Reflections at the Heart of Social Work


WORLD SOCIAL WORK DAY
21ST MARCH 2017

PROMOTING COMMUNITY & ENVIRONMENTAL SUSTAINABILITY

Adult Principal Social Work Network of England
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Lyn Romeo, Chief Social Worker for adults

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Foreword

Lyn Romeo
Chief Social Worker England

I am very pleased to be asked to write a brief foreword for this World Social Work day e-book being produced by the Adult PSW Network. Social work is a profession that should be at the very heart of communities, an intrinsic part of them, learning, sharing, enabling independence and control over peoples chosen outcomes.

As social workers we value the very nature of people, their aspirations and strengths. We understand that everyone no matter their circumstances has a right and ability to be an included member of all our communities. The drive to ensure that the skill, knowledge and opportunity that social work brings to the most difficult of situations for people is one that we must sustain and promote. The ideas of strengths and relationship based practice are not new to social work and we are very well placed to ensure these approaches are embraced and most importantly delivered correctly, ensuring real outcomes for people.

This collection of Blogs supports the determination social workers have to ensure that their profession is at the heart of supporting people but also allows us to reflect on the areas where we need to learn and improve. A great strength of social work is its ability to reflect and apply learning when needed, ensuring our practice goes from strength to strength. The sharing of blogs not just by social workers but also, people who experience social work and those who provide analysis of social work can only enhance our practice.

World social work day allows us to think about the role we can and must play in ensuring that practice, social justice and human rights is at the very heart of what we do now and in the coming years of significant change. Working alongside people, developing their own ideas of how they want to retain control and autonomy over their lives is essential and at the very heart of what we do. So please do read and reflect on the stories and ideas inside this book and most importantly support social work and what it stands for.

Lyn Romeo

With Thanks
The Adult PSW Network would like to thank everyone who has kindly agreed to share their Blogs and Articles for free. We hope that these reflective insights will inspire, challenge and help you in your roles as PSWs and your leadership across social work as a whole.

Mark Harvey and Rob Mitchell

‘You can be active with the activists or sleeping with the sleepers’ B Bragg

HAPPY WORLD SOCIAL WORK DAY 2017
Finding your voice

You do not know me. I appear at your bedside with a smile and introduce myself. I sense you are trying to recall if we have met before; you have seen so many faces since your admission; it would be understandable if you could not. I reassure you, we haven’t.

You have always been independent and enjoyed your freedom. Now you are retired, widowed and your mobility is limited. You did not initiate this. You cannot stop this. It is part of an uninterrupted continuum; there is no element of choice. I ask you about your time at home about before you came into hospital. You talk of times when your wife was alive and how you would go on holidays and dine with friends. You tell me that doesn’t happen now; that it hasn’t for a while.

I know that you have been in hospital for a while but I do not tell you this. Instead, I ask you. I don’t want to appear to be a know-it-all. I suspect you wouldn’t appreciate that. Besides, I want to hear your voice, your words, and your story because they are important. I wonder if you know this? You are seen often by the doctors and nurses but their time with you is brief. You have spoken only of a niece, living in the North.

The ward tell me she has telephoned once. I am conscious of these things. You do not identify that you are lonely. Your concerns are somatic in nature. It is easier, you feel, to talk about an ache in your elbow rather that your loneliness. Loneliness, once described as a ‘chronic disease without redeeming features’ (Weiss, 1973; 73), has crept over you slowly. So slowly, you haven’t labelled it. It just is.

I sit at your bedside. You look at me. What are you thinking? I smile. I hope you find this comforting. I am considerably younger than yourself. Do I prompt you to briefly recall your youth? Do you worry that I won’t understand your concerns… that although we are sharing time, we are also separated by it?

You tell me that you lose track of the time in hospital. I tell you that time moves so quickly that I often feel the same. You respond positively to this. You tell me that the nurses have been wonderful. I wonder; before you came into hospital, who was the last person you spoke to? Time. I check it. We have been talking for a while but I sense that now you have found your voice, you still have more to say. I will stay a while longer.

When you become upset as you relay your story, I hold your hand. Touch has been mechanical for you; temperature recordings, blood tests, being prodded and poked by all accounts. I hope this feels different. I hope this is comforting. I am not going to do things to you. We are going to face this together. You are not alone. I tell you this and I hope that you believe me.

Jemma A Hughes

Someone to safeguard

The referral was pretty bog standard these days. The neighbours didn’t get Elsie’s permission for any of her details to be referred to Social Services. In truth it had never crossed their minds they’d be asked for this. When pushed by the call centre about the issue of consent they said that they didn’t think they needed her consent and that this was a matter that ‘the Council must take seriously for everyone’s sake’. And then behind the thinly veiled threat to act the neighbour stumbled upon four little words. Magic words. Words that suddenly change the meaning of everything and words that seemingly come with their own legislation, procedures, judges and juries. ‘It’s a safeguarding issue’.

And boom, there it is. Elsie, aged 87, never known to the Council, never having failed to pay for council services or any other tax that propped up with welfare state that she didn’t really partake in, was known. Consent overridden. Case opened. Within moments Elsie had an electronic file. Elsie had a Reference Number. And Elsie would receive an automated letter thanking her for contacting the Council and she would receive a call within the next seven days. All done within five short minutes from the start of the phone conversation. Within ten minutes Elsie was on waiting list of other Reference numbers waiting to be allocated to a Social Worker and sat on the computer screen of the Manager. Whether Elsie used services or not, from that moment on to the day of her death, nothing was clearer – Elsie was a Service User and there was a record to prove it. There was, as far as everyone was concerned, someone to safeguard.

The social workers went in twos to the address. No-one was quite sure why. The referral mentioned that Elsie had got cats but there wasn’t any belief that the cats were dangerous. Perhaps the second social worker was there because social workers love cats. The referral said the house was ‘dirty’, ‘things everywhere’, ‘cluttered’, ‘soiled pads in the garden’ and Elsie, although not seen for some weeks, was wholeheartedly felt by the neighbours to be dirty herself. ‘She’s self neglecting’.

Having knocked at the door and getting no response the social workers pushed slightly at it and the door opened. A cat ran out and then back in again. No sign of Elsie in the hallway. The social workers called her name, walking gingerly through the hallway, past a sideboard with some framed pictures of a moustachioed man with the ‘Geraldo, King of Swing’ emblazoned on them. Calling out her name and holding out their ID badges the social workers continued inward.

Elsie was in the kitchen. She smiled when she saw the social workers and beckoned them in still further. The social workers introduced themselves and whilst doing so Elsie kept on smiling before raising her hand as if to stop the second social worker saying their name. Elsie bent forward and placed her right ear up against what looked like a radiogram from footage used to show listening to the broadcasts of Prime Minster Churchill telling them they wouldn’t surrender. Almost trance like Elsie’s smile remained fixed as she listened to the radio. Elsie probably listened to the radio for a full three minutes, to the social workers, observing the cats, the newspapers (one from May 1991 with a picture of Paul Gascoigne on) and moving their feet on the sticky floor tiles, the three minutes felt like a lifetime.
When Elsie moved away from the radio she asked the social workers ‘who are you again, love?’. The social workers explained who they were and said that they were there to see if ‘she was alright, you know, see how things are’. Elsie said she was fine and asked if the neighbour had asked for them to visit. ‘She’s lovely, like that. Looks out for me’. Elsie explained that she had lived in the house all her life. Her parents, who she said ‘died recently, in 1971 and 1975’ had left the house to her. The social workers listened. They wanted to be respectful, they had questions of course (and they had lots of boxes to tick) and had already decided that things ‘weren’t right’ but they listened nevertheless. Half way through talking Elsie’s eyes suddenly lit up. ‘John!’ she said. Within moments Elsie was back to the other side of the kitchen, head propped up against the radio, same expression on her face, which now to the social workers seemed almost rapturous. This time a longer a wait. Five minutes. Elsie broke her concentration just once, to beckon the social workers to sit down. Neither did. Elsie didn’t notice or care.

