Mental Health Social Work: Past, Present and Future

A discussion paper to inform the curriculum for Think Ahead

Where have we come from?

Prior to the creation of unified local authority social services departments in the early 1970s, there were two groups of mental health social workers in England and Wales: Mental Welfare Officers and Psychiatric Social Workers.

Mental Welfare Officers were employed by local authorities and provided community care in the early days of the de-institutionalisation of the asylums. There were no nationally recognised training courses for them, but many received training from their employers. Their roles included finding accommodation and arranging support for people at home. They also attended out-patient clinics with psychiatrists, but their role appeared quite subservient possibly due to a lack of professional training. However, as a precursor of the role of the Approved Mental Health Professional, they made applications for the compulsory admission of people to hospital under the Mental Health Act 1959. This role seemed to dominate their work to the extent that some described the Mental Welfare Officer role as primarily a 'sectioning service'[1].

Psychiatric Social Workers trace their origins to the Charity Organisation Society, which has a prominent role in the history of social work. They received professional training at institutions such as the London School of Economics, which was heavily influenced by psychiatry and psychoanalysis. Working in child guidance clinics or psychiatric hospitals their role was to investigate an individual's family background and social context. Their work focused on an individual's adjustment and personality to promote change in their lives. Their psychodynamic training and professional status set them apart from Mental Welfare Officers.

Unitary training for social workers fused these roles into generic social work in the 1970s. This arguably led to a loss of specialist mental health skills and a deterioration in the professional relationship between psychiatrists and social workers due to a concentration on child care within social services[2]. However, the Mental Health Act 1983 extended powers and brought greater professional autonomy through the creation of the role of the Approved Social Worker (ASW).

ASWs conducted assessments under the Mental Health Act 1983 for the compulsory admission of people to hospital. Their role was to explore the use of alternative options to a hospital admission to meet an individual's needs. Typically, fewer than 10% of assessments resulted in the provision of an alternative service[3-5], often because realistic alternatives did not exist or had been attempted prior to a mental health act assessment[6]. However, ASWs played an important role in bringing the social perspective into these assessments and were respected for managing highly complex situations and negotiating multiple roles[7, 8].

Mental health services became increasingly risk-averse in the 1990s following a series of well-publicised homicides and critical inquiry reports[9, 10]. Positive risk taking and the creation of innovative care plans to support people at home became more difficult. The number of compulsory detentions in England and Wales rose whilst the number of psychiatric beds fell[11]. Perhaps unsurprisingly, the job of an ASW became more challenging which contributed to increases in their stress and burnout[12, 13].

Where are we now?

The integration of NHS and local authority mental health teams in multi-disciplinary community mental health teams in the 1990s and 2000s brought social workers closer to health professionals such as psychiatrists, psychologists, mental health nurses and occupational therapists. Local

authority care management and NHS Care Programme Approach systems were brought together, in some cases fully integrated, in others working in parallel. Some NHS mental health trusts directly employed social workers and others seconded them from partner local authorities under section 75 partnership arrangements (NHS Act 2006). In the context of significant cuts to local authority budgets and a concern about the role of mental health social workers in mental health services, many of these partnership arrangements are currently being reviewed.

There has been a marginalisation of social perspectives in community mental health services and mental health social workers have experienced a diminution of their role[13]. On the one hand, in spite of their holistic aspirations, the Care Programme Approach and its allied risk management procedures favour a biomedical model. This has been reinforced by Payment by Results which has heightened the focus on throughput between diagnostically-based care clusters. This bureau-medicalisation of mental health care has led to social workers, as care co-ordinators, focusing on medication, risk assessment and crisis management to the detriment of working with individuals, families and communities to improve their capacity, resilience and mental well-being[14].

