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The Untapped Potential of Mental Health Social Work

Dr Martin Webber, Reader in Social Work

Our heritage (pre-1970s)

Mental Welfare Officers

- Worked for local authorities and provided community care with very little resources at their disposal
- Lacked professional status and recognition
- Performed statutory functions under Mental Health Act 1959
- Predominantly male

Psychiatric social workers

- Largely based in psychiatric hospitals, but were involved in after-care of discharged patients
- Focus of work was therapeutic, drawing on their psychodynamic training
- Higher professional status than MWOs, but fewer in number
- Predominantly female

Our heritage (pre-1970s)

"Work with mentally ill people was really a sectioning service … It was very strongly oriented in working mentally ill people towards compulsory admissions and there was little in the way of prevention, little in the way of after-care … the predominantly male MWOs saw their job as controlling and catching 'mad' people … they didn't see their task as curative, rehabilitative or therapeutic care. The general view was that a lot of it was man's work."

Rolph et al (2003) drawing on the perspective of a Mental Welfare Officer in 1968

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Our heritage (pre-1970s)

"It is doubtful whether psychiatric social workers would be willing to undertake the work and it is certain that many would consider that if they came to be associated with the duty of securing the compulsory removal of the mentally sick (which is the essential function of the authorised officer) it would seriously interfere with their primary function of assisting patients to solve their family relationship and other social problems. It may be that this final act of taking away the patient's liberty ought not to involve one who is so vitally and intimately concerned with the treatment of the patient, but should be the duty of someone with a more independent and impartial approach to the problem."

(Daley 1949)

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Where are we now?

- Typology of attitudes about MHSW from interviews with senior mental health social work managers / professional leads (n=50) in London in 2001-2:
  - Traditionalist: a traditional view of social work, advocacy and empowerment from a sociological stance, maintaining a local authority base and links to other fields of social work
  - Eclecticist: enthusiastic about multidisciplinary teamwork and reducing role demarcation, but keen to preserve the diversity of professional contributions
  - Genericists: subscribed to an inter-disciplinary model, overcoming assumed and statutory role boundaries where appropriate, and working towards a generic mental health practitioner

McCrae et al 2005

Where are we now?

- National survey of mental health social workers (including Approved Social Workers) collected data in 2002 found high levels of stress, burnout and common mental disorder amongst ASWs:
  - ASWs were more burnt out than mental health social workers without statutory duties and 52% met threshold for probable common mental disorder (Evans et al 2005)
  - Mental health social workers had higher rates of common mental disorder than psychiatrists (47% vs. 25%) and were more burnt out (Evans et al 2006). Reasons included high job demands, not feeling valued, long hours, low decision latitude and current position of MHSW

Where are we now?

- 2012 national survey of Approved Mental Health Professionals (n=504, 96% of whom were social workers)
  - 55% do not feel valued by their employer
  - 40% do not wish to continue as an AMHP or are unsure about doing so
  - Only 6% met threshold for burn out on the Maslach Burnout Inventory (Maslach and Jackson 1986), but they were all social workers
  - 44% met threshold for common mental disorder (depression and anxiety)

(Hudson & Webber 2012)

Where are we now?

- Variables associated with having a common mental disorder, after controlling for confounding factors:
  - Younger age
  - Larger caseloads
  - Higher emotional exhaustion (MBI)
  - Higher depersonalisation (MBI)
  - Lower personal accomplishment (MBI)
  - **Feeling less happy about non-AMHP duties**
  - Not feeling valued by employer
  - Feeling unsure about continuing as an AMHP
- Interestingly, workload associated with AMHP duties is not associated with common mental disorder

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Where are we now?

- MHSW has become subsumed within a bureau-medicalised mental health service and its distinctive contribution is in question (Nathan & Webber 2010)
- We argue that its unique contribution means:
  - Putting service users at the centre of the profession's practice and giving them a voice in relation to the dominating institutions in which they live
  - Working within dominant institutions (ie mental health services) but taking a position to challenge them alongside service users
  - Dual identification with institutions and service users (co-production)

What is MHSW?