Elsie said that John worked for the radio. He was in his late forties and his job was a ‘broadcaster’ and that each day John ‘either announced the news or introduced big bands… sometimes both’. Elsie said that John was based in London and he still lived there. She said John sometimes slept in the radio station and sometimes broadcast during the night, but not usually. The social workers continued to listen but really wanted to talk about the cats and Elsie’s ‘daily routine and keeping clean’. More in an effort to wrap the conversation up about John and move on to the matters at hand, the self neglect, one of the social workers asked a question. ‘John sounds lovely. Is he someone you have actually met and know’? And with that the tone of the conversation changed. Elsie explained that John had spoken to her on the radio for over 60 years. He was her man friend and he was engaged to marry her. Her betrothed. John had promised Elsie that one day he would drive up from London in a white Bentley car and marry her. Their plan was to live in London and take Elsie away from all this, including the cats. Elsie said the social workers could have the cats if they wanted them.

On walking to the door with the social workers Elsie thanked them for coming but they had to go now as John liked to ‘talk to her alone’. Elsie smiled as she shut the door behind them. The last thing the social workers heard Elsie say as the door closed was that John was her man and ‘was not for sharing, goodbye’. The social workers weren’t inexperienced. One had just become an Approved Mental Health Professional and the other had worked with older people for years. But as they walked to their cars and drove back to the office the silence between them spoke more than any words of completed boxes on the safeguarding form. ‘What was all that about?’

Safeguarding referrals can be complex. The social workers knew that. They also knew that to ‘help’ Elsie they had to get to know her, build up trust etc. So the visits continued throughout the next week. On each occasion Elsie spoke to the social workers but continued to ignore any questions about her health, her wellbeing, her cats and the state of her house. Most questions were met with ‘I know love. John’ll see to it’. All conversations were interspersed with long periods of Elsie listening to the radio and smiling with occasional, knowing nods and some ‘ah’s’ aimed at the social workers as if ‘John’ was further confirming plans that would need to be relayed to the social workers. For the most part the social workers just heard the hiss of the
untuned radio. For them there was no voice, no programme and without doubt there was no John. However what bothered the social workers more than this was that there was no progress. No getting Elsie to see what state she was in. No getting Elsie to consent to sorting the house. No getting Elsie to realise the safeguarding issue. The self neglect. The abuse.

Safeguarding doesn’t allow for stalemate or for someone to continue to be abused. It identifies the abuse and through a list of ‘outcomes’ it makes the social workers do something. For the social workers things needed fixing for Elsie. She had a choice. Either Elsie worked with them to ‘improve the situation’ or they would ‘Refer to other agencies’. The case notes were clear. Elsie wouldn’t engage. She lacked capacity to make the decision. It was all in her best interests. The risks were unmanageable. The hoarding was a fire risk. The cats were underfed and the RSPCA would be cross. She needed safeguarding. If only she could see it! She was a problem. The problem needed fixing.

The social workers didn’t seek Elsie’s consent to refer to other agencies. In Elsie’s case the ‘other agencies’ was the Mental Health Team. Elsie was visited by a Community Psychiatric Nurse, who within hours visited again but this time with the Psychiatrist. The social workers received a call ‘How has this gone on so long? and ‘she’s in a terrible way, totally delusional, paranoid ideation’ and is ‘refusing all treatment because of this bloody John thing’. The next call was to the AMHP. Pink papers in the bag, the Mental Health Act Assessment was to take place that evening. The Ambulance couldn’t stay and eventually the police were called. 87 year old Elsie was escorted out of her property by two young police officers. One of the police officers had to switch the radio off during ‘the incident’ in the house. He at least had the foresight to give the radio to Elsie and reassured her that she ‘could hold it’ in the back of the car. It was the only bit of humanity Elsie ever witnessed either that evening or throughout her entire dealings with the ‘support’ agencies. Section 2 completed. Safeguarding outcome achieved. No more self neglect. Someone had been safeguarded.

The first thing Elsie did on the ward was to find a plug for the radio. John was there. Reassuring her and helping her to stop crying. And that’s how things stayed for a number of weeks. The medication was taken, Elsie complied. The nurses moved on to the next person, Elsie listened to John. There was no more worry about Elsie from the neighbours, the problem had been fixed. No more self neglect, no more self to neglect. Elsie’s care plan said ‘needs all cares’. And that’s what she had. All cares attended to and a continued love affair with John.

The discharge planning never once considered home. Home was where the ‘multi-disciplinary team’ had felt that the bad thing happened. Home was where the cats had had to be removed and where the social workers had found Elsie’s love letters to John, which had ensured merriment on the ward due to the details that she went into about her feelings for him. The self-neglect would re-start at home and why risk things? Elsie was happy enough. Everything was fixed, apart from the John thing. The Care Home never fully read the care plan about Elsie and the new social worker had not really written much up about John and what had happened at home. The radio didn’t go with Elsie to the Care Home. Elsie noticed this on her first day at the home. However instead of asking for the radio Elsie screamed for 8 hours. In the end she was given medication. The Care Home didn’t call the hospital or speak to the
psychiatrist about how distressed Elsie was. They made one phone call that day, which was to the social worker requesting more funding ‘due to the screaming’ and the impact this was having on other patients and staff. Over the next 3 months Elsie moved into two different care homes and was returned to hospital following a fall. The radio was never switched back on.

Elsie died in a care home. It was four months, five days and 6 hours after the phone call from the neighbour.

Lord Justice Munby stated ‘what is the point in making someone safe if it merely makes them miserable’. In ensuring Elsie was miserable, we were unfit to even ensure her safety. John did exist for Elsie and we never saw that. John was the risk management plan. John stopped Elsie self neglecting, not the other way around. Elsie was the expert in her own situation and had an 87 year start on the rest of us who tried to study her and fix her within weeks. John was her flickering light of hope which we extinguished in the name of safeguarding people from themselves. I hope she saw John again somehow.

Rob Mitchell Link to original blog post
@RobMitch92
The Elephant in the room in adult social work is often the cat

Firstly, thanks to @Harr_Ferguson for the title which was inspired by this tweet:

I remembered this tweet today whilst driving home and reflecting on having heard several stories this week from amazing social work colleagues where pets featured in a critical role. The colleague who, having tried to engage with someone through their letter box had the dog set on them. The parents who were walking the dog every night past their son with a learning disability who was living independently in his new home to reassure them that he was OK. The mum and son with very complex communication needs whose face lights up when he sees the family dog come into the room. And finally, the amazing colleague who was planning to finish for the weekend only after they had sorted out 11 cats and 3 dogs so that the person they were supporting could feel safe enough that their pets were cared for to accept a period of convalescence and recovery from a period of acute ill health.

