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Original Article

Social work in a secure environment: towards social inclusion

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Abstract

A major social policy aim in the UK is to promote social inclusion in order that people with mental ill health have the same opportunities as other people to have a family, work and live. However, people with mental ill health remain amongst the most socially excluded in the UK and their social needs are largely unmet. In this article, the social policy, theoretical underpinning, and evidence base for the development of a social work model is considered with a focus on social inclusion. It is argued that in order to provide a more holistic package of care, each low secure service should have a dedicated social worker as part of its multi-disciplinary team. A social work model linking the areas of social work to an individual's progress through a low secure environment and into the community is presented and the social work process is discussed using a case vignette.

Keywords:

Social work; secure unit; social inclusion; multi-disciplinary working

INTRODUCTION

A major policy direction within the European Union and the UK's Department of Health National Service Framework (DoH, 1999) is social inclusion with the aim of enabling people to participate in mainstream society. The Government's Social Exclusion Unit recently considered what more could be done to reduce social exclusion among adults with mental ill health (Social Exclusion Unit, 2004). The two main questions posed can also, arguably, be used as the focus of social work in a low secure service or psychiatric intensive care unit (PICU). First, what more can be done to enable people to enter and retain work? Second, how can these people secure the same opportunities for social participation and access to services as the general population? More specifically, mental health services are currently driven by the National Service Framework which sets out seven standards, the first of which requires action to reduce discrimination against individuals and groups and promote their social inclusion (DoH, 1999; Sayce, 2000). In contrast, a policy coexists within the UK to provide more medium and low secure hospital beds (DoH, 1999; Sayce, 2000), which clearly has the potential to result in social exclusion because of the secure environment and limited access to community based activities.

The National Minimum Standards for Psychiatric Intensive Care Units (PICU) and Low Secure Environments (DoH, 2002) recommend that each unit should have a dedicated social worker as part of its multi-disciplinary team. In support of this recommendation it is argued in this article that social work has a significant role to play in relation to statutory duties, family work and the attainment of the policy aim of promoting social inclusion. Nonetheless, the standing of social work

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with politicians and the media remains low and, generally, its practitioners have minimal say in the development of practice and theory and are conspicuous in the professional press by their absence (Beresford, 2001).

In this paper the experiential evidence and theoretical basis of the social work model is outlined and the areas of work aligned with the four phases of recovery, from admission to community living. The social work process is then outlined using a case vignette. Although this model of working is primarily designed to meet the needs of patients in a low secure environment, the principles of inclusion apply equally within a PICU but the individual's mental state and length of stay will, inevitably, affect the process. The overall aim is to promote the development of social work practice within secure environments and, thereby, provide a more holistic service and more beneficial experience for the individuals concerned.

DEVELOPMENT OF THE SOCIAL WORK MODEL

In Gloucestershire, the Montpellier Unit, providing a low secure service, has as part of its Mission Statement that the service ***'. . . will have a therapeutic focus on rehabilitation and social inclusion'***. The following are the experiences, evidence and theories on which this social work model, as used by the Montpellier Unit, is based:

Personal experience

Preparing this paper provided me with the opportunity to reflect on my own experience of multidisciplinary practice which is a continuing goal of Government policy in relation to health and social care. For the Montpellier Unit, a multi-disciplinary team ethos was created at the outset with the formation of a group to manage the project and formulate the operational policy. Moreover, contrary to Beresford's (2001) comment regarding social workers having minimal say in the development of practice, social work has, arguably, made a significant contribution to policy and practice development within this service.

A year in advance of the Montpellier Unit opening, I took on the role of social worker for Greyfriars PICU at Wotton Lawn in Gloucester, undertaking the Nursing Induction Programme and Control and Restraint Training. With a background of community social work, this experience led to a much greater understanding of the unique situations that arise within 'locked door' environments and assisted greatly in preparing the Operational Policy for the Montpellier Unit. During the past two years, social work provision has been based on this model and the focus has remained on social inclusion with many social needs being met that otherwise may not have been.

Context

The evidence suggests that most people who use mental health services are likely to be poor, unemployed, living in sub-standard housing and socially isolated (Social Exclusion Unit, 2004). Furthermore, in terms of need, a large Gloucester based study of people with a diagnosis of psychotic illness revealed that the areas of highest unmet need were in relation to social life, intimate relations, sexual expression and psychological distress. However, there was a high level of satisfaction with the health care treatment provided (Macpherson et al., 2003). These findings are perhaps unsurprising because the power of psychiatry as a profession has ensured that the medical model has remained dominant, thereby marginalising social explanations for mental ill health (Cowen, 1999). Indeed, almost every witness at the MIND Inquiry (Dunn, 1999) into social exclusion agreed with this view and was concerned with the excessively medicalised nature of mental health services, at the expense of addressing social and economic issues. These findings indicate that the focus of service improvements, to meet identified need, should be in the area of social care. These needs can also be considered in terms of the relatively new concept of social inclusion, promotion of which is a central tenet of the National Service Framework (DoH, 1999).

