RESEARCH BRIEFING

26

July 2008

Mental health and social work

By Mo Ray, Richard Pugh, with Diane Roberts and Bernard Beech

Key messages

- Approximately one in six people in England experiences some form of mental health problem at any given time, with some groups more vulnerable than others.
- The traditional skills of social work remain important and social workers have a distinctive role in multi-agency settings.
- Social work needs to develop practices which help people with mental health problems identify and realise their own needs.
- Social work has a significant role to play in coordinating efforts to support individuals and groups who may often have negative experiences and perceptions of mental health services.
- Social workers need to maintain a broad social view of mental health problems especially in regard to concerns about discriminatory practices, civil rights and social justice.
- Policy makers need to focus on the role that social work plays in integrated mental health services and support further professional development.

Introduction

Providing effective social support for people with mental health problems is a key challenge in an environment where the views of people who use services are seen as increasingly significant, where some social groups do not receive services fairly and equably, and where organisational structures are changing.

At a time of considerable change to professional roles and organisational structures, where concerns have been expressed about the diminution of the distinctive part that social workers have played in the broader provision of health and social services for people with mental health problems,[4] this briefing focuses on the role and contribution of social work in community mental health provision in statutory community mental health teams, integrated or multidisciplinary teams, assertive outreach and

social care
institute for excellence
scie

crisis intervention teams within the UK. It acknowledges the diversity of people who use services throughout their lives, but does not review research relating to acute in-patient care, residential or domiciliary care, or dementia in older people. The issue of dual diagnosis is not included as this will be covered in a separate SCIE research briefing. The information contained in this summary of recent research is drawn from relevant electronic databases, journals and texts.

What is the issue?

Through the activities of user groups such as Shaping Our Lives and the National Centre for Independent Living, people who use services are finding social inclusion through supportive relationships, personal security and positive affirmations of hope, challenging the narrow definitions of their roles often made by mental health professionals and organisations. In particular, people who use services are developing knowledge and are effecting changes in service provision through their personal experiences of the social care sector.[1,2,3]

The 'independent living' movement, which originated in disability activism, and is now active in mental health, is becoming more influential in shaping policy and practice. The emphasis upon personal choice and a rights-based approach to service provision can be seen in the development of direct payments and personalised budgets for services. Social workers with their longstanding, formal commitment to the promotion of independence, dignity, choice and self-control, are well placed to support these developments, but policy makers and the profession as a whole need to recognise that the broad agenda of people who use services goes far beyond the promotion of a purely consumerist approach to self-directed service.

Current mental health services do not adequately meet the needs of some people, while others appear to be over represented in the more coercive areas of detention and compulsion. It has been recognised for many years that some sections of Britain's black and minority ethnic communities have not received culturally appropriate services and have suffered from ignorance and discrimination within the mental health system. For some time, efforts to address these continuing inequities have been a key feature of the Department of Health's plans,[33] by developing training materials to improve staff knowledge of particular ethnic groups, for example, and by commissioning research into decision-making in service provision.

Why is it important?

Approximately one in six people in England has a mental health problem at any given time, at an estimated cost of £77 billion a year, a cost which includes health and social care.[5] The possibility that mental health problems may derive from social injustice and oppression[6] is not widely recognised, nor is the fact that people with long-term mental health problems are likely to experience social exclusion and discrimination as a direct consequence of their difficulties. They can experience a vicious circle of social isolation, poverty, unemployment, insecure housing and scarce social and support networks.[5] Underlying social exclusion are the impacts of stigma and discrimination about mental illness, which can reinforce inappropriate assumptions; poor coordination between agencies; and a restrictive focus on the clinical aspects of mental health problems.[5]

There is significant under-recognition of mental health problems amongst some groups, such

as older people,[7] rough sleepers,[8] and people in the criminal justice system.[9] Moreover, such people as children and young people who have been abused or neglected;[10] looked after or accommodated children and young people;[11] young offenders;[12] people with drug and alcohol problems;[13] people who are homeless or at risk of homelessness;[14] and people who seek asylum or who are refugees,[15] are all at greater risk of mental health problems. A life course perspective is helpful in understanding why children and young people with mental health problems, for instance, are more likely to continue to experience them in adulthood.[16] Similarly, older people may experience depression and post-traumatic stress in later life as a result of unresolved traumas earlier in their lives, relating perhaps to war experiences, childhood sexual abuse, or loss and bereavement. In addition, people with mental health problems from black and minority ethnic groups,[18] women,[19,5] asylum seekers and refugees are especially vulnerable to the consequences of oppression and discrimination.

The National Service Framework for Mental Health (1999)[20] for the modernisation of services, continued to promote the integration of health and social care services within mental health trusts to provide 'joined up' services, with a strong emphasis on interprofessional collaboration, and the active participation of carers and people who use services. Consequently, specialist mental health teams have been developed to intervene quickly to prevent crisis and relapse, admissions to hospital, and to promote recovery. Assertive outreach teams, for example, provide support, treatment and interventions for people with long-term mental health problems who have complex needs and who may find it difficult to engage directly with services. Crisis assessment and home treatment teams provide multidisciplinary support and intervention for people with acute mental health needs who, without intensive home support and intervention, would need to go to hospital. Social workers employed in mental health trusts are likely to have additional responsibilities which include care coordination within the Care Programme Approach, care management and representation of social circumstances in Mental Health Tribunals.[21] Social workers in their role as Approved Social Worker (ASW) have traditionally had a key role in providing an independent view in assessments carried out under the 1983 Mental Health Act. The enactment of the provisions of 2007 Mental Health Act, however, will replace this with a new role, the Approved Mental Health Professional (AMHP). This role will be open to a wider range of professions, but will still require appropriate training and local authority approval.