On the other hand, the Mental Health Act 2007 opened up the ASW role to other mental health professionals such as mental health nurses or occupational therapists. The creation of the Approved Mental Health Professional (AMHPs) role was perceived as a further erosion of social perspectives in mental health services, though nurses appear as able as social workers to meet learning outcomes on AMHP programmes[15]. In spite of initial fears, few other mental health professionals have taken on the role and over 95% of AMHPs are social workers[16]. However, it has contributed to an obfuscation of the role of a mental health social worker.

Employers have responded in different ways. Some local authorities have rescinded their section 75 agreements and taken mental health social workers back into their employment to focus on local authority priorities such as adult safeguarding, personalisation or the AMHP role. Others have used this opportunity to develop roles for mental health social workers focused on recovery and well-being. In most places in England and Wales, though, mental health social workers continue to work in a variety of multi-disciplinary community mental health teams and specialist services bringing a social perspective and working with people with complex needs[17].

To help resolve ambiguity about the role of the mental health social worker in England, the College of Social Work published a paper[18] in 2014 which identified five key roles for the profession:

> ***A:*** *Enabling citizens to access the statutory social care and social work services and advice to which they are entitled, discharging the legal duties and promoting the personalised social care ethos of the local authority*
> ***B:*** *Promoting recovery and social inclusion with individuals and families*
> ***C:*** *Intervening and showing professional leadership and skill in situations characterised by high levels of social, family and interpersonal complexity, risk and ambiguity*
> ***D:*** *Working co-productively and innovatively with local communities to support community capacity, personal and family resilience, earlier intervention and active citizenship*
> ***E:*** *Leading the Approved Mental Health Professional workforce* (p.6)

In speaking to Chief Executives of Mental Health NHS Trusts, AMHP and mental health social work leads, the Chief Social Worker for Adults, the Mental Health Faculty of the College of Social Work, and mental health social workers, I have found widespread support for these roles. However, achieving them is proving elusive. Something needs to change.

Where do we go from here?

Mental health social workers are widely respected for their knowledge and application of mental health law, leading safeguarding and personalisation agendas, and assessing people for eligibility for social care services. However, their roles within community mental health services have become defined by policy priorities which have diminished their therapeutic and intervention potential. Just as psychiatry and clinical psychology are largely able to define their own professional practice, the mental health social work profession needs to articulate, evidence and implement our own programme of social interventions.

There is a growing recognition that the next stage in the evolution of community mental health care will be driven by social interventions rather than pharmacological or psychological ones[19]. Currently stymied by a lack of evidence[20], this may take some time to occur[21]. However, there are existing and emerging social intervention models which mental health social workers can use to inform their practice. These are supported by mental health policy and social care legislation in both England and Wales which encourage practitioners to work co-productively with individuals, families and communities to enhance their well-being and support recovery from mental ill-health.

Mental health social workers look beyond individual psychopathology and work with people in the context of their whole lives. As in the international definition, social work "engages people and structures to address life challenges and enhance wellbeing"[22]. In terms of mental health social work, Robert Bland and Noel Renouf provide a clear explanation of our role[23]:

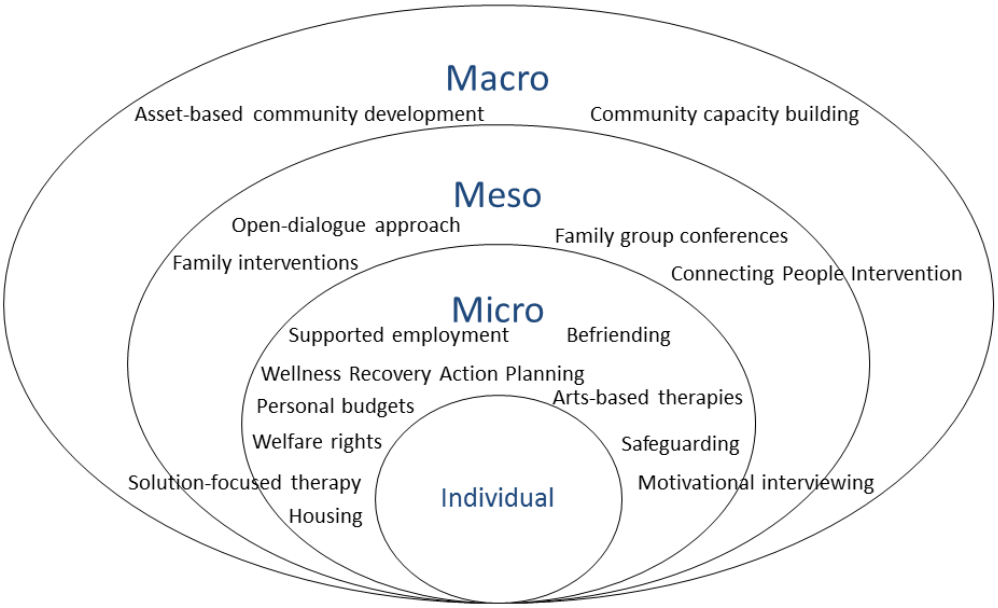
> *The domain of social work in mental health is that of the social context and social consequences of mental illness. The purpose of practice is to restore individual, family, and community wellbeing, to promote the development of each individual's power and control over their lives, and to promote principles of social justice. Social work practice occurs at the interface between the individual, and extends to the contexts of family, social networks, community and the broader society.* (p. 238)

Reflecting the complexity and inter-connectedness of our lives, mental health social workers intervene at the level of individuals (micro), their families and close relationships (meso), and their communities and wider social relationships (macro). Interventions at each level are focused on different aspects of an individual's life and require different sets of skills, knowledge and expertise. The focus on care management, care co-ordination and making referrals to other agencies has diminished mental health social work expertise in intervening directly with individuals and their social environments. This must change for the profession to be able to develop and define its own professional practice.

The process begins with an holistic assessment which identifies intervention options at micro, meso and macro levels. Assessments must characterise subsequent interventions and be strengths-based, recovery-oriented and systemic. They need to identify an individual's strengths and focus on the goals which they wish to achieve, in addition to providing an in-depth understanding of their social circumstances and context[24]. Eco-maps[25] provide the basis for assessing the relationships and assets of an individual, their family and wider social context, and should be used routinely.

Figure 1 identifies how mental health social workers can intervene at different levels of an individual's eco-system. While they may not personally undertake all these interventions, they will engage other practitioners with necessary expertise to ensure that the required social interventions are provided. Not all these social interventions have a strong evidence base but they are all focused on enhancing an individual's well-being and recovery.

Figure 1. Evidence-informed social interventions



Micro-level interventions

Interventions at the micro-level aim to meet fundamental human needs at the base of Maslow's hierarchy of needs[26]. They are focused on an individual's need for shelter, food and drink. Social workers have been unfairly caricatured as being only responsible for housing and benefits in mental health services, but we must not neglect the fundamental importance of having a place to live and food to eat. After all, interventions such as supporting an individual to claim the benefits they are entitled to[27] and improving housing conditions[28] have a positive impact on mental health.

Mental health social workers have the lead responsibility for adult safeguarding in mental health services. Keeping people safe involves ensuring appropriate support is provided and investigating potential abuse. However, safeguarding procedures should not discourage positive risk-taking where it is appropriate. As the implementation of adult safeguarding procedures is still in its early stage in some NHS mental health trusts[29], leadership of this agenda is required.

Action planning with individuals helps them to take control of their own recovery. Wellness Recovery Action Planning (WRAP) is an effective way to support individuals to manage their own mental health[30]. WRAP builds upon an individual's strengths and focuses on the actions an individual takes to self-manage their mental health. Mental health social workers need to work co-productively with individuals to develop plans, including joint crisis plans, which include an individual's preferences[31].

Individuals must be at the centre of their own care and support planning. Mental health social workers' dual identification with the institutions which employ them (local authorities or the NHS) and with people who use their services can help to facilitate this[14]. As gatekeepers to personal budgets, and in the future personal health budgets, mental health social workers can help people to develop creative solutions to meet their goals, self-manage their mental health and improve their well-being. Where people are given genuine choice and control over their care and support through the use of personal budgets, their outcomes improve[32].

