Professional Supervision: What are the Benefits for Mental Health Social Workers and Service Users?

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Abstract

This project aims to capture the perceptions of mental health social workers in an integrated mental health service regarding their experience of professional supervision and to assess whether such supervision has a positive impact on their ability to articulate their role and identity within their teams. This is particularly relevant for mental health social workers who are often located within teams where they are the only social worker. An additional factor in the area in which the study took place is that mental health social workers are frequently based in teams where the line manager is from a health background and may be perceived by social workers not to have an understanding of or interest in social care issues.

A secondary aim of the project is to assess whether access to professional supervision supported social workers to ensure that the social care needs of individual service users were identified and met in an appropriate manner.

Data was gathered from questionnaires and a focus group from a convenience sample of 25 mental health social workers based in adult community mental health teams. Social workers expressed varying levels of satisfaction with the supervision received from their line manager regardless of their professional background and although they valued additional professional supervision as an opportunity to focus on their specific personal and professional development needs, the hypothesis that this supervision would have a beneficial effect on their ability to articulate their role and identity was not proven.

However social workers did seem to derive some benefit from professional supervision in attempting to ensure that the social care needs of individuals were met both within their own practice and within the wider multi-disciplinary team context.

CONTENTS

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LIST OF APPENDICES

CHAPTER 1

Introduction

This chapter provides:

- An introduction to the context of mental health social work in integrated teams
- An introduction to issues relating to identity for social workers in multi-disciplinary teams
- An introduction current issues relating to service provision in adult social care
- A description of the remaining chapters of this study

1.1 Context of Mental Health Social Work

Since the introduction of the National Service Framework (NSF) in 1999 the model for community mental health services has been multi-disciplinary teams with a single line management structure across health and social services; the intention of which was to provide a seamless service for adults with mental health problems.

In the local authority in which this study was undertaken, social workers are employed in all community based teams including Assertive Outreach, Community Mental Health Teams (CMHTs) and Crisis Teams. In some instances there is only one social worker in a team, with the largest numbers of social workers tending to be located in CMHTs and a number of social workers have been recruited to posts described as Practitioner or Case Manager rather than social work posts. The number of team managers from a social work background has reduced significantly in some areas following the expiration of the clause within the Section 75 Partnership Agreement to maintain a balance of the numbers of managers from health and social care. Therefore social

workers in this local authority are often managed and supervised by a manager from a different professional background, usually nursing or occupational therapy and may find that their manager has little understanding of social work or social care issues.

1.2 Social Work Identity in Mental Health Teams

The issues of role blurring and professional identity for social workers in mental health teams have been identified within a number of different studies (Peck and Norman, 1999; Carpenter et al, 2003; Atkinson et al, 2007) with supervision being viewed as an important mechanism by social workers which promotes their specialist role within teams.

In the DH progress report *Mental Health: New Ways of Working for Everyone* (2007) four key areas for development emerged re the role of social workers in mental health teams, one of which was social work identity. The New Ways of Working for Social Workers consultation process had also highlighted the fact that although social workers may be part of a mental health team they often feel that their contribution is not valued.

Most recently BASW (2010) have produced a draft report regarding multi-disciplinary mental health teams and made recommendations as to the structures and support which must be made available to mental health social workers in order to ensure effective service delivery to adults with mental health problems, one of which is access to professional supervision from an experienced social worker to support the role and identity of social workers in integrated teams.

18 months prior to undertaking this research project I had conducted a survey of mental health social workers regarding how valued they felt by their employer, the conclusion of which was that social workers in integrated teams felt devalued by both

their employer and the Mental Health Trust and were struggling to articulate their role and identity within teams. Partly as a result of that survey the decision had been made to develop the role of Senior Practitioner within Adult Mental Health Services with the intention of ensuring that all mental health social workers had access to specific professional supervision focusing on their personal and professional development needs as a social worker in addition to supervision from their line manager. However recruitment to these posts had been problematic and at the time of undertaking this project almost 50% of posts remained unfilled, therefore potentially having an impact on social workers' experience of supervision which will be the focus of this study.

1.3 Current Issues Relating to the Provision of Services in Adult Social Care

The document *Putting People First* (2007) was a protocol which introduced the Government's commitment to support all adults to achieve maximum independence through a radical transformation of adult social care which would deliver services through a personalised system. The introduction of Direct Payments and individualised budgets has been a challenge for mental health services to deliver and social workers have been charged with promoting this new model of service provision within multi-disciplinary teams. A secondary focus of this study was therefore to assess whether supervision was supporting social workers to ensure that the social care needs of individual service users and carers were being met in the most flexible and appropriate manner.

1.4 Research Proposal

A research proposal (Appendix 1) was therefore developed to test my hypothesis that those social workers who were in receipt of specialist professional supervision would be more likely to be able to articulate their professional role and identity within the

multi-disciplinary team. A second hypothesis to be tested was whether receiving professional supervision supported social workers to ensure that the social care needs of service users were identified and met in an appropriate manner both within their own individual practice and within the team context.

1.5 This Study

The remainder of this study will include:

- A review of the literature relating to supervision
- A discussion of the methodology used in the study
- A discussion of the results produced by the study
- A summary of the conclusions and recommendations produced by the results of this study

CHAPTER 2

Literature Review

This chapter describes:

- An introduction to the literature reviewed
- Background informing the literature review
- Search strategy, including question formulation, key words
- History of supervision
- Evidence re impact of supervision on social workers
- Evidence re impact of supervision on outcomes for service users
- The implications of the literature review for this study

2.1 Introduction

The purpose of this review was to examine the literature available which discusses the role of supervision in social work in general and then to further explore whether the literature is able to define the role and function of supervision in assisting social workers to articulate their identity in multi-disciplinary teams. I also wanted to assess whether there is a body of literature which supports the role of supervision in achieving improved outcomes for service users.

2.2 Background

The implementation of the *National Service Framework for Mental Health* (1999) led to the development of multi-disciplinary mental health teams with a single line

management structure to support the delivery of high quality services to people with mental health problems and their families and carers. This has led to social workers being employed in teams where they may be the only worker from this professional background and being managed by staff from a health background. The consequence of this is that social workers often struggle to articulate their role and professional identity to managers and colleagues and that social care issues may not be fully addressed or acknowledged within teams to the detriment of service users and their families.

In its recommendations regarding supervision the final report of the Social Work Taskforce (Nov 2009) identifies that 'Where the line manager is not a social worker, professional support should be provided by an experienced social worker" (p35). However in my experience this professional support is often not made available to mental health social workers in any systematic and robust manner and as a consequence many of these staff are left feeling isolated and out of touch with developments in social care, e.g. the transformation agenda which has yet to be implemented in any meaningful way within mental health services.

2.3 Search Strategy

My question formulation at the start of the literature review was "Does access to professional supervision assist mental health social workers in articulating their role and identity in teams for the benefit of service users?" This question was formulated using the PICO format. In this case:

Patient Group = staff group, i.e. social workers

Intervention = access to supervision

Comparison = what alternatives could there be? This could be a negative comparison, i.e. the impact of not receiving supervision

Outcome = outcome would be for social workers to provide a world class service and the benefits of this for service users

In seeking to identify relevant literature I undertook a search using key words arising from the use of the PICO format and Boolean operators across a number of databases (see Table 1 for details) as well as a number of key texts and the references cited within the selected papers. This led to over 100 potential studies being identified.

I decided to adopt inclusion/exclusion criteria for the literature review which were:

(a) Studies focused on supervision in clinical practice (including social work, nursing, and psychology)
(b) Studies were published in English in the past 30 years

Using these criteria the number of studies to be included in the literature review reduced to 43, several of which focused on the development of supervision from a historical perspective (Barretta-Herman, 1993; Bruce and Austin, 2001).

Whilst many of the studies identify the benefits of supervision for workers (Beddoe, 2010; Cohen and Laufer, 1999) there is a general consensus in the literature that there is limited research on the impact of supervision on outcomes for service users (Vonk and Thyer, 1997; Bogo and McKnight, 2006).

Table 1 Databases Searched and Search Terms Used

Database	Subject Areas	Search Terms
MEDLINE	General Medical	social work; supervision; outcomes; clinical; client; service user; professional supervision; mental mental health
PsycINFO	Psychiatry, psychology, social sciences	social work; supervision; outcomes; clinical; client; service user; professional supervision; mental health; role; identity
CINAHL	Nursing & allied health	social work; supervision; outcomes; clinical; client; service user; professional supervision; mental health; role; identity
ASSIA	Social services, psychology Sociology, health information	social work; supervision; outcomes; clinical; client; service user; professional supervision; mental health; role; identity
SCOPUS	Social Sciences	social work; supervision; outcomes; clinical; client; service user; professional supervision; mental health; role; identity

2.4 History of Supervision

Many of the studies (Barretta-Herman, 1993; Smith, 1996, 2005; Tsui M-S, 1997; Bruce and Austin, 2001; Noble and Irwin, 2009) identify the work of Kadushin (1992) as key to the development of a theoretical framework for social work supervision. Kadushin's model is described as one in which three separate functions of supervision are identified: administrative, educational and supportive.

The literature reviews undertaken by both Barretta-Herman and Bogo and McKnight highlight the role of supervision in supporting the professional development of social workers. Both studies also comment on the particular issues for mental health social workers with Barretta-Herman concluding that practice in mental health settings of combining clinical administration and clinical supervision has the potential to mean that the educative and supportive functions of supervision will be neglected because "the task-oriented responsibilities of the administrative function may appear more critical to agency survival" (p58). Bogo and McKnight report that cost containment measures in mental health and other health settings had led to supervisory positions being eliminated, leaving some social workers with no supervision and small, though significantly increasing numbers of social workers, reporting supervision by non-social workers.

A review of seven major texts on supervision in social work by Bruce and Austin (2001) again highlights limited evidence in the literature on the nature and effectiveness of supervisory practice. Although limited to a small number of texts, their research does identify a number of recurring themes in the literature which reviews the history of social work supervision, i.e. administrative control; training and education; therapeutic support; professional independence and accountability for limited resources.

2.5 Impact of Supervision

Of the 43 texts reviewed 9 describe the lack of empirical evidence relating to the impact of supervision on either worker or service user outcomes. Bogo and McKnight claim that in the past decade there has been "a dearth of empirically-based knowledge to support claims made about the importance of supervision" (p61) This view is also repeated by Clare, 1988; Harkness and Poertner, 1989; Vonk and Thyer, 1997; Spence et al, 2001 and Milne et al, 2008.

Nevertheless several of the studies (Harkness and Hensley, 1991; Harkness 1995, 1997; Cohen and Laufer, 1999; Mor Barak et al, 2009; Beddoe, 2010) report an association between supervision and beneficial outcomes for either workers or service users.

A small number of the studies reviewed have as their primary focus the impact of supervision on either social workers or service users. Milne et al (2008) undertook a "best evidence synthesis" (empirical review) in order to establish how supervision works. Once again a lack of empirical evidence in this area is highlighted but using the best evidence synthesis method and eight inclusion criteria the authors identified 24 peer-reviewed articles although these were mainly from the field of learning disability.

From these studies 28 different outcomes, or mechanisms of change were identified which were summarised as 'changes to the supervisees' attitudes, increased emotional self-awareness, changes in supervisees' motivation and improved skills'. Milne at al report that the most frequently cited outcome was "experiencing"; that is the supervision intervention changed the supervisees' attitudes and perspectives towards their patients. They acknowledge however that their own research is not without flaws

as they frequently found that they had to draw inference from the categories used to define variables such as supervision interventions and outcomes since these were often ill-defined within the articles reviewed.

The research undertaken by Hensley (2003) focuses on the benefits of supervision following interviews with clinical social workers. Although the sample population is acknowledged as small, Hensley concludes from the research that "supervision contributes to the benefits that clients receive from clinical social work treatment" (p108). Key benefits of being a recipient of supervision were identified by the social workers interviewed as teaching and learning as well as professional growth and support.

2.6 Impact of Supervision on Workers

Mor Barak et al (2009) published a meta-analysis of the literature (27 studies) regarding the impact of supervision on worker outcomes. Their findings reinforce the importance of supervision in delivering beneficial outcomes as well as limiting detrimental outcomes for social workers.

Smith (1996, 2005) summarises Kadushin's model and explores the issue of in whose interest supervision works. He argues that each of the three functions of supervision have different goals: the primary goal of the administrative supervision is ensuring adherence to agency policies and procedures whilst ensuring that a first class service is provided to people who need it; in educational supervision the main aim is to support the development of the skills of the worker by encouraging reflection on interventions whilst the primary goal of supportive supervision is to improve the morale and job

satisfaction of workers and help them to deal with the stress which might otherwise lead to them providing a less satisfactory service to people in need.

Unlike much of the other literature, Smith does make a distinction between managerial and non-managerial supervision in social work. He refers to this non-managerial supervision as 'consultative' or 'professional supervision' which he says is sometimes seen as being concerned only with education and support. However he argues that both managerial and non-managerial supervisors have a responsibility to focus on the needs of service users as well as the development of the worker being supervised. It is with this area of professional supervision which my own research is primarily concerned.

In a paper reviewing the recent history of supervision Lewis (1998) describes the key focus of professional supervision as being that of accountability and service delivery. She concludes that the role of the supervisor is to facilitate the integration of theory and practice and to provide direction for the practitioner to identify with social work values and principles. In Lewis's view the supervisor is supporting the social worker to identify gaps in their knowledge and directing the worker towards learning opportunities to meet their ongoing professional development needs. In order to achieve this Lewis puts forward the view that the supervisor needs to have a level of practice wisdom which draws on theoretical knowledge and practice experience and enables him/her to make sense of current issues. However, the impact on workers of not being able to access such supervision is not addressed by Lewis.

Cohen and Laufer undertook a study in Israel in order to assess the correlation between the supervision workers received and their perceptions of their professional competence. The study had a reasonably large sample group (n=434) which yielded a response rate of 66.3% and confirmed the hypothesis of the authors that there was a

statistically significant association between the satisfaction of social workers with the supervision they were receiving and their perceptions of their professional competence.

In a small scale study (n=6) which focuses on the 'risk discourse' which is currently prevalent in health and social care and its impact on supervision, Beddoe reports that "a conceptualisation of two types of supervision emerges from the literature - a professional approach, anchored in social work and with a focus on practitioner learning and development, and a second approach emerging from the risk management imperatives" (p2). Beddoe (p11) refers to the work of Peach and Horner (2007) which suggests "an unhappy relationship between a high degree of surveillance and a low degree of support" which seems to reflect the experiences of some mental health social workers in my authority and therefore influenced my choice of subject matter for this research project.

Beddoe's study is different from many others in that it focuses on the perceptions of supervisors rather than supervisees and presents the view that the role of supervision is to provide a safe space where practitioners are able to reflect on the emotional impact of the work and that, while the risk environment in which social workers are operating is acknowledged, supervision is not allowed to be reduced into a surveillance activity. However the supervisors within this study are described as experienced both in terms of social work practice and in offering supervision across a range of practice settings - for mental health social workers such experienced supervisors are not always easily available to them within integrated teams.

This changing nature of supervision within health care environments is addressed in the study by Berger and Mizrahi (2001) which identifies the concerns of social workers in health care settings regarding the provision of appropriate and effective clinical

supervision and the potential sense of isolation for practitioners if such supervision is not made available to them. This study raises a number of questions about the impact on social workers who are receiving 'non-social work supervision', i.e. supervision provided by someone from a different professional background, and suggests further research is necessary in this area. This was further explored by Kadushin (2009) in a review of the supervision provided to social workers in hospital settings. The study found that respondents to the survey viewed the absence of supervision from a social worker as representing a lack of valuation of social work as a profession in the organisation.

Blinkhorn's discussion paper (2004) explores the impact of the modernisation agenda on mental health social workers in the North East. One of the areas explored is the experience of Approved Social Workers (ASWs) of supervision systems within integrated teams. The methodology used was in-depth semi-structured interviews and follow up sessions with what was intended to be a representative sample of ASWs from the eligible population but in reporting the findings the study provides generalised statements rather than providing statistical information to support of them.

However Blinkhorn reports that social workers in integrated teams who were line managed by someone from a different professional background frequently campaigned for separate 'professional supervision'. Such supervision was considered by social workers to provide a forum for discussion of professional issues as well as a vital link back to the local authority in order to reduce the feelings of isolation which was felt by a significant number of social workers in what was seen as a dominant health workforce.

In considering the role of different professionals in community mental health teams, the study undertaken by Peck and Norman (1999) also highlights that fact that for social

workers “strong professional support and supervision were crucial to ensuring a distinct social work contribution to adult community mental health services”(p242). Professional supervision is also considered as having a key role to play in ensuring that social workers are adhering to policy and procedures. The lack of such supervision is highlighted as undermining the social work role and identity within multi-disciplinary teams.

Only one paper reviewed for this project (Mullarkey et al, 2001) takes the view that uni-professional supervision can be seen to be negative for workers and “may in fact mediate against some of the founding principles of true multi-professional working, reinforcing difference rather than promoting collaboration and co-operation”(p206). The authors argue that it is not the professional background of the background of the supervisor which is most important, rather the quality of supervision and supervisory relationship. However this paper appears to take a simplistic view of multi-disciplinary teams and fails to acknowledge the professional isolation of social workers which is often experienced in such teams and which has been highlighted in other studies (Peck and Norman, 1999; Carpenter et al, 2003; Blinkhorn, 2004).

2.7 Impact of Supervision on Outcomes for Service Users

In their review of empirical literature regarding supervision, Harkness and Poertner (1989) report that none of the 26 research studies met their four question inclusion criteria in order to be considered as client-focused and therefore conclude that “supervision science has abandoned client interests”(p116).

Kilminster and Jolly (2000) seek to review the literature on effective supervision in clinical practice settings. A lack of empirical literature regarding supervision in

medicine is highlighted by the authors and although they draw on research from other disciplines, including social work, they acknowledge that again many of the articles reviewed had weak or flawed methodologies. In spite of this one of the conclusions they draw is that there is evidence within the literature reviewed that supervision has a positive effect on patient outcome and that a lack of supervision is harmful to patients. Although the requirement for further research in this area is highlighted by the paper's authors the conclusions drawn appear to be somewhat lacking in substance.

A positive correlation between supervision and improved client outcomes is made in three separate studies (Harkness and Hensley, 1991; Harkness 1995, 1997). All three studies refer to the work of Shulman (1982) which they argue led to a reconceptualisation of supervision as a three-link chain of social work practice involving the supervisor, the social worker and the client. All three studies report some level of correlation between supervisory practice and client outcomes. In particular the supervisory skill of problem-solving was described as linked to the increased goal attainment of clients whilst the skill of empathy on the part of supervisor had a positive association with the effects on client satisfaction and generalised contentment. However, Harkness (1995) concludes that this study produces evidence that supervisory skills and relationships have independent associations with client outcomes; a finding which challenges the general theory of Shulman.

Most recently Morrison and Wonnacott (2010) put forward a model of supervision which integrates the functions described by Kadushin with the reflective supervision cycle in order to produce a 'Supervision-Outcome chain' which sees supervision as part of the intervention with service users. They also identify the need to take account of the various settings within which social workers are employed and address the issues of workers in integrated teams where line management and professional supervision may be separated.

This view is reinforced in the recent draft document from BASW (2010) which highlights the sense of isolation and role blurring often experienced by social workers in mental health teams and proposes that in order to support these social workers robust arrangements are put in place to ensure that social workers receive good quality professional supervision. The paper also reinforces the role of mental health social workers in supporting service users to achieve social inclusion by ensuring that their social care needs are met in a flexible and supportive manner. It is these two areas of practice which I intend to address within my own research.

2.8 Implications for this Study

The literature review has provided evidence of the positive role of supervision for social workers in supporting high quality practice and professional development. The review has also highlighted some of the difficulties experienced by mental health social workers in particular in accessing such supervision which may have implications for their practice.

The evidence relating to the impact of supervision on outcomes for service users is less well evidenced due to the lack of empirical research in this area.

2.9 Summary

This chapter has reviewed the literature in the area of social work supervision and the impact of this supervision on outcomes for both workers and service users. The next chapter will begin to discuss the research question for my study in the context of the findings from the literature search and explain the methodology used to within the study.

CHAPTER 3

Research Methodology

This chapter describes:

- The background to the research undertaken
- An overview of the methodology
- Development of a questionnaire, including justification, strengths and weaknesses and design
- Ethical Issues
- Identification of the population and selection of the sample
- Collation and Analysis of the results
- Description of Follow Up Research Undertaken

3.1 Background to the Research

In seeking to explore the views and experiences of mental health social works in relation to professional supervision I decided to use empirical research methods as these involve the collection of data through field research in order to generate the evidence on which my conclusions will be based. I identified that, as a practitioner, I would be using the approach of action research which is identified by Bell (2005, p8) as “applied research, carried out by practitioners who have themselves identified a need for change or improvement”. She refers to the work of Denscombe (2002, p27) whose view was that the aim of such action research is “to arrive at recommendations for good practice that will tackle a problem or enhance the performance of the

organisation and individuals through changes to the rules and procedures within which they operate".

Through informal conversations and group discussions within the social work forums I organised I had become aware of difficulties experienced by some mental health social workers in accessing supervision which they considered to be appropriate to their professional needs. In addition the information generated from my literature review had led me to believe that there was a lack of research which focused on the outcomes of supervision for either social workers or service users.

On commencing the research I had two hypotheses:

Hypothesis 1 was that those social workers who had access to supervision which focussed on their specific professional needs would be more able to articulate their role in mental health teams, i.e. there would be a positive correlation between these two variables.