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

(IFSW Code of Ethics)

Where are we now?

"Until social work can assert the value of its unique contribution, its impact on policy and practice will remain weak, and the prospects for a more socially based model in integrated services may be undermined. A lack of evidence as to what mental health social workers actually achieve may hasten their demise." (McCrae et al 2005)

Evidence base for social work

BMJ

BMJ 2012;344:e1107 doi: 10.1136/bmj.e1107 (Published 13 March 2012)

Evaluation of a peer led parenting intervention for disruptive behaviour problems in children: community based randomised controlled trial

OPEN ACCESS

Crispin Day *head*[1,2], Daniel Michelson *senior clinical research associate*[1], Stacey Thomson *postdoctoral researcher*[1], Caroline Penney *specialist trainer*[2], Lucy Draper *specialist trainer*[2]

[1]Child and Adolescent Mental Health Services Research Unit, Department of Psychology, Institute of Psychiatry, King's College London, London SE5 8AF, UK; [2]Centre for Parent and Child Support, South London and Maudsley NHS Foundation Trust, Michael Rutter Centre, London

Reduced child behaviour problems and improved parenting competencies

Evidence base for social work

BRITISH JOURNAL OF PSYCHIATRY (1999), 174, 219–224

Befriending as an intervention for chronic depression among women in an inner city

I: Randomised controlled trial†

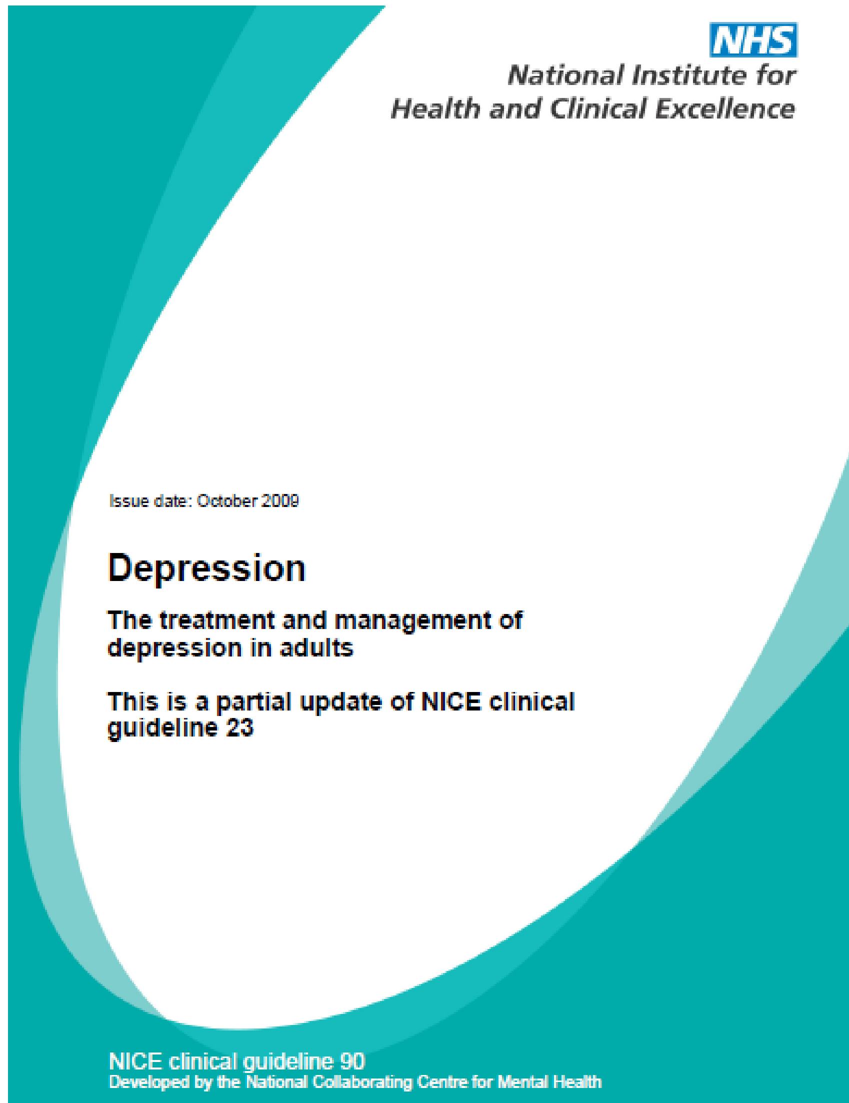
TIRRIL HARRIS, GEORGE W. BROWN and RUTH ROBINSON