Although they may not deliver them themselves, mental health social workers need to make use of evidence-informed social interventions where appropriate. For example, supported employment improves vocational outcomes for people with severe mental health problems[33], volunteer befriending supports people in their recovery from severe depression[34] and people with a diagnosis of schizophrenia have benefitted from arts-based therapies[35, 36].

Micro-level interventions frequently require people to be motivated to set goals for themselves and work towards them. Therefore, mental health social workers will need to be skilled

in motivational interviewing[37] and solution-focused therapeutic approaches[38] to support people to work towards change. These skills will also be required for social interventions at the meso and macro levels.

Meso-level interventions

Social relationships are essential for mental health[39]. Emotional support, associated with recovery from psychosis[40] and depression[41], is typically provided by close friends and family members. To help ensure a supportive network is available to people during episodes of mental distress and its aftermath, mental health social workers need to work with the people surrounding the individual. This small group is defined by the individual in the process of drawing the eco-map during initial assessments.

Systemic practice is not new in mental health social work. For example, working with a family to reduce expressed emotion is known to be effective in reducing relapse in schizophrenia[42]. However, new approaches which see an individual's family or close social group as assets in that person's recovery are emerging. For example, family group conferences, primarily used in children's services, are increasingly being used in adult services. These bring together all those involved in a person's care and support to discuss concerns and an individual's goals. This mobilisation of an individual's close network helps to provide emotional support and other social resources, producing short-term benefits for the individual[43, 44].

Additionally, a model of crisis care used in Finland is currently being trialled in the UK. The open-dialogue approach involves practitioners trained in family therapy working with an individual's family or network when they are in crisis. This approach involves working with the local community as well as an individual's family so that everyone in contact with that person is involved in discussions about their care and support. It has been found to reduce hospitalization and the use of neuroleptic medication, and is also suggested to be associated with a reduced incidence of psychosis in Lapland[45, 46]. Mental health social workers are ideally placed to lead its introduction into NHS mental health trusts in the UK.

Macro-level interventions

People with mental health problems require more than a supportive family and network to get on and get ahead with their lives. Tangible support (such as provision of favours or cheap goods) and informational support (such as where to find a job) is found in wider community networks and, when accessed, is associated with the community integration and social participation of people with mental health problems[47]. Social resources in wider social networks, known as social capital, help people to increase their wealth, power and status in addition to their mental health[48]. As people with mental health problems have access to less social capital than the general population[49, 50], there is a role for mental health social workers in supporting them to develop more resourceful networks.

Interventions which use asset-based approaches, support the development of social skills, build trusting relationships between workers and service users, and find community resources can enhance the community participation of people with mental health problems[51]. For example, the Connecting People Intervention[52] engages people with others in their local community or networks in the pursuit of their recovery goals. High fidelity to the intervention model is associated with increased access to social capital and enhanced perceived social inclusion[53]. A good knowledge of local community networks is required for these interventions to be effective, which requires a team approach and an outward-focused orientation.

Community capacity building is also essential for the success of personalisation. If personal budgets are to help individuals achieve a sustainable recovery, they need to utilise community resources and develop new networks which can provide access to social capital to help people get on and get ahead with their lives. This illustrates that intervention at the macro-level supports work

at the micro or meso-level, and highlights their inter-connections. Supporting people in their process of recovery involves work at all intervention levels to engage with the development of their social identity, relationships and participation in community life.

How can this be achieved?

This vision for the future of mental health social work is not particularly radical, as it includes many interventions familiar to social workers. However, the bureau-medicalisation of mental health care frustrates the opportunity for social workers to practice in this way. This needs to be challenged and new opportunities for mental health social work to develop its own professional identity need to be created. Practitioners will require supervision from consultant social workers who will provide case-specific intervention support and develop their professional expertise.