Hypothesis 2 was that such social workers would be more able to ensure that the social care needs of service users were met either through their own individual practice or by their influence in discussing individual service user needs within a multi-disciplinary team.

3.2 Overview of Methodology

As the research project was intended to focus on those mental health social workers in a specific service I felt it important to collect new, i.e. primary data rather than relying on the secondary data generated from the literature review. This presented issues of

time involved in gathering and analysing this new data as well as access to subjects, in this case mental health social workers.

I also had to consider whether I was going to gather quantitative or qualitative data or a mixture of the two. Bell (2005) states that "quantitative researchers collect facts and study the relationship of one set of facts to another. They use techniques that are likely to produce quantified and, if possible generalizable conclusions" (p7). On the other hand she describes those researchers who adopt a qualitative perspective as being "more concerned to understand individuals' perceptions of the world. They seek insights rather than statistical perceptions of the world". I also needed to be aware of the potential for subjectivity in collecting and analysing qualitative data and also of the requirement to be able to code such data in the future in order to identify themes from the responses.

When deciding to undertake this research project I had initially intended to use the qualitative methods of focus groups followed by semi-structured interviews with a sample group of mental health social workers in order to gather their view regarding the role and function of professional supervision. However due to changes to my own role and resulting time constraints which impacted on my ability to have access to social workers in order to conduct the research I decided to use the quantitative method of a questionnaire which was sent to all social workers working within adult mental health services (n = 118) together with a covering letter (see Appendix 2) explaining the purpose of the research project and an sae to promote the return of completed questionnaires.

3.3 Development of a Questionnaire

The questionnaire (see Appendix 3) consisted of 24 questions which were a mixture of open ended and closed ended questions. Whittaker (2009) describes closed ended questions as those in which a range of answers are set out for the respondent: either a yes/no or multiple choice and both of these variables were included in my questionnaire. The questionnaire also included 5 questions with a Likert rating scale. Bell (2005) describes Likert scales (originally devised by R Likert in 1932) as "devices to discover strength of feeling or attitude towards a given statement or series of statements" (p142). However Bell advises caution against the interpretation of responses against such ranked scales. Whilst they allow the respondents to indicate their rank order of agreement or disagreement by selecting the appropriate response Bell advises that "we cannot say that the highest ranking is five times higher than the lowest. All that can be said is that they indicate order". However in spite of these limitations Bell believes that the use of Likert scales can be helpful "as long as the wording is clear, there are no double questions, and no unjustified claims are made about the findings".

According to Whittaker (2009) "open ended questions invite comments or opinions without anticipating the results" (p104). He believes that the advantages of using open ended questions are that they make no assumptions about how the respondent will reply and also provide more scope for the respondent to articulate their thoughts and feelings.

The questionnaire I devised also included questions to gather demographic data and background information such as length of time qualified since I hypothesised that, as Whittaker (2009) describes, such variables might affect the relationships I was investigating as well as providing a baseline about the characteristics of my sample group.

Whittaker (2009, p73) describes a number of strengths and weaknesses in the use of questionnaires as a means of generating data:

Strengths:

- Questionnaires are relatively inexpensive and quick to administer
- Participants can respond when it is convenient for them and there is a greater assurance of anonymity
- There is less opportunity for errors or bias caused by the presence of the interviewer
- The questions are asked in a stable and consistent manner, with no interviewer variability
- They allow greater coverage because participants can be approached more easily

Weaknesses

- They do not allow opportunity for probing and clarifying responses with participants or for collecting additional information while the questionnaire is being completed

- The researcher does not have an opportunity to motivate the participant to complete all of the questions or ensure the questions are answered in the correct order if relevant
- There are limitations on how long participants are willing to spend on completing a questionnaire
- Only a limited number of open questions can be asked because participants do now want to write large amounts
- They are less appropriate for people with literacy difficulties or for whom English is not a first language
- The identity of the participant is not known so the researcher cannot be sure the right person has completed the questionnaire

In being aware of the limitations of using a questionnaire as the only method of data collection I initially intended to follow up the questionnaire by arranging semi-structured interviews with a sample number of mental health social workers in order to gather more qualitative data regarding their experience of professional supervision and the value they placed on it.

3.4 Ethical Issues

Unfortunately due to the lengthy timescales involved I was unable to gain ethical approval for my research project using the procedures required by the NHS, although ethical approval was given by the University and my employing local authority. However I did receive agreement from the Trust to proceed with the research as long as I complied with the following (see Appendix 4 for e-mail confirmation):

1. The questionnaire was only to be mailed to social workers who work on local authority sites. These could include sites where integrated teams were based as long as they were not owned by the Trust

2. The questionnaires could be distributed to social workers attending meetings on local authority, or other neutral sites (whether these were arranged as specific focus groups or meetings such as the County AMHP meeting which took place on local authority premises)

As a result of this my ability to access mental health social workers was severely restricted as I was unable to contact them either in writing or in person on NHS sites, which is where the majority of these staff are located. I therefore had to make the initial contact with social workers when they were attending meetings on local authority sites or other venues away from their place of employment which had the potential for reducing the numbers of participants in the project.

3.5 Identification of the Population and Selection of the Sample

The local authority in which I was employed whilst undertaking the research employs a total of 200 mental health social workers who work with Adults, Older Adults as well as in settings such as Forensic Mental Health Teams and Early Intervention Services.

For this research I intended to focus on those social workers based in integrated teams which where managed via a Section 75 Partnership Agreement between the Local Authority and the Mental Health Trust since it was in these teams where social workers

were often in the minority and were more likely to be managed by a professional from a health background.

I intended that the sample group would contain social workers from each of the three localities as well as a cross section of social workers from different teams, including Community Mental Health Teams (CMHTs), Assertive Outreach Teams, Early Intervention Teams and Crisis Teams, i.e. a cluster sample. Since managers from a social care background are predominantly located in CMHTs and on average there are larger numbers of social workers in these teams than in other parts of the service I felt this would also allow me to assess whether it is access to formal professional supervision, informal supervision with other social workers or both which has an impact on social workers perceptions of their role and identity within teams. I considered that it was also be important to gather data regarding the length of time respondents had been qualified and assess whether this had an impact on their confidence in their role and ability to promote access to services to meet social care needs for service users in their team.

Unfortunately due to the restrictions in accessing social workers I was unable to ensure a sample from all service areas since I was reliant on contributions from those staff who were attending meetings on non NHS sites during this initial period of the research project.

Whittaker (2009) describes this method as convenience sampling (sometimes known as accidental sampling) in which participants are chosen purely based on the relative ease with which they can be chosen. The researcher is said not to be interested in

how representative each participant is or whether they have particular knowledge or experience but are instead looking for participants that are relatively easy to contact. Although the latter was the case in this project, in distributing the questionnaires I did seek to ensure that the potential participants were from the target group of adult mental health social workers. Nevertheless this sampling method can be criticised as lacking credibility although Bryman (2008) argues that it is far more prevalent than is often recognised in social science research.

This led to me distributing a total of 51 questionnaires which, following a series of reminders, achieved a 49% response rate.

3.6 Collation and Analysis of the Results

Responses were inputted into an Excel spreadsheet where answers to closed ended questions and multiple choice questions were given a numerical value, e.g. Yes = 1; No = 2, No Response = 9 (described by Bell, 2005 as nominal scales).

A summary of the responses to the open ended questions was also undertaken with content analysis and coding of recurring items completed in order to indentify key themes.

Analysis of the responses was initially undertaken using the COUNTIF formula in Excel and pie charts produced showing the percentage responses to each question (see Appendix 5).

In order to analyse the correlation between different responses a number of key questions were identified as 'outputs' (Q5, Q11, Q12, and Q15). The responses to these questions were sorted from smallest to largest numerical value in order that the correlation between answers to these and other questions could be analysed and represented visually using column charts (see example at Appendix 6).

3.7 Follow up Research Undertaken

Although responses to the questionnaire were anonymous participants were asked to indicate if they were willing to be involved in a focus group/semi-structured interview and if so to provide their name and e-mail address for further correspondence. A noticeable gender difference was noted in those responding positively to this with 78.5% being female whereas the gender split in the responses to the questionnaire had been 60% female and 40% male.

All staff who had indicated they were willing to participate were invited to attend a focus group which was held at a local authority venue easily accessible from all parts of the county. A total of 6 people (all female) indicated they would attend but the final number of participants was 5. The focus group was facilitated by myself and lasted for a total of 1hour and 37 minutes.

Sim (1998) summarised in Whittaker (2009, p59), indentified three issues concerning the use of focus group data:

- The data obtained relates to a group rather than to a collection of separate individuals since, if a focus group arrives at an apparent consensus, it is difficult to conclude that individual participants hold this view. Group interactions are complex and can lead to individual participants apparently agreeing with a view that they do not privately hold
- Similarly, it is problematic to measure strength of opinion in a group in the same way as individual surveys.
- Attempting to make generalisations based upon focus group data is misguided, e.g. concluding that the opinions expressed by a particular group of social workers can be taken as representative of social workers as a profession.

In my case I was particularly concerned as to how my presence as facilitator and researcher might potentially skew the responses of participants. Ribbins (in Briggs and Coleman, 2007, p212) describes the key objectives of a focus group as being to achieve an accurate representation of the views of the group as a whole. He refers to the opinion of Morgan (2002) who believes that in focus groups the job of the 'moderator', as the interviewer is usually termed is "to keep the discussion on the topic while encouraging the group to interact freely".

I had identified that the purpose of the focus group was to add to the information gathered through the questionnaires rather than to generate new data. I therefore devised an agenda for the focus group which included the following questions:

1. What does the term professional supervision mean to you?

2. What is your experience of receiving supervision which focuses on your social work role?

3. What do you think are/would be the benefits to you of receiving regular professional supervision?

4. What are/would be the benefits to service users?

5. Are there any barriers to you receiving professional supervision?

6. Do you have any other comments you would wish to make?

At the start of the focus group participants were assured regarding the matter of confidentiality and all gave consent to the recording of the session and were offered the opportunity to receive a copy of the findings from the research project once complete (see Appendix 7 for Transcript).

I felt that the focus group was reasonably successful and the agenda proved particularly helpful in managing the session. All participants seemed comfortable in participating in the discussions and I tried to ensure that all were able to make an equal contribution. The participants, being all female could not be said to be representative of the total sample group of mental health social workers but nevertheless they raised many of the issues which had been highlighted in the responses to the questionnaires.

As with the open ended questions within the questionnaire, a coding system was used to analyse recurring and key themes generated within the discussions (see Appendix 9 for example).

3.8 Summary

This chapter has described the methodology used in the study. The next chapter presents and analyses the results.

CHAPTER 4

Results and Discussion

This chapter describes:

- The background to the research study and hypotheses to be tested
- The access of social workers to line management and professional supervision
- The satisfaction of social workers with the supervision they received
- The perceptions of social workers as to the impact of supervision on their ability to articulate their professional role and identity within teams
- The perceptions of social workers as to the impact of supervision on their ability and that of their colleagues to meet the social care needs of service users

4.1 Introduction

In order to analyse the data two separate steps were undertaken. Firstly a summary of the responses to the closed, multiple choice and scaling questions within the questionnaire was completed. Secondly a thematic and content analysis of the responses to the open ended questions within the questionnaire and within the transcript of the focus group was carried out. The results were combined and are discussed in a themed manner throughout this chapter.

4.2 Background

The questionnaire was distributed to social workers in adult mental health teams where, although still employed by the local authority, they are managed in integrated teams within the local Mental Health Trust.

Because of the decreasing numbers of managers from a social work background in community teams, I had been instrumental in creating posts of Senior Practitioners within districts, the remit of which was to support the delivery of specialist supervision to social workers and Approved Mental Health Professionals (AMHPs) within teams. At the point of completing the survey only around half of the posts were filled and several of the post holders were still completing their induction period and had not managed to negotiate the caseload reduction which was seen as necessary when establishing the posts in order to focus on the delivery of professional supervision.

My intention in completing this research project was to assess the experience of mental health social workers in accessing supervision, both line management and professional, and to attempt to determine whether the supervision they received helped them to articulate their role and identity within their teams. A second area of interest was whether social workers felt that the supervision received was beneficial to outcomes for service users. A summary of the responses covering these areas is given below.

4.3 Access to supervision

Social workers were asked to identify the frequency of the supervision received and whether this was provided by their line manager. 92% of respondents indicated that

they received regular supervision and in 76% of cases this supervision was provided by their line manager.

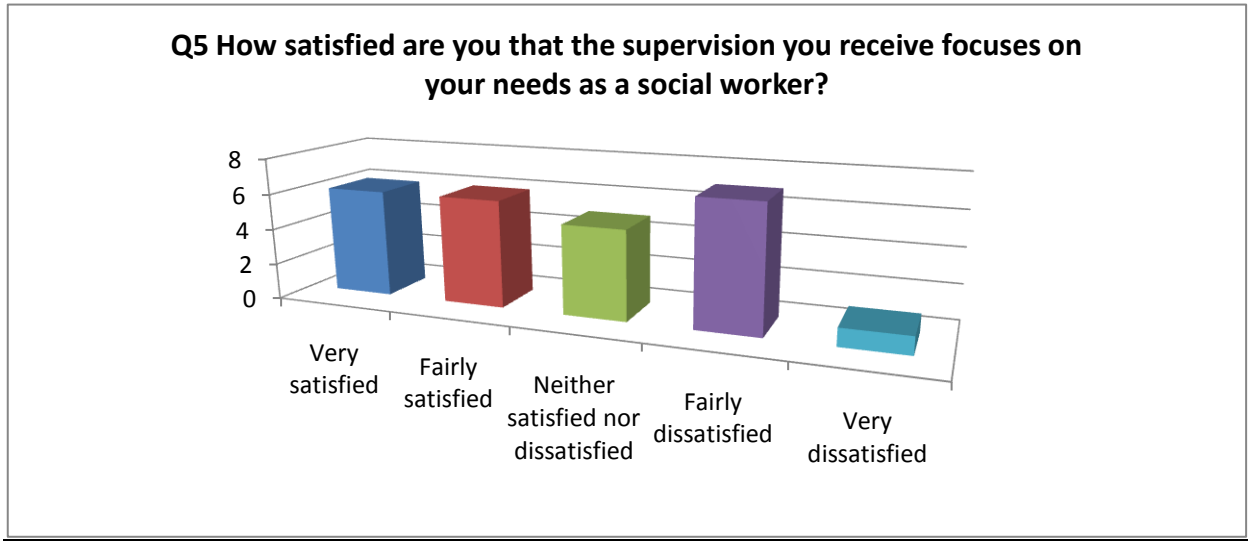
All the social workers who responded to the questionnaire were located in integrated teams where the majority of staff were from a health background and it is therefore unsurprising that 64% of social workers had line managers who were not from a social care background. The issue of social workers being located in teams where access to supervision from a social worker, i.e. professional supervision, may be restricted is highlighted within the literature review and it was the impact of this which was one of the areas I wanted to explore within this research project.

4.4 Satisfaction with Supervision

The level of satisfaction expressed by all the social workers surveyed as to whether the supervision they received focused on their specific professional needs was variable (see Table 2). Almost 50% of respondent expressed some level of satisfaction with supervision with an even split in the satisfied categories between 'very' and 'fairly' satisfied. However 28% of social workers were fairly dissatisfied with supervision and 4% were very dissatisfied. One fifth of respondents were neither satisfied nor dissatisfied as to whether the supervision they received focused on their professional needs as a social worker.

Across all categories 50% more social workers are satisfied than dissatisfied with the supervision they receive; a finding which I had not necessarily expected to see following the comments I had received from social workers before starting the research

project. Table 2



However when the responses were further reviewed to analyse the correlation between the satisfaction with supervision and the background of the social worker's line manager, a different picture emerged. 75% of social workers with a line manager from a social work background were either 'very' or 'fairly' satisfied that the supervision they received met their professional needs as compared to 35.5% of social workers whose line manager was from a health background. However there was only a small percentage difference between those social workers who were fairly satisfied with the supervision they received, regardless of the professional background of their line manager. In contrast social workers with a line manager from a health background were three times more likely to be fairly dissatisfied with supervision than their counterparts with a line manager from a social work background which links to the experiences of social workers in the studies undertaken by Berger and Mizrahi (2001) and Kadushin (2009).

Table 3

	Level of Satisfaction with Supervision					
	Very Satisfied	**Fairly Satisfied**	**Neither Satisfied Nor Dissatisfied**	**Fairly Dissatisfied**	**Very Dissatisfied**	**No Response**
Line Manager from Social Work Background (N = 8)	50%	25%	12.5%	0%	12.5%	0%
Line Manager from Health ground (N = 17)	12%	23.5%	23.5%	29%	6%	6%

Social workers were asked to identify issues addressed in supervision which they felt were particularly relevant to their professional role. A summary of the responses identified four main areas: caseload; performance management, their social work role and their role as an AMHP.

A discussion of caseload issues as the main focus of supervision was identified by one third of the respondents. This included safeguarding issues, the use of legislation to support individuals and carers as well as promoting the social care needs of individual service users and the statutory responsibilities of Social Services to meet these needs, sometimes in the face of pressure to close cases from the team. This was expressed by one social worker as:

> *'The drive to close cases only considers health needs and not social care I really have to explain there are still needs and not appropriate to close. I find I have to explain legislation and duties to ensure we don't act unlawfully'.*

The use of Self Directed Support as a means of supporting service users was also highlighted by several of the respondents as an important topic for discussion to balance the emphasis on medication and treatment.

The focus on performance indicators in supervision was an issue of concern for some social workers, particularly as the focus was seen to be only on health targets rather

than including those relating to social care. Two respondents made particular comment that their line manager appeared to have little awareness of issues relating to social care staff. This correlates with the findings of Kadushin (2009) where social workers in hospital based settings found that the supervision they received was focused on administrative issues and the needs of the organisation rather than being matched to their own individual needs. Respondents to Kadushin's study also highlighted difficulties with their supervisor as being distant from or out of touch with social work practice; similar issues to those mentioned within my own study. I was aware that these factors could potentially lead to social workers feeling devalued, an issue which was also identified by Kadushin.

The social work role and values was mentioned by six of the respondents with training relevant to the role highlighted as an area for particular discussion within supervision. Several of the social workers who completed the questionnaire were AMHPs and therefore discussion about this statutory role was a focus of supervision for four of the respondents. One social worker reported:

> *'My AMHP work is discussed which I find very beneficial. As a Social Worker in health setting things are very difficult and the Social Work role is diminished'.*

Worryingly one of the respondents reported not receiving any supervision since taking up post in the team eighteen months previously.

4.5 Impact of Supervision on Social Workers

In undertaking this research I was particularly interested to assess whether access to supervision which met their professional needs would assist social workers in articulating their role and identity within teams. This has been a particular issue for social workers located in multi-disciplinary teams as reported in the study undertaken

by Peck and Norman (1999) with supervision being highlighted as particularly important in supporting social workers to articulate their particular contribution to such teams.

Within the questionnaire social workers were asked to rate their confidence as to whether the supervision they received helped them to articulate their role in their particular team and I was particularly interested to find out the correlation between their answer to this question and the variable of the professional background of their line manager.

Over 50% of social workers expressed some level of confidence when responding to this question, with only 12% rating their response as unconfident. However over one third of respondents were neither confident nor unconfident about whether the supervision they received helped them to articulate their role within the team.

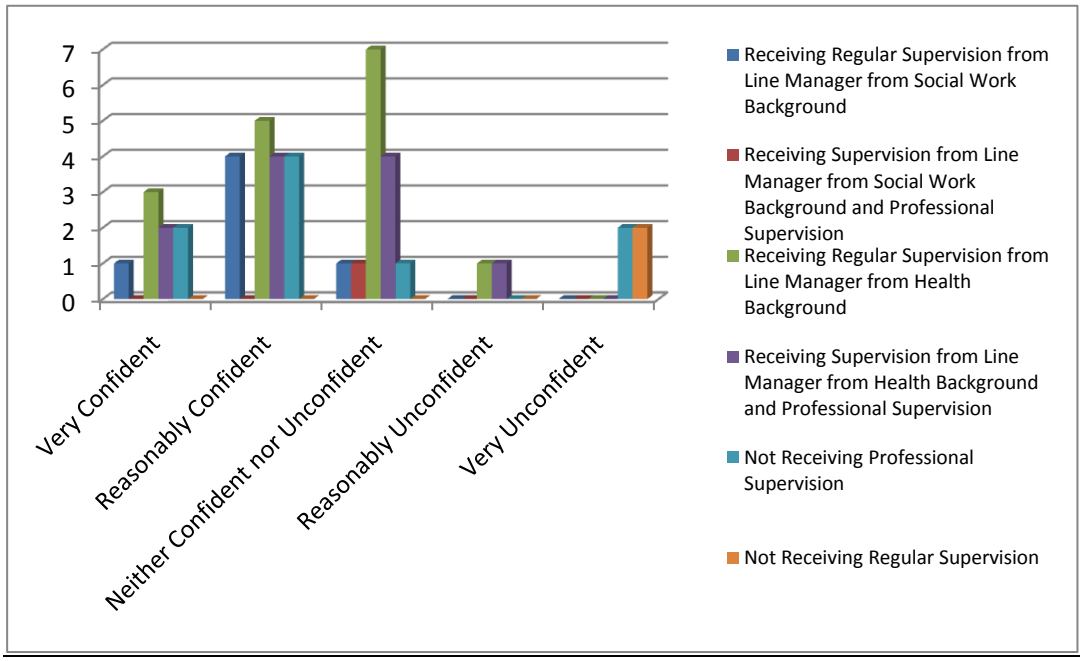
Respondents were asked to give examples of instances when they had felt confident in articulating their role. Several of the respondents highlighted occasions when they had promoted social care perspectives within team meetings or Care Programme Approach (CPA) meetings. Discussion of safeguarding and risk issues were also reported as well as assisting team members to understand the application of the Mental Health Act to particular case related issues.

