is relevant to mental health services, where professional responsibilities and forms of expertise frequently intersect. Leah's (2020) study of Approved Mental Health Professionals (AMHPs) provides an explicit example. Drawing on social workers, nurses and occupational therapists undertaking the AMHP role, Leah conceptualises these practitioners as hybrid professionals who work across multiple roles and areas of expertise. The AMHP therefore illustrates how professional boundaries can become permeable without disappearing altogether: practitioners retain an originating professional identity while simultaneously acquiring responsibilities, knowledge and authority associated with a distinctive mental health role. This is important to the present study because it demonstrates that movement across the social work/mental health boundary is already formally recognised within some areas of UK practice.

Collectively, this literature suggests that boundary spanning should not be understood simply as one professional occasionally undertaking work associated with another. It can involve formal and informal activity, negotiation between organisations, translation between different forms of professional knowledge, coordination of fragmented services, and the development of relationships across occupational divisions. Importantly, boundary spanning may also occur to differing degrees and under differing organisational conditions. In some circumstances it represents a recognised and supported professional function, as demonstrated by the AMHP role; in others it emerges informally as practitioners respond to complex needs that cannot be contained within existing organisational or professional divisions. Contemporary boundary-spanning literature therefore moves beyond the question of whether professionals cross boundaries and instead raises questions about what they do when crossing them, what competencies make this possible, how professional identity is maintained or altered in the process, and what organisational circumstances encourage or necessitate such activity.

While this literature has substantially developed understanding of boundary spanning within social work, interprofessional practice and specialist mental health contexts, it does not specifically address the experience of generic social workers encountering and responding to mental health issues as part of their everyday practice**.** Existing research has largely examined practitioners occupying formal boundary-spanning, multidisciplinary or specialist roles. Consequently, less is known about how generic social workers negotiate the social work/mental health boundary and it is these circumstances which this research addresses, specifically exploring what and how generic social workers boundary span into the mental health realm: exploring under what circumstances this take place, what emotions social workers experience in the process and what challenges they face. The concept of boundary spanning provides a helpful lens to understand, and make sense, of what is happening. It manifests itself in several ways in this project; via the interviews when social workers were directly asked how they broaden their practice to incorporate mental health issues and ideas and how they confront these. The thematic analysis is explicitly structured around boundary spanning principles by marking a beginning point from where social workers first see themselves through a transition into a different kind of practitioner. Lastly, the discussion chapter takes boundary spanning to its final endpoint and considers

how repeated movement across the social work/mental health boundary may develop into **a** more formalised form of advanced, socio-therapeutic social work practice**.**

Combing the orienting concepts of the medical/social model and boundary spanning provides a sound theoretical foundation on which we can now begin to ask how social workers consider the boundary between social work and mental health. The two work in harmony: the medical/social framework provides the "what" and "why" this phenomenon is happening and supplies the vocabulary and theoretical assumptions surrounding the professional social work/mental health world. Boundary spanning provides the "how" this happens by providing explanations and conceptual framework around the challenges, debates and considerations social workers face in the process of moving from one realm into another as well as offering insight into the skills they own to do so and the personal characteristics which allow them to do it well. Blending the two and interweaving their constituent principles provides a strong, theoretical fabric to help appreciate the complex phenomenon of social workers choosing, or being forced, to act outside their social arena and venture into the mental health one.

3.4 Conclusion

This chapter has outlined the theoretical foundations that underpin this research: the social/medical model debate and the concept of boundary spanning. Together, these frameworks provide both the substance and structure necessary to interrogate how social workers conceptualise and navigate the complex space between social work and mental health. The medical/social model offers a means of framing the origins and causes of stress and illness, shaping how professionals assign responsibility for care and intervention. Boundary spanning, by contrast, focuses on the processes through which social workers move beyond their conventional roles and responsibilities, illuminating the skills, challenges and personal qualities involved in working across professional boundaries.

By interweaving these two perspectives, the research is positioned to capture both the theoretical assumptions that shape social work practice and the lived realities of professionals who must negotiate them in practice. This dual foundation not only provides a framework for

interpreting participant experiences but also establishes a shared language through which more complex ideas can be explored. Ultimately, it enables a richer understanding of how social workers engage with mental health, both conceptually and practically, and lays the groundwork for the analysis and discussions that follow.

To clarify, these theories are being used in a top-down, deductive way, in that I am using them as foundations to make sense of the phenomena being studied and in ways which have informed how the data has been generated (Clark et al., 2021). However, in the next chapter these theories provide a basis for a more inductive process by which I generate a new way of thinking about phenomena using a more bottom-up approach. By considering and critiquing existing literature and synthesising selected work, the following chapter provides a unique way of considering how social workers are already venturing into the mental health realm.

4 Literature Review

4.1 Introduction

This chapter examines the existing literature relating to social work and mental health to situate the present study within the broader academic context. The chapter begins by exploring how mental health has been conceptualised within social work and how the profession's values and theoretical traditions have shaped its engagement with psychological distress. It then considers research examining social workers' roles within mental health systems and the challenges practitioners face when working alongside medical and psychiatric disciplines. Historically, social work has emphasised the social and environmental determinants of distress, positioning the profession as distinct from the medical and psychiatric disciplines that dominate much of the mental health system. However, in practice these boundaries are often blurred. Social workers frequently operate alongside mental health professionals in multidisciplinary settings, and in many situations, they are required to engage directly with issues traditionally associated with mental health services. Therefore, understanding how social workers encounter and respond to mental distress is important for clarifying the role of the profession within contemporary health and social care systems. Mental health concerns commonly feature in contemporary social work practice. Social workers in both child and adult services regularly encounter individuals experiencing psychological distress, often within complex social circumstances involving trauma, poverty, family breakdown and other forms of structural disadvantage. As a result, the relationship between social work and mental health practice has long been recognised as an important area of professional behaviour.

Following the narrative discussion, a brief scoping review will provide a broad exploration of how the literature concerning the mental health/social work intersection is structured. This includes multi-disciplinary settings and interprofessional agencies. The scoping review demonstrates a lack of research concerning general social workers. Therefore, following the scoping review, a systematic review of the literature is presented to synthesise existing

empirical research examining the relationship between social work practice and mental health. The review aims to identify patterns within the existing evidence base and clarify the extent to which research has examined how generic social workers encounter and respond to mental distress in everyday practice. By consolidating findings from multiple studies, the review provides a foundation for the empirical research presented in later chapters of this thesis.

4.2 Social Work and Mental Health Intersections

Unlike psychiatry and clinical psychology which traditionally emphasise diagnosis and treatment of mental disorders, social work has historically approached mental distress through a broader social and environmental lens (Tew, 2005b; Bamford, 2015). This perspective emphasises the influence of structural and relational factors such as poverty and trauma in shaping mental wellbeing (Cohen, 2019). Consequently, social workers have often positioned themselves as advocates for a more holistic understanding of mental distress that recognises the interaction between psychological experiences and social conditions (Golightley, 2020).

In contemporary practice, social workers frequently operate within multidisciplinary systems that include psychiatrists, psychologists, nurses and other health professionals (Rogers and Pilgrim, 1996). These environments can generate tensions between social and medical understandings of distress origins. While social work traditionally emphasises environmental and structural explanations, mental health systems often prioritise diagnostic and clinical frameworks derived from psychiatry and psychology (Fox and Prilleltensky, 1997). These different perspectives can produce ambiguity and confusion regarding the professional role of social workers within mental health contexts (Karban, 2011). While the profession promotes a social understanding of distress, practitioners frequently find themselves engaging with psychological crises, risk assessment and therapeutic interventions in everyday practice. This blurring of professional boundaries has been widely noted in the literature, particularly within multidisciplinary settings where medical perspectives often dominate decision-making (Agnew et al., 2011; Morriss, 2017).

As a result, a growing body of research has examined how social workers navigate the relationship between social work practice and mental health systems. Much of this work has focused on social workers operating within specialist mental health services, particularly within community mental health teams (Wilberforce et al., 2013; Abendstern, Hughes, et al., 2021) and Approved Mental Health Professional roles (Simpson, 2020, 2024). However, comparatively less attention has been paid to how generic social workers encounter and respond to mental distress outside specialist mental health contexts.

4.2.1 Limitations of the Existing Literature

Although a growing body of research has examined the relationship between social work and mental health, this literature remains fragmented. Much of the existing research focuses on specialist mental health roles such as Approved Mental Health Professionals (AMHP) (Simpson, 2024) and the dilemmas they face (Kinney, 2009; Dwyer, 2012; Simpson, 2020) or social workers embedded within Community Mental Health Teams (Wilberforce et al., 2013). Comparatively little attention has been paid to generic social workers practising outside specialist mental health settings, despite evidence that these practitioners frequently encounter significant mental distress in their day-to-day work (Karban, 2011; Golightley, 2020). Furthermore, the existing studies are dispersed across different practice areas such as substance abuse (Galvani, Hutchinson and Dance, 2014), self-neglect and hoarding (Day, McCarthy and Leahy-Warren, 2012), domestic violence (Johnson, 2002; Humphreys, 2007) and parental mental health (Oakes et al., 2023) have not been systematically synthesised.

Compared to other "frontline" professions (nursing, police, fire and rescue), the generic social work experience seems oddly unexplored and remains in the preliminary stages (Gordon, 2018). This research aims to help address this gap. Secondly, when referring to "generic" social workers, the thesis refers to social workers working out of either a children's or adult social work team. They are not specialising in any one area, e.g. mental health, or working in an interdisciplinary setting.

4.2.2 Rationale for a Systematic Review

As the preceding sections have shown, the relationship between social work and mental health has been the subject of considerable discussion within the literature. Existing research has explored the role of social workers within specialist mental health services, the profession's engagement with multidisciplinary systems, and the tensions that arise between social and medical understandings of distress. However, much of this work focuses on social workers employed within specialist mental health contexts, particularly within community mental health teams or Approved Mental Health Professional roles.

Comparatively little attention has been paid to generic social workers operating outside specialist mental health services, despite indications that practitioners working in child protection, adult safeguarding and other social care settings frequently encounter individuals experiencing significant psychological distress. Consequently, the extent to which generic social workers engage with mental health issues in everyday practice remains unclear within the research literature.

Furthermore, the available empirical studies are dispersed across different practice areas and methodological approaches, making it difficult to identify broader patterns regarding how social workers encounter and respond to mental distress outside specialist mental health contexts. In the absence of a comprehensive synthesis of this literature, the current state of knowledge within this area remains fragmented.

To address this limitation, a systematic review of the literature was undertaken to identify and synthesise empirical research examining how generic social workers encounter and respond to mental distress within non-specialist practice environments.

4.3 Methods

The Preferred Reporting Items for Systematic Review and Meta-Analysis (PRISMA) informed this reporting. The synthesis followed Timulak and Ladislav's (2023) six stages: (1) define the research question and the parameters around the question's key elements and determine the types of studies to be included; (2) search and identify relevant studies; (3) assess the quality of each study (4) analyse the studies to identify themes; (5) generate meta themes

and structuring the synthesis and (6) summarise the findings. Meta-synthesis methodology was applied due to the nature of the research question and its usefulness to identify emerging themes across the selected studies (Timulak and Creaner, 2023). This study's protocol was registered on PROSPERO (ID; CRD42023427055). However, it should be noted that as the research progressed, increased familiarity with the literature and a more developed conceptual understanding of the social work/mental health boundary resulted in the research question and objectives becoming more clearly defined and focused. Consequently, the final review question presented within this thesis differs to some extent from that originally recorded within the PROSPERO registration. These changes did not result from the findings of the review or from an intention to alter the inclusion of particular studies, but instead reflect the iterative development and refinement of the research question as the wider doctoral project progressed. The PROSPERO registration should therefore be understood as representing an earlier formulation of the review, while the review reported within this thesis reflects the subsequent development and clarification of the doctoral research.

4.3.1 Search Strategy

Initial scoping searches were undertaken in consideration of the review question to identify appropriate search terms, and the review question was defined under the SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type), (Cooke, Smith and Booth, 2012) framework, resulting in several search strings to capture the different dimensions of the research question. It should be noted that the "Evaluation" component of this model was not incorporated due to the nature of the research question. This is because nothing is being "evaluated" as might be the case if one were testing an intervention or theoretical application. Instead, the research question explores experiential matters. Cooke, Smith and Boothe (2012) emphasise that the model is flexible and amendable to suit the research needs, nor is SPIDER the only model researchers have amended (Methley et al., 2014) to meet their specific needs.

Sample: Social workers (and synonyms)
Phenomena of Interest: Navigating the boundary between the mental health and social work disciplines.

Design: Interviews, Focus Groups, Thematic Analysis, IPA, other qualitative methods

Research Type: Qualitative/Mixed Methods

The phenomenon of interest is conceptually diffuse and difficult to operationalise in database search terms in that one is not working with a tangible and definable structure. Instead, it's asking how one experiences a complex social phenomenon which is not consistently indexed and is described using diverse language (Booth, 2016). Due to the broad nature in which the "mental health" concept might be represented in the literature, the phenomena of interest dimension required multiple search strings to capture relevant research. Therefore, a broad range of related terms and synonyms were incorporated into the search strategy to maximise sensitivity and ensure that studies exploring the interface between social work and mental health practice were identified. The "toxic trio" paradigm provided a useful foundation to start this process, so "domestic violence," "substance use" and "mental health" (in addition to other practice areas commonly associated with underlying mental health issues, e.g. mental capacity, dementia, hoarding, suicide, trauma, etc.) and their respective synonyms were used to build search strings.

After truncation, Boolean operators were used to build the following search strategy which was applied to title and / or abstract:

Sample:
"Social work*" OR "casework*" OR "welfare work*" OR "support work*" OR "case manage*" OR "child protect*" OR "child* safeguard*" OR "adult safeguard*"
AND
Phenomenon of Interest
"mental* health*" OR "emotion*" OR "wellbeing" OR "wellness" OR "cognitive health" OR "stabl*" OR "balance* "OR "psych*" OR "psychopath*:, "mental* illness" OR "mental* disorder*" OR "psychological condition" OR "disturbanc*" OR "mental health condition" OR "behave*" OR cognit*"
OR
"substance *use" OR "substance abus*" OR "drug abus*" OR "chemical depend*" OR "substance misus*" OR "substance consum*" OR "narcotic utilisation" OR "psychoactive substance intake" OR "addict*" OR "psychoactive*" OR "prescription med*" OR "intox*" OR "chemical abus*"
OR
"domestic* violence" OR "spous* abus*" OR "coer* control*" OR "stalk*"
OR

“suicide” OR “self-harm*” OR “self*” OR “self mutil*” OR “homicide”
OR
“mental capacity” OR “capacity” OR “MCA” OR “MHA” OR “mental health act”
OR
hoard* OR "hoarding disorder*" OR "compulsive hoard*" OR "pathological hoard*" OR "excessive accumulat*" OR "object accumulat*" OR "clutter behavio*" OR "severe clutter*" OR "difficulty discard*" OR "impaired discard*"
OR
dement* OR "major neurocognitive disorder*" OR "neurocognitive disorder*" OR "cognitive impair*" OR "cognitive declin*" OR "cognitive deteriorat*" OR "neurodegenerative disease*" OR "progressive cognitive disorder*" OR "memory disorder*" OR "organic brain syndrome*" OR "acquired cognitive impair*"
OR
trauma* OR "psychological trauma" OR "emotional trauma" OR traumat* OR "post-traumatic" OR PTSD OR "post-traumatic stress"

AND
Location:
“United Kingdom” OR “England” OR “Scotland” OR “Northern Ireland” OR “Britain” OR “Great Britain”

EBSCO host was the primary search engine used to search the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and PsychINFO databases. MedLine, PubMed, Applied Social Sciences Index and Abstracts (ASSIA), the Campbell Collaboration, the Networked Digital Library of Theses and Dissertations (NDLTD) and Social Sciences Index databases were searched separately.

4.4 Study Selection

Prior to commencing the search, inclusion criteria were set. Included articles needed to have the following characteristics:

- Use a qualitative research design (or if mixed methods, only qualitative data were included in the synthesis)
- Discuss social workers engaging with mental health in some capacity
- Qualitative (e.g. interviews, focus groups, ethnography) methods directly involving social workers
- Experiences were explicitly explored
- Completed in the United Kingdom
- Completed with the last 30 years
- Peer reviewed

All yielded articles were screened against the above criteria, firstly by title and abstract followed by full text reading. 15 papers were excluded because they were not concerned with mental health, 30 papers were excluded because social worker experience did not form their data and one paper was excluded because it was not based on UK practice. The reference lists from each remaining paper was then searched, followed by a hand search using Google Scholar however no further relevant papers were identified.

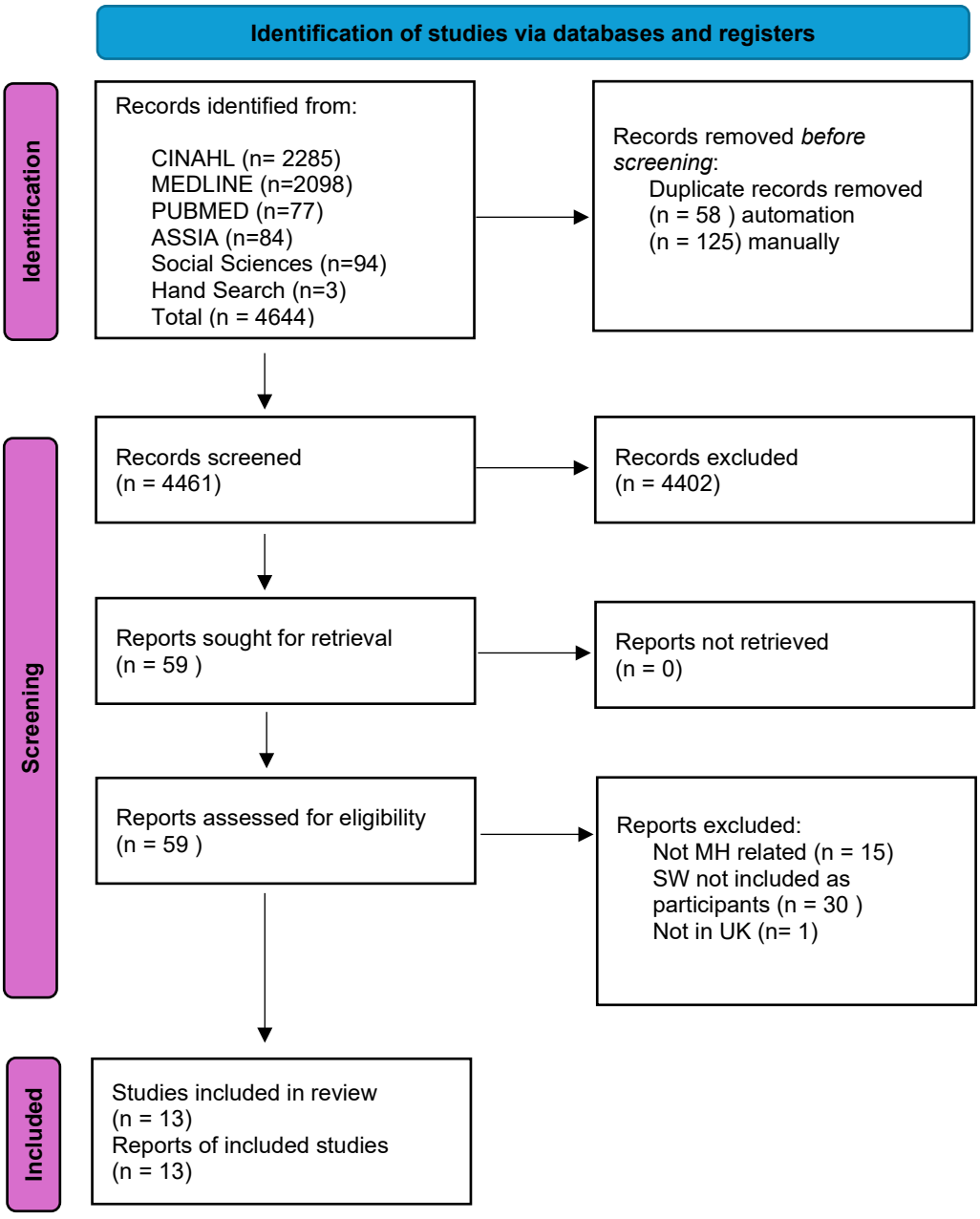


Figure 4.1 PRISMA Diagram

4.4.1 Quality Assessment

Quality appraisal is important for literature reviews to ensure the material is trustworthy, valid and relevant to the research topic. Screening included papers for research design consistency also supports a clear synthesis. Each paper was assessed for quality against the Critical Appraisal Skills Programme (CASP) checklist. CASP was selected for three main reasons. Firstly, it is specifically designed for qualitative research, which formed most studies included in this review. Secondly, the tool offers a clear and systematic framework for assessing methodological quality while remaining sufficiently flexible to accommodate the diversity of qualitative approaches commonly used in social work research. Thirdly, CASP is widely used and recommended within health and social care literature reviews, which enhances the transparency and reproducibility of the appraisal process (Booth, 2016; Aveyard, Payne and Preston, 2021). This tool consists of 9 criteria categorised into 3 sections: (a) are the results of the study valid, (b) what are the results and (c) will the results help locally. Each element is answered "yes", (+) "no" (-) or "unclear" (+/-) resulting in a total score. Of the 13 papers reviewed, 7 scored as high quality (9) and 6 scored as moderate (7-8). The lowest scoring paper (7) was included since it provided valuable insight to the research question which did not appear in higher scoring studies nor was it a particularly low scoring paper.

The results of the CASP appraisal are summarised in Table 4.1. Presenting the results as a scoring system provides transparency and evidences academic rigour (Butler, Hall and Copnell, 2016). Most studies were assessed as high methodological quality, with several rated moderate quality where reporting of reflexivity or methodological justification was limited. Consistent with guidance on qualitative evidence synthesis, quality appraisal was used to assess methodological rigour and transparency rather than to exclude studies, as studies of varying quality may still contribute valuable conceptual insights.

4.4.1.1 Reporting Bias

While the systematic search aimed to identify the available literature relevant to the research question, the possibility of reporting and publication bias should be acknowledged.

The review was limited to peer-reviewed research and therefore reflects evidence which researchers, reviewers and publishers have elected to report and publish. It is possible that studies identifying particularly significant, problematic or conflicting experiences between social workers and mental health services are more likely to have been published than studies reporting less notable or largely unproblematic experiences (Song *et al.*, 2010). Similarly, selective reporting within individual studies may have influenced which findings were available for inclusion within the synthesis. No formal assessment of reporting bias was undertaken because the review primarily synthesised qualitative studies and sought to identify and interpret conceptual patterns across the literature rather than calculate intervention effects or estimate the prevalence of particular experiences (Lewin *et al.*, 2015). Consequently, the themes identified within this review should not be interpreted as demonstrating how frequently these experiences occur within the wider social work population, but rather as recurring patterns identified within the available published qualitative evidence. This potential reporting bias should therefore be considered when interpreting the synthesis and the Endogenic Thinking and Practicing Model subsequently developed from it.

A further consideration concerns selective reporting within the individual studies included in the synthesis. Qualitative research inevitably involves decisions by researchers regarding which aspects of their data are considered significant and subsequently presented within published findings (Sandelowski and Barroso, 2007). The articles included within this review therefore represent an interpretation of the original qualitative data rather than providing access to the complete datasets from which their findings were developed. Authors may emphasise particular experiences, participant accounts or themes because they align with the research question, are considered theoretically significant, or provide particularly illustrative examples of the phenomenon being explored (ibid). Conversely, contradictory, less prominent or peripheral findings may receive limited attention or be omitted entirely due to publication constraints or decisions concerning the focus of the paper. This is particularly relevant to qualitative meta-synthesis because the present review necessarily synthesises the findings and interpretations reported by the original researchers rather than independently analysing their primary data. Consequently, the themes developed through this synthesis are influenced not only by the analytical decisions made during the present

review, but also by earlier interpretive decisions made by the authors of the included studies. This potential influence should therefore be recognised when considering the findings generated through the synthesis.

Table 4.1 CASP Appraisal

Study	Criteria									Total	Quality
	1	2	3	4	5	6	7	8	9		
Abendstern, et al (2021)	+	+	+	+	+	+/-	+	+	+	8	Moderate
Agnew, et al (2011)	+	+	+	+	+	+/-	+	+	+	8	Moderate
Aspinwall-Roberts, et al (2022)	+	+	+	+	+	+/-	+	+	+	8	Moderate
Batsleer J, et al (2003)	+	+	+	+	+	+	+	+	+	9	High
Boahen (2016)	+	+	+	+	+	+	+	+	+	9	High
Devaney (2008)	+	+	+	+	+	+/-	+	+	+	8	Moderate
Galvani, et al (2014)	+	+	+	+	+	+	+	+	+	9	High
Helm (2016)	+	+	+	+	+	+	+	+	+	9	High
Hood (2015)	+	+	+	+	+	+	+	+	+	9	High
Morriss (2017)	+	+	+	+	+	+	+	+	+	9	High
Phillipowsky (2020)	+	+	+	+	+	+	+	+	+	9	High
Smith M (2003)	+	+	+	+/-	+	+	+	+/-	+	7	Moderate
Smith M, et al (2004)	+	+	+	+/-	+	+	+	+/-	+	7	Moderate

4.4.2 Data Extraction and Synthesis

Using Thomas and Harden's (2008) Thematic Synthesis, the process was conducted inductively through repeated reading of the included studies, during which key ideas and interpretations were highlighted and compared across papers. Through an iterative process of constant comparison, these concepts were progressively grouped into broader categories and ultimately synthesised into overarching themes. This was a three-step process:

- Stage 1: Line-by-line coding of the findings
- Stage 2: Development of descriptive themes
- Stage 3: Generation of analytical themes

Stage 1:

Following study selection, each paper was read repeatedly to ensure familiarity with the data. During these readings, relevant sections of text relating to the research question were manually highlighted on paper and annotated in the margins. This process allowed concepts,

interpretations and observations reported by the original authors to be identified across studies.

Stage 2: Development of descriptive themes

Data extraction focused on capturing key ideas, interpretations and conceptual insights rather than solely descriptive findings. Initial notes and highlighted segments were compared across papers and gradually organised into conceptual groupings. Through an iterative process of comparing, ideas that appeared across multiple studies were clustered together and provisional categories were developed. This is an inductive process which centrally places the user's professional, personal and theoretical understanding into the process (Timulak and Creaner, 2023).

Stage 3: Generation of analytical themes

As analysis progressed, these categories were refined, merged and reorganised which allowed broader patterns to emerge across the literature. This constant comparison between studies facilitated the identification of higher-level themes that captured recurring explanations of how social workers conceptualise and respond to mental distress within practice. The process was therefore inductive, with themes developed through the researcher's iterative interpretation of patterns across the literature rather than through the application of a pre-existing analytical framework (Aveyard, Payne and Preston, 2021).

This approach is consistent with qualitative meta-synthesis in which findings from primary qualitative studies are interpreted and integrated to generate new conceptual understandings that extend beyond the individual studies themselves (Sandelowski & Barroso, 2007; Thomas & Harden, 2008). The final thematic framework represents a synthesis of the patterns identified across the reviewed studies and forms the basis for the analysis presented in this review, namely the Endogenic Thinking and Practicing Model detailed below in Table 4.3.

Table 4.2 Summary of Included Studies and Their Contribution to the Thematic Synthesis

Paper	Sample/Methods	Discussion/Key Findings or Results or What the paper is saying overall	Themes
Abendstern*	20 social workers, focus groups, TA	Topic: CMHT Adult Support Services Overall findings: Found that social workers make a distinctive contribution to community mental health teams through their commitment to the social model, relational practice, and advocacy for service users. Their presence supports holistic and person-centred approaches within multidisciplinary teams and enhances colleagues' practice. Participants expressed concern that removing social workers from teams could lead to more transactional, medically dominated care, delays in recognising social needs, and a reduced service-user voice. Contribution to thematic framework: This paper described a common context in which endogenic thinking takes place and describes the pressures which can contribute to it. The paper is a standout from the others in that it highlights examples of *exogenic* thinking among the social workers interviewed.	1.1, 1.2, 2.2
Agnew*	Interviews (n= 8), TA	Topic: Grief and Loss Support Service Overall findings: Found that bereavement support services were widely available in hospice settings but that assessment practices were inconsistent and often lacked reliability. Bereavement risk assessments relied heavily on checklists and multidisciplinary discussions, yet staff expressed concerns regarding documentation accuracy, ethical	1.1, 1.2, 2.2

		issues around consent, and limited training opportunities. The study highlighted the difficulty of identifying individuals at risk of complicated grief and ultimately informed the development of a more structured bereavement service model. Contribution to thematic framework: Social workers identified service users at risk of "complicated" grief as a diagnosable condition involving cognitive, emotional, behavioural symptoms lasting longer than six months (similar to DSM criteria). They used a checklist tool designed to identify "high risk" service users which aimed to predict grief outcomes and suicidal patients were referred to a GP (thus medicalising the problem). While some exogenic thinking was present, the assessment tool used largely represented endogenic thinking.	
Aspinwall-Roberts*	(n= 64) Natural Focus Groups, TA	Topic: How the Mental Capacity Act is used in practice Overall findings: Professionals across multiple agencies struggled to interpret and apply the Mental Capacity Act in cases of self-neglect. Practitioners reported confusion about the legislation, reluctance to conduct capacity assessments, and disputes between agencies about responsibility. Capacity determinations were viewed as central to safeguarding decisions, yet participants believed that assessments could be influenced by organisational priorities and resource pressures, creating tensions within multi-agency practice. Contribution to thematic framework: Endogenic thinking was evidenced by social workers framing capacity as service users "having it" rather than exploring exogenic factors contributing to the situation	1.1, 1.2, 1.3, 2.2, 3.1

		or behaviours. The social workers do not endorse this thinking but the system, vis a vis the MCA, encourages it. It provides a strong example of organisational pressures towards endogenic thinking.	
Batsleer*	(n=?) Interviews, TA, IPA	Topic: Supporting South Asian domestic violence victims Overall findings: Health and social care staff often responded to South Asian women who attempted suicide or self-harmed with mixed and sometimes negative attitudes, with some professionals interpreting these behaviours as attention-seeking rather than expressions of serious distress. Workers frequently attributed self-harm to cultural factors, yet both staff and survivor accounts highlighted that structural and gendered issues—including domestic violence, sexual abuse, racism, immigration pressures, poverty and social isolation—were key contributors to women's distress. It should be noted that it was not clear which "care staff" were qualified social workers. Contribution to thematic framework: Mirroring their nursing colleagues, staff grouped service users into a binary system of "deserving" and "non-deserving" which provides an element of certainty and order. Internalised cultural traits were perceived as contributors towards accepting violent relationships.	1.1, 1.2, 2.2, 3.1
Boahen	Interviews (n=9) Ethnography. Grounded Theory	Topic: Social workers in Community Learning Disability Teams (CLDTs) Overall findings:	1.2, 1.3, 3.1

		Social workers perform a broad, coordinating role across multiple areas of practice rather than operating as narrow specialists. Their work spans several domains including case management, safeguarding, assessments, mental health practice and duty work, requiring them to manage complex cases involving housing, mental health, safeguarding and transitions to adulthood. They make a distinct contribution to integrated teams through their ability to navigate complex service systems and coordinate multidisciplinary responses, making them indispensable within CLDTs. Contribution to thematic framework: Social workers were asked to step in to deal with "complex cases", but clinical staff retained control over the general culture of the organisation (medical). Because work was organised in a task-centred way, social factors were not routinely considered.	
Devaney	Interviews (n=2)/Case reviews Content Analysis	Topic: Inter-Professional Working in Child Protection Overall findings: Explored families involved in long-term child protection cases typically experience multiple, entrenched difficulties, particularly domestic violence, substance misuse, mental health problems and poverty, which often interact and reinforce each other. Effective intervention depended heavily on strong professional relationships with families and effective inter-professional collaboration, yet barriers such as poor communication between agencies, role ambiguity and reluctance from some professionals to engage in child protection processes limited this cooperation. Organisational factors also shaped practice, with limited access to specialist services, long waiting lists and high staff turnover among social workers undermining continuity of support and slowing progress in complex cases.	1.2, 1.3, 2.2, 3.2

		Contribution to thematic framework: Participants described limited access to mental health services requiring SW to hold risk responsibility and parents relied on medical diagnostic language to shift blame away from home/environmental issues and *into* the child. Formal assessments provided a sense of certainty to by providing medical certitude to explain complex family dynamics.	
Galvani	Mixed Focus Groups	Topic: Identifying and Assessing Substance Use Overall findings: Social workers frequently encounter substance use among service users, yet many feel ill-equipped to identify and assess it effectively. Practitioners typically recognised problematic substance use only when it began to visibly affect a person's functioning, such as their ability to perform daily activities or fulfil parenting responsibilities. Substance abuse was not routinely assessed and social workers lacked formal guidance to do so, resulting in identification post-crisis. Contribution to thematic framework: Social workers relied on health professionals to assess substance use while another participant ignored the issue to preserve the relationship with the service user. Other practitioners attempted to assess despite feeling confident to do so.	1.2, 2.1, 2.2, 3.2
Helm	6 social workers Ethnographic	Topic: Sense making in a child protection team Overall findings:	1.3, 3.1, 3.2,

		The study demonstrates that professional judgement emerges through collective sense-making processes rather than purely individual reasoning. Judgements are developed through dialogue within teams and through consideration of organisational responsibility across agencies. Because practitioners often operate under conditions of uncertainty and time pressure, decisions are typically "good-enough" judgements based on limited information, highlighting the central role of emotional intelligence, communication and professional discretion in social work practice. Contribution to thematic framework: Provides an example of SW adhering to SW practice when perhaps a more clinical approach would be more appropriate. Evidences that SW picks up risk when Health doesn't want to.	
Hood	Interviews/IPA	Topic: Experiencing complexity in a child protection context Overall findings: Hood (2015) explored how professionals experienced complexity when working collaboratively on child protection cases. Using an Interpretative Phenomenological Analysis of two cases involving 17 practitioners from social care, education, youth offending and mental health services, Hood found that complexity arose from the interaction of multiple needs, uncertainty around cause and effect, difficulties predicting outcomes, and practitioners' limited control over unfolding events. Hood concludes that complex cases require professionals to move beyond routine information-sharing towards more strategic and adaptive forms of collaborative practice, while recognising that this may result in the blurring of professional roles and boundaries.	1.1, 1.2, 2.1

		Contribution to thematic framework: Hood demonstrates how uncertainty around causality and risk increased reliance on diagnostic explanations and specialist mental health expertise. The paper also demonstrated how complexity could push practitioners beyond conventional role boundaries as they negotiated responsibilities and undertook work outside their formal remit.	
Morriss*	Interviews (n=17) Dialogical Narrative	Topic: Experiences of secondment to a MH team Overall findings: Found that mental health social workers seconded to NHS Mental Health Trusts experience their role as professionally invisible and poorly defined. Practitioners described social work as operating in liminal spaces, often filling the gaps left by other professions and addressing complex social issues overlooked by medically focused colleagues. Many reported professional isolation, particularly where links with local authority social work structures were weak and supervision was provided by health professionals rather than social work managers. Participants frequently contrasted the medical focus on symptoms with social workers' attention to social conditions such as housing or poverty, arguing that the latter were often overlooked within multidisciplinary teams. Contribution to thematic framework: Provides good evidence of the tension between SW and MH and influenced from the medical field. Provides examples where health ignores endogenic influences but SW successfully identifies them. Clear evidence of SW picking up tasks others don't want to do.	1.1, 1.2, 1.3, 2.2, 3.1,
Phillipowsky*	Interviews (n=5) TA	Topic: Social work perspectives in an integrated setting Overall findings:	1.1, 1.2, 2.1, 2.2, 3.1

		The paper found that social workers within integrated health and social care organisations often perceive themselves as undervalued and marginalised within health-dominated systems. Participants reported that social work knowledge and skills were frequently underutilised and that organisational cultures emphasising medical models limited the influence of social perspectives in assessment and decision-making. Integration was also complicated by structural differences between health and social care systems, including funding arrangements, organisational priorities and the impact of austerity. These factors contributed to concerns that social work identity was being eroded or diluted within integrated services, particularly where supervision and leadership from social work professionals were limited. Contribution to thematic framework: A lot of discussion about medical hierarchy and the powers medical staff enjoy. SW is marginalised in an MDT setting and austerity and process structures pushed SW to adopt endogenic thinking. The trust attempted to diagnose, quantify and pathologise people and SW asked to quantify the unquantifiable.	
Smith†	44 Interviews Interviews Phenomenology	Topic: How social workers experience fear Overall findings: The paper found that fear is a pervasive but often overlooked element of social work practice. Interviews with social services staff revealed that practitioners frequently experience fear in the course of their work, most related to the risk of physical assault from service users. Participants also described fears of death, losing emotional control in stressful situations and being criticised by managers through complaints procedures. These fears can influence decision-making and professional	1.1, 3.2

		judgement, particularly in high-risk environments such as residential care and child protection work. The authors argue that fear should be acknowledged as a legitimate aspect of social work practice and that organisations should provide opportunities for workers to reflect on and discuss these experiences. Contribution to thematic framework: The author seems to go out of his way to ignore any trauma theory. Makes no mention of trauma but mentions that social workers should undergo "fear audits." The author links fear to Freudian psychology. What is notable here is the absence of any PTSD discussion.	
Smith†	44 Interviews Interviews Phenomenology	Topic: How social workers respond to experiences of fear Overall findings: Found that fear is a significant and multifaceted aspect of social work practice. Participants described strong physical, cognitive and emotional reactions when encountering threatening situations, with fear sometimes impairing decision-making and causing workers to rely on an "automatic pilot" professional role to navigate risk. Experiences of fear frequently had long-term psychological effects, including intrusive memories and reduced confidence. Contribution to thematic framework: Makes references to SW's benefiting from "drama therapy." Again, while the word "trauma" is used, it's clinical significance or knowledge about it is completely ignored. A participant attributes a service user's violent behaviour to an obscure Bowlby theory, not the fact that she had been diagnosed as histrionic.	2.1, 3.2

(*indicates the study was completed within an interprofessional setting, in that staff from different professions were working together within the same organisation)
(†indicates paper is from one study)

4.5 Results

4.5.1.1 The Papers

In total, 13 sources were identified which were relevant to the review question. Six papers discussed social workers within a multi-professional agency (social workers working alongside other professionals in a single agency) three discussed social workers who were working in a multi-professional context (i.e., sharing a case with another agency) and four papers discussed social workers in a larger practice context. All the papers had the following characteristics: (a) social workers were interviewed; (b) their work intersected with a health, mental health or another clinical discipline. While each paper asks different research questions, they all qualitatively explore social workers' experiences of managing the mental health/social work boundary (see above Table 4.2).

12 papers used qualitative methods (i.e. semi-structured or focus groups), while one used mixed methods, however only the qualitative data was used for the synthesis. Most of the papers focused exclusively on social workers, however three included other professionals under the title "practitioner" while one did not identify the interviewee's profession at all. While this difference may not have been important to those specific papers, it does make a difference since the review question relates to social workers specifically, as the title assumes certain professional values, identity and training – factors which sit at the root of the research question. However, these papers were included since they do state that social workers were included in the sample and their findings reflect other papers which specifically identify social workers' views.

4.5.2 Thematic Findings and Structure

The following thematic structure was inductively developed as a product of the thematic synthesis process (Thomas and Harden, 2008). In short, this discussion argues for a new way

of thinking about how social workers adjust their practice when confronted with mental health situations for which they are not prepared or trained.

Across the selected papers, social workers adopted what could be considered an "endogenic" mentality. The word "endogenic" is used in a variety of fields, including geology, but is usually defined as "from inside," while "exogenic" can be used to describe a force originating "from outside" (Scheidegger, 2012). Therefore, this mentality suggests that the social worker is either implicitly or explicitly attributing the service user's source of stress to a factor *within* the service user- hence "endogenic," and the following discussions use this term to describe how the social worker is framing the source of the patient's/service user's stress. The social worker does this in two ways: by thinking about what is happening (or how the social worker is framing the issue) and how they behave (practise). I have separated "thinking" from "doing" because they are different phenomena with different characteristics, however the following exploratory discussions cannot be so neatly segregated and remain cohesive so some overlap will naturally exist.

This framework provides an intuitive way of identifying what is happening within the collection of these papers. While the first theme explains why social workers are behaving this way, the second theme explains how this manifests in practice. The third theme explains some of the thinking expressed by the collective participants which, by definition, underpins the first two themes. Thus, the themes can be represented visually by Table 4.3:

Table 4.3 Endogenic Practice and Thinking Model

Endogenic Practice and Thinking Model

<table>
<tr><th colspan="2">Social Work Endogenic Practice</th></tr>
<tr><td>Theme 1: Why

1.1 Need for Certainty

1.2 Influences from Medical Colleagues

1.3 No One Else Wants to or is Available</td><td>Theme 2: How

2.1 Practise Without Training

2.2 Let Health Do It</td></tr>
<tr><td colspan="2">Theme 3: Endogenic and Exogenic Thinking

3.1 Minimise Social Factors

3.1 Ignore MH Factors</td></tr>
</table>

4.5.3 Theme 1: *Why* Social Workers Practise Endogenically

This theme explores the different reasons why social workers appear to emphasise the perceived internal roots of service user's stresses, adopting a medical approach over the social model as previously explored in Chapter 3- Theoretical Foundations: The Social/Medical Debate and Boundary Spanning. Given the undeniable medically-modelled industry and agencies offering mental health services, this theme explores the more dominating dynamics which compel social workers working with and in these agencies to abandon their social model laden values and worldview and adopt those more parallel with the industry's ethos. The literature strongly suggests that this behaviour is attributable to system pressures, existing endogenic assumptions built into service structures and the perceived authority medical practitioners enjoy. The theme consists of three sub-themes: "need for certainty", "influences from medical colleagues" and "no one else wants to or is available" each of which uses data from the selected papers to explore these phenomena more deeply.

4.5.3.1 Sub-theme 1.1: Need for Certainty

Agnew (2011); Aspinwall-Roberts et al. (2022); Batsleer (2003); Devaney (2008), Hood (2015), Morriss, 2016, Phillipowsky, (2022), Smith (2003, 2004)

This sub-theme has the widest evidential base because most of the studies describe structural or organisational drivers of endogenic thinking. The sub-theme can be described as social workers' evidencing a need for certainty or objective rationale to explain or predict- key characteristics of medical practice. The literature demonstrated two reasons why this happens: 1) the desire to professionally protect oneself amongst chaos and from risk, and 2) an attempt to alleviate systemic pressures and adhere to pre-existing structures.

Fewer topics induce professional anxiety more than the avoidable death of a vulnerable adult or child by abuse or a service user completing suicide (Regehr et al., 2016) so it seems understandable that professionals would want a tool which better quantifies risk for both. However, there is no universally used or taught method to quantify suicide risk (Carter et al., 2019). While there do exist tools to help identify risk (e.g. safety risks to children) by their nature they do not perform in the same way or with the same confidence that a biologically

based medical test might indicate prognosis or the presence of disease. Yet practitioners attempt to use them as such. Agnew (2011) provides an example of this, describing practitioners using a grief assessment tool to identify "complicated grief." This tool strongly resembles diagnostic-style criteria and was used in a way which suggested an ad hoc suicide risk assessment device, thereby transforming a complex emotional experience into a structured mechanism aimed to predict and describe. Despite these incompatibilities, "risk" therefore takes on almost a tangible presence, a factor in and of itself to be managed and potentially shared or "owned" by other services (Helm, 2016) or better quantified via diagnosis by mental health services (Hood, 2015). This theme is echoed by discussions concerning people who self-harm where professionals stated feeling vulnerable (Batsleer, Chantler, and Burman, 2003). Categorising service users into groups of "genuine" (and presumably higher risk) and "attention seekers" (lower risk) provides a mental structure by which uncertain risk might be better internally managed.

The need for certainty also presents in complex family systems (Hood, 2015). Social workers look to Children and Mental Health Services (CAMHS) to provide a diagnosis which explains a youth's disruptive behaviour within a family system of bewildering complexity, impacted by a myriad of bio-psycho-social factors that are attempted to be siphoned through a medical model into a clear and, most importantly, treatable diagnosis- a theme echoed within the realm of Mental Health Trusts (Phillipowsky, 2022). This need for quantification further distils down to a "cause and effect" mentality, for which the youth's parents ironically hope to dispel any blame of their parenting, a phenomenon commonly recognised by child safeguarding social workers and later explored empirically in section 6.3.2.3 Label or Diagnosis. Parents described by Devaney (2008) sought certainty from the authority diagnosis brings, explaining their children's behaviour through the simple language of Attention Deficit and Hyperactivity Disorder (ADHD) or Autism. This not only brought comfort by labelling the problem (and subsequently the child) but had the added benefit of absolving them internal guilt or responsibility. Social workers gravitated towards this conclusion and was one of the key findings Devaney lists as how practitioners make sense of complex cases.