Social inclusion

It is widely accepted that people with mental health problems are amongst the most socially excluded in the UK today, because access to money, employment, secure housing and social networks becomes more difficult (Repper and Perkins, 2003). The scale of the social exclusion problem is identified in the Social Exclusion

Unit's (2004) report and is illustrated by the following data:

- **Only twenty four per cent** of adults with long term mental health problems are employed – the lowest employment rate for any of the main groups of disabled people.
- People with mental ill health are nearly **three times** more likely to be in **debt**.
- **One in four** tenants with mental ill health has serious rent arrears and is at risk of losing their home.
- People with mental health problems are **three times** more likely to be **divorced** than those without.

Furthermore, epidemiological studies have firmly established that people in the lowest social classes have a higher prevalence of mental ill health (Rogers and Pilgrim, 2003). Among people with mental ill health, the need for a more satisfying social life is a high priority and the area of greatest unmet need is associated with social life and relationships (Macpherson et al., 2003). Indeed, Sayce (2000) claims that people with mental health problems experience exclusion across every area of social and economic life. Nonetheless, mental health professionals find it extremely difficult to effectively help people meet these social needs but, for example, assisting someone into employment can be a route to increased friendships and social networks (Buckle, 2004). Although social inclusion is a relatively new social policy aim in health services, the importance of contact with other people was emphasised in Warr's (1987) seminal work in relation to mental health, work and unemployment.

There are many social policy texts analysing the origins and development of social inclusion as a concept and discussing various ways in which it has been defined (Percy-Smith, 2000). Nevertheless, at the mental health charity MIND Inquiry into social inclusion and mental health problems, a service user poignantly defined it thus:

"Social inclusion must come down to somewhere to live, something to do, someone to love. It's as simple – and as complicated – as that. There are all kinds of barriers to people with mental health problems having those three things."

(Dunn, 1999, p.23).

Consequently, social inclusion can not be seen as a treatment or a therapeutic intervention – it is about rights, choice and opportunities (Bates, 2002).

Social work

Before discussing the focus of social work, it is prudent to consider the four domains within which mental health professionals work, and the areas generally covered by psychiatry, nursing and social work practitioners (Fig. 1). The intention is not, in any way, to diminish the contribution made by other disciplines within the multi-disciplinary team but to simplify the diagram and demonstrate the need for social work in order to provide a holistic package of care covering all four domains. Nonetheless, it is evident that psychiatry sits mainly within the biological/psychological domain whilst nursing encompasses more of the social domain but, necessarily, extends far into the biological domain. Controversially, nursing is likely to relocate itself further into the biological domain as nurses increasingly take on the role of prescribing medication and, consequently, become more focussed on biological treatments. Importantly, all disciplines encompass each domain to a greater or lesser degree and, therefore, have the potential to contribute to all aspects of multi-disciplinary team working.

The model of social work proposed focuses on the social, psychological and environmental domains. Indeed, Howe (1998) claims that social work ***is*** psychosocial work if, by psychosocial work,

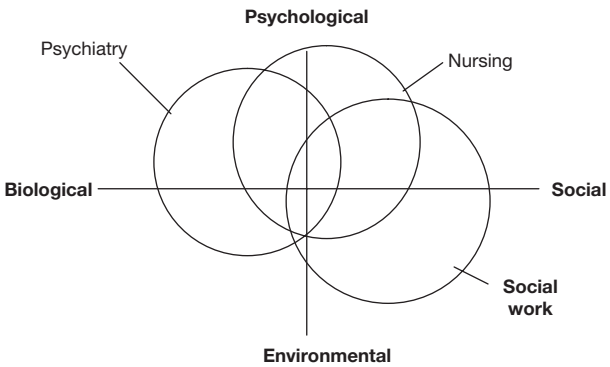

Figure 1. *Disciplines and domains*

we mean that area of human experience which is created by the inter-play between the person's psychological condition and the social environment. However, the many environmental factors and practical issues that affect an individual's life chances and experiences, such as housing and poverty, also need to be addressed. Therefore, although essentially a psychosocial model, it also considers issues in the environmental domain and, thereby, covers some aspects of an individual's care that are not central to the work of other disciplines.