Where social workers did not feel confident in articulating their role within the team in which they were based, they were asked to identify changes which they felt needed to take place in order to assist them to do so. Support from social work trained staff as well as greater focus by management on social care staff and social care issues were most frequently identified as key factors which needed to change in order to increase

the confidence of respondents in describing and promoting their specialist role within teams.

In order to support social workers in multi-disciplinary teams, many social workers are offered and access additional professional supervision, as described by Blinkhorn (2004) as well as line management supervision. In order to assess whether access to separate professional supervision supported social workers to feel more confident in their role and identity the responses to Q16 were then correlated against whether the supervisor was from a social work or health background and whether the social worker had access to additional professional supervision from an experienced social worker. The results are summarised in the table below.

Table 4



Total Number of Respondents = 24

The data revealed that 75% of social workers who were very confident that the supervision they received assisted them to articulate their role and identity within their team had a line manager from a health background. This was surprising data but of

these social workers two thirds had access to additional professional supervision which could account for some increased level of confidence.

36% of social workers indicated that they were reasonably confident in the supervision they received and 55% of these respondents had a line manager from a health background. Access to additional professional supervision was available to 80% of social workers who had health manager but none of the workers who had a social work manager accessed professional supervision. It is unclear from the data gathered whether these social workers did not feel the need for additional professional supervision or whether it was not provided to them as this has certainly been an issue for some adult mental health social workers.

Over one third of the social workers surveyed expressed a neutral response as to whether the supervision they received supported them to express their specific professional role within their team with 87.5% of these respondents having a line manager from a health background. Access to professional supervision was available to 57% of these social workers but this seems to have had little impact on their confidence in supervision supporting their role within the team.

Of those social workers who expressed a lack of confidence in supervision supporting their professional role within their team, one third had a line manager from a health background and one third reported that there was no line manger in place. Although two thirds of the respondents in this category reported that they should have access to professional supervision, in practice this had not been provided to them for a number of reasons and more worryingly their responses also indicated that they were not in receipt of line management supervision on a regular basis.

From the total responses to this question it can be seen that access to professional supervision appears to have had little impact on the confidence of social workers to express their role and identity within teams. This is a relatively new concept within adult mental health services in my locality with the role of Senior Practitioner, who are mainly responsible for providing such professional supervision not yet fully embedded within teams and with several posts still vacant. However within the focus group there was clear evidence that professional supervision was considered as an important source of support for mental health social workers with the focus of such supervision being considered as personal and professional development as well as a space to reflect on professional and practice issues, including the specialist AMHP role.

Professional supervision was seen to be in contrast to line management supervision which several of the participants felt focused only on caseload management issues:

> *"I think that the concentration in line management supervision is always on case management and the caseload that you have and the discussion around those cases rather than, there's usually a bit about you know the support element if you like, how are you are there any issues you want to raise and unfortunately the personal development element is not well done at all I don't think".* (Participant 4)

The assumption in my experience often made by Senior Managers that those social workers receiving line management supervision from a Social Worker were also receiving professional supervision was also explored in the focus group. The experience of the participants in the focus group varied as three of the five participants were in teams where the line manager was from a social work background but only one of these three participants expressed confidence in the professional supervision they received.

Focus group participants were asked whether it made the professional background of their line manager made a difference to the focus of supervision. One participant answered:

> *"In my personal experience it doesn't seem to make a great deal of difference as to whether it's a health professional or a social work professional offering the line management supervision; there's inconsistency on both sides. I think that's been my experience".* (Participant 4)

When discussing the split between managerial and professional supervision, which is often the model for mental health social workers, one of the participants contrasted their experience in mental health to that in child care where no such split takes place:

> "*Is that about split responsibility because in child care if you don't get regular supervision the manager could be sacked? Is it something about now the way mental health social work is, that it's sort of split between health and social care, that there doesn't seem to be anybody really taking responsibility for supervision".* (Participant 3)

Another participant described what she saw as the key role of professional supervision in supporting social workers to promote their specialist role:

> *" I do think from what you were saying before that if there was more of that professional clarity in terms of supervision we would assert ourselves more and have more of a defined role and perhaps if we do sometimes think within the team discussions that actually no you are missing that point there we would feel a lot stronger about saying it and maybe that's where it falls by the wayside".* (Participant 1)

4.6 Impact of Supervision on Outcomes for Service Users

The literature review highlighted the lack of empirical evidence regarding the impact of social work supervision on outcomes for service users. The role of social workers within mental health teams is to assess for health and social care needs and provide services to meet such needs in the most appropriate manner for service users and carers.

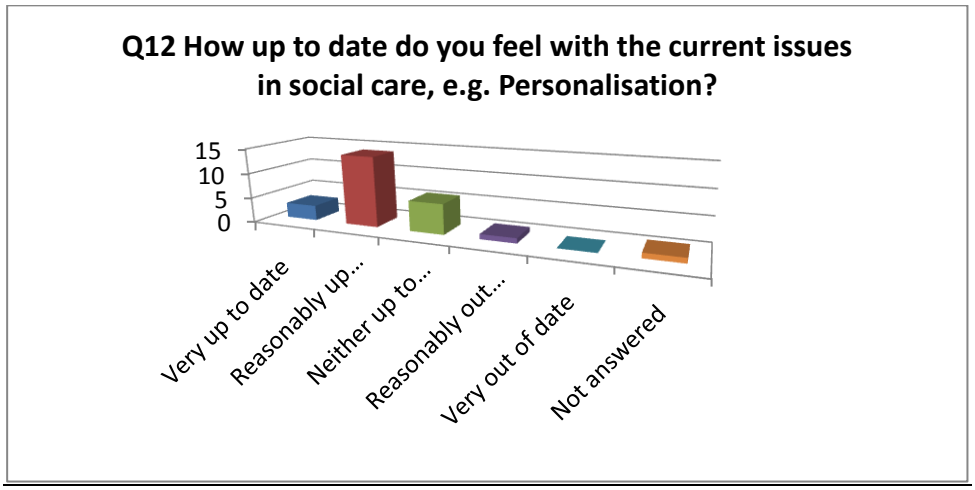
Following the modernisation and personalisation agenda within social care, it is increasingly expected that service users will have more choice and control regarding the way social care services are delivered through self-directed support and I therefore

included questions within the survey regarding the knowledge of social workers in this area since the take up of individual budgets has been somewhat limited in mental health services, both locally and nationally (DH 2006) and it is usually social workers within mental health teams who are expected to be up to date with such issues in order to support service users and other professionals to deal with the necessary systems and processes in order to enable services to be provided in a more flexible manner.

The DH document *Moving Forward: Using the Learning from the Individual Budget Pilots* which was published in 2008 highlighted that holding an individual budget was associated with better overall social care outcomes and higher perceived levels of control for service users.

The survey therefore asked social workers how up to date they felt with current issues in social care, e.g. Personalisation (Table 5) and responses to this question were subsequently correlated against the professional background of the line manager to assess the impact of this variable (Table 6)

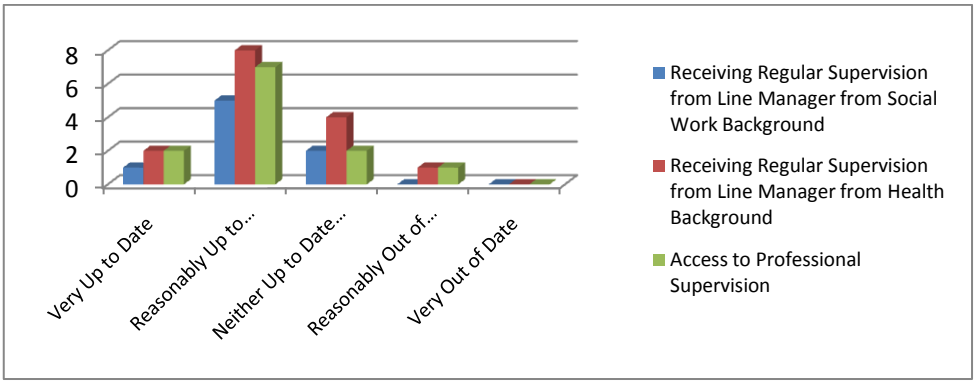
Table 5



68% of social workers reported feeing either ‘very’ or ‘reasonably’ up to date with current issues in social care with almost a quarter or respondents expressing a neutral

response to the question. When these responses were correlated against the professional background of the line manager two thirds of those social workers who rated themselves as being very up to date had a line manager from a health background but all of these social workers had additional access to professional supervision.

Table 6



56% of social workers considered themselves to be reasonably up to date with social care issues and over half of this group had a line manager from a health background. However 50% of total respondents in this category had access to additional professional supervision with this being provided to 62.5% of social workers with line a line manager from a health background. It would appear therefore that access to professional supervision does assist social workers to feel up to date with social care issues, regardless of the professional background of their line manager.

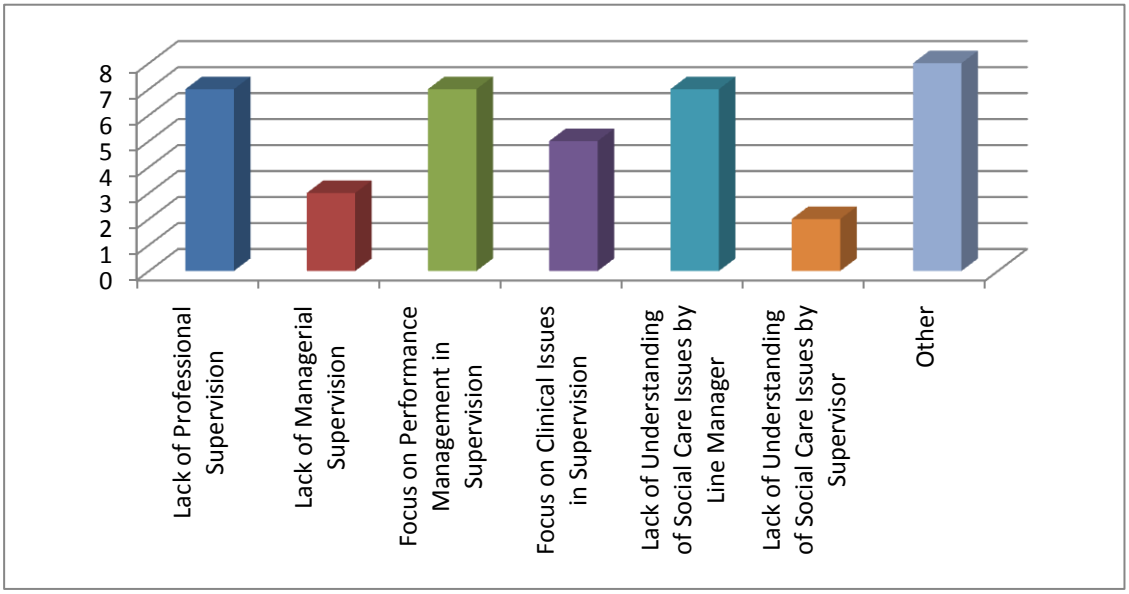
This important function of professional supervision was highlighted by the social workers surveyed by Blinkhorn (2004) who viewed professional supervision as providing a link back to the local authority which in my experience often provides the main training as well as policies and procedures relating to new developments such as Personalisation and it is difficulties accessing such information which can leave social workers feeling out of date. These same difficulties can often apply to managers, regardless of their professional background due to issues relating to IT systems,

procedures etc and it would therefore be a useful piece of research to ask these same questions of those line managers responsible for providing supervision to social workers in their teams.

When considering the frequency with which social care issues were discussed in supervision 20% of social workers reported that such issues were rarely or never discussed in supervision. In 80% of cases the line manager of these social workers was from a health background with one social worker reporting no access to line management supervision and although 60% of these social works reported having access to professional supervision it seems not to have included any meaningful discussion of social care issues and therefore potentially raises training issues for those staff offering this professional supervision.

Within the questionnaire social workers were asked to identify what they saw as the barriers to being kept up to date with social care issues. They were presented with a list of seven suggestions and asked to indicate all that applied, but were also offered the opportunity to add additional comments.

Table 7



A total of 39 responses were given and these were distributed across the range of the suggested options with three options being selected on the same number of occasions: i.e. lack of professional supervision; focus on performance management in supervision and lack of understanding of social care issues by the line manager.

Many respondents chose to include additional comments in the free text section of this question and the key themes from these responses were coded. 7 out of the 16 separate responses highlighted a lack of time as an issue in order to access relevant training and to keep up to date with the amount of information they were expected to read. 25% of respondents chose to emphasis the fact that their line manager had little or no understanding of social work or social care issues. One social worker commented:

> *"In regular supervision my health line manager is not particularly skilful at social care oriented interventions".*

Within the focus group one participant made the following comment when asked about how she kept up to date with social care issues:

> *"I rely on the things that you send and that come through your office. I've been there 6 months and I can't access the Social Services Intranet yet. A lot of it is health focused".* (Participant 1)

The focus of this research project was social workers rather than service users which means that the empirical basis for any claims regarding the impact on supervision on outcomes for service users is flawed and would require a separate piece of research in order to correlate the views of social workers re improved outcomes for service users either in their own practice or within the team as a whole with the perceptions of those receiving the service. However I felt it important to analyse the views of social workers with regard to this question in order to establish a baseline for any further research in this area within the Mental Health Trust. It might also be possible in the future to

correlate the results against service user experience surveys undertaken both nationally and locally.

Social workers were therefore asked a two part question in relation to the impact of supervision on outcomes for service users. Firstly they were asked to identify whether they felt the supervision they received ensured that service users had their social care needs addressed within their own professional practice. 68% of social workers responded positively to this question but when asked to consider if this supervision had a wider impact of ensuring that service users had their social care needs met within the team's context, i.e. social workers felt supported to influence decision making within the team and to assist colleagues to identify and meet the social care needs of individuals and their families and carers, the number of positive responses reduced to 48%.

Although positive in the fact that almost 50% of the social workers who responded felt that as a result of the support they received in supervision they were having a positive impact on the practice of the team for the benefit of service users, this means that over half of social workers did not have such a positive view of supervision in this regard. However the question was not asked as to whether they felt in general terms that they were able to influence their team colleagues regarding the identification of social care needs of service users and ensuring that such needs were met in an appropriate manner; this is potentially a flaw in the study and means that it is difficult to draw from this research more general conclusions as to the impact on service users of having social workers in multi-disciplinary mental health teams.

Again, in order to address my hypothesis, I felt it important to correlate the responses to this question with the professional background of the line manager concerned. 35% of social workers who considered that the supervision they received supported them to

address the social care needs of individuals within their own practice had a line manager from a social work background. Of the 11 social workers who had a health line manager 54% had access to additional professional supervision from an experienced social worker indicating that access to additional supervision from an experienced social worker was beneficial to the social worker's individual practice in focusing on the social care needs of service users.

When considering the impact of supervision on the whether the social care needs of service users were addressed within the team context, 42% of those social workers who believed there was a positive correlation had a line manager from a social work background. Of the remainder with a line manger from a health background, 57% had access to additional professional supervision which would again indicate a potential positive correlation between these two variables.

Within the focus group participants were asked about the potential impact of not receiving good supervision on service users. Participant 1 replied:

> "*You could be missing the boat. You never really get to discuss I don't find. I do get supervision, not always regular, but I tend to get it and we do look at my cases - it's limited but there's some scope as I said earlier. You're just missing the boat though because we think about what we're doing with these people, what are the targets and what are the goals and the expected outcomes. You don't really get to think about how you're moving people on…"*

However there was some scepticism about the commitment from line managers to issues such as Personalisation by one participant from the focus group. She commented:

> *"Well I've gone to the sessions on Personalisation which are being put on by LCC because I was interested in and wanted to know what it was about and knew that it was going to be important but I noted that none of the managers from my team were there to learn about it and hence it's never mentioned*

> *except as a kind of 'oh well it's another thing that's going to be happening but we don't know very much about it' kind of thing'".* (Participant 4)

Obviously one of the variables when analysing the views of social workers as to the supervision they receive and the impact of this on their practice is their length of experience in a social work role since at least one study in the literature review (Schroffel, 1999) had raised the possibility that the need for supervision diminished according to the experience of the worker concerned. In this study 60% of the respondents had been qualified for over 10 years and might therefore be considered to be less in need of supervision but just over a third had been in their current role for less than 12 months, which is possibly a reflection of the recent restructure within local mental health services and might well have an impact on the perceptions of social workers as to their role within their team.

Experience can also be seen as important in assisting social workers to be able to explain their specific professional role to colleagues and to service users. One experienced social worker within the focus group made the point that:

> *"Social workers who have had experience of working in social work settings, including child care or any other discipline, have a better idea of what it means to be a social worker "* (Participant 4)

However difficulties relating to a lack of professional supervision for newly qualified social workers were also identified in the focus group discussions:

> *"Well newly qualified is a major concern because early stages of practice as you describe are times when you get reinforcement about the ways you should be practising and if it's not given that status and is not from somebody from your own professional group then you can be getting really bad messages. You could be missing out on reinforcement and could be missing out on establishing a level of professional confidence which takes you forward"* (Participant 5)

4.7 Summary

This chapter had analysed the results from the questionnaire as well as key themes identified from these and the focus groups. The next chapter will draw conclusions from the study and make recommendations for further research.

CHAPTER 5

Conclusions and Recommendations

This chapter provides:

- Initial conclusions from the study as to the impact of professional supervision on social workers
- Initial conclusions from the study as to the impact of professional supervision on the outcomes for service users
- Discussion of the contribution of the study to the literature surrounding the subject
- Discussion of limitations of the study
- Recommendations for practice
- Recommendations for further research

Conclusions

5.1 Impact of Professional Supervision on Social Workers

This research project gathered the views of 25 social workers based in adult community mental health teams regarding their experience of supervision. From the comments within the questionnaires and the focus groups it can be seen that mental health social workers value both line management and professional supervision and perceive benefits from both forms of support for both themselves and service users.

According to respondents however the focus on performance management issues within line management supervision has led to social workers feeling that their needs regarding personal and professional development are not always met. Professional supervision from an experienced social worker is therefore seen as an opportunity to focus on the social work role and identity but from the responses to the questionnaire it appears that access to this professional supervision does not necessarily increase the confidence of social workers to articulate their particular specialist role within their team. It is therefore evident that the first part of my hypothesis is not proven but it would be interesting to repeat the survey in 12-18 months time when the role of Senior Practitioner, which is mainly responsible for providing specialist professional supervision to mental health social workers, is more established within the mental health Trust and to assess whether this has a positive impact on the confidence of social workers to explain their specialist professional role to team members including line managers.

5.2 Impact of Professional Supervision on Outcomes for Service Users

When analysing the results of the views of social workers relating to the impact of the supervision they receive on their practice with service users the conclusion can be drawn that those social workers who receive either line management supervision from a social worker, or alternatively have access to professional supervision in addition to supervision from a manager from a health background, are more likely to perceive positively the impact of such supervision on outcomes for service users in relation to meeting their social care needs. This conclusion would however need to be tested further in relation to the views of service users on their caseload.

Access to professional supervision also appears to have the beneficial impact of supporting social workers in trying to ensure that the social care needs of individual

service users are addressed by all team colleagues in order to improve outcomes. However these results are only the perceptions of social workers and would therefore require further validation against the views of other team members

5.3 Significance and Contribution of the Study

This study contributes to the evidence regarding the positive impact of supervision on social workers and, unlike much of the other literature, specifically focuses on the role of professional supervision (i.e. supervision which focuses particularly on social work practice and social care issues) in supporting social workers to explain their professional role and identity to managers and colleagues within multi-disciplinary mental health teams.

The study also provides some additional evidence regarding the impact of social workers receiving professional supervision on the outcomes for service users, particularly in relation to identifying and meeting their social care needs in an appropriate manner.

5.4 Limitations of the Study

The sample group of this study was small and was not necessarily representative of the whole group of mental health social workers within adult mental health services due to the restrictions on my ability to approach and contact people freely.

Data was not gathered as to the ethnicity of respondents so again the sample group cannot be said to be representative of the total population of mental health social workers but the literature review did not produce any studies regarding supervision where ethnicity of cultural background were considered as an important variable.

5.5 Recommendations for Practice

A number of recommendations for practice in mental health services arise from the results of the study. These are:

- Standards for Professional Supervision should be developed to include access, frequency and a proforma for the agenda to ensure consistency for all mental health social workers regarding the issues to be discussed

- Training in providing supervision should be available to all Senior Practitioners

- Where necessary Team Managers in mental health services should be supported to develop their knowledge regarding current issues in social care in order to better support social workers within their team.

5.6 Recommendations for Further Research

The outcomes from this study indicate that further contributions to the discussions could be made through additional research in the following areas:

- A repeat of the study, with a more representative sample group to be undertaken in 12-18 months time to better assess the impact of Senior Practitioners in delivering professional supervision to mental health social workers

- Research to be undertaken with service users in order to correlate their experience of social work practice with the views of social workers regarding how professional supervision supports their specialist role

- Research to be undertaken with colleagues in multi-disciplinary teams regarding their perceptions of role and identity of social workers in their teams and whether this correlates to how social workers view their impact in the team as a result of the professional supervision they receive.

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Appendices

Appendix 1

Research Proposal

Title

Does access to professional supervision assist mental health social workers in articulating and maintaining their role and identity within multi-disciplinary teams for the benefit of service users?

