EXAMPLE PORTFOLIO

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EXAMPLE PORTFOLIO

The Context of the Practice Learning

The placement is at X Regional Secure Unit. There are three social workers at X, each attached to one or two clinical teams. These teams consist of a Consultant Forensic Psychiatrist, a Specialist Psychiatric Registrar and a Senior House Officer, a pharmacist, an Occupational Therapist, a Psychologist and a Social Worker. Each clinical team serves approximately 15 patients spread over each of the 4 wards, and there are 4 clinical teams.

There are 60 beds at this hospital, and currently is almost at capacity, with only one spare bed. All the patients are male, diagnosed with a mental illness and subject to detention in a medium secure hospital and are therefore are detained under the Mental Health Act 1983. Most of the patients are detained under section 37 hospital orders, with section 41 for restrictions. The hospital serves patients from the North of England, the majority of whom are white working class, with a few patients from ethnic minorities. The hospital is split into four wards, these being the Intensive Care ward, the assessment ward, continuing care ward and rehabilitation ward.

The patients at this hospital cannot be representative of the general community as it is a specialist hospital for men with mental health issues that are subject to detention under the Mental Health act 1983. This therefore does not represent the female population, the population of people not affected by mental health issues, and as the majority of patients are of working class, it is not representative of other classes.

However, when working with the patient’s families, there will be more opportunities to work with people who are more representative of the general community, for example, with people who haven’t got mental health issues and with female family members.

Word Count 291.
Management of the Practice Learning Opportunity

Student: LJ
Practice Teacher/Assessor: DC

The practice learning structure of this placement was agreed at the first placement meeting. It was agreed that formal supervision should take place weekly and, of the sixteen or so weeks in the placement, we managed fourteen supervision sessions. The remaining two weeks were the Christmas and New Year period.

Practice Teaching sessions, both formal and informal, have taken place on a regular and an ongoing basis. For instance, L has completed a number formal teaching sessions on the major types of mental illness, on the basic law and practice of child assessment, the criteria for and procedures of the Mental Health Act, Keeping Safe Work and formal and informal risk and care assessment.

L has also been involved in a lengthy and complex case study which demonstrates the process of Mental Health Act Detention, treatment, rehabilitation and discharge under the Mental Health Act. On the first occasion, L completed this piece of work as a student and, on the second occasion, as copresenter of the piece of work to students of other disciplines.

The most important and useful teaching method has been ongoing, daily, discussion and analysis of ongoing and future work. This has focused on innumerable areas but, in particular, has covered risk and needs assessment.

There have been no significant factors which have impinged on the delivery of the curriculum during this placement, all the proposed areas of study, and many more, have been properly and satisfactorily covered to a very high standard.

Throughout the placement, L’s time keeping has been good and her attitude to learning and work generally has been excellent.

L’s presentation of herself has been wholly appropriate-her manner, style of dress, presentation skills and the like have raised no areas of concern whatsoever.

The learning objectives have been fully met and much else besides.

DC, Principal Forensic Social Worker/ Practice Assessor /Work Based Supervisor
KEY ROLE ONE
Prepare for, and work with individuals, families, carers, groups and communities to assess their needs and circumstances

Unit 3: Assess needs and options to recommend a course of action

In this Unit you will be expected to demonstrate your ability to:

- Assess and review the preferred options of individuals, families, carers, groups and communities
- Assess needs, risks and options taking into account legal and other requirements
- Assess and recommend the appropriate course of action for individuals, families, carers, groups and communities

Complete the following task to provide some of the evidence to demonstrate that you have met this Practice Requirement

Practice Learning Three
1. Identify a specific piece of work involving assessment and planning.

2. Reflect on how you used legal requirements and policy to inform your assessment and judgements.
   
500 words

This unit may have been completed in PLE1 but it must be completed again in PLE3

An example of work which required assessment and planning was a child-visiting assessment for a patient at this hospital (X Regional Secure Unit). Such an assessment was done because patient RW requested to have contact with his two half brothers, both of whom are under 18, and so such contact is covered by hospital policy informed by the Fallon Inquiry (1999) on child visits to secure hospitals. This process thus initiates Section 17 of the Children Act 1989.

Following a patient request, agreement has to be sought by the Multi Disciplinary Team for the assessment to continue. This was granted, and so the following step was a home visit to the children and their parents, in order to determine if child visits would be in the child’s ‘best interest’s’ (Bainham 1990:9) - in accordance with the
Children Act 1989. This was done by considering if the children themselves want contact with the patient and also if the parents of the children consent to it.

The desire to visit patient RW was evident from the children, as was the understanding and consent of their parents. Following a satisfactory assessment at the family home, I then referred the children to their Responsible Local Authority, as the LA make the final decision. My referral recommended that the child visit go ahead and the LA agreed to this.

Throughout the assessment, great attention was paid to the risk factors involved when allowing a child to visit a secure hospital. This was done by consulting the individual Risk Statement in patient RW’s patient file, and also by checking the previous convictions of the patient to ensure that there were no offences which indicate him being a risk to children. In the case of patient RW they were low level risks such as swearing in front of these children. Risks were also managed by checking whether the children had been or are known to their Responsible Local Authority children’s service. Referral of the children to them was completed under Section 17 of the Children Act 1989. Therefore during this assessment, there were a number of stages at which the child contact could have been halted. These were; the MDT decision, the children’s assessed need, the parental decision, my assessment and finally the LA’s decision, thus ensuring multiple safeguards and maximum protection of the children.

The patient needs assessed in this case included the need for family contact to be maintained. ‘Everyone has the right to respect for his private and family life’, (Human Rights Act 1998: Art. 8) however goes on to state that this right can be overridden in line with the law and for public safety or to protect the health, morals or rights of another. This means that, although the HRA (1998) recognises the need for family life, that need is not paramount over public protection. Therefore this Act ‘seeks to balance the rights of individuals with other public interests’ (Brammer 2007:30). This was taken into account during my assessment as it was important to assess the needs of the patient against the safety of the children and then to suggest an appropriate course of action to the LA.
The APIR cycle was followed using Sutton’s (1999) ASPIRE model; an assessment was carried out, a plan of action was put together, an intervention completed and a review will take place according to hospital policy, after each visit.

References


Word count: 544
The service user (DN) was an informal patient already admitted into The Mental Health Unit of X Hospital following a relapse of his existing mental disorder, Schizophrenia with a strong depressive element. The critical incident involved DN leaving the hospital in a disturbed and distressed mental state and staying out all night before being returned to the hospital clearly distressed and believing that he was going to be killed. The weather was very cold and it was feared that he had become hypothermic. The service user was then heard by staff to make threats to go home and kill his Mother who he believed to be involved in a plot to kill him. This was obviously a critical incident as DN had become a danger to himself by staying out all night in freezing temperatures and had become a danger to others by making threats towards his Mother. The staff at the Hospital felt it was necessary to have a Mental Health Act assessment carried out by the ‘on duty’ Approved Mental Health Professional (AMHP). The ‘on duty’ AMHP was my practice teacher and this provided an opportunity to jointly complete the assessment.

Concerns were that the service user would leave the hospital again and continue to spend his nights outside in particularly dangerous conditions that could potentially cause DM harm or even death. Another concern was the risk to this patient's Mother, as the patient had explicitly talked of killing her. This patient suffers from Schizophrenia and felt paranoid about his Mum. DN made references to the paranoia concerning his mum during the AMHP assessment and so there were real concerns that DN would leave the hospital and harm her. O'Hagen (1986) explains that systems theory underpins crisis intervention work and as the person experiencing the crisis is part of a family and a community, which are systems according to this model, systems theory is relevant in this case as DN is making threats towards a family member and could potentially cause problems within his community by being a danger within it. These systems are therefore contributing to the crisis.

The immediate response to DN’s behaviour was; DN’s consultant psychiatrist completed Medical Recommendation under Section 3 of the Mental Health Act 1983 and the AMHP was contacted. The on duty AMHP and I attended at the hospital immediately to carry out the assessment. Best practice when completing a Mental Health Act Assessment is to use the patient's GP for the second Medical
Recommendation, however, DN’s GP was unavailable and so a Section 12 approved Doctor (usually a psychiatrist but some are specially trained GPs) was used to carry out the second examination in this case. The Section 12 approved Doctor agreed with DN’s consultant psychiatrist that the patient met the criteria for detention under Section 3 of the Mental Health Act 1983. Following the interview with DN, myself and the AMPH considered whether detention was ‘necessary for his or her own health or safety, or for the protection of others’. We decided that this criteria was easily met in this case in terms of health and safety of himself and for the protection of others. The 'least restrictive' principle was considered (in accordance with Jones (2008) Mental Health Act Manual) by us and it was decided that detention under Section 3 of the Mental Health Act 1983 was both appropriate and necessary. Section 2 was deemed inappropriate in this case as DN had already been on the ward for two weeks informally which had given enough time for an assessment to be completed and it was decided that treatment under Section 3 was required.