PHASES OF RECOVERY IN A LOW SECURE SERVICE

Recovery refers to the real life experience of people as they accept and overcome the challenge of being socially disabled by their mental ill health and recover a new sense of self (Deegan, 1988). Whether this experience is time-limited or ongoing, the person faces the task of living with, and growing beyond, what has happened to them. Nonetheless, an understanding of the process of recovery is essential to the development of effective treatment, support and rehabilitation (Repper and Perkins, 2003). In terms of service provision, the four main phases of care in a low secure service can be defined thus:

- Assessment and admission.
- Continuing care, treatment and therapy.
- Pre-discharge planning.
- Community support.

Clearly, these phases are neither discrete nor time limited. However, they provide a useful framework within which to consider the social work process from admission to community living.

THE SOCIAL WORK PROCESS IN A LOW SECURE SERVICE

The social work model described in Fig. 2 identifies the main areas of work to be undertaken during each phase of recovery. However, neither the phases of recovery nor the areas of work are discrete but a framework on which to provide an overall description of the social work role. Indeed, many areas of the work identified, such as the legal aspects (including the Human Rights Act 1998 and anti-discriminatory practice) underpin all aspects of social work. The ethos of **multi-disciplinary working** and **risk assessment** is also paramount and permeates the whole social work process. Professionals in an in-patient setting often tend to over emphasise risk to others as a consequence of regularly dealing with untoward aggressive incidents. Therefore, the involvement of a social worker, as a professional advocate for the patient, has the potential to create a more balanced argument with regard to patient rights versus public protection.

The following case vignette is used to describe some aspects of practice in more detail.

Jamie is a 30 year old man with a diagnosis of paranoid schizophrenia, currently subject to section 37/41 of the Mental Health Act 1983. He has been involved with services since adolescence and has had five previous hospital admissions. He has a child living with foster parents and has himself lived in rehabilitation units, supported housing and independently. Prior to admission, he had been misusing drugs, isolated himself from his family, incurred large debts and has an index offence that included physical violence.

Admission and assessment phase

After the initial admission assessment two issues become priorities. Firstly, there is a need to solve outstanding practical problems. Secondly, it is important to compile a comprehensive social history – collecting information from as many sources as possible. This provides an opportunity to build a trusting relationship with Jamie, his family, friends and to discuss the case with other agencies. The practical matters to be addressed with Jamie are:

- Property to store safely.
- A home to be found for his dog.
- Electricity and mobile phone debts to be written off, if possible.
- Tenancy to be terminated.
- Welfare benefits to be maximised.

Undertaking this type of practical work consumes a large amount of time. Nonetheless, it helps build a trusting relationship because patients will readily engage with professionals if they foresee some tangible benefit. Furthermore, the process of dealing with practical problems inevitably proves to be therapeutic because as each problem is resolved,

there is an incremental improvement in the person's well-being. Exploring options for returning to the community may enable Jamie to see the positive aspects of not returning to his flat in which he had had many bad experiences and to recognise that, already, the discharge planning process has commenced.

Each of these practical problems can be resolved by adopting a problem-solving approach and working in partnership with the individual. Moreover, the following problem-solving principles can also be applied on a much broader basis, incorporating emotional, psychological, inter-personal and social problems (Thompson, 1998):

- Identify aspects of life or current circumstances that are problematic.
- Generate a range of possible solutions.
- Evaluate the options.
- Choose and implement the most appropriate solution.

Continuing care, treatment and therapy phase

The main focus of social work during the care and treatment phase would be to engage Jamie in community activities, visit possible future accommodation and places that help him to rebuild his self worth and identity. Moreover, work will be required to rebuild severed family links. Social work practice operates within the framework of the law and the legal system and, consequently, the social worker is best placed to take the lead role in dealing with child related issues. Should Jamie seek access to his child the social work role would be to ensure that the philosophy and concepts of the Children Act 1989 are upheld (Brayne and Carr, 2003).

During the period of continuing care issues such as drug misuse, family problems and financial problems can be addressed. Social workers base their practice on a range of theories but a useful method of working that may help Jamie deal with these problems, because it would allow his behaviours to

Phases of Recovery	MDT WORKING & RISK ASSESSMENT	Areas of Social Work
Admission and Assessment		Assess language, cultural and religious needs. Explore childcare and child protection issues. Assist with housing and financial issues. Assess and begin to develop family and social relationships. Compile a comprehensive social history. Consider discharge needs.
Continuing Care, Treatment and Therapy		Encourage patient and carer involvement in service provision. Promote anti-discriminatory practice. Facilitate access to advocacy schemes and legal representation. Statutory duties – MHRT and CPA reports etc.. Encourage and facilitate community based activities. Facilitate family and social visits to develop support networks. Provide emotional support.
Pre-discharge		Liaise with community services and other agencies. Devise a care package and obtain funding. Advocate for best possible home environment. Maximise welfare benefits, assist with housing and finances. Further assess childcare issues in relation to placement.
Community Support		Continue to develop/evaluate family and social support. Provide care/support to deal with problems of daily living. Act as Social Supervisor for restricted patients. Evaluate progress and hand over to community based team.
ENHANCED SOCIAL INCLUSION		