Mental capacity is another battleground between complexity and certitude, this time propelled by the Mental Capacity Act, a piece of legislation itself often described as "complex" (Aspinwall-Roberts et al., 2022a; Beale et al., 2024). Different professionals understand and use the Act differently and inconsistently, often in ways which either lessen workload or in other ways benefit their respective organisations' agendas (Aspinwall-Roberts et al., 2022a). While previous examples sought a diagnosis or attempted to quantify risk, this example attempts to take a complex issue and distil it down into the binary form of a service user either "having," or "not having," capacity. Couched within the context of self-neglect, the literature evidences pressures upon professionals to use the Act to justify action or inaction dependent on factors not remotely related to the service user and usually administered by someone either poorly trained or not trained at all to use it as it was intended.

Integrated mental health trusts and multi-disciplinary work concerning the Mental Capacity Act serve as a prime examples of systemic machinery which shape a social worker's practice away from their social values (Aspinwall-Roberts et al., 2022a). Given the health-driven ethos of these work environments, social workers discussed feeling marginalised in MDT meetings, their views dismissed and service users' issues overly medicalised to fit the categories by which resources are organised. For social workers seconded to a Mental Health Trust from the Local Authority, these dynamics appear even more acute (Morriss, 2016), with mental health social workers experiencing supervision by their nurse supervisors as more about target reviews and work performance resulting in "invisibility" and a loss of social work exogenic identity.

Mental capacity, and whether a service user is assessed as evidencing it, is a procedural focal point which can define practitioner workloads and organisational financial obligations. Social workers are more inclined to assess a service user as "having capacity," not by MCA (2005) criteria, but out of the need to protect resources and lessen caseloads (Aspinall-Roberts, et al, 2022). This view was often justified by the social work value of "self-determination," the idea that people have a right to live as they choose irrespective of how unhealthy those choices may be. However, it should be noted that social workers were not the only professionals "fudging" this complex and sometimes confusing assessment process for their own benefit. Mental capacity, like grief, serves as another example of a complex human

experience, this time legislatively sanctioned, siphoned through a marketised and target-driven industry into seemingly "managed" conditions – a filter to determine who needs assistance and who does not. Again, returning to risk, thresholds were another area where viewpoints about risk or other mental health factors could be adjusted depending on systemic pressures (Hood, 2015) resulting in disagreements between agencies about which agency would lead or whether a risk even existed. This phenomenon is later explored in the empirical chapter, specifically section 6.3.3 Sub-Theme 2.2: Services: Can't or Won't?.

Lastly, Smith (2004) discusses participants who, while not explicitly using the word "uncertainty", analytically infer it when fearing or worrying about the future which are "prey to the workings of the imagination" (pg. 664). Smith later builds on this argument, emphasising the importance of what happens in someone's mind over events in the real world. This suggests participants feel fear and/or stress and must act on or address these feelings, irrespective of the event actually coming to pass.

4.5.3.2 Sub-theme 1.2: Influences from Medical Colleagues

Abendstern (2021); Agnew (2011); Aspinwall-Roberts et al. (2022); Batsleer (2003); Boahen (2016); Devaney (2008); Hood (2015); Morriss (2017); Phillipowsky (2020)

This sub-theme discusses how medical staff influenced social work staff and is closely related to the previous theme but widens the discussion out to include other motives besides certainty. This sub-theme contains ideas stemming from papers which can be grouped into two categories. The first category contains studies focusing on interprofessional services (different disciplines working together in the same location) like Community Mental Health Teams (CMHTs) (Morriss, 2017; Phillipowsky, 2020; Abendstern, Wilberforce, et al., 2021), bereavement services (Agnew et al., 2011), or learning difficulties services (Boahen, 2016a). The second group focuses on papers interested in multi-disciplinary collaboration where professionals are in different locations but working together to achieve a shared goal, usually a safeguarding related task (Batsleer J, Chantler K, and Burman E, 2003; Devaney, 2008; Hood, 2015; Helm, 2016), or work underpinned by the Mental Capacity Act 2005 (Aspinwall-Roberts et al., 2022a),.

The social/medical hierarchy previously explored in the background chapter was clearly evident in both groups but due to the physical close proximity when working inter-professionally, social workers were more aware of this dynamic and openly discussed their medical colleagues enjoying a sense of prestige and professional recognition (Phillipowsky, 2020). Understandably, these interprofessional agencies demonstrated the most direct or noticeable "medical drift" where social workers looked to their medical colleagues to define the agency's culture or attitude towards service users. This is evidenced when social workers engaged with suicidal or self-harming service users and appeared to adopt nurses' perceptions of the difference between "biological" suicide attempts compared to the more frustrating "attention seeking" self-harming patients (Batsleer, 2010). This desire to "categorise" extends further, particularly in a system constructed by categorical services requiring an objective tool to direct care. When working with bereaved service users, social workers seemed to shed their social/environmental ideology and instead echoed nursing staffs' desire for certainty, sharing frustration of the lack of an empirical grief assessment tool which might measure or predict grief, thus directing service users to more acute services or justifying closing a case (Agnew, 2011). Interestingly, this contrasted with the theoretical framework the organisation championed which clearly stated that grief is personal and complex (Parkes, 2004).

The second category demonstrated social services closely liaising with external mental health agencies when working in safeguarding situations (Batsleer, Chantler, and Burman, 2003; Devaney, 2008; Hood, 2015; Helm, 2016), working with the Mental Capacity Act 2005 (Aspinwall-Roberts et al., 2022a), or working with substance users (Galvani, Hutchinson and Dance, 2014). Again, medical superiority is present, particularly when working with complex situations. Social services turn to Children and Adolescent Mental Health Services (CAMHS) in order to provide an authoritative label via a medical diagnosis, but when these services are not available, the social workers "hypothesise" their own diagnosis in the hopes of lending their conclusions more authoritative heft (Devaney, 2008; Hood, 2015). This again speaks to the authority medicine has, compelling social workers to practise outside their remit to the point of abandoning their "non-labelling" values. When working with people who self-harm, social workers sought professionals with "better expertise" and referred service users to medical providers, some of whom had originally referred the "patient" in their service in the

first place. Further, this attitude that health is the "authority" impacts social workers' confidence in completing routine tasks which arguably should be considered a social work task, (i.e. assessing drug use) however Galvani (2014) points out that, despite drug being one of the three "toxic trio factors" social workers are not usually trained to assess it and therefore rely on nurses to do so.

Risk assessment also seems to be an area reserved for the "better trained" and more authoritative medical staff, particularly when assessing risk from a violent young person (Hood, 2015). This latter example exemplifies the notion that health might be more appropriate to make the final "risk determination" while social workers, as Agnew describes when assessing grief related risk, are better at gathering the information. Ironically, this is not always case and seems to be dependent on the nature of the risk and how politically contentious the decision might be. Further highlighting the authority health carries and later discussed in the findings chapter, health professionals appear to have more latitude about what they will and won't do, explicitly demonstrated when considering mental capacity (Aspinwall-Roberts et al., 2022a), or when a CAMHS case could be closed (Hood, 2015). However, when social workers brought their social expertise to the proverbial multi-disciplinary table (Morriss, 2016; Abendstern, et al., 2021; Boahen, 2016; Phillipowsky, 2020), they experienced varying degrees of success towards impacting on the medical, neo-liberal, fix-it-and-move-on approach. In short, social work identity was defined by medical staff and structures, the tasks social work does identified by medical staff and how these tasks were completed were largely directed by medical values, some of which explored in the next sub-theme.

4.5.3.3 Sub-theme 1.3: No One Wants to or is Available

Agnew et al., (2011); Aspinwall-Roberts et al. (2022); Boahen (2016); Devaney (2008); Helm (2016); Morriss (2017)

Social workers felt compelled to complete tasks either because no one else wanted to do them (Agnew et al., 2011; Helm, 2016; Morriss, 2017; Aspinwall-Roberts et al., 2022b) or because perceived more qualified professionals were not available (Hood, 2015). Fear of

making an incorrect decision was one identified reason, specifically when determining capacity (Aspinwall-Roberts et al., 2022b) or assessing risk (Helm, 2016) which left social workers feeling professionally vulnerable and with the sense that service users were not getting the best service available. Becoming involved in, or having to make sense of, chaotic situations was another task left to social workers by their medical counterparts (Agnew et al., 2011; Morriss, 2017). Agnew encounters this in two ways. Firstly, social workers were left to address grief more frequently when medical staff determined the emotion did not rise to a pathological level- clearly a subjective judgement bordering on arbitrary given the previously mentioned lack of any objective tool which does this. Why medical staff were assumed to be better positioned to do this is not made clear. Secondly, social work was routinely tasked to address more chaotic families or situations irrespective of how serious the grief seemed to be. This suggests that when medical staff do not want deal with these situations, the previous criteria of pathology may be conveniently ignored. In both situations, social work seems to have little control over decision making or case directing, thus exacerbating the uncertainty factor previously described particularly in the face of unquantifiable risk.

Further, the literature presents moments where services are not available, or have withdrawn, leaving social workers to try to fill this gap, specifically by hypothesising a diagnosis (Helm, 2016), a task clearly demarcated to the health realm. Again, these situations arose primarily when risk was evident, and no other agency is mandated to intervene, leaving social work to hold these cases while direction was identified- a routine practice ridden with vulnerability which left some of the social workers with the sense that service users were perhaps not getting the best service available. Substance use scenarios provide a specific example of social workers filling gaps. Galvani (2014) highlights that health is again seen as the experts, but social work is presumed to be adequate if medical services can't or won't engage with certain cases. In this case, there is clear evidence that social workers do not get adequate training concerning substance use but this is overlooked when services experience pressure and overload. Commonly found with safeguarding concerns, these cases again carry high levels of risk leaving social workers unsure yet mandated to press on.

Previously touched upon, suicide risk pulls these concerns into sharp and stressful focus, evidencing previous themes seen with grief- the lack of any objective or widely accepted risk

assessment tool and health determining the level of risk. Batsleer (2003) explicitly demonstrates this, describing medical staff determining between "serious" suicide attempts and "attention-seeking" self-harm. The de-prioritised service users are then left with social work who may or may not agree with the assessment yet are forced to hold the risk, yet Batsleer does not make it clear how medical training qualifies staff to determine risk based on behaviour nor is this questioned by participants. Despite this, social workers often proceeded to perform tasks with which they were not professionally comfortable or competent, the focus of the next theme.

4.5.4 Theme 2: How Social Workers Practise Endogenically

The first theme explained why social workers tended or were compelled to practise from an endogenic viewpoint. This second theme explicitly describes practice originating from an endogenic framework and is broken down into two sub-themes: practising without adequate training and simply letting other health-driven professionals complete tasks. In short, this theme shows how the previously identified thinking manifests in observable actions.

4.5.4.1 Sub-theme 2.1: Practise Without Training

Aspinwall-Roberts et al. (2022); Boahen (2016); Devaney (2008); Helm (2016); Morriss (2017); Smith (2004)

Training issues were evident, either implicitly or explicitly, in almost all the literature. Across the literature, social workers frequently encounter situations requiring specialist knowledge that falls outside their formal training. In these contexts, practitioners often attempt to interpret complex issues such as substance misuse, mental health difficulties, or bereavement risk despite lacking formal expertise in these areas (Agnew et al., 2011; Galvani et al., 2014; Hood, 2015). This tendency appears particularly pronounced where specialist services are unavailable or difficult to access, leaving social workers responsible for managing risk and making decisions in areas traditionally associated with clinical professionals (Devaney, 2008). As a result, practitioners may adopt assessment tools, diagnostic language, or interpretive frameworks that provide a sense of direction in uncertain situations, even when they recognise their limited training in these areas. How social workers are trained and educated,

both in qualifying programmes and supplemental post-qualifying trainings, informs their identity and sets expectations as to what they will do in practice. However, the literature implicitly suggests and explicitly describes practice for which social workers are ill-prepared. Explicitly, social workers have little to no guidance about assessing substance use, resulting in service users getting minimum support with these issues and social workers failing to identify risks (Galvani and Forrester, 2011). Further, social workers are not taught suicide risk assessment skills in academic settings and find post-qualifying guidance inadequate (Awenat et al., 2017) and therefore are reliant on experience, a similar practice when assessing grief (Agnew, 2011).

The literature does suggest instances in which social work training was not always ignored by health or the social worker and should be explored here. Implicitly, social work training helps distinguish social workers from their health colleagues in terms of seeing health concerns from a social perspective including how poverty and discrimination contributed to poor mental health but as previously described, it remains unclear if these practitioners have the time and space, when working alongside health staff, to implement "long term" interventions compared to the "short term" medication solutions (Abendstern, Hughes, et al., 2021). In other instances, social work training allowed a social worker to view a situation more holistically than his nurse counterpart (Morriss, 2017), assessing wider circumstances such as housing, finances and welfare, family and social networks, and safeguarding concerns suggesting that when social work has the latitude to practise unhindered, these skills and insights bring meaning and depth to risk and needs assessments. Morriss (2017) reflects that, despite this, medical hierarchy still tends to lead. Contrastingly, training sometimes provided a blinkered approach to a problem, where it appeared the social worker only considered social work theory while discarding a rational mental health approach (Smith, 2004). In this case, a social worker visited a woman who she knew was diagnosed with histrionic personality disorder- the symptoms of which include over emotionally responding to everyday or inconsequential events. When the service user asked the social worker to look at a simple plumbing issue, the social worker responded with a smile, explaining that it was not a major problem. However, the service user responded violently, assaulting the social worker. Upon reflection, Smith reaches for attachment theory (Bowlby, 1979) to explain this behaviour, ignoring the more obvious mental health diagnosis.

4.5.4.2 Sub-theme 2.2: Let Health Do it

Abendstern et al., (2021); Agnew et al., 2011; (Aspinwall-Roberts et al., 2022a); Batsleer, Chantler, and Burman, 2003; Devaney, (2008); Galvani (2014); Morriss (2017); Phillipowsky (2020)

The other option available to social workers was to simply let health colleagues take charge and complete tasks, sometimes irrespective of the social worker's competency. This sub-theme explains practice where social workers stepped back in situations largely grounded in social factors, either consciously or unconsciously ignoring or downplaying them. However, the literature suggests that social workers' tendency to defer to health professionals can arise through two distinct mechanisms and it is important to differentiate between them. In some cases, deference reflects professional hierarchy, where biomedical knowledge and clinical authority dominate decision-making within multidisciplinary environments. In these contexts, social workers may step back from interpreting mental distress because psychiatric or medical perspectives are treated as more legitimate or authoritative. Studies of integrated teams illustrate how organisational cultures can privilege clinical knowledge, encouraging social workers to align their practice with medical frameworks even when social explanations remain relevant.

In other cases, the delegation of responsibility appears to stem less from hierarchy and more from perceived limits of professional competence. Here, practitioners defer to health professionals because they believe the issue falls outside their training or expertise. For example, social workers encountering substance misuse (Galvani, 2014) or complex mental health presentations sometimes rely on specialist services to conduct assessments or interpret behaviour (Devaney, 2008), particularly where formal guidance or training is limited. In such situations, the decision to defer reflects uncertainty about professional boundaries rather than acceptance of medical authority.

Although these two dynamics often produce similar outcomes in practice—namely that health professionals assume responsibility for interpreting or managing a problem—the

underlying motivations differ. The first reflects structural power relations within multidisciplinary systems, while the second reflects practitioners' perceptions of their own professional competence and role boundaries.

Specific representations of this sub-theme include assessing mental capacity (Aspinwall-Roberts et al., 2022a), coordinating care or risk planning (Abendstern, Hughes, et al., 2021), providing supervision (Morriss, 2017), and risk assessment (Batsleer J, Chantler K, and Burman E, 2003; Agnew *et al.*, 2011). As mentioned, this was particularly prominent in interprofessional settings where social work is supposed to be integrated but in fact is taken over by medical staff (Phillipowsky, 2020). This happens by health professionals defining priorities, acceptable interventions and how service user's needs are framed. In these situations, social workers abandon their social explanations and align assessments by medical framework, allowing health to lead in the face of clearly social issues like housing, relationships or poverty. This leading largely relates to health's control of resources and thresholds and the profession's perceived legitimacy contrasted against social work's ambiguous roles and goals.

Consequently, social work's role becomes limited to safeguarding, statutory tasks or crisis intervention (Abendstern, Hughes, et al., 2021), specifically when assessing cognition (Aspinwall-Roberts et al., 2022a). Supervision is a strong vehicle by which this happens, particularly when social workers are supervised by medical staff in integrated mental health trusts (Morriss, 2017) which, by definition, provides standards of good practice, performance management and target setting. In cases of interprofessional supervision, social work has no choice but to follow health examples of practice, standards and expectations, questioning just how "integrated" these services really are.

Collectively, the papers suggest that social workers frequently permit health professionals to assume responsibility for tasks that would traditionally be understood as social work activities, including holistic assessment, care coordination, interpretive meaning-making around distress, and decisions regarding the continuation or withdrawal of services. Importantly, this pattern is not presented as a deliberate or ideologically driven relinquishment of social work responsibility, nor as an indication that social workers consider

health professionals inherently better suited to undertake such work. Rather, across a range of interprofessional and multidisciplinary contexts, social workers appear to acquiesce to health-led practice due to the structural authority afforded to medicine, the dominance of biomedical epistemologies within mental health–adjacent systems, and the practical reality that health services control diagnostic legitimacy, thresholds for intervention, and access to resources. Within these environments, medical perspectives routinely set the parameters of acceptable knowledge and action, rendering social explanations more difficult to articulate, justify, and operationalise. Consequently, social workers often step back from asserting social work framings, not because these are abandoned or devalued, but because they are institutionally marginalised and less likely to influence outcomes. Letting health "do" social work tasks therefore emerges across the literature as a pragmatic response to professional hierarchy, organisational power, and the need to act within medically governed systems.

4.5.5 Theme 3: Endogenic and Exogenic Thinking

This theme consists of two sub-themes which explore the thinking implied when social workers practise either endogenically (representing misalignment with social factors driving stressors) or exogenically (when a mental health factor provides a better explanation of behaviour). While I am not pretending to know the minds of the participants in these studies, I can safely assume their thinking based on the documented statements the participants make. In this sense, this theme is derived somewhat differently than the previous two because I am relying on explicit rather than implied evidence to support the theme.

4.5.5.1 Sub-theme 3.1: Minimise Social Factors

Batsleer, (2010); Morriss, (2016); Helm, 2016; Phillipowsky, (2020)

The literature describes many of the external factors causing stress for service users, however some social workers indirectly and pragmatically minimised these issues. For example, when assessing trauma stemming from domestic violence, social workers categorised these situations as "difficult" or "unhappy relationships" and for those cases proving more complex, it was felt the service user would be better served by medical staff and referred back to their

GP (Batsleer, 2010). Childhood trauma was also reframed when social workers attributed a child's behaviour as originating from "his home life, his home background" (environmental factors) but referred the child to CAMHS (Hood, 2014), a medically based service. However, medical staff, namely nurses, also minimised environmental factors when assessing quality of life or risk (Morriss, 2016) when social workers describing them overlooking the housing condition as contributing to the "medical" condition. Both these instances imply that the boundary between medical intervention and social work is defined by intensity or complexity with medical professionals appearing more qualified to deal with the latter. This "intensity threshold", and how social workers use it, is more explicitly explored 6.3.2.1, Intensity.

Instead of re-framing social issues as medical ones, some social issues are simply muted in the psychological make up of some of these participants. Particularly concerning long-term neglect or cumulative harm, chronic stressors are talked down to avoid escalation, prevent case overload or to maintain inter-agency cooperation (Helm, 2016) and social factors are rarely central to MDT decisions, replaced by diagnosis and treatment eligibility (Phillipowsky, 2020).

This corpus suggests that social workers do not reject social explanations but frequently downgrade their analytic weight within decision-making when collaborating with health. Social factors such as poverty, trauma, and relational stress are acknowledged as context, yet practice increasingly privileges individualised, endogenic framings that are more defensible and actionable within health-dominated, risk-oriented systems. It is important to stress that these subordinate ways of thinking reflect organisational and professional constraint, not a departure from social work values.

4.5.5.2 Sub-theme 3.2: Ignore MH Factors

Batsleer, et al, (2010); Devaney, (2008); Helm, (2013); Smith, (2003, 2004)

The previous discussion concerning social worker endogenic thinking implies that social workers are doing so either erroneously or that others are doing so when social workers should be. Interestingly, this theme concerns moments where it appears that social workers

are ignoring a relevant endogenic factor, or relevant endogenic theory, that would be helpful or relevant to the situation.

While not explicit, the literature reflects moments where it appears mental health issues are either not considered relevant or simply ignored. Batsleer et al. (2010) discusses service users including substance use and eating disorders as contributing to self-harm, while surprisingly, none of the participants for this project mentioned these factors in their own interviews. Contributing mental health factors to family difficulties were minimised when services to address them were not available (Devaney, 2008) and Helm (2013) describes a social worker reflecting to a colleague that a mentally unwell service user is "not okay" but does not feel the need to share her feelings with the service user (contrary to most therapeutic or clinical practices) opting instead to use the usual strengths-based social work model (which could be seen as minimising the mental health concerns which she clearly has.)

Lastly, Smith's et al.'s (2004) papers exploring social worker's experiences and responses to fear seem to go out of their way to ignore established fight/flight, PTSD and trauma theory, routinely used by front line emergency staff, and instead resorts to esoteric drama therapy as a way of dealing with past traumatic experiences (despite using the word "trauma" to describe these events.) Further, Smith conjures Bowlby to explain why a histrionic service user turned violent, again, ignoring diagnostic criteria which explain a histrionic presentation. Lastly, Smith feels that a better awareness of anti-oppressive practice is more likely to prevent service users becoming violent, ignoring the fact that some people may simply be anti-social or psychopathic – concepts well understood from a medical model perspective. This paper offers the unusual phenomenon of a social worker ignoring mental health theory (histrionic presentation) and the paper's social worker author offering an exogenic explanatory theory (Bowlby). These situations describe moments in practice when adopting an endogenic perspective seemingly may have either improved the social worker's practice or more accurately explained the social workers' experiences.

4.6 Confidence in the Synthesised Findings

The confidence that can be placed in this synthesis can be considered at two related but distinct levels: first, confidence that the patterns identified across the thirteen included studies represent recurring features within the literature; and second, confidence in the higher-order interpretation developed from those patterns. This distinction is important because the synthesis does not simply aggregate findings but interprets relationships between them, ultimately developing the concept of endogenic thinking.

At the first level, there are reasonable grounds for confidence that the principal patterns identified are present within the existing literature. The included studies were subjected to CASP quality appraisal and most demonstrated moderate to high methodological quality. More importantly, the themes were not generally dependent upon a single study. Similar experiences appeared across independently conducted research, including social workers deferring to medical authority, difficulties negotiating responsibility with health services, the privileging of diagnosis and treatment eligibility, and the minimisation or reframing of social and environmental explanations of distress. Their recurrence across different studies provides reasonable confidence that these are identifiable phenomena within the literature. However, this does not establish their prevalence within social work practice or suggest that they occur consistently across all settings.

Greater caution is required at the second level. Endogenic thinking was not a concept explicitly identified within the original studies but emerged inductively through the process of bringing their findings together. Thomas and Harden (2008) argue that thematic synthesis permits the researcher to move beyond the descriptive findings of primary studies through the generation of analytical themes, thereby producing new interpretive constructs and explanations from the synthesised evidence. The synthesis proposed that apparently separate findings, including deference to health professionals, minimisation of environmental factors, transfer of responsibility and adoption of medically orientated explanations, could be understood as connected manifestations of how problems are located either within individuals or within their social environments. Endogenic thinking should therefore be understood as a higher-order interpretive construction derived from the literature rather than a finding directly replicated across the included studies.

No formal framework for assessing confidence in qualitative synthesis findings, such as GRADE-CERQual, was incorporated into the original review design. Retrospectively assigning formal confidence ratings would therefore risk implying a methodological process that was not undertaken. Confidence is instead considered in relation to the methodological quality of the included studies, the recurrence and coherence of patterns across the literature, and their relevance to the review question.

There is therefore reasonable confidence that the literature contains recurring examples of social workers negotiating competing social and medical explanations of distress. There is necessarily less certainty that endogenic thinking represents the only, or universally applicable, explanation for these patterns. The Endogenic Thinking Model is consequently presented as an interpretive framework generated through synthesis rather than as a claim that a singular process has been empirically demonstrated across social work practice. The subsequent empirical component of this thesis provides a separate opportunity to examine whether these processes are also visible within the accounts of generic social workers, but does not retrospectively alter the level of confidence attributable to the literature synthesis itself. Future empirical work should be undertaken to explore the prevalence of endogenic thinking in social work.

4.7 Conclusion

This meta-synthesis of thirteen qualitative studies capturing social workers' experiences navigating the social work/mental health boundary identified a complex web of interactions and conflicts captured by the themes describing how and why social workers may ignore or discount their social work perspective in the face of a more seemingly respected health perspective. How these themes are related to one another can be explained by adopting the Endogenic Lensing Theory.

Given the proximity between social work and health, the lensing theory can be useful because it could compel social workers to be more aware of when they might be adopting a medical

approach for reasons which do not benefit service users. Consequently, it may allow social workers an opportunity to recognise the value their training and experience brings, potentially in the very cases and situations where chaos seems to be underlying factor. As discussed earlier, social workers dwell in and among chaos and can help their medical counterparts navigate this, thus respecting and embracing the sometimes messy and uncertain nature of human existence and not short-circuiting service users' experiences with medical labels and certitudes.

Because social work ideology is often incompatible with that of medically modelled agencies and industries, social workers have had to mould, adapt, change, step back or completely abandon their own values to practise in these settings. Uncertain of their roles, it was easier for health to define them. Social workers adopted objective/empirical thinking which better aligns with target-driven services, but which are counter to their natural humanistic instincts. Social workers deferred to "medical experts" to provide answers which were rarely helpful or dissimilar to the social worker's own conclusions which lacked "credibility." Finally, health colleagues determine what they will do and what social workers will do, irrespective of who is best qualified, leaving social workers completing some tasks which could put them at professional risk while sitting on the side-lines for others.

This chapter has explored the existing literature landscape as it relates to this research question. It has provided broader discussions exploring how the literature is organised and clarified terms used when describing social workers who work with and among service users and professionals in the mental health services. The chapter described the systematic search used to identify specific papers which closely align with the research question and design. By applying meta-synthesis, it describes an intuitive framework which identified how social work practice is changed in these environments and why. These themes have been organised into an inductively developed theory which helps clarify how social workers change their cognitive framework to accommodate medically modelled driven interventions. This theory may be useful for all social workers working in a medical capacity to be more mindful of how their work culture can change how they frame service user stresses in the hope of maintaining a socially underpinned practice. Having reviewed the existing literature, we will now progress

to the next chapter which discusses the methods and underpinning methodology used for this empirical work.

5 Methodology and Methods

5.1 Introduction

This chapter discusses the methods used to conduct the research study. It will address the underpinning philosophy, justification for the research design as well as methods used for recruitment and analysis. Ethical considerations will be explored as well as discussions concerning the homogenous nature of the sample and reflections on my personal theoretical and professional perspectives. The chapter explains why serial interviews were used and justifies the use of thematic analysis.

5.1.1 Research Design Overview

This project qualitatively explores social workers' experiences of navigating the conceptual boundary between social work and mental health. It adopts relativist epistemological assumptions as well as an interpretivist ontology.

- Participants were recruited via social media, professional organisation adverts and word of mouth.
- The sample consisted of 11 qualified social workers sampled from different UK regions
- Each participant underwent one initial priming meeting followed by two semi-structured interviews
- Data was analysed using Reflexive Thematic Analysis (RTA)
- Findings were synthesised into a 4-themed intuitive framework describing participants' experiences

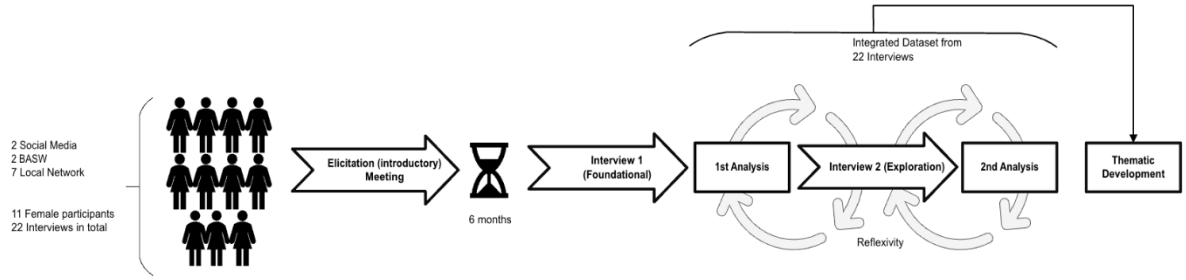


Figure 5.1 Research Design

5.2 Philosophical Foundations

Questions exploring how social workers understand and experience mental health in practice could be explored via qualitative and/or quantitative methods. For example, the question could be explored via a survey providing participants with options to choose which phrases best describe their experiences. Perhaps these could be captured using a Likert scale- asking them to agree or disagree with a particular position (Koo and Yang, 2025). This approach would also have the advantage of capturing how many social workers, and from which areas, provided certain responses. To provide a qualitative element, a select group of respondents could then be asked to participate in structured interviews, giving them an opportunity to further elaborate on their answers. One could then objectively state that X number of social workers experienced Y emotions in region Z. There are any number of ways in which data could be gathered and statistically analysed which might shed light on this question.

However, this research is not particularly concerned about how many social workers feel a certain way nor which regional variables might impact them. Further, it is not interested in statistically capturing or in some other way quantifying an emotional experience. More importantly, I did not want to presuppose the nature of this boundary and seek confirmation or disagreement concerning its nature. Instead, it is interested in *process* - how the individual, through her personal subjective lens, conceptualises, understands and feels about her social work practice without providing arbitrary parameters or categories from which she must select (Warren, 2007; Clark et al., 2021). Further, responses are individual and unique- a conglomeration of personality, circumstance, training and all other unquantifiable factors

which form one's outlook and worldview (Etherington, 2004). Lastly, this is not a positivistic endeavour of discovering an objective truth in the world but instead asks what factors contribute to an individual's experience of a subjective reality (Crotty, 1998), in this case the personal conceptualisation of where one's identity as a social worker ends and the role of a mental health practitioner begins. Because it is socially constructed, this boundary is impossible to objectively define in a way upon which its nature, parameters, characteristics and features could be universally agreed. In other words, because it is a personal entity, I must ask the person, a task best left to qualitative methodology (Punch, 2014; Braun and Clarke, 2022).

5.2.1 Qualitative Research

Gathering data concerning experiences requires tools which evoke depth of thought (Clark et al., 2021), allowing me to probe, explore and derive an underlying meaning which is specific to the individual (Braun and Clarke, 2013), and there are many from which to choose depending on which aspect of the boundary one wishes to foreground. For example, if shared experiences were the focus, perhaps gathering different professionals from the same service area might shed light on regional issues or anomalies (Warren, 2007). Conversely, the focus group could consist of individuals from the same profession, thus spotlighting how one discipline collectively experiences the boundary irrespective of location. An ethnographical approach might highlight the boundary in action, demonstrating its nature first-hand and allowing one to see how professionals navigate it in real time (Kwame Harrison, 2018). Further, a narrative approach could be adopted if one were concerned with how participants use language to make sense of their experiences through stories which organise events, identities and meanings over time (Riessman, 2008a). These different approaches not only highlight different dimensions of the question but also require different resources and ask different things from participants. Focus groups require a lot of time to gather professionals, all of whom are very busy, and if done correctly, often require more than one researcher to manage the groups. Ethnography would demand that one spend significant time with participants, normally 3-6 months (Pink and Morgan, 2013) for work concerning safeguarding. While a narrative approach would presumably be less time and resource intensive than these options, the research question is more interested in how participants structure and define

their understanding of the boundary within a professional and personal context, allowing for participants to draw on any emotion, experience or thought which helps them do so.

Semi-structured interviews, however, provide a broad canvas on which participants can explore these personal thoughts and experiences, are not overly time intensive for either participant or researcher, are not expensive and do not require additional staff. The advantages and disadvantages of semi-structured interviewing are explored more closely in section 5.6.3.

5.2.2 Philosophical Positionings

Ontology refers to the philosophical study of what *is*, or the nature of reality, specifically what exists and the nature of those things' existence in the social world (Punch, 2014; Clark et al., 2021), also referred to as the study of "being" (Crotty, 1998). This research is interested in the intersection or boundary between two socially constructed professional entities: social work and mental health work. Ontologically, social work is, by definition, socially constructed, the nature of which is undergoing ongoing reconsideration (Ornellas, Spolander and Engelbrecht, 2018). The idea that people may need assistance or protection by other people clearly does not exist without those people. Secondly, the idea that those people should think and behave within a certain latitude is defined by social norms which have fluctuated throughout the ages (Foucault, 1988; Shorter, 1997; Bentall and Beck, 2004; Tyson, 2019). Lastly, although services exist to help those who are struggling or require protection, they are constructed within frameworks and institutions created, defined and operated by human beings.

Social work operates under many definitions, the most globally recognised one provided by the International Federation of Social Workers (IFSW), (*Global Definition of Social Work – International Federation of Social Workers*, 2014) and locally by Social Work England (SWE), the regulatory body for social work in England. Historically, social work identity has been a point of consideration, as it is routinely redefined or constructed based on social movements, political factors and legislation, and boundary jostling of other professional boundaries (Bamford, 2015).

Understanding the ontological nature of mental health is more complicated but needs to be established, as "mental health" is the "object" under consideration (Crotty, 1998). While one might assume that participants and I share a Western-culture construct of mental health, in that health of any nature is determined by how well one's physical body is working, when considering mental health, this definition is not sufficient. Often, mental health is understood via a "disorder" lens, and different models have been proposed to understand its nature such as "diathesis-model" (Luiz and Tsutsumi, 2025). Some projects have been established to specifically define mental health's ontology, one of which is the Global Alliance for Living Evidence on aNxiety, depressiOn and pSychosis (GALENOS) project which aims to create a shared knowledge base to establish intervention efficiency (Schenk, Hastings and Michie, 2024). This project is aligned with a positivistic assumption, assuming a similar stance to that of the DSM series. However, mental health's ontology is much more subjective via its socially constructed nature (Conrad and Barker, 2010; Fixsen, 2025) and it is to this existing discourse that this research adds, albeit from a social work practice standpoint. Therefore, the ontology of mental health is the very thing which this research aims to explore- how do social workers construct mental health in practice?

Epistemology is the study of knowledge, and how it is produced is referred to as an epistemological position (Punch, 2014; Clark et al., 2021). Epistemology asks questions about what we assume is valid knowledge and how that knowledge is uncovered or developed (ibid). While there are volumes written about social work, mental health and how social workers work in mental health services, there is little research about how social workers think about or experience mental health issues within generic practice. These issues are rooted in subjectivity: how one thinks about their role as a social worker, how they formulate their ideas, and the nature of how we think and interpret the world provides little objective footing. These subjective experiences are best explored using qualitative methods because these methods *develop* or *create* a reality which is worth thinking about, not simply describe a pre-existing yet hidden artefact.

Epistemologically, this research was conducted using tools and methods rooted within the interpretivist paradigm, as the nature of the question is concerned about how social workers

are experiencing and interpreting their practice. Quantitative methods may measure the frequency of these experiences or provide a foundation for participants to categorise them but would say less about the richness and expression of the human experience of practice. Further, interpretivism allows researchers to not just describe, but to explore causal factors and the roots of these factors in an attempt to more deeply understand and explain what is happening (Carey, 2012; Punch, 2014; Grix, 2019; Clark et al., 2021). Phenomenology (Smith, Flowers and Larkin, 2009; Peoples, 2021), has much to say about the nature of experience and how it's constructed, however while closely aligning with the research objectives, phenomenology aims to explore lived experience in depth and focuses on individual meaning-making. While this research is interested in the emotional experience, it is also interested in how mental health is constructed and mobilised in practice and seeks to identify discursive, organisational and conceptual themes. Additionally, the research is focused more on practice (external events) rather than deeply personal, existential experiences more fitted to be examined by Interpretive Phenomenological Analysis (IPA).

The research question is firmly grounded in the interpretivist paradigm because I am interested in how someone experiences a social event (Punch, 2014; Grix, 2019; Clark et al., 2021). Interpretivism provides the foundation upon which one's cultural and experiential lens informs their experience and provides meaning. It would be illogical to assume that there was some sort of objective "mental health experience," the characteristics upon which everyone could agree. Therefore, the research aims to explore how social workers construct mental health within their social work context. Foundationally, constructionism is "the view that all knowledge, and therefore all meaningful reality as such, is contingent on human practices, being constructed in and out of interaction between human beings and their world and developed and transmitted within an essentially social construct" (Crotty, 1998, pg. 42). In other words, I am interested in how the participants construct their understanding of mental health as it related to their practice, and as such, it needs to be recognised that each of them will construct it differently based on their specific roles, values, personal and professional experiences.

This presents philosophical questions on a different level, as we are not exploring an event or experience which might be considered more subjective, i.e. childbirth, terminal diagnosis or

using a particular service. Instead, the social work/mental health boundary is not only constructed by the services which construct and deliver them, but also by the participants themselves. In this sense, critical realism (Archer et al., 1998) might provide a useful framework, as it explores the boundaries between the subjective (the participants' experiences) and the objective (the services through which the participants had those experiences), however in the case of this particular study, the experiences described seemed similar across the sample, pushing this dimension of their experiences towards the *objective* side of the spectrum. Because this project is not seeking to infer underlying causal mechanisms of mental health (Bhaskar and Hartwig, 2016), pursuing further critical realism considerations seems distracting from the study's purpose – exploring the personal, subjective social worker experience. Lastly, critical realism presumes that structures are stable (Pilgrim, 2014) whereas this research assumes from the beginning that the social work/mental health boundary is ontologically unstable. This last point further reinforces that critical realism is not the ideal approach here.

Instead, the research aims to *interpret* each participant's experience, therefore this philosophical construct is more useful here. Interpretivism counters the positivistic assumption that events would be experienced uniformly, irrespective of the viewer (Punch, 2014; Clark et al., 2021). Interpretivism provides a more useful set of philosophical tools, specifically hermeneutics, a phrase commonly associated with Interpretive Phenomenology. While this study does not explicitly use IPA as its sole analytical mechanism, the hermeneutic concept is useful since it helps explain the lensing phenomenon present here: the researcher viewing the participant viewing their experience, with each "viewing" representing a different hermeneutic layer. As argued by IPA advocates (Smith, Flowers and Larkin, 2009), I am not trying to "bracket" my own cultural or experiential lens, but instead, allow it to bring meaning and understanding (Braun and Clarke, 2021) to what might otherwise be a confusing and bewildering event.

This section has explored the philosophical paradigm in which this research is positioned and has justified its assumptions. The following discussions describe in detail what methods were used and why.

5.3 Methods: Recruitment, Sampling, and Demographics

5.3.1 Eligibility Criteria

Eligibility criteria consisted of two characteristics:

1) The participant must be a qualified social worker and,
2) They could not be working in a social work mental health team or within a mental health trust.

The first qualifier was required because the title of "social worker" is protected by Social Work England (SWE) which also standardises the educational programmes and courses required to become a registered social worker, and it is these professionals to whom the research question is directed. The second qualifier eliminated "non-standard" social workers, in the sense that the research question is interested in generically practising social workers, not those assigned to specifically work with mentally unwell service users or those working alongside mental health practitioners. I felt that including these specialised social workers would blur the picture I was hoping to paint of how mental health practice is experienced by those in a generic social work position. Further, as evidenced in the literature review, much more attention has been paid to inter-professional/multi-agency working, leaving generic social workers less heard.

I had originally considered limiting participants to those who had practised for more than five years, as I felt this period in practice would allow them time to develop and perhaps deepen their relationship with the mental health realm. However, this criterion was dismissed for the following reasons: 1) Some social workers may leave the profession within that period, thus lessening the pool, 2) Some social workers' generic practice occurs within the first years of qualifying, 3) No justification could be made to create a seemingly arbitrary cut-off period, and lastly, 4) A more heterogenous sample reflecting longevity in practice could offer opportunities to explore the deeper dynamics underpinning how social workers may change their thinking about mental health over the course of a career. As it would happen, this proved to be true.

Other than social workers practising within the United Kingdom, no geographical limitation was required. Historically, this may have been a consideration because interviews would have needed to have taken place in person, however since the COVID-19 pandemic, MS Teams and Zoom have become much more commonplace communication tools (Simon, 2021). This was useful and practical for the research design as it allowed me to interview anyone with access to a stable internet connection. The national pool also meant that I was sampling practitioners from different trusts, local authorities and regional support systems which would preclude any themes discussed later being attributed to regional or specific geographical circumstances, thus more accurately capturing the social work/mental health boundary as it occurs nationally.

5.3.2 Recruitment Methods

The first stage involved approaching a regional local authority located in the west Midlands with whom the University of Staffordshire has an existing relationship. I envisioned broadening this approach nationally and emailing each local authority separately, asking either a team manager or principal social worker to advertise the research. This quickly proved too time consuming and cumbersome, as I found I did not routinely get a response, reflecting the busy nature of these professionals' lives. Subsequent amendments to the ethics approval allowed for further recruitment strategies including advertising the research via the British Association of Social Workers (BASW), social media, and word of mouth. This rather eclectic recruitment process reflects the busy nature of social work practice and that social workers historically and currently have little time to review, read or participate in research (Sumpter et al., 2025).

5.3.2.1 Local Network

One of the advantages of teaching social work at a relatively large university is the access to our local network of social workers. This meant that, with relative ease via an email to our placement coordinators and team managers, I was able to advertise the research to our local authority statutory agencies with whom we naturally coordinate for teaching and placement

purposes. It is for this reason that 7 of the 11 (64%) participants were recruited in this fashion. It seemed possible that I would have been able to recruit all participants this way, however I wanted a more national representation given the different systems, and quality of those systems, across the country.

5.3.2.2 Recruiting via Social Media

I placed an advertisement on Twitter and LinkedIn (*Appendix B: Twitter (X) Research Advert*) on which I hold professional accounts linked to Staffordshire University, a practice known as "passive" recruitment (Gelinas et al., 2017) and could be considered the digital equivalent of posting a physical poster at a high foot-traffic location. Twitter (now known as "X"), Reddit and LinkedIn are three of the most popular social media platforms (ibid.) If interested, viewers were asked to contact me using my university email address.

There is an emerging body of research exploring the ethical implications of research participant recruitment using these methods (Andrews, 2012; King, O'Rourke and DeLongis, 2014; Lang et al., 2023) most of which concerns itself with privacy matters where concerns might be raised about researchers "lurking" in specific chat/member groups, specifically to target that specific audience. However, Twitter and similar global, or "open" platforms are available to anyone to join and therefore create a useful digital "high traffic" online space where anyone who might be interested can view a research advert without being specifically targeted. Regardless, the same ethical principles which apply to physical passive recruitment still apply in the digital, online arena, namely ensuring that confidentiality and transparency is maintained and that no participant is exploited for research purposes.

While social media is the most common method used to recruit research participants, social work is relatively late to this game (Jones, Walters and Brown, 2021), however two participants were successfully recruited in this manner. When asked why they responded, they all simply responded that the research "sounds interesting." This would infer that they are interested in mental health and therefore have some interesting insights to share and indeed, this was the case.

As previously discussed, I made amendments to the research question and the research design, all of which were shared with the participants, therefore the advert does not reflect the final research structure.

5.3.2.3 Recruiting via BASW

BASW membership provided some advantages to advertise the research. BASW's demographic may be slightly different to those who might hold a social media account for two reasons: primarily, one must pay a membership fee to join. This factor is more likely to attract more experienced or dedicated social workers as they would be willing and financially able to pay the fee. Secondly, those aged between 50-64, and therefore practitioners of similar age, present a smaller portion of social media users (Jones, Walters and Brown, 2021). Further, affiliating the research with the UK's preeminent social work professional association ascribed credibility and legitimacy to the study which may have helped potential participants feel more comfortable responding to the advert. Two participants were recruited via the BASW advertisement, stating they did so for the same reason as those who replied to the social media advertisement.

5.3.2.4 Participants not included

Two potential participants were not selected because they did not meet eligibility criteria, specifically because they were students and not qualified social workers.

5.3.3 Sampling

The purposive sample size consisted of 11 generically practising social workers who were either working in either a children and families team, adults team, or an otherwise non-mental health speciality team. The sample size reflects an attempt to provide a reasonable number of participants to generate meaningful themes reflecting a heterogeneous representation (e.g. variations of generic practice, locality, experience) providing rich data, a qualitative research goal (Braun and Clarke, 2013). While the original design called for 10 participants, the opportunity arose to recruit one additional participant which felt reasonable

because it provided further data without becoming overly burdensome, striking the desired balance of work vs. return.

Purposive sampling is appropriate for qualitative studies, as it allowed me to control the demographic and nature of participants who will be interviewed (Carey, 2012). A sample of between six and ten participants is a reasonable sample size for a qualitative study using Reflexive Thematic Analysis and semi-structured interviews, as it is a large enough sample to generate meaningful data but not too large to overload a single researcher (Braun and Clarke, 2022). Reflecting the research question, the sample needed to consist of generic social workers, excluding those who worked in a mental health team or trust because they would most likely have access to information generic social workers would not.

