SOCIAL POLICY AND PRACTISE IN THE UK: THE PATHWAY TO MODERNISATION

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Overview of Presentation

- Explore the historical development of the UK Social Welfare System
- Discuss the development of “Care in the community” (policies, legislation and practise).
- Children and family services (policy and practise)
- Mental health services (policy and practise)
- Questions from the student group)

HISTORICAL OVERVIEW AND CHANGES IN THE UK SOCIAL WELFARE SYSTEM

INTRODUCTION

- The United Kingdom (UK) consists of the countries of England, Northern Ireland, Scotland and Wales
- Health and welfare services in England (the largest country within the UK) are currently undergoing **substantial changes**.
- **Radical re-formulation of the relationship** between the state, the individual, the family and communities wherein the balance of responsibility for ensuring social security is shifting away from the state towards the citizen.
- **'Mixed economy of welfare'** has become common shorthand to describe a mixture of state, private, voluntary and informal provision of care for vulnerable individuals, whereby the role and function of state institutions becomes one of enabling rather than providing for the needs of the population, the focus of which is the protection of vulnerable individuals.
- **Uncertainty** as to the function, role and value of social welfare professionals working in both state and independent sector agencies.

From Welfare State to Welfare Market

- The **first twenty-five years** of the welfare state, from 1945 until approximately 1970, resulted in the **creation of public services** used and valued by the majority of the population.
- The institutionalisation of the personal social services within local government structures and the mature **role of social work emerged** relatively late within the English welfare state system. (HMG 1970), provided the organisational framework and rationale for social work within the English welfare state.
- With the adoption of the **'new right ideologies'** following the election of the Conservative government in 1979, social work became an early victim of the shift from a welfare state to a 'mixed economy of welfare'
- Implementation of the 'new right' social policy was introduced through out the 1980's and early 1990's in the through various **legislative and policy statements such as:**

From Welfare State to Welfare Market cont

- 1981 DHSS Publications: Care in the Community:
- 1984 DHSS Publication: Helping The Community to Care
- 1986 Audit Commission Report: Making a Reality of Community Care;
- 1988 The Griffiths Report: Community Care: Agenda For Action HMSO;
- 1990 National Health and Community Care Act:

Three ideas have been central in the drive to develop this new model by linking the social to the economic dimensions of welfare services.

- The **Production of Welfare Approach**
- The requirement that social services and social work practice to be subject to **managerial** (in contrast to professional) decision making, regulation and audit.
- The introduction of Consumerism into the welfare arena, whereby clients or **service users are re-framed as "consumers"** and service purchasers as "customers".

CARE IN THE COMMUNITY

The developments of the 1980s and early 1990s transformed the organisational structures for provision of care intended for **people living in the community** who are not able to fully care for themselves.

The White Paper (1989) famously states, the government acknowledges that the great bulk of **community care is provided by friends, family and neighbours.**

The implications for social work practice have been considerable, some **social workers** now hold budgets and are directly responsible for the **purchase of care** for their client.

These changes in the organisation provision of care have generated opportunities for significant **changes in relationships between social workers and service users;** for example there are increased opportunities for the full involvement of service users

Two major developments as part of these trends have provided opportunities to empower adult service users:

- Self advocacy
- Independent living

New Labour and Modernisation Agenda

Modernisation implies a transformation of the welfare system - from one of collective to individual responsibility.

The integration of policies, strategies and practice and the alignment of resource allocation, service interventions and intermediate outcomes.

Reference to the full range of relevant legislation, e.g. Universal Human Rights, National Health and Local Social Services Acts

Impact of the Modernisation Agenda

- **For the state**, the execution of its collective responsibility is evidenced through its capacity to produce policy and administrative decisions that successfully direct the unity and coherence of the welfare system.
- **For services co-ordinators and providers**, responsibility is specified as the achievement of de-limited objectives within pre-determined procedures and resource allocations.
- **For the service user**, personal responsibility is evidenced by the achievement and demonstration of congruence between individual behaviour and inters subjectively validated norms and values; that is, in the attainment of agency constructed within modern notions of personhood and citizenship.
- **For the professional social worker**, responsibility is demonstrated through successful role performance as a simultaneous contribution to the achievement of the state as the legitimate representative of society, the service as a responsible institution and the client as a responsible citizen.

CHILDREN AND FAMILY SERVICES

The Child Welfare System

The Children Act (1989)

This Act has been grounded in the following principles:

Paramountcy

When children are involved with the state through legal process or social work activities the child's welfare must be 'paramount', throughout his or her childhood.