I feel that this was an appropriate response due to the need to protect others and himself. The response was timely from all the professionals involved including the hospital staff, the Section 12 Doctor, myself and the AMPH. This is important in Mental Health Act Assessments as risks to service users and/or others usually exist. The legal timescales within the Act allow for an assessment period of up to two weeks, but good practice dictates that the process should be as prompt as possible.

This response was effective as it detained a man who was potentially going to cause harm to himself or someone else. DN will get the appropriate treatment in the hospital and will, hopefully, recover his mental health and return to his life in the community. DN’s mother (his Nearest Relative) expressed her satisfaction at this result as she knows from long experience that DN is treatable with medication and can (and has) become violent when he is ill.

Word Count 650


Unit 5 Interact With Individuals Families Carers Groups and Communities to Achieve Change and Development and to Improve Life Opportunities

This piece of work was with patient DB who has had two previous admissions to this hospital. His referral has been accepted at a local open rehabilitation unit where he has failed to settle previously. It was a joint piece of work between myself and my practice teacher which involved five sessions of motivational interviewing with DB, one of which was a family session with his mother, father and sister.

The intended outcome of the session was to improve DB’s attitude to moving to the rehabilitation unit and so to increase the likelihood of a successful transition to an open rehabilitation ward.

After discussion and negotiation with my practice teacher and DB, a plan of action was put into place which outlined how many sessions there would be and what each session would cover. After speaking to DB’s family, it was decided that a family session would be introduced and this increased the planned number of sessions from 4 to 5. This plan was discussed and agreed at Multi-Disciplinary Team (MDT) level.

‘Plans like assessments should be built on a developing relationship between you as a social worker, the other agencies and professionals who might be contributing to the plan and service users’ (Parker and Bradley 2003:64). This means that it is important to include all the relevant people in the plan in order to maximise the chance of a successful outcome.

In addition to a patient-focussed perspective, risk assessment of patients is also a fundamental part of the social work role within the hospital and in general social work practice. DB has an identified risk of violence when unsettled and this influenced the type of intervention used and the decision to introduce the family for the final session with DB.

Motivational Interviewing was used to encourage DB to feel more positive about his imminent transfer. This work was intended and designed to prevent a relapse in DB’s mental health that has in the past led to severe self harm and hostage taking. Therefore, if this work is successful, it should help to prevent a crisis in the future.
Motivational Interviewing was identified as an appropriate intervention in this situation because DB was fully aware that he needed to modify his behaviour in order to succeed in such a setting and therefore improve his quality of life. DB has previously failed to settle in less secure units twice in the past. As DB had identified the need to change and had established a goal of living successfully in an open unit, this was considered to be an appropriate intervention. ‘Motivation for change is created when people perceive a discrepancy between their behaviour and important personal goals’ (Miller 1991:57). This outlines that when DB has identified a goal, he must recognise that he has to change in order to achieve it.

The other stages in Motivational Interviewing as outlined by Miller and Rollnick (2002) involve being empathetic, avoiding argumentation, working with resistance and supporting self efficacy. This means that motivational interviewing is a positive intervention, and is anti-oppressive in its approach as it involves working with a service user and supporting them to achieve the change that they have identified themselves.

This work with DB, if successful, would improve life opportunities as he will live in an open ward as opposed to a medium secure unit. DB will be in a less controlled environment and therefore have an increased level of self determination. DB would also have increased access to his family and to education and employment opportunities. Should this prove successful, he will increase his quality of life along with his life opportunities.

Each session was an hour and a half long. At the end of each session, DB was debriefed about it and asked if it had been helpful and appropriate and if the next planned session still seemed to be relevant to him. The family session was introduced at the end after re-evaluating DB’s circumstances. This session proved valuable in addressing behaviours that DB needs to work on which the family had identified and DB had agreed with. DB’s family have been an important asset in his care and have, in the past, recognised DB’s deterioration before professionals and so it was felt that they should be included in the work on changing DB’s behaviour.

DB stated that after the sessions were all completed he felt less anxious about the transfer to lower security settings, and more confident that he would be able to settle
in such an environment. He did state that he still felt nervous about going on the initial pre-discharge visit there and therefore, I agreed that I would come along to DB’s first visit to the open ward as requested by him for support for the first time. We agreed that this would be for the first visit only and that after that he would have to visit by himself. This was done in response to monitoring and reviewing DB’s current feelings on his imminent transfer to the open ward.

By involving DB in the initial planning of the sessions, it was always clear how many sessions were planned and when the contact with myself and the co-facilitator would end on a this particular piece of work. I therefore feel that the contact was withdrawn from appropriately, leaving DB with the sense that he had been actively engaged in the planning, delivery and closure of these sessions.

My practice teacher's feedback from DB confirmed that that was the case.

**Word count-916**


**List of contacts with DB Motivational Interviewing.**

Pre session- planning of the future sessions and what they will be about. (26/11/08)

Session 1 - Identifying appropriate goals (03/12/08)

Session 2 - What went well and not so well in the past (10/12/08)

Session 3 – What can be done to achieve the goal (17/12/08)

Session 4 – Family Session (07/01/09)

Session 5 – Debrief of previous sessions (14/01/09)
1. The identified risk was of patient GR posing further risk of physical harm/abuse to his 6 year old son. The risk assessment model used in this situation was the Static and Dynamic Model which is currently used by the probation service and MAPPA. This model identifies ‘static’ factors that cannot be changed or modified, and ‘dynamic’ factors that can be. Risk management is ‘the process devised by organizations to minimize negative outcomes which can arise in the delivery of welfare services’ (Gurney 2000:300). This means that management of identified risks is focused on areas that are ‘dynamic’ that are able to be changed.

This model of risk assessment combines both the actuarial model of risk assessment and the clinical model. It takes into account the statistical information that cannot be altered and also information gained from talking to the patient and the patient’s family. As Ryan (1996) outlines the static and dynamic model is particularly useful when looking to rehabilitate a mentally ill patient, using mental health services. Therefore, this is an appropriate model to use with this particular patient.

2. After a lengthy interview with GR’s wife, it became apparent that GR’s behaviour had had a huge impact on both GR’s wife and his son. GR’s wife has developed post traumatic stress disorder as a result of GR’s arson attack on her home. She is nervous and is fearful of mental health service in which she has little faith. She has experienced flashbacks to the night when she and her son woke up in a burning house and is extremely anxious that GR may return to the village where they live upon discharge from the hospital. GR’s son has not mentioned the fire, however has become clingy with his mum and cannot sleep without her. As according to Swenson and Ezzell (2000) clinging is an indicator of emotional abuse, it appears that GR’s son has suffered emotional abuse from this incident. Children’s services are involved with GR’s son already; however, there will need to be joint working between the hospital social work team and children’s services prior to discharge in order to effect
proper safeguards for this family. The police are aware of the situation and GRs wife’s house has been ‘flagged’ on the police computer.

GR is detained under Section 37 of the Mental Health Act 1983, in a medium secure hospital. Staff at this hospital are trained to pay attention to minimising risk to themselves. As GR is in this hospital, he is deemed as too dangerous to be amongst the public and so there are numerous hospital policies that will prevent risk behaviour. The ones of particular relevance to GR are that the hospital is no smoking and lighters and matches are contraband. This obviously minimises the risk of arson. Staff also carry their own safety button, that alerts other staff members including the specialist security team. There are also hospital policies that dictate that staff should sit closest to the door in interviewing rooms and be observed by a staff member stood outside the room. These policies are always adhered to.

3. The static factors in this case are the previous offences against his wife and child, (GR has been convicted of reckless arson. Another static factor is patient GR’s mental illness, as GR has a diagnosis of bi-polar disorder and has had for a number of years. Also his history of alcohol abuse is a static factor and GR has a long history of serious alcohol abuse.

Dynamic factors are the symptoms of GR’s mental illness, which are currently being controlled by medication and GR is currently symptom free. GR will be less likely to pose a risk to his child if he continues to take his medication after he is discharged from the hospital. Therefore, I have recommended that GR attend the ‘Mental Health Awareness’ course run by the hospital, to help him to appreciate the importance of medication. It will also be likely that, on discharge, GR will be placed on a Community Treatment Order (CTO) that may ensure that he will take his medication whilst in the community.