The emphasis on professional collaboration and integration has sparked concerns that the distinctive contribution of social work in mental health services might be diminished.[21,4] The training of social workers in mental health services has been key in providing critical perspectives drawn from a broad range of social sciences.[2] In particular, it has supported social models of understanding which can challenge or complement clinically-oriented medical models of mental illness.[4] The widespread adoption of anti-oppressive and anti-discriminatory approaches in social work education and training has developed professional awareness and understanding of issues such as power, oppression and social exclusion, and social workers have become more aware of their own potential for oppression towards users. Their practice is formally underpinned by a commitment to promote social justice and challenge oppression, and social workers are

potentially well placed to help other mental health professionals work with the people who use mental health services and collaborate on ways to recovery.[22]

In this context, the National Institute for Mental Health (NIMHE) as part of the 'New ways of working' initiative reviewed the roles of a range of mental health practitioners including social workers, and identified the shared and distinctive contributions of the different professions.[23] The development of values-based practice acknowledges and recognises that people will bring diverse – and potentially conflicting – values to mental health practice.[24,25,26] Values-based practice involves making visible and working with this diversity and is at the heart of current mental health policy and practice. Social workers have, and will continue to have a presence in a variety of generic and specialist settings where they may work with people with mental health problems, even if these are not formally recognised through statutory assessment.[27] Social workers may, for example, work with children and young people in highly specialised settings, such as children's and adolescents' mental health services (CAMHS) but may also work with children with mental health problems in more general settings, such as leaving care or looked after children teams. Within community care teams, social workers may work with older people experiencing acute stress associated with loss and change, or depression, while emergency duty teams are likely to encounter a range of people with mental health problems who will often be experiencing acute distress.

What does the research show?

This section summarises key themes arising from studies undertaken in the United Kingdom and also cites work undertaken elsewhere where this has relevance. Unfortunately, the coverage of research studies evaluating social work contributions to mental health practice is patchy and many areas of practice remain under-researched.[28] Nonetheless, a SCIE report on improving the evidence base concluded that modernisation provided a 'unique opportunity' to develop the coherent infrastructure needed.[29] Moreover, there is increasing recognition of the importance of using different types of knowledge from a wider range of organisational, practitioner, user, policy and community perspectives.[2,30]

The significance of professional perspectives and values

People who use services value the non-stigmatising help and access to services provided by social workers[31] and the core values of social work practice directly support the principles underpinning self-directed support and the independent living movement.[32] Similarly, analysis of the 'essential capabilities' required to practice in mental health also emphasises the importance of a professional value base which promotes dignity, human worth and social justice, and includes a commitment to the principles and social perspectives of the recovery model.[33] Indeed, research exploring community care practices[34] found that social

workers frequently identified empowerment as a fundamental principle in their practice, both as a goal and as an underpinning value. There is also widespread agreement among people who use services, practitioners and researchers that service developments such as mental health promotion, crisis resolution, and the implementation of support based on the principles of recovery, must be explicitly underpinned by social perspectives.[35,36] These perspectives can help promote access for people susceptible to discriminatory institutional practices, including people from black and minority ethnic communities.[37]

Holistic approaches combining practical and emotional support

People who use services value social workers who are able to provide practical help, counselling and advocacy on their behalf[31,38] and have responded positively to practice that combines practical assistance with emotional support.[39,21,40] Diary-based research examining differences in approach to care management in different settings, found that care managers in mental health settings were more likely to provide direct help alongside their care management role (that is, combining the practice of assessment, care planning and review, with a significant allocation of time for counselling and emotional support), than care managers in an older person's team, who tended towards spending more time involved in care brokerage (that is, procuring care packages and practical support).[41] A study that examined attitudes and role perceptions in mental health teams in a London borough concluded that of all professional groups, social workers were most likely to identify the importance of support to children combining individual emotional and practical support, as well as appreciation of their social circumstances.[42] The significant role of social work in promoting the involvement of people using services and developing systemic approaches to practice with families and groups has also been identified.[38] Joint working initiatives between social services and CAMHS, which encompassed an extended therapeutic role for social work practitioners that included family therapy, have identified positive outcomes including quicker response times, more effective prioritisation, improved multidisciplinary work and a more positive experience for children and families.[43]

Reducing isolation and developing supportive networks

A number of studies have identified the challenges that people with mental health problems face in sustaining and preserving social contacts and social networks.[44,45] People with mental health problems who live in more isolated rural areas and small communities with little service provision are likely to find it more difficult to develop and preserve supportive social contacts and networks.[46,47] Research into the development of social networks in rural areas[46] has shown the crucial role that some services, such as drop-in and day centres, play in promoting and sustaining relationships between people who use services. The Highland User Group, for example, has provided opportunities

for people who use services to work together to influence the development of those services and challenge discrimination. Social work and social care staff have a key role to play in working with and supporting groups of people who use services to secure better practice and resist marginalisation and discrimination. For older people, the most effective interventions aimed at alleviating isolation and loneliness appear to be those which have an educational focus or where clearly focused support interventions are built into existing services, and where older people have been consulted about their own particular needs.[48]

As well as providing therapeutic emotional support and promoting the development of practical skills, group work approaches to service provision, especially those based on strengths, have also demonstrated the value of networking and mutual support. For example, a social work childcare team developed group work as a response to working with the needs of children with a parent with mental health problems.[49] The evaluation of this approach found that positive effects included an improvement in children's self esteem and confidence, as well as improvements in their academic achievement. Another study based in Northern Ireland assessed the benefits of therapeutic group work with young children aged four and five with continuous traumatic stress syndrome.[50] It also identified a number of encouraging changes, including improved sleep and a reduction in nightmares, and an increase in social confidence and improved social interaction with peers and adults.

Promoting independence and self-directed support

A random sample of 262 people with severe and lasting mental health problems[51] found that two thirds thought that their care programmes helped them to be more independent, but reported that they were rarely asked if they wanted family members or informal carers involved in their care. Frameworks which helped people participate in their own social care included common assessment protocols and the identification of a named, single key worker or care coordinator. Social work practitioners skilled in family work were identified as being particularly suited to this role. Research also found that people who use services responded more positively where there had been joint training of social workers and community psychiatric nurses towards a common goal of person-centred practice and a care management model based on strengths.

Research has confirmed that direct payments for people with mental health problems are under-used.[52] A national evaluation of direct payments identified a number of barriers to their use which included service reorganisation, work role uncertainties and difficulties in managing workloads.[53] It also found that care coordinators (including social work practitioners), rather than offering direct payments as a matter of course, tended to decide themselves who was suitable for these payments. The study reported that care coordinators overcame initial ambivalence about using direct payments as they found they were able to use a range of skills including

advocacy, partnership working and facilitating empowerment, to increase access to direct payments.[53] Nevertheless, there are gaps in the current evidence and research on self-directed care and direct payments. Little is known, for example, about why some people elect not to seek direct payments, nor whether the use of direct payments has any significant impact on reducing episodes of mental ill health, or leads to any reduction in the need for services.[54]

Social workers have an important role, especially with marginalised groups, in supporting user advocacy networks to promote the recognition of their interests and perceptions of service. Studies have shown their contribution in working with people who use services from black and minority ethnic communities, with women who have experienced domestic violence, with refugees, and with people in isolated rural areas.[55,56,40,57] These interventions focused on access to advocacy services, counselling and group work and highlighted the importance of mutual support and assistance.