Parental responsibility

Piece of legislation that seeks to define the legal nature of that relationship and those responsibilities not only in respect of 'troubled children' or children in need but for all children especially where families fragment due to divorce etc.

Partnership

The parents of children are expected to be involved in all elements of their children's lives. If the State is required to intervene, for whatever reason, social works are still obligated to seek to act in this spirit of partnership. This obligation remains even if the parents are suspected

of having abused their child

The Child Welfare System contd

The Children (Leaving Care) Act (2000)

was introduced to improve the life chances of young people living in and leaving local authority care. Its main aims are:

- to **delay** young people's discharge from care until they are prepared and ready to leave;
- to **improve the assessment**, preparation and planning for leaving care;
- **to provide** better personal support for young people after leaving care;
- to improve the **financial arrangements** for care leavers.

The Child Welfare System contd

The Adoption and Children Act (2002)

The Act includes provisions to:

- put the **needs of the child at the centre** of the adoption process by aligning adoption law with the Children Act 1989
- encourage **more people to adopt** looked after children by helping to ensure that the support they need is available.
- support the Government's efforts to build confidence in the adoption process and encourage more people to come forward to adopt by enabling the Secretary of State to establish a new **independent review mechanism** for prospective adopters who feel they have **been turned down unfairly;**
- **enable unmarried couples** to apply to adopt jointly, thereby widening the pool of potential adoptive parents.
- strengthen the safeguards for adoption by improving the legal **controls on intercountry adoption**
- place duty on **social workers to arrange advocacy services** for looked after children and young people leaving care in the context of complaints

The Child Welfare Services

Family Support Services

These include assessments of children in need and often the provision of support services for parenting and care, including for disabled children. Voluntary 'accommodation' comes within these services, whether for short periods of respite or a longer period, and the parent retains full

parental responsibility.

Child Protection Services.

At 31 March 2001 there were 26,800 children on child protection registers in England. This figure represents 24 children in every 10,000. Slightly more boys were on the register than girls in 2001, girls out-numbered boys before 1994. The numbers at risk from physical or sexual abuse continue to fall while the numbers at risk from neglect and emotional abuse are rising steadily.

The Child Welfare Services contd

The Children's Services Plan. Required by government since 1996, is a multi agency plan with shared objectives and priorities to address the needs of all children in the city. The first issues tackled by the new Social Exclusion Unit are exclusions from school, homelessness and the regeneration of 'problem estates'.

The Children's Fund Is targeted at 5-13 year olds and is a key part of the Government's strategy to tackle disadvantages and inequalities, which derive from child poverty and social exclusion. The Fund is focused on developing services that support multi-agency working

- Supports services to identify children and young people who are showing early signs of difficulty.
- Provides children and young people and/or their families with the support they need to realise their potential and thereby overcome poverty and disadvantage.
- Secures long-term improvement in children's lives by building capacity in the local community.
- Actively involves children, young people and their parents in planning and delivering services.

There is also a strong focus on supporting parents both in their parenting, and with other issues including domestic violence, counselling, family support and health awareness.

The Child Welfare Services contd

The Children's National Service Framework

Will develop new national standards across the NHS and social services for children.

The Children's National Service Framework will be an important way of responding to some of the key challenges facing children's health and social care services, for example, mainstreaming the successes of programmes such as Quality Protects and Sure Start.

Other services:

Local education authority - potentially all education functions, including the education welfare service, youth service, special educational needs and educational psychology, childcare and early years education, and school improvement.

Children's Social Services including assessment and services for children in need such as family support, foster and residential care, adoption services, childcare for children in need, advocacy services and child protection, and services for care leavers.

Community and acute health services, such as community paediatrics, Drug Action Teams, Children's and Young People's Joint Commissioning Groups, teenage pregnancy coordinators, and locally commissioned and provided CAMHS

Youth Offending Teams - multi-disciplinary teams working with young people and their families to prevent offending