Social care is full of evidence to suggest that pets are associated with psychological and emotional wellbeing. Something that we could perhaps pay more attention to in adult social work. Dr Sara Ryan (yes Connor’s mum) has written a really thoughtful paper on how pets are important members of the families they belong to and yet how often they are unseen by the “professional” in the room – it’s here if you want a read: http://onlinelibrary.wiley.com/doi/10.1111/1467-9566.12176/abstract

Sara’s paper reminds us that as social work practitioners, it is far too easy for important family member to become invisible when they are sat right in front of us – an observation which Harry Ferguson has written about in his brilliant piece about the unbearable complexity of social work decision making in the British Journal of Social Work. See here: http://bjsw.oxfordjournals.org/content/early/2016/06/29/bjsw.bcw065.abstract

In our induction for Newly Qualified Social Workers, we often talk about a real case which we got very wrong. The lady had 20 cats. We thought we knew best. We thought we could see something as professionals that she couldn’t about her life and experience. We took her away from everything she knew, everything that was important to her in her life. The result was that she deteriorated very quickly. It is telling, that when we talk about the lady with the cats, we only talk about her cats as a passing, almost jokey remark at the start of the story.
And if you want to know just how wrong we can get it in social care – see the case of Fluffy the Cat [https://ukhumanrightsblog.com/2015/01/29/what-price-liberty-damages-dols-and-a-cat-named-fluffy/] whose 91 year old owner was removed from his home and unlawfully deprived of his liberty in a care home leaving his beloved cat behind.

Today, pets have featured heavily as we have reflected on this week, appearing in several of the stories which I have heard being told as part of the end of week come down. All social workers will recognise the end of week come down. It is the really important bit of the week when social workers take care of each other and the complexity of the decisions they have supported people to take. It is the moment where social workers use story telling to reflect about the week which has past and as the social work office winds down, it is the process which enables practitioners to go home without carrying the weight of every potential risk with them into the weekend. Without that moment of story telling, social workers, the best social workers, the ones who will be back fighting for people’s human rights once they have rested and recovered, will often spot the small things they have missed during the heat of the busy week. That is the time when the pets emerge.

Today, as we told our end of week stories, we heard of that we had seen 11 cats and 5 dogs. We spotted something we didn’t know before, something we didn’t previously notice about what is important to the people we are supporting. And when we next speak to them, because of that moment of insight, we will be able to include in our conversations with them that they have another member of their family that we are interested in.

And crucially, we had a moment of laughter and mutual support which came out of that recognition – because we are pet owners too and we know what our pets mean to us. In that moment you become less professional and more human and you are closer to the person you are there to support. Which is a really good thing.

This week, however, I am left with unanswered questions which I leave me unsettled – what happened to the lady’s cats? What if we got it wrong? What if it was being removed from her beloved cats that was the tipping Point?

Honestly, I will never know what happened to the cats. But we do know what happened to the lady with the cats, we moved her, leaving her cats behind, she became very distressed and after a long and lonely 6 months on various hospital wards she died. It was traumatic for all concerned. Including the social worker who has never forgotten her. To quote Professor Ferguson “The powerful impact of unbearable levels of complexity and anxiety on social workers requires much greater recognition.” Have a safe weekend to all our EDT and hospital weekend colleagues working this weekend.

Elaine James
@ElaineLJames

[Link to original blog]
The rise of the new Social Work Bohemian and the death of Radical Special Work

I loved radical social work back in 1995 when I started to train as a social worker. It was edgy, different, reflected the culture of the home I grew up in and allowed me endless opportunity to debate in the halls of North Hertfordshire college. The trouble was that by the 90’s radical social work was taught as a thing of the past, an intervention that actually had no intervention. Its only focus to radicalise the oppressed and shout a bit louder. Radical social work as an idea seemed to already be dead and ridiculed as I traversed my way through two years of DiPSW learning. There was definitely an element of romanticism that attracted the 24 year old me to these models of social work and the writings of Roy Bailey, Mike Brake and others. In them I could see the conversations that happened around me as a child growing up, ward party meetings, debates and days spent at marches and rallies with my mum and dad. I loved the marches especially, the police officers always seemed to have a ready supply of sweets that they willingly shared with all the kids. So you can see how the ideas of radical approaches to social work and equality would appeal. But had i missed the boat, had radical approaches in social work had a very brief moment and been proven to be ineffective? That was certainly the learning I left college with.

I have often pondered the fate of radical social work and the impact it had if any on modern social care systems and social work practice. The rise of care management would suggest that it had very little impact as an enabler of equality. The case work model heralded as the early driver of social work relationship based practice had become the core model of social work through the 70s and 80s. For me, it seemed to have one drawback as a social work tool, it wholly looked at the individual as the source of the required change rather than the wider societal constructs that shaped and sustained individuals distress and inequality. From this model of case management, the seeds of care management seem to have grown. Developed as the ideal approach to deliver commissioned, prescription based care and focusing the causes of need at the individual level. Not in a way that allows for self empowerment and choice but one that meets perceived self failure with risk aversion and control dressed up as meeting need. The much maligned NHS and Community Care Act served in many people’s eyes as the legal bludgeon that forced through these new approaches. This Act at its heart was the first major attempt to reform care and introduce the small steps towards inclusion. It did however herald the dawn of care management, Social work as a tool of assessment to buy interventions. The industrialisation of social care was well and truly born.

If radical social work had anything positive to offer surely we would have seen it shaping care management and more importantly the ability of people it worked with to live the lives they wanted. If you took the teachings of North Hertfordshire College in 1995 you would know that the core concept of radical social work was to tell the individual you worked with to ‘man the barricades’ and demand their rights and as a social worker to stand right there next to them. One lesson 45 minutes long and what I thought was going to be a detailed analysis of social works role in resisting oppression and ensuring equality became nothing more than ‘well, we have to mention it in the syllabus’.
To a certain extent they were correct, in that they only taught the purely political concepts as set out in mainstream social work academia of the 90’s. An approach that I think social work academia has never recovered from. The chasm that many talk of between academia and practice for me started in that lesson. What those lecturers seemed to miss or not be willing to acknowledge was that the idea of radical social work had permeated much more than giving a narrow political message. Those approaches set out before my time of practice set a very firm foundation for some of the concepts we now take for granted.

At this point, in a parallel universe (well the first draft), this blog then launched in to comment on the chasm that had grown between social work academia and front line practice. I also attempted to prove that without radical social work and the joining of social work with disability activists groups, social care would not have embraced personalisation or advocacy, inclusion or human rights. However, much cleverer people than I explore these in articles and debates elsewhere but this blog wasn’t meant to be about what radical social work was and what it achieved but rather to state that it is a thing of the past.

Radical social work is dead, partly killed by the fact that radical is the new black, mainstream and compliant. Partly strangled by the horror I feel when listening to a speaker and they introduce themselves as a radical social worker but then go on to explain that what they do is what every social worker should do. They may well be a radical social worker but I don’t know what that means anymore and I’m not sure how it is reflected in modern day practice, more importantly how it benefits people. There is nothing radical in upholding people’s human rights, it’s what we do.

In a practice world where radical social work no longer exists something slightly different may be filling the void. Something that can only be described as the rise of the New Social Work Bohemians. Partly because I love a good name but more importantly because the history of the bohemian movement is increasingly reflected in this branch of social work.