Aims

- To review how mental health social workers are provided with and access professional supervision within an integrated mental health organisation
- To assess the benefits of professional supervision as determined by mental health social workers
- To make recommendations as to standards for professional supervision for mental health social workers

Background

The implementation of the National Service Framework for Mental Health (1999) led to the development of multi-disciplinary mental health teams with a single line management structure to support the delivery of high quality services to people with mental health problems and their families and carers. This has led to social workers being employed in teams where they may be the only worker from this professional background and being managed by staff from a health background. The consequence of this is that social workers often struggle to articulate their role and professional identity to managers and colleagues and that social care issues may not be fully addressed or acknowledged within teams to the detriment of service users and their families.

In its recommendations regarding supervision the final report of the Social Work Taskforce (Nov 2009) identified that *'Where the line manager is not a social worker,*

professional support should be provided by an experienced social worker (p35). However in my experience this professional support is often not made available to mental health social workers in any systematic and robust manner and as a consequence many of these staff are left feeling isolated and out of touch with developments in social care, e.g. the transformation agenda which has yet to be implemented in any meaningful way within mental health services.

Initial review of the literature indicates that there is a correlation between the provision of high quality supervision to the confidence of social workers in practice. Mc Donald et al (2008) undertook research regarding the barriers to social workers using and retaining knowledge in their practice with adult and identified that the professional identity of the line manager/supervisor was an important issue for the confidence of social workers in their practice.

In their research into the impact of working in multi-disciplinary teams on social workers and health professionals Carpenter et al (2003) reported the importance of support and supervision in ensuring role clarity and job satisfaction for social workers within integrated health and social care organisations. The research undertaken by Peck and Norman (1999) also reported that social workers clearly identified access to professional support and supervision as important factors in ensuring their ability to articulate their distinct contribution to multi-disciplinary teams.

The organisation within which this research is to be undertaken is currently undergoing a restructure and changes to professional social care leadership arrangements. It is therefore intended that the findings from this research are used to assess the effectiveness of current arrangements within this organisation for professional supervision for mental health social workers and to inform the development of a framework for professional supervision to be agreed and implemented at all levels and within/across all multi-disciplinary mental health teams.

Research Questions and Objectives

This research project intends to assess whether the provision of high quality professional supervision assists mental health social workers to be more assertive in articulating their role to their colleagues, managers and service users. I aim to test the hypothesis that social workers who are either managed by a worker who is a qualified social worker or who receive supervision/professional support from a more experienced mental health social worker will be more confident in their role and more able to ensure service users have access to services to meet their social care needs than those mental health social workers who do not have access to this professional support.

In testing the hypothesis I will need to define the elements of professional supervision in order to assess which, if any are most important in increasing the confidence of mental health social workers in expressing and undertaking their specialist role in teams.

I will also need to assess whether, being located in a team with other social workers has a positive impact on the ability to articulate their specialist role and whether in these circumstances access to formal professional supervision is less important.

I will also want to assess whether it can be assumed that, having a line manager from the same professional background means that issues relating to the specialist social work role are explicitly discussed on a regular basis.

I will need to gather specific information relating to the knowledge base of mental health social workers in relation to issues such as personalisation and the impact of this knowledge on their practice with individual service users and their families/carers.

Methodology

I had initially intended to use the qualitative methods focus groups followed by semi-structured interviews with a sample group of mental health social workers in order to gather their view regarding the role and function of professional supervision. However due to changes to my own role and resulting time constraints which will impact on my ability to have access to social workers in order to conduct the research I have decided to use the quantitative method of a questionnaire which will be sent to all social workers working within adult mental health services (n = 118) together with a covering letter explaining the purpose of the research project and an sae to promote the return of completed questionnaires. As well as gathering data about their access to professional supervision and the perceived benefits/problems with this framework for offering support I intend to offer social workers the opportunity to express opinions and beliefs through the use of free text sections within the questionnaire, i.e. a combination questionnaire. However, I am aware of both the advantages and limitations of using this methodology as described by Whittaker (2009) and, if I do have the time and access to workers, I intend to arrange semi-structured interviews with a sample number of mental health social workers to gather more qualitative data regarding their experience of professional supervision and value they place on it. I intend that the sample group will contain social workers from each of the three localities as well as a cross section of social workers from different teams, including Community Mental Health Teams (CMHTs), Assertive Outreach Teams, Early Intervention Teams and

Crisis Teams, i.e. a cluster sample. Since managers from a social care background are predominantly located in CMHTs and on average there are larger numbers of social workers in these teams than in other parts of the service this will also allow me to assess whether it is access to formal supervision, informal supervision or both which has an impact on social workers perceptions of their role and identity within teams. It will also be important to gather data regarding the length of time respondents have been qualified and assess whether this has an impact on their confidence in their role and ability to promote access to services to meet social care needs for service users in their team.

In testing the hypothesis regarding the impact of professional supervision on the confidence of mental health social workers in their role and identity in multi-disciplinary teams I will be undertaking empirical research using a deductive approach.

Project Management

The intention is to commence the research project in March 2010 with a completion date of the beginning of October. The research will require a small budget for the postage and return of questionnaires which will be met by my employer as long as I remain in post at this point. If this is not the case I intend to use my personal financial resources to ensure the dissemination of questionnaires.

If the project is to progress to the stage of semi-structured interviews it will be necessary to have the use of a personal recorder, but this should be available through the training section of my local authority.

Ethical Statement

This research project must meet the ethical requirements of both Leicester University and my employer. For the purposes of the University I have completed the required Ethics Screening Form (attached at Appendix 1A) and the Research Ethics Review Checklist (attached at Appendix 1B).

In order to comply with the DH Research Governance Framework for Health and Social Care (2005) my employer has developed a Research Strategy which requires all research proposals to be considered against the Risk Assessment Tool in the RGF Resource pack published by the Social Services Research Group (www.ssrg.org.uk). In order to achieve this I have been required to submit a Research Application Form for

consideration by the Learning Organisation Development Group (attached at Appendix 1C)

It will be made clear to potential participants when the questionnaire is distributed that their participation is entirely voluntary and that any responses given either within the questionnaires or any semi-structured interviews which take place will be anonymised and will be treated as confidential within both health and social care. I have inserted the information to be provided to participants within the Ethics Review Checklist as required.

Appendix 1A

Leicester University School of Social Work

MSc/PGDip Professional Leadership and Management

Ethical Review Form: Part 1

Please read the following two statements and place an X in the area indicated for the statement that most accurately represents your research intentions.

Student Statement.		**Insert X**	**Student Action.**
Statement 1	I have read the above information. I confirm that my research ***does not*** involve the study of live human beings.		You do not need to complete Part 2 of this form. Ethics approval is not required.
Statement 2	I have read the above information. I confirm that my research ***does*** involve the study of live human beings.	**x**	Please proceed to complete Part 2 of this form.

You are only required to fill in part 2 of this form if your research involves studying live human beings. In cases of automatic ethics approval or where no ethics approval is necessary please allow 8-10 weeks from receipt by the University for the return of your grade. In instances where part 3 of the Ethics Form is completed you should allow 8-14 weeks.

Research proposals that are received without the completed Ethical Review Form will be returned to the student unmarked.

Appendix 1B

Leicester University School of Social Work

Ethical Review Form: Part 2

Please answer all of these questions by ticking yes or no in the box provided

		Yes	No
1.	Does the study involve participants who are particularly vulnerable or unable to give informed consent? (e.g. people under the age of 18, people with learning disabilities, students you teach or assess)	☐	☑
2.	Will it be necessary for participants to take part in the study without their knowledge and consent at the time?	☐	☑
3.	Does the study involve audio or visual recording of people in public places?	☐	☑
4.	Will the study involve the discussion of sensitive topics? (e.g. sexual activity, drug use, illegal activities, death, whistle-blowing)	☐	☑
5.	Are drugs, placebos or other substances to be given to the study participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind?	☐	☑
6.	Will blood or tissue samples be obtained from participants?	☐	☑
7.	Is physical pain or psychological stress from the proposed project likely to cause harm or negative consequences beyond the risks in normal life?	☐	☑
8.	Will the study involve prolonged or repetitive testing?	☐	☑
9.	Will financial inducements (other than expenses) be offered to participants?	☐	☑
10.	Will the study involve recruitment of patients or staff through the NHS?	☐	☑

If your answer is yes to any of these questions, please fill in Part 3.

Leicester University School of Social Work

Ethical Review Form: Part 3

In no more than a page, explain why you ticked yes to one or more of the questions on Part 2, and how you plan to address the ethical issues raised.

You will need to do this in consultation with your Dissertation Tutor. Please identify which Tutor you discussed these issues with.

Tutor's Name: Dr Colin Price

I think ethics approval should be automatic here.

Dr Colin Price

9th March 2010

Assessor's Comments (to be completed by the markers of the proposal):

I agree with Chris' tutor (Colin Price) in that the proposal does not identify any significant ethical issues as long as Chris has gained approval from the appropriate managers in her organisation to undertake data collection and to present her findings in a dissertation.

There is therefore no need to send this to the University ethics approval panel for approval, and it is accordingly approved within usual course assessment procedures.

Assessor's Name: Dr Diana Bourn Assessor's Signature:

Date: 16.3.2010

Appendix 1C

Carry on Learning Group

Research Application Form

This form is to be completed for ALL research activities involving adult social care employees, services users, their families or carers. This includes formal research, student research, audits and service evaluations (i.e. anything that involves questionnaires, interviews or focus groups). Please email your completed form to shalini.duggan@lancashire.co.uk (01772 534388) or post to room 228, Park Hotel, East Cliff, Preston, PR1 3JE.

Please refer to the corporate research and consultation toolkit for help with writing a research brief and for access to a checklist of questions to ask yourself at the start of your research project – this will also help you to fill in this form.

Section A: About the research activity

1. Research title

Does access to professional supervision assist mental health social workers in articulating and maintaining their role and identity within multi-disciplinary teams for the benefit of service users?

2. Research lead *(name and job title)*

Chris Southworth

Professional Lead for Social Care

3. Research lead contact details *(address, telephone number and email)*

Room 121

East Cliff County Offices

Preston

Tel 01772 534322

Chris.southworth@lancashire.gov.uk

4. What is the reason for this research?

This research is being conducted as part of an MSc in Professional Leadership and Management at Leicester University which I have been supported to undertake as part of the Future Executive Development Programme. The aim of the research is to review the current arrangements for professional supervision for mental health social workers and assess the impact of this on how these staff are able to articulate their role within a multi-disciplinary team in order to ensure that the social care needs of service users are assessed and met in an appropriate manner.

5. How will this research be carried out? *(i.e. methods such as individual interviews, focus groups, questionnaires)*

This research will be carried out initially via the use of a questionnaire to be sent to all mental health social workers in adult mental health services (n=118). If time permits this questionnaire will be followed up with semi-structured interviews with a sample group of mental health social workers.

6. Who else will be involved in the research? *(please include the participants, i.e. who will be researched)*

Social workers working in adult mental health services

7. Research Sponsor/Commissioner

This research has been discussed with the Network Lead for Social Care who is in agreement with the project and believes that it will provide valuable data which can be used to ensure the development of a robust framework for professional supervision within adult mental health services.

8. Has Sponsor agreed roles of those involved? *(i.e. funders, researchers, organisations)*

Yes ✓☐ No ☐

If no, why not?

9. Who is funding the research?

The research is to be undertaken within normal working hours but will not impact on my professional role and responsibilities. Postage costs will be met via normal arrangements.

10. Is the research to be undertaken in-house or by an external body?

In-house ✓☐ External ☐

If external, please specify who

11. Has the research been approved by senior managers (internal) or has it been subject to independent expert review (external)?

Senior managers ✓☐ Independent expert review ☐ Neither ☐

If neither, please explain why not

12. Has permission been sought to allow access to service users (and their families and carers), staff and/or organisational data?

Yes ✓ ☐ No ☐

Please provide details

Discussed and agreed with the Network Lead for Social Care

13. How will participants (i.e. service users) be informed of the research results?

Participants will receive a copy of any recommendations generated by the research as well as a copy of the full report (electronically) if requested.

Please refer to the Caldicott Principles which constitute good practice and must be followed in social care settings before answering the next question.

14. How will any research information be handled/stored?

Research information will be stored securely. Prior to their categorisation questionnaires will be stored in a locked filing cabinet as will tapes of interviews and their transcription.

Research information will be stored until the Dissertation project is submitted and assessed after which it will be destroyed.

Section B: Risks

15. What are the potential risks to participants? *(i.e. Low – dealing entirely with secondary source data or organisational behaviour to High – may need independent advice)*

Low ✓ ☐ Medium ☐ High ☐

Please specify

All participants involved will do so on a voluntary basis and will be informed of the confidentiality of the views expressed during the course of the project.

16. Will this research directly impact on care services or on the work of staff?

Yes ✓ ☐ No ☐

If yes, please provide details

The intention of this research is to assess the effectiveness of current arrangements for professional supervision for mental health social workers and to inform the development of a professional supervision framework which will ensure social workers are better able to articulate their role and identity in order to improve access to information and services to meet social care needs for service users within mental health services and their families/carers.

17. Have you considered the implications of the Data Protection Act, Health & Safety Act, Human Rights legislation, etc, on the conduct of the research?

Yes ✓ ☐ No ☐ Not applicable ☐

18. Have you considered your responsibilities under the Research Governance Framework?

Yes ✓ ☐ No ☐

19. In the event of any adverse occurrences within the research, what actions will be taken to resolve the situation?

Ensure discussion with line manager and relevant senior managers within the Trust to resolve.

Appendix 2

Information for Research Participants

Dear Colleague

Re Research Project re Professional Supervision for Mental Health Social Workers

Please find enclosed a questionnaire relating to your experience of and access to supervision which focuses on your professional role and issues specifically relating to social care.

The purpose of the research project is to find out if access to high quality professional supervision has an impact on the confidence of mental health social workers to be able to articulate their role within multi-disciplinary teams and ensure that the social care needs of service users are acknowledged and addressed in an appropriate manner.

I hope you will feel able to complete and return the questionnaire in the envelope provided. All responses will be treated confidentially and it will not be possible to identify individual respondents in the final report.

If time permits I will be following up the questionnaire with semi-structured interviews with a sample of mental health social workers across different teams and with different levels of experience. I would therefore be grateful if you could indicate at the end of the questionnaire whether you would be willing to be involved in this process – again all responses will be treated as confidential and it will be themes rather than individual comments which are included in the final report.

If you would like to discuss this project further before completing the questionnaire please do not hesitate to contact me either on 01772 534322 or via e-mail chris.southworth@lancashire.gov.uk

Thanks in advance for your cooperation.

Yours faithfully

Chris Southworth

Professional Lead for Social Care

Appendix 3

Questionnaire re Professional Supervision for Mental Health Social Workers

I would be grateful if you could take the time to answer the following questions. Your responses will be treated anonymously and the questionnaire should take about 15 minutes to complete.

1. Do you receive regular supervision?

   ☐ Yes
   ☐ No

2. Is this from your line manager?

   ☐ Yes
   ☐ No

3. How often do you receive supervision?

   ☐ Monthly
   ☐ 6 weekly
   ☐ Quarterly
   ☐ Other - please give details below

4. Is your line manager from a social work background?

   ☐ Yes
   ☐ No

5. How satisfied are you that the supervision you receive focuses on your specific needs as a social worker? (Please indicate on scale below)

   ☐ Very satisfied
   ☐ Fairly satisfied
   ☐ Neither satisfied nor dissatisfied
   ☐ Fairly dissatisfied
   ☐ Very dissatisfied

6. Can you give examples of some of the issues discussed in your most recent supervision which you feel are particularly relevant to your social work role?

7. If your line manager is not from a social work background, do you have access to supervision from a qualified social worker?

- ☐ Yes
- ☐ No

8. If yes, is this supervision provided by?

- ☐ Team Manager from a different team
- ☐ Senior Practitioner
- ☐ Experienced Social Worker
- ☐ Other - please give details below

9. How often does this supervision take place?

- ☐ Monthly
- ☐ 6 weekly
- ☐ Quarterly
- ☐ Other - please give details below

10. Can you give examples of some of the issues discussed in your most recent professional supervision session?

11. How confident are you that the supervision you receive meets your learning and development needs as a social worker?

- ☐ Very confident
- ☐ Reasonably confident
- ☐ Neither confident nor unconfident
- ☐ Reasonably unconfident
- ☐ Very unconfident

12. How up to date do you feel with the current issues in social care e.g. Personalisation? (Please indicate using the scale below)

- ☐ Very up to date
- ☐ Reasonably up to date
- ☐ Neither up to date/out of date
- ☐ Reasonably out of date
- ☐ Very out of date

13. Are issues relating to social care discussed in supervision?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

14. What do you feel are the barriers to you being kept up to date? (Please tick all that Apply)

- ☐ Lack of professional supervision
- ☐ Lack of managerial supervision
- ☐ Focus on performance management in supervision
- ☐ Focus on clinical issues in supervision
- ☐ Lack of understanding of social care issues by line manager
- ☐ Lack of understanding of social care issues by supervisor
- ☐ Other - please add comments below

15. How confident are you that the supervision you receive helps you to articulate your role and identity in your team?

- ☐ Very confident
- ☐ Reasonably confident

- ☐ Neither confident nor unconfident
- ☐ Reasonably unconfident
- ☐ Very unconfident

16. If you do feel confident in articulating your role, can you give examples of where you feel this has happened?

17. If you feel lacking in confidence in articulating your role can you identify what would need to change to help you with this?

18. Do you feel that the supervision you receive ensures that service users have their social care needs addressed?

a) Within your own practice?

- ☐ Yes
- ☐ No
- ☐ Don't know

b) Within the wider team context?

- ☐ Yes
- ☐ No
- ☐ Don't know

19. If yes to either of the above, can you give examples of where this has happened?

20. If no to either of the above, can you identify what the barriers are to service users' social care needs being addressed either within your own practice or within the team?

21. Are you?

- ☐ Male
- ☐ Female

22. Are you?

- ☐ 21-30
- ☐ 31-40
- ☐ 41-50
- ☐ 51-60
- ☐ Over 60

23. How long have you worked in your current post?

- ☐ Less than 12 months
- ☐ 1-3 years
- ☐ 4-7 years
- ☐ 8-10 years
- ☐ Over 10 years

24. How long have you been qualified?

- ☐ Less than 12 months
- ☐ 1-3 years
- ☐ 4-7 years
- ☐ 8-10 years
- ☐ Over 10 years

Thank you for taking the time to complete this questionnaire. Please return in the envelope provided.

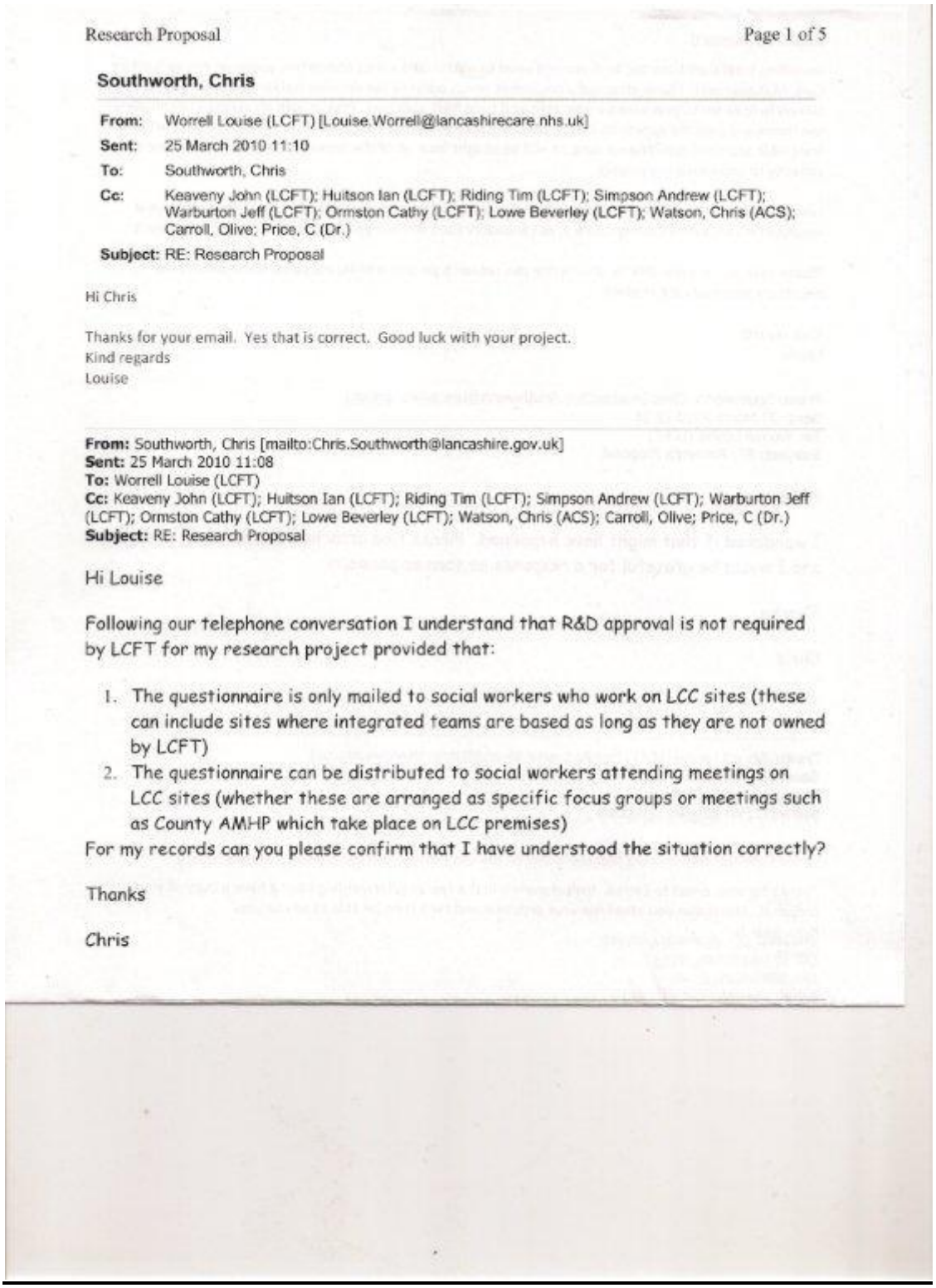
Could you please indicate if you would be willing to be involved in a focus group/semi-structured interview?