Table 5.1 Overview of Study Participants and Interview Details

Participant Pseudonym	**Role/Position/Population**	**Years Qual**	**Location**	**Recruit**	**Interview 1 Duration**	**Interview 2 Duration**	**Total Interview Duration**
Tess	SW/Safeguarding/Children	1	West Midlands Local Authority (A)	Local Network	56:48	41:41	1:38:29
Lita	SW/Safeguarding/Children	13	Northwest England Local Authority (C)	Social Media	1:03:57	36:58	1:40:55
Dawn	SW/Criminal Justice/Adults	13	Lothian (Scotland) Local Authority	Social Media	51:27	41:14	1:32:41
Christine	SW/Safeguarding/Children	11	West Midlands Local Authority (B)	Local Network	41:31	35:34	1:17:05
Violet	SW/Safeguarding/Children	1	London Inner Borough	BASW	51:45	39:35	1:31:20
Sydney	Duty & Assessment/Safeguarding/Children	1	West Midlands Local Authority (B)	Local Network	26:13	45:05	1:11:18
Elvira	Service Manager/C & F	25	Northwest England Local Authority (B)	BASW	1:01:30	55:59	1:57:29
Lila	SW/Learning & Development/Children	5	West Midlands Local Authority (B)	Local Network	50:50	28:49	1:19:39
Rachel	SW/Safeguarding/Adults	19	Northwest England Local Authority (A)	Local Network	59:00	37:56	1:36:56
Sybil	SW/Safeguarding/Children	5	West Midlands Local Authority (A)	Local Network	38:13	44:08	1:22:21
Tomasina	SW/Children in Care/Children	4	West Midlands Local Authority (A)	Local Network	43:06	30:06	1:13:12

"Data saturation" has historically been considered the benchmark to determine an adequate sample size and, as Clarke (pg. 386) states, "often claimed but not justified." While adopted widely across the qualitative theoretical spectrum, more contemporary meta-research has highlighted the term's origins in grounded theory (Glaser and Strauss, 2017a) as a possible limitation when applied to non-grounded theory based designs and therefore, I am not claiming, much less attempting, to justify saturation here. Instead, the concept of information power is more applicable to a reflective thematic analysis (Malterud, Siersma and Guassora, 2016; Braun and Clarke, 2021). Information power refers to the principle that the more relevant information a sample holds for addressing the research question, the fewer participants are required to provide an adequate basis for analysis (Malterud, Siersma and Guassora, 2016). Information power is well established covering a broad range of qualitative, experiential research including COVID-19 (Charania et al., 2024; Cogan et al., 2024), mental health (Nechaeva et al., 2024; Rich et al., 2024) and health care (Dewan et al., 2024; Lavesen, Paine and Bove, 2024) related studies.

Information power provides a framework to systematically appraise the quality of each interview (or participant's experience) as measured by the aim, specificity, applied theory, quality of dialogue and analysis of the study. In this case, the research question is relatively narrow, in that I am asking a specific group of people (generically practising social workers) about specific experiences (encounters with the mental health field). Further, the dynamic created by two social workers (one of whom is therapeutically trained) contributed to the quality of the dialogue. As would be anticipated, some participants shared more insight and could explore more deeply into their experience than others, but all brought a different dimension and perspective to the research question. The research question resides in firm theoretical territory, exploring themes around professional hierarchy, value-driven practice and using a well-established analytical tool (reflexive thematic analysis) to derive meaning from the findings. Further, Information Power speaks directly to longitudinal studies, and while I have not made the claim that this research firmly meets the definition, the nature of serial interviewing certainly draws on aspects of some longitudinal advantages, specifically that the two interviews allowed for a relationship and familiarity to develop between the participants and me.

As is common in reflective qualitative research, the nature of the study changed shape over time, (Braun and Clarke, 2013) and will now be discussed. The earlier forms of the research question were only interested in the mental health/social work boundary as it was understood by child safeguarding social workers. However, as the literature was engaged further, a deeper understanding of the issue was developed and one realised that adult safeguarding social workers were just as likely to encounter the boundary in meaningful ways which deserved exploration. While including this population in the research raised the concern that the sample would become too heterogeneous and create analytical difficulties in the future, it was concluded that the factors and experiences being explored, in many ways, were independent of the nature of the practice in which they were encountered. All good social workers practise under the same values and models on which the profession is based, and are used with all populations. The same applies to mental health therapists who may specialise in one area or another, but human beings all experience some degree of mental wellbeing/distress and the services they access are all founded within the same system and predicated upon the same diagnostic and treatment principles. Further, the sampling included social workers with different levels of experience (ranging from one-year post-qualifying to 25 years) as well as different managerial levels. Broadening the sample allowed for a richer and deeper exploration of the topic (Magnusson and Marecek, 2015), as participants with different levels of experience and working with different populations will encounter mental health differently. Broadening the sample had practical advantages as well. Social workers are very busy people and may not have time to participate, therefore including adult social workers essentially doubled the population from which I was sampling.

5.4 Heterogeneity and Homogeneity Considerations

Given that I had purposively sampled participants from a national pool of a particular occupation, and given the qualitative nature of the research question, a smaller sample is appropriate (Wengraf, 2011; Punch, 2014; Braun and Clarke, 2021; Clark et al., 2021) for this study. However, issues of hetero and homogeneity need to be explored further as they will have bearing on the subsequent analysis, interpretation and findings.

5.4.1 Gender

All participants in the study were female. This is not surprising since 82.6% of social workers in the UK are female (Social Work England, 2022) and women are more likely to participate in research (Otufowora et al., 2021). While having some male participants would present a more accurate picture of the national social work workforce, generalisability is not as much of a consideration with qualitative research as much as quantitative research (Clark et al., 2021).

To some degree, social work has always concerned itself with gender dynamics, stemming from its roots in the suffrage movement (Beck, Dorsey and Stutters, 2003; Orme, 2003) the feminism movement in the 1960s (Orme, 2003; Dominelli, 2018) and more contemporarily with the MeToo movement (Levy and Mattsson, 2019) and the most recent recognition of transgender rights and the non-binary nature of gender (Fish, 2012; Stevens, 2022). The research field itself, largely driven by the same social events, has considered gender dynamics and power structures, specifically concerning males interviewing females or where females have been under study because if their specific experiences or perspectives (Hollway and Jefferson, 2011; Hicks, 2015). However, I don't feel these power dynamics would have influenced the interview process or relationship for the following reasons.

Firstly, the power differential between me and the participants was mitigated by the fact that both are social workers, and the framework which exists between those in the same profession eclipsed any gender-based power structures (Dwyer and Buckle, 2009). If any power differential existed, it more likely would have originated from the interviewer/interviewee dynamic and the fact that I was consciously, yet gently, directing the conversation (Etherington, 2004). While one might assume I had more power here, ironically, I felt the opposite was true. This was because I needed the participant more than they needed me (they did not), and because the participant was agreeing to participate through no further incentive, I felt beholden to their generosity of time, and as such, worked around their schedule and kept certain interviews limited in accordance.

Secondly, as a male in a female-dominated profession, I currently work almost exclusively with women and have done so my entire career. While it is well established that men disproportionately represent positions of management in the social work profession (Thompson, Mullender and Campling, 2003; Thompson, 2016) for reasons discussed above, my masculinity has played a small role in how I relate to female colleagues, and as a male in a caring profession, my values and skill sets tends to align more with female gender roles, thus further masking any male/female power structure.

Thirdly, the research question was not focused specifically on the participant's gender, in that I did not ask questions eliciting insight into how her gender informed her understanding or actions. Except for one participant who worked with sex offenders, I would not have expected a female participant to answer differently from a male one. Further, the analysis did not identify any data to be gender specific which might have led me to think that the participant's gender had any bearing on her insights, feelings or thoughts. Conversely, having a more homogenous sample could be considered an advantage because I was able to exclude gender as a factor when analysing the data, in as much as I considered any other demographic factors, e.g. location, years in practice, or nature of practice. Lastly, the research topic is not of a particularly sensitive nature, (e.g. sex, sexual violence, assault, etc.) which may have made the gender difference more psychologically present in our discussion (Hollway and Jefferson, 2011).

Male participants may have presented differing perspectives which bear upon the research question here, but unless that work was explicitly linked with gender (i.e. a social worker working with an exclusively male or female population such as a domestic violence women's refuge) the participant's gender in this study would not seem to present a crucial consideration to the point of justifying targeting male social work participants to mitigate the imbalance. Nevertheless, future research in this area should consider the male perspective as it may reveal how one's gender may impact one's experience or thoughts around mental health in social work.

5.4.2 Time in Practice

One striking characteristic of the sample is the range in which the participants have been practising and licensed social workers, ranging from 1 year to 25 years. As previously mentioned, social workers of any qualified duration were allowed to participate and it was anticipated that experience would be a factor in how she thought about the research question, and this proved to be true. It seems intuitive that the longer one remains in practice, the more time she will have to consider, reflect, think about and experience a topic as complex as the nature of mental health. It was also anticipated that more experienced practitioners would have more insight and possibly be more well read about the topic than more newly qualified social workers. However, this was not the case, as some of the most interesting and insightful discussions came from those least experienced. Additionally, the more experienced social workers drew on experiences from other roles previously held to inform their understanding of mental health. Lastly, the length of time in practice also had bearing on the nature of work she was doing, as evidenced by the participant with 25 years of experience working as a service manager. Therefore, it's difficult to conclude definitively that there is a direct relationship between the length of time qualified and her understanding of the social work/mental health intersection.

The heterogeneity of this demographic does, however, provide the opportunity for a deeper understanding of this topic, as how one constructs mental health will surely be dependent on how long one has encountered it professionally and this will be explored further.

5.4.3 Nature of Practice

The origin of the research question manifested itself from my interest in child safeguarding; however, as previously mentioned, it became clear that the question was broader than the initial understanding and needed to include social workers working not just with children but with adults, and in all capacities, as well. Therefore, the range of social work practice also represents another point of heterogeneity. 7 participants (64%) were working in child safeguarding, 1 (9%) worked in an adult safeguarding capacity, with the remaining 3 (27%) working in either a child learning disability team, an adult criminal justice setting or a service manager capacity. These different roles allow different "angles of attack" towards exploring

the nature of the research question and provide a multi-dimensional approach to understanding this phenomenon.

5.4.4 Location of Practice

64% of the sample were recruited from the West Midlands area of the United Kingdom (City of Stoke, Staffordshire, Cheshire East), with the remaining participants from Lancashire, Wirral, Lambeth and the City of Edinburgh. These geographical distances represent an opportunity to consider the question as it relates to the potential cultural, service and resource issues which contribute to the mental health construction question and speak to a more "national experience" rather than a regional one. This sample clearly does not address the possibility that the social work/mental health intersection is regionally dependent, but could provide the foundation for future research to address this more specific question.

5.5 Ethics

This section will discuss the ethical considerations concerning the research design as well as the implications of using a reflexive framework. The foundations of qualitative ethical research align with other ethical frameworks in other disciplines (e.g. medicine and health care, legal and judicial and education) and are underpinned by early ethics philosophers such as Aristotle, expounded upon during the Renaissance by René Descartes and later by Thomas Paine, Immanuel Kant and David Hume (Rachels, 2007). These principles provide the basic ethical compass that aims to address potential abuses of power. Nonmaleficence (do no harm), veracity (telling the truth), and the tenets of basic human rights sit as the bedrock of ethical research (Purtilo and Doherty, 2011; Braun and Clarke, 2013; Clark et al., 2021).

5.5.1 Initial Approval and Amendments

The study was ethically approved by the University of Staffordshire Ethics Committee which acts in accordance with the principles outlined in the Concordat to Support Research Integrity. The committee's criteria for ethical research are underpinned by the "Belmont Principles," widely disseminated by Beauchamp and Childress (2001). These principles are normally given

as: respect for persons (and their autonomy), beneficence (doing good), non-maleficence (avoiding harm) and distributive justice (ensuring benefits and burdens are shared equitably). These principles provide the foundation for the ethics committee's Ethical Review Policy (2019) against which all ethics applications are measured. Further, the University of Staffordshire adheres to ethical frameworks provided by the United Kingdom Research Integrity Office (UKRIO) as well as the Social Research Organisation.

While I was also conscious that I was not working with a vulnerable population, I was conscious of the power dynamics present when interviews are undertaken and ensured that participants were informed of who they could contact if they felt the need or if they felt any ethical transgressions took place. Additionally, discussing cases of child or adult abuse, or any situation in which injustice or victimisation takes place, raises concerns about my ethical responsibility towards participants (Etherington, 2004). Further, there existed a propensity to explore emotionally tender areas with participants, specifically when exploring their personal values, as these are often rooted in sometimes painful or difficult times of life. When this occurred, participants were asked if they wanted to continue, take a break or change the subject. As I anticipated when this might occur, I also ensured I asked the participant if we could explore further and reiterated that she could choose not to answer if she wished.

Subsequent ethics amendments were made to slightly alter the research question. Finding participants proved more challenging than anticipated. Therefore, recruitment strategies were adjusted to include advertising the research on social media, specifically LinkedIn, X (known as Twitter at the time) and the British Association of Social Workers (BASW) website. One final amendment was made to formalise the two-stage interview process (Appendix A: Final Ethics Approval)

5.5.2 Consent and Information Sheet

While consent is often treated by both researcher and participant as a mindless kind of formality (Clark et al., 2021), it sits at the heart of any conscientious researcher's ethical framework. Deeper considerations of consent explore important questions, such as whether participants fully understand what they are consenting (Etherington, 2004), and if not, how

this ambiguity can be mitigated. Superficially, participants agree to be interviewed and have their data stored, analysed and used for research purposes. What is harder to anticipate in the initial stages is the emotional toll interviews can sometimes have. Addressing this requires an ongoing and dynamic consenting process where one routinely checks with the participant, particularly if approaching sensitive issues (ibid), and respects the participant's boundaries. Returning to research ethics bedrock, this practice aligns with the ethical philosophy of nonmaleficence, the idea that researchers do no harm during their research.

From a process standpoint, participants were sent a consent form once they agreed to participate. The consent form provided standardised language around no obligation to consent and the ability to withdraw at any time. Participants signed the form and returned it via email before the elicitation meeting. At the start of each interview, the participant was asked if she still consented to participating. To address the issue previously discussed, I paid close attention to the participant during each interview and if I felt it necessary to probe further, asked her if she felt comfortable doing so, reflexively moving forward and sometimes backward depending on her responses. The consent form can be seen as Appendix C: Consent Form.

Each participant was sent an information sheet along with the consent form. The information sheet explained the nature of the research, what the participant could expect from participating, who to contact if she felt any ethical transgressions took place, what my responsibilities were regarding reporting any statements of concern, and explained how her information would be stored. The information document can be viewed as Appendix D: Information Document

5.5.3 Interviewing Ethics and Reflexive Research

After receiving the signed consent form, I emailed the participant to invite her for the elicitation meeting. I purposefully worked around her schedule, recognising that social workers are busy people and that she was not participating out of any external incentive. Interviews started on time and lasted the predicted amount of time.

Ethical considerations loom largely in reflexive research, perhaps more than any other research technique (Etherington, 2004). The reflexive researcher operates from a place of continuous self-reflection and appreciation of the power held when discussing, and ultimately writing about, other people's lives. Much has been written about the overlapping ethical considerations between a therapeutic relationship and a researcher/participant one (McVey, Lees and Nolan, 2015; LaChenaye and McCarthy, 2022), particularly when a therapist is interviewing former clients (McLeod, 1999; Watkins and Schneider, 2024). While this thesis does not fall into this category, the skillset of a therapist demands additional ethical consideration because the skills and confidence to ask people to journey into their personal thoughts and feelings, irrespective of how sensitive one may consider the topic, brings with it a different power differential.

Interviewing has the potential of revealing previous trauma and/or unresolved conflict (Cowles, 1988) and it is the role of the ethical researcher to avoid this if possible. It is imperative that one treads lightly and sensitively in this territory, and only with the participant's explicit agreement before doing so (Grafanaki, 1996). As will be discussed in later chapters, this was an important point to consider with three participants.

5.5.4 Data Storage

I created a folder for each participant where I stored the consent form, information sheet, the interview videos and transcript. Additionally, I created tracking charts and spreadsheets containing participant data (location of practice, interview dates, lengths of interviews and which interview(s) she had completed. All documentation was stored in the university's secure cloud storage, accessible only to me and my supervisor via university login details (network username and password.) Per standard practice, documents which were shared with supervisors were anonymised (Magnusson and Marecek, 2015). Transcripts were eventually imported into Nvivo software for analysis purposes, the file of which was stored in the same location.

5.5.5 Confidentiality

Confidentiality sits at the core of both social work (Beckett and Maynard, 2017) and psychotherapeutic practice (Morrison, Layton and Newman, 1982), and as such, easily translates into a research/participant context (Gabriel, 2009; Watkins and Schneider, 2024). Like both my professional roles, safeguarding is paramount and would be the only context in which confidentiality would be breached. Participants were advised of this in the information sheet which was provided prior to giving consent to participate. For discussion purposes and in line with standard practice adhering to research ethics, participant names have been anonymised and replaced with pseudonyms throughout the thesis (Grix, 2019).

I only included the location of practice and the length of qualified practice to provide context to their discussions. Participants' names were used to easily identify their information in the digitally stored folders, as well as folders created in Nvivo, but exist nowhere else in the research material.

Interviews took place via Microsoft Teams over secure networks on both ends and were conducted in secure, private areas, either in my home or in a private space at the university campus.

5.6 Data Collection Process

This section will describe the three-stage process I followed to collect the data. It will also provide justification for this process. Overall, I met participants for an introductory (elicitation meeting), allowed for a six-month gap, and then each participant underwent two semi-structured interviews. Data was only collected during the two semi-structured interviews.

5.6.1 Online Interviews

All interviews were undertaken via video calls on Microsoft Teams. Video interviewing has become common in research as the technology has advanced, with researchers also using Skype and WhatsApp to conduct research (Gray *et al.*, 2020). These tools have become

more commonly used post the COVID-19 pandemic, with social workers using them more frequently than ever (Mishna et al., 2021). This tool was useful as it allowed convenient communication between me and the participants who were drawn from a wide geographical location and negated for travel arrangements. In designing this study, I considered both in-person and online interviewing as possible modes of data collection, recognising that each offers distinct methodological advantages and limitations. It was important to adopt an interview format that not only supported rich qualitative data generation but was also practical and accessible for participants working in demanding professional environments. After weighing these considerations, I determined that online interviewing via Microsoft Teams offered the most appropriate balance between methodological rigour and pragmatic feasibility.

In-person interviews have traditionally been regarded as advantageous in qualitative research because they facilitate stronger rapport-building through direct physical presence, more natural eye contact, and fuller observation of non-verbal communication such as posture, gesture, and subtle embodied reactions (Kvale, 2004). These elements can enrich interpretive understanding, particularly when discussing emotionally sensitive or professionally complex topics. In a study such as this, where participants reflected on experiences involving uncertainty, organisational tensions, and professional identity, face-to-face interviewing may have offered additional insight into how meaning was expressed beyond spoken words. However, in-person interviewing also presents significant limitations, particularly when participants are busy professionals (Lobe, Morgan and Hoffman, 2022). Social workers often work under conditions of high workload, changing priorities, and unpredictable schedules, making travel to interview locations burdensome and potentially reducing participation willingness. In addition, arranging mutually convenient physical meeting spaces introduces further logistical complexity and may constrain recruitment to geographically local participants only.

Online interviewing offered several advantages that made it particularly suitable for this study. First, it significantly increased accessibility and convenience for participants by removing the need for travel and allowing interviews to be conducted from participants' workplaces or homes. This flexibility was especially important given the fluid timetables and

unpredictable demands associated with social work practice. Online interviews also enhanced recruitment feasibility by allowing me to include participants across a wider geographical area without location becoming a barrier. This was beneficial in ensuring a broader range of perspectives while maintaining consistency in data collection. Furthermore, the reduced time burden associated with online interviewing likely contributed positively to participant retention across the serial interview design, in which each participant was interviewed twice. The familiarity of Microsoft Teams as a professional communication platform also reduced technological unfamiliarity, as many participants were already accustomed to using it in their daily work.

Despite these benefits, online interviewing also has limitations. Virtual interaction can restrict the researcher's ability to observe full non-verbal communication, potentially reducing access to subtle embodied cues that might otherwise enrich interpretation (Lobe, Morgan and Hoffman, 2022). Rapport may also develop differently online, as the mediated environment can create a sense of emotional distance or reduce conversational spontaneity. Technical issues such as unstable internet connections, audio lag, or interruptions may disrupt interview flow. Nevertheless, contemporary qualitative research increasingly recognises that online interviews are not methodologically inferior to face-to-face methods and are capable of generating equally rich and meaningful data when carefully conducted (Salmons, 2012; Archibald et al., 2019). Given the professional demands placed upon participants and the need for flexibility across repeated interviews, online interviewing represented the most ethically and practically appropriate choice for this study.

5.6.2 Elicitation Meetings

The introductory meeting was my first meeting with the participant. No data from these meetings informed later analysis. Instead, it allowed me to introduce myself, gain verbal consent for their participation and explain the nature of the research. Lastly, I asked that, for the following six months, participants keep a record of moments or experiences in practice where they encountered the mental health realm. It was not expected that I would see this record but instead it could act as a way for participants to keep track of their thoughts, notes,

etc. to aid in the future semi-structured interviews. This record could reflect working with someone with a diagnosed or suspected mental health issue, working with a mental health professional, i.e. community mental health nurse, consultant or Approved Mental Health Provider (AMHP) or a parent with a mental health issue. However, I left it to the participants to decide what they felt was important to include in this because their choices would reflect how they constructed mental health. This technique has been used previously in qualitative research, including studies utilising participant-generated audio diaries (Monrouxe, 2009) in which participants recorded their diaries as audio recordings for longitudinal studies. While my project is not longitudinal, the tool would seem to provide the same function.

While elicitation meetings have historically been conducted using photographs to explore participants' experiences or thoughts on a particular topic (Caldarola, 1985), the elicitation meetings provided a similar advantage despite not using a visual tool or artefact. Instead, I simply encouraged participants to more thoughtfully consider their practice for the next six months when it concerned/impacted or somehow intersected with the mental health sector and, if helpful, to make use of a journal or make notes concerning those experiences. The practice has roots in anthropology, specifically Caldarola's (1985) study of photographic research methods, stating "selecting and defining the event before photographing places the photographic record into perspective…" (pg. 34). To use the photo analysis, I in a sense, showed them a picture (albeit a mental one) of "mental health" and asked them to think about this, within the context of their social work practice, and provide their thoughts and feelings. Further, I wanted participants to draw their thoughts on recent and specific experiences, not just provide me their thoughts on mental health in general. This provided the "perspective" to which Caldarola speaks, prompted by the "selecting and defining" the elicitation meeting provided.

Elicitation meetings are the first step in building rapport which is more fully discussed shortly. However, my intention for this meeting was to lessen any anxiety participants might have, answer any questions concerning the nature of the study and give them an idea of what will be asked. For the purposes of the study itself, these meetings can act as a cognitive primer and encourage participants to start thinking about the research question. This is particularly important when the question concerns a conceptual topic about which participants may not

have thought to reflect. Elicitation meetings can also act to enhance depth for the first semi-structured interview, especially if followed by a period to reflect, because the participants are more likely to arrive to the first interview prepared with previously established ideas and examples. This is because "simply prompting people to discuss a topic may not be enough to capture the nuances of their thoughts and experiences" (Kahlke *et al.*, 2025, p. 383).

However, elicitation meetings can present risk to research integrity. For example, they provide an opportunity to direct participants towards answers which might support a researcher's assumptions (Chenail, 2011). To mitigate this risk, I made it clear that I was seeking their construction of this conceptual boundary, and as such, made it clear that they could take this question in whatever direction they felt best reflected their experiences. Elicitation interviews may also present an ethical risk if participants are asked to reflect on particularly sensitive or difficult information (Newman, Guta and Black, 2021). However, it seems unlikely that professional social workers would find the natural act of reflecting on their practice to be traumatising. Despite this unlikely event, I confirmed with participants that they had read the information sheet which outlined who to contact should they have any issues with the nature of the study.

5.6.2.1 Participant Profiles

Following each elicitation meeting, I created a "participant profile." At this early stage, the profile only included her name, location, and the nature of her social work practice. As the interviews progressed from the first to the second, I kept adding more information to this profile. Before each interview, I would review it to ensure my questions were relevant to her experiences. For the second interview, I included questions originating from the first interview. While this was not a longitudinal study, these profiles served as case records, capturing contextual, professional, and emerging analytic information. Using them enabled targeted follow-up questioning, preserved idiographic depth, and strengthened the reflexive and interpretive rigour of the study. It should be noted that these profiles were not used in a way which would inform a longitudinal study but were instead a useful way for me to keep track of participant narratives, make notes and include follow up questions. To see an example one such profile, see Appendix E: Participant Profile Example.

5.6.3 Advantages and Disadvantages of Qualitative Interviewing

There are multiple ways one could go about collecting data around this topic. However, I selected semi-structured interviews as the primary method of data collection because they offered the most appropriate means of exploring how social workers experience and interpret the boundary between social work and mental health practice. My research question is concerned not with measuring fixed variables, but with understanding participants' subjective experiences, perceptions, and meaning-making processes. Semi-structured interviewing was particularly well suited to this form of qualitative inquiry because it enabled participants to articulate their experiences in their own words while allowing me to maintain sufficient focus on the core aims of the study (Wengraf, 2011; Clark et al., 2021).

This balance between structure and flexibility was especially important because participants practised in different professional contexts and brought varied experiences of working. Semi-structured interviews allowed me to explore these contextual differences. They were also particularly compatible with the serial interview design adopted in my study. The first interview enabled me to gather broad exploratory accounts of participants' experiences, while the second interview allowed me to revisit issues raised previously, seek clarification, and examine them in greater depth. This iterative process strengthened the richness and nuance of the data and enabled themes to be progressively refined over time.

I considered alternative methods but found them less appropriate for the aims of the study. I rejected structured interviews because their rigid format would have restricted participants' ability to elaborate on complex and often unpredictable experiences, thereby limiting the depth required for meaningful qualitative analysis. At the other extreme, I also deemed unstructured interviews unsuitable because, although they offer maximum openness, they provide insufficient consistency across participants and make cross-case thematic comparison more difficult. Since I sought both depth and thematic coherence across multiple participants, a wholly unstructured format would have reduced analytic comparability (Punch, 2014; Braun and Clarke, 2021).

I also considered focus groups but did not select them because the study required detailed individual accounts of professional experience that may not have been readily disclosed in a group setting. Discussions of uncertainty, organisational tension, and professional boundary negotiation are often sensitive, and participants may have been reluctant to speak openly in front of peers. Similarly, I did not adopt observational or ethnographic approaches because, although they may reveal aspects of professional behaviour in practice settings, they are less effective at accessing participants' internal interpretations, perceptions, and reflective meaning-making which are central to this study. Additionally, this method would have required me to embed myself for long periods of time in different locations which was unrealistic. Surveys and questionnaires were likewise unsuitable because they prioritise breadth over depth and cannot capture the nuanced experiential narratives required to understand how professional boundaries are negotiated (Clark et al., 2021).

I also considered narrative interviewing and Interpretative Phenomenological Analysis (IPA), but ultimately rejected both. Narrative interviews tend to generate broad life histories and are better suited to research focused on biographical identity development than on specific professional phenomena (Riessman, 2008b). IPA, while valuable for exploring lived experience in depth, is typically based on smaller, highly homogeneous samples and prioritises idiographic analysis over broader thematic patterning (Smith, Flowers and Larkin, 2009). Because I sought to identify shared themes across a wider group of social workers while still preserving individual nuance, reflexive thematic analysis combined with semi-structured interviewing offered a more appropriate methodological fit.

Overall, I found semi-structured interviews to provide the most effective balance between openness and consistency, enabling participants to describe complex professional experiences in depth while ensuring sufficient comparability across interviews to support robust thematic analysis. Their adaptability, compatibility with reflexive qualitative research, and suitability for serial interviewing made them the strongest methodological choice for addressing the aims of this study.

The disadvantages of semi-structured interviewing are related to the practical issues. Interviewing, when done reflexively, is tiring for one person to do because it requires one to simultaneously listen, interpret, emotional attune, and self-monitor, all while remaining

responsive to the evolving dynamics of the interview encounter (Etherington, 2004). This layered attentiveness can generate significant cognitive and emotional fatigue, particularly in qualitative studies involving complex or sensitive subject matter. Additionally, arranging and scheduling Microsoft Teams interviews can present practical challenges for both participants and the researcher. This is particularly pertinent in the case of social workers, whose professional roles are often characterised by high workloads, shifting priorities, and unpredictable schedules, all of which can complicate the coordination of mutually convenient meeting times.

Additionally, transcribing interviews can also be very time consuming and can be impacted by human error. Transcription introduces significant potential for human error because it is an interpretive, rather than purely mechanical, process (Bird, 2005). Errors may arise through mishearing speech, especially where audio quality is poor, participants speak quickly, or specialist terminology is used. Important non-verbal features such as pauses, laughter, emphasis, and tone may also be omitted, potentially altering meaning. In online interviews, technological disruptions can further increase transcription inaccuracies. Such errors may affect the dataset and influence subsequent coding and analysis. This risk was minimised through the process of watching the recording while amending the corresponding transcript which helped to capture accuracy and preserve the integrity of participants' accounts. Therefore, while semi-structured interviews presented with some practical challenges, these were far outweighed by the opportunities for gathering rich data, a key criterion for qualitative research (Tracy, 2010).

5.6.4 Serial Interviews

The two-interview serial design may be understood as analogous to a process of prospecting followed by excavation. In the first interview, the participant was afforded the freedom to explore broadly the experiential terrain relevant to the research topic, enabling the identification of areas in which rich and meaningful data may be located. During this exploratory phase, I adopted a guiding role, sensitively directing the discussion toward domains that appear particularly salient or theoretically significant. Insights gained from this initial encounter allowed me to develop a provisional interpretive map, informing the design

of more focused and strategically targeted follow-up questions. In the second interview, the participant and I returned to these identified areas of significance, engaging in deeper and more deliberate exploration to uncover layered meanings and generate more nuanced data. This iterative process enables the progressive refinement and enrichment of understanding across successive interviews.

There are several advantages to serial interviewing: time to build rapport with participants, time to reflect on data, time for both researcher and participants to reflect on their thoughts, and time for narrative stories to emerge from the data. This is especially true when exploring multi-dimensional or complex topics which the participant herself may not have consciously considered (Read, 2018). The research is not exploring a known, objective fact, the characteristics upon which all can agree. Instead, it is trying to define ambiguous, conceptual constructs exhibiting and characterised by porous and unstable boundaries. Serial interviewing is appropriate when the researcher and participant are working together to explore complex phenomena which can be sensitive and not readily "available" in a single interview. It would be unrealistic to expect participants to define their understanding of mental health, relate experiences and make sense of these experiences in one discussion, and serial interviewing allows these experiences and ideas to be pieced together (Read, 2018). Further, a longer process allows for variation over time, in that her ideas have had time to ripen during our time in contact, or what Murray (2009, pg. 3) refers to as "shifting around." This provides a deeper, richer, more robust and continuous account which would be harder to capture in a single, snapshot interview.

It is possible that information may be misunderstood by either me or the participant. Serial interviews strengthen credibility because they allowed me to review previous data to ensure accuracy, verify and cross-check accounts (Read, 2009). Further, participants may unconsciously re-frame, re-structure or change their minds entirely during the interval, and while it was not one's job to "catch out" contradictions, exploring these re-shaping events as data about competing discourses provides some deeper meaning about how, and from where, participants draw their ideas. These events then illuminate participants' relationships with their employing organisations and the systems in which they engage- structures which shape their professional world (Potter and Wetherell, 2010).

Ethical considerations are also important here because meeting with a participant more than once ensured ongoing consent and allowed me to check how she is experiencing the process. Ethical interviewing would also suggest that some form of rapport is established before participants are questioned about their thoughts and experiences surrounding any topic (Kapiszewski and Wood, 2021). While mental health (if not discussing one's own) is not a particularly sensitive issue, building rapport with participants is still important to improve the chances of eliciting honest and reflective data (Gubrium, 2012; Goyes and Sandberg, 2024). It also gives her the chance to process any particular feelings resulting from previous discussions, not only providing her a safe space in which to do so (Kapiszewski and Wood, 2021), but also creating a deeper, emotional connection, further enriching the data (Goyes and Sandberg, 2024).

While the first interview took place six months after the elicitation meeting, it would not be fair to refer to the study as "longitudinal" as this usually refers to measuring some sort of change in a participant's circumstances or feelings (Clark et al., 2021). Instead, this time was used for the participant to actively think about their practice within the context of the research question – in short, I wanted to "sample" 6 months of their practice. Time between the first and second interviews was also productive and allowed both researcher and participants time to reflect and re-interpret previous discussions (Goyes and Sandberg, 2024). The time allowed me space to return to the previously mentioned participants' "profiles" to more thoroughly flesh out the dimensions of their approaches, worldviews and interpretations. These intervals also allowed me to reflexively evolve my own understanding of the topic which informed further enquiry and deepened the investigation, allowing me to reflect on data from multiple participants where patterns emerged and identified areas of further exploration and enquiry. Lastly, serial interviews allow time to verify information and cross-check or triangulate information discussed in earlier interviews which can be gently challenged in subsequent interviews. This was particularly important when participants made specific claims to knowledge or facts as they understood them or had unusual positions or strong thoughts about certain ideas.

Multiple interviews also played well to my skill set as a social worker and psychotherapist; professions which require a relationship between practitioner and service user or patient (Fook, 2016). This relationship is built on trust, which in turn is built on a set of boundaries and shared goals, in this case our agreed goal of exploring mental health in social work practice, framed by the boundary of the signed consent and agreed structure. Continuing the parallel, instead of steering her towards a solution or a better understanding of herself, I used the same skills to steer her towards a deeper understanding of her practice as it related to mental health; querying her values, the origin of these values, her knowledge and the source of that knowledge and asking her to question assumptions. I used all the same skills I would in a home visit or a therapy session: maintaining eye contact, adapting an open posture (at least as much as one can on a video call), verbally reflecting my understanding of what she said, allowing silence while she explored her thoughts, and gently questioning or challenging when necessary. I also tried to gauge how much I could "push" her without her becoming frustrated- "push" meaning challenging to go further, deeper, to examine assumptions. Some candidates were more willing than others to do this, and I could intuitively sense when I had figuratively "bottomed out," while other times this was indicated by the participant simply stating that she did not know the answer.

5.6.4.1 First Semi-Structured Interview

The first substantive interview took place roughly six months following the introductory meeting. After verbally confirming consent, the participant was asked what she thought mental health is and to provide examples of her experiences within the last 6 months. Like Hollway and Jefferson's (2000) "free-association narrative", participants were allowed to wander into several mental health related areas, as I wanted her to take her time and feel she could express herself in any way she felt comfortable. The term "semi-structured" exists on a spectrum (Wengraf, 2011), and these first meetings were located towards the "less-structured" end of the continuum but were still structured to discuss mental health and social work practice.

Starting the interview by simply asking the participant to define mental health provided a good foundation to start the exploration. Using the participants' real world practice

experiences, I could explore and probe these experiences, and using the overlapping skillset between therapist and qualitative researcher (McVey, Lees and Nolan, 2015), I was able to challenge, check possible assumptions and gently direct the conversation towards getting a picture of the participant's "inner world" of the social work/mental health boundary. The mean interview time was 46 minutes, ranging between 38 minutes and 55 minutes, and concluded with the participant agreeing to be contacted again for a second interview. For a specific breakdown of interview times, see Table 1.

The transcripts from these interviews were read through while listening/watching the recorded interviews which allowed me to "clean" the transcript (i.e. removing the phonetic misspellings and verbal ticks) while still maintaining the words the participants used. This provided several advantages including creating a more readable document for future analysis and allowing me to review the data prior to coding (Heritage, 1984).

From the more readable transcript, I read/listened/watched two or three more times, allowing me to generate further questions or clarifications in preparation for the second interview. Commonly referred to as "expansion questions" or "follow-up questions", (Magnusson and Marecek, 2015), this questioning usually highlighted inconsistencies I missed during the first interview, points of clarification, and provided an opportunity for further insight into points of interest which spoke directly to the research question. While some of these questions were very similar across the sample, each participant's experiences were different and thus the set of questions for each was tailored to reflect this. The "participant profile" discussed above succinctly captured the basic data (where, for how long and in what capacity she practised) as well as notes about the framework she used to think about mental health, (i.e. values, systems, legislation, etc). This can be seen at Appendix E: Participant Profile Example. Also referred to as an "interview guide" (Clark et al., 2021), it included specific cases from which she drew her ideas, inconsistencies she expressed, challenges she encountered or ideas, knowledge, etc. about which she expressed confidence or lack of confidence. In short, this process allowed me to sharpen my inductive focus for each participant to further "drill down" into her perception and experience of where the mental health/social work boundary existed and its nature. Once the profile and questions were prepared, I contacted the participant to arrange the second interview.

5.6.4.2 Second Semi-Structured Interview

The second interview was more structured because I had generated specific questions for each participant after processing the data from the first interview. These interviews also lasted about an hour each during which I explored more specifically each participant's experiences, thoughts, assumptions, dilemmas, challenges or other insights into her experience of the social work/mental health boundary. As this was the final interview, it was important to finalise any ambiguous, opaque or vague statements from the foundational interview. While serial interviewing is useful in many contexts, there is no guarantee that participants will tell me everything I want to know (Read, 2018) and there came a point where enough data had been extracted and I had enough to start building a "mosaic" to build a picture of the phenomenon (ibid). The interview was concluded once the questions had been answered satisfactorily, however there were times where the participant simply could not go any further (or deeper) into her experiences or insight, and it would not have been productive to continue probing or attempting different angles. Similarly to the first transcripts, the second transcripts were cleaned for transcription errors in preparation for coding.

5.7 Data and Analysis

This section will describe, analyse and justify the methods used to analyse the data. At this point it is important to understand that the data generated from the two interviews described above were aggregated to inform the final analysis. While both interviews were semi-structured, their purposes and nature were slightly different due to the iterative and discursive nature of the conversations. For a comparison of each interview, please see Table 5.2 below.

Data analysis methods shape what kind of knowledge can be produced and must align epistemologically with the research question, aims and the other methods used in the research design (Punch, 2014; Grix, 2019). Further, the chosen method should align with my intentions and specific approaches brought to the metaphoric methodological table. In this

case, the method should align with an interpretivist, constructionist standpoint allowing for high levels of researcher reflexivity.

Given that the research question is concerned with experiences, Interpretative Phenomenological Analysis (IPA) may stand out as the most useful method (Smith, Flowers and Larkin, 2009). However, IPA was not the most appropriate approach for this study because IPA is primarily concerned with detailed idiographic exploration of how a small, relatively homogeneous sample makes sense of lived experience at an individual level. In contrast, this study sought to identify broader thematic patterns across a wider and more professionally varied group of social workers, rather than producing highly detailed case-by-case phenomenological accounts.

When exploring experience, Grounded Theory (GT) is another method commonly used (Glaser and Strauss, 2017b). As the name implies, GT aims to construct theory grounded in data. GT is best used when one is trying to understand a core process, stages of that process and/or develop a theory explaining those processes (Charmaz, 2025). These aims did not align with this research's goals. Further, GT requires methods not used in this research, e.g. theoretical sampling and concern for saturation. Had the research question sought an underlying theory explaining the experience of navigating the mental health/social work boundary, then GT would have been more appropriate.

For these reasons and more described below, Braun and Clarke's (2019) reflexive thematic analysis best met my needs because it assumes meaning is constructed and interpreted, foregrounds my subjectivity, and is designed to identify phenomena across a sample.

5.7.1 Reflexive Thematic Analysis (RTA)

Braun and Clarke distinguish between three types of Thematic Analysis: Coding Reliability, Codebook TA and Reflexive Thematic Analysis (RTA). Coding Reliability is more positivistically driven and seeks reliability and consensus. It is often used for deductive or hypothesis-verifying research whereby one or more coders are seeking to test a pre-existing theory, and the findings can be verified by other raters (Byrne, 2022). This approach does not

epistemologically align with this research because the research question is not constructed by objective and concrete entities, nor is the aim to reach a verifiable consensus. For example, Coding Reliability might be used if a pre-defined structure, say a barrier to mental health services existed, and one was interested in the prevalence of this phenomenon. Codebook TA is epistemologically positioned between Coding Reliability and RTA but is more structured than RTA. As the name implies, Codebook TA requires an existing set of codes defined by the research question, e.g. a particular theory, policy or legislation and can evolve before being applied consistently across a dataset. RTA does not rely on a predetermined set of codes but instead allows the codes to reflect my creativity and subjective positioning as the data is analysed, not before. While this research could have used Codebook TA, Reflective TA better highlights my expertise in this area, as more fully explored in the reflexivity section below.

Therefore, the data were analysed using Braun and Clarke's (2022) Reflexive Thematic Analysis informed by an inductive, latent and constructionist orientation. An inductive approach was adopted to ensure that themes were generated by closely engaging with participants' stories, feelings and thoughts rather than imposed upon by existing theoretical frameworks. While the study was theoretically informed by concepts such as boundary spanning and the medical/social model debate, coding and theme development were grounded in patterns identified across the dataset. Analysis was conducted at a latent level, moving beyond the explicit content of participants' statements to examine the underlying assumptions, professional logics and identity constructions shaping how the boundary between social work and mental health was articulated. Consistent with a constructionist epistemology, language was treated not as a transparent reflection of experience but as a site in which meaning is actively produced; themes were therefore developed as interpretive accounts of patterned meaning-making rather than descriptive summaries of topics. This approach enabled the generation of a theoretically informed yet data-grounded analysis of how social workers construct and negotiate boundary experience in practice.

Situated within Big Q research, Reflective Thematic Analysis (RTA) is an interpretive method for identifying meaning across a dataset (Braun and Clarke, 2019) which foregrounds my interpretation, subjectivity and positionality as an anchor to help construct meaning. This meaning, constructed as themes, is not "discovered" per se, nor does it "emerge"; two

common misconceptions often attributed to RTA's original name, simply "Thematic Analysis" (TA). Braun and Clarke's seminal paper "Using thematic analysis in psychology" (2006) outlined an approach by which a researcher reviews data, codes it (by virtually or physically highlighting statements, words, phrases) and then intuitively and creatively derives meaning from the data by way of a thematic structure. The approach took on a popularity which the authors did not anticipate and therefore had opportunity to understand how it was being used. Recognising that it was commonly being treated as a rigid method, Braun and Clarke revisited the model, re-titling it "*Reflexive* Thematic Analysis" to emphasise the active role I took as well as to reinforce the recursive, messy and sometimes circular nature of the process (K. Campbell et al., 2021; Braun and Clarke, 2022). This interpretive process results in a thematic structure buttressed by themes which do not so much *contain* data as much as they *say something* about the data by making an interpretive claim which revolves around a conceptual core.

This research question, and my relationship to it, is fertile ground for RTA. Firstly, the question is around experience and meaning. It is not seeking causality, prediction or seeking to define an objective structure. Secondly, how one experiences the mental health/social work boundary requires interpretation of a subjective experience and creative insight to make sense of these common, shared experiences. The research seeks to understand more than just what participants say. Instead, it aims to highlight assumptions they make, how they construct their professional identity and how power and responsibility shift across their professional landscape. Thirdly, the theoretical position requires reflexivity, discussed in the next section. The medical/social model debate, boundary spanning, moral distress and the other theories upon which this research rests required me to recognise my own subjectivity to these ideas which in turn informs the shaping of the thematic structure. This process is grounded in interpretivism, demanding that I explicitly describe my own positionality and how this has informed interpretation. Fourthly, the research is neither purely inductive nor purely deductive. Instead, the study uses "orienting concepts" (Layder, 1998), but data is not being forced into predefined categories. RTA allows for inductive coding, discussed in the next section, but allows room for a theoretical deductive exercise, blending semantic and latent analysis. Lastly, the research is asking for a patterned meaning across the dataset and seeks an underpinning, cohesive story which might be later useful to explore wider populations. It

is not interested in a single existential, interpretive experience; a task perhaps best left for Interpretive Phenomenological Analysis (IPA). For these reasons, RTA was the best tool to be used to analyse the data.