The term radical seems to have shifted from its natural descriptor “believing or expressing the belief that there should be great or extreme social change” to one that describes radical approaches as characterised by a departure from tradition; innovative or progressive change. The shift of radical ideas in health and social care seems now to be the domain of management models and a way of re-branding change programmes.

At its core this tips a nod to the traditions of the past. Radical thinking of previous decades is often what has defined current policy. Think personalisation, advocacy, human rights as a core to practice and the foundation of all modern care law. But now there are dedicated NHS websites calling for the radicalisation of its staff and offering training on how to be radical with a School for Health & Care Radicals. There is nothing wrong with this organisational approach to new ideas, however, organisationally owned and led ideas can never be truly radical. That is not to say you can’t have radical ideas from within health and social care and implement them but this is generally done despite the system not because of it. Radical ideas from practitioners grow and challenge the system they cannot be commissioned by it. The modern penchant for reactive short-term responses to perceived wicked questions within health and social care is as far removed from any idea of radical thinking as
you can get yet seems to want to wholly align itself to the concept, or at least the terminology. As I say radical social work is dead. So is radical nursing if there ever was such a thing!

In 2014 I was lucky enough to host an event at which Lyn Romeo the chief social worker was present. It was a positive event looking at social work taking back and owning its own destiny of practice, driving community social work and strengths based approaches. We had a question time panel and one of the questions put to Lyn was “is social work an art or a science”. A great question. Lyn’s answer as I recall was that it was both. This is so true, social work is both. A profession based on research and evidence that works alongside people to effect change but one that also requires artistic responses and freedom of thinking to create something new with people. More importantly it requires a capacity for love in its infinite forms, the acceptance of humans as unique individuals that may require a truly creative relationship to overcome the rigid discriminations of society.

Whilst inequality in society has been a constant its inherent discriminations ebb and wane in their public support. At a time where there appears to be an increased tolerance of ill-informed and stereotyped discrimination, let alone an outwardly vile application of such abhorrent principles dressed up as political viewpoints, you will generally see the rise of Bohemianism. Predominantly in the Arts and historically in the youth culture but now increasingly more so in the new social work movements and ethos. A collective of practitioners committed to ideas of equality in their truest form, creatively shaping a social work response in the post Care Act world, seeking to end the incarceration and commodification of people.

In a world where the delivery of social care and social work is tougher than I have ever experienced before you see something new emerging. There is a clear momentum of creative social work. In part embedded in the old heart of social work but driven by a new desire, an enhanced application and will to create. Whilst Kate Tempest tells us why Europe is lost or others gaze upon KRANKENHAUS (HOSPITAL) by Maria Lassnig or The Blindfolded Man by Marlene Dumas, Social work is changing and joining these creative Bohemian opportunities.

The growth of social media and the ability to connect is a key driver in these new ideas. Now not only can social work across the UK start to connect and share but social work across the world is beginning to influence at an international level. The art of the Blog has been harnessed by many to share new ideas and thinking, no longer shackled by the dogma and rigidity of a singular academic approach but driven by a passion to shape and harness something new in our profession. Casting a nod to the 17th-19th century pamphlet writers, seeking equality and citizenship at the individual and community level, influencing policy and direct action. Across the internet you can see growth in the insightful and challenging commentary of social work and social care. All of these offerings can only be relevant if you understand the reality people face and live everyday, you only have to look at what surely must be the Samuel Peeps of 21st century London @MarkNeary1 and his insight into social care.

The marking of a life taken embodied in the Justice for LB quilt is yet another reminder of the power of art. I have followed the campaign every step of the way using it to question my own practice and reflect through a previous blog. The quilt for
me was an image that defined the pain but also the creativity that would not let a young man’s death be forgotten or unanswered. The stories and creativity of @sarasiobhan images have to be felt by social workers to shape what they do. We must understand that statements of human rights and radical practice from social workers are meaningless if they do nothing more than fill a conference slot.

For me Twitter has played a huge part in not just sustaining my knowledge and learning at a real level but has connected me to a wider network of social workers and inspirational people in the social care world. Individually developing something new, something shaped by people not done unto them. Creating challenge through examples such as the #unwisedecision day. This event sought to highlight the ludicrous subjectivity that many public sector professionals apply to their practice. The Social Worker sharing their unwise decision about chocolate, sex or alcohol was not a flippant piece of publicising but one that highlighted the perceived worth of people by some that would refuse such a life for others. The key was a collective act across the country at the same time. Not to get people to follow the law, although that would be a great by product, but to grow the idea beyond the perception that people are allowed to make unwise decision to one where the creative delivery of social work makes it a reality.

Many a self proclaimed modern ‘radical social worker’ will tell you they are because of their drive to promote people’s human rights and deliver choice and control. No, sorry that is your job not a radical approach. If we believe radical is doing what we are supposed to do then it is no wonder that the term has been hijacked and used as confirmation of the new ‘change management style’. If you need proof have a look at the PCF

Social workers recognise the fundamental principles of human rights and equality, and that these are protected in national and international law, conventions and policies. They ensure these principles underpin their practice. Social workers understand the importance of using and contributing to case law and applying these rights in their own practice. They understand the effects of oppression, discrimination and poverty.
Recognises the contribution of social work to promoting social justice, inclusion and equality. Is receptive to the idea that there may be conflicts in the social work role between promoting rights and enforcing responsibilities.

See, we were supposed to be doing that all along

Obviously the world of social media can also engage those in our profession who cannot see beyond the negatives, engaging in a self promoting downward spiral of doom. Don’t get me wrong, debate and questioning is excellent indeed vital to enable the continued growth of the job many of us love. However, the trap of critiquing continually without suggesting solution or responsibility will only play out in your practice and well being. As the No1 New Social Work Bohemian once said “being a social worker is an honour. If it ever stops feeling like an honour then stop doing it”

Social work has to be so much more than the application of legislation. It has to embrace the responsibility it has to people. A responsibility it is granted by society, not one it owns to deliver. We can and should hold on to the very elements that took us on this journey in the first place. Celebrating all that was right in the social work models of the past and merging them with not just the evidence of today’s research but the desires and creativity of people’s aspiration, assets and strength. Social work has to earn it’s right to enter living rooms, walk the streets, sit on park benches and at peoples bedsides. Knowing and delivering much more than the forms you clutch has to be a given or you have no right being there. Indeed if we proffer forms and abdicated the responsibility of our role to citizens our profession will die.

Modern social work is well placed and key to understanding and mitigating the inherent failings of reactive ideas, policy and commissioning that trips up its own outcome due to narrow thinking. The ability to understand beyond the systems yet work within them, moulding what is good with what is progressive, is an art. An art that social work can bring. One that should be inherent whether you are a case holding frontline worker a manager or any other role. We are a single profession defined as such not by a qualification but a common value base and belief. If you haven’t taken those steps towards the positive new age of social work or if you have drifted from its path then come and join in.

Social work has to be part of the solution. In a time desperate for strong professionals with a will to fight positively through dark days we need to respond. Its to easy to become the negative face of adversity when times are tough. I read a tweet not long that stated “We need social work in every area to put right what is wrong in society”. Now I may be misinterpreting the intent of this tweet but it is so wrong, wrong in every way. We are not the custodians of society, we need to learn to be part of it, in fact we need to ask humbly if we can come and play again. Then and only then on an equal footing can we work alongside people and create opportunity, not risk averse application that does unto. That’s why we need to join and start to be part of the solution.