☐ Yes ☐ No

If yes can you please add your name so that I can contact you - your responses to the questionnaire will still be treated as anonymous.

Name ……

Appendix 4



Southworth, Chris

From: Worrell Louise (LCFT) [Louise.Worrell@lancashirecare.nhs.uk]
Sent: 25 March 2010 11:10
To: Southworth, Chris
Cc: Keaveny John (LCFT); Hultson Ian (LCFT); Riding Tim (LCFT); Simpson Andrew (LCFT); Warburton Jeff (LCFT); Ormston Cathy (LCFT); Lowe Beverley (LCFT); Watson, Chris (ACS); Carroll, Olive; Price, C (Dr.)
Subject: RE: Research Proposal

Hi Chris

Thanks for your email. Yes that is correct. Good luck with your project.
Kind regards
Louise

From: Southworth, Chris [mailto:Chris.Southworth@lancashire.gov.uk]
Sent: 25 March 2010 11:08
To: Worrell Louise (LCFT)
Cc: Keaveny John (LCFT); Hultson Ian (LCFT); Riding Tim (LCFT); Simpson Andrew (LCFT); Warburton Jeff (LCFT); Ormston Cathy (LCFT); Lowe Beverley (LCFT); Watson, Chris (ACS); Carroll, Olive; Price, C (Dr.)
Subject: RE: Research Proposal

Hi Louise

Following our telephone conversation I understand that R&D approval is not required by LCFT for my research project provided that:

1. The questionnaire is only mailed to social workers who work on LCC sites (these can include sites where integrated teams are based as long as they are not owned by LCFT)
2. The questionnaire can be distributed to social workers attending meetings on LCC sites (whether these are arranged as specific focus groups or meetings such as County AMHP which take place on LCC premises)

For my records can you please confirm that I have understood the situation correctly?

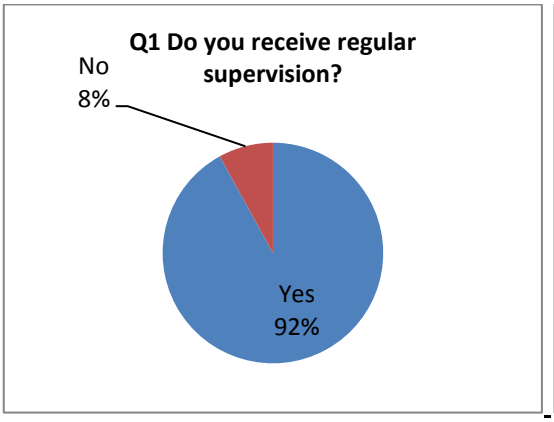
Thanks

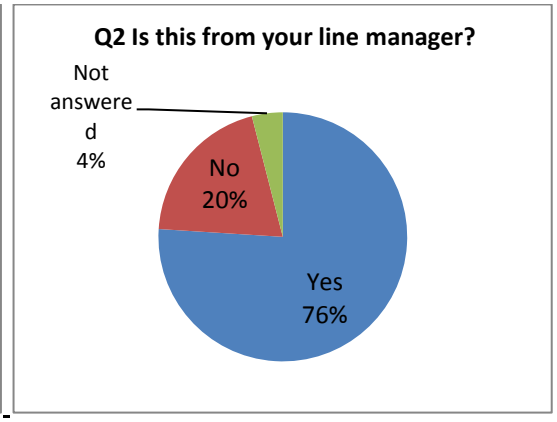
Chris

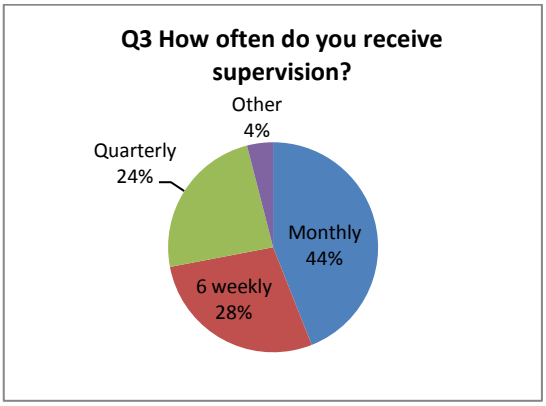
Appendix 5

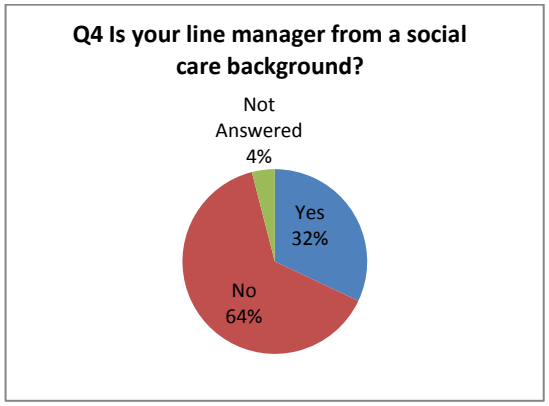
Charts from Spreadsheet

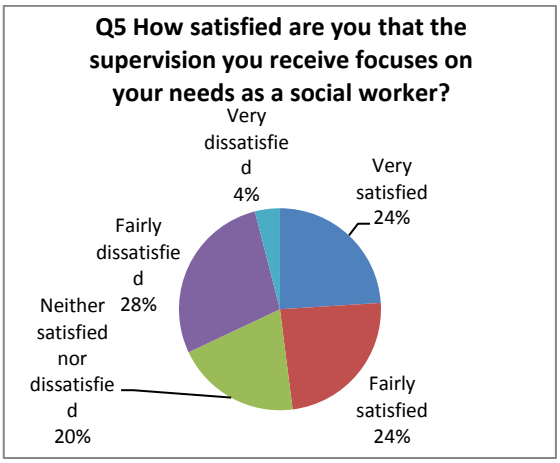
Number of Questionnaires = 50 Response rate = 50%

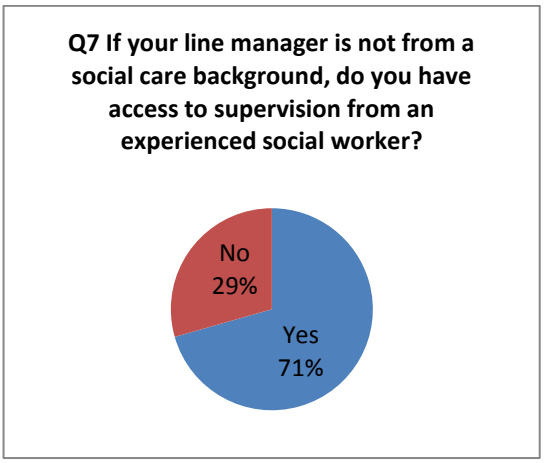




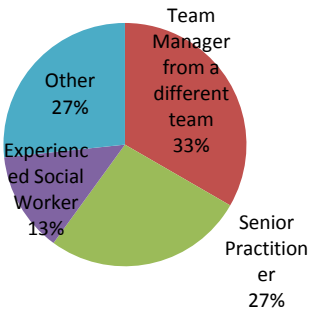




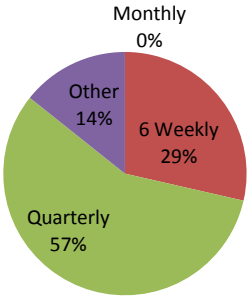




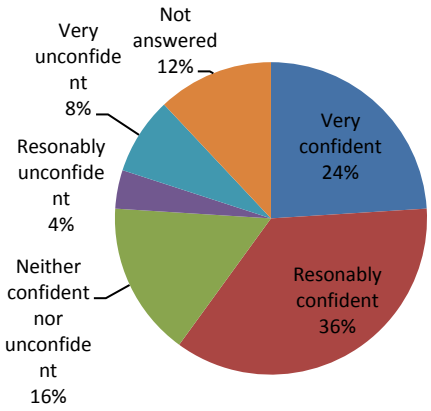
If yes to Question 7, is this supervision provided by?



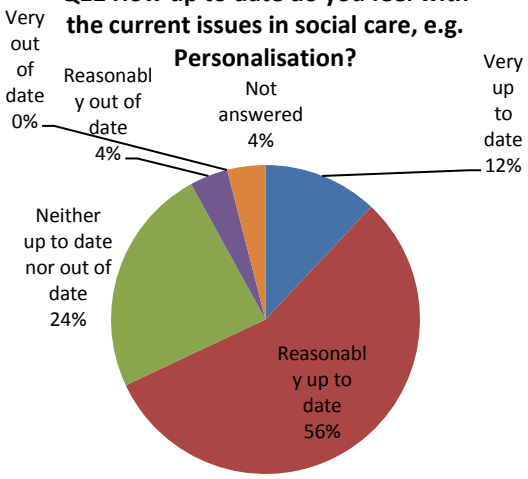
Q9 How often does this supervision take place?



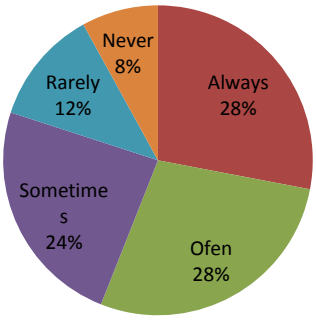
Q11 How confident are you that the supervision you receive meets your development needs as a social worker?

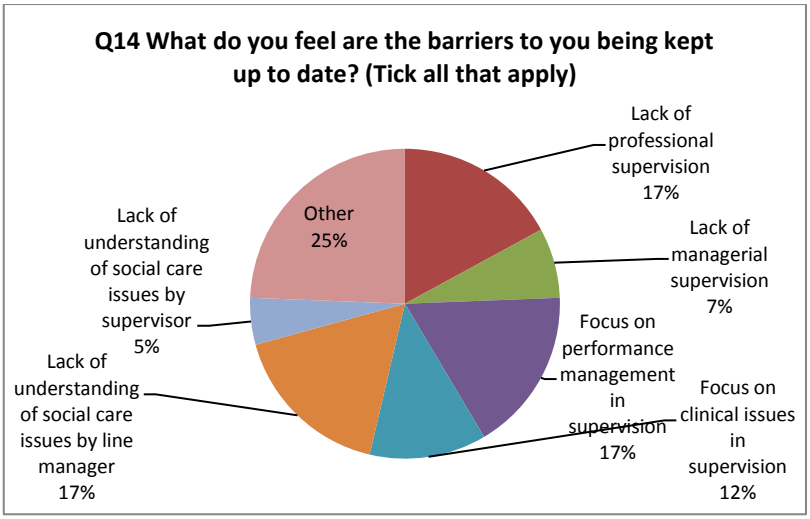


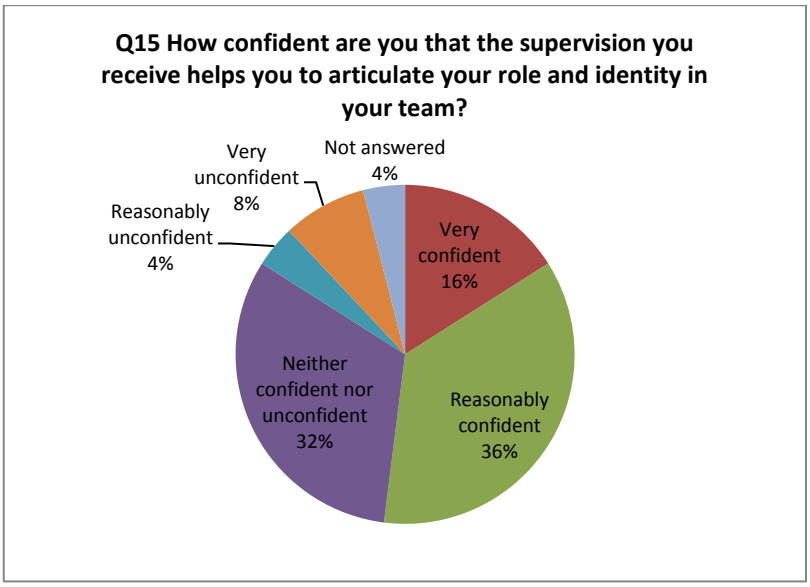
Q12 How up to date do you feel with the current issues in social care, e.g. Personalisation?

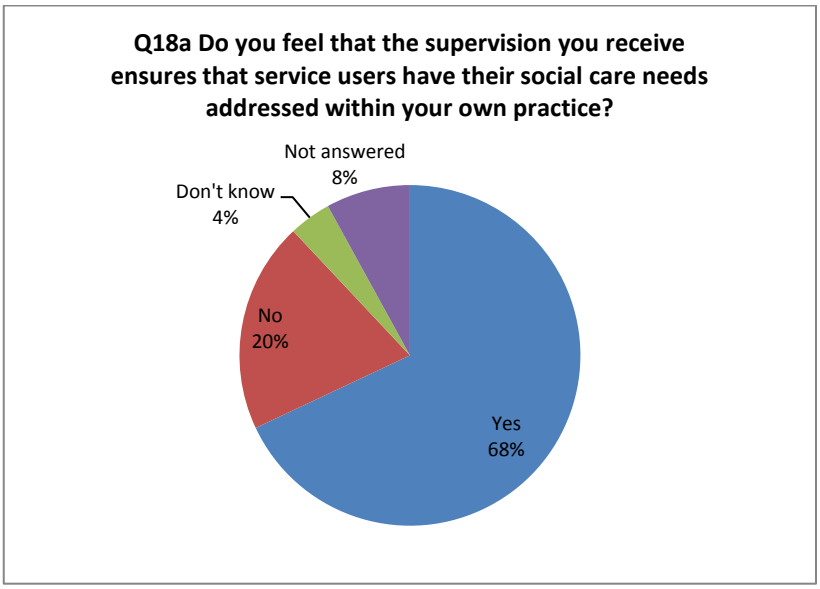


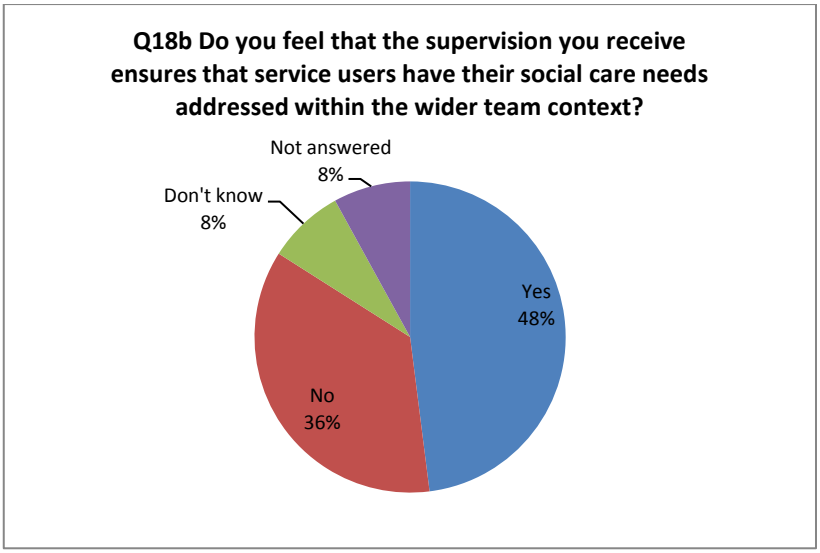
Q13 Are issues relating to social care discussed in supervision?

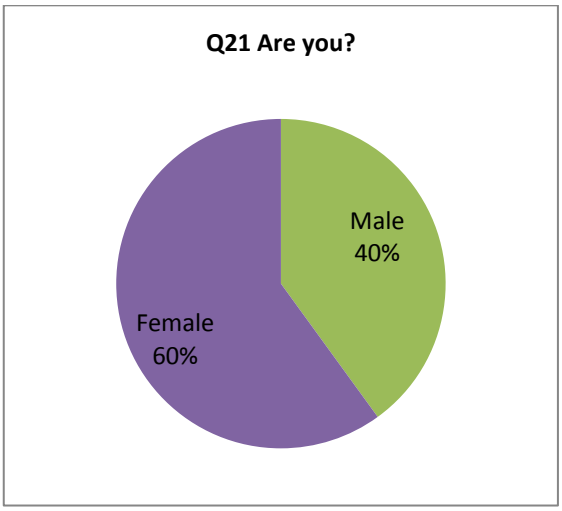


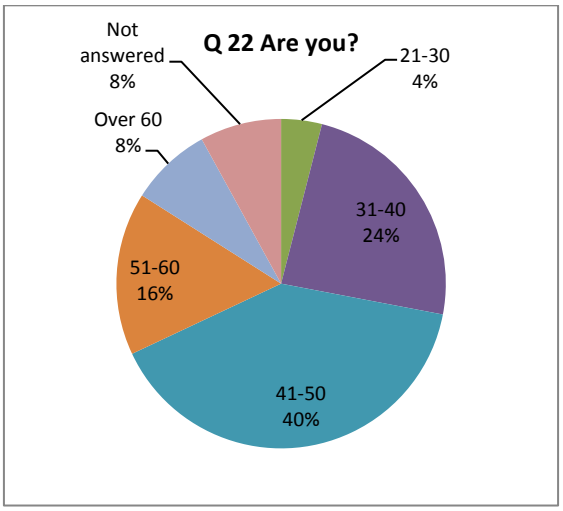

Q14 What do you feel are the barriers to you being kept up to date? (Tick all that apply)
Lack of professional supervision 17%
Lack of managerial supervision 7%
Focus on performance management in supervision 17%
Focus on clinical issues in supervision 12%
Lack of understanding of social care issues by line manager 17%
Lack of understanding of social care issues by supervisor 5%
Other 25%

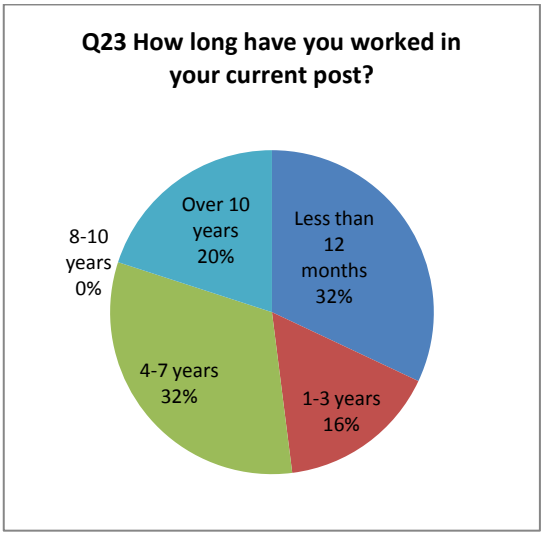

Q15 How confident are you that the supervision you receive helps you to articulate your role and identity in your team?
Very confident 16%
Reasonably confident 36%
Neither confident nor unconfident 32%
Reasonably unconfident 4%
Very unconfident 8%
Not answered 4%

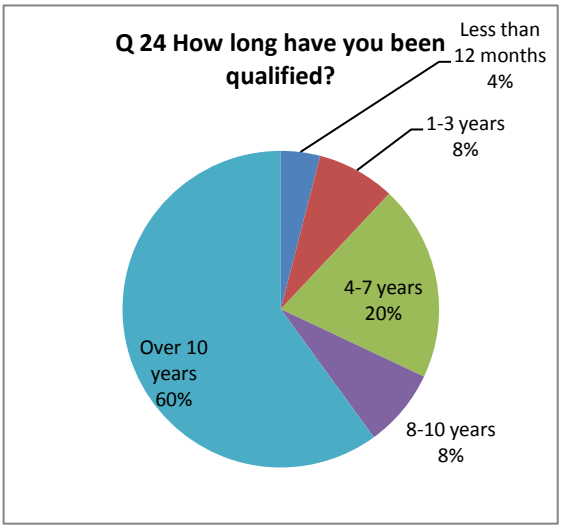

Q18a Do you feel that the supervision you receive ensures that service users have their social care needs addressed within your own practice?
Yes 68%
No 20%
Don't know 4%
Not answered 8%


Q18b Do you feel that the supervision you receive ensures that service users have their social care needs addressed within the wider team context?
Not answered 8%
Don't know 8%
Yes 48%
No 36%