Figure 2. *The social work model*

be challenged, is Egan's three stage approach. This first explores the problem, second, helps the person understand the situation and, third, sets the goals before accessing resources to carry out the action and evaluate the outcomes (Coulshed and Orme, 1998). Undoubtedly, in a secure environment an individual's autonomy is diminished. Consequently, the utmost effort should be made to fully involve the person in all aspects of their care because humans need to feel that their autonomy is respected (Rogers and Pilgrim, 2003). Regularly held Community Meetings, involving patients and staff from all disciplines, also provide an opportunity for empowerment and self-determination within the confines of a secure environment.

In all probability, the most significant event in relation to an individual's freedom during a hospital admission is the Mental Health Review Tribunal. Social workers are usually best placed to prepare the required social circumstances reports which consider the patient's needs and whether they could be met in the community with an acceptable level of risk. The social worker also needs to be fully involved with the Care Programme Approach (CPA) with a focus on cultural issues, family and carer needs, accommodation, discharge planning and access to advocacy and legal services. Efforts should also be made to engage community based services at an early stage.

Pre-discharge phase

In preparing for discharge, the old adage – to know where you are going you must know where you have been – is useful in order not to set people up to fail. Consequently, the comprehensive social history, which identifies social circumstances that have or have not worked well in the past, knowledge of Jamie's current social support networks and clinical information, may then be used to assess the current risks. A comprehensive discharge plan that identifies accommodation and support needs can subsequently be devised, based on this knowledge. Where possible, it is essential to work closely with carers and involve them in the discharge planning process, but it is also necessary to be aware of any previous victim related issues.

Social workers often undertake the care management role of establishing a community base for a person leaving hospital. Various placement options should be considered, allowing people to have the maximum autonomy with acceptable levels of risk to themselves and others. Funding can then be obtained by the social worker for a care package, including appropriate accommodation and support. Applications can be made to the relevant agencies to maximise the person's welfare benefit entitlement and grant applications submitted for financial assistance to provide furniture and household items, if required.

Community support phase

During this phase of recovery, the social work focus is on mobilising human and practical resources, and evaluating the care package. Moreover, there should be a seamless handover of care to community based services in order to minimise the stress of leaving hospital, because although people want to progress, there remain, inevitably, issues of loss, uncertainty and ambivalence. This can be achieved by attending CPA reviews and liaison with all others providing support, **not** just professionals. At this stage, there is also a need to reinforce the work individuals have done in hospital to develop coping strategies to avoid problems such as drug misuse. Furthermore, there is a clear need for ongoing work to encourage and facilitate Jamie's engagement in community activities with other people, thereby promoting social inclusion.

There are also statutory duties such as acting as Social Supervisor for patients restricted by their section 37/41 conditions in accordance with the Home Office Guidelines for Restricted Patients (Vaughan and Badger, 1995). Restricted patients inevitably require greater continuity of care and, consequently, the social worker with a knowledge of their history is probably best placed to carry out this role for a few months before handing over to the community team when a therapeutic relationship and knowledge of the person is fully established.

CONCLUSION

It is undeniable that social policy in the United Kingdom is placing a greater emphasis on the concept of social inclusion in order that people with mental ill health have equal opportunities to

engage in every aspect of life in the community. Social workers, with their value base of empowerment and self-determination, are clearly suited to promoting inclusive strategies to maintain the roles and relationships that are so important for an individual's recovery.

The ultimate aim should be for people in a low secure environment to live in supported or independent accommodation, not residential homes, have real jobs and attend ordinary college classes, not 'special' day centre projects, and develop friendships with a diverse community of citizens, not just mental health staff and other people with mental ill health. Whilst recognising that some people may never achieve these aims, they are valid, make a significant difference to individuals and promote social inclusion. However, this approach is not an easy option because it takes ***more*** time and creativity to include people in all aspects of their care and facilitate their participation in community based activities than it does to exclude and confine them by focussing on custody.

Finally, it can be argued that if people with mental ill health in a low secure environment are to have similar opportunities to those of others, the multidisciplinary team should include a dedicated social worker in order to provide a more holistic service. Indeed, without such a service the social needs of these people with mental ill health are likely to remain largely unmet and, thereby, increase the likelihood of further episodes of mental ill health.

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