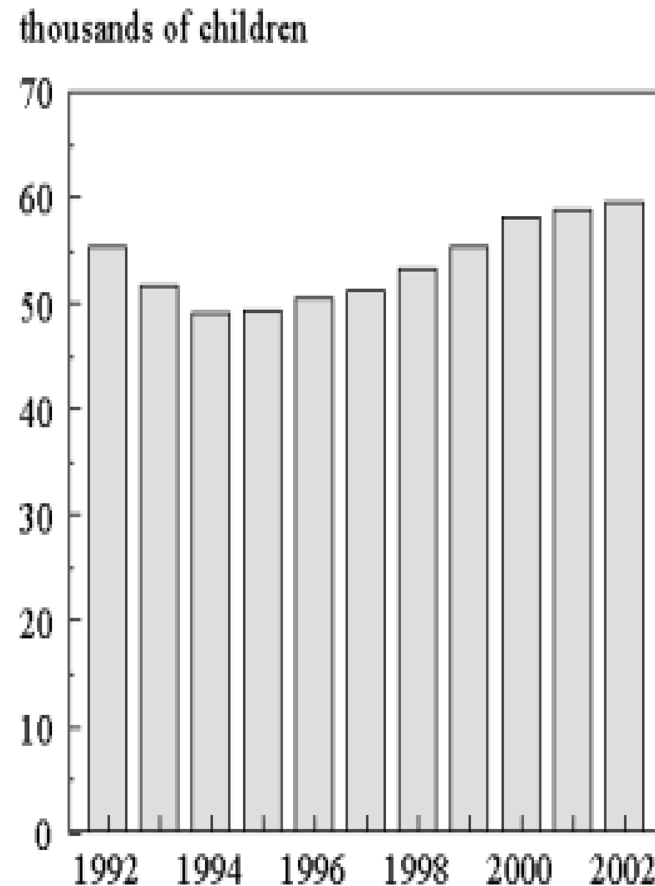
Connexions Service - multi-agency information, advice and guidance service for 13-19s.

Interesting Statistics

Children looked at 31 March 2002

- estimated number - **59,700 children**, 1% higher than a year earlier (58,900) and 22% higher than in 1993/94 (49,100) - see chart
- **legal status** - 64% under care orders, 32% under single voluntary agreements
- **placement** - 66% in foster placements, 13% in children's homes and residential schools, 11% placed with parents
- 15% had experienced **3 or more placements** during the year (indicator A1 of the Performance Assessment Framework)

Interesting Statistics contd



Interesting Statistics contd

Care leavers aged 16 or over during the year ending 31 March 2002

- the number of 16 year old care leavers **2,100**, (compared with 2,400 a year earlier); the number leaving care on their 18th birthday - 3,200 (up from 3,100 a year earlier)
- 2,600 (41%) of care leavers aged 16 or over gained at least 1 **GCSE or GNVQ**
- 5% of care leavers aged 16 or over gained **5 or more GSCEs** at grades A* to C
- councils were in touch with 75% of care leavers on or near their 19th birthdays and **46% were either in education, training or employment**

Interesting Statistics contd

Child protection register findings for the year ending 31 March 2002

- .There were 25,700 children on child protection registers at 31 March 2002, just over 4% less than a year earlier. This figure represents 23 children per 10,000 of the population aged under 18.
- .There were 27,800 additions to the registers (registrations) during the year ending 31 March 2002 and 28,800 children were de-registered over this same period. This was an increase of 3% for registrations and a decrease of 5% for de-registrations in comparison with the previous year (see chart).
- .At 31 March 2002, there were more boys on the register than girls; a reversal of the position a decade ago.
- .4,600 (18%) of the children on the register at 31 March 2002 were also looked after by local authorities.
- .39% of registrations during 2001/2002 related to children considered to be at risk of neglect. Physical abuse accounted for 19% of registrations followed by emotional abuse (17%) and sexual abuse (10%).
- .14% of children registered during 2001/2002 had previously been registered; this is the same proportion as last year.
- .10% of children removed from the register had been on it for over 2 years;

  this percentage has decreased slightly since the previous year.

MENTAL HEALTH SERVICES

Introduction

At any one time one adult in six suffers from one or other form of mental illness. In other words mental illnesses are as common as asthma. They range from more common conditions such as deep depression to schizophrenia, which affects fewer than one person in a hundred

The National Service Framework for Mental Health spells out national standards for mental health, what they aim to achieve, how they should be developed and delivered and how to measure performance in every part of the country. They are intended to raise standards, tackle inequalities and meet the special needs of women, men, and different ethnic groups of working age adults up to 65.

The National Service Framework sets standards in five areas.

Standard One: Mental Health Promotion

Health and social services should:

- **promote mental health for all, working with individuals and communities**
- **combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.**

Mental health problems can result from the range of adverse factors associated with social exclusion and can also be a cause of social exclusion. For example:

- **unemployed people are twice as likely to have depression as people in work**
- **children in the poorest households are three times more likely to have mental health problems than children in well off households**
- **half of all women and a quarter of all men will be affected by depression at some period during their lives**
- **people who have been abused or been victims of domestic violence have higher rates of mental health problems**
- **people with drug and alcohol problems have higher rates of mental health problems**
- **between a quarter and a half of people using night shelters or sleeping rough may have a serious mental disorder, and up to half may be alcohol dependent**
- **some black and minority ethnic communities are diagnosed as having higher rates of mental health problems than the general population - refugees are especially vulnerable**
- **people with physical illnesses have twice the rate of mental health problems**