Q21 Are you?
Male 40%
Female 60%

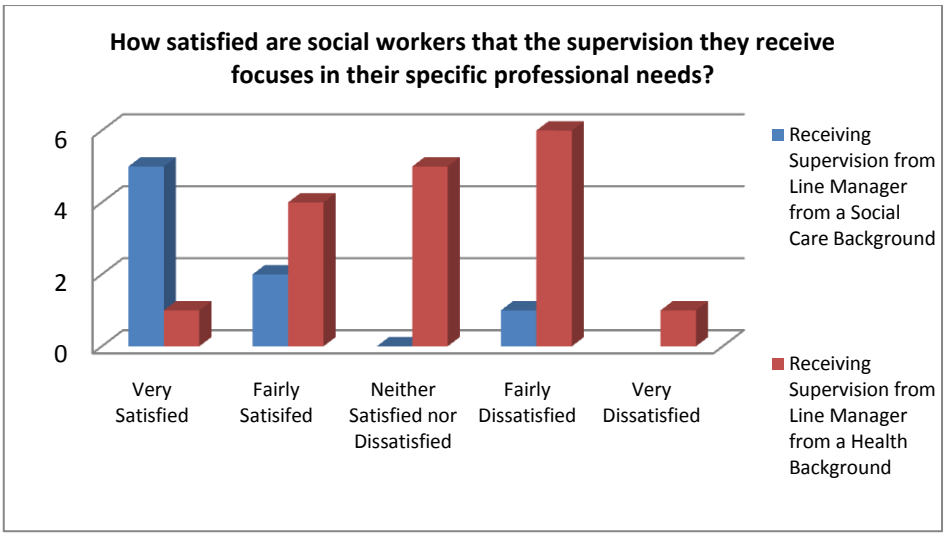

Q 22 Are you?
Not answered 8%
21-30 4%
Over 60 8%
31-40 24%
51-60 16%
41-50 40%

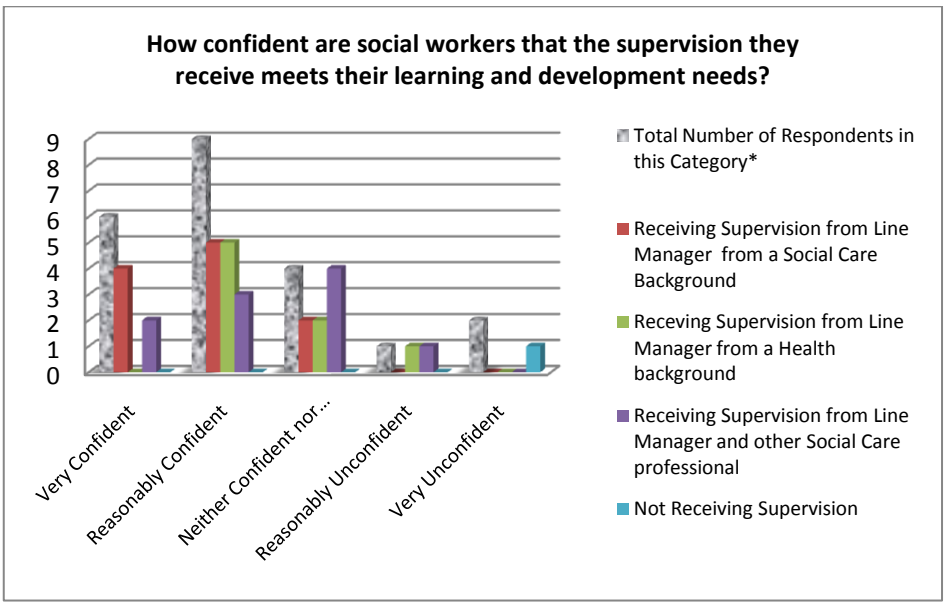

Q23 How long have you worked in your current post?
Over 10 years 20%
Less than 12 months 32%
8-10 years 0%
4-7 years 32%
1-3 years 16%


Q 24 How long have you been qualified?
Less than 12 months 4%
1-3 years 8%
4-7 years 20%
Over 10 years 60%
8-10 years 8%

Appendix 6

Correlation Charts





*The total number of respondents across all categories = 23

Appendix 7

Transcript of Focus Group re Professional Supervision on 5.7.2010

CS: So thank you for coming. We're just going to do some introductions so that we know who's here and then I'll explain a bit about the purpose, confidentiality etc. So I'm Chris Southworth and I'm leading this focus group and I'm currently Professional Lead for Social Care.

P1: P1 Social worker. I work in A in the Assertive Outreach Team

P2: I'm P2 and I work at the Community Mental Health Team in B.

P3: I'm P3. I'm the Deputy Manager of Team C

P4: I'm P4. I'm an AMHP and Senior Practitioner for D area.

P5: I'm P5 social worker at E.

CS: Ok. So the purpose of today's meeting is as you know it's a focus group. I just want to take us through some questions. You've obviously all filled in the questionnaire, thank you very much, and indicated that you would be willing to attend a focus group. As you can see I've done some questions. We may want to talk outside of those - there may be other things you want to talk about but they were just a starter really for this morning. As I said everything is confidential. If I do feel that you know there is a quote that I would want to use I would contact you directly and ask for your permission to do that. I'm assuming that you are all here and all happy to participate and that you are giving your consent to the recording of this session. Is that ok? Thank you. So I'll just start it off with the question really about what do you understand by Professional Supervision? What does it mean to you in terms of how it differs from other supervision? What are your thoughts around Professional Supervision?

P3: For me it's about personal development. It's about developing your practice. Also it's about exploring issues that you perhaps sometimes you deal with stuff and you're very much thinking on your feet and sometimes it's good to reflect and bounce ideas back off someone but I see it in terms of my professional development and to discuss issues, challenge issues.

P4: It's something I've had to think about with the creation of the new role of Senior Practitioner because the remit of Senior Practitioners is to provide Professional Supervision as opposed to case management supervision which we are used to so it took a bit of thinking about really because it's something that we hadn't had a great deal of over the years in mental health. We've had a lot of case management supervision but not much in terms of professional social work supervision and obviously in mental health the professional supervision aspect always concentrated a lot on the role of the AMHP which still is a role mostly carried out by social workers. But of course it's not just about the role of the AMHP, it's about the social work role as well and how social workers see themselves carrying out that role and what difficulties they are coming up against in terms of their career progression, professional development and how they are fitting in with other professionals in a multi-disciplinary

team - all those sorts of issues so I found myself having to read a lot about what professional supervision meant and concentrating on the core aspects of professional supervision which are around the educational element; the Kadushin model which you are probably familiar with and support as well and accountability and that's a big problem for us really because mental health social workers are kind of hived off if you like onto health as we know and so it's difficult to kind of work out what accountability means in terms of our employer, which for the majority of us is still the County Council. So that takes a bit of working out really. There are a lot of conflicting issues in terms of management and supervision and the way social work is configured in mental health.

CS: When you said that there has been a lot of caseload management supervision and not a lot of professional supervision, has that depended on your line manager do you think and whether they are from a social work background or not? Obviously you have had both haven't you? Does it make a difference if your immediate line manager is from a social work background do you think?

P4: In my personal experience it doesn't seem to make a great deal of difference as to whether it's a health professional or a social work professional offering the line management supervision; there's inconsistency on both sides. I think that's been my experience.

CS: Because people might assume that if you have got a social work manager that you are getting Professional Supervision but actually that's maybe something that we need to explore. Is that actually the reality that you are getting Professional Supervision if you have a social work manager?

P4: I don't think so. I think that the concentration in line management supervision is always on case management and the caseload that you have and the discussion around those cases rather than, there's usually a bit about you know the support element if you like, how are you are there any issues you want to raise and unfortunately the personal development element is not well done at all I don't think. I mean I don't know what it's like in other areas but I know in our area Personal Development Plans for instance are non-existent and years old and not done at all.

P3: P4 can I ask, so you have two lots of supervision?

P4: Theoretically yes. We have line management supervision from, at the moment we have a health manager so we get our, well it depends, we have a - the manager of our team is from a health background, the deputy manager is from a social work background so at the moment if you were to ask me I get line management supervision from the manager who is a health background and I get AMHP supervision or Professional Supervision from the deputy manager who is from a social work background.

P3: So you've set up two then two different lots of supervision because we tend to combine the two. Yes I do when I supervise my team.

P1: I think that's right. I've only been in mental health for three years now so it's limited anyway but whenever I've had supervision it's usually just looking at the cases as you were saying, how do you feel they are going along but you don't ever get to explore what do you think in your social work role can you actually do, how will you develop these cases? I've just had a little quick look at that thing you sent out to us, you know that document?

CS: Which one, the one last week?

P1: Yes, the one about the roles and things and professionalism. You don't get to look at like you know do you think we are doing too much for these people or are we going to promote more independence. You know like we don't ever get to look at that you know it's just a quick let's look at them, are they alright and it's more recently I think about you know have you got your recordings up to date, you know are care plans relevant? Have you thought about CPAs and it's more about

P3: Ticking boxes

P1: That's it rather than like what do you bring to the table?

CS: And all those things are important aren't they?

P1: They are but I don't think you ever really get to explore about what you'd like to do and what you think is pertinent you know

CS: It's what you bring you know different from what other people bring isn't it?

P1: You are an integrated team but I think there's still that quite big focus on like, particularly in AOT anyway on how we are treating them - there's a big emphasis on medication still and things like that rather than looking at the bigger picture which is what we should be doing as social workers isn't it and I know all my health colleagues do as well but that's clearly more our role in a team like that isn't it. It's definitely what we should be doing if nobody else is. Yes it doesn't always happen but then again you know I think we have to recognise there is pressure on managers to allocate a lot of time and stuff like that so sometimes you are just going through the motions aren't you which is unfortunate but that's the way it is isn't it.

CS: Because you are fairly newly qualified aren't you really?

P1: Yes, only three years.

CS: So in terms of the professional supervision that you have received - do you think you have received any?

P1: Not really no. When I was with, because I worked with Connexions as well for a year, it was more just looking at the young people or now with the service users and like where you up to, but not what are you doing? Just recently I've had like a meeting with my manager and that was looking at what courses I would like to go on, what I'd done previously like the mandatory ones but again that was more just what would you like to do, not really why do you want to do it or why do you think it will make you work better as a social worker or again how is it going to improve your practice? I think a lot of it is time constraints though to be fair but again that's not excuse for not having proper supervision is it?

CS: No, and is there any recognition that you might need anything other than that line management supervision as a social worker because your line manager is from a health background aren't they?

P1: I have had one session with a Senior Practitioner from the Crisis Team but again it's hard for them to have that on a regular basis and I don't know if other social workers from the team have had any sessions from that particular person and that's not the fault of hers that's just because she hasn't got the time you know she's constantly on call or whatever. Yes to that's been identified but it's just not happening

as often as it should. It's getting there but it still needs a lot more emphasis on regular rather than ad-hoc.

CS: Just let me ask you one more thing. Is that replicated for the nurses? Do they get clinical supervision?

P1: I'm not too sure. I think the only supervision they get is from the line manager.

CS: Ok

P2: Well as you know from my area and my questionnaire supervision has been absolutely appalling. I've been with the team almost two years and apart from an odd ten minutes of number crunching, can you take another case, sign this, this is your PDP you're going on this course, I've had one session with SP in the two years I've been there. I've had no guidance, no support and I moved from a different area - I was a child care social worker before I was in mental health so it was a completely new area to me and I've had no support whatsoever.

CS: Does that include line management supervision as well as professional supervision?

P2: The line management supervision has been - "have you got any capacity", pretty much or I've come across this course, the course we were talking about before the CBT course, I actually got a phone call while on holiday walking round London Zoo "I've found a course I think you might be interested in, give me a ring if you want to go on it", that sort of thing but we haven't got a regular manager in post.

CS: I think that's particularly difficult in your area with the manager covering two sites.

P2: Yes but there is no regular time. If you do book a time it's always running late or you literally end up with ten minutes, if that.

P3: Are you an AMHP?

P2: No, just due to start training in September. But even the AMHPs don't get supervision they way they should do because there just isn't anyone to do it. We've got that few AMHPs they are overworked, there's no time to actually put any supervision in place. It's really bizarre for me coming into mental health and finding it like this because in my previous job it was very regular that you had supervision once a month and your manager knew your caseload inside out. They knew how you were working, whether you were stretched, whether you could take any, any manager knew that and I'm finding it quite difficult to come to terms with the fact that nobody knows what caseload I've got. Nobody knows that I could be sat on a caseload of thirty people who don't need a service. You know there's nobody managing our caseloads to actually look at them which I think is quite shocking really.

P3: Is that about split responsibility because in child care if you don't get regular supervision the manager could be sacked. Is it something about now the way mental health social work is, that it's sort of split between health and social care, that there doesn't seem to be anybody really taking responsibility for supervision.
P2: I think that, it's a valid point because I think our role as social workers you've got to really fight to keep it really, even though we are in a multi-disciplinary team. Sometimes I think we're just absorbed into the nursing staff, the health staff and our professional role and especially with this move towards mental health practitioners - you're not

social workers and nurses any more. You're sort of losing your identity really and you've got to hold onto it really.

P4: Do you not have a Senior Practitioner in your area then?

P2: We have one in the crisis team but again she works shifts.

CS: And unfortunately AMHP supervision has been prioritised over professional supervision and that's just something that has happened due to capacity. What about you P5? There's quite a strong social care focus where you work.

P5: There is yes because M is Social Services. She's changed her approach but still it's very good and I find supervision very good. My situation makes a difference as well because I don't carry a caseload so I don't really need to focus on individual cases and going through the practice that I may be applying but then I have duty responsibilities. What I've found is over the years because now it's fourteen years as a social worker in mental health, I agree there is a change of emphasis from each case going through the detail and looking at how you are addressing those cases in social work terms , how you're practising and how your practice can be developed. It's much more about numbers and performance through the system; pressure is having a definite impact on the nature of supervision. I think although in supervision I get, my supervision now consists, because I supervise or manage a small day service then some of it is about that management role so it does cater for what my needs are. It's adapted and probably adapting is a good part of supervision if it can be tailored to the person's needs and individual's needs so in my case it has moved and has shifted. It looks at my personal issues really, about personal development, personally coping with stress and how I manage that. So there are different elements to it, all of them make me feel comfortable about the supervision I get. But you are right I think I would find it difficult perhaps getting the type of support I need if it wasn't for social care.

CS: Because you have always been managed by social care.

P5: Pretty much, yes. I mean there is a question for me whether at a certain stage supervision changes in nature for people who are staring out in the career. Later on in the career I would say that perhaps I wouldn't be so dependent on developing my practice. That's not an arrogance attached to that but as an experienced practitioner I would be less dependent on that and perhaps have less of a need.

CS: What about in terms of keeping up to date with sort of social care issues and things that are happening in the social care world as opposed to mental health?

P1: I rely on the things that you send and that come through your office. I've been there 6 months and I can't access the Social Services Intranet yet. A lot of it is health focused. I was just going to say before though that in my last supervision we did sort of look at some of the things that I need more training around so it's getting that way but whether they get picked up on. You discuss them but they might not be developed. It's just one of those things say around medication and safe doses because we don't do that as social workers but we're going into teams where it's quite important aren't we and things like that so it has been picked up on but it's just waiting for that opportunity then for someone to say this needs to be done and it happens - whether it will or not I don't know. There's not a lot of things like that out there. We'll maybe have to organise a little seminar for people. You know it can be in house can't it so it was addressed.

CS: But you've yet to see whether that gets followed through? I suppose it's also having a personal and professional responsibility to check what's happening with that. So that's a bit about the second one then "What is your experience of supervision which focuses on your social work role?" I just wondered what you thought about the links between social work and OT really and what you thought about how they have managed to keep their identity as far as I can see and be really strong and really focussed and they do generally get as far as I can see Professional Supervision - that's really important and really inbuilt into their ongoing professional development. Is that something you see in your teams because that's my perspective but not having worked operationally for a while I just wondered whether, what you thought about that and whether there is anything we can learn from OT?

P1: I don't know what supervision OTs get within the team but they definitely do maintain that 'I'm an OT', this is the role and this is what we are bringing to the team but they carry smaller caseloads anyway, that does help in fact only one or two to sort of have that hands on role of care coordination and being able to keep up to date with what is required. That's part of it isn't it - they are sort of seen as OTs whereas we are all just Care Coordinators aren't we. It's not nurses or CPNs and social workers, it's definitely Care Coordinators. We have Care Coordinators meetings. You know we don't have separate focus groups like this and then there's the support workers meeting. Obviously OTs are involved with the Care Coordinators meeting but they are seen as a separate entity aren't they and very much used to do what they are expected to do like social inclusion and occupational therapy but we just get lumped together don't we. Probably because it's the role and you go to the team knowing that though don't you and in some ways you know you are going to be a Care Coordinator don't you.

P2: No I went to the team thinking I was going to be a social worker

P4: The OTs are very protective of their role, always have been. They are also being respected by health managers and other health professionals for the uniqueness of the role they represent and they are well supported by their line management in protecting the uniqueness of their role as well and they are the only professional group within the team that have a waiting list, very small caseload, a waiting list for occupational therapy assessments and we have not been able to maintain the uniqueness of our role at all. We have been sort of integrated and assimilated almost as opposed to integrated in that we've allowed our role to become a generic mental health professional role as opposed to having a uniqueness to it.

P2: As I see it I came to the team as a social worker who was a Care Coordinator second but I was a social worker first. I have held on to that and I still want to remain as a social worker first and care coordinate cases because care coordination is for me the role of the social worker. It is a role within the social work role

P4: Social workers who have had experience of working in social work settings, including child care or any other discipline, have a better idea of what it means to be a social worker which is why those of us who have been around a while and have that experience before coming in to work in multi-disciplinary teams which I mentioned this to you the other day in an e-mail, you know they are talking about reducing the number of days training and my argument is that when we qualified as social workers years ago we would normally go and work in a social services setting, in a social services office and we would get our post-qualifying experience there in mental health or child care or working with older adults or whatever it was. In fact we would fail to get a job in a community mental health team or a community resource centre as they were then until we had had a significant amount of post-qualifying experience. That situation

really no longer exists for social workers now qualifying in mental health and as with nurses they have no choice but to try and get jobs working in community mental health teams or multi-disciplinary teams wherever and I think those new entrants to the profession are struggling more than we perhaps did with identity and with understanding the role because they are from day one being in a multi-disciplinary setting where roles tend to get confused and blurred and you are just struggling to get to know the job without concentrating on your contribution to that job as a social worker. My worry about the reduction in the social work number of days of placement is that how are these social workers going to be able to get their post-qualifying or their pre-qualifying experience even to get this grounding that they will not get otherwise

P5: Can I reassure you that I have handed it over to the people who are actually going to help put the proposals to the ministers so it's gone right to the point at which decisions are being made.

P2: I do question why it doesn't seem to work as well in mental health. I did my last placement at the Intermediate Care team at the hospital. Now that was a fully integrated, multi-disciplinary team and it worked whereas it doesn't seem to work in mental health and I don't understand.

CS: When you say it worked what do you mean by it worked?

P2: There was a separation of roles but everyone worked together so social workers were social workers, OTs were OTs and nurses were nurses and everybody had their own specific role and everybody had their own specific line management and supervision structure but it worked as a team.

P5: In mental health part of the reason I think that maybe our role has disappeared a little bit is that our assessments, social services assessments, were amalgamated with the health ones and basically that distinction went away and what has become of it is

P2: Health and social needs assessment rather than social needs assessment

P5: So if you take OTs they would be distinctive because the main assessment form never took in the elements of OT so that means that some of our distinction goes because part of the problem in my belief is that we don't have distinct enough things about our profession. That has been a core problem for me and it's some of the reasons that I have attended some of the forums and had discussions around this and even in the early stages of the CMHTs nursing staff would ask what is a mental health social worker, what is social work? It was a difficult one to answer and still is.

CS: Do you think supervision has a role to assist you to sort of be able to articulate that? My hypothesis at the start of this research was that those people who were getting good, professionally focused supervision would feel more confident and more able to articulate their role in the team. What do you think about that?

P2: It does need proper structure though. It seems to be very ad-hoc arrangement and does need setting up as a proper structure and allowing people the time, if you are going to create the role of a senior social worker post, actually create it properly so they have time and they don't actually run around doing AMHP assessments constantly and doing shift patterns that don't fit in around actually fulfilling the role of supporting people because I've only been in mental health for two years and I do feel just thrown in at the deep end and abandoned and it's sink or swim and hopefully I swam but it could very easily, I've seen plenty of other social workers go by the wayside and think I can't cope with this because they're not supported enough. I think

I was hopefully strong enough and had enough background experience in other kinds of social work to actually think I can.

P5: Is there a reason to maintain social worker as something separate within mental health?

P2: I think it does have a specific role.

P5: How's that?

P2: Well the nursing staff don't look at social care aspects do they? They are very medical model and I still feel that nurses do go very much down the medical model.

P5: The assessment asks them to do that - family settings and social networks

P2: It does but it's not their priority. I think they tick the boxes and fill them in because they've got to do on a form and not because they've got an interest or actually experience in looking at those specific issues that affect people.

P1: I think it depends on who you work with because I work with some CPNs and they are very much focused the way we are, looking at the bigger picture. That's the sort of thing in mental health anyway and the big lobbies that come off the back of like disability and stuff like that. It's become a lot more political hasn't it so some of the nurses who have gone into training, I don't know if it' just the ones I have come across, aren't just looking at treatment they do think about oh this person has got social problems, their housing is inadequate. Maybe they don't explore it as much as we would like them to but they don't ignore it, it has to be addressed. I do think from what you were saying before that if there was more of that professional clarity in terms of supervision we would assert ourselves more and have more of a defined role and perhaps if we do sometimes think within the team discussions that actually no you are missing that point there we would feel a lot stronger about saying it and maybe that's where it falls by the wayside, particularly again with AOT where the focus is on people who have been in hospital and a lot of it is about treatment and stability but perhaps sometimes it is a little bit ignored that we need to factor in some other things as well you know what I mean. Perhaps we lose that because it's become a bit blurred but I do think the people I work with are looking at those things as nurses. I don't think they are ignored.
P5: The psycho-social approach is a very strong model. Some of the stuff I've read on social work, evidence based practice over in America, the users there are very strongly for psycho-social approaches towards mental health. My opinion is that the psycho-social model is very fertile ground for social work. We should develop expertise in that as an interaction between the social environment and the individual.

CS: Isn't that what we do, the core of what we do?

P5: Well that's exactly the thing that the nurses within the team have had specialist training in this and therefore our specialist role has vanished. About twelve years ago I did the psycho-social course that was running at Kirkham. That was before Health started to do the training.