Another dynamic factor is alcohol abuse; this is a risk factor as at the time of the arson, GR was under the influence of alcohol. In order to minimise this risk, I have referred GR to the Drug and Alcohol misuse group. Also, GR himself recognises this risk and has suggested attending an Alcoholics Anonymous group on discharge.
Abstinence from alcohol is considered an important factor in him staying safe and well.

GR’s financial situation is also dynamic factor, as, at the time of the arson, GR had serious debts and his house was in the process of being repossessed. Therefore the arson had numerous contributing factors and so, on discharge from hospital, these factors need to be identified, addressed and managed in order to minimise risk. GR’s financial situation needs to be dealt with by services with specialist knowledge in this area, such as by the Citizen’s Advice Bureau, and GR has been advised of this. Of course, even if these dynamic factors are effectively managed, there is still a level of risk due to the static factors. However, Young (1999) points out the sole use of actuarial factors, focuses on probability and not the cause of the risk behaviour. It must be understood that historical factors, such as previous fire setting, increase the probability of future similar behaviours, but do not necessarily predict them. Dealing with these risk indicators, therefore, cannot prevent GR’s child from physical abuse from him, nor can they predict that abuse will occur in the future, but only reduce the likelihood.

4. An alternative strategy for managing risky behaviour is described in Prochaska and DiClemente’s (1983) Stages of Change Model, this strategy was rejected as the environment (the hospital) that GR is in does not allow for this model to be used. This is because GR will not be able to carry out certain stages of this model in an environment where he is exposed to some of the dynamic factors that need to be changed in order to minimise risk. For example, alcohol abuse, using the stages of change model, GR would have to contemplate changing the behaviour and have the will power to carry the change through. This would not be possible, as GR does not have access to alcohol whilst detained in hospital. Therefore such models are not appropriate in this situation.

Word Count 1,078
REFERENCES


RM approached the social work team asking how he would go about finding his son, with whom he had lost contact with since being in hospital. RM was advised that this could be done through the Salvation Army Family Tracing Service. As the first step in this process is to request the application form online and patients do not have access to the internet, I asked RM if he would like me to apply for it for him. RM agreed and I made sure RM was involved in this process by asking him to tell me what to write. The paperwork arrived and in a similar manner as I filled in the application form, filled in this on RM’s advice and wishes.

I felt it was appropriate to act as an advocate for RM in this instance as he said that he could not complete them without help. The BASW Code of Ethics (2002) guideline is to advocate when appropriate and Banks (2006) explains that effective advocacy can improve the service user-worker relationship. I felt that the completion of this task would both help the service user and improve our future working relationship. Power issues were addressed; RM does not have access to the tool that would enable him to start and complete this process by himself; he did not feel able to complete the forms himself, and therefore was disempowered. With help, RM was able to complete the process and apply to the Salvation Army Family Tracing Service to try and find his son. Therefore, advocacy is a tool which can address power issues.

The Human Rights Act (1998) states that ‘people have a right to maintain family life’ (Brammer 2007:21). RM’s rights in this case would therefore be met by him being helped to find his son. The Salvation Army family Tracing Service website explains that the person being traced ‘has the right not to be found’ (Salvation Army Family Tracing Service website). This was explained to RM. If he had applied for the paperwork himself he would have come across this and therefore it was important for this information be passed on to him in order to be honest and make sure RM was aware of the information that the Salvation Army wanted to ensure everyone tracing a family member should know.
RM’s right to family life by joint working with him was maintained by this exercise. It also used an independent advocacy service to carry out the finding of his son. Advocacy is an important role that social workers can fulfill successfully by empowering individuals to exercise their rights. I learnt that service users should take responsibility for their own needs as far as possible to avoid over reliance and disempowerment. Advocacy is also an important tool that can help to achieve a good working relationship between a worker and service user.


SALVATION ARMY (2008) *Tracing Family Members* (online) at: [http://www2.salvationarmy.org.uk/familytracing](http://www2.salvationarmy.org.uk/familytracing) last accessed: 19/12/08

Word count – 476
1. This report was written following a home visit to the sister of patient JL. The purpose of the visit was to carry out a child visiting assessment on patient JL’s niece and nephew. The purpose of the report was to produce a written record of the information obtained from the visit. It also made recommendations for further action and was used in a Multi-Disciplinary Team (MDT) meeting to inform the decision on whether or not the child visit should take place.

The report contents included: a brief overview, its purpose, the information gained from the home visit and recommendations for further action. The main body of the report contained information that supported my assessment and explained why I felt the child visit should go ahead. This included views of the patient, the parents of the children, and the children themselves, all of whom supported the visits going ahead. The report was accepted as representative of the views expressed by the people involved in the assessment by the practice teacher. In line with social work ethics that social workers must ‘record information accurately and impartially’ (BASW Code of ethics for Social Workers 2002:10).

2. This report was also a vehicle for the views and wishes of the patient and the family to be expressed, in an MDT meeting that would determine whether or not the process would continue. The family were informed that a report would be written and would be used in this way and were happy with this form of representation. The MDT decided that the process could continue. The report proved to be an effective tool that not only achieved the desired result but also involved the service users in the process. The service users were then informed that the MDT decision was positive and of the next step in this complex procedure.

This report was then filed in JL’s social work and medical files, and serves as a record of the home visit and the information obtained from it. It also serves as a record of my assessment of the situations and evidence for my decision that the visit should go ahead.
As this is a written record, it is subject to Trust policy on record keeping which states that ‘whenever a person is seen by a health or social care professional, an entry must be made in the clinical record to document this’ (X Healthcare NHS Trust 2007:9) This data is subject to the Data Protection Act (1998) and therefore, as outlined by Wadham and Griffiths (2005), must be obtained fairly and for lawful purposes, be adequate and relevant, accurate, and secured against unauthorised processing. The system in which my report was used, circulated and filed are in accordance to the guidelines outlined above and so was a lawful and appropriate way of recording of the home visit.

A way in which my practice would have been improved would have been by systematically going through the report with the service users, in order to check the accuracy and compliance with; the BASW Code of Ethics, X Healthcare NHS Trust Policy and The Data Protection Act 1998 on keeping accurate records.

Word Count: 526


Unit 18 Research, Analyse and Use Current Knowledge of Best Social Work Practice

1. My powerpoint presentation on research into the Risk of Suicide is attached to this unit. The feedback I received was positive; it was reported that I presented in a clear and confident manner, that the material was relevant and that the use of several pieces of research was good. In particular, my use of several sources demonstrated how different pieces of research may come to contradictory conclusions. This is the case with research into suicide.

The feedback also pointed out that the example used was relevant to the topic and that I had made good use of the Mental Health Act law within the presentation. The observers also noted that the historical law on suicide was interesting.

Points to improve on, as identified in the feedback, included the view that statistics on how many people attempt suicide and then go on to complete suicide, (as mentioned in slide 8 on the research done by Barak et al (2008)) would have been useful. It was also pointed out that there should have been some information relating to the critique of these studies and this was then discussed in supervision with my practice teacher.

2. In supervision, we looked at critiquing research in order to identify whether a piece of research is sound to base our practice on. We took the Barak et al (2008) research and identified that it was conducted by Israeli Doctors and does not explicitly state where the research was conducted. It was noted that Israeli Doctors may have different ways of diagnosing Schizophrenia or different criteria for hospitalisation than UK or other doctors. This discussion raised the idea that concepts of what constitute 'mental health', 'schizophrenia' etc are culturally based and not fixed as physical illness diagnoses are. This is a basic idea behind culturally sensitive practice and it also raises the question of why certain groups (e.g. young black men) have higher levels of diagnosis of schizophrenia and other serious mental illnesses.

I have learned to appreciate that research is not 'proof' and that data can be interpreted in different ways. Anti oppressive practice dictates that we should be aware of the negative stereotyping which racism, sexism etc lead to and also be aware that the
same racism etc will cause negative life experiences which, in themselves, will lead to
greater levels of depression and hopelessness and so to higher levels of suicide..

Suicide remains a major problem in the UK and the use of actuarial tools is proven to
be helpful in identifying levels of risk (Siris 2001). Therefore, when doing a risk
assessment, it is important to be aware of these factors and assess accordingly. In
cases where a person is threatening suicide, it is important that the threats are taken
seriously. The threat of suicide, if accompanied by a mental disorder, is enough for
detention under the Mental health Act 1983 under the criteria of ‘in the interests of
his or her health or safety’.