BJPsych | The British Journal of Psychiatry (2010) 196, 404–411. doi: 10.1192/bjp.bp.108.061465

Supported employment: randomised controlled trial*

Louise M. Howard, Margaret Heslin, Morven Leese, Paul McCrone, Christopher Rice, Manuela Jarrett, Terry Spokes, Peter Huxley and Graham Thornicroft

NICE guidelines



- Depression (2009)
  - Stepped care
  - Drug treatment
  - Psychological therapies
  - Social interventions - befriending

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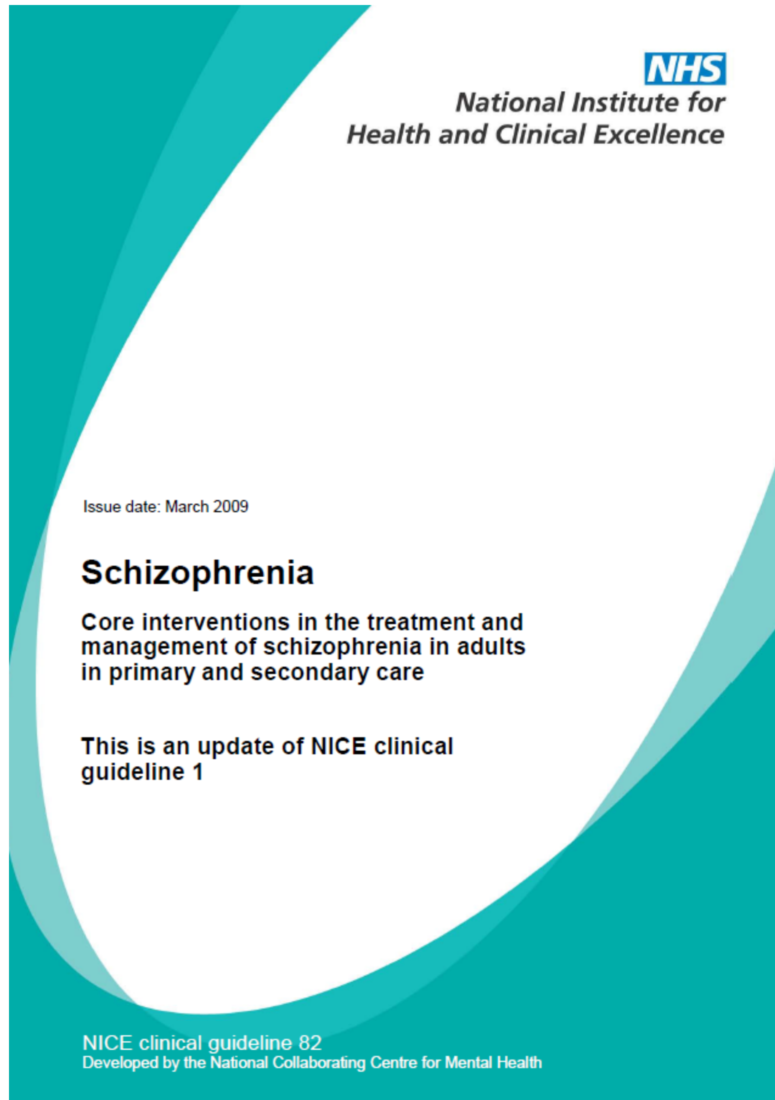
NICE guidelines