5.7.2 RTA's Six Steps

RTA is described as following a six-stage process:

1. Familiarisation
2. Coding
3. Generating themes
4. Reviewing themes
5. Defining/naming themes
6. Writing up

As per the above, Braun and Clarke caution against following a strict linear approach, however they do outline the following six steps which are used to *inform* the recursive nature of RTA. (1) First, I familiarised myself with the data. This first took place by editing the poorly produced transcripts while simultaneously watching the corresponding video. Not only did this ensure the transcripts were accurate, but it also provided the first opportunity to "get close" to the data (Bailey, 2008), or what Campbell (2021) refers to immersion in depth and breadth of the content. It should be noted that transcriptions were edited as interviews were completed. At this stage, informal notes were made and areas were circled as different ideas occurred to me. (2) Coding was the next step and NVivo 12 was used for this task. This software allows for researchers to highlight bits of text and categorise them by "codes" or labels: single words or phrases which capture the underpinning idea of the selected text. RTA rejects coding reliability logic and instead sees coding as an organic, flexible and iterative exercise. These codes were semantic in nature, almost shorthand for what was happening with the participant, such as "frustration with CAMHS" (see Appendix F: Coding (First Interviews). (3) The third "step" is for the semantic codes to begin evolving into more latent patterns. This involves understanding how the codes begin to relate to one another and how they might start informing a larger theme. Commonalities across the data came into focus, and while they were not used to direct later interviews, were instead treated like signposts which might be useful if later participants touched on previously identified phenomena.

Similar approaches have been used in social work and therapy related research when applying other analytical tools such as grounded theory (Coxe, Pence and Kagotho, 2021) and content analysis (Bastemeijer et al., 2021). (4) At this stage, the themes began to take shape and needed some further cohesion, and six themes were then collapsed into four (see Appendix G: Coding (Second Interviews). In terms of where this took place in the entire process, once all the first interviews were completed and transcribed, definite forms began to take shape within the data. Beginning the second round of interviews brought these forms into focus and by the time the second interviews were completed and transcribed, these forms had become more defined, clear and had taken on a definitive vector. (5) This then informed the fifth stage of reviewing the themes and it was at this point that an intuitive story-like structure took form which described a definite beginning, actions or change, and subsequent results. Sub-themes were shifted around to better support and buttress the overall structure. (6) The final stage involved the final analysis where the findings were written. Even at this last stage, the thematic structure underwent some fine-tuning and Braun and Clarke (2009) argue that writing is part of the analysis. Here, the arguments were clarified, linked with existing research and further grounded by Layder's (1998) "orienting concepts" which brought a different analytical dimension to the themes. The final product resembled a story-like narrative which provided a framework to make sense of the data, a process Braun and Clarke cite J.A. Smith as "doing what humans do." This process is described by Braun and Clarke (2021, pg. 196) as "telling a story," that "makes sense of what is going on": in this case, the story of how a social worker transforms into a mental health/social worker hybrid professional.

To view preliminary notes used to form the themes, see Appendix H: Preliminary Themes.

5.7.2.1 Serial Interviewing and Analysis

As described above, the 11 participants were all interviewed twice (a total of 22 interviews), and data was treated as an integrated dataset. This means that all 22 interviews formed one data set with the second interview more fully exploring ideas discussed in the first interview. In terms of how the serial interviews aligned with the six steps, per Braun and Clarke (2022), this was a highly recursive process in several ways. To better understand this process, the

overall dataset can be divided into four sections: First interview-front half, first interview-back half, second interview-front half, second interview- back half. Each quadrant's interviews had slightly different characteristics which were based on where the interview took place in the overall process. Below is a table describing each group:

Table 5.2 Evolution of Interview Strategy and Analytical Focus Across Serial Interviews

First Interview - Front Half (the first 5-6 participants)	First interview - Back Half (the remaining participants)
Researcher had pre-formed ideas, sought confirmation (first two participants) Open ended, exploratory questions Freedom allowed for participants to self-direct No themes identified	Researcher dismissed some pre-formed ideas Open ended, exploratory questions Freedom allowed for participants to self-direct but subtle prompting from researcher Notions of possible themes
Second Interview - Front Half	Second Interview - Back Half
Questions specifically targeted based on participant's previous ideas/experiences Clarification sought, previous statements were challenged Deeper meaning more fully explored via direct questioning Themes are present, require clarity	Questions specifically targeted based on participant's previous ideas/experiences. Clarification sought, previous statements were challenged. Deeper meaning more fully explored via direct questioning. Themes are quite clear, questions used to fine-tune, reinforced credibility

It should be noted that the second round of interviews did not strictly follow the same participant order as in the first. Some participants were more readily available than others, so I needed to work around their schedule. Consequently, there are different gaps of time between the first and second interviews (see Table 5.1).

This process was an iterative movement between data generation and analytic reflection. Firstly, earlier interviews informed how later interviews were done. Not only did I become more familiar with the process as the interviews progressed but previous data, once transcribed and considered, informed questions used in later interviews. Secondly, ideas about what the data meant began to take shape. Questions in later interviews helped to crystallise these ideas and bring them into better focus. However, I was mindful of not constructing questions in a way which would confirm pre-conceived ideas but instead, offered open-ended questions concerning a topic discussed previously. The first front half interviews were more open, allowing the participant to go in any number of directions., however this changed slightly for the back half as I became more familiar with the conceptual topography. The second round of interviews were more directed, as there were specific conceptual areas which needed further exploring or clarifying and these were directed by questions generated by data from the first round. Once thematic structure became clear (between second front and back half) the final interviews were used to confirm the validity of the structure and to fine-tune any rougher points.

5.7.3 Reflexivity

Per Braun and Clarke (2021), reflexivity plays a large role when using thematic analysis because it is crucial that one display, and to the best of his or her ability, acknowledge how their own perspectives informed the research process. While it would be impossible to acknowledge every personal factor which may have played a role, I do feel the need to address two key personal characteristics which informed not just how the research was done, but the formation of the research question itself: my American citizenship, international practice and my qualification as a licensed psychotherapist in the state of California.

As a reflective and reflexive researcher, it is important to be transparent about how I was interpreting the data. Foundationally, my own work as a social worker in the UK, New Zealand and in the United States allowed me to understand my participants' stories and easily picture and relate to their drives, pressures, experiences and values. In this respect, this common ground gave us similar language, an assumed shared set of values and similar skills. Further, as I have social work experience in other countries, I was able to conceptualise the systems,

legislation and other nation-specific institutions against the more global, human experience which transcends borders. However, my relatively unique training as a licensed clinical social worker in America provided insight into the mental health world they described and afforded opportunities to explore their knowledge, assumptions and practices from perhaps a more authoritative or knowledgeable standpoint- a point that I want to explore briefly.

My initial thought when starting this research was to explore social worker's' experiences of mental health within the context of the pre-conceived notion that a good clinical background would enhance their practice. However, as I met my participants and heard their stories, I learned that this was a very small part of a much larger and more important story to tell. When reviewing my interviews, sometimes 12 or 18 months later, I could see evidence of this thinking and reflected on how much more broadly and deeply my developing understanding had evolved. Counter to my expectations, I did not find social workers stymied and hindered by their lack of clinical mental health knowledge. Instead, as my findings will show, I found insightful, dedicated and resourceful practitioners who were doing extraordinary work under difficult circumstances, driven by their solid social work values, hindered not by their knowledge, but by the limited systems in which they were practising. In other words, they were already practising "clinical" social work but did not have the training, resources or support to do it in a way which was safe for them physically or psychologically. While I regret my initial ignorant assumption, I am glad I can reflect on this part of my research journey.

Reflexivity refers to the ability, to a degree which any researcher can, recognise the cultural and experiential lens through which he or she is viewing the phenomena of interest. Instead of attempting to "bracket" these perspectives in a positivistic attempt to isolate an objective reality, these experiences instead bring unique insights and depth to the research (Clark et al., 2021). Below, I will argue that the two characteristics I bring to this study do just this.

5.7.3.1 American Citizenship and International Social Work Experience

I was raised and educated in the United States and came to the United Kingdom shortly after receiving my Master's degree in social work at the age of 27 in 2002. I practised child protection social work in the UK until 2006, when I immigrated to New Zealand where I spent

approximately 2 years working in social work and other human service professions. I returned to the United States where I remained for approximately 10 years. From the years 2013 to 2016, I worked and studied towards my Licensed Clinical Social Work (LCSW) qualification which was awarded to me by the Board of Behavioural Sciences in the State of California in 2016. In that same year, I returned to the UK where I worked in a Priory Mental Health Hospital for about two years before I started teaching in 2018.

Having practised social work in the UK allowed me to more intuitively and intimately understand the participants and relate to their experiences. My clinical work in the United States provided the mental health knowledge which is not easily accessible to UK social workers. Blending these two spheres of knowledge presents a unique opportunity to explore this research question. I used this knowledge when participants discussed diagnosis, symptoms, and treatments, specifically when I wanted to better understand their own understanding of these terms. While there are some terminology differences between the American definitions used in the DSM5 and the UK's use of the ICD 11, the concepts are essentially interchangeable.

Additionally, my American education as a social worker provides a different perspective from that of UK-educated social workers, primarily because the mental health and social work realms are not as institutionally separated in America as they are in the UK. This is due to the existence of the NHS in the UK which is seen as the primary medical institution which provides national health care to UK citizens, and because mental health is seen as a medical condition, it falls within the NHS remit.

Not being born or educated in Britain does present challenges. Despite having lived a total of 11 years in the UK, I will never match the familiarity and fluidity of British existence as someone born, raised and educated here. While I did not perceive any limitations in this area during the research, it remains a fact that I am essentially "an outsider looking in" in terms of the cultural differences and will inherently have a different perspective than a natural British citizen interacting with another.

5.7.3.2 Psychotherapist

My LCSW allowed me to practise as a psychotherapist in America, a role which does not exist in the UK. Outside of prescribing medication, the role resembles that of a mental health nurse combined with that of a counsellor in the UK. The skills inherent in this role informed my ability to carefully and sensitively explore the participants' experiences and socratically question when appropriate to do so. Further, recognising therapy skills informed my ability to recognise when the participants were using them irrespective of whether they recognised this themselves.

The knowledge base which informed my therapeutic work in America, while useful, did temporarily hinder my early interviews, primarily because I was asking my research question for a different reason than that into which it eventually evolved. When conceptualising the research, I was operating under the assumption from a more clinical background would better inform UK social work practice, and as such, some of my early interviews reflected this. When analytically reviewing videos and transcripts, I noticed some of my questioning had a "quizzing" characteristic, which I did acknowledge at the time, but upon reflection, did nothing towards helping the participant or me understand their experience. Further reflecting, this kind of questioning came from an assumption that UK social workers had little to no clinical understanding, and while clinical knowledge informs a very small part of the later analysis, again, it has little bearing on the overall thematic framework which eventually emerged.

Reflexivity plays a key role in thematic analysis, as it allows me to bring my unique understanding and perspectives to bear on the research question while also acknowledging potential theoretical or perspective blinders which are integral in any research, specifically qualitative.

5.8 Quality

Qualitative research requires a qualitative quality measuring tool, and there are many from which to choose (Lincoln, 1985; Clark et al., 2021). When considering quality evaluative

frameworks, Lincoln and Guba have dominated the qualitative field since their seminal work in the 1980's and 1990's which retorted the quantitative, positivist paradigm, recognising that a positivist framework was incompatible with interpretivist, human experiences. Lincoln and Guba's *trustworthiness* consisting of *credibility*, *transferability*, *dependability*, and *confirmability* remain the bedrock on which other criteria sit, one of which is Tracy's Big Tent model (Tracy, 2010), and after reviewing the model, I found that it provided more flexible and congruent criteria which better fit with the study, particularly the language around transparency and reflexivity, which as mentioned previously, will help me highlight the specific perspective to which I approached the research design as well as capture the dynamic and fluid nature of my understanding of the topic as the study progressed. The Big Tent model makes linkages between the qualitative paradigm and the quantitative, aligning the 8 criteria to the positivistic measurements (e.g. validity, generalisability and the previously mentioned saturation point-) all criteria considered important to research quality. The Tracy criteria are also more contemporary yet have, relatively quickly, established themselves as a reliable measure of quality research (Gordon and Patterson, 2013).

Tracy asserts the following criteria to evaluate qualitative research quality:

1. Worthy Topic: The topic is relevant and interesting.
2. Rich Rigour: The study uses sufficient theoretical constructs and methods.
3. Sincerity: There is evidence of reflexivity and transparency.
4. Credibility: the study includes "thick description," detail and uses triangulation methods.
5. Resonance: The study is important to audiences or drives them to action.
6. Significant Contribution: The study evidences unique approaches.
7. Ethical: The research was done in an ethical manner.
8. Meaningful Coherence: Meets intended goals using appropriate methods and builds on existing literature.

This framework is particularly well structured in some specific areas as it relates to the research. Firstly, mental health as a national issue of concern in the UK has garnered much attention, exacerbated by the COVID-19 pandemic of 2020 and previous austerity measures

taken by the Conservative government between 2010 and 2019 (Mattheys, Warren and Bambra, 2018). Social work, as a profession, appears to have taken a backseat to this discussion, leaving the NHS as the institutional spokesperson. This research provides a small contribution towards providing social work a voice on this topic. The third criterion, related to reflexivity and transparency (sincerity), is particularly fitting for this research, specifically given that social workers and psychotherapists hold reflection and self-examination as a core value. Lastly, as the research relates to criterion six, it aims to be a kind of wake-up call to social work as a profession, asking if social work should be demanding the same kinds of provisions for its staff as does the NHS and other medically foundational professions. These discussions will be more fully explored in later chapters.

Recognising that no quality criterion is ever a perfect fit for any study (Yadav, 2022), the research will refer to these criteria as appropriate to highlight how the study meets the quality threshold, demonstrates quality characteristics or how obstacles towards ideal quality were mitigated.

5.9 Limitations

This section will describe the limitations in the study, as it is recognised that no single study can capture all dimensions of a particular phenomenon. The limitations within this study are centred around the sample's heterogeneity, specifically in terms of gender and ethnicity. Limitations inherent to qualitative research are also explored.

5.9.1 Gender

The sample in this study consists entirely of female participants. As previously mentioned, this is not a gendered study, in that it did not aim to explore specifically female perspectives of the social work/mental health boundary. Nor, as previously argued, is there evidence that the participants' gender played a large role in their experiences. However, it cannot be ignored that the female perspective is only represented here, and to ensure that gender is not a factor when exploring this research question, future research should include male social

workers and be used comparatively against this study. This exploration could be of particular interest given the female dominance in social work (Social Work England, 2022).

5.9.2 Ethnicity

With one exception, all the participants were White/British. Much has been written about the intersection of race/ethnicity and mental health experiences (Fox and Prilleltensky, 1997; Fernando and Campling, 2002; Faber et al., 2023) and no study about mental health experiences, either from a patient/service user perspective or a professional one, should fail to acknowledge racial and cultural implications. Again, this study did not explicitly seek to understand these specific experiences, and because of the sample's demographics, opportunities to do so were not obvious. Future research should specifically explore the views of social workers of minoritised populations/non-British heritage to illuminate phenomena and experiences outside the White/British perspective.

5.9.3 Sample Size and Qualitative Issues

Qualitative research is not concerned about issues of generalisability, and therefore, this study does not make claims of describing a national experience. However, it would be illuminating to use quantitative methods to explore a broader, national perspective of these phenomena, as it would provide further depth, understanding and context to the perspectives offered by these 11 participants.

5.10 Conclusion

This chapter has described the methodology and methods used in this study and framed the research approach regarding key principles. It has discussed how participants were recruited, the tools and methods used to explore their experiences and how the data was captured, stored and analysed, specifically exploring the advantages and considerations of serial interviewing. Ethics were also explored, paying particular attention to the therapeutic skills and background which informed the interviews. Tracy's Big Tent Model was deployed as a framework to address quality assurance. Reflexivity, within the context of thematic analysis,

was deployed to explain how my perspective informed the data collection and analysis. Lastly, limitations and areas for future research were identified. The following chapter will report the findings from the 22 interviews and will include a narrative to help the reader understand what is happening. However, deeper discussion and analysis will be reserved for Chapter 7.

6 Findings

6.1 Introduction

This chapter will provide the foundation to begin answering the research objectives which are being restated here to properly frame this chapter:

6.1.1 Research Objectives

1. Develop an understanding of how social workers conceptualise what it means to be a social worker.

2. Evaluate how social workers define and conceptualise mental health.

3. Investigate social workers' experience when working with mentally distressed service users.

4. Understand challenges social workers face when interacting with mental health services.

5. Examine how social workers think and feel when reflecting on these experiences.

Four themes have been generated from 22 transcripts. They have been organised in a way which intuitively describes a social worker's journey:

Table 6.1 Thematic Framework of Findings

Theme	Sub-theme	Description
Being a Social Worker	Social Work Values	Explores some of the participants' personal and professional values, why they entered the profession, their training, and how they view themselves within a larger service system, particularly their relationship with the medical field.
	Pre-Post Qualifying Training	
	Medical/social hierarchy	
Theme II: The Approach	Ontology of Mental Health	Describes how they conceptualise mental health, some of the mental health issues they encounter in practice, how they interact with other services and their perception of those services.
	Services can't or Won't	
Theme III: Metamorphosis	Acute Mental Health Issues	Describes how the participants actively engage with mentally distressed service users, how they attempt to fill a perceived gap in mental health services and some of the dangers they encounter.
	Suicide Risk and Assessment	
	Psychotherapy Skills	
	Physical and Emotional Danger	
Theme IV: Aftermath	Outcomes for Social Workers	Describes the outcomes of all those involved, including the outcomes social workers see for their child and adult service users. For social workers, this includes frustration and mental burnout, while for

	Outcomes for Young People	children, it can mean the suppression of emotional trauma which translates into adult mental health issues. For adults, it can mean being over-medicated in a less-than-ideal care environment.
	Outcomes for Adults	

Table 6.2 Mapping of Themes and Sub-Themes to Participants and Research Objectives

Theme	Sub-Theme	Participant Group*	Associated Research Objectives
I: Being a Social Worker	Social Work Values	Dawn, Violet, Rachel, Lila, Lita, Sydney, Elvira	4, 6
	Pre-Post Qualifying Training	Sybil, Tess, Lila	4
	Medical/Social Hierarchy	Christine, Elvira, Tomasina, Rachel, Lila	1, 2, 5, 6
II: The Approach	Ontology of Mental Health	Lita, Sybil, Christine, Sydney, Lila, Elvira, Tess, Violet	1, 2, 3
	Services: Can't or Won't	Sybil, Lila, Elvira, Tess, Lita, Violet, Rachel	5, 6
III: Metamorphosis	Acute Mental Health Issues	Lita, Dawn, Christine, Tomasina, Rachel	3, 5, 6
	Suicide Risk and Assessment	Sydney, Tess, Violet, Elvira, Lila	5, 6
	Psychotherapy Skills	Sydney, Christine, Lila, Tess	5, 6
	Physical and Emotional Danger	Dawn, Rachel, Sydney	4, 5, 6
IV: Aftermath†	Outcomes for Social Workers	Dawn, Sybil, Sydney, Lita, Christine	N/A
	Outcomes for Young People	Christine, Tess, Elvira, Sybil, Lila	N/A
	Outcomes for Adults	Rachel, Tomasina	N/A

*Participants' names below are pseudonyms.

† No research questions are associated with the last theme because this theme was a product of an iterative process, and as such, was generated after reflecting on the research questions and the data they generated.

6.2 Theme I: Being a Social Worker

6.2.1 Theme Introduction

This theme describes the social worker identity: who they feel and think they are, what they want to do, what is important to them and how they consider their profession within the context of other helping professions. It covers the dimensions of social work identity which informed most participants' experiences underpinned by their values, training and the societal structure of professional hierarchy. Many students want to study social work because they hope to improve the lives of vulnerable people (Bozek, Raeymaeckers and Spooren, 2017). Irrespective of what this looks like to the individual, the desire remains with them, and on a basic level, translates to seeing a service user somehow bettered because of their work with the social worker. This theme captures this misleadingly simple idea and incorporates the sub-themes of values and training.

6.2.2 Sub-Theme 1.1: Social Work Values

6.2.2.1 Empathy

Previously discussed in the theoretical chapter where empathy was explored as a mechanism for boundary spanning, it is important to return to this exploration, this time as a component of social work identity. Empathy is the ability to understand and share the feelings of another (Stevenson, 2010). Identified as a core social work value, empathy was discussed explicitly or implicitly at length by several participants. Borrowed from Carl Rogers' seminal works and referred to as "unconditional positive regard" (Rogers, 2020), it is the idea that social workers look past a service user's actions and focus on their intrinsic worth as a human being- using that worth as a foundation on which a relationship can be built. The social work profession considers empathy as one of its defining characteristics, appearing prominently in the International Federation of Social Workers (IFSW) (Global Definition of Social Work – International Federation of Social Workers, 2014), the American National Association of Social Work (NASW) (NASW, 2025a) and the British Association of Social Work (BASW) (BASW,

2025a) behavioural and professional standards. Participants discussed this concept as a key focal point of how they thought of themselves as professionals, sometimes as one of the defining principles which separated them from other helping professionals.

The data evidences the role empathy played in one of the most extreme examples- when one is working with someone who is incapable of feeling it (Hare, 1999). When navigating the boundary between a service user who could be considered mentally ill or psychopathic, criminal justice social worker Dawn stated:

> Yeah, I think it's about having that empathy as a social worker to understand what's really going on for people...
>
> (Dawn, Interview 1)

This value again appeared to be considered paramount in the face of other considerations. Dawn's account explicitly positions empathy as part of social work identity rather than simply a communication skill. This is important when considering later findings, where participants described remaining involved with distressed service users, developing strong relationships and undertaking tasks which appeared to extend beyond conventional social work boundaries.

When asked about the prospect of working with someone labelled as a psychopath, another participant expressed concern, or empathy, for the person labelled as such, stating:

> The label would provide me with some kind of information, but the benefits of receiving that information would probably be outweighed by the disbenefits in terms of the consequences for the person.
>
> (Violet, Interview 1)

Here, Violet is more concerned about the impact the label has on the service user, and it seems her own safety doesn't play a role in her thoughts. This last statement reinforces the previous, indicating just how strongly the empathy value informs Violet's views of a potentially difficult or dangerous hypothetical service user. The fact that empathy even plays a role in these professionals' identity when working with this population speaks to the primary

nature of this value and how largely it looms within the social worker's identity and value system.

While legislation helps construct the social worker's "structure", discussed in the next theme, it also helps inform her professional identity because it attempts to define what social workers can and cannot do and often separates social work duties from other professionals. Legislation sits at the root of social work education and has historically shaped and moulded the profession as it has responded to societal and political changes (Bamford, 2015; Bamford and Bilton, 2020). However, some participants used the legislation, not only as practice guidance, but as an emotional tool which might absolve her of guilt of having to perform duties she finds distasteful or limiting her ability to provide further support, a topic which will later be explored. Another participant describes finding legislation useful to manage what she feels are overly empathetic emotions:

> …you do have to be mindful of being guided by the legislation. And two, because my heart is very in it. My sort of emotional responses to stuff is probably overly empathetic… I really overthink things and say for me it works quite well.
>
> (Rachel, Interview 1)

Rachel seems to feel overwhelmed with her empathy to the point that she feels it's something which needs to be managed and her use of the legislation to help shape her professional identity is useful in this regard. Empathy acts as a kind of double-edged value; it motivates people to enter and remain in the profession but at the same time, if not checked, can erode away at the professional, leading to frustration and burnout (Beckett and Maynard, 2017). Rachel's description suggests that empathy was not experienced solely as an abstract professional value but as an emotional force capable of influencing practice. Her reliance on legislation appears to provide a means of containing this response and maintaining a professional boundary. This tension between empathy and professional boundaries becomes increasingly visible in participants' later accounts. Empathy, and the skilful use of it, provides the foundation for the next value dimension, that of building relationships with service users.

6.2.2.2 Relationship Building

Sitting at the heart of social work identity, this core professional value provides another dimension which social workers feel separates them from other helping professionals (Fook, 2016; Beckett and Maynard, 2017). "Relationship" is a highly fluid word and can mean a range of connections, however, per below, social workers aim for a relationship which presents qualities where change can be effected. While one could argue that all professionals need to have some sort of relationship with those with whom they engage, social work considers the ability to create, maintain and base the relationship at the centre of any meaningful change or intervention as a distinguishing feature of the role.

One participant describes it well, conjuring images of trust and honesty:

> It's building a relationship first of all, to try and develop some trust and I think that's easier in some circumstances than in others. So, I think building that relationship to try and work towards a position where they trust you enough to be able to share with you and be honest.
>
> (Lila, Interview 1)

Lila recognises that this skill is not always easily deployed, yet the desire or need for it remains. The implication here is that the trust and honesty go both ways; the service user should be honest with the social worker, and vice-versa. Interestingly, this expectation is later questioned by the same participant, not within a mental health context, but within a safeguarding one which raises questions around the inherent conflict present when harm or abuse is investigated. This conflict is further explored below.

All participants described creating, or attempting to create a meaningful relationship and introduced and discussed this concept as a "given" of social work, almost as if it is without question that this is what social work does. Several participants presented specific instances of this. One participant described the efforts she took to connect with a young person recently discharged from a mental health hospital. Because she felt the need to move at the young person's pace, she visited the home several times, making incremental steps towards this goal starting with speaking through a closed bedroom door to convincing the young person to attend a CAMHS appointment. This narrative illustrates the tenacious and relentless nature of her attempt to engage, recognising that this consistency and willingness

to work at the young person's pace would eventually yield results, all buttressed by relationship value.

This commitment towards a working, unconditionally regarded relationship manifested itself in other ways, providing further dimensions to the core nature of this professional value. Dawn, working with those involved in the criminal justice system, described the relationship as a catalyst for change. Again, this is interesting in that it conflicts with our current understanding of the psychopathic mind- that it is incapable of change- yet Dawn still maintains the relationship value:

> You may not be able to change their behaviours, but if you can build a relationship with them …, you can help them to maybe productively change things to support their own risk.

(Dawn, Interview 2)

Finding a balance between relationship and risk management sits at the heart of working with this population (Heintzsch and Hausam, 2025), yet without any formal training in this regard, Dawn seems to naturally gravitate towards the relationship end of the spectrum, a factor which contributes to later consequences for her.

As alluded to earlier, the empathy value either seemed contrary to other statutory social work duties or exacerbated organisational or risk management pressures. This is well-documented conflict, particularly when assessing risk (Barry, 2007; Green, 2007; Gladstone et al., 2014). Returning to Lila, she discusses her struggle to rectify the need to maintain a relationship with the need to fulfil her duty as a mandated reporter. Below, she speaks almost despairingly at the idea that maintaining a relationship is possible in this circumstance.

> I'm having to ring the police because I'm worried that (the service user) is going to kill (her)self… How do you keep that relationship going?

(Lila, Interview 2)

The nature of the successfully established social worker/service user relationship creates a porous boundary which, per below, leads to the social worker feeling compelled to act outside

of her remit. Describing the relationship she had with a mother to be the reason why she was contacted before other professionals:

> …it should have been mental health professional … or adult social care or whatever.,, but I had a good relationship with this mom who… felt that I was the right person for her to ring to share her worry and agreed for me to take her to the (mental health hospital.)

(Sydney, Interview 1)

Ironically, this relationship building contributes to the pressure the same participant describes in the next dimension of social work identity; the perception that social workers must always be available and have no latitude to withdraw or decline working with service users. The relationship is often seen as the reason why social workers remain involved with service users, irrespective of the legislative need for it, contributing to the next value dimension, that of the infinite availability.

6.2.2.3 Constant Availability

Participants described experiencing never-ending availability and having to "catch" service users who might otherwise fall through system gaps. This conjures images of overworked social workers underneath a kind of cascading waterfall of need, tasked with jumping from one crisis to another in a never-ending preventive dance. These experiences often manifested themselves because of the porous nature in which services attempt to fit together, the "intersectoral" and collaborative nature of policy driven government bodies (Williams, 2012) and the blurred boundaries between them (Stoker, 1998). How service users' needs are categorised sits at the root of this discussion which is more fully explored in later discussions. Here, the focus remains on the social worker's identity as the "always present, always available, all-providing" professional who will support when others won't or cannot.

Returning to Sydney's experience, below she justifies her actions. She alludes to the idea that these experiences are isolated to her own practice, yet this sentiment was echoed by several other participants, suggesting that this is a much more common experience. Here, she questions a total of four times, almost demanding an answer that she already knows.

> Because I personally I feel that- Everything just sort of comes back to social services and then it's…, if we don't keep them open or put something in place, … then what? Who else is going to do that? Who else is going to keep an eye on this child? Who else is going to put that support in?
>
> (Sydney, Interview 1)

While Sydney does not explicitly describe these actions as empathetic, her account illustrates how the empathetic and relationship-based identity described earlier may manifest in practice. Having recognised unmet need, simply withdrawing appears difficult; instead, she assumes continued responsibility because she perceives that nobody else will. Empathy therefore begins to appear alongside constant availability as a possible influence on participants moving beyond clearly defined professional responsibilities.

Perhaps the demanding nature of her tone suggests the desperation she feels, underpinned by a sense of injustice that social work is in this "catch it all" position. Her statement has a further, almost accusatory, characteristic where we might imagine her directing these questions to the other services as a rhetorical challenge. Further driving this need to be ever present is the perceived consequences of the wrong action or inaction. She justifies this anxiety, evidencing her awareness of the general public's opinion and possible stereotype of social workers as a scapegoat when things go wrong and the public medium in which these errors are advertised.

> I guess you know the impact of, yeah, like social media. …, something that goes wrong, it's always comes back to social services, isn't it? … just on our heads, …, if somebody, something happens… some child died by suicide.
>
> (Sydney, Interview 1)

This sense of constant availability is also evidenced on a systemic level, baked into the service infrastructure by adult and child safeguarding legislation such as the Care Act 2014 and the Children Act 1989, respectively. Elvira, a service manager, describes this phenomenon. Incongruously, she laughs when describing the perceived injustice of non-statutory services having the latitude to decline service provision while social work cannot.

> …we cannot say 'No, we're full up. We can't take any more. We don't have capacity.' We cannot do that. It feels like every other bugger in the world can say that and there's not a lot we can do about it (laughs)… well, it's the statutory responsibility.
>
> (Elvira, Interview 1)

Elvira is referring to the concept of "gate keeping," (Tushman, 1977) which includes ideas of discretionary practice, a luxury Elvira feels others enjoy. Her experiences as a service manager provide a unique perspective of the "wicked" arena, a term coined by Ritell and Weber in 1973 (Williams, 2012) which describes the interweaving and overlapping nature of societal problems in which governmental agencies can pressure other agencies to provide resources to lessen demands on their own. This idea will be more fully explored in the next theme. Because she acknowledges the role the statutory legislation plays, it's understandable that social work identity reflects this. Reflecting on Sydney's experience with the hospitalised mother, it seems that some participants struggled to see what duties were legislatively required and when her personal responsibility to the service user stopped. However, Elvira's insights suggest that despite any "relationship" based responsibilities, the legislation alone unfairly burdens social workers.

6.2.3 Sub-Theme 1.2: Pre-Post Qualifying Training

One area of particular interest to the research question was what mental health training social workers received, both pre- and post-qualifying, and if they felt that training prepared them for practice. Training could be thought of a second layer of professional identity, a kind of blanket over the values and natural skills which students already have. Much has been written about the connection between training and education, targeted towards specific areas of practice, i.e. drug use and assessment (Galvani et al., 2009; Galvani and Forrester, 2011), mental health (Karban, 2003) and risk assessment (Calder, 2008). This discussion aims to provide a generic overview of the kinds of mental health training these specific participants had, their thoughts about it and how it prepared them for encountering mental health issues in practice.

6.2.3.1 Undergraduate Training

Participants described little mental health training during their post-qualifying education, and per the comments, what they did get had varying degrees of impact. The most impacting mental health training came from placement settings which were not available to all students. This would appear to be consistent with the literature which suggests that mental health is often viewed as a "side" or "addition" to the core social work educational curriculum (Galvani et al., 2009; Martin, 2016; Kourgiantakis et al., 2022). Most participants described learning about mental health in their placements. It is likely that these social workers agreed to participate in this study out of an interest in mental health, and it's similarly likely that whatever choice they might have had around their placement also reflected this interest. Consequently, the participants here may reflect a disproportion of mental health related placements. Continuing this thought, if placement is where mental health is learned, then it seems most social work students receive little to no mental health training as part of their undergraduate experience. Two participants link their mental health knowledge to their undergraduate placements:

> I don't know necessarily the bits that we were taught in the university from the legal perspective, you know, the paperwork, the practical parts of it. So, my placement was with a mental health team that was incredibly helpful.
>
> Sybil (Interview 1)

Sybil's comment highlights the difficulty of using the phrase "mental health" when referring to training. To answer the question, she describes learning about mental health legislation which inarguably is just one dimension of the larger "mental health" umbrella. One can speculate that students are only exposed to the legislative side of the issue because the role of the Approved Mental Health Provider (AMHP), (where social work most commonly and formally intersects with mental health), is largely legislatively based and requires little to no clinical or diagnostic insight. As she states, her deeper learning came from her placement, a point reinforced below.

> So, my understanding of psychosis … I had done a placement with adults with mental health issues … so I did have some understanding of psychotic behaviours and people like hearing voices or having paranoia or, you know, having inhibitions (sic).

(Lita, Interview 1)

Further comments bring another point of consideration to the student training experience. It seems that while some social workers received little to no mental health training, some received training that was detrimental to their later practice. Dawn, a criminal justice social worker, comments that her training instilled the importance of person-centred practice but in her experience, this seemed counter to what she needed in her role as a criminal justice social worker.

> …because everything that you learn in uni kind of goes out the window a little bit because you can't have a kind of person-centred approach because what you're dealing with is risk management.

(Dawn, Interview 1)

I recognise that her role is unique among my sample, however her experiences highlight an important idea – that perhaps a person-centred approach is not appropriate for all service users, particularly when risk management, either for a vulnerable person or the social worker, is a priority. The idea of defaulting to the partnership relationship seems to more represent how social work would like to think of itself, i.e. a helping, non-judgemental guide who is working with a willing and honest service user rather than the reality which many social workers confront, that of a hostile, dishonest and potentially dangerous service user.
Others were blunter about their undergraduate learning but unfortunately were not very positive.

> Covered some basics but very little.

(Lila, Interview 1)

6.2.3.2 Post-Graduation Training

Most mental health training was available once participants were in practice, yet it seems these experiences were limited to a select few. Other participants spoke of receiving one- or two-day training sessions about personality disorders. While the quality of local authority training was not well regarded, two external programmes were exceptions.

One participant, who was undergoing AMHP training at the time, had access to mental health training provided by her employer, but she had to request this and found it limiting.

> Yeah, it's really, really basic. I had to speak to our learning Academy to request that they send me links … We don't have it on any of our online portals for training… It wasn't anything that I would have found if not (requested). I think you have to go beyond what our Council offer if you want to educate yourself on diagnosing, diagnosis and treatment and how to support people… the resources are shocking and it's really frustrating.
>
> (Sybil, Interview 1)

However, some external training was helpful, specifically Mental Health First Aid which helped one participant identify crisis. This is a free online course which can be accessed via one's employer and was discussed in a previous chapter.

> I think it gave me a bit of reassurance as well about that fine line between, like, when you can actually go out and do direct work as a practitioner and try and speak to them (young people) about their mental health and what they're struggling with, but also when you need to actually utilise specific services… So it was a good course. It was helpful.
>
> (Tess, Interview 2)

Two participants spoke highly of the Oliver McGowan course, a newly developed training tool based on the death of an autistic young person who was misdiagnosed and prescribed incorrect medication. This specific course was mentioned due to how it was presented and produced, in that it seemed particularly powerful to social workers and highlighted the need to listen to neurodiverse service users. Interestingly, again we see the phrase "mental health" used to cover a wide variety of topics, as it could be argued that listening to a service user or patient would be important in any profession, but because Oliver McGowan had autism, the training is viewed as "mental health" related.

With a few outliers, it seemed most participants did not feel their undergraduate training prepared them to deal with many of the mental health issues seen in practice, and those who did receive training did so via their practice learning placements. Post-graduate training

appeared difficult to access, was accessed only to those who were "interested" and when accessible, seemed limited and reactionary (e.g. to address the DSM 5 re-organisation of personality disorders). While some training was useful, again, these seemed limited to those social workers who actively sought it out.

6.2.4 Sub-Theme 1.3: Medical/Social Hierarchy

This last dimension of social worker identity concerns itself with how social workers think of themselves in relation to other professions, namely those in the medical field. Participants were keenly aware of what they could and could not do, specifically diagnosing service users, however, there seems a highly blurred boundary around diagnosing which will be later discussed. Social workers routinely referred to themselves as "just the social worker," implying a lower professional status, and routinely deferred to the opinions and conclusions of perceived "more qualified" professionals. This is an interesting point, as it appeared that the social workers were often more informed about service users and their situations and brought these insights to bear, but lacking a medical qualification, these insights were either ignored or "medicalised" into a diagnosis- a phenomenon discussed later.

6.2.4.1 Medical Experts

When discussing working with mentally ill service users, participants were clear they would defer to medical professionals, but only in certain situations, dependent on the nature of the diagnosis and situation. Psychosis or any presentation including psychotic features were generally considered easily outside the social work remit, whereas more "every day" presentations such as depression and anxiety, were thought of as more approachable, understandable or natural. This relates to how social workers construct mental illness which is described in a later discussion.

When discussing personality disorder, some were led by the clinical staff around the service user (the young person was in a residential home). Here, the phrase "clinical level" and "clinical people" are used which refers to the decisions around diagnosis and treatment, reserving other tasks for social work or non-decision-making staff.

> Some of the other diagnosis I was never going to get involved with on a clinical level and I was always going to take my cues from clinical, from clinical people working with her.
>
> (Christine, Interview 2)

This separation and relationship are again described below, reserving medical expertise for psychotic service users with social work being guided by medical experts.

> I mean, there are bits about mental health I will never, ever get my head around. You know people that experience, psychosis, schizophrenia. But I do think that's the other end of the scale and we rely very heavily on psychiatrist, mental health professionals to guide us with the people that, whose behaviour is or who's displaying those symptoms that fit into that kind of diagnosis.
>
> (Elvira, Interview 2)

This deferment to the medical experts also sometimes came with a certain amount of blind following where the decisions were not only left un-questioned but not understood. This relates to a later sub-theme, medical mysticism, where it's felt that the medical services are so mysterious that other professionals not only don't question, but they also don't appear to know how to formulate their question. When discussing medication, it did not occur to her to research the medication, stating:

> Actually, maybe I need to. You made me think about it, actually. What was he really on? Because, you take the word of the medical experts, don't you?
>
> (Tomasina, Interview 1)

While it appears that in some situations social workers will be guided entirely by medical staff, this contrasts with Rachel who works with adults with dementia. Here, she discusses her feelings about querying medication. This was a point of importance for her as she discussed the impression that adults were often over-medicated to meet the needs of the care staff:

> From my perspective, because I'm not medically trained, I'm always slightly cautious about asking about medication. I will always ask medication questions, but … I'm not a pharmacist.

(Rachel, Interview 1)

In this short statement, Rachel makes three statements that separate her from the medical field, evidencing the clear social/medical hierarchy. However, in contrast with Tomasina, she knows where to go to research the medication which implies that while she is not an "expertly" trained medical practitioner, she can still question how the medication is being used.

> So yeah, I would feel confident about doing it in that I'd look at … NICE guidelines about medication that look at maybe the BNF guides and see maybe even look at other people that I know on my caseload that say take a dose of Trazodone…

(Rachel, Interview 2)

Rachel is a good example of how social workers attempt to manage the boundary between their role and those reserved for medical staff, even though her role as a Best Interest Assessor (BIA) requires her to ask such questions. Here, the legislation requires her to query medication and its appropriate use, and while she does so, she does so cautiously yet confidently: confident because she is required to legislatively do so but cautiously because she lacks the training to question from a position of professional authority. This last statement is also interesting because she is drawing from knowledge from the British National Formulary (BNF) and National Institute of Clinical Excellence (NICE) Guidelines, both of which are accessible and understandable to non-medically trained staff, yet in other situations when diagnosis is questioned, participants were not confident about using the DSM5 OR ICD-11, other easily accessible and understandable medical resources. This last point echoes previous discussion about how social workers view diagnosing and may explain the reluctance to access the tool used to perform that task.

6.2.4.2 Contention with Medical Professionals

While it appears that social workers routinely reserve the medical decisions for the medical staff, the opposite does not appear to be the case – medical staff had no problem offering social insights or using social factors as part of their medically-based treatments or diagnosis. Further, social workers described frustrating situations with medical staff who would either

over-ride or ignore social work recommendations or solutions, or who would take social work insights and re-word them into medical reports which were perceived as more authoritative.

Here, the service manager Elvira describes a case involving a disagreement between health and social about which direction the case should go.

> … I think there's been some situations where there's been some very strong feelings based on very good knowledge (about a) young person or a family where it's been challenged. But what we generally find is they just close the door. 'We don't like what you're saying,' and the door gets closed. They pull ranks and we've had a situation where the CAHMS professional involved with the young person was very clearly on the same page as ours and until there was a meeting where the psychiatrist made his views clear, then the professional view also changed.
>
> (Elvira, Interview 2)

This is a good example of the power a consultant has over how a family or individual's case is framed and echoes similar experiences described in the literature review chapter (see Sub-theme 1.2: Influences from Medical Colleagues.) She later describes her thoughts about why this happens:

> I think the medical model very much draws from the way populations were managed, supported, helped, early on (historically). I think because we do not have a fully open understanding of what mental health, mental wellness, mental unwellness, is. I think it's a scary thing… So I think because there's a fear around that and we also look to experts and we believe, because it has always been so that psychiatrists like other doctors are experts. It sounds a bit simple that, but I do think it is quite simple in some respects.
>
> (Elvira, Interview 2)

This is an interesting insight which is not surprising, given her role as a service manager. Here, the social worker has little chance overcoming or challenging the historical and societal authority medicine holds. This further manifest itself when medicine appears to "own" social work insights in medical reports, echoed by discussions in the literature review (Hood, 2015).

> I got this report back (from CAMHS) and I was really looking forward to reading this report. And I was like, 'oh, this is gonna tell us so much.' So I spoke to a colleague and I was like, 'I'm really confused about this report … it's just kind

> of what I've told them and he went, 'Yeah, yeah, yeah. That's what kind of happens.' But because it's in written by someone with a different job title it's considered in a different way... Well, I could have written this. There's nothing here that I did not know.
>
> (Lila, Interview 2)

This exchange is enlightening, as it suggests that the social worker was expecting some sort of expertise of which she was not capable, only to find that her opinion was simply framed in a medical way and written by a medical professional making the report more authoritative. Additionally, based on her colleague's response, we can assume this happens on a regular basis and it's "just how it is," suggesting a kind of acceptance on social work's part that this is their place and there is little that can be done about it. More will be discussed about the medical-social hierarchy in the discussion chapter.

6.2.5 Theme Conclusion

This theme discussed the dimensions of social work identity which seemed to inform most participants' experiences as informed by their values, training and the societal structure of professional hierarchy.

Participants recognised the role that empathy played, specifically when developing relationships with social workers; a core task participants identified as being a social worker. They discussed a sense of having to be available, or at least offering services, when other services were not available. They explained their social work education and post-qualifying training with insights into its relevance and application. Lastly, participants discussed their experiences practising within a medically dominated service system and how this hierarchy manifests itself.

The next theme will explore how social workers understand mental health, the systems they encounter and their understanding of their role within them.

6.3 Theme II: The Approach (Mental Ill health in Practice)

6.3.1 Theme Introduction

This theme describes what mental health issues social workers are encountering in practice, how they construct mental health, and the systems they encounter. It discusses the ontological framework participants use, including the dimensions of severity, mental illness aetiology, and diagnosis vs. labelling. It will explore the issues participants encountered when engaging with mental health services as constructed by agencies' willingness or ability to engage with service users, the service quality the participants experienced and the mystical nature of these services as perceived by social workers.

6.3.2 Sub-Theme 2.1: The Ontology of Mental Illness

Understanding how social workers define a mental health issue and separate it from normal emotions was a key objective for this research. This is of particular interest given the extent to which everyday societal language has been infiltrated by clinical terms, as previously discussed. Therefore, it is against this backdrop which this objective is explored: do social workers have a more informed understanding of what constitutes a mental disorder and how do they construct this understanding? How do they differentiate between normal, every-day emotions and a clinically significant mental health disorder? These questions form the participants' ontological understanding of mental health.

6.3.2.1 Severity

Some participants tended to categorise a mental illness based on the severity of behaviours; the more severe, the more likely they tended to think of the emotion as a disorder. This could be considered the "non-clinician's" definition of clinically significant, as defined by the DSM as a condition which impacts someone's social or professional functioning to a significant degree, as subjectively reported by the person themself or a close family member. Only two participants referred to the DSM or ICD 11 during the interviews, and only one was able to speak to them accurately, so it is interesting that severity was the overall default or intuitively identified boundary between a disorder and a normal emotional response.

The involvement of medical staff with the service user, for some, denoted the severity of the condition, assuming that if things got bad enough, the service user would seek help. The

assumption here is that the service user identifies their emotions as abnormal, and the GP or prescribing practitioner agrees with this.

> If you've been assessed by a doctor, GP or something, that would be a (sic) clinical depression, wouldn't it? And that you're on medication and stuff or receiving other treatments like talking treatments and stuff.
>
> (Lita, Interview 1)

Some participants were highly vocal when describing the "over-use" of medical terminology, thus confusing the boundary. Here she relates it to the idea of stigma, the negative label one might perceive if given a mental disorder diagnosis, yet here she states that not only is stigma absent in her experience, but service users (in this case a parent) will seek out a pathology for what is understood to be a normal emotional response.