Word Count 494

BARAK et al (2008) Suicide Attempts of Schizophrenia patients; A Case Controlled

127-135
An example from my practice where ethical dilemmas were managed is the assessment process leading to patients being granted unescorted leave. In particular, this was managed when patient JL was ready to commence his S17 (Mental Health Act 1983) unescorted leave. This was because JL had been convicted of a violent offence against a member of the public. Patient JL had been on numerous escorted leaves without incident and was on the rehabilitation ward, prior to a move to lower security. Therefore, he was considered by the Multi Disciplinary Team for unescorted community leave.

This was an ethical dilemma as JL wanted to commence his unescorted leaves (Self-determination) however, this had to be considered carefully in order to ensure public safety (utilitarianism). The dilemma is, therefore, self-determination versus utilitarianism.

Social workers have a duty to ‘show respect for all persons, and respect service users’ beliefs values, culture, goals, needs, preferences, relationships and affiliations.’ (BASW Code of Ethics (2002:2)). This means that self-determination; respecting the goals, needs and preferences of a service user, is a social work duty according to the BASW Code of Ethics. Utilitarianism is also important when assessing for unescorted leave for patients from secure units. Public safety is an issue of high importance. As Teichman and Evans (1999) explain, utilitarianism is concerned with the outcome that produces the most happiness for the most people; in this case, this may lead to unescorted leaves not being granted. Therefore, in order to make a decision, both arguments need to be carefully considered. ‘To act ethically requires us to balance our values, goals and responsibilities before we can make an all things considered decision.’ (Bowles et al 2006:205). This outlines that all factors need to be taken into account when making such a fundamental decision.

The assessment should lead to a course of action which maximizes the patients liberty and self determination whilst protecting the public from harm. Therefore the decision is a strategic one that formed a strategy. It was decided that the first unescorted leave, should be only 20 minutes long and be in local area. Another strategy was to only
allow patient JL to carry a small amount of money, to prevent him from absconding. Also, because the conviction was more than 3 years ago and there have been no violent incidents since and no problems whilst on escorted leave patient JL should be granted unescorted leave. It was agreed by the MDT, including myself, that this strategy would be effective and leave was granted.

On reflection, I feel that this decision was made considering both the self determination of the service user and the consideration of utilitarian principles to protect the public. Both arguments were raised in the MDT, carefully examined and a decision made with strategies in place to minimise any risk to the public, whilst allowing the service user to demonstrate his self determination in this situation. In this setting, public protection is a paramount consideration, service users views and requests must be considered and this exercise demonstrates how both can be managed.

**Word Count: 510.**

**REFERENCES**


Direct Observation Assessment Report 1

Student: LJ
Practice Teacher: DC

Situation:

Patient G was recently convicted of deliberate fire setting in the home shared with his partner and six year old child. The offence was accepted to have been psychotically driven and the matter disposed of at court by way of a hospital order under Section 37 of the Mental Health Act. The fire raising offence was the culmination of a series increasingly risky and abusive behaviours exhibited by G and his partner has decided that the relationship should not continue as she feels that her own and her child’s safety could not be guaranteed should she choose to continue living with him.

As part of the information gathering process which will lead to the preparation of a lengthy and detailed social work report, LJ and myself visited and interviewed Ms G at her new home. The purposes of the visit were as follows:

1. To establish and make a record of Ms G’s experience.
2. To address risk issues, in particular child protection issues which are raised by this event.
3. To consider information gained from this piece of work alongside other information sources to inform risk assessments and other judgments about the patients future needs when he is considered fit for discharge from this hospital.

The observation was particularly focused on L’s ability to establish and maintain a proper relationship and environment for a difficult and complex interview to proceed, to question effectively using open questions, to demonstrate active listening and respond appropriately and sensitively to answers given, to be able to consider, analyze and discuss the interview afterwards in order to form opinions which would be contained within a report at a later stage.

4. Those present were LJ, Student Social Worker, X Hospital, DC Principal Forensic Social Worker X Hospital, Ms G, Ms K, (Ms G’s sister who attended to offer her support.)
5. **Positive Aspects of Practice.**

LJ’s performance was, once again, of a very high standard. L demonstrated her ability to introduce herself and the piece of work clearly and properly, explained to Ms G’s full satisfaction that this was “a safe place” in which to discuss such sensitive matters and, most notably, L was able to ensure that this woman did not feel that the purpose of the visit was in any way coercive (she stated that she feared that the purpose of our visit was to make her reconsider her decision not to continue her relationship with patient G.)

L presented herself as knowledgeable engaging and interested; she covered the agreed subject areas thoroughly and without any prompting from myself. It was a mark of the progress that L has made over the last four months, that she was able to structure her interview properly and effectively with excellent active listening. L demonstrated this by effortlessly following lines of enquiry which were not predicted prior to the interview but were raised by Ms G. It was clear that L’s interviewing technique allowed Ms G to relax and speak openly and clearly.

Ms G’s sister, Ms K, was keen to add clarification and further detail where she thought it necessary. Ms K was clearly a well informed and well meaning family member and L skillfully allowed her to contribute whilst ensuring that she did not dominate the interaction.

6. On occasions where matters about which L was unclear arose, L very properly requested and received guidance from myself before resuming control of the interview and continuing unflustered.

In the preparation for this piece of work, I had suggested that L might continue with the interview for twenty minutes. In the event, L maintained the interview for almost an hour. I considered that an outstanding achievement and told her so after the interview had been completed.

7. This piece of work demonstrated to me that L has learned very effectively during this placement; her innate brightness and enthusiasm have been apparent since the beginning, but her ability to learn, both technically and theoretically, is equally apparent. Areas of technique which I have attempted to teach L, such as interviewing prompts and understanding of how a social worker in an interaction should be aware of their
presentation, the use of open questioning, the following up of prompts from the interviewee, etc were all displayed effortlessly and skillfully during this interaction.

8. **Areas for Further Development**

As noted in the report of the previous observed practice, L continues to strike me as a fast and able leaner who is developing visibly into the role of a professional social worker. That role is one which, I have no doubt, she will fulfill with ease.

L’s areas for further development, in this and other areas of her practice, will all be easily met by further experience.

L is clearly at the point where she is moving from “a trainee” to being “a practitioner” and I have no doubt that she has the range of skills necessary to continue that development in the future.

This piece of work demonstrated no areas where L lacks competence which would require urgent attention in the remainder of her placement here.

9. **Reflection**

As previously noted, L is able to reflect and criticize her own practice. One of my few criticisms of her, remains, that she is not as able to recognize the high quality of her practice as she, by now, should be.

DC  
Principal Forensic Social Worker/ Practice Assessor/ Work Based Supervisor
Direct Observation Assessment Report 2

Student: LJ

Practice Teacher: DC

Situation:

Patient G was recently convicted of deliberate fire setting in the home shared with his partner and six year old child. The offence was accepted to have been psychotically driven and the matter disposed of at court by way of a hospital order under Section 37 of the Mental Health Act. The fire raising offence was the culmination of a series increasingly risky and abusive behaviours exhibited by G and his partner has decided that the relationship should not continue as she feels that her own and her child’s safety could not be guaranteed should she choose to continue living with him.

As part of the information gathering process which will lead to the preparation of a lengthy and detailed social work report, L and myself visited and interviewed Ms G at her new home. The purposes of the visit were as follows:

6. To establish and make a record of Miss G’s experience.

7. To address risk issues, in particular child protection issues which are raised by this event.

8. To consider information gained from this piece of work alongside other information sources to inform risk assessments and other judgments about the patient’s future needs when he is considered fit for discharge from this hospital.

The observation was particularly focused on L’s ability to establish and maintain a proper relationship and environment for a difficult and complex interview to proceed, to question appropriately using open and appropriate questions, to demonstrate active listening and respond appropriately and sensitively to answers given, to be able to consider, analyze and discuss the interview afterwards in order to form opinions which would be contained within a report at a later stage.

9. Those present L (Student Social Worker), X Hospital, DC Principal Forensic Social Worker X Hospital, Miss G, Miss K, Miss G’s sister who attended to offer her support.

L’s performance was, once again, of a very high standard. L demonstrated her ability to introduce herself and the piece of work clearly and properly, to explain to Miss G’s full satisfaction that this was “a safe place” in which to discuss such sensitive matters and, most notably, L was able to ensure that this woman did not feel that the purpose of the visit was in any way cohesive (she stated that she feared that the purpose of our visit was to make her reconsider her decision not to continue her relationship with patient G.