- Social interventions in the schizophrenia guidelines (2009):
  - Family interventions
  - Social skills training
  - Vocational rehabilitation
- Mostly about drugs and psychological therapies

In summary …

- Mental health social work is largely defined by statutory functions – MHA Act, personalisation, safeguarding
- Statutory functions can be given and taken away
- We have not fully exploited our therapeutic potential
- Evidence base for mental health services is defined by psychiatry and psychology through the dominant paradigm of the randomised controlled trial
- We need to provide better evidence about what we do well to influence NICE guidelines, local authorities and mental health services
- We should define mental health social work ourselves

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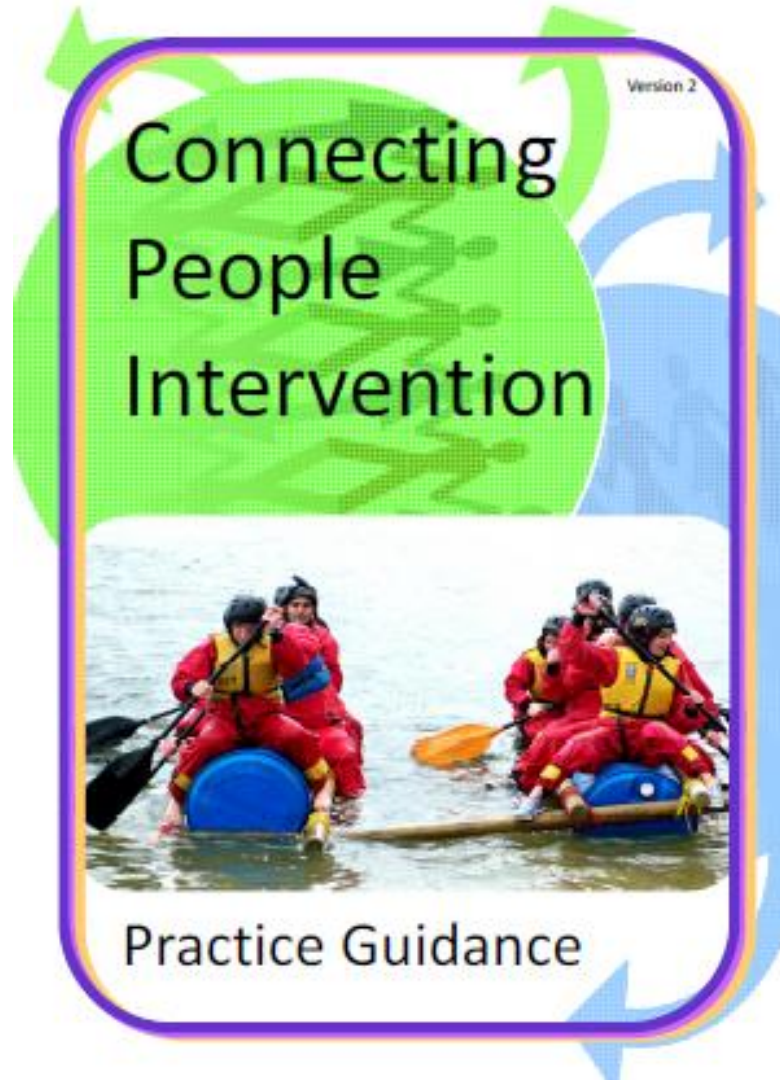
Connecting People Intervention



Connecting People Intervention

The Agency: explained

These three factors are key to assist the worker and the individual to start moving forward with the intervention.

Physical Environment

This will obviously vary according to facilities available.
However, it needs to be as inclusive as possible. Creating a non statutory ethos is key to engaging NHS-weary people
For example, no sharps cupboards, don't lock equipment away, encourage service users to assume front line positions e.g. answering phone, working on a reception.