P4: The difference between us and Health staff in terms of psycho-social interventions and all that sort of thing, they seem to focus on filling in the paperwork and getting all that side of it right and doing all the written part of the assessment but the actual going out there, seeing this person in their social context, looking at the problems and the interactions of that person with their social environment and how that's impacting

adversely on their mental health is our strength. That is what we are trained to do and that is why our health and social care needs assessments are much more holistic. They come at it from the perspective that social care problems impact adversely on people's mental health and that's where they come from and that's the focus that we have. With Health it tends to be a bit narrower I think they sort of like don't, they're not as good at holistic assessment, they're not as good at going out there interacting with people in their social environment and you know trying to resolve the social difficulties which are impacting on this person's mental health. You know we have strengths, we just need to identify them and champion them really I think - as social workers that's what we need to do.

P5: I agree

P3: But hasn't that been eroded in part, I think it comes back to supervision because a lot of people don't access social care supervision and I think that that, obviously I'm from a different setting from the rest of you but I do go into a team and I sort of see the change from when I was an AMHP trainee to now and how it's gone from having a social care manager to a health manager and the impact that that had on the AMHPs that are working in social care and I think you mentioned about newly qualified staff coming. I was in my office one day, just as an example of it, and there were two people there who I took to be social work students because of the questions they were asking and it later transpired that in fact they were qualified agency staff and they are operating as social workers.

P2: I think there's a focus on management, from my experience as being its number crunching, it's all strategic, it's all. The management, maybe it's just from my experience, they're not hands on any more, there's no hands on managers, there's nobody checking caseloads, nobody monitoring what's going on, popping in and out of offices, seeing what's happening to people. We need hands on managers or supervisors who can be there, not going to strategic meetings with the Chief Exec and number crunching.

P3: It's like for these two people, they both had issues and there was nobody to take with them. The manager was health and wouldn't have understood

CS: Do you think there is something about do they not understand or do we just assume that they don't understand in terms of thinking that they are an integrated manager and obviously you have to look at other disciplines and try and accommodate and try and understand.

P2: Just in terms of the computer, the health managers know the health computers. If health managers have to do something on a social services machine they haven't got a clue.

CS: So they don't want to know do you think?

P2: I don't think they see it as important you know they come and ask us how to do things. Even in terms of setting up new staff who are coming in, how do I access HR for this and how do I set this up and how do I - well you're the manager actually, you should be doing this I shouldn't be telling you this. I do think they are very much focused on they know how to do things on Issis and that's about as far as the knowledge goes.

P5: Then there would be a case to have some training for health managers

P2: In how Social Services are set up, policies and procedures

P5: In supervising people from a social care background, social workers so that they can be made aware of some of these things and take them into account

P2: Just in terms of policies and procedures it's different for LCC than it is for health

P5: It's around the distinction between social care, social work approaches as opposed to nursing approaches so that when you are in supervision that you are not guided away from what social work is purely because they don't understand what it is.

CS: By enlarge the managers are nurses aren't they?

P5: The problem is that across the whole of the area social workers are under so much pressure to go away from social work practice, to conform to general practice within teams and not only that the teams are becoming and approaches are becoming more medical.

CS: So what do you think the benefits of supervision, professional supervision would be then? It's varying degrees isn't it to what people receive.

P2: It's having someone, it's having that confidence that somebody actually knows what I'm doing, knows that I'm actually doing things right, somebody I can turn to if I need to question something. I think that for me because I don't have any supervision, the fact that I feel like I'm working blind a lot of the time and I don't feel like I can actually go to anybody and say "I'm having a bit of a problem with this - how would you handle this? I'm doing this, I'm doing that, is this right?" It's very basic. I don't get any. When it does I say it's ten minutes of number crunching and can you take another case? Or we've got this mandatory thing to fill in, can we fill this in?

CS: Have any of you just out of interest been, heard anything about the health check, you know the thing that came out of the Social Work Taskforce - the health check that the local authority has been asked to complete. Obviously for mental health social workers that responsibility is really going to fall to the Trust and it's supposed to have been sent out to teams for teams to start some discussions around.

P4: Do you mean our health?

CS: It's called the social work health check and there are things in it about, it's not personalised, it's done as a team and it does raise, ask some questions about social work within teams, about waiting lists and those sorts of things. So none of you have seen it? I'd encourage you to go back and ask your manager where it is.

P2: What's it called?

CS: Social work health check. It's the manager's responsibility to fill in. Have you not seen it P3 from Team C

P3: I don't know to be honest.

CS: Because you assume that within ACS that people are more likely to have seen it. It's the social work health check and it's a template that teams have been asked to fill in. The manager shouldn't be just doing it on their own; there should be discussion with social workers.

P1: Are you filling it in like a little group of social workers?

CS: I think it's supposed to be done as a team. That's the way that it's been agreed.

P5: It's supposed to be done at frontline and it's supposed to be taken up then back to the managers. It's supposed to be trying to address some of the issues.

CS: I think it had to be done by the end of June.

P5: We had this in London last week when someone from the Department of Health was asking the social workers if anyone had hear do it because we are all frontline practitioners and nobody had.

CS: So it's not just Lancashire then?

P5: No, I find it embarrassing because RJ is on the Board, the Social Work Reform Board so he should; you'd have thought his Council or Authority would have been more.

CS: My understanding is that there is work being done on it and I thought it was further progressed within ACS than it is for mental health.

P2: How would managers actually access this in order to bring it to the team discussions?

CS: It's been sent out to them by e-mail. It's gone out by e-mail to managers by ND, asking for them to fill it in and return it to him before it goes back to Social Care.

P2: So if they haven't got it who would they contact?

CS: N.

DL: N who?

CS: ND So that's interesting isn't it? I'm wondering what you think if that had been around health, do you think it would have made a difference? If they had been asking questions about health staff do you think it would have made a difference or not?

P1: I don't know there's a lot of pressure on them I don't know about the discipline.

CS: So it's not necessarily about the discipline.

P1: You just find they are focused on what's topical at the moment.

P4: Management organisation is very poor I think across the board at the moment.

CS: It's because we are going through a period of restructure

P4: Yes, yes

P2: There's a focus for managers on the strategic stuff isn't there. There isn't focus for managers on managing teams. They don't manage teams; they manage things that are shouted at them from above. They don't actually manage teams on the ground.

CS: Does that mean that the teams self manage?

P2: Yes, self manage completely.

CS: And do you think nurses feel the same way?

P2: I think they do yes.

CS: So obviously this is about supervision and whether they get anything different really and whether they feel the same things about identity and role? You know you read stuff around supervision and role and identity. It tends to be social workers that feel it more acutely I think.

P5: Social work supervision was very different. I mean I haven't been through nursing supervision so I wouldn't know the detail.

CS: I think nursing supervision hasn't really had a focus. It's a much newer phenomenon isn't it really clinical supervision for nurses. It's core, it's inbuilt isn't it into social work and that's what you expect that you get supervision.

P1: Particularly in the light of all these problems in the papers.

CS: Yes, I don't think nurses have ever had those same expectations around supervision so I think that's a bit of a difference. What about the whole agenda in terms of personalisation and supervision. Do you think there is a role to play for professional supervision to help social workers?

P1: And other team members really

CS: With personalisation

P1: It gets bandied around and we know that it's a massive agenda don't we that this is the way things are going whether we like it or not but I think a lot of the works are used, a lot of the jargon but on the ground there's been no real sort of training delivered. I know that sessions have been held by Lancashire County Council but it's not been systematic in the everyone will attend, everyone will know how to address these points, Again it's like if you're interested can you get the time off to attend but I don't think it's really been like this is what we need to be focusing on. There's been no introduction of it really.

P4: Well I've gone to the sessions on Personalisation which are being put on by LCC because I was interested in and wanted to know what it was about and knew that it was going to be important but I noted that none of the managers from my team were there to learn about it and hence it's never mentioned except as a kind of 'oh well it's another thing that's going to be happening but we don't know very much about it' kind of thing'. They have a very narrow interpretation of what it's about which is SDS basically and not much else besides. But you know it's a worry when managers don't turn up to the training and learn what things are about to be able to cascade that down within the team

P1: I think that in mental health it doesn't apply as easily as maybe with people with physical disabilities because there's more of an assertiveness there of what they want and you know of what they'd like. In mental health often you are dealing with people who haven't really got a focus on what would help them but that's part of the problem that the drive isn't there anyway.

P2: It is going to change anyway. We're going to have to change even though we don't know how it's going to work with the changes in contracts like we've lost our day services. You know we're going to have to start using it to actually access day services for people in the future because that's the way it's going to be isn't it.

P4: It's imperative really for managers to grab hold of the SDS part of the personalisation agenda because you know any social worker in mental health will recognise difficulty in applying SDS in relation to care packages that we might set up for our service users for fairly obvious reasons- many of them wouldn't be able to cope with the responsibilities of managing their own budgets and things like that and you know the onus is on managers really to grab hold of that fact and be a positive and forceful representation at all the training levels or discussion levels on SDS in order to work out how this would apply in mental health or it could be implemented in mental health and to make sure that you know that the systems were compatible with mental health systems, which they're not of course. It's a nightmare trying to; I've done it once, to set up an SDS care package in mental health because of the incompatibilities and the length of time it takes.

P2: I tried to do an SDS last August and it's still in dispute because the package of care that's needed doesn't meet the bandings and they're still fighting over it and it's been a year nearly. It is a very complex area for mental health, more so I think than setting up a home care agency for somebody who is elderly.

P3: But there again for people with dementia there's even difficulty with those.

CS: So how in touch do you feel with what is happening in ACS around social care, Personalisation, what's out there, what support you can get from Lancashire County Council either on the Intranet or any other places, just accessing that if you've not got supervision that's maybe pointing you in the right direction which is what you might expect. Like you say you're not getting it if there's not that management buy in.

P5: Well there's a practical difficulty which exists anyway. If you take frontline practitioners they have to address change and that's part of the role. The pressure of change tends to be when you have a new policy or a new practice to implement and that imposes on their day to day roles. What we've got is two organisations so there's two streams or two agendas of change coming through the Health Service and coming through Social Services so there's already a greater difficulty for a Social Services member of staff.

CS: So how do you get that support and access to information and access to resources if you've not got supervision that's helping you with that?

P1: There's e-learning stuff around that but again I can't get on to it but I know it's there. I don't know really.

P2: It's down to yourself but when you have a full caseload you don't always have time to sit down whereas if you had specific time set aside for supervision that was actually maintained and kept. You know a couple of hours of quality supervision time rather than a snatched

P3: Well it should be the priority shouldn't it? It almost feels like it's the icing on the cake rather than an integral part of it.

CS: Do you think that supervision, if you were receiving it, you would expect that things like SDS and Personalisation would be on the agenda and you would be challenged around 'what are you doing with that?'

P1: You'd have thought so.

P5: If SDS exists, if you view it as offering opportunity to provide a wider variety of care and support for an individual, if that opportunity exists it's for the social worker to notice that opportunity and if that's not happening then those supervising should be raising it and should be pointing directions. So I think yes it should be there and encouraging people to use it but the difficulty is, it comes back to it doesn't happen that frequently. There are other areas of social work where it happens more frequently, you know organising packages of care.

CS: But is that partly because service users didn't have services that they wanted to access and if we were looking at it more broadly, looking at Personalisation, we might service users saying I want, I would like the support and my budget so that I can purchase my support package.

P2: We're going to have to do that now aren't we because of the contracts with things like Day Services and things are changing. We're going to have to buy into

P5: You see conversely it's the other way round in our area because our Day Service is still a local authority provided service and the difficulty is going to be identifying charges and costs.

P2: The contracts have just changed for us

P5: It's going to slow down the process

P2: We're going to be speeded up rapidly with no management supervision or management support and knowledge about the process.

CS: One of the things I've been interested in in looking at this is about the hypothesis being that if you are getting good professional supervision then you are able to provide a good quality service to service users so what's the impact do you think of, either personally or as a group of social workers, on not getting that good professional supervision on service users?

P1: You could be missing the boat. You never really get to discuss I don't find. I do get supervision, not always regular, but I tend to get it and we do look at my cases - it's limited but there's some scope as I said earlier. You're just missing the boat though because we think about what we're doing with these people, what are the targets and what are the goals and the expected outcomes. You don't really get to think about how you're moving people on and hence this is why AOT have people stuck with them for four or five years and almost like see us as a taxi service or like a social network and that's not right is it. I think that's across the board with a lot of Assertive Outreach Teams, not just mine. That's it we're not really thinking about what are we expecting to achieve, what would the service users like from our input. We never look at that do we it's just like are things ticking along?

P2: Yes, are things ticking along, can you discharge them, can you take anybody new? That's how I see it.

P1: So you're not really delivering the best service are you, you're delivering a service, they're paying lip service aren't they.

P5: They're not resolving social issues

P1: No, no and you're just kind of like people are stable but are we really moving people on, you know being exposed to things that we take for granted because a lot of them aren't are they . A lot of people still struggle with going out independently. They will go out with our team members and sit for hours at a time but have you been out this week, no and you've got to think well why aren't they doing that. If we looked at our professional development we'd be able to think well what do you think you could do to enable that, how could you support that shall we say. What's been done in the past, have you spoken to other team members, even to say speak to somebody else about it. As you are saying if some of the team managers had more of a kind of awareness of other cases and other successes that could be implemented as well. You know you learn from good practice don't you. It's time constraints I find though.

P2: It does worry me the fact that we don't I think, not getting the supervision we should get, it's very dangerous practice. It's very dangerous.

CS: You're not the only social worker in your team are you so do other people feel the same way?

P2: Yes

CS: So what do you think you could do as a team, the social work team?

P2: Well we haven't got any managers

CS: Do you think you could form a support group?

P2: Again everybody is part time workers and we're that busy doing other things. We've tried setting it up in the past and it's never really worked.

P5: Why?

P2: Because we've got a lot of part-timers. There's myself full time, we've got one ASW or AMHP and the other social worker is part time and a vacant post so it's pressure of work.

P5: Then there's surely a strong case for supervision as something that supports.

P2: You'd think so wouldn't you?

P5: Well it would have to be acknowledged. The driver at the moment is looking at supervision. It's all coming out in the Task Force isn't it?

CS: There's supposed to be a supervision audit being done locally.

P4: Well you (P2) are a particularly extreme situation with no supervision but even where there is supervision the quality of it is so poor. You go into supervision for example to discuss a case and the best you get out of that if it's a complex case is 'oh well organise a complex case meeting'. That wasn't exactly what I wanted to do. I wanted to be able to go through the issues and get you to concentrate as my supervisor on listening to the issues from my perspective and try and engage with me

in a discussion about this case to enable me to work out a way forward. That doesn't happen.

CS: Is that what happened in the past though? Is that down to personalities or has it always been that you have not really been satisfied with supervision?

P4: Yes I've never been satisfied with supervision at all. If I can't work something out for myself I've always felt it ain't going to happen. I have had to think things through myself and work out a way forward with cases rather than relying on supervision as a way to help me to do that.

CS: Supervision should be about helping you shouldn't it. It's not about giving you the answers because you know that person best but it's about having that dialogue in my opinion and helping you to see, putting a few pointers there. Saying things like well I know someone in the team has done that, have you thought about that?

P4: Exactly but that isn't what you get really.

CS: You've obviously worked a long time in social work. Was there a time when you got that supervision?

P4: No

CS: No, right Ok.

P4: I've always had to be quite independent because rightly or wrongly there is always the accountability thing that you have to be careful about but I've always had to learn to think for myself and work things out for myself which is why now that I have got another bit of a hat on if you like I try to offer supervision to other people to make it meaningful for them, make it look as though I listen to them for a start rather than have your supervisor yawn all the way through your supervision session.

P2: I've been lucky in the past because previous to this job I've had really really good supervision which is everything you said about working through cases, discussing things and bouncing things around, looking at different ideas

P4: Just to feel that you are listened to as well

P2: I think it's down to the personality of the supervisor as well. I think that's part of the problem as much of the training they've got.

P5: But shouldn't their skills be developed?

P2: Should be

CS: Because supervision is no different than engaging with service users. It's about being able to tease things out and work things out with somebody isn't it? You'd hope that good supervision leads to good outcomes for service users. The reverse of that is that maybe bad supervision doesn't, because that's the hypothesis.

P1: Because I know like you said you've been qualified for a long time and it's never been the case because when I was in training that was always a key thing when we went into a workplace or on placement in the early stages before you qualified you know supervision was very very integral. Now whether it was good or bad it was still integral but I just wonder if it is again, I know it's going off on a tangent, but again if it

leads to all these problems that we're having and hitting the headlines that they are kind of like focusing on because they're saying that there's a lot of social workers that are not able to do their jobs now they're qualified. Because they are talking about having a period where you are almost like a probationer and then the whole thing about having a separate school for social workers we're not really looking at the wider picture of why the world is a bit of a mess but it's interesting if before it wasn't that fundamental but now it's become more fundamental because of like the nature of things.

P3: I've been in social work a long time and mine's been variable. I've had some excellent supervision and when I first qualified and was working in child care I had a really good supervisor who laid very firm foundations for me which I've built on then as time's gone on. I've had a variety; some have been absolutely appalling and some have been good.
CS: How have the different experiences of supervision affected how you have felt in that particular team?

P3: Of course it has because it impacts on your confidence. I went forward from having a really good grounding in child care, which gave me confidence that I was able to make good decisions and also I could go back and say well look you know there's x, y and z because you're literally I mean in those days there perhaps wasn't the support that there is now and you'd be going out on your own and making decisions which could be life and death. That's not being dramatic but you could sort of test out and that's followed me through because you do build on your experiences and as Rachael said as you become more experienced you get more confidence and perhaps the issues which you might have been wanting to address at the beginning they change into different issues really don't they whereas when and following on from that when I got bad supervision in child care or non-existent I still felt confident enough that I know what the issues were and also if I wasn't getting them from my supervisor I knew where else I could go and get that support or advice.

CS: But that's quite different in mental health though isn't it because you could be the only social worker in a team.

P3: Well I think it is different. The example I was giving of those two newly qualified and where would they have taken those issues, who would they take them to?

P5: Well newly qualified is a major concern because early stages of practice as you describe are times when you get reinforcement about the ways you should be practising and if it's not given that status and is not from somebody from your own professional group then you can be getting really bad messages. You could be missing out on reinforcement and could be missing out on establishing a level of professional confidence which takes you forward.

P3: And competence because if you don't know where to look for stuff. I mean I do find Jones is absolutely horrendous. You know compare it to child care with the Children Act it's quite simple. You could find your way round so knowing where to go round that and various procedures and that. People, if the manager doesn't know where to say well go and look at this, this is what you need to be looking at well where do they - it really worries me because I think people are very vulnerable and part of the problem as well is that some of them don't recognise how vulnerable they are.

P2: As I said before the lack of supervision is quite dangerous.

P3: It is absolutely because that's when and I think group supervision does play a part but I think, particularly in your early years individual supervision is vital. Well you're not going to leave yourself wide open if there's something, well depending on how confident you are as a person but there might be issues you'd discuss on a one to one with your supervisor that you're not going to discuss you know in a wider forum. I think it's important that people have individual supervision.

P5: There's a flip side to this as well that if you've got, say Social Services now as they stand, how are they going to get information that there are difficulties in front line for their practitioners because if you don't have a clear link of supervision down to the front line. In reverse you don't have means of feeding back down to senior managers to identify that people are not receiving the right messages or are alarmed at the front or have adopted poor practices

P2: It links back to the problems with recruitment and retention of social workers because if people don't feel valued they don't feel supported so they leave but that has an impact on service users as well but also for the County in terms of recruitment and retention of social workers. You're better supporting the staff you've got and actually keeping them long term rather than constantly having to bring new people in who've got less experience.

CS: Have any of you got a current PDP?

P1: We did discuss it a few weeks ago and the training I've had, what needs to be looked at, what I'd like to do in the future.

CS: Is it written down?

P1: Yes so it could be better but it could be a lot worse

P2: Mine was done in probably ten minutes, written by my manager just to get me on the course that I started last September because I needed a PDP to go on the course. It wasn't meaningful in the slightest, no discussion about it, nothing about my needs. It's just we've got to fill one of these in to get you on the course - very functional.

CS: Anyone else got a PDP?

P5: With M yes it's been done.

P4: There was an attempt to deliver, how many years ago was it now when they were first sort of

CS: Yes it's an integrated PDP process now that was agreed between health and social care. We don't use those green files any more, we should be using the integrated process.

P3: Isn't there something though about when you're having, I mean I've seen it from the other side though as well because I also have staff who come not prepared for supervision.

CS: Do you not have supervision contracts?

P4: I have a kind of format that I use which says this is what we ought to be looking at in professional supervision and AMHP supervision.

P3: But that's where you can as well, I've got a format for mine because in our team we do both and of course we're generic so it's not just mental health so it's the whole thing and I split my supervision, I've got a proforma, that I actually use for staff. We'll look at, there's health and safety issues we look at, we look at childcare issues, older adults, mental health. We talk about other issues and included in that is personal development. We look at training needs, what courses they are going on, what others they might need to go on and then we've got an overall of any other issues so it's flexible enough but it's also like an aide-memoire. But of course our supervision is very different because we don't carry caseloads as such so it's more, in many ways it is more to do with issues and people raise cases where there have been particular difficulties so we tend not to get bogged down. I could see that when I was a daytime social worker it would be very case related but I also needed that as well because there are cases that you need to talk through but I was just trying to think when we are talking about professional supervision and case supervision for me and my learning style I would need to have the two of them together

CS: I think that's what's happened in Social Services that they have generally been done together. Because we've moved into a world where they aren't delivered together, in a health world really where they have very much separated out management supervision and clinical supervision, which happened elsewhere and didn't necessarily have any relationship with the management supervision so I think they've struggled with the idea of social work supervision.