L presented herself as knowledgeable engaging and interested; she covered the agreed subject areas thoroughly and without any prompting from myself. It was a mark of the progress that L has made over the last four months, that she was able to structure her interview properly and affectively with excellent active listening. L demonstrated this by effortlessly following lines of enquiry which were not predicted prior to the interview but were raised by Miss G. It was clear that L’s interviewing technique allowed Miss G to relax and speak openly and clearly.

Miss G’s sister, Miss K, was keen to add clarification and further detail where she thought it necessary. Miss K was clearly a well informed and well meaning family member and L skillfully allowed her to contribute whilst ensuring that she did not dominate the interaction.

6. On occasions where matters about which L was unclear arose, L very properly requested and received guidance from myself before resuming control of the interview and continuing unflustered.

In the preparation for this piece of work, I had suggested that L might continue with the interview for twenty minutes. In the event, L maintained the interview for almost an hour. I considered that an outstanding achievement and told her so after the interview had been completed.

7. This piece of work demonstrated to me that L has learned very affectively during this placement; her innate brightness and enthusiasm have been apparent since the beginning, but her ability to learn, both technically and theoretically, is equally apparent. Areas of technique which I have attempted to teach L, such as these prompts, and understanding of how a social worker in an interaction should be aware of their
presentation, the use of open questioning, the following up of prompts from the interviewee, etc etc were all displayed effortlessly and skillfully during this interaction.
1) **Situation**

Patient A is a three times convicted child sex offender who has been transferred from the prison system into this hospital under Section 47/49 of the Mental Health Act 1983 (transfer direction in respect of a convicted prisoner).

Patient A suffers from bipolar disorder and has been treated in this hospital for a little over a year. It is the opinion of his clinical team that he is now stable enough to be transferred to a Low Secure Unit where he can complete the Sex Offender Treatment Programme (SOTP) under hospital conditions rather than being returned to prison to complete this work.

Patient A is known to the Multi Agency Public Protection Panel (MAPPP) and is subject to consideration under the Multi Agency Public Protection Approach (MAPPA).

Concern has been expressed by MAPPA members that his high level risk to children and young people renders a move to a Low Secure Unit inappropriate. As a result, MAPPA referred this patient for an independent assessment of his sexual risk to the Lucy Faithful Foundation, and organization which undertakes independent sexual offending and risk assessments on behalf of the Ministry of Justice and the Probation Service.

Prior to the formal assessment taking place, a number of paper assessments need to be completed and I agreed to do them on the Lucy Faithful Foundations behalf.

Such is my faith in L's ability, that I readily agreed to her completing this very complex and sensitive piece of work.

2) **Aim of Intervention**

The aims of this piece of work are numerous and complex:

1) To establish an appropriate relationship with the patient to allow for open and unembarrassed discussion of complex professional issues including the sexual abuse of children and the sexual attitudes of the patient.
2) To do so with sensitivity to the patients individuality. In this case, the patient is a British born Bangladeshi Muslim, an individual with a long term and severe mental illness and a multiply convicted abuser of children.

3) As discussed and preplanned, this piece of work was an opportunity to observe communication skills, the ability to give and receive information, to demonstrate an ability to be open and honest about the purpose of the assessment and the fact that the eventual outcome of this process lies in the hands of others.

    Additionally, this was an opportunity to demonstrate an ability in active listening and relationship building.

3) Those present; patient A, LJ (Student Social Worker), DC (Principal Social worker).


    L’s performance in this piece of work was exceptionally good.

    1) L rearranged the furniture in the room to ensure that the physical environment was both safe and appropriate to the needs of the interaction.

    2) L explained the purpose and the format of the interview clearly and precisely and offered the patient the opportunity for feedback and any questions he might have before the piece of work began.

    3) L was sensitive to the immense stress that this piece of work engendered in the patient and very skillfully put him at ease before commencing. In particular, L offered the patient the opportunity to complete the piece of work in shorter sections, to take a break whenever he so chose and was warm, supportive and appropriate in her manner.

    4) L’s posture, tone of voice and the pace at which she conducted the interview were all completely appropriate, demonstrating an ability to present herself as both authoritative and warm.
5) L had clearly done good quality preparatory work; she was fully aware of the patient’s history and needs, the background and purpose of assessment and its role in a wider, very complex process.

5) This piece of work had been completed following a detailed preparation. The competencies described above had been identified and agreed and the way in which they would be evaluated was determined.

6) It was agreed that L would be evaluated on her ability to present herself as a knowledgeable and skillful practitioner with an ability to research and prepare for a piece of work and to demonstrate an ability to open an interview, maintain it over a lengthy period and close it in a proper way.

Particular attention had been given to the skills of self presentation both in terms of posture, physical approach, appropriate gestures and eye contact, pauses for thought and supportive comments and the resumption of the interview after such a break.

As agreed, I sat slightly away from L and patient A allowing me to observe her closely whilst not interfering with her interaction.

7) **Positive Aspects of Practice**

As mentioned previously, L completed this task at a very high level.

1) This was L’s first experience of interviewing in complex and difficult areas (in particular issues of sexuality and sexual abuse) and her ability to address these matters in a neutral, non judgmental and open way was extremely notable.

L had taken on board all that we had discussed about herself presentation skills; her judgment on the layout of the room was exactly right, her posture tone of voice gestures and both verbal and non verbal prompts allowed the interview to flow without disruption. Equally, on a number of occasions, the patient became flustered and confused. L was both tactful and skillful in offering a breathing space, re asking the question and being warm and supportive until the interview was back on track. The patient involved is a notoriously difficult
person to deal with and I was extremely impressed by L’s skilful handling of him.

2) The interview, consisting of some 100 questions, focused on sexual attitudes and matters related to child sexual abuse. I was immensely impressed with the way that L tackled these matters without any visible loss of composure; L’s authoritative presentation, her firm clear voice and the absence of “giveaway” gestures allowed the patient to be honest and clear in his responses. There was no speeding up or attempts “sidetrack” on the more difficult topic areas; L approached comparatively banal subjects and those of a highly sensitive nature in an equally skilled way.

Equally, L, once again, demonstrated her ability to put previously discussed and taught techniques and approaches into practice extremely quickly.

At the beginning of this placement, L and myself did some work on basic interviewing and interactive techniques. L’s first attempts at complex interviewing were faltering and unconfident. With very little practice, she has assimilated different approaches into her own style and, after around 20 interactions of various levels of complexity, is now clearly able to interact confidently, with a marked level of skill. Increasingly, in her own style.

8) **Areas For Further Development**

As noted previously, L is an exceptionally fast leaner. In all areas of her practice, she has developed skills, become more confident and is visibly growing into the role of a professional Social Worker. The remainder of the placement will offer ample opportunity to continue to develop her skills in this and other areas and this development will continue to be the focus of regular formal supervision as well as ongoing day to day discussion of her progress.

9) **Reflection**

L is more than able to reflect on her own practice and, if I were to have a criticism of this, it would be that she tends to be overly critical and has a tendency not to appreciate how well she is performing.
In formal supervision, L is quite able to raise issues, look critically at herself and challenge and disagree with me.

In day to day joint work, L is critical both of her own practice and style and, increasingly of those her around her including myself. I consider this to be a very positive feature of this placement.

Signature:

DC, Principal Forensic Social Worker
Date:
Designation Practice Assessor/Work Based Supervisor
Direct Observation Assessment

The aims of the session (in accordance with the national occupational standards) were to establish a professional relationship with the service user. I began by explaining my role and what I was going to do. I felt that this went well as the service user understood from my instructions what was going to happen, how many questions would be asked, and the scale used for the answers.

Another aim of the session was to be non-judgemental. The service user was a Bangladeshi Muslim, has a mental illness of bipolar disorder, and has been previously convicted of sexual abuse of a child. The session’s main aim was to explore issues of sexual attitudes of the service user and to ensure that I maintained respect for the service user and enable there to be an honest and non-judgemental forum to feel comfortable to discuss sensitive issues about his sexual attitudes. I feel that I achieved an open environment for this to occur as the service user seemed to feel comfortable and also seemed to answer honestly. I also felt comfortable discussing these issues, which before the session I was slightly worried about and therefore this aspect of practice went better than expected.

The aims about demonstrating communication skills also seemed to work well, as I believe that the service user felt relaxed in his answers of the sensitive questions, which I don’t think would have occurred if the communication skills weren’t exercised properly. I also feel that suggesting breaks and letting the service user know how many questions were left also contributed to the success of the communication demonstrated throughout.

There were no unexpected problems as such, however, the service user sometimes found it difficult to decipher whether his response to the statement meant he agreed to it or not, and so in these cases the statements had to be broken down and worked out with the service user appropriately.