Vulnerable groups – children and young people

The importance of challenging traditional separations between adult and child services has been noted.[58,59] One exploratory study on infant mental health problems found that many mental health professionals, including social workers, were reluctant to recognise the possibility of such early difficulties and tended instead to see them as indicative of parental behaviour.[60] The needs of children and young people who play a vital role in caring for a parent or parents with mental health problems may also be neglected[42,61] and social workers have an important role in mediating and liaising between professionals, and with families and children.[42]

It has been suggested that those children and young people who have been caring for a parent for some time, are themselves at risk of developing mental health problems and should receive intervention from social workers.[58] Disruption to parenting capacity has been found to have profound and persistent implications for children and their parents.[59] Because a history of childhood mental health problems may be a high risk factor for developing adult mental health problems,[62] there is a need for better coordination between services as young people make the transition to adulthood. Research indicates, however, that transferring from CAMHS to adult services is problematic for young people, often resulting in multiple referrals to a range of different agencies.[16] Service responses for black and minority ethnic children and young people have also been found to be inadequate, and deficiencies have been reported in the availability of services for older adolescents or young adults with mental health difficulties.[31,61]

Vulnerable groups – older people

Older people may enter later life with an enduring mental illness or may develop mental health problems in old age. Unfortunately there is little research into how potential risk factors in later life, such as social inequalities, operate.

There are many causes of mental distress in older people, and biomedical perspectives on ageing should not exclude the contribution of psycho-social and structural perspectives. There is, moreover, an absence of research which looks at the whole course of people's lives in terms of mental health and older age.[63] Consequently, there is no comprehensive evidence base for proactive and preventive mental health and promotion for older people.[63] The National Service Framework for Older People[64] identified the need for fully-resourced specialist mental health services for older people to be in place by 2011, but developing a workforce capable of responding to older people with complex needs and eradicating age-related discrimination are considerable challenges.[65]

There is evidence of unmet needs amongst older people, especially those living in rural areas where isolation and loneliness may be significant factors.[66] Depression in older people, for example, is a significant mental health issue[67] but it is often undetected and interventions for older people are poorly developed, rarely including therapeutic interventions such as counselling and cognitive behavioural therapies.[7] There is evidence that active treatment of depression in older people in residential care, based on a mix of social and health care goals, can lead to a significant improvement, especially for those with pronounced depression.[68] Traditional social work skills, however, such as active and empathetic listening and helping older people to manage change can also make a significant contribution to their wellbeing.[69] Achieving a balance between ensuring an older person retains a sense of autonomy and control, and helping them accept support is identified as a key social work skill.[69] Depression and other forms of mental distress are also risk factors for suicide amongst older people, and while a relatively small number of older people attempt or succeed in suicide, it is thought that this might be the 'tip of the iceberg' for the existence of under-detected psychological, physical, social and health problems.[70]

Vulnerable groups – people from black and minority ethnic communities

Some black and minority ethnic groups have higher rates of hospital admission, compulsory detention, and interventions including seclusion, than the general population. The reasons for these differences are not fully understood[71] but the greater risk of mental health problems may partly be due to social inequality, stress and marginalisation, while treatment and services based on inappropriate assumptions and prejudicial stereotypes can also play a part. These disparities have become a key focus within mental health planning and research.[72] It has been suggested that national initiatives to improve treatment across different social groups are unlikely to be successful without a better understanding of the decision-making processes that apparently lead to these more intrusive and coercive outcomes.[61]

There is evidence that people from black and minority ethnic communities may be reluctant to seek help from mental health services and may delay an approach until a situation has reached crisis point.[18] Black and minority ethnic people who use services and their carers frequently express dissatisfaction with mainstream services which they often perceive as misunderstanding or misrepresenting their situation.[71] Services can be improved by raising the participation and profile of black and minority user and advocacy groups in service planning and development.[37] For example, Hillingdon MIND have developed a range of services for Asians with mental health

problems, such as befriending schemes, drop-in centres, and groups for women with anxiety and depression, initiatives which demonstrate the value of working in partnership with the local community.

Vulnerable groups – asylum seekers and refugees

Asylum seekers and refugees also appear to be more vulnerable to mental distress than the general population, often, it is thought, because of the experiences that led them to seek asylum, but also because of their uncertain and marginal status within the UK. Asylum seekers are likely to experience considerable uncertainty, severely curtailed resources, difficulties in accessing services and significant financial hardship.[73] Two-thirds of refugees have experienced anxiety or depression, compounded by experiences of social isolation, poverty, racism and language difficulties.[74] Research into the circumstances of children who are asylum seekers has concluded that a failure to understand their often complex backgrounds and experiences can lead to poor take-up of services, inappropriate interventions, and loss of engagement with services.[62] The Refugee Council[15] has recommended that social workers and other mental health workers receive appropriate training to help them develop culturally appropriate responses, and better understand asylum seekers' rights within mental health and health services. Access to appropriate language services can be a crucial factor in promoting access to mental health services,[75] though a survey of the general provision of language services within local authorities and larger voluntary sector agencies showed considerable variability in the local availability of interpretation and translation.[76]

Detention, compulsion and concerns about risk

An extensive study of people assessed by ASWs under the 1983 Mental Health Act analysed some 14,000 assessments over a nine-year period and found that 73 per cent of these resulted in detention in hospital.[77] Overall, these individuals were less likely to be homeowners or in employment. In the early years of the study the proportion of women had exceeded men, but this had shifted so that younger men under the age of 40 years were most likely to be assessed and detained. These men were more likely to be single and to have other problems with alcohol and drug misuse. The reasons for this shift are not known, but it may be that the increased focus on public protection in recent years has influenced perceptions. This possibility is supported by the fact that the identification of risk of 'harm to others' had increased from 48 per cent to 57 per cent of cases in the period 2000 to 2004. The study also found an over-representation of people of African-Caribbean origin being assessed in one local authority: 15 per cent compared to less than three per cent in the local population. The proportion of people already known to mental health services at the point of assessment was 64 per cent, and nearly half of those assessed were already receiving services under the Care Programme Approach. In 48 per cent of cases, applications were for detention for treatment for a period of up to six months.