So what is a New Social Work Bohemian?, the very question I was asked on Twitter recently, Well how about this; ‘Positive, progressive, creatives with a humanist understanding of the art of people, cultures, love and a dash of science to add colour. We are certainly not there yet but every member is doing something new,
something beyond the rigidity of purest models of the past and the pressure of the money or lack of. Creating with citizens, making the tears bearable the opportunity real, the ends of life the best they can be and the next generations ready to drive us forward.

You don’t need to sign up or tell everyone you’re a New Social Work Bohemian just go create.

**Mark Harvey**  
@Mwharvey  
[Link to original blog](#)
Defining Social Work

I’ve often talked and written about my pride in being a social worker and how much it has shaped my life. In seeing the very sad demise of the College of Social Work and the lack of interest in professional representation by the profession (yes, there’s BASW but that can’t be said to represent any other than it’s own members—which is fine, as that’s the point) I wonder what it is that makes social workers less likely than other professions to join a collective group to drive the profession forward collectively.

Maybe it’s something about what we do as social workers. We train generically (at least for the moment, although that is under threat). We practise very differently. Some of my friends from my social work training course went to work in different areas of social work—child protection work, fostering and adoption work—comparing their day to day jobs with mine one can begin to think we are actually practising different professions. But it’s important to remember we aren’t. Social work has a fundamental core value base that distinguishes it, in whatever form it takes. More than ever we need to cling to that as political manoeuvrings seem intent on drawing and expounding divisions between different parts of the profession.

We can talk about what we DO as social workers. But the difficulty is that what we do is so varied and so different. I’m a social worker but I am not in a job which requires that I am qualified or registered as a social worker. I see it as being inherently a part of what drives what I do though and certainly, every day I use social work skills and remain bound by the values. Yet, trying to describe what I do will sound very different from a job I was doing 3, 5, 10, 15 years ago which would all have been ‘social work’.

What social work isn’t, is David Cameron imagining that a bit of voluntary work in the community is ‘social work’. What it isn’t, is what police officers say they are doing when they are working with people who are mentally ill or have dementia. Any more than nursing is knowing a bit of a first aid or clinical psychology is listening to your friend’s problems and suggesting they might need to try a bit of meditation. Nurses have a Chief Nursing Officer who came up with the idea of ‘6Cs’ (Care, Competence, Communication, Courage, Commitment) to embody nursing practice. I am not a massive fan of them to be honest. I think those values shouldn’t need to be delineated and say nothing specifically about nursing but really are fundamental to most people, whatever their job or area of practice—whether a vicar, a shop worker or a vet—those 6Cs are equally valid. But it did make me think where the leadership and inspiration for social work is? Are the Chief Social Workers going to be inspirational in driving us collectively forward? Unfortunately, I think that’s unlikely so we need to find the inspirational voices amongst ourselves.

I have also been thinking about what ‘6C’ equivalent would underpin social work. What key words and values can we share that explain what we are all about.

It’s a bit tenuous but I’ve come up with 5Hs which for me would embody the work that any and all social works can and should do—whatever area they work in.
HOPE—however difficult the task, however tired the practitioner, however seemingly desperate the situation, we need to remember and hold on to hope for progress for individuals, families and society as a whole. We need to reflect that things will and can change and that if we can be witnesses to effecting positive change, it is one of the truest joy of the jobs we have the privilege to do. When we don’t have hope, even when those we work with seem to be throwing it away, willingly, we can’t give our all to moving things forward.

HUMILITY—I’m a big fan of humility. I think it is the key quality that anyone working with others in any capacity needs. We need to learn from those who we come into contact with and not come from the ‘we know better, we’ve studied x/y/z’ point of view. People are experts in their own situations and we need to learn and grow from that. We make mistakes. When we do, we need to drop defensiveness, admit and apologise. But most importantly, we need to challenge our own assumptions that we think we might know best. Each situation is different. Each person has different skills and talents. We need to understand and admit that there are social workers who are poor and who do damage to people and families and be alert enough to condemn poor practice when we see it, rather than develop a bunker mentality. If we can do ‘humility’ well, I think a lot of other things follow.

HONESTY—This follows a little from humility, but it’s about more than just saying things as we see them. It’s about being honest with ourselves as well as those we work with. It’s about being honest with the organisations and structures we work in and challenge where we need to. It’s about being honest with our goals and ethics. We also need to ensure we are honest with those we work with. Peddling in jargon can be exclusive and excluding. We need to be honest with our language which may well be about simplifying it.

HELP—This is a bit of a tenuous one, although I’d hope the backbone of social work is about doing things that make a positive difference. Help is more than about a hand being given to someone who may need a brief shove—it’s about actively having a positive impact. It’s about individuals we work with, community we work in and self. Sometimes it’s clearer with individuals and less clear with self but really, it’s all about the same things really. We can’t do the job effectively or well if we don’t look after ourselves and give ourselves time to have a break away from things or do things that are not ‘work related’.

HEART—We need to do what we do with passion. We need to be able to believe in what we do. Yes, that’s nice and fluffy but it includes knowing, understanding and believing the reasons behind our actions. Being able to reflect and learn and grow. Being open and actively searching information and evidence to improve our practice, even when we work in environments which do not give us much ‘learning’ space. It’s about learning and relearning to love what we do and remembering that passion is really at the centre of wanting to do this work. Without passion and without ‘heart’, it can be a very difficult cliff to climb.

(ADDITION/LATE EDIT—a couple of people have suggested HEAD as a sixth H which I think is fantastic and should have been there all along. Because however kind, thoughtful and skilful you are—however much you listen and advocate for people and for yourself and your profession—we need a knowledge base and the ability to translate concepts and theories into practice and make the work real. We
need to provide an intelligent challenge to the oppressive systems we see. We all need a fair bit in those heads to be effective).
I’m sure many people, far more intelligent and experienced with me can do much better—but I think it’s helpful to spend a little time trying to distill what social work is and what is does and what makes it different to reignite or develop some of the real job of the profession. Rather than looking at my examples, I’d urge other practitioners to write their own ‘key fundamentals’—ones that are meaningful for you and the work you do—and reflect on remembering to ensure they are alive even on those tough friday afternoons when you know you have more to do than time available.

Ermintrude
@ermintrude2

Link to original blog
Risky Business

Another nerdilicious blogpost. This one is about a central part of the NHS England-led plan ‘Building the right support’ [https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf](https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf), which is the latest Transforming Care reboot. ‘Building the right support’ makes the welcome point that reducing the number of people going into inpatient services will require much more extensive, earlier, and more useful community support.

As part of this, the plan says that there are an estimated 24,000 people ‘at risk of being admitted to hospital without the right support’ (page 36). My understanding is that there is quite a lot of head-scratching around how to identify in practice who these 24,000 people are, and then to work out what services are needed to support them so that they don’t end up in inpatient services.

Personally, I’m not convinced about this ‘risky cohort’ idea, and I think it might have some unhelpful unintended consequences.