Overall, I think the whole session went well, however, think that the termination of the session could have been better, as I failed to point out to the service user how well he had done in answering so many difficult questions and therefore this was done by
my practice teacher. Therefore in future sessions I will endeavour to end the sessions appropriately and thank the service user for their time and contribution.
I also feel that as professional relationships build up, it will become easier to have sessions with the particular service user and build upon the trust, honest and safe environment to talk about sensitive issues.
LJ Placement Report

Statement of Competences

Unit 3 Assess Needs and Options to Recommend the Course of Action

L has clearly demonstrated her ability to make good quality, clear and appropriate assessments and recommendations.

This ability is illustrated as follows;

1. Visit to patient to JL’s sister and her family to assess whether the children should visit JL in hospital. The assessment was a “best interests” assessment and took place under the Regulations for Child Visits to Secure Hospitals (Fallon).

L referred to many sources of written information, very properly interviewed the patient and his sister, reminded herself of the relevant sources from Policy Procedure and Children Act 1989 and produced a brief and precise written report recommending that the contact go ahead. Subsequently, L made a formal referral under Section 17 Children Act 1989 to X Social Services.

Also, L has completed numerous pieces of work which also illustrate her high competence in this area.

– Patient GR, also interviewed for child contact. Interviews with patient GR, his estranged wife JR and her sister, brief contact with child K. L concluded (properly) that there are numerous and complex child safeguarding issues and her recommendation was that child contact not be proceeded with at this stage.

– L completed a Carers Assessment on DL. It concluded that family work would be appropriate and referred the matter on.

Sources

Direct observation, discussed in supervision, discussed (with myself present) with the service user who received a copy of her assessment and recommendations.

This unit is passed to a very high standard.
**Unit 4 Response to Crisis Situations**

L took part in a post incident assessment when patient DL was found with a ligature around his neck. This emergency multi-disciplinary meeting assessed the situation, including the patient's mental state, actual risk of suicide and what action was necessary to protect the patient from further harm. L involved herself in this discussion between senior professionals (Consultant Psychiatrist, Senior Nurse, Psychologist, myself etc). L was clear precise and objective.

Source-direct observation, subsequent discussion at supervision and very positive colleague feedback.

- L dealt with a telephone complaint from a patient AS’s mother. Mrs S had received an abusive letter from patient AS and was angry and upset about it. L very patiently listened to her complaint, offered her sympathy and apology for the upset and proposed a response to the situation which was subsequently accepted by the General Manager of the hospital.

Source-direct observation and feedback from senior member of staff.

- L took part in a Multi Disciplinary team discussion following a violent incident between two patients and acted as the Social Work member of the team that devised the subsequent management plan. –Sources: direct observation, discussion at supervision and colleague feedback.

Unit passed to an extremely high standard. Senior colleagues within the hospital, including Consultant Psychiatrist and Senior Managers, have commented on L’s ability in this area. Similar comments will be apparent in this area. Similar comments will be apparent through this report.

This unit is passed to a very high standard.

**Unit 5 Interact With Individuals Families Carers Groups and Communities To Achieve Change and Development and to Improve Life Opportunities**

Once again, L has demonstrated a very high level of commitment and competence in this area.
From the outset of this placement, L demonstrated her keenness to work in a wide variety of settings and with as varied a groups of service users, carers etc as possible. Her communication skills have always been good but the level to which they have improved over this placement is outstanding.

L took part in complex and difficult family work with the family of the patient SA. SA is an African Caribbean British man who committed a very serious knife attack on his elderly mother. A series of group sessions has been ongoing with his family, parents and adult sisters. The work started before L’s placement began and she joined the process on the third visit. L was able to interact very skillfully with this family, aware of the deep trauma they had suffered. At discussion in supervision following this, L was able to display her sensitivity to issues of race and disability (the elderly mother is severely harmed by the attack).

L completed a interview with JR (wife of patient GR and victim of his arson act along with her child). L’s approach to the interview was outstanding, much work had been completed on the technical side of interviewing, including posture gesture tone and rhythm of voice etc along with proper framing of questions and appropriate responses to answers. The intention was that L would maintain her part of the interview for around 15 minutes and cover the less contentious areas. In the event, L interviewed this woman for an hour and questioned her in depth about the trauma of a life threatening event, its emotional impact and ongoing effects and the child protection implications and her own future emotional needs.

It is not an exaggeration to say that I considered this to be one of the most impressive pieces of student work I have observed.

Other pieces of work which illustrate L’s interactive skills include:

– Discussion with patient TD following his recall to hospital under Section 42 Metal Health Act 1983. L very appropriately and skillfully discussed the series of events, the process of recall and the emotional effect of a return to hospital, with a patient who was clearly upset and angry. L was considerate and warm; her approach allowed patient TD to express his feelings of anger and remorse without becoming in any way aggressive. This was a very skilled interaction.

Source direct observation, subsequent discussion at supervision and positive feedback from service user.
– L’s first piece of work on this placement was a telephone interview with patient MH’s ex partner to complete a DLA form. The piece of work was undertaken with clarity and sensitivity to the issues of disability. At the time of the interview, under direct observation, I was struck by L’s sensitivity and kindness. However, it is illustrative of the extent to which L has developed in this placement that this piece of work was not particularly impressive.

L’s competence in this area has been demonstrated by direct observation, and the liturgical discussion at supervision and feedback from services users.

The unit is passed to an extremely high standard.

**Unit 6 Prepare, Produce, Implement and Evaluate Plans With Individuals, Families, Carers, Groups, Communities and Professional Colleagues**

From the beginning of the placement, I have stressed the importance of preparation for any piece of Social Work. I have stressed the need to read all available written records, to consider possible outcomes, and, so far as possible, to have a clear view based on solid knowledge and assessment. As in all other areas of her practice, L has demonstrated her very notable competence in this area.

Towards the beginning of the placement, L represented myself in a planning meeting with the Social Worker of patient TD following his recall to hospital. L prepared for the interaction and was knowledgeable about the case, she had successfully interviewed the patient (see previous unit) and I was confident of her ability to represent our department.

My colleague AG reported back that L was fully competent and (as has become a common theme during this placement) he noted how impressed he had been with her.

L took an active part in the planning for patient DB to be transferred to an open rehabilitation hospital. DB is a potentially a very dangerous patient with convictions for attempted murder and rape. L negotiated with the patient’s family, professional groups from the accepting hospital the local police Dangerous Persons Unit and the community social worker who was to act as care coordinator. In addition, L attended a MAPPA meeting which considered the public protection implications of this move.
L’s excellent preparation, her ability to communicate and interact with people at all levels, her keen interest in process and her commitment to the needs of the patient were all illustrated by this extremely complex piece of work.

Obviously, L’s involvement in such a complex piece of work was completed under close supervision but, at no point, did I have to intervene or challenge her assessment of how to proceed.

Direct observation, discussion at supervision.

L was involved in the process of consideration as to whether a patient JL should be granted unescorted leave (Section 17 Mental Health Act 1983). Patient JL has been a hospital patient for 2 and half years and prior to that was in prison for a similar period. Therefore, even a brief period of unescorted leave required careful consideration.

L represented the social work view at the MDT discussion, she discussed the matter with patient’s family and was able to consider the needs of the local community, including public safety.

From direct observation, discussion at supervision, feedback from the patient’s family and from fellow professionals all indicate a very high standard of competence.

This unit is passed to a very high standard.

**Unit 9 Address Behaviour Which Presents a Risk to Individuals Family’s Carers Groups and Communities**

This Unit has been met to a very high standard and may be illustrated by the following:

L completed a pre screening for sex offender treatment program on patient AU. AU is a three times convicted child sex offender who suffers from bipolar disorder. It is proposed that AU be transferred to a lesser Secure Hospital to complete Sex Offender Treatment Programme with a view to requesting release from an indeterminate sentence (IPP). Prior to his transfer, MAPPA insisted that an independent pre screening take place. L completed this by interviewing the patient using a screening tool. Prior to this very complex piece of work, L prepared by reading all this patients notes, by researching the nature of the sex offender treatment programme and by discussion with other members of the multi-disciplinary team responsible for his care.
The original plan that she complete a small part of this piece of work was unnecessary as L completed the task by herself without additional input from myself.

This piece of work was completed with great sensitivity to anti-oppressive practice. AU is a Bangladeshi Muslim who suffers from bullying within the hospital on the grounds of race and also on the grounds of his status as a child sex offender. These issues were discussed with L in advance and she very clearly displayed her ability to detach herself from her negative feelings towards sex offenders and be sensitive to the issues of race, culture and religion which were raised with this patient.