Standard One: Mental Health Promotion contd

Service models

- **Through health improvement programmes and local mental health strategies, local health and social care communities - local health authorities, local authorities, NHS trusts, primary care groups and trusts, and the independent sector - should develop effective mental health promotion for:**
    - **whole populations - through initiatives to promote healthy schools, healthy workplaces and healthy neighbourhoods**
    - **individuals at risk - supporting new parents, unemployed people, and families in distress, for example, making use of local self-help groups**
    - **vulnerable groups - including specific programmes for black and minority ethnic communities, people who sleep rough, those in prison, individuals with alcohol and drug problems, people with physical illnesses, and others at greatest risk action to combat discrimination against people with mental health problems and to promote positive images of mental ill health.**

Standard Two: Primary Care and Access to Services

Any service user who contacts their primary health care team with a common mental health problem should:

- **have their mental health needs identified and assessed**
- **be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.**

Standard Three: Common Mental Health Problems

Any individual with a common mental health problem should:

- **be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care**
- **be able to use NHS Direct, as it develops, for first-level advice and referral on to specialist helplines or to local services.**

Mental health problems are common. The majority of all health care is provided by the primary care team, and this should also be the case for the majority of mental health needs. There are a number of points of access to mental health services, and local health and social care communities need to ensure that advice and help is consistent. NHS Direct will provide a new source of first-level advice, and should in time be able to provide a route to specialist helplines such as the Samaritans, SANEline, National Schizophrenia Fellowship and MIND helplines.

Standard Three: Mental Health Problems contd

Service models

Local health and social care communities need to build capacity and capability in rimary care to manage common mental health problems and to refer for specialist advice, assessment and care appropriately:

- **using protocols, for depression as the first priority; then also for postnatal depression, eating disorders, anxiety disorders, and for people with schizophrenia. A number of protocols have been developed locally. The National Institute for Clinical Excellence will be asked to review these, and, where appropriate, to kitemark examples of good practice, which will be promulgated for local use**
- **managing referrals to specialist services, including psychological therapies, and monitoring waiting times**
- **specialist mental health services providing primary care liaison, and support for primary care staff through continuing professional development**
- **supporting patients and their families in understanding their mental health problem and its treatment, and to make contact with local self-help groups.**

Local health and social care communities also need to establish explicit and consistent arrangements for access to services around the clock:

- **via the GP or primary care team**
- **through NHS Direct and other helplines**
- **in Accident & Emergency (A&E) departments through mental health liaison services**
- **with a gateway to specialist services through effective out of hours arrangements**
- **including people detained by the police**

Standard Four: Care Programme Approach

All mental health service users on the Care Programme Approach (CPA) should:

- **receive care which optimises engagement , pr events or anticipates crisis, and reduces risk**
- **have a copy of a written care plan which:**
  - **includes the action to be taken in a crisis by service users, their carers, and their care co-ordinators**
  - **advises the GP how they should respond if the service user needs additional help**
  - **is regularly reviewed by the care co-ordinator**
- **be able to access services 24 hours a day, 365 days a year.**

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Standard Five: Assessment

Each service user who is assessed as requiring a period of care away from their home should have:

- timely access to an appropriate hospital bed or alternative bed or **place, which is:**
    - **in the least restrictive environment consistent with the need to protect them and the public**
    - **as close to home as possible**
- **a copy of a written after care plan agreed on discharge, which sets out the care and rehabilitation to be provided , identifies the care co-ordinator, and specifies the action to be taken in a crisis.**

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Standard Five: Assessment contd

Service models

Local health and social care communities should focus on:

- the integration of CPA and care management,
- implementing arrangements for the assessment and, where appropriate, care of people who are detained by the police, brought before a court or are in prison
- ensuring that staff are competent to assess the risk of violence or self-harm, to manage individuals who may become violent, and to know how to assess and manage risk and ensure safety
- implementing local protocols for the effective and safe care of people with severe mental illness, including a protocol for sharing information about individuals on enhanced CPA. A number of protocols have been developed locally. the engagement through assertive outreach and effective medication of service users who are at risk if they lose contact with services
- integrated arrangements to prevent and manage crisis, including access to services round the clock

Investing in a balance of hospital beds (including secure beds), staffed and supported accommodation, day places and home treatment to ensure access and to enable effective use of resources, taking account of the conclusions of the National Beds Inquiry. A shortage of provision at any point will result in pressures in other areas -for example, a lack of secure beds may result in reduced access to acute hospital beds or to hostel provision. .

QUESTIONS AND ANSWERS