Concerns about the role of social workers in decisions about compulsory treatment outside of hospital have arisen in a number of studies,[78,79] and reviews of the use of community treatment orders in other countries question whether they

produce better outcomes.[80,81] The professional dilemma being, how best to balance the need for protection and care and uphold the civil rights of individuals when they appear to lack the capacity to make informed decisions about treatment? A review of practice in Australia, Canada and the UK indicated that professional guidance remained patchy and unsatisfactory.[78] User views from the small studies that have been conducted have found mixed feelings about compulsory treatment in the community.[82,79]

There are concerns too about how social workers make judgements about risk. In particular, concerns about the ways in which black men with mental health problems may be perceived as dangerous,[83,84] and how gender assumptions may influence social workers' assessments. While both male and female social workers are more likely to judge male clients as risky, for example, on the basis of potential harm to other people, female social workers not only judge more clients to be risky, but are also more likely to identify female clients as high risk on the basis of harm to themselves or impaired capacity to care for their children.[84] Concerns about the effectiveness of risk assessment procedures, poor record keeping and inaccurate transmission of information about risks, and the potential for abuse of patients' rights have also been noted,[85] as well as concerns about subjectivity in assessments of mental capacity.[86,87]

Best practice guidance in risk assessment[88] attempts to address these concerns by highlighting the importance of positive risk management as a required competence for all mental health practitioners. The guidance suggests that positive risk assessment is best undertaken by multi-agency and multidisciplinary teams working collaboratively within an open and transparent culture, grounded in reflective practice and using a value base which recognises the importance of the involvement of people using services and carers, as far as that is possible. Research about people who use mental health services and their involvement in risk assessment and management[89] found that user involvement was variable and dependent upon the individual professional's decisions. While people who use services often had some influence on the type of support they received, the research found that their choice was typically limited to accepting or rejecting services. This study recommended developing formats for assessing and managing risk that as a matter of course incorporated the views and wishes of people using services, and stressed the importance of an holistic approach as a means of developing more appropriate risk management strategies with individuals at their centre.

User-led research and involvement

It is now increasingly accepted that an approach based on a medical model, uncritically assuming the superiority of ways of producing knowledge through randomised control groups and quantitative methods, is not always appropriate. Research methods should be appropriate to the problems or research questions at hand and should include the needs and concerns of people who use services, their carers, and the wider mental health community.[2]

User-led research understands that people who use services and their carers are experts on their own situations, and that research strategies should harness their active participation in their own recovery.[90] The Mental Health Foundation user-led research, *Strategies for Living*,[91] identified the strategies and resources that were found to be most helpful for living and coping

with mental distress. In particular, it highlighted the value placed on shared experience and identity; having emotional support; feeling valued and having a reason for living; taking control and having choices; feeling safe and secure; and being able to do things for fun and pleasure. Although the active involvement of people who use mental health services in the development of those services is a formal aim of most service providers, this has been criticised as often unproductive and tokenistic.[3]

Workforce issues

A large survey of mental health social workers found high levels of stress arising from overwork, vacant posts, a lack of access to service resources and the pressures of constant change and reorganisation.[92] It also noted, however, that social workers positively rated direct contact with people who use services, appreciated the support of colleagues and being valued by their managers. Nonetheless, there are some persistent workforce problems, including professional isolation and a lack of supervision and resources for some social workers.[21] It has been recognised that the numbers of mental health social workers will need to be maintained if integrated services are to remain genuinely multidisciplinary in nature.[93]

Implications from the research

For organisations

Social workers in the mental health sector need effective leadership and governance in order to be confident in their skills, knowledge and values,[21] and contribute effectively to integrated mental health teams.[39] There is evidence that people who use services value some of the more 'traditional' contributions that social workers can make in helping them, and integrated services in multi-agency settings should recognise this.[23,93] Sustaining good mental health and supporting those with problems is a complex and multifaceted task that involves social, political and economic issues as well as medical factors. Accordingly, the role of social workers will overlap with other professions in helping people to access stable and safe accommodation, education, training, and suitable employment, for example. In some areas the process of service integration continues as Mental Health Trusts apply for Foundation status. Concerns have been noted, however, that this process places a very limited emphasis on partnership working, social inclusion and the social care agenda,[94] though the participation of people who use services should be fundamental to the modernisation of the mental health sector.

The challenge for social service organisations, at a time of great change in the sector, is to maintain and preserve the existing skills base while providing opportunities for appropriate training and further develop the capacity of the workforce. In order that informed judgements may be made about the merits of available research, organisations need to develop their own capacity for evaluating their services and extend their critical skills for the appraisal of research. Organisations with statutory responsibilities under the Mental Health Act will have to ensure that the independence of the AMHP role is not compromised and also establish appropriate training and approval processes so that wider social considerations of context and culture are not neglected in such assessments.[95,23] The social work role itself could also be developed to include a wider range of responsibilities and be developed into a specialist career pathway,[23] but this would require that

social workers have access to reliable ongoing professional development, supervision and support.[21]

Social service organisations need to develop more effective ways of working with vulnerable groups and ensure that broader perspectives on need and user context are not overlooked.[62,16] For instance, they need to ensure that they coordinate their efforts to support children and young people and their families, and try to minimise the disruption to parenting that can occur when there are changes in a parent's mental health. The considerable misgivings that some sections of the community have in seeking help must be addressed in several ways. Social service organisations need to develop better knowledge of and better links with local minorities, develop and recruit a more culturally aware and representative workforce, and ensure that people likely to use services from linguistic minorities can gain access to appropriate help and support. It is imperative that people from black and minority ethnic groups have equal access to strategies and interventions that will preserve their independence and choice, and which are offered in a culturally appropriate way.[61,96]

For the policy community

Policy makers should recognise that people who use services value some forms of social work service and that while existing legislation and regulation provide a potentially sound basis for the delivery of integrated services, they will need to be clear about the contribution of social work when contemplating further changes. Considerable work remains to be done to enable integrated services to achieve significant change in challenging the inequality, oppression and stigma that people with mental health difficulties face, and in providing equal access for all people regardless of their age, culture, or complexity of need. Mental health social work is in a strong position to champion this work, but it will require strong leadership and good links to local authority adult social services departments to implement policy initiatives equitably across all adult care groups. For instance, direct payments are one crucial way of creating opportunities for choice, individual control and independence. Research has indicated, however, that policy makers and practitioners need to address the complexities associated with fluctuating mental health and capacity as these will have implications for the ways in which direct payments are used and the degree of flexibility required.[96] As understanding of self-directed services and the move towards the personalisation of social services develops, policy makers will not only have to try to ensure that the principles and values of the independent living movement are sustained, but will also be faced with some difficult choices about whether and how to sustain existing provisions for those people who do not opt for direct personal control.