I considered her performance in this piece of work to be outstanding.

Sources – Direct observation, discussion and analysis during supervision, and service user feedback.

In the case of GR (patient who has been convicted of an offence of Reckless Arson against partner and child). L has shown her ability to address risk behaviour.

L’s assessment of this case involved gaining a full knowledge of the facts of the case by pre reading, very full and detailed interviews with the patient, his partner and her sister, discussions with other members of the Multi-Disciplinary Team, discussion with the community based Social Worker/Care Co-ordinator, the production of a report and its subsequent presentation to the Multi-Disciplinary Team.

Once again, L’s performance in this task was outstanding.

Sources – direct observation, discussion and analysis in supervision, feedback from fellow professionals, feedback from carers, and feedback from service user.

In the case of DB, L attended a MAPPA meeting which considered the public risk implications of this patients move from Medium Secure care to an Open Rehabilitation Unit prior to the meeting, L fully briefed herself on the case by access to written records and discussions with fellow professionals involved in the case and she was able to discuss and analyze the issues raised by it in subsequent discussion at supervision.

Sources – supervision, direct observation.
In case of patient N, L accompanied myself on an assessment under Section 2 of the Mental Health Act on a previously admitted patient of Rotherham General Hospital Mental Health Unit. This patient had been admitted informally following a severe depressive episode. This patient has a previous history of self harm and suicide attempt.

Prior to the assessment, I was able to discuss with L the nature of a risk of suicide assessment which covered areas such as actuarial risk and the impact of affective disorder on the risk of suicide.

L was able to assess and identify the high risk of harm to this patient and, further, to identify a risk requiring the protection of others (criteria of Mental Health Act 1983) to his Mother.

It was notable that L was somewhat distressed by this assessment, it involved a patient in a high level of emotional and mental stress. In a following ‘debrief’ L was able to express her personal distress and work through it in a way which will allow her to deal with very complex and difficult pieces of work in the future, given proper supervision and guidance.

This unit is passed to a very high standard.

**Unit 10 Advocate With and on Behalf of, Individuals, Families, Carers, Groups and Communities.**

In the case of RM, L responded to a request from patient RM to act on his behalf in tracing his son of whom he has had no contact since his admission to hospital some 2 years ago. L interviewed patient RM and formed the view that he lacks the ability to proceed with a tracing service offered by the Salvation Army. After discussion, L was clear that acting on RM’s behalf would not disempower him but allow him to meet his needs with help. We discussed the fact that the use of help is not necessarily disempowering and we used the example of wealthy people’s use of accountancy and legal services in the management of their own affairs.

In L’s interview with patient RM, she displayed great sensitivity to his needs and did not patronise or demean him in any way. The request for a tracing service was completed successfully and, at the time of writing, we await its outcome.

As previously noted, L completed a DLA application form on the behalf of patient MH’s ex-partner. This piece of work was completed to a good standard.
In the case of patient MH, L liaised with the housing department on the patient’s behalf, to secure his possessions prior to the termination of his tenancy on the grounds of long term hospitalisation. This piece of work was complicated by the fact that MH’s Mother, his primary carer, vehemently disagreed with the decision to give up the flat despite the fact that he is accruing considerable arrears because he is at the end of his housing benefit entitlement period.

L successfully took instruction from patient MH, formulated a plan of action with him, discussed this with his Mother who (in my opinion quite unreasonably) disagreed, discussed the case at a wider level within the multi disciplinary team and proceeded on patient MH’s behalf.

Sources are from direct observation and patient feedback.

Patient AU was the subject of a Mental Health Review Tribunal at which he asked for support for a move to conditions of lesser security in the face of opposition from the probation service, the police and other agencies represented at MAPPA. L was involved in the preparation of a statement to the Mental Health Review Tribunal detailing both the patients views and those of his family.

Source – direct observation and supervision.

Patient D is a chronically Schizophrenic individual convicted of a serious arson with intent at an HNS hospital. Patient D’s only contact in the community is a friend R, with whom he has had a long standing emotional and sexual same sex relationship. In the past, ‘concerns’ have been raised about this relationship. L was able to identify that the relationship was a positive factor in the patient’s life. This was argued at The Multi-Disciplinary Team meeting and L was able to arrange a visit between the two on Christmas Eve.

Sources – Direct Observation, discussion in supervision, discussion in Multi-Disciplinary Team meeting and patient feedback.

This unit is passed to a very high standard.

**Unit 11 Prepare for and participate in decision making.**

L has prepared for and delivered clinical arguments based on social care principles to a wide variety of meetings.

For instance, L presented the social work report to patient GR’s CPA meeting. This involved research of the case, her considerable work
in interviewing the patient and members of his family, her work on
the child protection issues generated by the case and her
discussions with outside agencies. L’s presentation was well
researched, clear and precise and formed the basis of the patient’s
care plan for the next six months.

Source – Direct observation and very positive feedback from
professional colleagues.

L has attended and presented to the hospital ‘bed management’
meeting. This is a meeting of the senior staff within the hospital
which, amongst other things, makes decisions about admissions
and discharges from the hospital. L’s presentation was clear, precise
and based on good knowledge and understanding.

Source – Direct observation and feedback from senior colleagues.

L has been party to two assessments under the Mental Health Act
1983. In both cases L was expected to take an active part and
express her views on the outcome of the assessment. Whilst, clearly
L was not able to dictate the outcome, she was very able to express
a clear and well informed opinion.

Source – Direct Observation.

As a student social worker, L is obviously limited in the decisions
she is able to make. However, it is clearly the case that she is a
quite capable and confident decision maker whose assessments and
opinions may be relied on in her future carer.

This unit is passed to a very high standard.

**Unit 12 Assess and Manage Risks to Individuals, Families,
Carers, Groups and Communities.**

Given the nature of the social work role in a medium secure mental
health unit, much work has been specifically focused on risk
management.

Formal teaching sessions have taken place on the use of risk
management models and tools which inform objective assessment
of risk to others. In particular, there has been considerable time
devoted to consideration of the ‘Static and Dynamic’ model of risk
assessment which underpins the probation service/MAPPA system,
‘OASYS’. L has used this model to assess the risk of a number of
patients and situations.
In addition, all our patients are assessed using the HCR-20 which considers risks in historical, clinical and risk categories. L has proved herself quite capable to use and understand this model effectively. Also, in supervision and general discussion, we have discussed the use of actuarial approaches, in particular to the risk of suicide. L was able to note that suicide risk is higher in groups of individuals such as young males, the poor and those with mental health and substance misuse problems. This model was used in practice during the Mental Health Act assessment on patient N.

Further specific work was completed on the increased risk of violence in acutely psychotic, disturbed patients. We have used resource sources to confirm that acutely paranoid patients present a vastly increased risk of violence and the ways in which the increased risk to those working with such patients may be managed. This has included “keeping safe” work to ensure the maximum chance of escape if a difficult and dangerous situation is encountered professionally.

L has successfully completed “breakaway” training within the hospital along with “De-escalation” training which seeks to manage potentially violent situations from the earliest stage.

L has been taught and clearly understands the need to have a full and working knowledge of a patient’s behavioral history in order to properly assess the riskiness of a situation. L has reviewed previous conviction records, contacted and discussed cases with child protection registries and has discussed risk issues with several patient families including patients SA and GR.

L has discussed risk issues through interview with patients themselves, their carers, community based staff with previous knowledge of the patient and groups (such day centers), with whom the patient has had previous contact.

Examples include, preparation and review of risk assessment in the case of patient GR. This included consideration of the service user’s risks to children, domestic violence, and alcohol related community based violent action. In the case of patient AU, L has completed assessment of his risk of child sexual abuse, of his risk of suicide and of the risk that he himself will be bullied. A risk assessment was completed by L in the case of patient DB covering risk of child abuse (physical, emotional and neglect), of the risk of further sexual offending against adult women, of violence, and of suicide and self harm.
At multi-disciplinary team meetings, CPA meetings, MAPPA meetings and discussions with outside agencies.

L has demonstrated very clearly her understanding of risk issues and the use of care plans, management plans and the like, to address such risks.

Sources direct observation, supervision, feedback from colleagues.

This unit is passed to a very high standard.

**Unit 13 Assess, Minimize and Manage Risk to Self and Colleagues**

Much of this unit is covered in Unit 12. As discussed in Unit 12, L has undergone direct teaching on safe working, she has completed breakaway training, she has completed training on de-escalation technique and, further, we have completed two “post incident analyses” of incidents which led her to feel personally unsafe.