> It's so open and out there that instead of kind of saying, 'OK well my child is just a bit anxious like most 5-year-olds might be anxious in that particular element of life.' There becomes almost a need to say 'my child has anxiety.' They need to have a diagnosis. It's almost gone to the complete other extreme.
>
> (Sybil, Interview 1)

This observation speaks to the power that language holds; "feeling anxious" connotes a normal human response, while "has anxiety" suggests a condition in need of treatment. While not explicit on this point, Sybil recognises the difference, yet it remains unclear if the person doing the labelling, in this case the hypothetical parent, does.

Interestingly, participants assumed that the mental health services would not identify trauma or attachment issues as a cause of the mental disorder unless, again, the presentation was substantially severe. This perhaps again speaks to the nature of the DSM which, by design, does not speak to any causes of the disorder (Frances, 2013) and it is interesting that, again, while participants did not know this, they seemed to intuitively infer that this was the case and how the medical profession treats mental disorder.

> …trauma and attachment is …not really something CAMHS will pick up unless it's having a really negative effect, negative impacts on behaviour.

(Christine, Interview 2)

It is worth noting that, while both participants considered the severity of the issue, they both needed a medical professional to identify or treat it (or potentially treat it). However, this was not always the case.

> …I've got a boy in my case at the moment where, I mean, I'm not trained to diagnose in autism, but I'd put money on this boy being autistic…

(Sydney, Interview 1)

This tendency to "pseudo-diagnose" will be explored further, but here, the participant does not need a professional to confirm her own suspicion and appears to use the word "autism" to describe behaviours which she feels are outside a standard behavioural spectrum. This is an example of the loose nature in which all professionals will use diagnostic terms, irrespective of who (if anyone) originally provided the diagnosis. The consequence of mis-using diagnostic terms is explained:

> I remember a case from years ago for a lady (who) was blind in both eyes. She was fully blind, and when she would talk to people, because she can't see them, she wouldn't be looking at you. She'd be looking kind of over here and at times she'd get quite upset with people so she'd be shouting in the air and she got a label of being schizophrenic… but that slipped in the social work paperwork because when we did the assessments, they would tell us she's schizophrenic.

(Sybil, Interview 2)

While this was the only time it appears that a service user's case was defined by a fictional diagnosis, it is a good example of the porous nature mental health and diagnostic language has, existing both in the clinical world and the everyday. This presents another blurring of the mental health/social work boundary, as social workers are exposed to the misuse of clinical vocabulary just as everyone else, making it confusing to know if a person has been formally diagnosed, has self-diagnosed or is using the diagnostic term as an adjective or metaphor. Language is discussed in a different context later in this chapter and in the discussion chapter.

Other participants were much more ambiguous about what they thought constituted mental illness and some appeared openly uncomfortable with being asked the question.

> I think it depends. I think for some people they're, you know, if someone's got a diagnosis of schizophrenia and or bipolar or kind of a lifelong condition that's almost different. I think if someone is…. If we talk about situational, don't we… is this is, is this to do with their current situation? Is this a much deep, deeper-rooted difficulty. Is it the counselling they need? Is it actually inpatient treatment? Is it something a lot more intense?
>
> (Lila, Interview 1)

Here, the participant seems to struggle to identify what she thinks a mental health problem might look like. This was a common response to a relatively straight-forward question and speaks to the highly subjective nature of how society defines mental health and how we do so as individuals which will be discussed in a later chapter.

6.3.2.2 Aetiology

What social workers think causes mental health issues was another research objective and is discussed here. Underpinned by the social/medical debate, participants reflected ambiguity on this topic, fluctuating between biology and environment. This question is important because it relates to who might be considered in the best position to address the issues, again, being mindful of the medically dominated service structure. This topic is more fully explored in the discussion chapter, however, the below exchange, discussing the origins of a young person's mental illness, highlights this point and seems to exemplify the practice of medicalising environmental issues. When discussing how frequently she has encountered a service user with purely biologic mental health issue, Elvira admitted that in her 26 years of practice, she had never seen this. This was confirmed by a second participant who stated the same. These statements highlight the tendency for medicine to drive medical interventions, despite the environmental origins of the condition. However, other participants discussed some conditions which they felt had more biological origins.

> Eating disorders are particularly likely to be influenced by biology because there's the whole issue of how different people's bodies sort of respond to food and the psychology of how much food is being taken in.
>
> (Violet, Interview 2)

Other participants discussed the "chemical imbalance" theory as a medical root of mental disorder. This is reference to the highly cited 1965 Schildkraut and subsequent 1967 Coppen papers which first hypothesised that mood disorders could be attributed to imbalances of neurotransmitters in the brain and which has since provided the justification for pharmaceutical intervention (Healy, 2000; Davies, 2014; Hirshbein, 2014). Yet other participants were more philosophical about the question and provided a Foucauldian explanation of societal control and deviance.

> …it partly it feels like it's a bit of a population control to keep everybody where they should be and to make sure everybody knows what their position is… it generally tends to be men and that have come up with the diagnostic criteria. So, you know, maybe there are things about power and control in the wider population.

(Elvira, Interview 2)

Almost all participants discussed trauma as a contributor, if not the actual root cause, of many of the mental health issues they encountered. These traumatic experiences included the death of a life-long partner, sexual trauma, incest and domestic violence. Substance use was another point of discussion. Social workers tended to see substance use as a function of self-medication, while mental health services saw it as a cause of mental disorder, a debate which is more fully explored in the discussion chapter. Interestingly, when participants were asked why they felt the medical field was treating those afflicted by an environmental issue, none, aside from the service manager, were able to reflect on this outside of accepting that this was just how things are set up.

6.3.2.3 Label or Diagnosis

Only two participants referred to either the DSM5 or ICD-11 when defining mental disorder, which leads to the next dimension of this theme; the use of diagnosis and how social workers think about it. Diagnosis and diagnostic criteria serve a distinct purpose for service users and practitioners because it often acts as a gateway to other, more specific services. However, the concept of diagnosing someone clashes with the social work theory of labelling. Labelling theory is concerned with the social processes which identify those considered "deviant" or "outsider" (Bentall and Beck, 2004) as means of social control and social work gives

importance to the theory, specifically concerning stigma (Corrigan, 2004) and addiction (Mekonnen and Lee, 2022) and therefore are very cautious about when labelling is occurring, particularly when the label acts a lens through which all behaviour, or identity, is seen.

Per above, social workers are usually concerned with the social stigma a mental health diagnosis brings for a service user; however, some participants described the opposite effect- that some service users, specifically young people, welcomed the label/diagnosis.

> When does it (diagnosis) become labelling? I don't know… It didn't really matter because she was kind of looking for that label. She was looking for that, you know, stigma would have been quite a positive thing for her, really… I think she'd given herself that label anyway, along with all the other labels she's given herself. And she kind of hung on them.
>
> (Christine, Interview 2)

This statement suggests that the diagnosis/label provided the young person with a kind of identity, a phenomenon I have seen personally in practice. The participant later discusses the young person using the diagnosis/label as a reason to not try to improve her relationship skills, implying that an internalisation has taken place for this young person and she now considers herself too damaged to even try to get better. This could be considered an extension of the medical model internalised, as the young person equates herself similarly to a person with disabilities who is unable to negotiate physical limitations in the environment due to a condition beyond her control and therefore ceases to make the effort. In the first case, a person with disabilities might withdraw from the world physically, while in the second case, she appears to be withdrawing emotionally.

Some participants described benefits of the diagnosis, or at least benefits service users perceived. Instead of feeling labelled, the diagnosis provided service users insight into their own mental health difficulties- a framework to help them understand their feelings and experiences. In a sense, the diagnosis seemed to normalise or make more accessible, a complex web of confusion.

> I think it's harder when people haven't got a diagnosis sometimes and haven't got that understanding of their own mental health needs… diagnosis gives a

> clear understanding of what that is, what that looks like, but also treatment and other ways that support can be offered and what is available to them.
>
> (Lila, Interview 2)

This approach fully assumes the medical hierarchy and places great faith in the medical model; that once a conditioned is accurately identified, it can be treated. This approach seems to provide a sense of hope, realised or not, for both service user and social worker. This can be easily linked to the "need for certainty" theme identified in the literature review, but here the certainty, in addition to making sense of chaos, seems to provide a pathway forward.

The same phenomenon held true for parents who found diagnoses/labels helpful because they felt that the "condition" absolved them of responsibility for their child's difficulties. This phenomenon was also identified in the literature review (Hood, 2015) and similarly adopts the medical determinism that Christine's service user conveyed- that it was a condition over which neither the person experiencing the condition nor those affected have any control.

> I would say that's often what a parent wants to hear because they say 'It's not my fault and it can't be anything to do with me', If you have this medical diagnosis.
>
> (Elvira, Interview 2)

Further, the same participant described the monetary benefits that come with a diagnosis, not just for individuals, but for institutions. How money is allocated based on a condition also echoes medicine and is routinely used to manage hospitals and community health operational resources (Evans, Leggat and Samson, 2023) and fits neatly into the current neo-liberal, target driven industry.

> And I think it has some benefits that not necessarily people purposely use it for that. But in order to get some monetary benefits and additional help. I think it has a lot to do with funding and because schools will get additional help for children that have got diagnosed special needs.

(Elvira, Interview 2)

Interestingly, this feeling was not expressed by all participants, one of whom described a parent's concern of how an autism diagnosis would impact her son's educational experience.

> But she's worried about if he's diagnosed, about doors closing for him in terms of schools he could go to…

(Sydney, Interview 2)

Participants themselves found benefit in a label, but not for the same reasons. Dawn discusses the need for the "psychopath" label. Her insights here are interesting when compared to her comments in the earlier discussion about empathy. Here, she attempts to balance her empathetic approach with the need to ensure her own safety.

> If you can't recognise that label (of psychopath), then…something bad's going to happen to you in that interview or in that situation, because they will use anything against you.

(Dawn, Interview 2)

The label/diagnosis appears to be manipulated by services to meet their own agendas, also described in the literature review (Boahen, 2016b; Aspinwall-Roberts et al., 2022a). In relation to a young person diagnosed with Oppositional Defiant Disorder (ODD), she states:

> I just think he doesn't like to be told no. It just feels like we kind of label these things and my concern is we'll label them and then we say, 'but it's not a mental health problem. It's a psychological problem. Therefore, we can't treat it. Therefore, you need to look for solutions elsewhere.'

(Elvira, Interview 1)

What the difference is between a "mental health" problem and a "psychological" one remained unclear, yet his tendency to change or interpret conditions, irrespective of whether they are called "labels" or "diagnoses," leads to the next dimension of this theme, that of the

perceived pattern of services unable or unwilling to support people with obvious and clear mental health issues.

6.3.3 Sub-Theme 2.2: Services: Can't or Won't?

This dimension discusses social workers' experience of navigating, and often negotiating, with mental health services. These experiences seemed underpinned by frustratingly and arbitrary reasons why services will either not engage, or disengage, with service users. Further, service quality was described as less than ideal, as experienced by both service users and practitioners when working with both children and adults.

6.3.3.1 Delayed or Unavailable

Participants described services which were either not available or delayed to the point of irrelevance, often exceeding a six month wait. These delays often required the social worker to step in and provide services for which they had no training or support, an issue which informs much of the third theme. For many participants, social services were expected to bridge this gap, as described below.

> …an autism assessment is a two year wait. You know? But then mental health don't ever put in anything to bridge that gap, they would refer back to social services.
>
> (Sydney, Interview 1)

> People said to me, 'well, there's no point in going to the doctor and telling about this because nothing will happen. They'll refer me for counselling, and the waiting list is 18 months long.'
>
> (Lila, Interview 1)

One participant described the length of time needed for some talking therapies to be effective. While it's not clear to which therapies she is referring, even one of the most brief modalities such as CBT can keep a patient "on the books" for up to 6 months (NHS, 2021). CBT and its efficacy was discussed in the background chapter however for the sake of this

argument, “talk therapy” offered by the NHS usually refers to CBT, EMDR or DBT, modalities of therapy which all take months, at least, before any chance of improvement could be expected (Gabbard, Beck and Holmes, 2008).

Participants described mental health services as being highly selective and using inconsistent or arbitrary admission criteria. Substance use was a particular issue which prevented mental health services from engaging with service users. While it is common practice for therapists to require service users to be substance free for therapy to start, this often presents a conflict for both social worker and service user, as they are often using substances to self-medicate (Khantzian and Weegmann, 2009). What frustrated social workers more was the assumption that the behaviours or symptoms service users were experiencing were caused by the substances, and thus outside the remit of mental health services.

> …I'm going in there as a social worker saying, ‘I'm really concerned about this, this and this.’ And I'm being told by health professionals, ‘this is a drug induced psychosis’. And I'm saying, ‘I don't care what's induced the psychosis this young person has attempted to take their life and are saying that they will do it again’. And I think that's where there's this massive clash.
>
> (Lila, Interview 1)

Participants described highly obscure, arbitrary or circular reasons to decline services such as attributing the behaviour, ironically to simply “behaviour” in that the service user was behaving in a dangerous or odd way due to poor upbringing or lifestyle choices and not because of some acute mental health crisis. Another participant expressed frustration with the lack of planning medical services demonstrated, noting that if services were put in place earlier, it would prevent a more expensive, (e.g. hospital admission) in the future.

One participant described struggling to get a service user support (and eventually diagnosed) because, circularly, she did not yet have a diagnosis. Other services seemed to generically create perceivably impossible criterion to admit young people to services, usually related to acuity or state of crisis. What made these arguments difficult to address was the vague understanding social workers had of the mental health world, compounded by the authority medical practitioners enjoy.

> I think it's probably fair to say we're finding a little bit of challenge because the criteria for some of these things is very high, as it appears to be for most services, so making some of our children fit into the criteria sometimes just isn't possible.
>
> (Elvira, Interview 1)

6.3.3.2 Quality Issues

Once mental health services were available, participants described concerns about the quality of mental health services, ranging from how mental health practitioners engage with service users, decisions about the nature of the appointments, practitioners' inability to leave their offices and propensity for closing cases very quickly. One participant describes taking a young person into her CAMHS appointment and the difficulty she experiences because of the nature of CAMHS working style:

> So, I'm sat there as their social worker, but having to ask the questions because they won't speak to the worker who's the trained mental health professional because they haven't got the relationships because they don't go out and see the children and families, they have to come to them.
>
> (Tess, Interview 1)

Lila echoed this frustration when working with a young person who refused to leave her home. The work this social worker did to develop a relationship with this young person is described above; the goal of which was to develop enough trust to persuade her to attend the CAMHS appointment because CAMHS workers do not leave their offices. However, once service users did get to the office, participants expressed frustration with CAMHS workers and the quality of the service. This was usually directed at the way the worker engaged with the young person and was perceived as untherapeutic or lacking evidence of a caring, person-centred approach.

> But then I then get frustrated because I'm like, "but you're making no effort to build a relationship with this child, you're not, you're not doing anything to get them to wanna talk to you.
>
> (Tess, Interview 1)

Sadly, this social worker described taking a girl to a CAMHS service where the practitioner allowed the child's grandmother, with whom she was living, to attend the therapy sessions. The young person struggled to talk and was subsequently discharged. It was later learned that she had been sexually abused by her grandfather, the spouse of the woman who was attending her sessions.

Other participants described difficulties working with CAMHS and struggling to navigate their boundaries and limitations, which again, seemed arbitrary and existed only to lessen workload or involvement. This included not participating in group conferences or other multidisciplinary events or interventions. This issue also manifested itself in how CAMHS services communicated with social work in general, with participants noting that they would rarely get feedback on therapy progression and practitioners were generally difficult to reach by phone or email.

Disengagement was another common experience for social workers who felt that CAMHS workers would close cases, usually because young people would not engage with the service, but as above, felt that this was due to the practitioner not working well with the person. Other social workers felt that CAMHS workers would close cases if an appointment was missed and therefore categorised as "disengaged."

> It baffles me every time when they say, 'oh, this person didn't turn up for an appointment. So therefore we've now cancelled them.' And I'm like 'this person's got anxiety. So actually, getting them to your office is a big deal, you know.'
>
> (Lita, Interview 1)

This heavily contrasted with the social work ethos of continually trying to develop a relationship with a service user. Comparing CAMHS ways of working with the statutory nature of social services:

> …for children's services, we can't just (say), 'Oh, yeah, somebody's not speaking to us, we're just going to close.' So, it was almost like, 'well, we've done our bit and we can't do anything else.

(Sydney, Interview 2)

All these issues led some practitioners to feel that local services have a poor reputation, per below.

> I would say it's (the quality) quite low. My understanding of what they offer is very poor.

(Lita, Interview 1)

However, not all the participants experienced difficult working relationships with mental health professionals. One participant describes her work with a community mental health team when supporting a young person recently discharged from a mental health hospital. Interestingly, she identifies the legislation as the key driver behind this good working relationship, specifically Sec 117 of the MHA because it made agency roles quite clear.

> That's been a bit easier because actually we've had quite clear roles. So, when she returns to the community, we will be dual funding a placement, so we've got health have agreed their side and I've agreed our side from social care.

(Tess, Interview 1)

Most of this discussion has revolved around children and young people services, however adult social workers experienced other frustrations, usually around access to services in the form of supported accommodation and acute mental health services. Cutting across both therapeutic services and local community housing resources, most of these issues related to the nature of adult service provisions and lack of appropriate services, leaving participants with a sense of having to make do with services which did not meet service user needs, but it was either these or nothing. These participants, differing from their children's services colleagues, identified flaws in the larger systems, not specific practitioners or agencies.

6.3.3.3 Medical Mysticism

Ironically, despite these issues, both social workers and service users appear to hold great expectations about what CAMHS can do. These assumptions are based on the "specialist

nature" of the therapy, specifically because they offer Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT) and Eye Movement Desensitisation and Reprocessing (EMDR). No participants were able to clearly explain what these therapies were intended to do or how they worked, only that they knew of them. This will be explored in a later chapter, however, hope and confidence in medical treatments extended beyond just the use of these therapies, with social workers attributing other skills and resources to CAMHS. Interestingly, this confidence in the skills medical professionals have remained despite social workers being very unclear about how exactly medical staff are trained, what specific skills they have or tools to which they have access that other professionals do not.

> The world of mental health is always a bit of a mystery. I think it, it seems, to exist in its own little special place. (They) purport to hold more knowledge about those things than anybody else. Whether that's true or not, given that it's not an exact science and it is about interpretation.
>
> (Elvira Interview 1)

When probed further about the nature of her local authority's mental health team and how what they do is different to what her generic social workers do, she struggled to identify any key differences.

Despite not understanding how medical staff are trained or what they do, social workers frequently described having faith that something productive would come from medical input. This hope extended to young people who expressed ideas to participants that they hoped they could be "fixed" like one might be cured from a disease. It remained unclear if social workers felt comfortable allowing this expectation to continue or if they themselves gained something from buying into it. The mysterious nature of mental health services migrated into admission criteria as well, similarly related to the above discussion about the arbitrary nature in which services accepted or declined service users. The decision-making process seemed opaque, seemingly to protect the decision-makers, making it difficult for outsiders to question these decisions. One participant described the mental health team who had previously declined a service user as eventually agreeing to provide services.

> …the following week the mental health professionals that had seen her in hospital then came back and obviously did a bit of a U-turn and said, 'oh,

> actually, she was presenting differently to how we've seen her before. Actually, I think she might need a mental health assessment.'
>
> (Sydney, Interview 1)

This statement represents other participants who described situations where it felt that social work had to convince medical services to step in, and they would often only do so once a situation appeared highly dangerous from the social worker's perspective. This might suggest a differing threshold between social work and mental health, a topic which will be later discussed. Irrespective of the reason, social workers routinely discussed "battling" with mental health services to participate or provide services and required the social worker to "build a case" to present to health who would make the ultimate decision.

6.3.4 Theme Conclusion

This theme has explored social workers' understanding of the mental health realm; what structures they used to understand mental health while exploring dimensions of labelling and diagnosis, and how they perceived their role in the professional hierarchy. Social workers described their experiences when collaborating with mental health services, which while mostly frustrating, offered some insights around how the two professions engage. The next theme will explore some of the situations social workers are encountering and the tasks they find themselves doing on a regular basis; in a sense- experiences which change them in some way into social worker/mental health hybrid practitioners.

6.4 Theme III: Metamorphosis (Becoming Something More)

6.4.1 Theme Introduction

This theme describes the cases and people social workers encounter in practice which participants feel fall outside their social work remit but which they find themselves managing anyway. It explores their thoughts, feelings, frustrations and challenges that come with these experiences.

6.4.2 Sub-Theme 3.1: Acute Mental Health Issues

All participants described working with service users with acute mental health issues, meaning these mental disorders were either actively present during the social worker's practice or were in a stage of assessment or post-hospitalisation. Most of these service users were young people, but others were adults either working directly with an adult service's social worker or a young person's parent working with their child's social worker. Common experiences were usually of a crisis nature where it appeared that the social worker was the only professional either available, able or willing to engage- reflecting on the previously discussed theme of social workers identifying as such. Participants encountered a variety of mental health issues, all of which could be organised into three categories: mood disorders, personality disorders, or psychosis. The following discussion reflects these categories.

6.4.2.1 Mood and Anxiety Disorders

Social workers seemed to almost assume they would be working with mentally unwell people and referring to the previous mental health ontology discussion, perhaps do not consider depression and/or anxiety the kind of issues which they are not qualified to support. While the entire set of diagnostic criteria is too lengthy for this discussion, it seems reasonable to assume that the service users described here would meet the two primary criteria described in DSM5 and ICD 11: (a) the presence of marked low mood or (b) loss of pleasure, for more days than not, for a period of two weeks or longer (American Psychiatric Association, 2013). Worth noting is that these are cases of actual diagnosed depression, not the more common self-diagnosed "having a bad day" depression used in everyday more informal parlance.

Similarly, anxiety presented just as commonly, and again, did not consist of young people describing a normal anxious response to a stressful event, but ongoing, clinical generalised anxiety disorder, described as recurrent, excessive distress or worry occurring for more days than not for six months or longer (American Psychiatric Association, 2013). For the most part, these categories of service users did not present as the occasional "one off" or infrequent case- instead, it appears that these concerns were at least always present on the caseload or

represented a significant proportion. One participant describes a routine young person on her caseload, and she makes a point to clarify these cases are not a "low mood" situation but young people who are actively suicidal.

> …so, we work with teenagers and one of our criteria is teenagers with mental health (issues). So, for most of that period, well, all of that period I've had at least one young person who has had some level of mental health issues, and I'm not just talking like, feeling a bit sad. I'm talking young people who've been sectioned, young people who have repeatedly tried to walk to motorway bridges.
>
> (Lita, Interview 1)

Note that she says that teenagers with mental health issues are one population her team manages, not the only one. Later, she elaborates to describe some of the experiences her young people have had and the acute nature of their needs. Given the difficulty social workers described getting CAMHS involved (discussed above) we could only assume some of these situations were indeed serious enough to warrant using the Mental Health Act, described here:

> I have (on the caseload) young people who have anxiety and depression and some of those mental health issues present with those right up to young people who are sectioned, so one of my young people was sectioned for total about 30 odd weeks. I actually think she did 16 weeks then she came out for a month. Then she went back in for 22 weeks.
>
> (Tess, Interview 1)

Given the time periods she described, it's clear this young person was detained under Sec 3 of the MHA (1983) which means she was kept beyond the assessment phase and into the treatment phase. Further, because this person's detainment was not consistent in duration, it suggests that she was at one point considered safe enough to be discharged but then required further hospitalisation. This would further suggest that perhaps this social worker expected her to again deteriorate and would require immediate, crisis led intervention on her part.

Personality Disorders and Psychopathy

Exposure to serious mental health issues transcended beyond crisis or episodic issues and into life-long, permanent presentations. The third most common personality disorder is what DSM refers to as "Borderline Personality Disorder" (Sansone and Sansone, 2011), but which the ICD 11 identifies as "Unstable Personality Disorder" (Tyrer, 2023), and refers to those who experience profound self-esteem issues which manifest in often unpredictable, impulsive and manipulative behaviour. While the determinism debate is too broad to fully explore here, it is worth noting that these conditions would not be expected to change during the relatively short period of time social workers are involved with these service users. These presentations are present in all aspects of one's life (American Psychiatric Association, 2013) and generally cause confusion, chaos and inter-professional disciplinary conflict (Linehan, 1993). While narcissism is the second most diagnosed personality disorder (Tyrer, 2023), psychopathy cannot be present without it but can be diagnosed separately (Hare, 1999). People labelled as psychopaths are defined as those who struggle to experience empathy or express remorse and can be highly manipulative and dangerous (Hare, 1999) and as such, practising emotionally and physically safely with this population requires a highly trained and specialised practitioner. Previously, Dawn described getting none of this specialised training, yet below, describes the frequency with which she routinely sees these challenging service users.

> I've got lots of bi-polar, generalised anxiety disorder, I've got a lot of narcissistic and psychopaths on my case load.
>
> (Dawn, Interview 1)

Dawn is unusual in the sense that she works in a criminal justice capacity and therefore the proportion of those demonstrating psychopathic traits will be higher in her caseload, however, if we assume Hare's conclusion that 1% of the generalised population could be considered clinically psychopathic, it's easily assumed that other social workers will have encountered them without their knowledge, simply because they are not aware of the presentation outside of the usual, Hollywood theatrical, criminal context. Further, given the kinds of work social workers do, it can be easily argued that the chances of a social worker encountering someone with these characteristics are higher than for the average professional.

6.4.2.2 Psychosis and Delusion

Psychosis is defined by behaviours caused by the response to non-existent external stimulation (Morrison, 2014) and can be caused by any number of factors including the onset of schizophrenia, an infection in the brain, acute stress or, as described below, usage of substances with psychedelic properties.

One participant describes working with a father who was using monkey dust, a synthetic hallucinogenic drug common to her practice area.

> …we had a dad who was trying to dig his partner out of the back of their settee with a knife, pulling all the springs out of the back of the settee because he thought she was inside it.
>
> (Christine, Interview 1)

While she was not there at the time of this incident, she worked with him within a child safeguarding context, and he was not in any way detained or under treatment during this time.

Closely related are delusional symptoms which occur when a person holds bizarre or supernatural beliefs, usually of a persecutory nature (American Psychiatric Association, 2013). People can experience delusional symptoms for similar reasons as psychosis. Below, Elvira describes her team working with a young man experiencing a delusional episode:

> But some of the things like pulling up the floorboards and trying to cut off his own electricity because he felt like you know, he was (under) surveillance.
>
> (Elvira, Interview 2)

Ironically, it seemed obvious to this participant that the young man was having a psychotic/delusional event, however when her team referred him to the local mental health team, they declined working with him, citing the substances he was using at the time as the cause of the delusions. He was eventually detained and remanded to a long-term mental

health hospital, and as such, not using drugs, where his symptoms remained. He was eventually diagnosed with schizophrenia. The frequency with which social workers accurately diagnosed someone, often, and in this case contrary to the medical professionals, will be explored in the next chapter.

Working with delusional parents also fell into social work's remit as part of their risk assessment duties in relation to the children. This is arguably the most concerning context in which this overlap takes place because a vulnerable child is part of the equation. Another participant, when risk assessing a father with schizophrenia, describes his delusions and statements of harming his child:

> He (a child's father) had a dream that, you know, the child's mother had died, and she's been murdered and he was actually going to be going to heaven with this young child together in the next six months.
>
> Tomasina (Interview 1)

It appeared that even service users not on one's caseload could still access hybrid mental health services by ringing social service's referral line, as described below. Here, the social worker does not appear to have had a previous relationship with the person and was only involved because she happened to be working the duty line on that day.

> I think she was standing on the street telling people that she needed to get a new dog because her dog had been lost. So, I went out on duty and tried hopelessly to get into her house. I rang her phone there was no response it just rang out and out and out… she would come to the door but not let anybody in any further and she wouldn't go anywhere with anybody. It was when it was very hot. The smell of the drains was overpowering the house, the smell coming out of the house and her cousin thought that she told him her toilet wasn't working.
>
> (Rachel, Interview 1)

These situations are scary for social workers, not only for their own safety, but because of the possibility of the service user causing real harm to themselves or other people. These situations also present professional risk to the social worker because they are aware of the

media attention that comes with injury or death associated with mental health issues, specifically the case of Valdo Calocane who murdered three people while under the care of a local mental health trust for a paranoid schizophrenia diagnosis. As discussed in the background chapter, social workers are acutely aware of the quality assurance role the media plays and the often-unfair way social workers are portrayed. The unpredictable nature of working with mentally ill service users reasonably raises this anxiety and presents a factor which social workers are unprepared to address or manage.

6.4.3 Sub-Theme 3.2: Suicide Risk and Assessment

One of the most anxiety inducing situations any social worker encounters is working with someone who displays suicidal ideation or is actively attempting to complete it (Slater, 2015). Social workers have been documented stating that they are worried about saying the wrong thing and unintentionally encouraging suicide while others are worried that they will be blamed for missing "signs" of suicidality (Regehr et al., 2016). As will be discussed in the next chapter, social workers are not routinely trained to assess suicidality which may further exacerbate anxiety (Kourgiantakis et al., 2022). Four participants shared their experiences in this respect. These experiences range from someone in the process of overdosing to assessing parents expressing suicide ideation.

Below, a participant describes a text message exchange she had with a mother who had just been released from a mental health hospital:

> Well, she messaged back straight away and said, 'I've left and I've taken tablets. I'm just waiting for them to work.'
>
> (Sydney, Interview 1)

Sydney rang the police and advised them of the mother's location.

Another participant received text messages, although she appears to see these statements as "cries for help":

> I will receive messages telling me that she wants to die, so then I have to support with that and work with her around that.
>
> (Tess, Interview 1)

It's unclear in this context on what grounds Tess determines this to be "a cry for help" compared to an actual statement of intended suicide. Presumably it is based on her relationship with that young person and the participant knows how this young person communicates. However, given the limitations text messaging presents, this is clearly a higher risk situation.

6.4.3.1 Risk Assessment via Text Messaging

The medium of text messaging seems worth noting here. Texting is one of the most limiting forms of communication, as the reader is unable to see or even hear the sender, robbing her of visual cues like body language and facial expression or information embedded in tone of voice. Texting may be part of the "relationship" which social workers value, yet here it creates uncertainty and could be used or manipulated to meet the needs of young people (or in the case above, their parents) with underlying caring needs. It is further worth considering that other professionals in the role of assessing suicide do so either in person, or at least over the phone where they would use these other communication forms to inform their risk assessment (Chambers, 2017). Social workers may be exclusive in this respect, and if so, presents another example of unrealistic professional expectations which will be discussed in the next chapter.

Parental mental health is routinely assessed by social workers as part of their standard practice (Brandon M and Thoburn J, 2008), including suicide risk and ideation (McManama O'Brien et al., 2015). Suicidal parents, and the risk this presents to their child(ren) was touched on by four participants.

When assessing risk towards a child:

> Also, the mom there, we've had previous concerns about potential- about the mum experiencing suicidal ideation and I've tried to explore this with her.

(Violet, Interview 1)

When describing her thoughts about why suicide training isn't routinely taught to social workers, she stated simply that she didn't know.

The statement above was made within a risk assessment context, however below, it appears two social workers were working together to actively prevent a suicide. Elvira describes a situation her team managed with a mother on a bridge:

> …and my social worker was talking to the mom, while another one was on the phone to the police…

(Elvira, Interview 1)

Below, it appears that some social workers discuss suicide on a regular basis with some of their service users. This seems to suggest that the social worker remains on a kind of constant alert and tries to differentiate between comments indicating active intent or ideation or somewhere in between. Doing so successfully usually requires years of experience and/or access to empirically supported assessment tools (Chambers, 2017).

> …we've got an 18-year-old with, again, autism and he quite frequently expresses suicidal ideation.

(Sybil, Interview 1)

These experiences provide a range of situations in which suicide is present in the social worker's practice and range from talking with actively suicidal service users or listening to service users express suicidal thoughts. Suicidality will be discussed in more depth in the next chapter.

Other participants described acting as a surrogate mental health crisis line and acting as a liaison between the service user and the police. They performed this service for not only the service users on their caseload, but in the case of young people, their parent as well. This

blurred the social worker's boundary of responsibility, a topic of further discussion in the next chapter.

6.4.4 Sub-Theme 3.3: Psychotherapy Skills

Participants described situations where they found themselves providing counselling/therapy, or what they considered moments that felt outside of their social work remit. They either did this alone or in conjunction with a mental health practitioner. The content of these exchanges included traumatic events such as physical and sexual abuse, and while it's clearly a social worker's job to ask about these events, the boundary between disclosure and trauma work for some social workers is heavily blurred. As is the nature of child safeguarding social work, the social worker is often tasked with investigating instances of abuse and "hearing the voice of the child," a phrase borne out of the Victoria Climbie case and subsequent Lord Laming Report (Ferguson, 2009; Bamford, 2015) yet what is less explored is when this "hearing" turns into something more.

6.4.4.1 Primary Therapist

The below quotes evidence social workers clearly acting in a therapeutic role. While not therapists, these social workers see this kind of work as part of their job function. One participant described a child disclosing abuse to her. The child seemingly has a kind of realisation before going into some detail for which the participant was not prepared to hear:

> …she just looked at me like rabbit in the headlights and just went 'shit'.. And then just the tears came and she said 'it's him'…But you know, she said all the things from what she could remember…I just happened to be that person that that she shared all of that… and it was graphic.
>
> (Sydney 1, Interview 1)

Another participant describes a child she worked with in a residential home during the night:

> Taking what I know about child development and trauma, I kind of made a hypothesis that nighttime was the most difficult time for her. So I had a really

> good conversation with her about how this might be the case and we worked on things to help her try and switch her brain off.
>
> Christine (Interview 1)

In this instance the participant appears to be providing some sort of therapy based upon a hypothesis she's identified. This clearly goes beyond disclosure and enters the realm of talk therapy. Interestingly the participant does not recognise this and describes the work she does as "working on this with her." As discussed briefly above, language here plays a role because other participants used similar linguistic acrobatics to, perhaps unconsciously, avoid the word "therapy," and instead chose other euphemisms such as "exploring" or "supporting" when describing a therapeutic task.

Participants were clear that it was difficult to determine the boundary between "supporting" a service user who was suffering from the aftermath of traumatic events and when this "support" dipped into what might be considered therapeutic "trauma work." This participant described her work as clearly separate from clinical work yet, below, makes a very clinical judgement when deciding how deep to explore the trauma and if this exploration could perpetuate further trauma, further destabilising the young person's presentation.

The same participant refers to the same young person from above:

> And I think I worried that if I tip too far into that trauma, all that (the young person's stability in the residential home) would stop… She'll become so overwhelmed that she wouldn't be able to function in the normal day stuff, and that we don't have any resources to kind of be able to manage that.
>
> (Christine, Interview 1)

Social workers found themselves in the role of "listener" or "support person" but often did not recognise the skills they were using here to be of a therapeutic nature. Instead, they routinely attributed "counselling" to exclusively include structured modalities such as CBT, MDT or EMDR. Lila described listening to a young person talk about her day and her concerns and stated that this was a routine part of her work yet failed to recognise that this is characteristic of a therapeutic relationship or could be considered therapy. When this was

pointed out to her, she stated that it was not therapy because it was less structured, did not have a formal goal or use a modality but then agreed that what she was doing could be considered counselling, but circularly, the only difference is that she is not a trained counsellor.

> You're visiting and they're saying 'Oh, do you know today this has happened' and we haven't set a plan to 'Let's sit down and talk about this aspect of it.' It's just kind of come up but I guess that can happen in formal counselling as well, but I guess you know, we're not trained counsellors.
>
> (Lila, Interview 1)

The notion that this kind of work is not counselling because it's not being done by a counsellor is an interesting psychological trick which seems to work to discredit the participant of the work she is doing and downplays the skills she is deploying. Ironically, this juxtaposes against the earlier complaints that clinical practitioners fail to develop a therapeutic relationship with a service user. In short, it appears that social workers recognise that therapists should develop relationships, but when social workers do this, they don't see it as a therapeutic skill.

6.4.4.2 Therapeutic Advocate

Finally, some social workers found themselves acting in a role which could only be considered a therapeutic advocate. This occurred when participants tried to act as a kind of "go-between," - bridging social work and therapy, usually within the context of encouraging a young person to share something in a therapy session. Sometimes this included the social worker sitting in on actual CAMHS sessions, as per below, and acting as a voice for the young person.

> So I go, 'OK. So, in the car on the way here, (the young person) has said that she's really struggling at the moment with this.' So, I'd say 'Say that to the CAMHS worker. Do you want to talk a little bit more about that? Is there more you'd want to say?' And sometimes she would say 'No, can you say it?' And I'd say 'OK, but you need to stop me if I'm not saying it right.'
>
> (Tess, Interview 2)

Other participants discussed working in conjunction with CAMHS practitioners, with one consultant asking the social worker to pick a diagnosis for a young person while completing an admission form.

> The doctor at Huntercombe (mental health hospital) said, 'You know, what do you want me to diagnose her with? …PTSD, Multiple personalities, disorder, emotional unstable, like there's just a list…. I'm filling this paperwork for transition to try and get a service from adults. …And one of my boxes was around what diagnosis does this young person have? And he literally said, 'right, well, any of these, whichever you feel, will work the best in your form.
>
> (Christine, Interview 1)

This exchange seems strangely ironic given social work's clear boundary of not diagnosing and medicine's position that it is exclusively their right to do so, yet in this instance medicine defers to social work's judgement seemingly for administrative purposes. Diagnosis and its social construction are more fully explored in the next chapter.

Other participants described acting as a surrogate mental health crisis line and acting as a liaison between the service user and the police. They performed this service for not only the service users on their caseload, but in the case of young people, their parent as well. This blurred the social worker's boundary of responsibility, a topic of further discussion in the next chapter.

> ..we've had them (service users) in crisis where they're on the phone and we're ringing the police to get them to go out to their house.
>
> (Lila, Interview 1)

6.4.5 Sub-Theme 3.4: Physical and Emotional Danger

Some participants described moments in practice where the blurred boundary between therapy/mental health management and social work created instances of either physical or

psychological danger. For example, participants reflected on the different resources psychological services enjoyed compared to those of social work.

6.4.5.1 Physical Danger

When visiting service users in prison, Dawn contrasted the information she has about the person prior to the visit, compared to that of her health colleagues:

> They have access to the medical stuff. Whereas I don't have access to medical stuff. I hope I will have access to social work records, if I want access to medical stuff, I'd have to ask a medical professional.
>
> (Dawn, Interview 2)

She went on to discuss how this lack of information put her at a clear disadvantage and created a potential safety issue because she did not know what to prepare for when meeting with the individual.

> I get allocated a court report and all I get is one bit of paper telling me the offense list. That's that. So, when I go, I go in there completely blind. I have no idea what how this person is going to present. I have no idea what this person, anything about them, if they're under a substance, if they're whatever, and I just have to find that out when they sit in front of me. It's like a really scary lottery.
>
> (Dawn, Interview 2)

The physical environment also created a risk for this social worker, who described the space in which she meets potentially dangerous service users as “Victorian,” and “unsafe.” Physical safety for social workers has always been an issue, but it is becoming more visible due to more recent research and larger discussions around safety for other professionals such as ambulance staff and firefighters. Specifically, high profile cases of social worker injury or death include that of Marcia Grant, killed by a 12 year old in 2023, a northern Ireland social worker was stabbed three times by a 16 year old in 2022, and in 2021, a social worker was stabbed eight times by a child in Haringey (BASW, 2024).

Working with adults with dementia presented a risk for another participant, describing an older man with whom she worked and who was eventually sectioned under the Mental Health Act.

> Police had been in, had to break in to let him out at one point. They found a revolver under his pillow. He had a knife somewhere, just, right, loads of risk factors at play.
>
> (Rachel, Interview 1)

6.4.5.2 Psychological Danger

Participants described circumstances they found psychologically distressing but without resources available to help them manage these events. Sydney was exposed to the titles of child sexual abuse videos, an event she found particularly distressing. When describing the support around this, she stated:

> So, after that, like immediately after, we never had like a debrief or, you know… there was no like, 'right, you know, you need to go and have a session with somebody about this.
>
> (Sydney, Interview 1)

However, this social worker did self-refer to a service and receive six sessions which she stated were very helpful. It seems telling that this participant had to seek out her own support because none was provided by her employer.

Criminal justice social worker Dawn describes her typical workload as "high tariff," stating:

> It doesn't feel safe because you're then you're working with really dangerous people…telling you all sorts of stuff and you're coming out of your head spinning, thinking 'What should I do with this? Am I now supposed to report and who am I supposed to report that to? Yeah, you're just, you're not trained for any of this, and you know you're not…You're just told to social work.
>
> (Dawn, Interview 1)

Dawn also experienced what she described as "intrusive thoughts" after working with a child sex offender, an event which prompted her to resign from that role and find another.

Intrusive thoughts are one of the key diagnostic criteria for Post Traumatic Stress Disorder (PTSD) (American Psychiatric Association, 2013) yet it was not clear that either Dawn or her employer recognised this for what it was.

6.4.6 Theme Conclusion

This theme has described experiences through which participants progressively extended their practice into activities more conventionally associated with mental health practitioners, therapists, counsellors and crisis workers. Although participants remained professionally located within social work, these experiences demonstrate an expansion of the social work role as practitioners repeatedly crossed the boundary into mental health-related practice. These experiences included working with acutely, mentally unwell service users, and or their parents where distressing and graphic information was often shared and where suicidality was commonly present. Some participants struggled to identify the boundary between being a supportive social worker and a therapeutic resource. Other participants attempted to explore this boundary while realising that doing so could have potentially negative outcomes for the service user. Other participants found themselves in informal therapeutic roles, either acting as a secondary counsellor or providing diagnosis for administrative purposes. Their attitudes around these experiences ranged from borderline ignorance to discomfort to outright fear for their physical or psychological safety. How these experiences impact social workers and their service users is explored in the next theme.

Viewed alongside the earlier findings concerning social work values, these experiences also suggest a possible role for empathy in this professional transition. Participants did not simply identify gaps in mental health provision; they frequently responded to the distress they encountered by attempting to fill those gaps themselves. Although participants did not always explicitly identify empathy as the reason for doing so, their accounts suggest that empathetic concern, relationship building and a perceived responsibility towards the service user may have made disengagement difficult. Empathy therefore appears to be one possible mechanism through which the social work/mental health boundary became increasingly permeable in practice.

6.5 Theme IV: Aftermath (Outcomes for social workers and service users)

6.5.1 Theme Introduction

This theme explores the outcomes for both social workers service users- for social workers, because of managing situations for which they have little training, knowledge or resources and for service users transitioning from youth services into adult services. Social workers describe burnout and their own mental health issues and describe young and adult service users experiencing poor outcomes. Social workers described poor outcomes for the young people with whom they worked and attributed these to the gaps in mental health services and how trauma was "managed" to maintain care arrangements. Lastly, adult service users were described as placed in inappropriate care homes and/or over medicated.

6.5.2 Sub-Theme 4.1: Outcomes for Social Workers

It seems telling that in the relatively short period of time knowing these eleven social workers (roughly 6-12 months), five of them transitioned roles in that time, two of whom citing acute professional stress as the reason. Participants used words such as "traumatic" and "frustrating" to describe how they feel doing their jobs.

6.5.2.1 Secondary Trauma

Secondary trauma, also referred to as vicarious trauma, is the phenomenon by which a person can be traumatised by hearing about traumatic events, usually in graphic detail and usually on a re-occurring basis (Rayner et al., 2020; Weiss-Dagan, Ben-Porat and Itzhaky, 2022). Not surprisingly, it is usually associated with therapists, social workers, pastoral workers or anyone in the role of working with traumatised people. The symptoms include intrusive thoughts, anxiety, compassion fatigue, poor sleep and other symptoms commonly related to PTSD (Park et al., 2024) and were noted to increase among social workers, particularly post the COVID-19 pandemic (Kranke et al., 2024).

> I think that secondary trauma, which is what I'm realising (I had), was from doing a job like, that I did. Not managing such horrendous things every day, but also the pressures of that role. What was expected as an employee, the caseloads, the workload, the lack of kind of supervision, just all of that

> contributed to a real rundown in my physical and my mental health. And coming home and feeling that absolute burnout.
>
> (Dawn, Interview 2)

Above, she described not just the work and its intensity, but the amount of work. This results in her hating the idea of going into work to the point that it impacts her time off, as the mere thought of returning to work the next week raises anxiety. She also notes the lack of supervision, creating a three-prong attack on her well-being: intense work, too much of it, and lacking support. Interestingly, during the second interview, this participant had transitioned into her new role and was able to reflect on what was happening with her at the time:

> I see how that job was absolutely killing me. And…I was unwell in that job for a year without knowing that I was unwell. But like, really, really seriously unwell and I didn't realise it. And I actually just thought it was the stress of the job.
>
> (Dawn, Interview 2)

This participant described a secondary health, concern in that the stressful nature of her job hid the fact that she was diabetic. When describing her symptoms to her GP, the GP asked her what she did for employment. After telling him, the GP mistakenly attributed her symptoms to work-related stress, and this delayed her accurate diagnosis for a year.