For practitioners

Research so far undertaken indicates the importance of maintaining a broad base of professional skills in a range of methods of intervention and support. Generally, the most pressing challenges to social workers will be to respond effectively to the shift in service provision towards self-directed and personalised services, and to develop the skills required for working in integrated teams where there are

overlapping responsibilities and expectations.[23] For example, social workers may need to have improved access to therapeutic training, such as cognitive behavioural therapy and psycho-social interventions.[4] Developing the skills and knowledge to support individuals in accessing and commissioning personalised services may require mental health social workers to adopt and adapt what has been learned in other adult social services. Recent developments in the post-qualifying framework for social work education and training in mental health will provide a valuable opportunity to develop specialist knowledge and practice skills, while supporting the development of the proposed new career pathway.[97,23]

Social workers need to play their part in ensuring that their contribution to the welfare of people who use services is recognised, but the social work contribution to the mental health research knowledge base remains minimal.[98,98] Indeed, the 'New ways of working' initiative has identified it as an area for future development of the workforce.[23] The development of research capacity faces some hurdles, such as a lack of acceptance of the need for a research-minded workforce, and the risk of social perspectives becoming subjugated in the interests of integration.[28] Nevertheless, social workers are well placed to work in partnership with people who use mental health services to develop service evaluation, and undertake research which can challenge traditional power arrangements and promote change.[90,39,3] Finally, it has been noted that the changing occupational location of social workers in regard to health services will provide them with opportunities to advocate with and for people who use services when they directly witness inadequacies in in-patient care.[75]

For users and carers

People who use services and carers have a vital role in promoting and developing the knowledge and research base. The gains that people who use mental health services have achieved in terms of, for example, highlighting the importance of direct payments and individual budgets is evident. While considerable improvements have been made in building user representation into all areas of service development, effective participation is by no means guaranteed.[3] If user-led research and user-commissioned research is to develop it will need to be supported by appropriate training in research skills and in the critical appraisal of research and funding proposals. For instance, the participation of user groups and their representatives in local research governance review processes is one way in which such knowledge and skills may be developed. People using services who are particularly at risk of exclusion from participation, because their needs are deemed too complex, or due to oppressive practices, also need to be included. This will require the continuing development of research methods and practices that are sensitive to this diversity. Furthermore, some existing research has highlighted the importance of ensuring that the aims and philosophy of the independence movement are not diluted by professional interests, as well as ensuring that these developments are not used as a means of monitoring or managing people who use mental health services. [61,96]

Useful links

Care Services Improvement Partnership (CSIP) – supports positive changes in services and in the wellbeing of vulnerable people with health and social care needs.
www.csip.org.uk

Department of Health (DoH)
www.dh.gov.uk

Depression Alliance – provides information and support services to those affected by depression through publications, supporter services and network of self-help groups. A user-focused organisation with offices in England and a sister charity in Scotland.
www.depressionalliance.org

Joseph Rowntree Foundation (JRF) – charity supporting research on social issues.
www.jrf.org.uk

Mental Health Foundation – leading charity that provides information, carries out research, campaigns and works to improve services for anyone affected by mental health problems.
www.mentalhealth.org.uk

MIND – the leading mental health charity in England and Wales providing a variety of services including publications and a confidential information line for users, carers and practitioners.
www.mind.org.uk

National Centre for Independent Living – a support, advice and consultancy organisation that aims to enable disabled people to be equal citizens with choice, control, rights and full economic, social and cultural lives. The website provides information on independent living, direct payments and individual budgets.
www.ncil.org.uk

National Institute for Mental Health – is responsible for supporting the implementation of positive change in mental health and mental health services.
www.nimhe.csip.org.uk

Refugee Council – the largest organisation in the UK working with asylum seekers and refugees.
www.refugeecouncil.org.uk

Sainsbury Centre for Mental Health – works to improve the quality of life for people with mental health problems, through research, policy work and analysis to improve practice and influence policy in mental health as well as public services.
www.scmh.org.uk

SANE – a charity concerned with improving the lives of everyone affected by mental illness.
www.sane.org.uk

Shaping Our Lives – is a broad network of people who use services promoting user perspectives, involvement in service planning and development, and the sharing of information between different user groups.
www.shapingourlives.org.uk

Social Perspectives Network (SPN) – based at the Social Care Institute for Excellence in London, SPN is a coalition of people who use services, survivors, carers, policy makers, academics, students, and practitioners looking at mental health from a social perspective. SPN also seeks to promote the importance of social care and social work. Free membership and e-newsletter at **www.spn.org.uk**

Related SCIE publications

Research briefing 03: Aiding communication with people with dementia (2004)

Research briefing 04: Transition of young people with physical disabilities or chronic illnesses from children's to adult's services (2004)

Research briefing 11: The health and wellbeing of young carers (2005)

Research briefing 12: Involving older people and their carers in after-hospital care decisions (2005)

Research briefing 16: Deliberate self-harm (DSH) among children and adolescents: who is at risk and how is it recognised (2005)

Research briefing 17: Therapies and approaches for helping children and adolescents who deliberately self-harm (DSH) (2005)

Research briefing 20: Choice, control and individual budgets: emerging themes (2007)

Acknowledgements

The Keele Editorial Board: Prof. Peter Jones (Pro Vice-Chancellor, Research and Enterprise, Keele University); Tom Owen (Research Manager, Policy, Help the Aged); Dr Sara Scott (DMSS Consultants) and Prof. Nick Gould (Professor of Social Work, Department of Social and Policy Sciences, University of Bath). The Keele Steering Group: Prof. Richard Pugh (project coordinator and Professor of Social Work); Prof. Miriam Bernard (Director, Keele Research Institute for Life Course Studies and Professor of Social Gerontology) and Prof. Steve Cropper (Director, Keele Research Institute for Public Policy and Management and Professor of Management).