Initial training for mental health social workers must have strength in depth and breadth. A focus on mental health can be woven throughout a generic curriculum by infusing it with examples drawn from mental health practice contexts. This curriculum might include, for example, an introduction to social work focusing on values, history, roles and tasks, sources of knowledge, practice contexts and co-productive working; a skills-based preparation for practice including assessment skills, communication skills, intervention skills, inter-professional working and anti-oppressive practice; law and social policy including mental health, mental capacity, human rights, community care, childcare and welfare rights; sociology for social work with a focus on the social aetiology of mental disorders; human development through the life-course from childhood to old age, with a focus on age-specific mental disorders; psychology for social work with a particular focus on psychological interventions used in mental health practice; and social theory including person-centred approaches, attachment theory, systems theory, and strengths-based approaches with a focus on how they are applied in interventions.

The curriculum needs to equip future practitioners with in-depth knowledge about mental health problems and expertise in effective social interventions. It should be inter-professional in nature and draw upon knowledge from other mental health professions, but distinctive and original to provide graduates with the potential to lead change within community mental health services. The curriculum will need to equip practitioners with a critical understanding of mental health policy, the contexts in which mental health social workers practice (such as child and adolescent mental health services, community mental health services, crisis intervention and home treatment teams, early intervention in psychosis teams or forensic services, for example) and processes within mental health services (such as the Care Programme Approach, risk assessment and care management).

Building upon the generic curriculum, an in-depth understanding of the social determinants of mental health is required such as inequality, poverty, urbanicity, social support, social capital, stigma and discrimination, social networks, migration, housing, substance misuse, debt and life events involving trauma, grief, loss or childhood abuse. This needs to be taught in the context of contemporary mental health practice and a critical understanding of recovery models, personalisation, safeguarding and user-led services.

The curriculum needs to engage critically with the biological origins of, and treatments available for, mental disorders from childhood through adulthood to old age. Taught by a psychiatrist this could also introduce emerging evidence from the frontiers of mental health research in neuroscience, neuroimaging and genetics. Additionally, psychological theory and interventions such as cognitive behavioural therapy, dialectical behavioural therapy or psychodynamic psychotherapy could be introduced and key skills taught.

The most significant departure from current social work curricula which will be required is teaching and supervision in family therapy techniques. Although included in many curricula, it will need to be taught in sufficient depth that practitioners can practice systemically and use family group conferences or the open-dialogue approach effectively and routinely. This needs to be accompanied by teaching in brief interventions such as motivational interviewing, solution-focusing

therapy and problem-solving or task-centred practice. Additionally, practitioners need to be skilled in, or at least very familiar with, family interventions in psychosis or working with whole families which address issues of parental mental health, and models of supported employment such as Individual Placement and Support. Finally, community development approaches such as the Connecting People Intervention and asset-based community development need to feature on the curriculum so that practitioners can more readily engage with the rich diversity of resources within civil society.

Mental health social workers must be trained to critically engage with the evidence base of other mental health professional groups in order to narrow the perceived gap in expertise[54]. This will include teaching the qualitative and quantitative methodologies used in mental health research and the skills to critically appraise research which informs mental health practice[55, 56]. Additionally, students should be trained to conduct their own practice research to contribute to the development of the evidence base for mental health social work to take a modest step towards bridging the research divide between social work and the leading professions of psychiatry and psychology.

Final thoughts

Community mental health services need to change to permit social workers to practice in the way that is outlined in this paper. However, social work employers and educators must work together to develop robust practitioners who can shape the future of mental health social work[57]. The curriculum needs to be infused with the meaningful involvement of service users and carers[58, 59]; be based on the best available evidence to stimulate the integration of research in practice[60]; and be informed by multiple psychosocial approaches to develop confident practitioners who are equipped to effectively deliver social interventions.

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Please email your thoughts about this paper and the proposed content of the Think Ahead curriculum to martin.webber@york.ac.uk. Thank you.

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