Sydney also describes her work as “traumatic” and cited it as a reason why she needed to take time off work. She attributes this partially to her professional boundaries in the respect of how much she found herself supporting a child’s mother and feels she lost focus on the child. This is a hard boundary to differentiate because a child’s mother’s mental health problems are creating or contributing to the risk. However, below she describes another situation which had an impact on her:

> …and having one girl share a whole load of information about, you know, sexual abuse by a granddad, graphic, just tipped me over the edge. That secondary trauma, vicarious trauma, just couldn't get it out my head, you

> know, thought everybody around me was an asshole, you know, was just constantly in tears. So, I was off sick for two months.
>
> (Sydney, Interview 2)

This is the second participant describing hearing graphic detail of abuse and describing it as "secondary trauma". Yet again, she describes not getting support from her employer and having to pay privately for therapy.

6.5.2.2 Frustration

Frustration was the second most acute emotion and participants expressed ongoing frustration in any number of mental health related areas such as: accessing training, working with mental health professionals (including local authority mental health teams discussed previously), limitations around their practice, the quality of other services and accessing resources for service users and themselves. When describing not feeling comfortable pursuing the traumatic work with the young person in the residential home above, a participant stated:

> It's very, very frustrating when, when you're having to manage it (the young person's mental health issue) as well as a social worker when you're not able to, to try and do something that you think might make a difference. That was really frustrating with her.

Lita discussed how she believed accessing services earlier in someone's life would have prevented the need for more acute services later. This was echoed by several participants:

> …that is quite frustrating when you know if you get it (therapy) early…you can resolve it and not have the presenting behaviours that are more extreme.
>
> (Christine, Interview 1)

Frustration manifest in other areas, specifically when accessing mental health training which she subsequently found unhelpful:

> …the resources are shocking and it's really frustrating…
>
> (Sydney, Interview 1)

Trauma and frustration can be seen like destructive geologic events; trauma as sudden pressure releases like a volcanic eruption or earthquake- easily identifiable and catastrophic. Frustration seemed a more underlying, corrosive, covert element going unrecognised until it was directly questioned or explored. Like rocks on a shore, over time, they can be worn away by constant bombardment and exposure. Working together, it's not surprising that social workers use the phrase "worn down" when describing their experiences.

These accounts also provide a further dimension to the earlier findings concerning empathy. The same capacity to engage closely with and respond emotionally to service users' experiences may leave social workers vulnerable to carrying elements of those experiences beyond the immediate encounter. In this sense, empathy appears within the findings as both a resource for practice and a potential source of emotional vulnerability.

6.5.3 Sub-Theme 4.2: Outcomes for Young People

Unresolved and Suppressed Trauma

Unresolved trauma was the root of many of the reasons participants were working with young people. Participants noted several reasons why traumatic events were not resolved, many of which are described above and relate to the difficult nature of accessing services. Consequently, social workers and other services were instead managing the outcomes of unresolved trauma such as violent behaviour, substance use, poor choices or emotional instability. While the myriads of ways in which unresolved trauma manifests itself is outside the scope of this research, participants held this perception and felt it contributed to several poor outcomes for the young people with whom they worked.

Interestingly, one participant described young people being encouraged to actively suppress their trauma. This usually manifested itself when the young person was in care and the aim was to "stabilise" him or her and avoid a breakdown in the care arrangements or disrupt schooling. It was unclear if this need to "stabilise" was meeting the needs of the young person or those responsible for their care.

described some of the behaviours a person in care was displaying:

> She'd become so overwhelmed that she wouldn't be able to function in the normal day stuff, and that we don't have any resources…to manage that. If she hadn't stopped smashing the home up, she would have had to move to something that maybe looked like secure accommodation. So, we managed her behaviour to a level where she could engage in that kind of normal life.
>
> (Christine, Interview 1)

The word "manage" appears a great deal of the time and speaks to the values underpinning the work with the young person. This participant was very vocal and aware of how this "management" might have met the young person's needs in the short term, as well as those of the service, but as will be explored, had long term consequences that ultimately were not in the young person's best interest. Interestingly, for this young person, her needs were so well "managed" that when she transitioned into adult services, she did not appear to need a high level of support. However, it appears that in the process of containing some of the emotions around trauma, other behaviours and concerns manifested which further complicated the young person's case and presentation and she was ultimately placed into a secure adult accommodation. In short, it appears that for this young person, it was in the best interest of the child services for her to suppress her trauma long enough for her to graduate into the adult services and therefore, impact another service's budget.

6.5.3.1 Substance Use

Participants recognised substance use as a manifestation of unresolved trauma which provided other services a reason to not intervene as previously described. Self-medication with alcohol or other substances to address trauma symptoms is well documented (Sheerin et al., 2016; Costanzo, Santoro and Schimmenti, 2023). Here, participants talked about their perceptions of young people self-medicating with substances to cope with trauma.

> They tried to put some of his behaviours down to his substance use as opposed to looking at his mental health where whereas maybe other young people in

> there (not using substances), they seem more likely to get (mental health support).
>
> (Tess Interview 1)

> It feels to me like it doesn't matter about the drugs. Obviously, that has an impact on people's mental well-being, it does mask things, but just because somebody's doing that doesn't mean that isn't covering up or exacerbating what is a mental health problem.
>
> (Elvira, Interview 2)

Both participants discuss how substances were used to manage or self-medicate underlying social or environmental issues and how, ironically, this provided a barrier to accessing services. Interestingly, none of the participants experienced working with a substance using young person who did not have a history of trauma in their lives, and while this does not describe a definitive cause and effect relationship, it does describe the difficulty they experienced trying get services for this population.

6.5.3.2 Labels, Personality Disorders and Adult Hospitalisation

Some young people's trauma was masked by labels, another mechanism used to "manage" someone's behaviour as the label will often categorise people to determine what level of resources are required to manage their own safety as well as the staff and other patients. This does not suggest that safety should not be the primary focus in a care situation, but as was previously discussed, the label tends to define the person and simplify their character down to one or two words.

> She's had some really bad things happen in her life. She was just labelled as an aggressive, violent person that was being kind of "three-to-one" staff supported. No worker in the team wanted to work with her because she's so challenging and so difficult.
>
> (Sybil, Interview 2)

Participants felt that the “labels” young people held then turned into formal diagnoses later in life. Because personality disorders can’t be diagnosed until the age of 18 (notwithstanding the use of “emerging” personality disorders reserved for adolescents) (Morrison, 2014), young people were seen to “graduate” into adult hospitalisation arrangements where the trauma was perceived to then transition into a personality disorder.

6.5.3.3 Medication

Medication was another medium through which young people’s trauma was managed, but some participants felt that while it was prescribed to treat depression, anxiety, or another medicatable diagnosis, trauma was perhaps the root cause of the issue. Other studies have confirmed this tendency, particular within the context of using the Mental Health Act (Campbell, 2010) but it seems there may be a shortage of research to verify this study’s findings.

> ..for some people they end up in this cycle in which they're almost entrapped on that medication because the root of the issue hasn't actually been supported...
>
> (Lila, Interview 2)

Some participants recognised that medication is clinically used to help service users manage overwhelming emotions to assist with therapy engagement. However, the consensus was that medication was the only treatment available, leaving the underpinning trauma unexplored. Below, Sybil expresses her wishes for what she would like to happen:

> …we will medicate OCD, not ‘it's a response to her trauma. Let's unpick and see what's happened and try and help her develop different coping mechanisms...’
>
> (Sybil, Interview 2)

Children social workers represented most of my sample and most were quite vocal about their feelings concerning young people. Their moods around this ranged from frustration to a kind of resignation that these outcomes were the expected by-products of an imperfect

system and that there was little anyone can do to change it. Similar feelings were expressed by participants working with adults, the next dimension of this theme.

6.5.4 Sub-Theme 4.3: Outcomes for Adults

While only one participant came from an adult safeguarding background, it seems important to include her contribution as it's likely her experiences are not unusual. Similarly to above, medication was used in a way which the social worker felt was counter to her values in that service users were medicated to better meet the needs of the service caring for them and, again like young people, were used to "manage" behaviour. However, dissimilar to the younger population, medication was not always "masking" underpinning emotional issues but instead used in a way which prevented the adult from living the most independent life possible. One participant discusses her experiences with this:

> …he got there and there was a few physically aggressive incidents when he was in the respite placement and the GP dealt with it by basically knocking him out with a shedload of Lorazepan and Zopiclone and I'm just not sure that it was very well managed and I was uncomfortable that he was being sort of chemically managed to a degree in that placement.
>
> (Rachel, Interview 1)

This participant also reflects on some of the conditions she found in some of these homes which were less than ideal:

> ...on the third floor of an old building that isn't fit for purpose, occasionally being looked into by a care worker that doesn't speak the same language as you do.
>
> (Rachel, Interview 1)

These experiences seem to reflect a similar theme to those experienced by children social workers, that of less-than-ideal resources managed by the only means available- in this case, medication, with the social worker acting somewhere between active participant or helpless bystander. Below, she comments on how she feels about this:

> They're just working with very limited resources that don't match what people's needs are. And then there's both health and social work trying to keep him and other people safe… That's the system, though. And I went on leave after that for a week on my holiday and when I came back, I thought 'am I complicit in a really shitty system here?'
>
> (Rachel, Interview 1)

It's interesting that she uses the word "complicit" which implies a less than active role, but still condoning practices which she feels are not in-tune with her social work values. Yet she recognises, similarly to previous participants, that she is powerless to address these larger systemic powers, leaving her with the only option but to do the best she can.

While perhaps not rising to the level of "moral injury," there is a clear sense of "moral distress," a term first coined by Andrew Jameton in 1984 (Jaskela et al., 2018) and describes the emotions arising from the inability to do the right thing because of organisational limitations. While Rachel recognises these factors are out of her control, her mere participation in the process raises moral anxieties for her- presenting a scenario in which she feels she must choose between not doing anything (by not participating) or pursuing an action which has its own consequences for the service user.

Another participant described a similar moral murky situation. While not working in an adult social work team, Tomasina described her work with a father with schizophrenia. In this situation, he was prescribed medication to treat it and failure to do so was one of the reasons the child was removed. However, confusingly, she later stated that one of the requirements for him to have his child back was that he would not be required to need medication. Because people with schizophrenia will need medication for the rest of their lives, this is an unfair and unrealistic expectation and appears to be an example of "goal post moving." In her case, it was not clear if Tomasina fully recognised the moral implications of this, raising the question if moral distress can occur if one is not fully aware of the implications of their own actions.

6.5.5 Theme Conclusion

This theme has explored the results of social workers providing services, attempting to provide services or participating in under-resourced services. It also explored some of the impacts seen on young people and adults, some of whom have experienced less than ideal outcomes. Social workers described feeling burned out, worn down or traumatised by some of their experiences with little to no resources to address their feelings. They described seeing young people migrate from labelling institutions where their trauma was suppressed and "graduating" to inpatient adult services where these labels became formal diagnoses of personality disorders. These outcomes were frustrating for social workers and made them question their roles and values.

6.6 Summary of Key Findings

Social workers have strong values around social injustice and inequality and feel skilled to address these issues with service users. They worked with a high proportion of mentally unwell service users who exhibited symptoms of depression, anxiety, mood disorders, personality disorders and psychosis, some of whom were emotionally or physically dangerous. They commonly found themselves engaged with an institution which de-emphasised the social origins of mental health issues in favour of a more "treatable" medical one. Consequently, social workers felt de-valued in clinical discussions and case planning, but also found their views and insights used to inform "medicalised" reports. Paradoxically, social workers found themselves performing what could be considered psychotherapeutic tasks, ranging from counselling, exploring trauma or acting as a second therapist either because mental health services were not available or because young people did not want to engage with a CAMHS worker. Social workers, despite their remit not to do so, also provided diagnostic language, sometimes formally via a medical professional, and occasionally more accurately than their medical colleagues. These experiences left some participants feeling burned out, exhibiting symptoms of secondary trauma and described poor outcomes for service users who struggled to get the mental health services they needed.

6.7 Conclusion

This chapter has explored the themes derived from 22 transcripts. They have been organised into four main themes which describe a social worker's journey. Theme I: Being a Social Worker explored some of the participants' personal and professional values, why they entered the profession, their training, and how they view themselves within a larger service system, particularly their relationship with the medical field. Theme II: The Approach described how they conceptualised mental health, some of the mental health issues they encountered in practice, how they interacted with other services and their perception of those services. Theme III: Metamorphosis described the participants actively engaging with mentally distressed service users, how they attempted to fill a perceived gap in mental health services and some of the dangers they encountered. Theme IV: The Aftermath described the outcomes of all those involved, including the outcomes social workers saw for their child and adult service users. For social workers, this included frustration and mental burnout, while for children, it meant the suppression of emotional trauma which translated into adult mental health issues. For adults, it meant being over-medicated in a less-than-ideal care environment.

There are several overlapping and interplaying dynamics present in these social workers' professional lives; the overlapping professional and personal values, the complexities of how these manifest in a neo-liberally driven industry and the trauma experienced both personally and secondarily. The next chapter will more fully explore these themes and analyse some of the deeper meaning present in these experiences.

7 Analysis and Discussion

7.1 Introduction

Building on the previous findings, this analysis and discussion chapter explores how personal identity, professional values, organisational pressures, and gaps in mental health knowledge converge to shape day-to-day practice. This chapter examines how contemporary social workers in the UK navigate the increasingly blurred boundary between social work and mental health practice. The data reveal a profession deeply rooted in empathy and values-driven motivations, yet simultaneously constrained by fragmented services, limited training, and the pervasive influence of neoliberal, process-driven systems. These tensions give rise to a series of paradoxes: social workers who feel compelled to respond to acute mental health crises despite lacking specialised training; practitioners who challenge diagnostic labels on ethical grounds yet unconsciously work within clinical frameworks; and empathetic professionals who absorb profound emotional burdens while receiving little reflective or therapeutic supervision.

Using boundary-spanning theory and the social/medical model debate as overarching conceptual anchors, the chapter traces how social workers make sense of mental health presentations, navigate unclear professional borders, and manage the moral, emotional and clinical dilemmas inherent in their roles. The discussion also interrogates established models such as the "toxic trio," arguing that contemporary practice realities demand a fundamental re-thinking of how mental health is conceptualised within social work. Ultimately, this chapter builds towards a proposal for a socio-therapeutic model of advanced social work practice, referred to here as a "socio-therapist," capable of bridging the widening gap between statutory social work and mental health provision. Through this analysis, the chapter contributes new theoretical insights and practical implications for understanding how social workers operate within, across and beyond the boundaries of current UK helping systems.

7.2 Social Worker Identity

Who social workers are, as a product of their personal background and professional training, sets the stage for how they may interact with distressed service users and mental health services. When exploring personal identity, participants described several reasons why they entered the social work profession, chief among them were values-driven motives evidenced by phrases like "making a difference" and "helping" vulnerable people. These statements echo Petersén (2024) who used folk logic and Mills' "vocabularies of motives" (Brissett, 2006) to analyse how Swedish students verbalised their values. Additionally, Stoltzfus' (2017) study in the Federation of Russia states similar value-driven motives suggesting a global acceptance, albeit in European cultures, of these altruistic motives. Both papers describe the sources of these values as rooted in participants' personal experience, including childhood contact with social workers and friends and family who are social workers. In the UK, the 2023 report "The social work workforce" published on behalf of Social Work England (SWE) quantitatively reflects these findings. This thesis, contextualised with the mental health intersection, contributes a qualitative perspective to this established discourse.

Most importantly, and echoing participants' statements in this study, were traumatic family experiences including growing up with parents with mental illness, drug abuse or domestic violence (Stoltzfus, 2017; Petersén, 2024). Trauma often informs lifelong values and can act as a catalyst for occupational choice later in life (Tedeschi and Calhoun, 1995), instilling a strong personal connection with her chosen profession. However, the reverse is equally important; the professional values echo her personal ones, providing a legitimate and recognised outlet where her personal values manifest themselves through socially recognised and legitimate professional actions. Some participants spoke quite passionately about their social work identity, suggesting that perhaps unlike other professions, social work identity not only informs the job, but the nature of those who do it. From a purely values standpoint, "I am a social worker" means more than "I am a salesclerk" or "I am an engineer." Social work is not alone in this regard and the personal/professional values intersection has been well explored in teaching, nursing, and medicine (Ellis and Hogard, 2021). Previously explored through the lens of another helping profession, occupational therapy (Dige, 2009), these statements might say something about people's skillsets, but we know nothing of their values.

Indeed, social work attempts to differentiate itself from other professions by its values-notions of self-determination (Kirzner and Miserandino, 2023), unconditional regard (Wilkins, 2000) and relationship building (Ruch, 2018) drawing a specific kind of person into its domain and the work therein acts as an expression of who she is as a person. This self-expression demands manifestation through practice, bringing with it the challenges and frustrations more fully explored below. Out of all the key social work values and skills, empathy existed as a defining characteristic and within the context of this research, deserves further exploration.

Empathy and how it is used, experienced and manifested, presented numerous short and long- term dilemmas for participants. Existing at one end of the empathy spectrum, one participant, when considering what the "psychopath" label meant for her, dismissed her own safety and was more concerned about how it might impact the labelled service user. Staying with the psychopath example, another participant placed her own safety as the primary consideration; empathy for the labelled was not even considered. Other participants experienced empathy at every point in between, and returning to the boundary spanning concept, seemed to be one of the driving forces for participants to venture further outside their boundary.

The phenomenon previously described as "constant availability" is another example. Participants felt the need to be available to service users because "no one else" (children and adult services) was. One participant, while on duty, went to the home of a clearly mentally unwell service user because no one else was available, only to later call for an ambulance. Another participant, again claiming unavailability of adult mental health services, was essentially acting as a personal mental health nurse for a child's mother. These examples suggest that the empathy value compels the social worker to respond, irrespective of eligibility criteria, organisational mandates or physical and mental safety considerations, to the needs of those on her caseload, their relatives, or anyone with whom she happens to connect during her working day.

A second example of empathy-driven action concerns not just with whom participants communicated, but the medium used when doing so. Because some service users, mostly

young adults, were more comfortable with smartphone-based communication, participants found themselves in the professionally risky role of assessing suicide ideation via short and truncated text messages. Despite not having access to the person's body language, physical presentation, facial expressions or tone of voice, participants appeared to assume she should engage in this exchange – the notion of declining or requesting the service user to present in person (the general practice in clinical mental health settings) did not seem to occur to her. Suicide assessment via text is not unheard of, and given the increase in smartphone usage, particularly among teens, has been the subject of recent research (Forte et al., 2021; Côté and Mishara, 2022; Morgan et al., 2025). However, the professionals in these studies had all received some form of suicide assessment training, some of which involved the specific texting app being researched. Contrastingly, participants in this thesis stated they had never received any basic suicide assessment training, much less via text messages.

These short-term experiences seem to represent, albeit on a smaller scale, what Bar-On (1994) refers to as "the threadbare areas" when describing social work identity, in that social work fills the gaps between other, poorly-fitting services. This notion was confirmed by another participant, a service manager, stating that social services, due to statutory legislation, do not enjoy the health services' practice of defining their own eligibility and closing criteria. Lastly, participants discussed the constant anxiety of a death or serious injury becoming a national discussion point, also echoed by Slater (2015). All these factors work in tandem with the underlying empathy value to keep social workers engaged, using any medium and under any conditions.

Despite the skills these tasks require, participants used language which denoted how they perceived their role within the larger context of the helping industries. In 1902, the sociologist Charles Horton Cooley coined the following: "I am not what I think I am, I am not what you think I am, I am what I think you think I am." Sometimes referred to as the "mirror man image," or "the looking glass self" (Siljanovska and Stojcevska, 2018), it describes the notion that our identities, including our professional ones, are formed by our internalisation of what we believe others perceive us to be. Participants reflected their beliefs of how others viewed them via the language used when describing their role, e.g. "I'm *just* the social worker," a phrase laden with the assumption that other professionals view themselves as more qualified

or skilled than the social worker. The ease with which this phrase rolled off participants' tongues might suggest that this subservient role has been well internalised, and unconsciously at that.

However, this contrasts with data from other literature. As explored in the literature review chapter, Agnew's (2011) study of social workers employed in a bereavement service described some of the more complex cases being referred to the social worker, suggesting that social workers have skills and knowledge that others do not. Because my study is focused on the mental health intersection and introduced the medical model into the equation, the "just the social worker" phrase and its subservient implications may be more common when medical professionals are involved- again reflecting socially accepted and embedded cultural medical/social hierarchy. This dynamic has been explored but mostly within multi-disciplinary settings (Abendstern, Wilberforce, et al., 2021; Cootes, Heinsch and Brosnan, 2021), and inter-disciplinarily, both in the United States (Fantus, Cole and Hawkins, 2022) and in the UK (Devaney, 2008). However, this thesis indicates this boundary may be more superficial and blurred than existing literature suggests.

7.2.1 Empathy as a Boundary-Spanning Driver

The findings suggest that empathy is more than a social work value or interpersonal skill but may function as an important driver of boundary-spanning behaviour. Participants described empathy as central to understanding "what's really going on" for service users, while other accounts demonstrated how this understanding translated into relationship building, continued availability and an apparent reluctance to disengage when needs remained unmet. Empathy's significance therefore appears to lie not simply in the social worker's capacity to understand another person's distress, but in the sense of responsibility which can follow that understanding.

This provides a mechanism through which the findings concerning social work identity can be connected with the boundary-spanning practices previously explored in Chapter 6. Empathy enables the social worker to recognise distress and unmet need, but recognition creates a dilemma when the service formally responsible for addressing that need is

unavailable, unwilling or unable to respond. In these circumstances, participants did not consistently respond by withdrawing to the limits of their own professional remit. Instead, they remained involved, advocated, liaised between services, responded to crises and, at times, undertook activities which increasingly resembled mental health practice. Boundary spanning therefore appears not simply to result from poorly defined organisational boundaries or gaps between services, but from the interaction between those structural conditions and a professional identity which makes leaving an identified need unanswered particularly difficult.

Importantly, empathy should not be understood as inevitably producing boundary spanning. Where appropriate services are available, the empathetic response may be expressed through conventional social work activities such as advocacy, referral, relationship building and interprofessional collaboration. The distinction emerging from these findings is what occurs when those routes fail. Empathy may initially draw the social worker towards the boundary, but service gaps create the conditions in which she crosses it. In this sense, the boundary spanning identified within this research can be understood as both supported and necessitated**:** supported boundary spanning occurs through legitimate collaboration and connection between professional domains, whereas necessitated boundary spanning occurs when the social worker extends her practice because an identified need would otherwise remain unmet.

This interaction also helps explain why boundary spanning can become personally costly. Rachel's description of herself as "overly empathetic" is particularly illuminating because she simultaneously recognised the need to use legislation to contain her emotional responses. Elsewhere, participants described frustration, burnout and moral distress when they were unable to achieve outcomes which aligned with their personal and professional values. Empathy may therefore be paradoxical in nature because it facilitates the relationships and understanding upon which effective social work depends, while simultaneously increasing the likelihood that practitioners will feel responsible for needs which sit beyond their formal remit. When organisational boundaries prevent an adequate response, the social worker is left with an uncomfortable choice: respect the boundary and

leave the need unmet, or cross it and assume responsibilities for which she may have neither specialist training nor organisational support.

This provides a deeper explanation for the permeability of the social work/mental health boundary identified in this thesis. The boundary is not crossed solely because social workers lack clarity about where their role ends. To the contrary, participants were often very clear about activities which formally sat outside their professional remit. Rather, the findings suggest that they sometimes crossed these boundaries despite recognising them. Empathy, interacting with relationship-based practice, professional values and gaps in mental health provision, appears to create a form of pull towards the unmet need. The resulting boundary spanning is therefore not simply an organisational phenomenon but also relational and emotional. Simply stated, the very qualities which participants identified as making them good social workers may be the same qualities which make remaining within clearly demarcated professional boundaries difficult when confronted with a distressed person whom nobody else appears willing or able to help.

7.3 The Social Work/Mental Health Boundary

This blurred boundary manifested in the data in different ways. All participants were very clear that they were not qualified to diagnose patients. Yet one participant reported that health used her insights and observations, medicalised the language and produced the more authoritative diagnosis. This is an apparently long-standing practice, discussed previously in the literature review chapter (Hood, 2015), describing this as occurring quite frequently. This suggests that social workers are indeed "diagnosing," vis à vis a medical practitioner's report, but until the environmental issues are translated into medical language, the social worker is only qualified to describe "what's going on." Another participant described a doctor asking her which diagnosis should be included in a service user's report. While this last example seemed to appear within a purely administrative context, it contributes to the argument of an underlying linguistic game played within the industry: "diagnosis" can act as a purely medical product directing treatment, a quick shorthand to explain a set of behaviours (irrespective of social or biologic origin), a label to justify and fund further services or in most

cases, a combination of all these goals. Aside from operating from within a purely medical context, it therefore seems that social workers, having access to service users' homes, family and general environment, are indeed able, if not more informed than medical colleagues, to provide insights into lives which can easily explain the impacting stressors and traumas. These social insights do not need to be categorised as "diagnoses" but should still carry with them the same authority and intervention-directing weight as a medical assessment. What this might look like will be discussed in more detail last in this chapter.

The "diagnose or not to diagnose" conundrum raises further questions about the social work/mental health boundary, asking the rhetorical question: in which domains should social work remain and where should it never go? Historically and currently, social work roams unobstructed when addressing substance abuse and domestic violence issues, yet when addressing mental health concerns which might underpin or contribute to both, somehow social work is supposed to withdraw unless invited in or when providing useful insights. Faced with this perplexing paradox, the social worker is pushed into a kind of mental dissonance where no solution seems adequate.

As previously discussed in section 2.2.4.1 Neo-liberalism, these linguistic acrobatics are a result of the helping industries' neo-liberal constructs; measured and delivered via quantifiably defined outcomes (Dustin, 2016; Hughes and Wearing, 2022). For service users unaware of these pressures, this creates a misleading and potentially psychologically dangerous minefield, resulting in service users and their parents and family using them as they wish. As Hood (2015) is described previously in the literature review, parents will use diagnostic labels as ways of absolving themselves of responsibility- a phenomenon also echoed by participants. Further, participants discussed young people using these words to form their identities and ways of managing self-expectations, also reflected in the literature (Mogensen and Mason, 2015). There is a growing discourse around pathologisation, and it falls into two camps: Literature maintaining that youth are being over pathologised, (sometimes referred to as "disorderism" (de Ridder and van Hulst, 2023; Van Hulst et al., 2025)), and those who maintain that the increase in diagnosis reflects better recognition of legitimate and debilitating disorders (Skovdal, 2025). Between these ends of the spectrum resides the practice of "decontextualisation" (Van Hulst et al., 2025) whereby an individual's

circumstances and/or environment are ignored in favour of an internal, or as I coined in the literature review chapter, an "endogenic" cause of their distress. Irrespective of the ongoing debate, this research highlights the social worker's role in this complex web of systems and linguistics. How her role in this manner could be better used is a topic discussed later, but suffice it to say, her own understanding of these terms and how mental health is framed requires a deeper discussion.

Participants, when explicitly asked to define mental health, provided a range of answers, most of which generally revolved around vague notions of "wellbeing," or "wellness," language reflecting a broadening societal discourse around an apparent increase in overall unhappiness and dissatisfaction, particularly among young people (Hou et al., 2021). However, from a clinical standpoint, all DSM diagnoses contain the phrase "clinical significance," Robert Spitzer's way of differentiating between normal human experiences and a "disorder" (Horwitz, 2021). While conditions of a psychotic nature were clearly outside her remit, symptoms of depression, anxiety, autism, ADHD and some personality disorders which arguably exist on a severity spectrum, were much more difficult to discern. When probed further, participants unconsciously but intuitively used the "clinical significance" benchmark, but lacking the clinical language, substituted their own, stating "gut feelings" or "being worried" about the service user. Often referred to as "mental health literacy" (Morgan, Ross and Reavley, 2018), a broad term capturing how one understands mental health intricacies, these internal gauges are based on her own values, her personal mental health ontology, her experience, knowledge, confidence and all other manner of personal factors informing how she differentiates between underlying unhappiness and an acute condition. This suggests that mental health does not exist as a clearly boundaried, objectively identified entity but instead exists as an underpinning, permanent presence, informing and contributing to all behaviour. At the time of this writing, this research project seems to be the first time social workers were directly asked to qualitatively describe what internal factors inform their personal mental health ontology.

Basing the question within the medical/social debate, all participants were asked to explain their understanding of what causes mental health issues. Interestingly, participants demonstrated a lack of concern about the source, instead seeing the aetiology as something

with which they did not need to concern themselves. Driven by her strong sense of empathy, she saw a person in distress, albeit because of a biological issue or environmental (and it should be noted that no participants encountered a service user whose issues seemed purely biological) and therefore wished to help in whatever way possible. Therefore, relying on the medical/social model proved unhelpful here as participants viewed "clinically" significant issues resulting from a combination of social and biologic factors, commonly using phrases such as "a predisposition for" or "a combination of things." This is not a criticism and is known to happen with other populations including clinicians and lay people (Ernecoff et al., 2026). The frequently used "chemical imbalance" argument was mentioned by several participants, but when probed further, none were aware of its origin, the research supporting it or its criticisms. Again, social workers are not alone when behaving like this (Schroder, Russman Block and Moser, 2024) which speaks to the widespread nature of clinical language being used without an informed knowledge base (Pisl, Bucur and Podina, 2025).

Intuitively, it might be expected that participants' mental health knowledge could be easily traced to their pre- and post-qualifying education. Surprisingly, this was not the case. Participants discussed the lack of mental health training in their undergraduate courses, and the training they did get occurred during their practice placements. Social work education appears to consider mental health a "separate" concept, something that one can specialise in, like a practitioner might specialise in working with older adults or youth offenders or that mental health is something reserved for others; specialists, other trained- not social workers (Walker, 2010). For social workers who wished to pursue further mental health training, this was also difficult to access and reserved for those who specifically sought it out. One participant, studying for her AMHP training, reflected that some of the material to which she had access should be disseminated to all social workers, but was unable to explain why this seemed impossible.

Excluding suicide, there are a variety of reasons why general mental health is overlooked in generic social work education, and the issues are not limited to the UK. Gaps in accreditation standards (Whitaker et al., 2023), variability and insufficiency in curriculum content and training methods (Kourgiantakis et al., 2023), limited faculty support and challenges in defining and integrating behavioural concepts (Padykula, Berrett-Abebe and Haven, 2020)

were all highlighted as reasons that make mental health difficult to integrate into social work education. The issue may also be rooted in social work's history. Social work's identity as "non-expert" or "expert" without the capital "E" had set it aside from other professions (Bamford, 2015). Social work has historically drawn ideas, practices and theories from other older and perceivably more legitimate professions, reserving members of those fields as the "Experts." Consequently, social work has adopted a kind of "jack of all trades" identity whereby it sees itself competent in many areas but lacks the research impetus to become truly specialised in any one of them (Cootes, Heinsch and Brosnan, 2022). Like a multi-functional kitchen appliance, because it's designed to do many things, it doesn't do any of them particularly "Expertly." In the UK, the siloed nature in which mental health is treated, as a primary territory for the NHS, exacerbates this dichotomous thinking, further removing social work from the mental health industry. Interestingly, some of the models social work uses also reflect this separate nature, specifically the "toxic trio" model, more fully discussed in the key contributions section 7.7.3.

7.4 Social Work and Determinism

Personality disorders resided in another mysterious clinical and highly controversial realm. Largely informed by labelling theory (Feldman and Freedenthal, 2006), some participants were uncomfortable with how these phrases were used, particularly "Emerging Emotionally Unstable Personality Disorder" reserved for those under the age of 18 exhibiting symptoms of the adult version, "Emotionally Unstable Personality Disorder" or "Borderline Personality Disorder" as it is known in the United States via DSM5 (American Psychiatric Association, 2013). The diagnosis seemed to provide participants with little insight about service users and, as discussed previously, was considered a mechanism by which further services could be provided. No participants were aware of the criteria needed for EUPD but recognised that it had something to do with suicidality and self-harming behaviours. What seemed striking was the lack of interest or concern, or even curiosity, as to what this term meant and if it might have any bearing on her work with the service user. Like the psychopath label, more concern was expressed about what the label/diagnosis meant for the service user and less about how it might inform the participant's approach or practice. So far, much of this discussion has centred around the tendency for health to overlook social work's contribution to the clinical

landscape, but here, the opposite seems relevant- what social work can take from health, particularly when it concerns physically and psychologically dangerous service users.

If we accept that roughly 1% of the general population demonstrate psychopathic traits (Hare, 1999), it seems reasonable to suggest that any social worker is likely to meet a someone potentially meeting this criteria during their social work career. Only one participant routinely encountered psychopathic service users, and because of the nature of her work, had developed an entirely different perspective of this presentation and was very vocal about the danger they can present to those who are not prepared or trained. Physically dangerous, but more concerningly also psychologically dangerous, those demonstrating these traits can be highly manipulative, deceitful and misleading, creating chaos and discord around them (Hare, 1999; Blair, 2003; Stout, 2005). As such, interactions with them must be done cautiously, mindfully and be planned and prepared. Failing to do so can be emotionally and psychologically dangerous (Kennedy, 2021).

While not on the same level or pathologically like those demonstrating psychopathic traits, those with profound personality disorders can be equally daunting for professionals to support (Darongkamas et al., 2020). Underpinned by profound low to non-existent self-esteem, service users diagnosed with EUPD can also be highly manipulative, not for malicious entertainment like the psychopath, but out of a profound unmet need to be recognised and valued (Kernberg, 1995; Yeomans and Levy, 2018). Irrespective of the reason, social workers not familiar or prepared for this presentation can find themselves surrounded by chaos and confusion orchestrated by service user diagnosed with EUPD. Per DSM and ICD-11, these behaviours are pervasive and present in all aspects of the individual's life. The nature of these disorders again challenges the notion that "mental health" somehow sits apart from other concerning features of a person's life or the risks they may present for a vulnerable person.

There are several valid reasons why social workers feel the need to challenge these labels. Social work values suggest that instead of embracing these clinical terms and potential insights they might bring, in concordance with social work's mission of addressing injustice and marginalisation, we should instead challenge the deterministic assumptions they make about service users (Torales et al., 2023). Historically, social work has successfully done this,

particularly when the mental health industry has reflected gender (Bernal Arenas et al., 2025), racial (Jegarl et al., 2023) and homophobic (Kantor, 2014) bias. Further, social work generally takes exception to determinism and prefers to believe that no matter the difficulty, anyone can change with the right kinds of support- that if society changes or certain environmental factors were addressed, the real, true and kind person beneath these destructive behaviours might emerge, and by labelling them, we are only further perpetuating the marginalisation they have experienced. This then sets up the social worker for yet another paradoxical experience implicitly evidenced in the data- recognise the label but try to somehow navigate or bend around it: Use it, but don't understand it. Understand it, but don't believe it. Failing these options, simply ignore it.

Alternatively, social work could take a more balanced and nuanced position concerning those diagnosed with personality disorder or labelled psychopaths. Grounded in a more balanced and deeper understanding of mental health's social constructs, social workers could better recognise that not every diagnosis is equally assessed or presents the same risks. Ethical clinicians do not use these terms inconsiderately and recognise the lifelong stigma they can bring. If social workers encounter those so labelled, common sense suggests an adjustment to practice to promote psychological and physical safety; doing so does not ignore the potential stigma or value-based human rights recognition but may act as an indicator to the social worker that more caution may be required.

The deterministic nature of psychopathy may be hard for social workers to embrace. Because psychopathy is rooted in brain function (Blair, 2003), there is little hope this person will change. Again, we encounter a disconnect when assuming that one's mental health sits away from or in conjunction with other areas of their lives. Because psychopathy is understood to be caused by an individual's malfunctioning or under-performing amygdala, this condition will underpin many of their behaviours and for some, like one participant, will be stand out as the service user's key defining characteristic. It would be impossible to therefore somehow separate off this part of the person's presentation, to be treated or addressed by another professional.

This strong deterministic assumption may not be true for EUPD service users because aetiology is understood to be rooted in childhood experience, not hard biologic brain structure. First developed by Marsha Linehan in the late 1970's and later recognised as a distinct form of therapy, Dialectic Behavioural Therapy (DBT) is the usual treatment modality identified to treat those diagnosed with Borderline Personality Disorder (BPD) (Maxmen and Ward, 1995), or as it's known in the UK via ICD-11, Emotionally Unstable Personality Disorder (EUPD). Despite the frequency with which participants mentioned DBT, none could explain what it was, how it worked, where it came from, why it's used or how successful it is. While EUPD is considered treatable, it is highly difficult to do so (Kernberg, 1995; Yeomans and Levy, 2018). Irrespective of the treatment, social workers would do well to understand the basics of this presentation, adjust practice accordingly and prepare themselves emotionally when encountering them.

When explicitly asked, DBT was only one of several therapeutic modalities participants encountered in practice. CBT and EMDR were the other most frequently mentioned, but no participants could explain the nature of these treatments. When more fully explored, participants considered these modalities as "counselling" and "therapy" because they were structured and took place in a clinician's office. Interestingly, participants failed to recognise their own therapeutic skills, even when pushed to do so. "It's not counselling because I am not a counsellor," remarked one participant- an odd circular logic which ignores the very existence of any permeable boundary between the two professions. What happens in a therapy office remained a mystery to some participants, existing as an almost magical and clearly incomprehensible experience outside the realm of social work. Others recognised that most therapy consisted of talking and listening – yet still insisted that therapy does not take place in social work. Exploring this self-constructed mental differentiation sits at the heart of this research project. Where this boundary lives, and the nature of its curves and contours is defined by the social worker; an intricate fabric made up of personal beliefs she has about what mental health is, what her role is, her confidence in her skills and knowledge and how she conceptualises therapy. Irrespective of how she views herself (social worker, therapist or something in between) and despite her knowledge or skills to fill this role, she had plenty of opportunity to do so, describing several reasons why service users were not getting the mental health support they needed: long wait times, arbitrary eligibility criteria or case

closing criteria and poor quality of service. Consequently, it's worth exploring the disconnect between clinical counselling and what social workers are doing in this capacity.

7.5 Social Worker or Psychotherapist?

Psychotherapy is recognised as an emotionally taxing profession (Rothschild, 2006; Sodeke-Gregson, Holttum and Billings, 2013). Psychotherapists reflexively make clinical decisions to therapeutically lead a conversation, actively listen, observe tone of voice and body language while remaining mindful of their own (Nelson-Jones, 2016). The patient/therapist relationship can be intense, intimate and needs to be handled with care, compassion and caution for both patient and therapist (ibid.). Consequently, psychotherapeutic work is highly boundaried and structured. Psychotherapists have strictly set times when they see patients, and the work is done in a controlled, prepared space. The therapist is clear on their role and always mindful of any potential parallel relationships. The therapy has a goal, agreed upon between the patient and the therapist. The relationship is generally structured by an introductory period, reaches a point of maximum productivity, and formally concludes.

In the UK, clinical supervision is mandatory for accredited members of the major UK professional bodies, e.g. the British Association of Counselling and Psychotherapy (BACP) and the National Counselling and Psychotherapy Society (NCPS) who require their members to attend at least 1.5 hours per month (British Association for Counselling and Psychotherapy, 2025; National Counselling and Psychotherapy Society, 2025). Therapists receive regular clinical supervision to help manage transference, any secondary trauma issues and promote the therapist's skills and professional development (Guiffrida, 2014; Kangos et al., 2018).

During their work, participants found themselves engaging in what could only be described as psychotherapeutic work with service users where suicidal ideation and past and present trauma were routinely discussed. However, participants described none of the above luxuries. Instead, the nature of these conversations was controlled by the service user- when they took place (service users did not always discuss these issues, but were never discouraged from doing so) and where (home, car, walking in public or wherever the social work visit took place). While participants controlled when and where they met with service users, they were

never sure if traumatic events would be discussed or how (thus turning that interaction into a therapeutic encounter), what the end goal of that discussion might be or when it might conclude. Further, how long the relationship lasted was determined by other factors outside participants' control, e.g. when the case was closed or passed to another social worker. Lastly, participants described a lack of supportive supervision around the emotional burden some of these discussions created. Instead, supervision sessions focused on workload and process-driven concerns which participants stated left them feeling unsupported, anxious and unsure what to do with the emotions generated from these encounters.

The neoliberally process-driven nature of contemporary social work has increased the likelihood that social workers do not find supervision emotionally supportive (Hafford-Letchfield and Engelbrecht, 2020) and supervision has taken on an even greater process-emphasis during the recent and current state of austerity, with more pressure on social work teams to evidence productivity with fewer and fewer resources (Pawar and Anscombe, 2022). This thesis contributes to this global discussion by arguing that other services, namely mental health services experiencing the same pressures, are adding an additional emotional burden on social workers. This perspective addresses a different dimension, not of *quantity* of work as measured by time, but the *quality* of that time and how emotionally impactful it is. This idea seems less explored in academic circles, and given the outcomes later described, warrants further research. In the meantime, and in typical social work fashion, perhaps other disciplines, namely psychotherapy, can be mined for useful ideas and practices to first recognise and then address the traumatic nature of modern social work. Participants described their thoughts and feelings about all these experiences: the frustration they felt when working with health services, listening to trauma and graphic tales of abuse, the unsupportive nature of social work supervision and the uncertainty and lack of confidence to support profoundly unwell people. Using the existing theoretical framework, the following discussion examines their reflective thoughts on their own mental health and the outcomes for those they are trying to help.

The term "moral distress," also referred to as "ethical distress" (Fenton, 2015) was first coined by Andrew Jameton in 1984 in relation to the stresses found in the nursing field when medical staff failed to provide the care quality they wanted due to lack of resources, organisational

obstacles or other environmental barriers (Mänttäri-van Der Kuip, 2016; Papouli, Marson and McKinney, 2019). Like other concepts, e.g. boundary spanning, it has migrated into other disciplines and institutions, e.g. education (Ganske, 2010) and law enforcement (Papazoglou and Chopko, 2017) where ethically and morally driven professionals find themselves acting in ways counter to their personal and professional value systems due to circumstances outside their control. Moral distress is not the same as "moral injury," a term commonly associated with military veterans who are forced to act or participate in acts, often under violent or chaotic circumstances, which are counter to deeply held moral codes (Currier, Holland and Malott, 2015; Frankfurt and Frazier, 2016). Moral injury, moral distress and "burnout" collectively exist under a larger umbrella known as "moral suffering" (Weisleder, 2023). While moral injury has more recently been applied when considering nursing and care staff experiences during the COVID-19 pandemic (Riedel et al., 2022), it seems less often applied to social care or social work practitioners outside the pandemic context.

Moral distress has two stages: initial moral distress and reactive moral distress, or moral residue (Jameton, Andrew, 2017). Initial moral distress refers to the initial feelings of frustration and anxiety a professional may feel in the face of obstacles which prevent good care or practice. Reactive moral distress refers to the frustration felt when the professional does not take any action towards the initial distress. The literature suggests the majority of moral distress situations arise from conflict between professional ethics and organisational demands (Weinberg, Merlinda, 2025). For example, a social worker may feel a sense of initial moral distress because she cannot provide an adequate housing environment for an adult with special needs, then experiences a sense of reactive moral distress because she did not pursue this issue with budget holders or her management due to a fear of "causing trouble." Ongoing and unresolved moral distress has physical consequences (Weisleder, 2023) including somatic symptoms such as high blood pressure, fatigue and a compromised immune system and psychological ramifications such as anxiety and depression (Papouli, Marson and McKinney, 2019). These conditions often lead to professional "burnout," often described as diminished empathy, loss of motivation and cynicism (Papazoglou and Chopko, 2017).

Participants described thoughts and feelings consistent with those described by the moral distress framework. Burnout was a common theme, and as previously noted, at least half of

the eleven participants had obtained new employment during their time participating in this study while others were either newly appointed from a previous role or seeking a new role. This kind of job migration illustrates a chronic sense of dissatisfaction at the least, and for two participants, manifested on the other side of the spectrum in physical health conditions and mental health concerns requiring professional help. This is reflected in the literature, specifically Evans (2006), who researched burnout among approved social workers (ASWs) who received substantial mental health training. Therefore, it is not surprising that social workers with no specialised training experienced the same. Like other phenomena described here, this appears to be a global issue (Kheswa, 2019; Lombardero Posada et al., 2022). This research contributes to this global discourse by examining the *nature* of the work generic social workers complete as it relates to the growing mental health crisis in the UK.