References

1. Beresford, P. (2000) 'Service users' knowledges and social work theory: conflict or collaboration?', *British Journal of Social Work*, 30, pp. 489-503.
2. Gould, N. (2006) 'An inclusive approach to knowledge for mental health social work practice and policy', *British Journal of Social Work*, 36, pp. 109-125.
3. Beresford, P. and Croft, S. (2004) 'Service users and practitioners reunited: the key component for social work reform', *British Journal of Social Work*, 34, pp. 53-68.
4. National Institute for Mental Health in England (2005) The Social Work Contribution to Mental Health Services: The Future Direction: A Discussion Paper, Leeds, National Institute for Mental Health in England
5. ODPM Social Exclusion Unit (2004) Mental Health and Social Exclusion, London, Social Exclusion Unit in the Office of the Deputy Prime Minister.
6. Sheppard, Michael. (2002) 'Mental health and social justice: gender, race and psychological consequences of unfairness', *British Journal of Social Work*, 32, pp. 779-797.
7. Godfrey, M. and Denby, T. (2004) *Depression and Older People: Towards Securing Well-Being in Later Life*, Bristol, Policy Press
8. Griffiths, S. (2002) Addressing the Health Needs of Rough Sleepers, London, Office of the Deputy Prime Minister.
9. Ministry of Justice (2007) Statistical bulletin: Statistics of Mentally Disordered Offenders England and Wales 2006, London, Ministry of Justice.
10. Walker, Steven. (2003) 'Social work and child mental health: psychosocial principles in community practice', *British Journal of Social Work*, 33, pp. 673-687.
11. McCann, J. B., James, A., Wilson, S., and Dunn, G. (1996) 'Prevalence of psychiatric disorders in young people in the care system', *BMJ*, 313, pp. 1529-1530.
12. Rutter, M. (1999) 'Preventing anti-social behaviour in young people: the contribution of early intervention', in Bayley, R. (Eds.) *Transforming Children's Lives: The Importance of Early Intervention*, London, Family Policy Studies Centre.
13. Crawford, J. (2001) Co-existing Problems of Mental Health and Substance Misuse ('Dual Diagnosis'): A Review of Relevant Literature, London, Royal College of Psychiatrists.
14. Vasiliou, C. (2006) Making the Link between Mental Health and Youth Homelessness: A Pan-London Study, London, Mental Health Foundation/Centrepoint.
15. Refugee Council. (2005) *A Study of Asylum Seekers with Special Needs*, London, Refugee Council.
16. Richards, M. and Vostanis, P. (2004) 'Interprofessional perspectives on transitional mental health services for young people aged 16-19 years', *Journal of Interprofessional Care*, 18 (2), pp. 115-128.
17. Busuttil, W. (2004) 'Presentation and management of post-traumatic stress disorder and the elderly: a need for investigation', *Psychiatry*, 19 (5), pp.429-439.
18. Bhui, K., Stansfield, S., Hull, S., Priebe, S., and Feeder, G. (2003) 'Ethnic variations in pathways to and use of specialist mental health services in the UK: a systematic

review', *British Journal of Psychiatry*, 182, pp. 105-116.

19. Department of Health, Mental Health & Social Care Standards & Quality Group (2003) Mainstreaming Gender and Women's Mental Health Implementation Guidance, London, Department of Health.

20. Department of Health (1999) National Service Framework for Mental Health, Modern Standards and Service Models, London, Department of Health.

21. Foster, J. (2005) Where are we going? The Social Work Contribution to Mental Health Services, London, Social Perspectives Network.

22. Bailey, D. (2004) 'Exploring the concept of recovery from the perspective of people with mental health problems', *British Journal of Social Work*, 34, pp. 1055-1056.

23. Department of Health (2007) New Ways of Working for Everyone: Developing and Sustaining a Capable and Flexible Workforce, London, Department of Health.

24. Allott, P., Fulford, B., Fleming, B., Williamson, T., and Woodbridge, K. (2005) 'Recovery, values and e-learning', *Mental Health Review*, 10 (4), pp. 34-38.

25. Fulford, B., Williamson, T., and Woodbridge, K. (2007) 'Values-added practice', *Mental Health Today* (October).

26. Woodbridge, K. and Fulford, B. (2003) 'Good practice? Values-based practice in mental health', *Mental Health Practice*, 7 (2), pp. 30-34.

27. Huxley, P., Korer, J., and Tolley, S. (1987) 'The psychiatric "caseness" of clients referred to an urban social services department', *British Journal of Social Work*, 17, pp. 507-520.

28. McCrae, N., Murray, J., Huxley, P., and Evans, S. (2005) 'The research potential of mental-health social workers: a qualitative study of the views of senior mental-health service managers', *British Journal of Social Work*, 35, pp. 55-71.

29. Marsh, P., Fisher, M., Mathers, N., and Fish, S. (2005) 'Developing the Evidence Base for Social Work and Social Care Practice', *Report 10*, London, SCIE.

30. Pawson, R., Boaz, A., Grayson, L., Long, A., and Barnes, C. (2003) 'Types and Quality of Knowledge In Social Care', *Knowledge Review 3*, London, SCIE/Policy Press.

31. Social Services Inspectorate (2004) Treated as People: An Overview of Mental Health Services from a Social Care Perspective, 2002-04, London, Social Services Inspectorate.

32. Brewis, K. (2007) A Voice and a Choice: Self Directed Support by People with Mental Health Problems: A Discussion Paper, In Control, available online at www.in-control.org.uk

33. Department of Health, Care Services Improvement Partnership (CSIP), and National Social Inclusion Programme (2007) Capabilities for Inclusive Practice, London, Department of Health.

34. Hardiker, P. and Barker, M. (1999) 'Early steps in implementing the new community care: the role of social work practice', *Health & Social Care in the Community*, 7 (6), pp. 417-426.

35. Tew, J., Beresford, P., Plumb, S., Ferns, P., Wallcraft, J., Williams, J., and Carr, S. (2002) Start Making Sense. Developing Social Models to Understand and Work with Mental Distress, SPN Study Day 11 November 2002, London, SPN/SCIE.

36. Hope, R. (2004) The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce, London, NIMHE/SCMH Joint Workforce Support.

37. Rai-Atkins, R. (2002) *Findings: Mental Health Advocacy for Black and Minority Ethnic Users and Carers*, Findings York, Policy Press.

38. Gilbert, P. Integration of Health and Social Care: Promoting Social Care Perspectives within Integrated Mental Health Services, www.spn.org.uk accessed 8-5-2007.

39. Gilbert, P. (2003) *The Value of Everything: Social Work and Its Importance in the Field of Mental Health*, Lyme Regis, Russell House Publishing.

40. Humphreys, S. C. and Thiara, R. (2003) 'Mental health and domestic violence: "I call it symptoms of abuse"', *British Journal of Social Work*, 33, pp. 209-236.

41. Jacobs, S., Hughes, J., Challis, D., Stewart, K. and Weiner, K. (2006) 'From care management to case management: what can the NHS learn from the social care experience?', *Journal of Integrated Care*, 14 (3), p. 22.

42. Slack K. and Webber M. (2008) 'Do we care? Adult mental health professionals' attitudes towards supporting service users' children', *Child and Family Social Work*, 13 (1), pp. 72-79.