First, the 24,000 figure is extrapolated from a study examining the prevalence of challenging behaviours amongst a population of people with learning disabilities in a large area of Wales (total population 1.2 million) in 2007 (Lowe et al., 2007). It is a relatively large, well-conducted study, with similar findings to previous research. However, using this as a benchmark to construct a ‘risky cohort’ raises a number of problems, including:

1) There are no nationally comprehensive data on who is currently showing ‘challenging behaviour’, and trying to construct such a dataset is likely to be highly expensive, difficult and time-consuming.

2) We also don’t know if the cohort of people with the types of ‘challenging behaviour’ used to derive the 24,000 number make up all/most of the cohort of people who end up in inpatient services. For example it's likely to miss out relatively able people who end up in inpatient services via ‘offending’ routes, where even standard forensic risk measures don't seem to be brilliant at predicting what people do once they arrive in an inpatient service (O'Shea et al., 2015). From the sparse research that has been done it's also likely to miss out some people with learning disabilities who end up in inpatient units with a diagnosis of a mental health problem - it's unclear how many of these people would be picked up as showing 'challenging behaviour' (Chaplin et al., 2015; Devapriam et al., 2014).

3) In its original form, the definition of ‘challenging behaviour’ is a social construction, dependent on what the person is doing only within the context within which they are doing it. Hand someone a pair of glasses and you can be put in a temporary cell - flatten someone running past you and you can be a hero (both of these things happened to Burnley FC mascot Bertie Bee - see this article for a brief explanation of context [http://www.mirror.co.uk/sport/football/news/burnley-mascot-sent-jailed-after-2644050](http://www.mirror.co.uk/sport/football/news/burnley-mascot-sent-jailed-after-2644050)). Staff who don’t or choose not to really understand a person may very quickly reach for a ‘challenging behaviour’ label and punitive response that is completely unnecessary, establishing a punitive spiral with no ready exit. Identifying a risky cohort of relatively fixed quantity locates the ‘risk’ squarely within individuals,
rather than paying careful attention to people’s histories, what matters to them, and the influence of environments (and other people).

4) We don’t know what impact changing patterns of/reductions in the group of people supported by/known to social services will have on who is visibly ‘at risk’. It’s entirely possible that the more able ‘offending’ cohort of people will stop being identified as people with mild learning disabilities at all (either in education or adult services). Although a lack of support might make this group more likely to get into trouble with the law, and might mean they are more likely to end up in prisons or even mental health inpatient services, they will become invisible to learning disability services and drop out of the ‘Transforming Care’ remit altogether. Which will buff up the Transforming Care target indicators no end, while doing a grave disservice to that group of people.

5) We don’t know what impact changes to inpatient services themselves will have (assuming that there ever are any!) on the quantity of people that could be admitted and the ‘problems’ that would make someone ‘eligible’ for an inpatient service, and therefore what a ‘risk cohort’ would look like. Over a ten year period, some of the ‘reasons’ for admission to a single inpatient unit, and what happened to people once admitted, changed quite substantially (Oxley et al., 2013). And of course, if community support services do increase and improve, then this would also change who is ‘at risk’.

6) The boundaries between ‘inpatient’ services and other residential services (the infamous Daisy residential service) are becoming increasingly fuzzy, as local areas look to claim that their inpatient numbers are going down. The ‘risk cohort’ might be less likely to go somewhere called an ‘inpatient service’, but they might be more likely to end up somewhere with a different label but serving a similar function (residential special schools are part of this too, I think). As Mansell and colleagues said in 2010: "The large number of patients in low secure services raises the question whether this type of service is recreating the intellectual disability institutions which government policy intends to close” (Mansell et al., 2010).

So I think if you want to know anything meaningful about the group(s) of people who might be ‘at risk’, there are a number of questions you need to ask:

1) Does having an ‘at risk’ cohort, who are maybe getting extra support as a result of their risky status, create more de facto eligibility hurdles? Do people and families have to show a ‘problem’ to get this extra support, and what if the extra support reduces the ‘problem’ – does the support stop? How are the boundaries to be policed? Personally I think support needs to be offered universally as the only way to get round this gatekeeping, avoid unnecessary labelling, and develop coherent support that is rooted within meaningful communities.

2) At risk’ of what? At risk of admission to an inpatient service is too restrictive (for the reasons I’ve outlined above) and will lead to ‘gaming’ the system from unscrupulous types. I think instead there needs to be a recognition that trying to get a definitive ‘at risk’ list of people will be likely to be highly expensive and slightly self-defeating as circumstances change. Instead, I would propose some more pragmatic steps to be done on an ongoing basis to monitor what’s happening, for example:
a. We don’t know much at all about the histories of people who are being admitted to inpatient services. It should be relatively straightforward to find out some details of people’s histories and collate them either at the point of admission and also for people ‘averted’ from inpatient admission. This would need to be ongoing to look for potential changes in ‘risky’ histories as the pattern of inpatient services changes.

b. We need to do something similar for people in residential special schools (and to examine their onwards trajectories too).

c. We need to look at people who get/acquire some label of learning disabilities when they come into contact with the criminal justice system (police contact onwards) in terms of histories and what happens to them (diversion to forensic services, for example?).

d. Within annual health checks we need better coverage of mental health problems and ‘risky’ behaviours.

e. We need to find a way of understanding what is happening to the group of people formerly known as people with mild learning disabilities. Within local areas, we need to build a comprehensive picture of what is happening to people that is monitored in real time. This shouldn’t need a complicated extra special database of ‘risky’ people. It needs to get a whole picture of where people are (including people who are sent out of area). Are apparent reductions in inpatient services accompanied by increases in emergency hospital admissions, or people getting into the criminal justice system, or into forensic services? As the number of people identified as eligible for learning disability services decreases, are there local increases in emergency hospital admissions or generic mental health inpatient admissions? I think in areas that have their act together, most of this information will already be available – it is just very rarely put together in ways that make any kind of sense. I think this is much more achievable than identifying an ‘at risk’ cohort of people with learning disabilities.

Chris Hatton

References
Whose Voice?

On Thursday I spoke at the Dignity in Care conference in Birmingham. I was booked to tell the get Steven home story and then later be part of a panel of 4 chaired by the former Labour home secretary, Jacqui Smith, taking questions from the floor.

I’ve done several of these events now but two things happened that floored me. Firstly, in the nicest but most emotional way, Ms Smith gave me some feedback that was so moving it left me choking back the tears. Then during the lunch break I was challenged by one of the delegates and I’ve been pondering his challenge since. His first questions were focused on how Steven has been since 2010 and whether he has any ongoing trauma. We chatted for a bit and he asked me why Steven wasn’t here today, telling his own story. I explained why and as he got up to leave, he said “We can speak for ourselves. (He has aspergers) Just remember, you’re not telling Steven’s story. You’re telling a fiction”.

It completely threw me and I’m still pondering it 48 hours later. I know that if it were possible for Steven to be at the lectern, he would tell quite a different story. Steven has a catalogue of stories of things that happened to him whilst he was at the Unit but they don’t include all the meetings, the DoLs, the council’s plan or the court appearances. I use Steven’s words in the presentation. For example, when I talk about his barefoot escape on the night of the Take That reunion, I use the exact words he used to me the following day when he was describing his escape plan. But all in all, am I telling Steven’s story?

I don’t think I’m telling my story. I’m not being booked to tell my story. I’m in the story but its not mine.

Am I telling ” our story”? Steven and I aren’t on the platform together, so probably not. But at the same time, I am telling a story that involves the pair of us.

So perhaps I’m just telling “a” story.