P2: It needs to be brought together though.

CS: What about if you're managed by a health manager, can they offer professional supervision for you as a social worker?

P2: Not as well as a social worker could or someone from a social care background.

CS: Because the Task Force does say that if your manager is a health manager you should be able to access professional supervision from a social worker.

P2: I would feel more comfortable with it being the same person. I would rather if I had a supervisor and could discuss personal issues and training issues.

P5: We are looking to define what is the nature of social work supervision and specific aspects of it and trying to separate those out. I was in this discussion last week where it was suggested that if they looked at it almost like a module, with what it is that's particular to social workers and then going back and saying that ok supervision with a health member of staff has to have these elements in it.

P2: For me it would work if I could have supervision with one person and agree points that could be shared with my manager out of that supervision

P5: But all this is something about understanding. If you take mental health services now working in the community, the nursing staff work in the community but the social workers have a different view about working in the community. They have a different background and understanding of the community, different understanding of what an individual might experience in their social world. That background and training in the approach is lost when we have supervision from a person with a nursing background. The professional background and the professional core materials you do when you qualify are different and it gives you a different perspective and that's always lost.

P2: But as I was saying I would rather have personally supervision in its entirety with a social care member of staff and then have agreed points that will be shared because some things you want to keep private in a supervision session. You don't necessarily want to share it all but agree points that you want to take back to your manager and say we've had supervision and x,y,z, you know these have come up as issues.

CS: It's about accountability isn't it and where that sits?
P5: It seems to me that in the organisation what's happening is that instead of having Social Services and Health now through the integration what appears to be happening is a distinct management structure and there's also supposed to be professional structures.

CS: OTs have that really clearly and there was an attempt with the Senior Practitioners to deliver that for social workers but unfortunately we have identified capacity issues. They are part time posts in effect as they still have a half-time caseload

P5: It should be that you have access to a Social Services or a social work supervisor.

P3: Providing they were given the time to do it. It's time consuming. Our staff have two hours supervision and if they need longer that happens and then there's time afterwards typing it up so you're talking about three hours. You know if you've got a few people to supervise and you've got other tasks to do as well it's how that role is looked at.

CS: When I was a team manager I had 15 staff to manage. They all had monthly supervision, they all had PDPs which were up to date and it's not about numbers I don't think it's about a commitment.

P2: It is currently about numbers.

CS: It is about the view of the manager isn't it and how they prioritise supervision. What supervision do they get as well? You learn from the supervision that you get don't you about how you deliver it and if they don't get supervision, or they get supervision that's focused only on targets then what they are going to deliver is supervision focused on targets isn't it?

P5: I'd also suggest that it's a long-term and short-term view because longer term view supervision would have a very healthy outcome for the individual because if you're helping that person manage cases and stressors then that has a long-term impact.

CS: For me supervision was always about the impact of the work on the worker. It sounds like that something that's got lost.

P2: I don't feel valued there as a worker particularly because I go in, I do my job, I come home. I don't actually feel valued or that anybody knows what I'm doing. You have to rely on your colleagues, that's the only way you can do it and if you have a query you have to go to your colleagues. You can't bounce things off a manager because there isn't one there on a regular basis

P3: I've been thinking about this when I have been at this particular CMHT because where does responsibility lie? There are people there doing things or not knowing what they're supposed to be doing and there's a manager there, a health manager, so where does responsibility lie? When it was a social care manager you got there is this issue, x, y and z. The nursing manager does not understand parts of the mental health act because they are nurses that haven't had to deal with that so how can they sort of

give advice and where does the responsibility lie? I mean I'm surprised there haven't been more tragedies really with the lack of support and advice that's given. I mean I will give you an example of this. When I was doing, I think I was on placement, a nurse came in to the AMHP on duty and said I am setting up a Mental Health Act assessment because this woman she was sort of obsessed with knives and was threatening to stab people. She was downstairs in the office with her husband and the Consultant couldn't come out until half past five, six o'clock so they were going to send her home with her husband and nobody had thought to ask what was going to happen to the children in that household and if I hadn't said 'what about the kids' they would have sent this woman who was really risky just go and not see the wider picture and I think that's what we as social workers do look at that, rather than the nurse focusing just on the patient. I mean it might be changing.

P2: That distinction of being called patient or service user. You know the nurses still call service users 'patients' and I find that quite bizarre in the team really. We need a generic term for what we call people. I don't see people in the community as patients.

P1: In some ways you can get wrapped up in the jargon because they are people at the end of the day

CS: We've not got a lot of time left and I supposed we've touched on this question which is about what do you think are the real barriers to you receiving professional supervision?

P1: Definitely time constraints for you and the managers because I'm aware of the different meetings my manager has to attend. Maybe they need to address that and as a manager you have to focus on 'am I managing a team or am I just looking after the bigwigs?' for want of a better phrase. Perhaps there are things that they don't have to attend, there's e-mails circulating all the time about what's gone on. Within an area one person could attend and feedback. They've got pressures on them from above which I think they do struggle to find the time. I find that my supervision is pencilled in but gets changed because I've had to go somewhere or they've had to deal with something that's come up but it's just like it's about well maybe it's got to be done and rather than three weeks later on, it's not happened today but we will make time for it within the next two days because it drags on otherwise and then in the space of three months you maybe have one supervision when you should have had three.

CS: So it comes back to a contract.

P4: I wonder about the confidence in people who are in a situation where they are offering supervision- managers, senior practitioners or whoever they are- the confidence, the skill in delivering effective professional supervision, the training to do so to give them the skill and the confidence

CS: Because we assume that once you have got to a level of management then you've got the skills to deliver supervision but clearly you don't do you?

P4: If you've got to a level of experience you're assumed to have that skill but it doesn't follow.

P1: So it's a question of why we have supervision and what should be happening in supervision because we've lost that focus haven't we. It's just become a bit like automatic in that you go in, you look at your cases and that's it. The whole thing of today's discussion is that none of that really happens. We get some supervision and

other people don't but it's not just about automatic response you know the meaning of it and the importance of what should be discussed.
P4: I think P3 mentioned earlier on about people coming unprepared for supervision but I think it also could be said that managers or supervisors don't prepare for supervision with their supervisee and I think that it is imperative on both sides to think it important to prepare for it but again I don't think a lot of people in supervisory positions realise things like that, realise the importance of being a good listener for instance and hearing what people are saying and trying to make sense of it; the basic interviewing skills or techniques or engagement skills

CS: It's essentially no different than having a conversation with a service user because you are wanting to achieve the same goals and outcomes aren't you. You'd assume that managers would have those basic skills but it sounds like you can't make those assumptions.

P4: So managers feel that basically all they have to do is pontificate for a while and that's their job done.

P5: This is the quantity and quality debate again in an organisation. But I still think there's a strong case for training specifically in supervision.

CS: There is some leadership training being offered because you do need to be a leader as well as a manager.

P4: But specific supervision training would be good.

P5: There are two strings which are coming through from the results of the Task Force and the Reform Board and the College of Social Work. They are looking to try and define what is distinctive about social work and also looking at; this is going to be as a result of the health check, looking at defining what supervision should be for social work.

CS: Do you think having some standards around supervision for mental health social workers would be helpful?

P3: I think though that the top and bottom of it is that people need time and it needs to be given priority and I have concerns about the Senior Pracs because I think they are in an invidious position because they are managing caseloads as well as having supervisory responsibilities and I think they are going to find that it's just too much. It would almost seem in this environment, in mental health, that you could almost employ someone who would actually supervise staff - just do that and be some sort of link with the managers of the various teams. They would be then responsible for passing on issues that needed passing on but if the Department wants to have good quality supervision and to support their staff and also to ensure that we get better social work for want of a better word I can't see how else they are going to get it you know in this environment because I just think the Senior Pracs. I mean I had one of those roles as a Child care social worker and you were just so, because you got all the complex cases, people would come to you for advice which wasn't formalised but you were absolutely pulled out because you only need a couple of complex cases

CS: It would be interesting to have a similar focus group with ACS staff to see what is their experience of supervision?

P2: I've never felt as isolated as I do now. I mean I've worked for the County for nearly twenty years and I actually feel very isolated now. I don't feel valued and I feel very

isolated. I mean I enjoy my job, I love the job and I'm not going to walk away from that but I don't feel managed, I don't feel supervised, I don't feel supported.

CS: Do you think being an AMHP will make a difference?

P2: In our team, no.

P5: It used to make a lot of difference.

P2: I don't think it will do currently where I work. I think maybe it would be different in a different team

P3: Where are you going to go for your support when you're an AMHP?

P2: It does worry me a little bit because we are lucky in that the AMHPs we have got are very experience and self-supporting in some respects. There isn't any external support for them in terms of supervision.

P3: But it worries me how I am going to go on in respect of AMHP supervision, because obviously I get mine from PL

CS: Ok, are there any other comments that you want to make? Any final thoughts? Just to let you know that BASW are working on some standards for social workers in mental health Trusts, whether they are seconded or employed by Trusts, do you think those would be helpful to have - they will include some standards around supervision so what a social worker working in a Trust can and should expect around supervision.

P1: I think it would at least highlight that professional difference.

P5: The difficulty is how do you enforce any requirement on Trusts? They could look at including some form of performance indicator around supervision

CS: It's the quality isn't it as well as the quantity. Any other final comments? Well thank you very much for agreeing to participate. When it's written up would you like a copy of the final report? Well I am happy to send it out.

Appendix 8

Summary of Comments from Questionnaire

Question 3 - How often do you receive supervision?

Supposed to be monthly but is cancelled regularly and works out approximately 3 monthly

Since joining this team in Nov 2008 I have had a couple of caseload management meetings with line managers from a health background - I have not had any social care/case supervision

Every 6-8 weeks

Four times per year for AMHP supervision and once per year for PDP appraisal. Peer supervision of cases occurs daily due to nature of the team (Crisis Team)

Question 6 - Can you give examples of some of the issues discussed in your most recent supervision which you feel are particularly relevant to your social work role?

Supervision is generally focussed around discussion of my caseload and training needs/opportunities

I tend to access social work management for advice and guidance re social care related matters as my health line manager is not fully conversant with social care policy, pathways, procedures

Caseload issues, problem solving, duty issues, training needs

Role of SW in FCMHT

AMHP practice - case example - impact on daily work

Supervision for SWs in local area
Support for SWs

Pay review
Role and contract of manager (VR)
Future of my role in restructure of social services

Equal pay review issues
Social care needs of SU with Aspergers
Recent SDS care package which I had set up
Issues re incompatibility of SDS system with e-cpa

Senior Practitioner issues

I am concerned about rights of DPs to access washing/showering facilities which are available at Police station but are not offered. My manager shared these concerns which I feel have a gender related strand. It can be humiliating for women in custody

We also had a discussion about continuing rights to legal advice under PACE as unfortunately one particular custody officer feels I am "acting outside of my role" where I have reminded DPs of this. I am lucky to have a manager who has the knowledge and intellect to consider the issues I raise

Focus much more on health service targets and performance indicators

N/A - not had any supervision

Intervening when a SU became unwell when team decision was to leave in care of parents. Question around duty of care as allocated Care Coordinator
Questions also around lack of contact and updating assessments, care plans etc

Line manager does not have an understanding of the issues facing social care professionals.
Emphasis of supervision is about throughput of cases. Have requested professional supervision to be made available

My AMHP work is discussed which I find very beneficial. As a SW in health setting things are very difficult and SW role is diminished

Psycho social interventions regularly discussed for all my clients
Medication issues relating to physical health concerns
Establishing independence outside medical model of MH services

The impact of social work and Adult Network restructuring on future mental health social work
The practical application of SDS with SU in mental health services and potential for creating dependence if not reviewed appropriately

Training/personal development/case management in clinical supervision with NHS Integrated Team Leader

I'm not sure what my role is now - there were issues discussed about recording/planning/safeguarding

Mostly discuss AMHP related issues during supervision, not social work ones but these do sometimes overlap.
PDP yearly does look at knowledge/skills/abilities to do the job of a crisis practitioner but not the role or Senior Practitioner

The drive to close cases only considers health needs and not social care I really have to explain there are still needs and not appropriate to close. I find I have to explain legislation and duties to ensure we don't act unlawfully.

Casework with service users/packages of care
Training relevant to social work role
Workload and stresses
SDS agenda

Problems with FMEs
Puerperal psychosis in relation to Sec 13 assessments
Recent 136 - doctor discharged alone although patient had mental disorder
Social Work values

Reorganisation of SSD
Pay review
Future of AMHP

My supervision consists of how my needs as a social worker will be met. This is achieved by arranging supervision with an experienced AMHP

Question 8 - If yes, is this supervision provided by?

Other:

Team Manager - team in which I work. Deputy Manager in this team provides caseload supervision

Deputy Team Manager is from social care background. I plan to have AMHP supervision from him

This was recently offered but cancelled at the last minute due to supervisor being called away on AMHP duties - this has not yet been rearranged despite me e-mailing to request this

Deputy Manager

Deputy Manager from the CMHT

Social Care Lead

Question 9 - How often does this supervision take place?

Other:

For a lot of reasons regular professional supervision has not yet been properly established

In the 18 months since I joined the team I have had 2-3 caseload management sessions - no supervision

Not sure yet - only just started

Still waiting for it to happen

Every 6-8 weeks

Question 10 - Can you give examples of some of the issues discussed in your most recent professional supervision session?

Application of MCA and subsequent access to Court of Protection via Adult Safeguarding Finance Team
Procedures re Guardianship transfer/renewal

AMHP issues

The session was meant to be about AMHP supervision but the DTM wanted to use it to discuss team related issues

NCRS targets
Cases to be closed
How many SUs have a support worker

Last supervision was mainly about signing the honorary contract. I felt the supervision gave me the answers I needed to make that decision

AMHP rota involvement from AMHPs in LD and Older Adult services

Self Directed support and training in this area

Implementation of personalisation in Lancashire
FACS - qualification for social care services
Charging policy and information

Restructuring and possible impact at grass roots level

AMHP Supervision - lack of resources/beds/S12 doctors and impact on decision making

Safeguarding Issues - training needs

Restructure of social services
Caseload management whilst on AMHP training

Social Care issues are not discussed in supervision with my line manager

Personalisation and SDS - the difficulties in practical application with mental health services re potential for creating dependency and management problem
My need to access SDS training relevant to MH as well as other team members including CPNs

Sec 136 and charging for warrants; interpreters; AMHP role and recording; JE and support from Social Services lacking; Safeguarding requirements

AMHP assessments that I had done recently and issues of practice/law/policy surrounding this.
AMHP student training and social work values/differences between social work and nurse training expectations etc
Supervision of other AMHPs
Local/county meetings
Alternatives to hospital admissions - role of CRT/HTT
Personalisation agenda and person centred planning

AMHP Activity
Personalisation, safeguarding, SDS

SDS, social inclusion and recovery

Impact of health managers on the role of the AMHP

AMHP training and rota
Focus on social needs
SDS and personalisation

Question 15 - What do you feel are the barriers to you being kept up to date?

Other:

In regular supervision my health line manager is not particularly skilful at social care oriented interventions

Lack of time to read all e-mails and attachments

Pressure with caseload/duty reduce time for research/keeping up to date

Being out of loop of communication from LCC and Unison as on NHS e-mail only

I work had to keep myself up to date on social care issues and would not feel at all happy to rely on either managerial or professional supervision to do so

Working as only SW in my team

Response to changes in health and social care provision - reactive to target

Uncertainty about the future

No line manager in post at my location and patchy access to management advice from other local office
MH services are significantly health biased with little acknowledgement of the role and value of the social work profession

Need further training. Team not always up to speed with changes

Line manager from health background has nor experience of social care background and focuses on competence based at work

Lack of knowledge by manager of mental health law and its impact on my role

My lack of time to access training and forums to access information re Social Services agenda. Other management functions i.e. caseload/team management/AMHP issues take priority

Information overload and no protected time to read. Recording systems demanding and caseload high

I feel I keep myself updated on social care issues by linking in with relevant literature/attending meetings in social care. I do not have separate supervision for social care issues - it weaves in and out of all my supervisions on a regular basis depending on what is being discussed currently

Time to access the various sources of information and read these

A lack of informal peer supervision in current role

Question 17 - If you feel confident in articulating your role, can you give examples of where you feel this has happened?

Generally just experience, I don't feel that his confidence has stemmed from supervision

Role is emerging as a Senior Practitioner. Supervision and support will help fully articulate this role within the team

In CPA review meetings in the community and on the wards

As a Senior Practitioner it helps us to identify areas I can become involved with i.e. increasing team knowledge of areas relating to law/social care

I feel confident in articulating my role but I have not gained this confidence from supervision. I feel that my confidence and SW identity have been developed through my SW training and practice as well as through my own efforts to internalise SW theory and concepts over the years

I often hold discussions with colleagues on safeguarding issues and multi-agency risk assessment as I have the background and experience to support them. I am team safeguarding link and MARAC rep.

At present AMHP status (or soon to be) is the most obvious definition

Usually around looking at SU in a social context and accepting of more behaviours rather than just going along with the belief that the SU has become very unwell and therefore have questioned need for inpatient treatment

I can articulate my role but it has changed since moving from the community to the prison environment

Giving advice on mental health law occasionally and its relation to Mental Health Act assessments

In interaction with Health Team Manager
During team meetings re highlighting social work perspectives
In supervision with social workers in the team as well as supervision with AMHPs

I outline my role in assessments, commissioning and how I positive risk take to empower individuals. I had to explain a police constable did not have the power to pick people up off the street, they had to have grounds and the individuals have human rights

Within the team setting, meetings, allocation meeting, CPA meetings. I am a strong advocate for Social work

It assists me to clarify issues which I am not sure about - to provide people I have line management responsibility for with accurate information

Only social worker integrated into team. Need to articulate role of social work and appropriateness of referrals to social work

Started a social care peer group

Question 18 - If you feel lacking in confidence in articulating your role can you identify what would need to change to help you with this?

Only because it is a new role within the service. I envisage that social work supervision will be essential in developing confidence

Greater insight/focus from management to relate to social care staff

I personally don't lack confidence in articulating my role but know many MH Social workers do.

I am often viewed as controversial for expressing my views. I try to do so in a professional manner

Social perspective and resources to help service users achieve better social inclusion is not given enough presidence due to lack of resources

To receive support from SW trained staff

Professional AMHP support would help me build confidence

More time to access forums available to maintain links with wider social work network

I don't feel there is an understanding of the pressures of AMHP work. I feel that pressures coming from the numbers of referrals means you are seen as a 'worker' only. I am not sure we see a clear role as easily as psychology/OT/nursing does.

Question 20 - If yes to either of the above can you give examples of where this has happened

Confusion/disagreement is usually addressed

Clinical/NHS staff appear to be developing awareness and competence in supporting service users in self directed support which is good for the team. "Health" supervision from health supervisor means social care related issues are not explicit on agenda unless I ensure they are

Effective and efficient duty system

Discussion of how we can use SDS

Ensure social care needs are addressed in own practice and highlighted in supervision

Due to previous experience in terms of practical and legal knowledge around cases there are many areas where I have more experience than my manager

I am keen to ensure that in relation to my work in the Court that the impact of sentencing is considered on children and families, particularly where women and single parent males are concerned

I feel that I have needed to self manage and rely on the support and advice of colleagues in order to get by. No one with line management responsibilities has any knowledge of my caseload other than the number of clients I have allocated to my name.

Discussion around social inclusion and purpose of our interventions alongside looking at appropriate housing, activities and support

Carers assessment

In day to day working with carers and clients

In promoting social work quality assessment and work that is complex. This can be difficult for social workers in the target culture.

I think there is an understanding of social needs but there are financial constraints. We have a significant STR team.

Supervision encourages me to reflect on my own practice and keeps it focused on the client's need and needs led rather than resources led. It focuses on skills I need to do the job and how these can be developed to deliver a good service to the client and achieve the best outcomes on their behalf

I am able to identify social issues and address them whereas some team members identify symptom control as all needs being met. They don't consider social inclusion as an issue.

It provides experienced and supportive advice on social care issues - issues of practical importance and necessary to aid effective working, e.g. resource options, practice approaches

Where there has been a particularly problematic assessment which has impacted upon the Service user I have been advised to complete a Serious Untoward Incident Form

Question 21 - If not to either of the above, can you identify what the barriers are to service users social care needs being addressed either in your own practice or within the team?

Need to further develop and enhance confidence in engaging the process of self directed support. The engagement of Care Organisers and people outside of the team, away from familiar services can prove daunting for anyone undertaking SDS with service users for the first time

Lack of knowledge of the law

I feel quite confident that addressing social care needs is a high priority within my own practice. I see is as a significant aspect of my role as Senior Practitioner that social care needs are addressed within the team.

Focus is put on medical diagnosis. There is insufficient access to psychological services due to problems with staffing. People with social problems do not qualify for care coordination necessarily. The criteria to access care coordination is very loose.

Social care issues not on the agenda of the team I work in

The emphasis is mainly on how to maintain and move on the person through the prison services. This has a limited impact with how I work with a person's social needs. Work mainly surrounds links with care coordinators and housing

Team is dominated by NHS staff - ratio to SW is 5:1

Within the team the focus is on quick fix solutions as the most valued. Social workers have always encompassed carers/service user needs in a holistic assessment. I feel this can become a superficial, token gesture if time is not allocated specifically

Service users needs are not always discussed due to financial constraints from LCC and many workers feel LCC does not value social workers or STR workers, especially where their salaries have been reduced