43. Cottrell, D., Lucey, D., Porter.I., and Walker, D. (2000) 'Joint working between child and adolescent mental health services and social services – The Leeds model', *Clinical Child Psychology and Psychiatry*, 5 (4), pp. 481-489.

44. Huxley, P. and Thornicroft G. (2003) 'Social inclusion, social quality and mental illness', *The British Journal of Psychiatry*, 182, pp. 289-290.

45. Corry, P., Drury, C. D., and Pinfold, V. (2004) Lost and Found: Voices from the Forgotten Generation, April, 2004, Kingston upon Thames, Rethink, available online at www.mentalhealthshop.org.uk

46. Burns, N., Parr, H., and Philo, C. (2002) User Networks, Findings Paper Report No.15 Glasgow and Dundee, Department of Geography, University of Glasgow and University of Dundee.

47. Philo, C. and Parr, H. (2001) Social Geographies of Rural Mental Health: Experiencing Inclusion and Exclusion, Working Paper Report No.1 Glasgow and Dundee, Department of Geography, University of Glasgow and University of Dundee.

48. Cattan, M., White, M., Bond, J., and Learmouth, A. (2005) 'Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions', *Ageing and Society*, 25 (1), pp. 41-67.

49. Orel, N. A., Groves P.A., and Shannon, L. (2003) 'Positive Connections: A programme for children who have a parent with a mental illness', *Child and Family Social Work*, 8 (2), pp. 113-122.

50. Stewart, D. and Thomson K. (2005) 'The "Face your Fear" club: therapeutic group work with young children as a response to community trauma in Northern Ireland', *British Journal of Social Work*, 35, pp. 105-124.

51. Carpenter, J., Schneider, J., McNiven, F., Brandon, T., Stevens, R., and Wooff, D. (2004) 'Integration and targeting of care for people with severe and enduring mental health problems: users' experiences of the care programme approach and care

management', *British Journal of Social Work*, 34, pp. 313-333.

52. CSCI and Health Care Commission (2007) No Voice, No Choice, London, CSCI.

53. Spandler, H. and Vick, N. (2005) 'Enabling access to direct payments: an exploration of care co-ordinators' decision-making practices', *Journal of Mental Health*, 14 (2), pp. 145-155.

54. Research in Practice for Adults (2006) Evidence Cluster: Direct Payments for Those Using Mental Health Services, Dartington, RIPFA.

55. Newbigging, K., McKeown, M., Habte-Mariam, Z., Mullings, D., Jaye-Charles, J., and Holt, K. (2008) 'Commissioning and Providing Mental Health Advocacy for African and Caribbean Men, *Resource guide 10*, London, Social Care Institute for Excellence.

56. Watters, C. (2001) 'Emerging paradigms in the mental health care of refugees', *Social Science and Medicine*, 52, pp. 1709-1718.

57. Pugh, R. and Richards, M. (1996) 'Speaking out: a practical approach to empowerment' *Practice*, 8 (2), pp.35-44.

58. Cree, V. E. (2003) 'Worries and problems of young carers', *Child and Family Social Work*, 8, pp. 301-309.

59. Smith, M. (2004) 'Parental Mental Health: disruptions to parenting and outcomes for children', *Child and Family Social Work*, 9, pp. 3-11.

60. Woodcock Ross, J., Hooper, L., Stenhouse, E., and Sheaff, R. (2008) 'What are child-care social workers doing in relation to infant mental health? An exploration of professional ideologies and practice preferences within an inter-agency context', *British Journal of Social Work*, Advance Access, March 26, pp.1-18.

61. Sainsbury Centre for Mental Health (2006) The Future of Mental Health: A Vision for 2015, London, Sainsbury Centre for Mental Health

62. Walker, Steven. (2005) 'Towards culturally competent practice in child and adolescent mental health', *International Social Work*, 48 (1), pp. 49-62.

63. Seymour, L. and Gale, E. (2004) Literature and Policy Review for The Joint Inquiry Into Mental Health and Well-being in Later Life, London, Mentality (for Age Concern England and The Mental Health Foundation)

64. Department of Health (2001) National Service Framework for Older People, London, Department of Health.

65. Department of Health and Care Services Improvement Partnership (2006) 'Everybody's Business' Integrated Mental Health Services for Older Adults: A Service Development Guide, London, Department of Health and Care Services Improvement Partnership.

66. Scharf, T. and Bartlam, B. (2006) Rural Disadvantage: Quality of Life and Disadvantage Amongst Older People – A Pilot Study, Cheltenham, Commission for Rural Communities.

67. Manthorpe, J. and Iliffe, S. (2005) *Depression in Later Life*, London, Jessica Kingsley.

68. Lyne, K. J., Moxon, S., Sinclair, I., Young, P., Kirk, C., and Ellison, S. (2006) 'Analysis of a care planning intervention for reducing depression in older people in residential care', *Aging and Mental Health*, 10 (4), pp. 394-403.

69. Moriarty, J. (2005) Update for SCIE Best Practice Guide on Assessing the Mental Health Needs of Older People, London, Social Care Workforce Unit, Kings College, London.

70. O'Connell, H., Chin, A. V., Cunningham, C., and Lawlor, B. A. (2005) 'Recent developments: suicide in older people', *British Medical Journal*, 329, pp. 895-899.

71. Keating, F., Robertson, D., McCulloch, A., and Francis, E. (2002) Breaking the Circles of Fear: A Review of the Relationship Between Mental Health Services and African and Caribbean Communities, London, Sainsbury Centre for Mental Health.

72. Department of Health (2005) Delivering Race Equality in Mental Health Care: A Summary, London, Department of Health.

73. Independent Asylum Commission (2008) Fit For Purpose Yet? The Independent Asylum Commission's Interim Findings, London, Independent Asylum Commission.

74. Burnett, A. and Peel, M. (2001) 'Health needs of asylum seekers and refugees' *British Medical Journal*, 322, pp. 544-547.

75. Glasby, J. and Lester, H. (2005) 'On the inside: a narrative review of mental health inpatient services', *British Journal of Social Work*, 35, pp. 863-879.

76. Pugh, R. and Williams, D. (2006) 'Language policy and provision in social service organisations', *British Journal of Social Work*, 36, pp.1227-1244.

77. Hatfield, B. (2007) 'Powers to detain under mental health legislation in England and the role of the Approved Social Worker: An analysis of patterns and trends under the 1983 Mental Health Act in six local authorities', *British Journal of Social Work*, Advance Access, 24 May 2007), pp.1-19.