Community resources

An agency should aim to link in with other local resources in order to help an individual feel less segregated and more grounded when accessing their service—this will increase the likelihood of attendance

Help accessing the service

The agency can play a key role in encouraging an individual to attend a service:
Creating a welcoming environment e.g. a café;
Not forcing paperwork on an individual as soon as they start attending

The underlying ethos of the agency has to support the whole intervention process

Modelling of Good Practice

An agency needs to set an example from the top down for all of its staff.
Barriers and boundaries need to be clearly set out within policy to allow staff to feel confident in sharing and being a real 'person' to the individuals that they work with.

Skill sharing

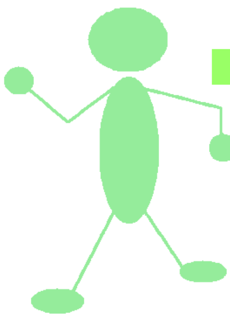
An agency should not keep its skills and resources private. It should share knowledge—whether this be a skilled staff member going and helping other community organisations, or being happy to share policies and procedures. By keeping an open mind and creating a sharing ethos, the agency is opening up more opportunities for itself

Community engagement

Agencies should invite community members and groups in wherever possible. This reduces the stigma of mental health services

Local knowledge

There should be a database of local knowledge within the agency. Although staff will build up their own connections the agency should collaborate with staff to produce a record of useful links that can be passed on to other workers



Partnership

Equality

Worker

Individual

Developing skills, relationships and resources with this individual and for the future

Shared processes

Developing ideas, goals, and confidence and working to attain and expand on these