In the case of patient A, L felt personally threatened when this young man approached her very inappropriately, invading her space and behaving in a manner which appeared threatening. Patient A suffers from Asperger's Syndrome and psychosis and his behaviour is generally bizarre and unsettling. L was able to express her personal feelings whilst noting that the behaviour was very unlikely to be a precursor to assault. L dealt with the situation very well and my advice to her was to always act on instinct and remove oneself from a situation which feels unsafe.

Patient NR is a sufferer from a particularly severe form of schizophrenia which expresses itself in aggression and, not uncommonly, acts of violence against staff. Patient NR approached L and myself and loudly and vociferously expressed delusional beliefs alongside quite intense anger. Along with myself, L felt at risk of assault.

Following this, we discussed the matter in detail and L was able to be open and honest about her fearfulness. At the time of incident, L followed the practice guidelines she had learnt in training and removed herself from the situation for which I commend her. I have stressed the fact that inexperienced staff are more likely to feel in some way “responsible” to remain in alarming situations and I have commended her for removing herself in the way that she did.

Sources direct observation, supervision, training.
This Unit is passed to a high standard.

**Unit 16 Manage, Present and Share Records and Reports**

L has made numerous entries on RIO (the NHS Mental Health recording system). These entries have been clear precise and appropriate from the outset and, along with every other area of L’s practice, have improved markedly in the course of this placement.

As previously noted, L has shown a notable ability in the consideration of previous written reports which inform her own assessments and her presentations.

L has completed high quality written reports in the cases of patient JL and GR. These reports have been formally circulated within the hospital and presented at decision making forums such as CPA and Multi-Disciplinary Team meeting.

In the preparation and use of information, we have discussed in detail the implications of the NHS Forensic Trusts regulations on records, confidentiality and the like. In addition, L has displayed her knowledge and understanding of the Data Protection Act and general principles of confidentiality, fairness and commitment to anti-oppressive practice when making and sharing records. L has, on many occasions, presented the weekly social work notes to the Multi-Disciplinary Team meeting. These have been completed with precision and clarity.

Sources-direct observation, supervision, feedback from colleagues.

Unit passed to a good standard.

**Unit 18 Research, Analyze and Use Current Knowledge of Best Social Work Practice**

L has a broad and impressive knowledge and understanding of current Social Work Practice which, it has to be said, outweighs my own.

Examples include: use of actuarial data in risk of suicide (see previous units), a good knowledge of anti-oppressive practice which includes a good understanding of the nature of the myth of “race”. L has been a regular reader of Community Care during this placement and was able to discuss the featured articles in detail, L has used the opportunity of working in a hospital with an academic library, including a broad Social Work section, to good effect, she has read, understood and been able to discuss in detail the considerations and
recommendations of the Fallon report which underlines our Child Visiting Process, was able to discuss the BASW guidelines on mental health and Code of Ethics, L has also had contact with a specialist Sex Offender Assessment Organization (The Lucy Faithfull Foundation) and has thoroughly researched the matter prior to her own piece of work. In particular, L is possibly one of a very few Student Social Workers who has a good working knowledge of Friends Courtship Disorder Model (1990) (it was certainly new to me!). L treated me to a teaching session on this very interesting subject.

Further, L was able to discuss and quote from the serious case review in respect of child A (“Baby P”). L attended a training session for AMHP’s on the final stage of implementation of the Mental Capacity Act/Deprivation of Liberty Regulations. L has attended the Safeguarding Forum at the Social Work Department at X Hospital and has completed Adult Protection Training with X Social Services Department. L has also attended an Adult Protection Case Conference with a Community Based Social Work Colleague.

Sources for this unit include direct observation, supervision and other discussion, report back from colleagues within the profession and the training department. This unit is passed to a high standard.

**Unit 20 Manage Complex Ethical Issues, Dilemmas and Conflicts.**

This unit has been addressed in great detail during L’s placement because of the very nature of a Medium Secure Unit. The fundamental issue of a patient’s right to liberty and free determination versus the need for public and personal protection underpins, along with the closely associated issue of Risk Assessment, the very work that we do.

L has considered a violence convicted patients request to be allowed unescorted leave into the community under Section 17 of the Mental Health Act 1983. L was able to consider both the historical risk factors and the patients excellent progress when, on behalf of the Social Work Team, she rightly recommended that this leave should be agreed. That view was communicated to the Multi-Disciplinary Team for consideration.

L conducted an interview with patient TD following his recall to hospital under Section 42 Mental Health Act 1983. L understood both the need for public protection and the very real emotional distress of the recalled patient. In supervision, she was able to
balance both very impressively. (Source direct observation and supervision).

L has completed a lengthy and complex piece of work to assess the sexual and predatory views and beliefs of patient AU. L was able to identify her own distaste at matters relating to child sexual abuse and objectively deal with the patient taking into account his own needs and vulnerabilities. I considered this an outstanding achievement which would be difficult for the majority of my experienced and qualified colleagues. (Source direct observation and report back from service users).

L has presented on the issue of confidentiality displaying a notably good understanding of the subject. For instance, L interviewed the patient GR’s ex-partner at great length, including discussions of his abusive and sexual behaviour. It was agreed that the details of this discussion would not be passed to patient GR as that may increase the future risk to her. L very skilfully discussed these issues with patient GR using discloseable sources, such as old reports, as the basis of her assertions. (Direct observation and supervision).

L has been involved in a MAPPA meeting on patient DB. DB remains unaware of the MAPPA process as, at that stage, further police investigations were ongoing which may have been jeopardized by disclosure. L was able to consider this complex ethical matter with great skill.

L has been involved in the Child Protection Assessment relating to patient GR convicted of an arson attack against his partner and child. GR is keen, “desperate”, to see the child and it is the view of many of the hospital staff that his not being able to do so is unfair and cruel. L has been able to assess and consider child safeguarding issues and accept that non contact is a necessity.

In the case of patient AU, sensitive court depositions, including statements from child sexual abuse victims, have been taken from him in order to prevent their sharing and misuse as a form of pornography. Discussions have taken place with L about the basic right of an accused to have access to the evidence against them versus the right of a child victim to be protected from further abuse.

Patient DB, convicted of the rape and attempted murder of his ex-wife requested that personal items be removed from his flat around 2 years ago. In the course of collecting these items, I found a number of other objects in his home, including lurid literature about violence against women and a number of martial arts and other weapons which caused great concern. These items were removed
by myself and are now kept in a secure part of the hospital. The existence of these items led to detailed discussion about the infringement of a patient’s rights (i.e. effective invasion of privacy) versus the need for broader public protection. These issues have been discussed in detail with L.

These issues have been dealt with by way of training session and discussion at supervision.

This unit is passed to a high standard.

**Unit 21 Contribute to Promotion of Best Social Work Practice**

During this placement, L has contributed to the improvement of Social Work Practice within our team. L has continually shown a good and impressive knowledge of current practice, procedure, policy and law.

In discussions of practical pieces of work, such as child visit assessments, she has been able to quote from a range of formal sources such as the Fallon report, the serious case review of child A, the Children Act, and BASW Guidelines. L has a knowledge of up to date practice and theory, in particular motivational interviewing, and task centered Social Work which have underpinned her approach. L has routinely included patients, carers and others in discussions and assessments and has a notably good understanding of anti-oppressive practice. In the course of this placement, L has attempted to inform herself with reference to fellow students, other Social Workers outside our team and her Practice Teacher from X University.

As the placement has progressed, L has become increasingly (and admirably) critical of myself. From the beginning of the placement, I made clear that I welcome and enjoy critical feedback (so as long it is not too critical!) from my students and that I hope, in the course of the placement, to learn from them as much as they may learn from me.

On several occasions, L has been able to identify areas in which I clearly have a level of ignorance. In particular, L recently noted that I had confused two major reports which underpin my practice. Whilst clearly embarrassing, I applaud her for confidence and ability in pointing that out and I have now attempted to rectify the situation so far as is possible at my advanced age.

Sources for this unit are direct observation, supervision and feedback from colleagues.
This unit is passed to a very high standard and contributes to my overall impression of L as a truly outstanding student who is now more than ready for professional practice and who will shine in whichever role she eventually takes on.

DC
Principal Forensic Social Worker
BA (Hons) CQSW (1992), Dip APP SOC Studies, Dip CRIM (X University 1982)
ASW/AMHP Section 114 Mental Health Act 1983 since 1993.
18 February 2009

I have read and agree with this report.

Signed LJ
PORTFOLIO REFERENCES


SALVATION ARMY (2008) Tracing Family Members (online) at: http://www2.salvationarmy.org.uk/familytracing last accessed: 19/12/08