78. Campbell, J., Brophy, L., Healy, B., and O'Brien, A-M. (2006) 'International perspectives on the use of community treatment orders: implications for mental health social workers', *British Journal of Social Work*, 36, pp. 1101-1118.

79. Gibbs, A., Dawson, J., and Mullen, R. (2006) 'Community treatment orders for people with a serious mental illness: a New Zealand study', *British Journal of Social Work*, 36, pp. 1085-1100.

80. Calsyn, R., Winter, J., and Morse, G. (2000) 'Do consumers who have a choice have better outcomes?', *Community Mental Health Journal*, 36 (3), pp. 149-160.

81. Kisely, S., Xiao, J., and Preston, N. J. (2004) 'Impact of compulsory community treatment on admission rates', *British Journal of Psychiatry*, 184 (5), pp. 432-438.

82. Brophy, L. and Ring, D. (2004) 'The efficacy of involuntary treatment in the community: consumer and service provider perspectives', *Social Work in Mental Health*, 2 (2), p. 157.

83. Care Standards Improvement Partnership, Healthcare Commission Mental Health Act Commission and National Institute for Mental Health in England (2005), Count Me In: Results of a National Census of Inpatients in Mental Health Hospitals and Facilities in England and Wales, London, Commission for Healthcare Inspection.

84. Warner, J. and Gabe, J. (2006) 'Risk, mental disorder and social work practice: a gendered landscape', *British Journal of Social Work*, pp. 117-134.

85. Langan, J. (2007) 'Mental health, risk communication and data quality in the electronic age', *British Journal of Social Work*, Advance Access, November 15, pp. 1-21.

86. Johns, R. (2007) 'Who decides now? Protecting and empowering vulnerable adults who lose the capacity to make decisions for themselves', *British Journal of Social Work*, *37*, pp. 557-564.

87. Manthorpe, J., Rapaport, J., and Stanley, N. (2008) 'Expertise and experience: people with experiences of using services and carers' views of the Mental Capacity Act 2005', *British Journal of Social Work*, Advance Access, February 16, pp. 1-17.

88. National Mental Health Risk Management Programme, Department of Health (2007) Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services, London, Department of Health.

89. Langan, J. and Lindow, V. (2004) *Living with Risk: Mental Health Service User Involvement in Risk Assessment and Management*, Bristol, Policy Press.

90. Tew, J., Gould, N., Abankwa, D., Barnes, H., Beresford, P., Carr, S., Copperman, J., Ramon, S., Rose, D., Sweeny, A., and Woodward, L. (2006) Values and Methodologies for Social Research in Mental Health, London, SPN/SCIE.

91. Mental Health Foundation (2000) Strategies for Living, London, Mental Health Foundation.

92. Huxley, P., Evans, S., Gately, C., Webber, M., Mears, A., Pajak, S., Kendall, T., Medina, J., and Katona, C. (2005) 'Stress and pressures in mental health social work: the worker speaks,' *British Journal of Social Work*, 35, pp. 1063-1079.

93. Huxley, P., Evans, S., Webber, M. and Gately, C. (2005) 'Staff shortages in the mental health workforce: the case of the disappearing approved social worker', *Health & Social Care in the Community*, 13 (6), pp. 504-513.

94. ADSS (2007) Advisory Paper on Mental Health Foundation Trusts, London, ADSS

95. ADSS (2007) Summary of Response to the Mental Health Bill, 2006, London, ADSS/LGA

96. Spandler, H. and Vick, N. (2006) 'Opportunities for independent living using direct payments in mental health' *Health & Social Care in the Community*, 14 (2), pp. 107-115.

97. GSCC (2006) Specialist Standards and Requirements for Post-Qualifying Social Work Education and Training: Social Work in Mental Health Services, London, General Social Care Council.

98. Gould, N., Huxley, P. and Tew, J. (2007) 'Finding a direction for social research in mental health: establishing priorities and developing capacity' *Journal of Social Work*, 7 (2), pp. 179-196.

About SCIE research briefings

This is one of a series of SCIE research briefings that has been compiled by Keele University for SCIE. SCIE research briefings provide a concise summary of recent research into a particular topic and signpost routes to further information. They are designed to provide research evidence in an accessible format to a varied audience, including health and social care practitioners, students, managers and policy-makers. They have been undertaken using the methodology developed by Keele in consultation with SCIE, which is available at **www.scie.org.uk/publications/briefings/methodology.asp** The information upon which the briefings are based is drawn from relevant electronic bases, journals and texts, and where appropriate, from alternative sources, such as inspection reports and annual reviews as identified by the authors. The briefings do not provide a definitive statement of all evidence on a particular issue.

SCIE research briefings are designed to be used online, with links to documents and other organisations' websites. To access this research briefing in full, and to find other publications, visit **www.scie.org.uk/publications**

SCIE research briefings

1. Preventing falls in care homes
2. Access to primary care services for people with learning disabilities
3. Communicating with people with dementia
4. The transition of young people with physical disabilities or chronic illnesses from children's to adults' services
5. Respite care for children with learning disabilities
6. Parenting capacity and substance misuse
7. Assessing and diagnosing attention deficit hyperactivity disorder (ADHD)
8. Treating attention deficit hyperactivity disorder (ADHD)
9. Preventing teenage pregnancy in looked-after children
10. Terminal care in care homes
11. The health and well-being of young carers
12. Involving older people and their carers in after-hospital care decisions
13. Helping parents with a physical or sensory impairment in their role as parents
14. Helping parents with learning disabilities in their role as parents
15. Helping older people to take prescribed medication in their own homes
16. Deliberate self-harm (DSH) among children and adolescents: who is at risk and how it is recognised
17. Therapies and approaches for helping children and adolescents who deliberately self-harm (DSH)
18. Fathering a child with disabilities: issues and guidance
19. The impact of environmental housing conditions on the health and well-being of children
20. Choice, control and individual budgets: emerging themes
21. Identification of deafblind dual sensory impairment in older people
22. Obstacles to using and providing rural social care
23. Stress and resilience factors in parents with mental health problems and their children
24. Experiences of children and young people caring for a parent with a mental health problem
25. Children's and young people's experiences of domestic violence involving adults in a parenting role
26. Mental health and social work

Social Care
Institute for Excellence
Goldings House
2 Hay's Lane
London
SE1 2HB

tel: 020 7089 6840
fax: 020 7089 6841
textphone: 020 7089 6893
www.scie.org.uk

Registered charity no. 1092778 Company registration no. 4289790

RB2608