One participant, describing her involvement with an adult being detained under the MHA, used the word "complicit" to describe her moral conflict about her role. While this may not rise to the extreme "moral injury" described above, it does suggest a deeper level of internal discord which has begun to impact her sense of self and moral compass. Highly contrasting with her values, these moments of self-betrayal can have a deeper and more profound corrosive result. Again, existing literature suggests that this is not new or limited to the UK (Mänttäri-van Der Kuip, 2016; Lev, 2024) however, the bulk of the literature explores social workers in health care settings (Bernhardt, Forgetta and Sualp, 2020) and there has been an increase in moral distress research since the COVID-19 pandemic (Beadle et al., 2024). However, moral distress among UK generic social workers, irrespective of the nature of their encounters, appears to be less explored and this thesis provides a foundation for future work in this area.

Other participants discussed symptoms commonly associated with secondary trauma including intrusive thoughts, difficulty sleeping and a sense of dread associated with work. Secondary trauma can be more insidious because it results from a cumulative effect, several low-level events spanning over time, compared to its better-known cousin, PTSD, which usually results from a single intense event (Motta, 2023). Social work identity, discussed earlier, contributes to this erosion because participants' personal values so deeply overlap with their professional ones, deepening the sense of loss, failure, frustration, sadness and

overall moral distress. Further, this overlap makes psychological compartmentalisation more difficult, as she cannot easily separate herself neatly from her job because, in a sense, she *is* her job.

Separating profession from self is not exclusively a social work dilemma. The literature can be described as a disciplinarily broad, including first responders, nursing and other emergency medical personnel (Mopkins, 2022) and includes mental health professionals (Devilly, Wright and Varker, 2009) and sexual assault survivor social workers (Choi, 2017). "Psychologic detachment from work" conceptualises mentally disconnecting from work (Sonnentag and Schiffner, 2019; Baktash and Pütz, 2025), and is the act of consciously thinking and concerning oneself with non-work related thoughts and activities. As previously seen, health related fields seem to dominate the literary discourse concerning this topic (Sonnentag and Schiffner, 2019; Cho, Han and Baek, 2025). What remains less explored is how generic social workers experience secondary trauma, specifically within the UK as a product of mental health service user overflow into social work's realm. This thesis begins this discussion.

7.5.1 Boundary Blurring Revisited

As discussed in Chapter 3, boundary blurring is often the result of boundary spanning and the empirical data shows several instances of this occurring. Although participants generally retained a clear professional identity as social workers, their descriptions of everyday practice revealed considerably less clarity around the activities contained within that identity. This was particularly apparent where they encountered acute mental distress, suicidality and trauma (Violet's social workers talking to a woman on a bridge; Christine discussing historic trauma with a young person; Sydney listening to graphic disclosures of sexual abuse). This contradiction becomes particularly apparent in the assertion of one participant that "it's not counselling because I am not a counsellor." Participants appeared to locate therapy partly within the identity of the person delivering it rather than within the nature of the intervention itself. Therapy was understood as something undertaken by a therapist within a clinical setting, whereas similar processes undertaken by a social worker remained "support".

Finally, a similar process was evident around diagnosis. Participants were clear that social workers were not qualified to diagnose, suggesting the persistence of a recognised boundary between social and medical authority. However, their accounts also demonstrated that social work assessments and observations sometimes contributed directly to diagnoses subsequently formalised by medical practitioners. In some circumstances, participants described medical professionals translating social work observations into clinical terminology or even asking social workers to suggest a diagnosis. The boundary surrounding diagnosis therefore remained symbolically powerful while becoming more ambiguous in practice. Social workers could undertake much of the interpretive work associated with identifying and explaining distress while the formal authority to name that distress remained elsewhere.

Boundary blurring therefore appeared to operate at two levels. There was an observable overlap in professional activity, but this was accompanied by participants' attempts to preserve a clearer conceptual boundary through the language they used. The professional boundary could consequently remain relatively distinct within participants' identities while becoming considerably less distinct within their actual practice. This distinction is important because the findings suggest that boundary blurring was frequently reactive rather than intentional because they encountered mental health needs that could not readily be separated from the social circumstances they were already addressing, alongside difficulties accessing appropriate mental health provision. This is captured in Theme III – Metamorphosis which evidences an incremental boundary blurring as a pragmatic response to what they encountered rather than a deliberate decision to practise outside their remit.

Importantly, the findings do not suggest that the social work/mental health boundary disappeared. Leah's (2023) conclusion that hybridity can problematise professional boundaries without erasing them is useful here. Participants continued to identify themselves as social workers and frequently articulated what they believed they were not qualified to do. The contradiction is that their practice did not always conform to those distinctions. Instead, they could simultaneously believe that an activity belonged outside social work while finding themselves undertaking something closely resembling it.

Boundary blurring therefore appears within this research less as the disappearance of the social work/mental health boundary than as a growing discrepancy between the boundary as professionally understood and the boundary as actually practised**.** This distinction may be particularly important to understanding generic social work. The participants did not formally become mental health professionals; rather, unmet mental health need, relationship-based practice and the breadth of the social work role progressively made the location of the boundary harder to sustain. In this sense, the blurred boundary identified within the findings may represent not professional convergence, but the gradual incorporation into generic social work of activities generated by gaps elsewhere in the mental health system. Routinely filling these gaps without training, psychological support or professional recognition is the topic for the following discussion.

7.5.2 Organisational Support, Training and Supervision in Boundary Spanning Practice

The empirical findings of this research suggest that participants were not simply working with mental health issues but were, at times, operating considerably beyond what they believed their education and training had prepared them to manage. As discussed in Chapter 3, successful boundary spanning cannot be understood simply as a product of an individual's willingness or capacity to work across professional boundaries, as the organisation must also provide the conditions which allow this to occur effectively. When viewed in this context, participants' repeated descriptions of limited mental health training, difficulties accessing further training and inadequate supervision become particularly significant, as these represent the absence of several of the organisational conditions identified as necessary for effective boundary-spanning practice.

Training was problematic from the beginning of participants' professional careers, with most describing their qualifying education as providing insufficient preparation for the mental health issues subsequently encountered in practice. Lila's assessment that her course “covered some basics but very little” was broadly representative, while those who did recall useful mental health learning frequently attributed this to individual practice placements rather than the university curriculum itself. Post-qualifying provision appeared similarly inconsistent, with training frequently limited, reactive or dependent upon individual

practitioners actively seeking it out. Sybil, despite undertaking AMHP training, described the mental health resources available through her local authority as “really, really basic”, explaining that she had needed to contact the learning academy herself and concluding that “the resources are shocking and it's really frustrating”.

The significance of this becomes clearer when considered alongside what participants were actually required to manage. Theme III described social workers responding to acutely distressed service users, suicidality, traumatic disclosures and situations which sometimes resembled counselling, therapy or crisis work, despite participants having little specialist preparation for these activities. Indeed, the conclusion to that theme described a kind of professional transformation, whereby participants appeared to become hybrids between social worker, mental health therapist, counsellor and crisis worker, while simultaneously expressing uncertainty, discomfort and sometimes fear about the activities they were undertaking. The organisational contradiction appears reasonably clear: participants' practice was extending across the social work/mental health boundary without an equivalent extension in the training, knowledge and resources available to support them.

This contrasts with the organisational conditions identified within the boundary-spanning literature. Stamper and Johlke (2003) identify organisational support as important in reducing role ambiguity and role conflict, while Satheesh et al. (2024) similarly demonstrate the importance of management and co-worker support where individuals are required to negotiate competing expectations across organisational boundaries. These findings are particularly pertinent here because participants were not simply describing a lack of technical mental health knowledge, but uncertainty about what they should be doing with the knowledge they did possess. In this respect, Tess's experience of Mental Health First Aid is especially revealing. She described the training as providing “reassurance” about the “fine line” between undertaking direct mental health work herself and recognising when specialist services should become involved. Training therefore appeared to do something more important than simply increase knowledge; it helped Tess to locate the boundary, providing greater clarity around when spanning it remained appropriate and when responsibility should pass elsewhere.

Paradoxically, this clarity appeared to be least available where the situations encountered were most serious. Participants described managing situations involving suicide, acute distress and trauma while acknowledging limited preparation for doing so, and the findings explicitly identified outcomes arising from managing situations for which social workers possessed “little training, knowledge or resources”. Consequently, while empathy, professional values and the needs of service users may have pushed participants towards and sometimes across the mental health boundary, there appears to have been considerably less organisational infrastructure available to tell them how far they should travel, what they should do once there, or when they should retreat.

Supervision should potentially provide some of this containment, particularly where the complexity of practice makes it impossible for training to anticipate every situation a social worker might encounter. However, the findings suggest that supervision was itself sometimes absent or inadequate, and Dawn's account provides perhaps the clearest example of the consequences. Reflecting upon what she subsequently understood as secondary trauma, Dawn described managing “horrendous things” alongside excessive caseloads and workloads, but specifically identified the “lack of kind of supervision” as contributing to the deterioration in both her physical and mental health and the “absolute burnout” she experienced. The significance here is not simply that Dawn found her work stressful, but that the organisational mechanism which might reasonably have helped her process that work, recognise its impact and negotiate its boundaries appears to have been insufficient.

Sydney's experience reinforces this point. Following a graphic disclosure of sexual abuse, she described being unable to remove what she had heard from her thoughts, becoming constantly tearful and eventually taking two months' sickness absence. Despite describing this experience explicitly as secondary or vicarious trauma, she reported receiving insufficient support from her employer and ultimately paying privately for therapy. There is something particularly problematic about an organisation benefiting from a social worker's willingness to enter emotionally demanding territory, while leaving the practitioner individually responsible for managing the psychological consequences of having done so. Boundary spanning, under these circumstances, risks becoming less an organisationally

supported professional activity and more an individual coping strategy through which gaps between services are temporarily held together by the practitioner.

This also connects with Satheesh et al.'s (2024) distinction between organisational expectations and the support necessary to meet them. If social workers are expected, either explicitly or implicitly, to respond to mental health needs which extend beyond conventional generic practice, then training and supervision cannot reasonably remain organised around a narrower conception of what social workers are supposed to encounter. Otherwise, a mismatch develops between the formal role for which the practitioner is prepared and the actual role which the organisational environment requires them to perform. This mismatch may contribute to the role ambiguity identified within boundary-spanning literature, but within the present research it appears to carry an additional psychological dimension because the work being absorbed is frequently distressing, traumatic and associated with risk.

The frustration described by participants further illustrates this tension. Participants identified difficulties accessing training alongside frustration with mental health professionals, limitations upon their own practice and inadequate resources, while one participant described the particular frustration of having to manage a young person's mental health difficulties while simultaneously feeling unable to undertake the intervention she believed might help. This places the practitioner in a difficult position, where she is sufficiently responsible to continue managing the problem, but insufficiently trained, resourced or authorised to resolve it. In this sense, inadequate organisational support does not necessarily prevent boundary spanning; rather, it may produce a less safe and less sustainable form of it.

Importantly, the findings also demonstrate what happens when appropriate support is provided. Tess's positive description of Mental Health First Aid suggests that relatively focused training increased not only knowledge but confidence and boundary clarity, allowing her to distinguish between mental health conversations which could legitimately remain within her practice and those requiring specialist intervention. This provides a useful counterpoint to the experiences of Dawn, Sydney and Sybil because it suggests that the problem is not that generic social workers are incapable of operating effectively across the

mental health boundary, but that their ability to do so is contingent upon the organisational conditions surrounding them.

Consequently, the findings suggest that successful boundary spanning requires organisations to support the boundary as well as the person crossing it. Training provides knowledge and, importantly, helps practitioners understand the limits of that knowledge, while supervision provides a space in which ambiguous responsibilities, emotionally difficult experiences and decisions about professional limits can be considered. Where these are absent, the practitioner may continue to boundary span because service-user need has not disappeared, but does so with fewer mechanisms for determining whether the activity remains appropriate or for recognising its accumulating impact. The experiences of participants therefore suggest that unsupported boundary spanning does not necessarily fail because the practitioner stops crossing the boundary; paradoxically, its failure may lie in the fact that she continues to cross it, despite lacking the training, supervision and organisational support necessary to do so safely and sustainably.

7.6 Outcomes for Social Workers and Service Users

When reflecting on struggling and challenged mental health services, participants discussed how they were emotionally impacted by the outcomes they saw for both adult and child service users. Adults with dementia were housed in environments which either did not meet their needs or stressed them further, exacerbating their behaviour. Some of these adults were then overmedicated, essentially chemically imprisoning them. Sometimes referred to as “polypharmacy” (the use of five or more medications), since the advent of Thorazine in the late 1950’s (Davies, 2014; Horwitz, 2021) psychotropic medication, specifically tranquilisers, has become a global staple of inpatient treatment/management, particularly to treat potentially challenging behaviours (Muir-Cochrane et al., 2020; Belayneh et al., 2024), a phenomenon also known as “chemical restraint.” However, there is little UK-targeted research and none that directly connects the UK’s chronic adult care bed shortage (Oliver, 2023; Leuchter et al., 2025) with an increase in chemical restraint practices. The anecdotal data points from my study provide another foundation for further research. However, what this thesis specifically addresses is the secondary trauma social workers may experience by

observing service users in these situations and the moral distress arising from participating in a process which leads to this outcome; hence the word "complicit" used by one participant to describe her experience. Circling back to the identity discussion, it's likely these experiences will be felt more profoundly by a professional who links her identity and practice so closely with empathetic values and a desire to improve lives.

Outcomes for children were equally disturbing. Participants' experiences with traumatised children saw them migrate to the "adult system" in which they were further labelled/diagnosed with EUPD and placed in high security mental health hospitals for further "management." Upon reflection, participants could not help but attribute this to the suppression of trauma which seemed required to "stabilise" the young person in their accommodation. Some participants were very articulate about this, reflecting on their own role where they tried to find an equilibrium between allowing the trauma to be explored but not letting the trauma go too far out of the metaphorical bag, unable to be contained by the professionals around them, resulting in a "placement breakdown." Finding this balance can be challenging even for experienced trauma practitioners and requires an established therapeutic relationship, a structured plan, a consistent and safe space for the work to happen, and clear parameters around therapeutic goals (Johnson, 2015; Gartner, 2017). One participant attempted to do this work with a young person during the night, before bed, because that's when she would become distressed- an encounter hardly meeting the controlled circumstances described above.

Social work literature (Tufford and Dylan, 2025) refers to "trauma-informed care" and "practice" and discusses ideas like "collaboration", "choice", "trust," and "empowerment." However, unless the practitioner has undergone specific trauma-related training and has the time and space to establish and practise these principles, these ideas seem little more than buzzwords which read very similarly to the established social work principles of partnership, autonomy, and, of course, "empowerment." In other words, without therapeutic training, social workers could very easily argue they already evidence trauma-informed practice without fully understanding what therapeutic trauma work really means.

Irrespective of how social work borrows and reframes trauma principles, the previously mentioned participant appears to have used some of them when working with a traumatised young person, but without the training, space, time or support to do it thoroughly, this was indeed a very dangerous endeavour for both her and the service user. Described as more of an emotional suppression exercise than a safe, therapeutic or healing transformation, the participant felt that suppression resulted in a deeper trauma-internalisation whereby on the young person's 18th birthday, the participant witnessed the "traumatised young person" social-constructionally transform into an adult diagnosed with a personality disorder and transferred to an adult secure hospital. This felt like a failure of "the system" in which this participant played a role, leaving the participant reflecting that "we do the best we can." Like the previously discussed participant but not using the word, this participant implied that she also felt "complicit" in a system designed not to safely and therapeutically explore traumatic experiences, but better suited to suppress or "manage" the young person's emotions for fear of disrupting accommodation and education.

7.7 Key Knowledge Contributions

This research makes theoretical and practical contributions to knowledge, as well as broadening existing social work discourse. The following discussions outline potential ways forward or new ways of thinking about old problems, as well as new theoretical approaches when considering contemporary dilemmas such as medical/social hierarchy (Hood, 2015) and social factor minimisation (Morriss, 2017; Phillipowsky, 2020). Firmly situated within existing theory and evidenced by this research's empirical findings, this section will explore the following key knowledge contributions:

7.7.1 Endogenic Thinking Model

The concept of endogenic thinking emerged inductively from the systematic literature review and meta-synthesis presented in Chapter 4 (Sections 4.5.3, 4.5.4 and 4.5.5), rather than being developed initially from the empirical findings of this study. Viewed through the theoretical

framework of the medical/social model debate, the synthesis identified recurring patterns in which social and environmental stressors were reframed as problems located within the individual, leading to the development of the Endogenic Practice and Thinking Model. However, the empirical findings in Chapter 6 subsequently strengthened and extended this theoretical contribution. In particular, Theme II: *The Approach* demonstrated how participants conceptualised mental distress and negotiated responsibility between social work and mental health services, while Theme III: *Metamorphosis* demonstrated how these conceptual positions translated into practice as social workers moved into activities more conventionally associated with mental health professionals. These findings provided empirical support for the processes initially identified within the literature synthesis, while also demonstrating how endogenic thinking may operate specifically within the practice of generic social workers. The contribution to knowledge therefore lies not only in identifying and defining endogenic thinking through the synthesis of existing literature, but in demonstrating through original empirical data how this process can influence the way generic social workers conceptualise mental distress, negotiate professional responsibility and, ultimately, extend their practice across the social work/mental health boundary.

While it is important to understand why social workers gravitate towards medical models, it is helpful to identify and label this way of thinking and practicing. By adopting the term "endogenic," those interested in this phenomenon now have language to quickly describe the action or thought process by which an environmental issue or stressor is being framed and thus acted upon as if that stressor was located *within* the person experiencing it. Hence the following definition:

Endogenic thinking: The interpretive process through which external social or environmental stressors are reframed as internal characteristics or deficits of the individual experiencing them.

This thinking resonates with other critical literature and contributes to existing discourse exploring the over-medicalisation of society (Conrad, 2007), individualisation of social problems (Beck and Beck-Gernsheim, 2002; Bauman, 2004), psychologicalisation of distress (Smail, 2013) and Fook's (2023) critical reflection on internalising explanations. While

concepts such as medicalisation and individualisation describe broader social processes, they do not necessarily describe the moment-to-moment interpretive shift that occurs in practice reasoning. The concept of endogenic thinking provides a specific mechanism or analytic label through which this shift can be described more precisely, capturing the interpretive reframing through which practitioners move from recognising environmental stressors to interpreting distress as primarily located within the individual. This analytic distinction helped illuminate how practitioners made sense of complex cases and the reasoning processes underpinning their responses.

Endogenic thinking may have several potential applications within practice. Firstly, it could be used as a reflective tool through which practitioners, or supervisors working with staff, consider whether social or environmental factors are being inadvertently reframed as characteristics of the individual and whether greater attention should be given to an exogenic interpretation. Broadening the argument out, applying the endogenic/exogenic labels may also help practitioners more clearly identify environmental structures from internal characteristics, promoting the accurate use of language and subsequent interventions. Secondly, it may help strengthen the social model in multi-disciplinary team/interprofessional by providing practitioners language to challenge medical model dominance, for example one might say "we may be engaging in endogenic thinking here instead of considering what has happened to the service user." Framing the discussion in this way may provide a more explicitly analytical language through which assumptions can be questioned within multidisciplinary settings, potentially making such challenges more accessible to professionals working from different disciplinary perspectives. Lastly, adopting this language speaks to the social work commitment to anti-oppressive practice and the recognition of societal and systemic structures which impact marginalised populations, while potentially helping to minimise the propensity for the mental health industry to perpetuate those forces.

Below is a table comparing an exogenic approach with an endogenic one:

Table 7.1 Endogenic/Exogenic Comparison

Situation	Endogenic Interpretation	Exogenic Interpretation

Parent struggling with engagement	"The parent is resistant."	"She's experienced power misuse in the past."
Young person self-harming	"Emotional dysregulation"	"He's responding to previous, unresolved trauma.

In short, this concept provides conscious language to describe a possible unconscious assumption and promotes the social worker's awareness of her own thought processes.

7.7.2 The Social Worker's Transformation

The second contribution emerges from bringing together the two theoretical frameworks underpinning this research: boundary spanning and the medical/social model debate, as outlined in Chapter 3. The medical/social model provides a means of understanding how participants conceptualised mental distress and where responsibility for responding to it was located, while boundary spanning provides a framework through which their subsequent movement beyond conventional social work activities can be understood. These theoretical concepts were reflected within the empirical findings in Chapter 6, particularly across Theme II: *The Approach* and Theme III: *Metamorphosis*. Participants described encountering mental health needs which they understood as extending beyond conventional social work practice, but nevertheless found themselves responding to these needs when specialist services were unavailable, inaccessible or unwilling to intervene. This movement was demonstrated through participants undertaking activities including recognising and assessing mental health difficulties, managing suicide risk and using therapeutic or psychologically informed approaches, frequently despite describing limitations in their formal mental health training and professional support.

The contribution of this research, however, extends beyond identifying these activities as examples of boundary spanning. As operationalised within this thesis, boundary spanning describes movement beyond the conventional knowledge, activities or responsibilities associated with the social work role and into those associated with another professional

domain. The findings suggest that, for some generic social workers, this movement may become sufficiently sustained and extensive that it is no longer adequately understood as an occasional crossing of a professional boundary. Instead, repeated engagement with mental health-related responsibilities appears capable of producing a more substantial transformation in practice, whereby the social worker remains professionally located within social work while simultaneously undertaking functions associated with the mental health realm. The medical/social model helps explain the conceptual tensions encountered during this movement, while boundary spanning explains the professional movement itself. When considered together with the empirical findings, these frameworks therefore identify a potentially hybrid form of practice situated between the two professional domains. The original contribution is consequently not the observation that social workers cross professional boundaries, which is already recognised within boundary spanning literature, but the finding that repeated and unsupported boundary spanning into mental health may progressively expand the generic social work role to the point where existing professional boundaries become increasingly difficult to meaningfully maintain.

Building from the previous contribution, the thesis makes new and intuitive sense of what otherwise may be considered chaos. When exploring the transformation occurring as social workers move increasingly into mental health-related practice, the endogenic model provides one means of understanding how this movement may occur in the context of medical model dominance. In short, the thematic structure describes what is happening, whereas the concept of endogenic thinking provides one of the reasons *why* it's happening. The social worker, working with substantial mental health presentations due to systemic issues outside her control, is on several levels pressured towards adopting an endogenic position. This happens by way of her providing her version of a diagnosis, providing therapy (irrespective of whether she recognises it as such) and managing suicide risk and potentially other dangerous behaviours. Aside from the external pressures, endogenic thinking may therefore act as an additional interpretive mechanism through which the social worker moves further into mental health-related practice. It is situated at the fulcrum of the two structural halves between Theme II: The Approach and Theme III: Metamorphosis, like a metaphorical gate through which she must pass through during her journey.



Figure 7.1 The Social Worker's Transformation

This conceptual way of thinking about social work practice pulls previously separated explorations of shared social work/mental health territory together into a useful framework. While previous research has documented social workers engaging with mental health issues, it typically describes the nuances of specific issues, (e.g. substance use, depression, etc.) without pulling back focus and examining what these cumulative experiences are doing or what they mean to the professional. This framework developed within this thesis provides this broader perspective.

The framework acts as a *process*, going beyond a simple explanation, description of events or a static state of existence. Instead, it shows stages of a transformation and movement and the reasons behind those stages. It may be applicable to generic social workers supporting service users experiencing mental health difficulties who find themselves working across the sometimes ideologically conflicted yet overlapping domains of social work and mental health. Theoretically, it provides a means of understanding *what* is happening (one profession increasingly undertaking activities associated with another,) *why* this may be happening (systematic pressures, medical hierarchy), and the potential consequences of this process, including burnout and moral suffering (Payne, 1997; Layder, 1998; Opp, 2020).

What the framework does not do, however is necessarily provide a means through which the social worker can resolve these tensions. It may, however, have potential value as a reflective tool, allowing social workers and their supervisors to recognise how organisational pressures, professional boundaries and medical hierarchy can shape practice at the social work/mental health interface. In doing so, the model may provide language through which experiences of

frustration, anxiety and professional uncertainty can be contextualised rather than understood solely as individual practitioner difficulties. Supervisors may similarly find the model useful in identifying circumstances in which practitioners are moving beyond conventional role boundaries without adequate training, support or organisational recognition, allowing these issues to be addressed through supervision and, where appropriate, liaison with mental health services. These potential applications require further evaluation, but demonstrate how the conceptual framework developed within this research might be translated into practice.

7.7.3 The Toxic Trio and the Conceptualisation of Mental Health

Previous discussions have alluded to the presence of mental health across many of the situations in which participants encountered service users and their stresses and difficulties: social workers diagnosing service users, either indirectly or informally; how social workers construct their personal mental health ontology and how this informs their mental health literacy; the difficulties arising from the siloed nature of NHS and Local Authority services; and the pervasive presence of psychopathy and personality disordered behaviour.

The “toxic trio” concept (also known as “toxic trilogy” or “trilogy of vulnerabilities”) is usually identified in any child safeguarding curriculum. It was first coined in 2009 (Brandon, 2009) following a review of Serious Case Reviews (SCR, now known as Child Safeguarding Practice Reviews or CSPRs) where there appeared to be a pattern of characteristics associated with families who had experienced child significant injury or death. The model is used to show the intersection of “mental health”, “domestic violence” and “substance use” and is usually depicted as a Venn diagram with the highest risk for the child residing within the centre, or the intersection, of these three factors (Hood et al., 2021). The concept has worked its way into common social work lexicon as a useful, if not oversimplified way of quickly assessing risk to a child.

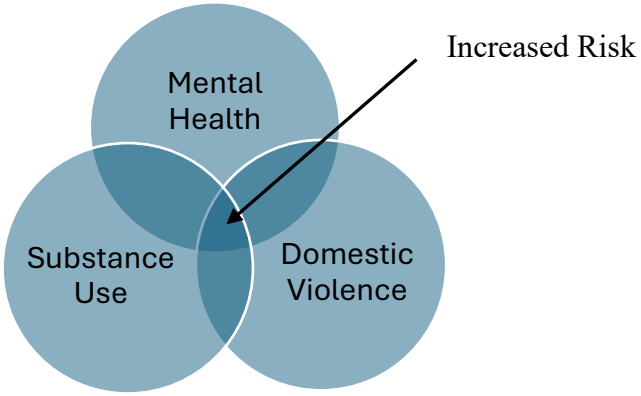


Figure 7.2 The Toxic Trio

Despite all child practising participants describing cases resembling this model, the three separate sections can be seen to fall within the remit of other professions: "mental health", depending on the nature of it, is treated by a psychiatrist or community mental health nurse; the substance issue being referred to a substance abuse service and the domestic violence being treated as the key risk factor with the victim either being sheltered or the perpetrator removed. However, communication between professions creates a minefield of risk when different disciplines are involved (Brandon and Bailey, 2010), a phenomenon reflected by participants. This siloed approach reflects how the "separate" nature in which mental health is often viewed, as previously discussed, and is assumed to be best addressed by mental health "experts." This is significant within the medical/social model framework underpinning this thesis, because it raises questions about where the source of distress is understood to reside and, consequently, which professional or service is considered responsible for responding to it.

There is substantial research highlighting a strong relationship between parental substance use and child safeguarding (Forrester, 2000; Amodeo M and Fassler I, 2001; Barrett et al., 2024), for instance, out of 95 children on the Child Protection Register in an inner London area, substance misuse (specifically alcohol abuse) was a factor in 52% of them (Forrester, 2000). Globally, substance use was a factor when children were found to be neglected (Brandon et al., 2008), physically abused (Bell, Herring and Annand, 2020) or sexually abused (Leung et al., 2025). Participants described parents using "monkey dust" (a synthetic hallucinogenic), young people abusing marijuana and cocaine, prescription drug abuse, and

alcohol abuse. While some of this use seemed recreational, participants spoke more commonly of substance use being used to manage unresolved trauma.

The concept of "domestic violence" has broadened and become more complex since the "toxic trio" was first introduced. Stereotypically, the word conjures images of a husband or male partner physically battering his wife or female partner. Now, more recognition is made of same sex domestic abuse (Messinger, 2018; Ali and Rogers, 2023) and female-on-male domestic abuse (Bernardi and Steyn, 2019; Barber, 2023). Further, the definition of "violence" is also broadening and now incorporates other forms of abuse such as coercive control (Candela, 2016; Kassing and Collins, 2025), stalking (Logan and Walker, 2009; Bennett Cattaneo, Cho and Botuck, 2011) and financial domination (Stylianou, 2018). The mental health impacts these forms of abuse have on victims and children are extensive.

The model is not without criticism, however. As previously alluded to above, the model suggests an oversimplification of complex family dynamics (Skinner et al., 2021) and has been used by conservative parties to describe families potentially impacted by social factors, thus depoliticising larger, macro-systems (*Troubled families speech*, 2011). Further, the model does not explain how these factors interact with one another or what constitutes their "presence" in a family system (Morris et al., 2018). Further, simply stating a relationship exists does not reflect the complex nature of the relationship: Underlying trauma is often self-medicated with substances (Leeies et al., 2010), and can be an issue in relationships (Cintora and Laurent, 2020); substance use often leads to domestic violence (Ross, 2010) and can exacerbate an underlying mental health issue, and the stress of domestic violence is often self-medicated with substance use and can lead to depression (Leeies et al., 2010).

Despite criticisms noted above, the toxic trio concept, in some form or another, still looms large in social work parlance and informs how many social workers still think about risk (Duschinsky et al., 2021). It is here that the model becomes particularly relevant to the findings associated with Research Objective 2. The idea that mental health can be modelled as a distinct category sitting alongside domestic abuse and substance use did not closely reflect how participants described mental health within their practice. Participants' accounts instead moved repeatedly between mental distress, trauma, substance use, relationships

and environmental circumstances, with these factors often understood as interacting with and shaping one another. This does not establish that mental health necessarily causes or underpins domestic abuse or substance use, nor was this research designed to test the validity of the toxic trio model. Rather, participants' accounts highlight the difficulty of imposing clear conceptual boundaries upon mental health when social workers encounter it within the complexity of everyday practice.

The contribution of this discussion is therefore not to propose a replacement for the toxic trio, but to use the model as an example through which social workers' conceptualisations of mental health can be critically considered. The findings suggest that participants understood mental health as contextual, relational and closely interconnected with the wider social circumstances of service users rather than as an isolated category of need. This finding is consistent with the medical/social model debate underpinning this thesis: determining whether distress resides within an individual or within their social environment becomes considerably more difficult where the two are experienced as mutually interacting. The toxic trio remains useful as a shorthand means of identifying important areas of risk, but its categorical structure risks implying a degree of separation between mental health and social experience which was not reflected within participants' accounts. In this sense, its relevance to this thesis lies not in whether the model itself should be redrawn, but in what its limitations reveal about the complexity of how social workers define and conceptualise mental health**.**

7.7.4 A British Clinical Social Worker: A "Socio-therapist?"

The thesis makes an argument for the creation of a new social work credential. The generic social work role in the UK is different to other Western countries due to the institutional separation between the local authorities and the NHS. Heavily based on Boundary Spanning theory, the thesis argues that some generic social workers have "boundary spanned" so extensively into mental health-related practice that their activities can no longer be adequately understood as occasional crossings of a professional boundary. Instead, they are operating within a hybrid space between social work and mental health which demands greater training, support and professional recognition. However, there is an existing role

which needs to first be considered, that of the Advanced Clinical Practitioner (ACP), which shares some characteristics with the proposed model of practice.

7.7.4.1 The Advanced Clinical Practitioner

The ACP, more recently referred to by NHS England as Advanced Practice (AP), provides a multi-professional framework through which experienced health and care professionals can develop greater autonomy, clinical competence and professional responsibility. Advanced Practice is not a single profession, but a level of practice which can be undertaken by professionals from different disciplinary backgrounds. The NHS England framework describes Advanced Practitioners as registered health and care professionals working with a high degree of autonomy and complex decision-making, underpinned by postgraduate education at master's level or equivalent (NHS England, 2025).

Advanced Practice is structured around four principal pillars: clinical practice, leadership and management, education, and research. Within the clinical pillar, practitioners may undertake comprehensive assessment, exercise advanced clinical reasoning, manage complex presentations and plan and implement interventions. The precise scope of an Advanced Practitioner depends upon their original professional registration, subsequent education, competence and the context in which they practise. Consequently, Advanced Practice does not remove the practitioner's original professional identity; rather, it extends the level at which that professional is able to practise. Importantly within the context of this thesis, Advanced Practitioners may work across traditional professional boundaries, occupying areas of practice which might previously have been associated with other professional groups (Skills for England, 2026)

Although Advanced Practice has commonly been associated with professions such as nursing, physiotherapy, pharmacy and paramedicine, the framework is multi-professional and can include social workers. Examples within NHS services demonstrate social workers undertaking Advanced Practitioner development within mental health settings, where their work may incorporate advanced assessment, formulation and diagnosis alongside the psychosocial knowledge associated with their original profession (NHS, 2026). In this

respect, Advanced Practice provides an existing mechanism through which some of the traditional boundaries separating social and clinical practice can become more permeable.

However, identifying the extent to which social workers currently undertake Advanced Practitioner roles is difficult. National social work workforce data do not separately identify social workers who have completed Advanced Practice training, while evaluations of the Advanced Practitioner workforce have demonstrated considerable variation in professional background, job title and scope of practice. Therefore, while an established pathway through which social workers can undertake Advanced Practice clearly exists, the prevalence of social workers following this pathway cannot currently be reliably established from national workforce data.

The existence of Advanced Practice is nevertheless important to the argument developed within this thesis. It demonstrates that the extension of professional practice across traditional disciplinary boundaries is already recognised within UK health and care structures and that social workers are not necessarily restricted to the conventional boundaries of generic social work practice. Consequently, the Advanced Practitioner framework provides an important existing point of comparison when considering the socio-therapeutic model proposed within this research.

7.7.4.2 Advanced Practice and the Socio-Therapist

When comparing the two, there are clear similarities, particularly in relation to advanced knowledge, professional autonomy, complex assessment and the ability to operate across traditional professional boundaries. The Advanced Practitioner framework demonstrates that some of the functions proposed for the socio-therapist are already possible within existing UK professional structures. Consequently, it would be inaccurate to suggest that the socio-therapist represents an entirely new professional role without an existing UK equivalent. However, while there is considerable overlap, the two should not necessarily be considered synonymous. Their differences relate less to individual clinical competencies and more to their purpose, theoretical orientation and the professional problem they are intended to address.

Perhaps the most important distinction is that Advanced Practice describes a level of professional practice rather than a single occupational role. NHS England (2025) specifically moved away from the term “Advanced Clinical Practice” partly because the word “clinical” risked suggesting a generic professional role rather than a level of practice applicable across different professions and settings. The Advanced Practitioner therefore remains rooted within her originating profession while acquiring the autonomy and capabilities associated with advanced-level practice. Professional identity is considered fundamental to this arrangement rather than replaced by a generic Advanced Practitioner identity. The socio-therapist proposed within this thesis is narrower. It is specifically concerned with social workers who operate across the contested boundary between social work and mental health and describes a particular configuration of knowledge, values and therapeutic skills considered necessary to practise effectively within this space.

Another key distinction is that AP starts with the profession and extends it whereas the socio-therapist starts with the boundary and asks what the social worker needs to operate within it while placing considerably greater emphasis on preserving the social contextualisation as its organising principle. The medical/social model tension identified throughout this thesis suggests that acquiring greater clinical knowledge is not, by itself, sufficient to address the social work/mental health boundary. Indeed, one of the risks identified within this research is that sustained exposure to medicalised environments can encourage social workers to adopt increasingly endogenic explanations for distress. The socio-therapist is therefore not simply intended to make social workers more clinically capable. Rather, clinical and therapeutic knowledge is used to strengthen their ability to understand, navigate and, where necessary, challenge medical interpretations while maintaining attention to the social, relational and environmental circumstances surrounding distress.

This final contribution moves from theoretical and empirical explanation towards a practice-based response to the phenomena identified throughout this research. It is grounded particularly within boundary spanning theory and the distinction between professional role and professional identity discussed in Chapter 3, Section 3.3 and 3.5 respectively. Boundary

spanning provides a means of understanding how practitioners extend their activities beyond established professional boundaries, while the distinction between professional identity and role allows this movement to occur without assuming that social workers cease to identify as social workers. The empirical findings demonstrate this tension particularly clearly. Across Theme I: *Being a Social Worker* and Theme III: *Metamorphosis*, participants described retaining recognisable social work values and approaches while simultaneously undertaking increasingly complex mental health-related activities, including recognising and responding to acute mental distress, managing suicide risk and using therapeutic or psychologically informed approaches. Importantly, participants also described undertaking some of these activities without corresponding specialist training, supervision or organisational support. Theme IV: *Aftermath* subsequently demonstrated some of the emotional and professional consequences associated with practising within this space.

The contribution of this thesis is therefore not the empirical demonstration that a new professional credential is necessarily required, as the study was not designed to evaluate such an intervention. Rather, the proposed credential represents a theoretically and empirically informed response to the disparity identified between what generic social workers are formally prepared and supported to do and the mental health-related responsibilities they may nevertheless undertake in practice. Boundary spanning is particularly important to this proposition because the findings suggest that, for some practitioners, movement into the mental health realm is neither exceptional nor temporary, but may become a sustained component of their professional role. At the same time, participants' continuing identification with social work suggests that this development need not require the creation of an entirely separate profession. Instead, a recognised post-qualifying credential could provide a means of formally acknowledging this expanded area of practice while retaining social work as the practitioner's principal professional identity. Such a credential might provide the additional knowledge, skills, supervision and professional recognition required to undertake this work more safely and effectively. The proposed credential should therefore be understood as a practice and educational recommendation arising from the theoretical and empirical findings of this research, rather than as an intervention whose effectiveness has itself been established by the study.

Clinical social work models found internationally demonstrate that social workers can combine a recognisably social work orientation with more advanced mental health assessment and therapeutic capabilities. Drawing upon these models, and the particular social work/mental health boundary identified within this research, the socio-therapist is proposed as a post-qualifying social work credential through which practitioners could develop enhanced mental health and therapeutic knowledge while retaining social work values, professional identity and a contextual understanding of distress. Rather than replacing existing mental health professionals, the role would be intended to strengthen practice within the area between generic statutory social work and specialist mental health provision identified by participants within this research.

The socio-therapist is a social worker but is specially trained to navigate the ways mental distress can emerge from, and be sustained by, social, relational and environmental circumstances, while also recognising when specialist clinical assessment or intervention is required. She does not necessarily practise solely within conventional clinical environments, but may go where the service user is; the home, a park, a school. She sees the service user in situ and forms her conclusions and insights based on an understanding of the service user's personality, home environment, upbringing, family and friends. Consistent with the relational orientation identified within participants' accounts, the model would provide sufficient continuity and autonomy for meaningful professional relationships to develop. By structuring and managing her time, she has some autonomy over when she visits, where and for how long and in the process, develops the relationship social work so highly values, travelling as an emotional guide through the difficult terrain of that person's life.

To do this, she is armed with multiple tools: a confident grasp of trauma-informed therapy; not vague notions of the thought/behaviour cycle, but a firm understanding of CBT and its structured nature. Her broadened clinical vocabulary and assessment skills help her identify when medical professionals or hospitalisation is needed. Her reflexivity promotes her safety if she encounters a potentially dangerous person. She feels confident challenging potentially unethical or short-sighted medical interventions or hospitalisations and can translate medical jargon into understandable language. She does not prescribe medication, but she is familiar

with pharmaceuticals, recognises common dosages and feels confident to question these. In short, she is a translator for those caught between the social and medical worlds: clinically literate enough to speak the language of mental health services, but sufficiently grounded within social work to question when human distress is being stripped of the social circumstances which give it meaning.

The socio-therapist is proposed as a recognised post-qualifying credential for registered social workers rather than as an entirely separate profession. Its development would require clearly defined educational and competency standards, including substantial mental health and therapeutic training, together with appropriate arrangements for clinical supervision and continuing professional development. The intention would not be to replace the social worker's existing professional identity, but to provide formal recognition of an advanced area of social work practice situated specifically at the social work/mental health boundary. Such recognition could provide practitioners with greater professional legitimacy when contributing to multidisciplinary assessment and decision-making, while enabling them to articulate socially contextualised interpretations using both social work and clinical language. The precise regulatory arrangements, scope of practice and relationship between the proposed credential and existing pathways such as Advanced Practice and AMHP training would require further consultation and research and cannot be determined from the findings of this study alone.

There are several potential benefits to creating this credential, not least of which is providing some relief to generic social work, mental health services and other human services. Potential benefits might include providing an additional response to service users whose mental health-related needs fall between generic social work and specialist mental health provision, while providing greater clarity, training and support for social workers undertaking this work. In principle, earlier socially and therapeutically informed intervention might also reduce some escalation into crisis services, although this proposition would require empirical evaluation. The development of the credential could additionally provide greater clarity between generic statutory social work and more specialised socio-therapeutic practice. These potential benefits should therefore be regarded as propositions for future investigation rather than outcomes demonstrated within the present research.

The development of such a credential would nevertheless need to be considered within the distinctive structural position of British social work. The institutional separation between much statutory social work, located within local authorities, and specialist mental health provision, predominantly located within the NHS, forms part of the context within which the boundary identified by this research has developed. Existing attempts to integrate social work within multidisciplinary mental health provision demonstrate that organisational integration is possible, but do not necessarily resolve the medical/social model tensions identified throughout this thesis. The feasibility of developing a specific socio-therapeutic credential would therefore depend not only upon its educational content, but upon its professional recognition, organisational location and relationship with existing social work and mental health structures.

The socio-therapist should therefore be understood as a proposal for the formal development of a form of practice already partially visible within the findings of this research. Participants demonstrated that generic social workers can find themselves operating extensively within mental health-related territory while retaining a recognisably social work identity and orientation. Advanced Practice demonstrates that the UK already possesses mechanisms through which professional practice can be extended and formally recognised; however, the socio-therapeutic credential proposed here would be specifically organised around the social work/mental health boundary and the particular tensions identified within this thesis. Further research would be required to determine its appropriate curriculum, regulatory status, organisational location and effectiveness. Nevertheless, the findings provide a theoretically and empirically informed basis for the development and evaluation of a specifically British socio-therapeutic social work credential.

7.8 Conclusion

The contributions to knowledge presented within this thesis are not uniform in either their theoretical origins or the extent to which they are supported by the empirical findings, and it is therefore important that they are not interpreted as making equivalent evidential claims. The concept of endogenic thinking emerged inductively from the systematic

literature review and meta-synthesis and was subsequently strengthened and extended through the empirical findings. The social worker transformation, by contrast, is more directly grounded within the empirical data and uses the established theoretical frameworks of boundary spanning and the medical/social model debate to interpret participants' movement into increasingly complex mental health-related practice. The proposed reconsideration of the toxic trio has a more limited empirical foundation and should instead be understood as a conceptual proposition arising from the interaction between existing literature, the theoretical framework and patterns observed within participants' accounts, rather than as a model directly demonstrated by the findings. Finally, the proposed social work mental health credential represents a theoretically and empirically informed response to the disparity identified between participants' professional preparation and the mental health responsibilities they described undertaking. These contributions therefore occupy different positions along a theoretical and empirical continuum, ranging from empirically supported conceptual development to theoretically informed propositions and recommendations requiring further investigation.

To conclude this chapter, the thesis contributes new knowledge in four ways. Firstly, the contemporary literature review generated a new way of thinking about how social workers operate in the contested space between social work and mental health: an iterative theoretical framework describing practice in which social and environmental stressors may be interpretively reframed as characteristics or problems located within the service user, referred to as "endogenic" practice and thinking. This provides a language through which to identify elements of social work practice which may not fully align with the profession's values of emphasising the social environment and working in partnership with the service user.

Secondly, and building on the first, the thesis's thematic framework offers a new and broader perspective on social work experience beyond the specific and seemingly independent moments of social work/mental health overlap. This process conceptualises the progressive transformation of the social worker's role through repeated boundary spanning into mental health-related practice and makes sense of what would otherwise appear to be an overwhelming and chaotic experience. Rather than claiming that social

workers literally become mental health professionals, the contribution lies in demonstrating how sustained and insufficiently supported boundary spanning may progressively expand generic social work practice, producing a hybrid space in which established professional boundaries become increasingly difficult to meaningfully maintain.

Thirdly, the thesis critically considers the Toxic Trio as an example through which social workers' conceptualisations of mental health can be explored. Participants' accounts demonstrated the difficulty of neatly separating mental health, domestic abuse and substance use within the complex social circumstances encountered in practice, raising questions about the usefulness of treating mental health as a discrete and readily identifiable category. The contribution is therefore not a replacement for the Toxic Trio, nor a claim that mental health necessarily causes or underpins domestic abuse or substance use, but an examination of what the model's limitations reveal about the complexity of how social workers define and conceptualise mental health.

Lastly, the thesis addresses the tensions identified across these contributions by arguing for the development of a specifically British post-qualifying social work credential: the "socio-therapist." Informed by Boundary Spanning theory, the empirical findings and the comparison with existing Advanced Practice, the socio-therapist provides a means of formally recognising a social worker who can exist within the contested territory between the social and mental health realms without abandoning the professional identity, values and social contextualisation which brought her there. Such a credential could provide generic social workers with a professional pathway through which the mental health and therapeutic skills already evident within participants' accounts could be developed through appropriate education, supervision and professional recognition. Its potential to address gaps between generic social work and specialist mental health provision, strengthen the professional authority of social workers operating within this space and contribute to improved outcomes for service users now provides an important basis for further research and evaluation.