Does that matter? I think it did to the guy who challenged me. Later that day, I followed a discussion about LBBill, where the focus was that it was a “parent led” project. In the same way that I had been telling a parent led story. Steven led the events of 2010, I lead the telling of the story. Is the LBBill parent led? There are a lot of parent voices involved, for sure. There are also lots of non parents involved. There are also, most importantly, lots of disabled voices in the Bill.

I get confused and embarrassed when I’m challenged by a disabled person over what they see as the shortage of disabled voice in the Bill. Instead of me trying to ensure Steven’s wishes and best interests are included in the Bill, should I step out and hand over to an advocate to speak on his behalf? Even the non verbal have a voice but seldom have a platform, so how will their voice be heard? Is it really so wrong for the parent or carer to try and provide that platform. Steven knows about the LBBill. If I’m totally honest, he hasn’t shown a blind bit of interest in it, no matter how much I’ve tried to involve him. But without me, LBBill wouldn’t get within 100 miles of Steven’s radar because his voice isn’t available unless he’s asked. And nobody, and I include all the disabled organisations in this would ask him. There is no point in waiting for, for example, Mencap to find him. Steven, and his voice, is
inaccessible unless it is sought and nobody but his friends and family are going to do that.

My apologies for the confusion of this post. I certainly have more questions than answers. And it's probably going to take ages, if ever, for me to get my head around these issues.

Mark Neary
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You Couldn’t Make It Up / The True Story Of A Botched MHA Assessment

I have never written a blog before so I apologise in advance for its shortcomings however I can no longer keep inside me the terrible experiences of the past few months.

Last year I experienced two major life stressors, a death in the family and a move from the home where I had raised my children to a smaller home in a different part of London. I also experienced “empty nest syndrome” as the youngest left for university and I found myself alone in an unfamiliar part of the city.

Before the move I was on Enhanced CPA and had had the same care coordinator for many years, she was almost a friend and had actively supported and encouraged me to remain in work. It was to be a huge loss as without that support I slowly began to unravel.

My diagnosis is schizoaffective disorder, at the age of 19 in my second year of university I had to take a year out after what was initially described as a “psychotic” breakdown, by 24 I had been diagnosed with schizophrenia and by 30 it was changed to schizoaffective disorder. I hear voices which to me are real and sadly I have on occasion obeyed their commands.

When I moved house my then care coordinator was still responsible for supporting my MH which was to continue until I had registered with a new GP and she had transferred my care to the new “recovery team” and arranged a CPA meeting.

For reasons still unknown this transfer did not go smoothly and by December I had become increasingly unwell and needed a visit to my new GP who appeared shocked that I had been 3 months without support and so she quickly arranged a meeting with the new team. However I was wrongly offered a telephone triage.

The person I spoke to on the phone was both rude and abrupt and asked me “what I wanted from services?” she informed me that as I was apparently “high functioning” and able to hold down a job there was little point in having support as the “purpose” of the Recovery Team” was to get people back into employment! I had never heard this before and believe that recovery is personal and is more than going to work everyday.

My GP who could see I was still unwell did not accept this and I was invited to a face to face meeting at the surgery with a psychiatrist and a mental health social worker.

I don’t recall too much about this meeting as by this point I was very unwell, I do know I was promised a treatment plan by the following week and when after four days I hadn’t heard anything; on January 28th I called the social worker and this is when the nightmare began.
The Nightmare

The SW informed me that a plan was being formulated and she would contact me soon, at this point both she and the GP knew that a section 135 Warrant had already been issued and a Mental Health Act Assessment was being planned. I should have been informed of their concerns, offered a date to attend an assessment, been invited to bring my nearest relative and or an advocate, been interviewed in an appropriate manner and offered treatment in the least restrictive manner. Sadly this did not happen and this led to a possibly illegal and certainly traumatic Section.

On Friday 30th January after a long day at work, I came home late had a bath and by 9pm was in bed. My youngest was home for the weekend and out with friends in West London. I was just drifting off to sleep when I heard a ferocious knocking at the door, initially I thought my son was home early and had forgotten his key, so I ran downstairs just as a man shouted “open the door now, it’s the police.” Immediately I thought that something had happened to one of the children and I burst into tears, opening the door and crying “what’s happened”?

There were three police cars with flashing lights in my street, seven police officers, six male and one female, a male social worker and a male doctor. I later discovered that both the SW and the doctor were locums and had barely read my notes.

The SW quickly took control and barked orders that I was to get my coat quickly as an ambulance was coming and I was going to be taken to hospital where a third doctor was waiting to section me. I rapidly went into shock, two police were guarding the front door and neighbours were out on the street, the policewoman could see I had shut down and said to the SW to hang on and at least let me get dressed, call a friend or relative and pack a bag. He barked at her that it was already late and he had a home to go to. Fortunately the ambulance hadn’t arrived so the policewoman called my son and explained what had happened, he said he disagreed with taking me to a strange hospital and would they please wait as he was on his way home. The SW refused saying it was late and as the ambulance had arrived I had to go to the hospital.

A male police officer who could see my distress also intervened saying “hang on mate this is overkill, you can’t behave like this” but I was still forced into an ambulance. I had no time to pack a bag but at least I was dressed and had a warm coat which was later to prove invaluable.

In the ambulance I was with two female crew who I can’t praise highly enough, they took control, rang my son, told him the name of the hospital and instructed him to meet us there.

At the hospital I was immediately sectioned without being interviewed let alone in an appropriate manner. I was just informed by the SW that the 3rd doctor had seen enough and if I didn’t cooperate and come to the ward he would “drag me” which he started to do. I was as you can imagine distraught.

On the ward I was taken to a filthy cold room on the male corridor, the night nurse, gave me no welcome, no orientation, no kind words and laughed at my distress saying “Oh God one of those”. Up until this point I had been a mother, an employee,
a friend, a good neighbour, a person with interests and a life but none of this mattered, from the moment I entered the ward I ceased to be a person and I will never forget the cruel and inhumane treatment I suffered that night. My phone was confiscated, my shoes removed, and I was incarcerated in what can only be described as a cell. A male nurse sat outside the door and no one comforted me or explained my rights and of course I had no phone to contact the outside World.

To be continued……..

@schizoaffected
My social work journey in substance misuse services

I came into social work by accident at age 19 when I had completed my A levels and was trying to work out what I wanted to do with my life. I was advised that doing a counselling course would equip me with communications skills that would benefit me in any job, so off I went to complete a ten-week course.

This was my first experience of listening to people who were in emotional pain and started my pathway towards working with people who were facing adversity and needed professional support.

When I began a degree in social work, I don’t think I really understood where it would take me. But I came to learn that it is a profession that engages with people at some of the most complex and challenging periods of life where hopelessness, fear, isolation and distress are common – not just for the individuals, but also in their families, children and wider communities. I was inspired by the area of substance misuse services very early on, through completing a specialist module and practice placement. I saw the widespread impact of addiction and was humbled by the sheer determination people had to find to achieve independence and wellbeing.

I started my first job in a drug intervention programme – a qualified social worker, employed as a drug and alcohol worker. I used social work skills on a daily basis to engage with people, assess their needs, and help them to plan their care and achieve their goals, but was discouraged from sharing my professional identity due to a belief within the organisation that service users would not engage with social workers.