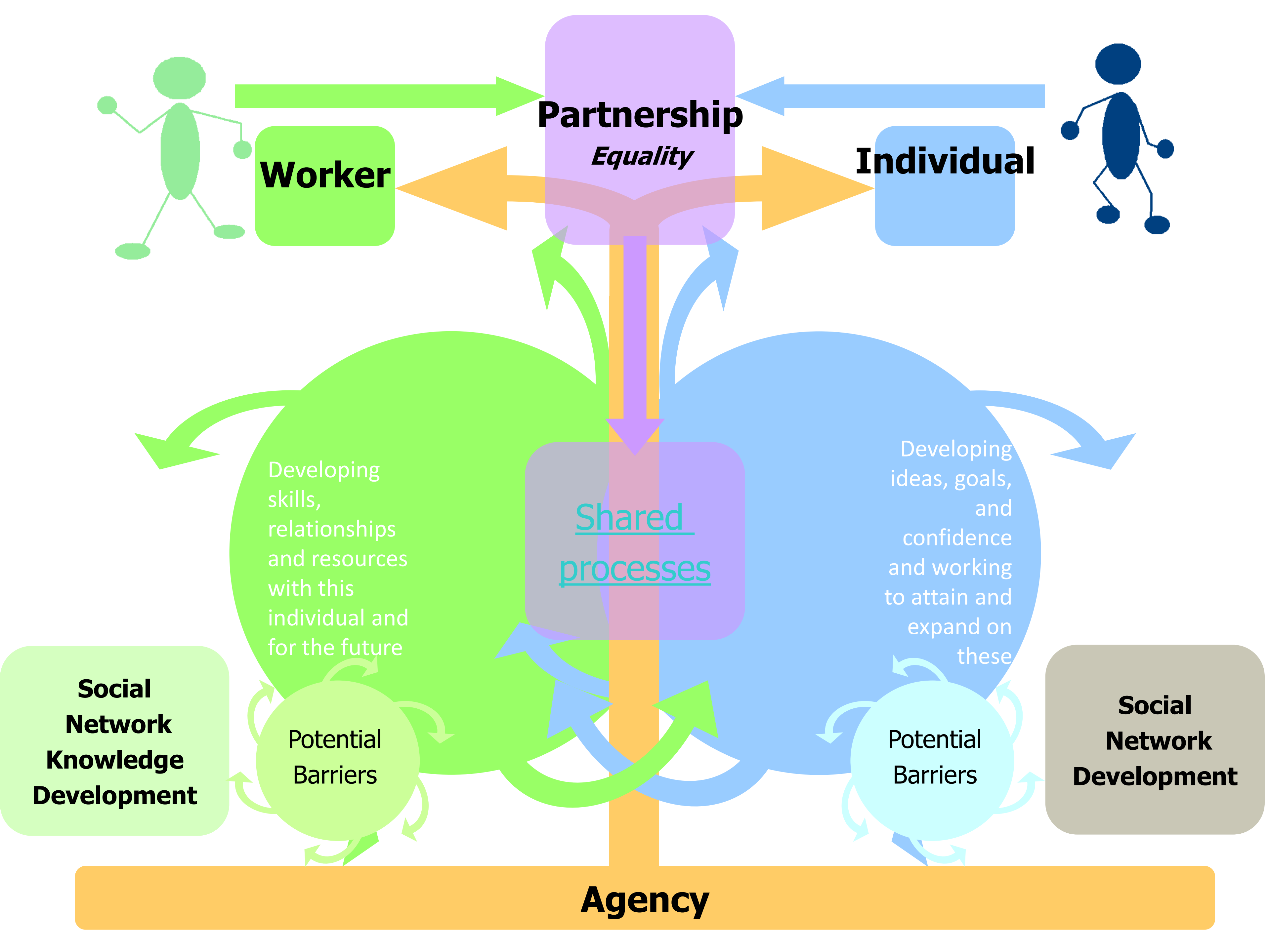
Social Network Knowledge Development

Potential Barriers

Potential Barriers

Social Network Development

Agency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Connecting People study

- Combinative ethnography of social care practice
  - Semi-structured interviews, observations of practice and focus groups
  - Exploratory, not evaluative
- Setting
  - NHS mental health services (mental health professionals and support time & recovery workers in early intervention in psychosis teams, social inclusion and recovery services)
  - Housing support (supported housing & floating support workers)
  - Third sector (social enterprises, voluntary organisations)
- Sample
  - 150 workers, service users, managers, commissioners

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Connecting People study

- Intervention model has been adapted for use with adults with learning disabilities and older adults with mental health problems
- Scoping study identified about 18 agencies who are willing and able to implement intervention in the three social care user groups – including Wandsworth SCART
- 2/3 day intervention training provided to each agency
- 240 new referrals are interviewed at baseline and 12-month follow-up
- Outcomes being measured:
  - Social participation (SCOPE, Huxley et al 2012)
  - Well-being (WEMWBS, Tennant et al 2007)
  - Access to social capital (RG-UK, Webber & Huxley 2007)

Connecting People study

- Potential confounding factors:
  - Socio-demographics
  - Attachment style (RQ, Bartholomew & Horowitz 1991)
  - Life events (RLEQ, Norbeck 1984)
- Hypothesis: Higher fidelity to CPI will be associated with improved outcomes
- Economic evaluation:
  - Service use (CSRI, Beecham et al 2001)
  - EQ-5D (EuroQOL 1990)
  - ICECAP-A (Al-Janabi & Coast 2009)
- Process evaluation will involve qualitative interviews with service users, workers and managers

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Connecting People study

"In choosing to participate in the study, I felt that it dovetailed very well with the move towards self-directed support and would help social care colleagues to be able to use a model which would guide and inform their practice. I was particularly attracted to the partnership approach to work with clients as this also linked into the recovery model in mental health.

I feel that the intervention helps to enable social workers to identify what they are able to offer in the field of mental health, particularly in relation to developing and enhancing individuals' circles of support and looking to link in with community resources"

Griff Jones, Social Care Lead, Derby City Council

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Untapping our potential

- Increase focus on social interventions
  - Defining, articulating and evidencing
- Decrease reliance on statutory functions as a defining characteristic of MHSW
- Engage with discourses in mental health services to enhance social perspectives in policy decisions
  - Recovery agendas
- Explore creative opportunities with user-led social enterprise and co-produced services
- Reduce bureaucracy associated with personal budgets to unlock the potential for creative care planning

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Thank you

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