The following chapter will conclude the thesis by summarising the study's context, research design, findings and discussion and will directly address the research questions identified in

the introduction chapter. Lastly, the next chapter will make recommendations for future research, policy changes and educational changes.

8 Conclusion

8.1 Introduction

This chapter will summarise the thesis by reviewing the stages the research project followed and how they have worked together to address the research aim and objectives, culminating in new knowledge. Lastly, it will highlight the key knowledge contributions, make recommendations for policy, research and education and include suggestions for future research.

The thesis has answered the question: what is the nature of the social work/mental health boundary? It did this by first exploring the history of both social work and mental health industries, focusing on how the two have intersected and departed via UK policy, societal shifts and contemporary service structures. The question is then answered using existing literature, culminating in a theoretical framework derived from the synthesis of systematically selected papers. This synthesis deductively suggests the concept of "endogenic thinking" as the underpinning mechanism driving social workers' actions and thoughts. The thesis then empirically asked the same question. Informed by the medical/social model debate and Boundary Spanning Theory, the novel research design of completing an elicitation interview prior to two serial interviews approached the question from a unique perspective by allowing participants to reflect directly on recent practice. Using Reflexive Thematic Analysis allowed the author to bring an informed and insightful perspective to the findings which are structured in a way which shows a process through which social workers progressively become something more than their conventional professional role appears to encompass**.** By describing and analysing the porous and epistemologically contested nature of the social work/mental health boundary, these findings then informed recommendations for the social work industry in the UK.

This thesis has answered the research question by demonstrating that the boundary between social work and mental health is not fixed or clearly defined, but porous, contested, and produced through practice**.** While social workers maintain a conceptual distinction between

their role and that of mental health professionals, they routinely operate across this boundary in practice. This contradiction is driven by medical dominance, organisational constraint, and service gaps, which require social workers to undertake mental health work while remaining positioned outside it. The boundary, therefore, is not an objective line but a subjective site of ongoing negotiation, shaping both practice and professional identity.

8.2 Research Objectives

To understand the nature and location of the boundary between social work and mental health, this research sampled a total of 11 generic, qualified social workers from the UK who participated in a total of 22 interviews. The subsequent data were thematically analysed, generating a four-theme framework which intuitively made sense of their experiences. In the process, it answered the following research questions:

8.2.1 Research Objective 1

Develop an understanding of how social workers conceptualise what it means to be a social worker.

This research has developed an understanding of how social workers conceptualise social work identity when confronted by mental health issues in practice. Social workers are strongly informed by their sense of empathy, desire to help others via a non-judgemental, unconditional positive regard philosophy. They differentiate themselves from medical professionals by their emphasis on the environmental impacts of well-being and overall mental health. They paradoxically see themselves as less academically qualified compared to their medical counterparts but more qualified to make informed conclusions about service users and the dynamics which contribute to their mental distress.

8.2.2 Research Objective 2

Evaluate how social workers define and conceptualise mental health.

The research has evaluated how social workers define and conceptualise mental health. Their notions of mental health are highly individual; informed partially by their modest academic education and post-qualifying training but unconsciously constructed by personal experiences and the sense they have made of their own and others' mental health struggles. They derive little meaning from clinical definitions and use their intuition to determine levels of risk. They simultaneously feel the need to challenge potentially harmful mental health labels but also seek them to establish certainty and provide direction. They recognise the limitations these labels have but again, paradoxically, see them used by others to provide means of a personal identity.

8.2.3 Research Objective 3

Investigate social workers' experience when working with mentally distressed service users.

This research has investigated social workers' experience when working with mentally distressed service users. Social workers are confronted with all manner of serious mental health conditions including acute anxiety, depression, psychosis, dementia, personality disorders and psychopathy. With little to no training, they routinely assess suicide ideation and listen to narratives of past and present traumas. Social workers continuously struggle to identify the sources of some of these conditions but recognise that trauma sits at the root of many of them and offer what they consider to be "trauma-informed" practice. Despite obvious overlaps in skills and tasks, social workers do not see themselves as clinical therapists, including their role when informally or indirectly diagnosing service users.

8.2.4 Research Objective 4

Understand the challenges social workers face when interacting with mental health services.

This research has developed an understanding of the challenges social workers face when interacting with mental health services, manifested when working with or referring cases to

mental health providers. Mostly due to extreme wait times and large caseloads, social workers witnessed service users receive sub-optimal quality of services, yet again paradoxically, valued whatever insights mental health clinicians could provide. Frustratingly, social workers find their own conclusions "medicalised" and turned into a diagnosis, offering little more than a diagnostic stamp used to access additional services. Social workers observed mental health practitioners work poorly with service users, only to then close cases when service users did not find the service helpful. When mental health professionals remain involved, social workers simultaneously provided expert opinions about vulnerable people and families yet allow other professionals to drive the narrative and definitions of treatment and management. These challenges simultaneously undermine the social work profession yet paradoxically put more pressure on caseloads, and as such, participants found themselves performing psychotherapeutic tasks yet struggled to recognise that this was happening.

8.2.5 Research Objective 5

Examine how social workers think and feel when reflecting on these experiences.

This research has examined what social workers think and feel when reflecting on these experiences. Social workers felt powerless when observing poor outcomes for children, reflecting that some were avoidable if adequate services had been provided earlier. Adults, due to limited resources, were placed in inappropriate housing which exacerbated their distressed behaviour, only to be over-medicated to better manage them. Consequently, social workers were left feeling burned out, reflecting signs of moral distress because they felt complicit in processes and systems which work in contradiction to their personal and professional values. Some social workers felt the need to seek out privately paid psychotherapy while others had serious physical symptoms masked by the nature of their stressful work. Still others experienced clear signs of secondary trauma including intrusive thoughts and emotional dread.

This research has qualitatively explored social workers' experiences of the space existing between social work and mental health. While previous research has explored some of the systemic issues affecting social workers, this is the first research exploring how social workers

think, feel and operate in this contested space. It seems to make little sense to provide solutions from a systematic or organisational perspective before understanding what social workers are already doing, what they feel they are required to do, what is clearly outside their boundaries and how they navigate the undefined or unaddressed needs which they either choose to consider, or which are involuntarily put on them. Operating in a highly neo-liberally driven enterprise but driven by a sense of justice and empathy predisposes the social worker to professional frustration which, depending on the acuity of trauma she experiences in practice, can then manifest into moral distress and secondary trauma. These are deeply personal experiences which, prior to this research, have not been explored but deserve to be.

8.2.6 Final Deliberations

The following fictional story is composed of factors the participants described. A young person refusing to leave her house to attend her CAMHS appointment is diligently visited by a social worker who sits outside the closed bedroom door, asks questions, listens, provides encouragement and insight. In doing so, the social worker sees, hears, and smells the home where the young person lives, talks with her family and invariably starts to figure out "what's going on." However, this "support" is not the "treatment" the young person needs which is waiting for her at CAMHS. Eventually, the young person agrees to go but insists the social worker stay with her during the appointment, during which the social worker observes the CAMHS worker struggle to develop a relationship with the young person. The clinician speaks condescendingly, makes little eye contact and in general, does not appear to be a source of help. Later, the social worker tells the clinician what she thinks "is going on" and asks for the diagnosis needed for further help. However, the CAMHS worker is unable to provide a diagnosis until the young person has been seen several times. However, because the young person did not find the clinician helpful, she refuses any future appointments and the social worker is told the case will be closed due to "disengagement."

While all these events did not happen in a single case, participants reported several examples of their environmentally informed insights dismissed or medically plagiarised by mental health clinicians who purported to be the authority on a service user they saw perhaps once or twice, ex situ, using stigmatising language or, on at least two occasions, providing an

inaccurate “diagnosis” counter to the later proven accurate “what’s going on.” In short, while the diagnosis holds the authority, the social workers, unqualified to provide it, are often better situated to provide this insight, irrespective of what it’s called.

The above situation is untenable. Like a support vessel sailing around a larger fleet of warships, social work has historically and globally revolved around the peripheries of the helping industries, dipping in to fill gaps and “threadbare areas” determined by an ever-changing landscape of social, political and economic pressures. This has led to a diffusing of social work’s identity and a dismissal of the myriad of skills social workers bring to the clinical table. The thesis argues, from a qualitative standpoint, that one of these “gaps” has become so wide and prevalent that social work, in its current form, can no longer fill it. Further, the global conversation and our deepening understanding of mental distress recognise the social factors which contribute to it.

8.2.6.1 Diagnosis and Treatment

The thesis suggests that social workers are often in a better position to provide “treatment” just so long as they call it “support.” Social workers see homes and meet family members, both of which are often the root of the issue. Social workers can work with people in all environments; while driving, walking down the street, in a McDonald’s, in a park- wherever someone feels the most comfortable talking, a social worker will go there. Social workers are trained to “develop relationships,” a skill participants noted appeared absent from clinical encounters or recounts from service users. Yet the authoritative diagnosis or clinical help often needed for further resources (an educational benefit, in-patient treatment, medication) was ring-fenced by an overburdened service which found obscure clinical language, circular logic and arbitrary eligibility criteria useful to manage neoliberally driven metrics. Without clinical training or a basic understanding of the mental health industry (and often lacking the confidence to ask) social work shuffles away, overshadowed by the omnipotence of medical authority, left to manage the best it can.

Dissonantly, despite these issues, social work and service users continue to endorse the medical authority while dismissing social work, insisting that once we know what to call a

condition, it will be fixed. While this is sometimes true, this phenomenon often comes down to the language used. Participants described clinical treatment provided by a counsellor, but when she talks and listens, this is “support”, simply because she is not a counsellor.

The assertion that “social workers are not qualified to diagnose people” reflects a longstanding professional assumption grounded in the view that diagnostic authority properly belongs to medically trained practitioners. This position is often justified on the basis that social workers do not receive the same formal clinical training as psychiatrists or psychologists, particularly within specialist settings such as mental health hospitals or the criminal justice system. However, the realities of practice are considerably more complex. In everyday professional and social contexts, diagnostic language is used widely and often informally, both within and beyond healthcare environments. Terms such as anxiety, obsessive-compulsive disorder, or depression have entered common discourse, shaping how distress is described and understood.

Social workers are inevitably situated within this broader linguistic and cultural landscape and are therefore not exempt from the routine use of diagnostic terminology. Indeed, given their close engagement with service users’ lived circumstances, they are often well placed to make informed assessments about the sources of distress, even if these are not formally recognised as medical diagnoses. If diagnosis is understood more broadly as the process of identifying and explaining the causes of a person’s distress, then social workers frequently undertake forms of interpretive diagnostic work in practice.

The tension arises because mental health continues to be conceptualised predominantly through a medical model, in which explanatory authority is reserved for medical professionals. This creates a paradox: although many experiences of distress arise primarily from social, relational, economic, or environmental conditions rather than purely biological causes, the dominance of medical discourse means that diagnostic terminology remains the principal language through which such experiences are interpreted. As a result, social workers may be denied legitimate professional authority to name and explain distress in ways that reflect its social origins, despite often being uniquely positioned to do so.

By trying to observe professional boundaries and respect medical colleagues, social workers seem to indignantly dance around this ideological minefield to find creative ways to practice without "diagnosing" or "treating." Sometimes this is as simple as changing the language: "diagnosing" turns into "what's going on" and "treatment" turns into "management" or "support." The irony continues when medical staff then turn to the social worker to inform the medical diagnosis, sometimes by taking a social work report, medicalising the social worker's language, and reversing the process: "what's going on" turns into "diagnosis", carrying with it the professional authority the social work report lacked. Other times medical staff will simply ask a social worker to "pick a diagnosis" whereupon his medically-authoritative hand scribbles it on a form.

8.2.6.2 Social Work Identity in the face of the Mental Health/Social Work Boundary

Resulting from these experiences, the social worker is not the same. Training, which promised battling social injustice and marginalisation, now only acts as a reminder of traitorous emotions, now all too familiar, that accompany her through this alien journey. She struggles to support vulnerable people, now labelled and stigmatised by a system in which she is an unwitting participant, over which she has no control --her authority marginalised in the face of the overwhelmingly authoritative and medicalised mental health industrial complex. Her values, once cherished and brightly guiding friends, now lie bruised, broken and burned into oddly unfamiliar shapes.

It is time to rethink social work. Its members are highly skilled, dedicated, insightful and empathetic. They are already, as best they can, fulfilling many of the tasks reserved for their clinical, medical-based professional cousins, yet without the professional recognition, resources, support and training, social work's full potential to help vulnerable children and adults is stymied. Social work is well positioned to address the complex interplay of social and biological factors which contribute to mental distress, and this is evidenced in America, Canada, New Zealand, Israel, and Australia. Only social work in the UK, painted into its local authority corner and overshadowed by the politically present NHS, remains an outlier. Approaching social work more broadly from a professional perspective, aiming to work in partnership with service users was more realistic when social workers were "helpers" and not

there to enforce policy, curtail liberty and assess risk. Asking some social workers to walk this tightrope between therapist, partner, and enforcer is confusing, even for experienced social workers, and has the propensity to lead to tragic outcomes.

This change is not without considerable challenges. The UK, recovering from its economic separation from Europe and the COVID-19 pandemic and responding to the global immigration crisis, has its hands full with more politically visible issues. Social work in the UK is poorly politically represented and is facing several challenges of its own, both internally and externally. At the time of this writing, Social Work England, the relatively recently appointed non-governmental body tasked with regulating the profession, is under scrutiny and is currently being reviewed. Educationally, social work remains poorly organised, piecing together a framework from the previously disbanded College of Social Work while still adhering to aged value-based notions of political and social justice which struggle to materialise in a neo-liberal driven workplace.

But these changes are not unrealistic. The UK has historically made significant legislative changes when there is a large enough outcry for it. Following the 1996 Dunblane massacre which tragically saw 16 children and a teacher gunned down in a Scottish playground, the UK enacted the 1997 Firearms Act which prohibited private possession of almost all handguns. The Marriage Act of 2013 legalising same-sex marriage is another example. The UK has also historically and legislatively responded to the needs of vulnerable populations, e.g. the Equality Act of 2010 and the Health and Care Act of 2022 which attempts to better combine health and social care. While this last example attempts to address some of the issues described here, an organisational remedy has proved inadequate and does not provide social work with the recognition it deserves. If we carry on as we are, we can only expect a continuation and likely increase of institutionalised young people marginalised by arbitrary and often inappropriate labels, overburdened NHS and CAMHS resources and burned-out social workers.

However, with some political courage and a strong enough voice, the social work/mental health integration could reside within the professional, not exist somewhere between an ungraceful organisational amalgamation. The “socio-therapist,” if constructed and

implemented thoughtfully with adequate funding, could revolutionise the social work/mental health landscape in the UK, bringing some hope to a largely overlooked and increasingly vulnerable population.

9 Recommendations

9.1 Introduction

The previous chapter discussed and explored the conclusions drawn from the research study. These conclusions included reconsidering the toxic trio model, developing a new social work credential in the UK, introducing the concept of "endogenic thinking" and demonstrating how serial interviews can be used in conjunction with an elicitation meeting. The following discussion builds on these conclusions and makes recommendations concerning changes to existing policy, education and suggestions for further research. These recommendations follow the START structure in that they are **S**pecific, **T**angible/**T**argeted, **A**chievable, **R**elevant and **T**imely. In short, they are:

Policy

- Changes made to the Children and Social Work Act 2017 to allow for the new role of "socio-therapist" as described above. The role would be administered under the NHS while maintaining its socially based ethos but regulated by psychiatric and counselling organisations given the nature of the work the position would complete.

Practice

- Current social workers to recognise their "endogenic" thinking and use this new adaptation of this word to capture this mental shortcut.

- Social workers to be more mindful of therapeutic practice which has the propensity to cause secondary trauma and/or moral distress, leading to professional burnout.

- Social work supervisors to be more mindful of the above and support social workers to be aware of endogenic pitfalls and emotional burnout.

Education

- Accredited social work education programmes need to better reflect the shifting nature of social work in their curriculum and address the overflow from mental health. This means providing clinical knowledge, terminology, ethical debates, etc. within the core of their curriculum as specific mental health modules.

- Accredited social work education programmes may want to consider adopting the endogenic thinking concept into their curriculum, situating it within their ethics and values material/modules. To accommodate this, these programmes may want to consider reducing their emphasis on social justice and macro ideology.

Further Research

- A national, quantitative study should be funded to determine the pervasive nature of the ideas captured in this thesis. This would provide policy makers with the ammunition needed to make national change and would help identify regional anomalies.

- Male and more minority populations should be invited to contribute to further qualitative studies which would identify if the mental health/social work boundary construct is impacted by their gender and cultural lenses.

These recommendations are more fully explored in the following sections.

9.2 Policy

A new credential for social work should be created to formally reflect the dual nature of social work practice.

The thesis suggests the current legislation which governs social work should reflect the need for a post-qualifying social work credential which can operate on the boundary between social work and mental health. This would require changes to the Children and Social Work Act 2017 which makes provisions for the Social Workers Regulations 2018. After completing further education, this professional would hold an extended qualification to the standard social work credential, like the current AMHP credential. However, dissimilar to the AMHP, the "socio-therapist" would not fulfil a policy/legal role but would instead provide ongoing therapy to service users outside a medical office and outside a medically framed context.

The specific details of how this credential should be created is beyond the scope of this research; suffice it to say that it will require substantial political will, creative thinking, negotiation and a willingness to risk stepping outside old ways of thinking about siloed systems and professions. Further, some institutions, including social work, must be willing to critically reflect on their roles when striving towards providing meaningful services to people. Some of these institutions may require abandoning sacred but outdated notions of professional identity and must be willing to adopt ideas and practices which, until now, might be considered anathema.

9.3 Practice

Social workers should learn about and recognise endogenic thinking and practice.

The thesis discusses several systemic issues where conflict exists between disciplines, largely due to the medical/social model debate and medical hierarchy. Making practice recommendations to address these issues would result in a list of unrealistic objectives and would rely on the action of other professionals and organisations. Instead, it makes more sense to recommend actions which can be put in place now by currently practising social workers.

Firstly, social workers can begin to recognise the idea and language of endogenic thinking. Given the depth to which the medical model has permeated the general culture (Frances, 2013; Horwitz, 2021), social workers are more likely to unconsciously slip into this way of thinking more than ever before. Social workers can build into their reflective models an opportunity to double-check that assumptions and language about service users are not reflecting an endogenic premise. This could take place in private, singular reflection or manifest in supervision.

Secondly, the thesis acts as a reminder of the pitfalls of practising outside one's skillset and taking on an overly therapeutic role, recognising that the resources needed to manage the emotional fallout from these exchanges not likely available. In addition to the more widely discussed and understood stressors associated with social worker frontline practice, social workers would do well to remain mindful and aware of the additional emotional baggage of secondary trauma and be highly aware of any changes to their physical and mental health and question if these changes might be related to overly boundary-spanning into therapy.

Lastly, social work supervisors can be more aware of the propensity for social work to pick up clinical overflow by monitoring the nature of their staff's interactions with service users and supporting them to maintain strong boundaries which promote a clear social work objective. Practically, this means that staff do not share work or personal mobile phone numbers with service users. This would limit out-of-hours or inappropriate communication and help protect practitioner boundaries and promote staff using downtime to recharge and self-care. This could also mean ensuring staff attend self-care training and clinical mental health knowledge courses, ensuring these are quality services and are available to staff. If these do not exist, they can be easily created or contracted out with minimal cost to the local authority.

9.4 Education

Social work education needs to better prepare generic social workers for their dual role.

Generic social work education needs to shift substantially to reflect the mental health challenges service users currently face. Social work students should be exposed to clinical

mental health terminology including diagnostic criteria, broader and more substantial substance abuse training and introductory pharmaceutical knowledge. While not meeting the requirements for the "socio-therapist" role, they should be armed with the knowledge necessary to navigate themselves and service users through the mental health industry. By maintaining social work values (recognising social factors, self-determination, inclusive and service user partnered practice) social work students should be prepared to engage with the mental health industry from an informed and clinically sound foundation. This does not mean creating conflict with medical professionals or trying to undermine sound clinical treatment, but instead acts as a socially based voice, asking appropriate and knowledgeable questions and arguing for more environmental interventions, (i.e. social prescribing, psychodynamic therapy) and pushing back against the over-reliance and quick-fix approach of psychotropic medications. These changes could easily be required by Social Work England which regulates social work education and could manifest in specific modules dedicated to mental health, or at the very minimum, a single module which covers these areas.

Social work students should learn to be prepared to confront and work with potentially physically and psychologically dangerous service users. As discussed in previous chapters, social workers are more likely than other professionals to encounter those exhibiting predatory behaviour, yet currently lack the psychological tools to safely do so, including an ignorance of their very existence. Given social work's sensitivity towards deterministic labels, this may prove a challenge. However, it does not seem unreasonable to help students understand the difference between a potentially damaging, socially constructed label and one rooted in objective medical science. Further, one does not need to label someone a psychopath to deploy the skills needed to protect oneself. This skillset need not override social work's values of acknowledging service user's strengths and working in partnership. However, should that service user's strengths include causing harm, lying and manipulating, social workers should know when to shift direction and protect themselves and those around them from those who can cause harm.

Lastly, social work education may want to consider incorporating endogenic thinking into their ethics and values standard curriculum, treating it as either theoretical or practical material or both. Doing so prepares social work students for a professional career

characterised by medical dominance and provides them with language to challenge this when appropriate. Educating students about endogenic theory at an early stage has the additional benefit of highlighting the culture-wide practice of victim blaming, overmedicalisation and depoliticising larger social oppressive forces. This speaks directly to core social work values, strengthens social work's contribution to the wider helping industry and demarcates conceptual territory for the social work discipline. In short, social work can start defining itself as the profession which routinely pushes back on endogenic practice, language and assumptions and this begins with educating students.

To accommodate this extra curriculum, social work education may also want to consider reducing the high emphasis around macro social justice. Defining social work by these values in contrast with other professionals may create more problems than it solves. Firstly, social work may risk alienating itself from other professionals by continually espousing values of social justice and suggesting that these values are exclusive to social work. Social work is not immune to discriminatory practice towards service users. Further, the gender and racial imbalance evident among social work leadership and research roles suggests that even within the profession sexism and racism are present. Secondly, there is no strong evidence to suggest that social workers behave or practise in a more socially aware way than other professionals despite their purported social values. By so vocally aligning themselves as such, the profession runs the risk of self-isolating into an echo chamber of their own good intentions but lacking credibility in the face of political inaction. While these ideas may provide social workers with a sense of identity and act as a moral-affirming compass, without any political presence, they appear to have little use or place in today's contemporary, neoliberally driven social work practice.

9.5 Further Research

Further research should include a national, quantitative study which would indicate the prevalence of some of these themes on a macro scale. A national survey consisting of thousands of participants may highlight regional nuances and provide a different dimension to the qualitative data discussed in this research. As I am calling for change on a national scale, it seems reasonable to perform nationwide research which may further justify such

changes or suggest that the experiences discussed here are limited to the regions from which the sample was drawn.

Because my sample was 100% female, further research should also include exploring the mental health/social work boundary from male social workers' experiences. While my analysis did not incorporate any gender specific theory or determine that gender was a specific factor informing how social workers experience the social work/mental health boundary, principles of academic rigour demand that this factor be explored in the hope of developing a more generalisable understanding of this boundary. Additionally, as my sample size was roughly 90% White-British, the same argument justifies further research exploring this boundary from a non-white perspective. As discussed in the background chapter, mental health and how we understand it have historically been defined by White-European males and this has consequently led to institutional victimisation and marginalisation of both women and members of non-European populations. For these reasons, their voices, when asking any mental health-related question, need to be heard as prominently as any other.

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Appendices

Appendix A: Final Ethics Approval

School of Health, Science and Wellbeing

ETHICAL APPROVAL FEEDBACK

Researcher name:	**Anthony Bruner**
Title of Study:	**SU_22_040** How do social workers engage with mental health concepts in practice. Amendment of SU_21_010
Award Pathway:	**PhD**
Status of approval:	**Amendment approved**

Thank you for your correspondence requesting approval of a minor amendment to your previously approved application, as outlined in your e-mail of 21st September 2022.

Your amended application is approved. We wish you well with your research.

Action now needed:

Your amendment has now been approved by the Ethics Panel.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal. This approval is only valid for as long as you are registered as a student at the University.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site

Signed: **Date: 21 September 2022**

Prof. Roozbeh Naemi

Ethics Co-ordinator
Sport and Exercise
School of Health, Science and Wellbeing

Appendix B: Twitter (X) Research Advert



Anthony Bruner MA, PE, PGCE, FHEA, PhD Candidate

PURPOSE: This study will explore social worker's experience of encountering mental health concepts while in practice

PROCESS:
You will be interviewed twice with a six month interval

Interview 1 – Explanation of the research, purpose and answering any questions (5 – 10 minutes)

Interview 2 – Reviewing how you used mental health concepts within the six month period (1 – 2 hours)

PARTICIPANTS WANTED

You may be able to claim your participation as part of your annual SWE continuing training.

This research has been approved by the Staffordshire University ethics committee.

STAFFORDSHIRE UNIVERSITY

Expectation of the participant:
In addition to the two interviews you will be asked to keep a personal log pertaining to some of the work you might do within the next six months, however if keeping a journal seems too time consuming, you can simply make a few notes during this period of time. We will then use this to support our conversation in the second interview

What about after?
Once your participation has completed, you will have the opportunity to debrief with the researcher to discuss how you found the experience or to ask any final questions.

Once the research has been completed, you will have the opportunity to review the research findings or read the entire thesis.

For further information : **anthony.bruner@staffs.ac.uk**

Appendix C: Consent Form

CONSENT FORM

Title of Study: How do social workers navigate the social work/mental health boundary in practice?

Name of Researcher: Anthony Bruner

Participant number:

		Please initial box
1.	I confirm that I have read and understand the Information Sheet dated [...] (version 1.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical or legal rights being affected. I also understand that I can withdraw my data from the study at any time up to one month after the interview, by contacting the researcher.	☐
3.	I understand that individuals from Staffordshire University may look at relevant sections of data collected during the study, where it is relevant to my participation in the research.	☐
4.	I understand that my manager/supervisor may be contacted if I disclose that I have engaged in illegal behaviour or intentionally caused harm to a service user.	☐
5.	I understand that anonymised data from the interview may be used in the study report and subsequent publications.	☐
6.	I agree to the use of audio and video recording using MS Teams.	☐
7.	I agree to take part in the above study.	☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

Appendix D: Information Document

How do social workers navigate the social work/mental health boundary in practice?

Participant Information Sheet – [Social Workers/MH]

Introduction

My name is Anthony Bruner. I am Lecturer in Social Work at Staffordshire University. I would like to invite you to take part in this research on how social workers engage with mental health concepts. Before you decide whether to participate, I would like to explain why this research is being done and what participation would mean for you. We can go through this information sheet together and you can ask any questions that you might have. This should take about 15 minutes. You might also find it helpful to talk to other people about this research before deciding whether to participate.

What is the purpose of the study?

This study will explore social worker's experience of encountering mental health concepts while in practice. "Mental health" refers to knowledge and confidence around the diagnosis, treatment, prevention and symptoms of various mental health conditions.

Why have I been invited?

You have been invited to participate in this research because you expressed interest in the information you received from your team leader or service manager.

Do I have to take part?

If you do not wish to take part that is absolutely fine, and no explanation will be required. Participation in the study is entirely voluntary. In addition, if you offer to take part but change your mind then you can withdraw from the process at any stage and no explanation will be required. You can also request to have your interview data removed from the study, up to one month after each interview. Please note that if you request to remove data from the second interview, then data obtained from the first interview would still be retained.

What will happen if I take part?

We will meet a total of three times. We will first meet briefly to discuss the nature of the research and answer any questions you may have. You will be asked to keep a personal log pertaining to some of the work you might do within the next six months, however if keeping a journal seems too time consuming, you can simply make a few notes during this period of time. The second interview should take about .5 to 1.0 hours and will involve reviewing your thoughts and feelings when you were working with mental health issues in practice within the last six month and we will review what information you recorded in your journal.

You can use your journal to keep track of your experiences and we can use it to help our conversation. This interview is likely to take longer since we will be exploring some of the ideas around your experiences. The third and last interview will be more targeted and probably last a similar time as the first. We will use this time to more deeply explore some of the ideas you expressed in the first interview.

Both interviews are semi-structured, meaning they are informal and we can allow the conversation to go where you would like, however there will be some set questions which I will need to ask as part of the research.

What are the possible disadvantages and risks of taking part?

You may find discussing your social work practice uncomfortable or may find discussing particular cases distressing. If you find yourself experiencing any adverse emotions during the interview, there is no pressure to continue or we can take a break.

What are the possible benefits of taking part?

You may be able to claim your participation as part of your annual SWE continuing training. Information you provide will contribute to the findings of my research. It is hoped that social workers will be able to more fully understand and use clinical mental health knowledge to protect vulnerable people and/or participate and feel more confident when working in MDT settings or coordinating discharge plans. You may also learn more about your practice as a result of participating.

Will my participation be kept confidential?

All information which is collected about you during the course of this research will be kept strictly confidential under General Data Protection Regulation (GDPR) guidelines. Further, any information you may reveal about service users or families will either be anonymised in, or omitted from, any future documentation under GDPR guidelines. Throughout the study access to personally identifiable data will be restricted to the researcher. All video-recorded interviews and transcripts will be anonymously filed in password protected cloud storage for the duration of the study. Following completion of the study, anonymised interview transcripts will remain in password protected cloud storage for an additional 10 years per university policy. In order to demonstrate the experience social workers may have, I should like to use anonymous quotes from your interview responses in publications such as books and journal articles, or seminars/conference presentations.

Additionally, my direct supervisor, Dr. Edward Tolhurst, may need to access your data. However, this would only be done should any issue arise.

If you choose to stop your participation, all the data will be removed from storage and destroyed.

What happens if I disclose something that may need reporting?

If you provide me with any information which highlights a risk of harm to you or another person, then I shall need to inform a senior colleague at the University, Dr Peter Kevern, in the first instance. If necessary, the university might contact you. Dr. Kevern can be contacted at P.Kevern@staffs.ac.uk.

In extreme circumstances, i.e. harm has intentionally been caused to a service user or you disclose that you have engaged in illegal activity, then your direct line manager may need to be contacted.

What will happen to the results of this study?

The data gathered during this study will be analysed and submitted as part of my post graduate thesis. It is also anticipated that the findings of this study will be disseminated through oral presentations delivered at events and seminars. These findings will be anonymised and you will not be identifiable in any of the material that is disseminated from this research. It is also possible that some parts of the thesis, and therefore anonymised information you report, may appear in published articles or journals.

What if there is a problem?

If you have concerns about any aspect of this study, you should contact the researcher using the details provided below, who will endeavour to answer your questions. If you remain unhappy and wish to complain formally you can contact Nachi Chockalingam at:

Research, Innovation and Impact Services
Cadman Building, Staffordshire University, College Road, Stoke-on-Trent
ST4 2DF
n.chockalingam@staffs.ac.uk

What will happen if I become upset during this research?

If you find any aspect of this research upsetting, then this can be raised with the researcher. Alternatively you can discuss this with Dr. Edward Tolhurst at E.Tolhurst@staffs.ac.uk.

Who has reviewed this study?

All research is looked at by a group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by the ethics panel at Staffordshire University.

Thank you for taking the time to read this. It is hoped that the information provided above clearly answers any questions you may have about this study. However, should you have any further queries or require additional information, please do not hesitate to contact me. I

should be pleased to hear from you. You can also contact my supervisor, Dr. Edward Tolhurst at E.Tolhurst@staffs.ac.uk if you have any concerns.

What happens once the research concludes?

Once your participation has completed, you will have the opportunity to debrief with the researcher to discuss how you found the experience or to ask any final questions.

Once the research has been completed, you will have the opportunity to review the research findings or read the entire thesis.

GDPR Statement

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).
The data controller for this project will be Staffordshire University. The university will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the GDPR is a 'task in the public interest'. You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.
You have the right to access information held about you. Your right of access can be exercised in accordance with the GDPR. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

Thank you.

Researcher Contact Details
Anthony Bruner, MA, PGCE, PE, PhD Candidate
Social Work Lecturer, BA Course Leader
Ashley 2, LW143
College Road
Stoke-on-Trent
ST4 2DE

Tel: 01782 295783
Anthony.bruner@staffs.ac.uk

Appendix E: Participant Profile Example

Participant Profile

Name: Elvira

Role: Service Manager

Years Qualified: 25

Location/Local Authority: Northwest Local Authority

Framework for how she understands MH: Elvira is a service manager so she is very interested in how the systems work together from a managerial standpoint. She raised some very good critical questions about MH, particularly around what we call things and why we call them that.

Training Issues:

Questions for 2nd Interview:

If they feel they can question the dx, what makes them think they can't provide one in the first place? (3:51)

What does she mean by MH or behavioural? If we diagnosis MH disorders via behaviour, how are they different? (3:08)

Everyone seems to think everything is tx with DBT, EMDR, CBT but no one really understands what these are or what they treat. Does she know what these are? (7:47)

So what does the MH Team actually do? 28/09/2026 13:36:00(13:36)

Can she say more about behavioural vs MH. 15:51

Why does she think he was taking all these drugs? Self tx, addiction, recreation, etc. (16:17). How were they justifying this? (behaviour)

How does she feel about the fact that it appears her team's dx was more accurate than the MH team's dx? (18:50)

``what training did this SW have to do this? Do you know how she managed to do this? (24:47)

Does it matter WHY they may not engage? (27:58)

Challenge her about the nature of work her SW'ers are doing (32:59)

s it possible that SW does more MH work because the issues causing the problems are social? (32:59)

Labelling vs.diagnosis. When is it one or the other? (40:21)

Do you think SW should combat this in anyway? (52:47)

Appendix F: Coding (First Interviews)

Name	Description	Files	References
COVID-19		2	3
MH-SW boundary blurred since Covid		1	1
Diagnosis		7	21
Benefits of having		3	4
Benefits of not having one		1	1
Don't diagnose		3	5
Eating Disorder		1	1
EUPD		3	4
Over diagnosed		2	4
PTSD		1	1
To get services		3	4
Trauma		7	9
vs. Label		7	15
ID MH		4	6
Rx		2	5
Something that is diagnosed		3	4
What is NOT MH		1	1
Autism		0	0
Substance Abuse		1	1
Trauma		2	2
Medical-Social Model		6	6
Medical is Harmful		1	2
Medical is Helpful		2	2
Medical is not Useful		1	2
Medication		4	7
Masks Pain		2	2
MH Aetiology		0	0
Chemical Imbalence		1	1
Drugs		0	0
Past Experiences		1	2
DV		0	0
Grief and Loss		1	1

Name	Description	Files	References
Sexual Abuse		1	1
Social Isolation		1	1
Trauma		5	6
MH Definition		1	1
Age		0	0
Adults have PD		0	0
Kids are traumatised		0	0
An environmental issue txed with drugs		0	0
Defined by Severity		1	1
Managable in care or education		1	1
I don't know		1	1
Not Behavioural		0	0
Txed with meds or an acronym		0	0
Outcomes		0	0
Adults		1	1
Kids removed		0	0
Over Medicated		1	2
Children		0	0
Adults with PD in Hospital		4	9
Have children removed		1	1
Self harm or suicide attempt		1	1
Trauma is Suppressed or managed		5	20
Social Workers		6	12
Risk Assessment		2	2
SW Confidence		1	1
Confident but incompetent		1	1
Not confident but competent		5	10
SW Identity - How they see themselves		6	12
Advocate		2	2
Defined by leg		2	9

Name	Description	Files	References
Expectations of Honesty		1	1
Fill gaps		2	2
Just the SW		2	2
Not Qualified to Dx		4	5
Medical-Social Hieracrhy		9	14
Practical Things		0	0
Reasons SW feel compelled to work		1	3
Support		2	4
Accomodation		1	2
Informal		2	3
Listen		1	2
Values		4	4
Concious of medical language		1	2
Empathy		2	2
Live freely		3	3
Live safely		0	0
Not be over-medicated		0	0
Not feel complicit in a devaluing system		2	3
Prepared to help explore trauma		2	3
SWers as defacto MH workers		5	11
Actually providing therapy		3	4
Arbitrary Boundary		1	2
Assess suicide		3	3
Diagnose but don't diagnose		2	3
Discharge management		3	5
Find someone who is suicidal		1	1
Had correct diagnosis		1	1
Manage acute MH issue		15	38
Not My Job		2	2
Prevent Suicide		2	2
Provide Aetiology		1	1

Name	Description	Files	References
Provide information to health		4	6
Psychopaths		3	12
Second Therapist		5	11
System Issues		3	4
Adults		1	1
No beds		1	1
No Services		6	12
Poor services		4	5
Service does not engage		5	9
Autism		1	1
CBT and EMDR		4	6
Children		1	1
CAMHS or MH Teams		1	1
Can be selective		3	7
Behavioural		3	5
Drug using		4	5
It's social		1	1
Discourages therapeutic work		1	4
Doesn't leave the office		1	1
Not available		3	8
Offers poor services		7	18
What SW thinks CAMHS does		6	15
Will disengage for any reason		5	12
Working well		3	5
GP		0	0
Medical Mysticism		5	14
Training		5	8
What They Do Inlieu of no training		3	3
Ask for Training		0	0
Ask someone else		4	6
Find Other Sources		1	2
Google		4	5

Name	Description	Files	References
Ignore or Overlook the Issue		1	1
Learn on the Job		3	3
Provide Pseudo-therapy		1	3
Rely on Personal Experience		6	9
What They Get		2	2
MH First Aid		3	9
Training Programs		2	4
UG Training		3	5
What They Need		1	1
Medication		3	5
Process		1	1
Suicide Risk Assessment		1	2
Vocabulary		5	14
What SWers Need		0	0
Clinical Supervision		1	4
Information about SU		3	5
Safety		0	0
Physical		4	13
Psychological		4	14
Time		5	8

Appendix G: Coding (Second Interviews)

Name	Description	Files	References
Theme 1- Being a social worker (Values and Identity)		0	0
Idenity		0	0
Training		0	0
Values		0	0
Theme 2- Metamorphosis (Transitioning into a Mental Health Professional		0	0
Sub-Theme 1- The Approach (Mental Unhealth in Practice)		0	0
Mental Health Ontology		0	0
Social and Environmental Factors		0	0
Systems		0	0
Sub-Theme 2- The Becoming (Turning into a Mental Health Professional)		0	0
Acute Mental Health Management		0	0
Managing Safety		0	0
System Gaps		0	0
Training Gaps		0	0
Theme 3- Aftermath (Outcomes for SW and SU)		0	0
Outcomes for Social Workers		0	0
Burnout,Sick, Poor Work-Life Balance		0	0

Name	Description	Files	References
Professional Identity Crisis		0	0
Retention		0	0
Secondary Trauma		0	0
Stress-Related Illness		0	0
Outcomes for SU		0	0
Adults		0	0
Inappropriate Accomodation		0	0
Over-Medicated		0	0
Children		0	0
Hospitalisation at 18 and PD		0	0
Self-Harm and Suicide		0	0
Suppressed Trauma		0	0

Appendix H: Preliminary Themes

Themes

How do SW'ers define mental health?

Defined by severity.
    This is defined by whether the "behaviour" is "manageable, i.e. in a care situation
Defined by "not-behavioural"
Defined by age
    Kids are traumatised, adults have PD
Something that is tx with an acronym or medication

An environmental issue which is treated with drugs (making it a MH/medical issue).

"It's a 'hot potato', no one want to touch it." SR

SR said she did not appreciate the medical model until she did her AMHP training. Is this something worth considering?

(ZM)
Someone who is self-centered, is difficult to work with.
Someone with dyslexia or not very bright (someone who doesn't iron clothes, poor parent)
"Someone whose thinking is not as normal as it should be."
Someone who is happy or if they aren't they can ask for help (presumably to be happier.)

Because everything is pathologized now, it's hard for specialist services to get involved when it's the real deal.

What isn't "mental health?"

Autism
Truama
Substance Use

What causes mental illness?

Drugs
Someone's past

What kinds of MH things are SW'ers doing?

"Managing" behaviour
    While being mindful of not digging into the cause
    To meet the needs of services, i.e. the care placement
Assessing suicide

"preventing suicide"
"Listening"
Providing aetiology to behaviour (BF)

How confident are SW'ers when dealing with those with mental illness?

Confident but incompetent
Not confident but actually doing a pretty good job
Learning on the job

Are SW'ers defacto MH workers?

Manage people while they're waiting
Manage people because they've been declined or disengaged by MH services
Doctors asking SW'ers to "pick" a diagnosis.
Sitting in with a young person and acting as a "secondary therapist."
"First Aiders"
Challenging suggestions made by CAHMS for work SW to do (life story work, XX)
SWers provide information to health who then make the dx

What informs SWer's conceptualisation of MH?

Own experience
Learn on the job

Label or Diagnosis?

"I can't diagnose, but-"
"I think they have this…"
"I can see they are struggling"
"I don't agree with the given diagnosis"

Diagnosis = the person can't help these behaviours (helps to allow empathy)
Some SWers see all behaviour as "MH" despite some people actually have reason to be upset (XX). This is combatting the labelling.

System Issues

CAMHS will disengage for a variety of reasons
CAMHS or MH Teams can be selective about who they see
CAMHS offers poor services
CAMHS uses substance use to avoid working with people
CAMHS will look for social reasons why someone is behaving a certain way and put this back on SW (but no social worker has ever seen someone with a "pure" mental health issue, i.e. no social issues, ie trauma (BF and KM).
Adults, No beds =put him somewhere which is not appropriate and then overmedicate him to keep him calm so he is better managed. RP felt "complicit" in a "shitty" system.

The irony about this is that through the social worker's natural role of "befriending" and listening, they encourage the YP to open up, one of the key criticisms lodged against CAMHS. But then they don't have the "training" or anything else to support the young person to process what they need to, which is left to CAMHS, but the kids don't open up to them because they're tools and the trauma is internalized. For XX, she befriended this young person to get her to go to CAMHS to get the diagnosis knowing CAMHS would close the case if she didn't go, but I just wonder if a better outcome might have been possible if Debbie could have diagnosed her, worked with her, etc. and helped the young person process whatever was at the root of the issue. The same applies to XX and her young person. But because we are so hung on the diagnosis and because this is the key to services, this step is required. But then even when the kid goes to CAMHS, the kid doesn't find it helpful despite viewing them as the ones who can "fix" them and they go away no better.

Behavioural vs MH (mad vs bad?)

Social worker seem come up against this a lot from CAMHS (BF, KM)
Diagnosis = mad, dismisses "behavioural"

How are SWers expected to support people when the diagnosis keeps changing? (XX)

Outcomes for Young People

YP are "managed" which means oppressing their feelings of trauma and rejection. This is done to keep them in school, keep them in a foster home, keep them out of hospitals, (organisational needs) so then the trauma starts to internalise into a PD and the chaos creating behaviours start. So we "scaffold" with supports which disappear at 18 instead of allowing emotional release f/u with internal resources.

Had a YP been given trauma support, they wouldn't turn into an adult with a PD (XX).

Outcomes for Adults

Parents are given unrealistic or impossible standards or expectations
    Don't need drugs for schizophrenia
SW'ers who don't understand their illness and/or make judgements

What don't SW'ers have that they need to do what they are now doing?

Training

They often don't know what any of the terminology is (diagnosis, tx, medication, concepts)
"MH First Aider Training" (XX)
"All I have is what I've picked up." Training does not provide any insight.

Clinical supervision
Safety
    Physically
    Emotionally
Time

What do social workers do to meet their need?

Google
Ask someone (husband, friend, colleague)
Try to get training

How do social workers learn about mental health?

"MH First Aider Training" (XX)
Online Training (very surface level, and this AMHP level training) (XX)
Some councils don't offer any training to SW (XX)

What learning support would SWers like and what do they currently experience?
    Who can explain things to me? What kind of services are available?
    If adult doesn't consent, no one will speak with the SWer

Google (SR)
Even when SW'ers ask for MH information, it's "blocked" only for AMHPs. Why? (XX)

Social Worker Identity

Not qualified to "diagnose" but seem qualified, and do, a lot of other things
SW'ers help the person manage their lives with the diagnosis, not their job to treat it (even if it's a social issue.)

SW'ers address the "practical needs." (XX)

We offer "informal" support which seems basically being a friend who will listen.

We're trying to do everything all at once (XX)

Parents keep things from SWers because they will use information against them.

What mechanisms do social workers use to determine the boundary between SW and MH?

Legislation (BF, RP)

The Role of Medication

The medication doesn't fix the problem. Anti-depressants act as pain killers which masks the problem.

Values

Social workers want to see people live safely and be able to express themselves, not overly medicated and warehoused.

SWers feel "complicit" or "guilty" in engaging in a dehumanising system which does not reflect their values.

Mental Health Issues SWers Experience

Is this worth including in the thesis?

COVID-19

The boundary between MH and SW has blurred due to lockdown exacerbating underlying difficulties (XX).