I began to see the lack of understanding in society of my profession, and the misconception that all social workers were people to be suspicious of. Being part of someone taking control of their life and thriving in recovery was rewarding and I knew I had made the right decision to work within this sector, but I was keen to retain my professional identity.

In 2006 I had the chance to take on a role that incorporated the two things I had developed a real passion for, and I became employed by a local authority as a specialist social worker for substance misuse. This gave me an opportunity to focus on developing my social work skills further, and over the next six years I saw the substance misuse field change and grow following the introduction of the recovery agenda. As services have been recommissioned and austerity has hit, service providers have been reconfiguring their staffing, leadership structures and their use of peer support and mutual aid, while supporting people to build recovery in their communities.

The social work profession has also seen huge reform, new legislation and workforce challenges, bringing it closer to the substance misuse sector than ever before. There is now a real opportunity for social work to support the recovery agenda with its underpinning principles of empowerment, self-efficacy and community cohesion.

I currently work as the social work lead for The Alcohol and Drug Service (ADS). Like many providers, ADS has employed social workers for many years but began
thinking closely about its workforce several years ago as it formed partnerships with NHS trusts. Leading on the social care element of the services they provide, ADS made a decision to use the skills and accountability of social work professionals to lead the frontline workforce, developing reflective practice within their teams and contributing to the skills development of others. My role is therefore to build and lead a social work structure across the organisation’s partnerships that is robust and enables career progression, is in touch with national policy and governance and is constantly developing and adapting to the change that reform brings.

Alongside the strategic element of my role I am responsible for enabling, monitoring and evaluating continuing professional development (CPD) from social work placements, through the assessed and supported year in employment (ASYE) and into postqualifying learning and development. As a practice leader for the social work professionals that ADS employs, I thoroughly enjoy watching them thrive in their professional roles within our services. One of our social workers said, ‘As a recognised social worker I have begun to bring other areas of my training into my work, including reflective practice and the confidence to challenge other professionals… it is greatly appreciated that we are recognised in the sector that we work in.’

The social work team at ADS are now spread among our services, supporting the holistic approach required for effective recovery-focused services. We engage with and contribute to a number of university social work programmes and fast-track schemes, giving our social workers opportunities to develop other skill sets that are valuable to them and the organisation. ADS holds a strong belief that social work as a profession has a key role to play in the future of substance misuse services and I feel great excitement about what this could mean for our workforce and the wider substance misuse field, for social work – and ultimately for the people who need and use our services.

Hannah Feeny

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Guest Blog for #HospSW16

My first job after completing my social work training was as a hospital social worker so I’m delighted to write this blog in support of hospital social work day. As well as the wider challenges facing the social work profession across the board, it has never been more important to speak up for the value of good social work practice in hospital settings.

During my career I felt most valued as a social worker when working alongside doctors and other health professionals as part of a multidisciplinary team than in the remote municipal outpost of an area office. Perhaps I was lucky. We had a well-resourced team, a management structure that had enjoyed parity with community-based social work teams, reasonable caseloads and good supervision. This may sound too good to be true and it probably was. But in many respects this was no golden age of social work, especially for older and disabled people. There were more hospitals that were generally smaller but not necessarily better (prompting 1940s Health minister Nye Bevan to say that he “…would rather be kept alive in the efficient if cold altruism of a large hospital than expire in a gush of warm sympathy in a small one”, raising issues about the size and scale of hospitals that continues to this day).

A key difference from today is that in the late 1970s the NHS still provided long term care in geriatric and psychogeriatric wards on an almost industrial scale that would be unthinkable today, a reminder from history why we should resist the resurrection of institutional models of nursing home care. But as part of the NHS it was free at the point of use so the problem of continuing healthcare – now the running sore of our fractured health and care system – did not really exist as such. With a relative abundance of local authority run residential care (‘part 3’ homes – referring to part 3 of the National Assistance Act), home care and day centres, commissioning as such did not exist. Access to services – nearly all in-house – was relatively straightforward if bureaucratic, though I suspect many older people who today would be supported with reablement to resume living at home ended up in long term residential care. With the benefit of hindsight it is clear that many traditional services were misplaced expressions of civic virtue.

Thirty years on the landscape of policy and services has changed beyond recognition, in many, but not all, respects for the better. Changes in the pattern of illness and the way the NHS is organised have had profound implications for how hospitals work and what they do. Thanks to a combination of science, longevity and demography, numbers of very old people with dementia, frailty and complex comorbidities are soaring. The acuity of their needs in all settings is rising, but under-investment in primary care, community health and social care services means that more are ending up in hospital and then getting stuck there whilst waiting for future care arrangements to be sorted out. The scale of this challenge is unprecedented in the history of health and social care and will intensify over the next decade when the number of over 85s is set to double.

This represents a strong and compelling argument for more hospital social work not less. Yet the trend is in the opposite direction. Many local authorities, driven by budget cuts, have withdrawn social workers from hospital settings. Like disinvestment in prevention, I fear this will prove a false economy. There will be more
people with complex needs that cannot be sorted out quickly or easily and certainly not by clinicians on their own. Preventing hospital admission and facilitating early discharge requires skilled social work involvement in assessing need, understanding social, family and housing circumstances (including the possibility that the need of the individual may not coincide with the preferences of the family), assessing and managing risks and care planning and coordination with the hospital and external providers. Doing this in the pressure cooker environment of a modern, busy acute hospital is tough. It will best achieved by close, regular and proximate working by social workers with hospital teams so that they develop a good working relationships and a mutual understanding of their respective roles, professional cultures and ways of working.

Despite the essential role of social work in hospitals, there is an emerging post-factual narrative which sees social care as a ‘problem’ in terms of delayed transfers of care, as though social work were little more than a bed clearing service for the NHS. Although the number of delayed days in hospitals due to social care reasons has shot up by 37% in the last year, the majority of delays are still down to the NHS – and the single biggest cause of all delays, irrespective of who is responsible, is waits for packages of care at home. The narrative of blame – thankfully rejected now by the majority of health and social care leaders – distracts from the real value of hospital social work as part of the solution rather than part of the problem.

Acute illness is often a time of pain, distress and anxiety. Hospitals can be strange and frightening places, with the possibility of great pressure on individuals – perceived or real – to make life-changing choices that can easily be driven by the need to free up a bed. In these circumstances good social work is a bulwark of the needs and rights of the individual, especially those less able to speak for themselves and without the support of families and friends. In my career the emergence of a human rights perspective has been one of the most positive and progressive developments in social work and social care but one we should not take for granted.

But human rights in practice is not straightforward as that. People who are waiting for admission to hospital have needs and rights too. Modern acute hospitals – with fewer beds per capita than most other advanced countries – have to be efficient and effective in meeting the needs of the whole population, balancing the needs of the individual with the overall smooth-running or ‘flow’ through hospital from admission to discharge. It is ironic that social workers are usually more aware than many clinicians that acute hospital is not a safe place for an older person unless they are very acutely ill.

The overall challenges of our health and care system has never been greater. With our population growing older and sicker, the pressures across all parts of our health and care system – primary care, mental health, community health, social care and hospitals – are unrelenting. With winter upon us and no let up in demand, for a mixture of reasons hospitals will continue to be the most intense and visible pressure point. The role, value and contribution of hospital social work has never been greater and can make a huge difference to individual wellbeing and outcomes. It is hard to see how hospitals will cope without it.