Background and overview of learning
This piece concerns my work with Mick (not his real name), a 59 year old white British gentleman who had previously spent 8 years in prison for arson. While in prison, his mental health had deteriorated and he was diagnosed with paranoid schizophrenia. He was transferred to an out-of-area secure mental health unit 8 years into his sentence, which was subsequently commuted to admission under section 47/49 of *The Mental Health Act 1983* (2007). Following successful treatment, Mick’s formal admission was discharged and he became an informal patient with section 117 aftercare entitlement. It was at this point in his recovery that I became involved in his care. My role was to co-ordinate transfer to a "step-down", rehabilitative environment with a view to enabling Mick to live as independently as possible in the community going forward. [Editorial note: the following was noted as evidence of the 'Contexts and organisations' domain] My work with Mick is ongoing and through discussions in supervision, as well as using models of reflection such as Korthagen and Valasos' (2005, p. 54) 'onion model', I have been able to draw out two key areas that this account will explore.

Preparation for intervention
My first feelings when allocated Mick's case were a combination of expectation - that my intervention could have a significantly positive impact on his life - and apprehension, given my limited experience in working on a case of this complexity. It was clear at an early meeting that expectations from Mick, and others involved in his care, surrounding my role were significant. [Editorial note: the following was noted as evidence of the 'Knowledge' domain] My pre-qualification experience of working with individuals holding a diagnosis of paranoid schizophrenia was extremely limited, so I spent significant time reading literature focused on its signs and symptoms (World Health Organisation, 2012, Craig, 2006). The manner in which these can manifest in individual cases is extremely disparate and my experience in translating intellectual knowledge into practical skills was still very limited.

[Editorial note: the following was noted as evidence of the 'Contexts and organisations' domain] Given Mick’s recent life history and then current circumstances, there was also significant input from medical and criminal justice agencies (care provider, PCT funders, probation service) who approached Mick’s ongoing care - understandably - from their own professional platforms, and offered numerous qualified preferences regarding what his care should include. I became aware that, perhaps, they viewed the social care role as one of alternative funding and the devolution of responsibility for the management of risk.
Prior to a CPA review I had decided to spend time with Mick in order to ascertain his wishes and needs. Following the review, I spent two hours with Mick and offered him the opportunity to fill out a "self assessment" feedback form which asked him to identify the most important aspects of his future care, as well as requesting how professionals involved in his care - myself included - might improve their practice towards him. Mick preferred to complete this on his own and posted it to me a few days later.

**Reflection on Intervention**
I was immediately taken by the honesty and clarity of Mick's feedback. He wanted to move nearer to my locality (where he had previously lived, prior to incarceration); he did not like me to only contact him by phone or post (something that had happened quite often initially, given the location of his placement), preferring face-to-face contact; he wanted to be in control of his own finances (which were significant following the recent sale of his house); and he should be allowed to avoid all contact with potatoes.

[Editorial note: the following was noted as evidence of the 'Diversity' domain] This last request was a consequence of delusional thought processes (World Health Organisation, 2012) that saw Mick verbalise beliefs that he has a brain tumour "the size of a potato" and that by touching or eating potatoes, the tumour will worsen. This request had been turned down by the prison service and his then care provider, on the basis that this was an unreasonable, psychotic perception that could not be catered for on an individual basis. Although Mick had not eaten or touched potatoes for decades, their proximity to him in prison and ward canteens caused him significant distress.

[Editorial note: the following was noted as evidence of the 'Professionalism' domain] The resolution of this concern was, I believe, a vindication of the social work role within mental health. Whereas medical (it was a sign of mental illness that should be treated) and criminal justice (it was not considered to be an important aspect of Mick's punishment or rehabilitation) models of human development did not appear to offer an agreeable resolution to Mick's concerns, by developing an holistic assessment of Mick's needs - that held Mick at the heart of service provision - I was able to offer him hope that this concern would be considered when determining his future care. This was perhaps also only possible by maintaining social work values at the centre of my work that respected Mick's autonomy and dignity (BASW, 2012).

[Editorial note: the following was noted as evidence of the 'Values & ethics' domain] The motivation to work in my current field after completing my undergraduate course was borne out of personal/family experience, and it was always more important to me to work in mental health, rather than be a social worker as such. My relationship with social work has been ambivalent at times. Having a British, middle-class, Catholic upbringing, I believe I have a strong moral code that is best portrayed by Virtue Ethics (Beckett and Maynard, 2005) and the value of being a "good person". I believe these motivations were apparent in my desire to work towards meeting Mick's needs in terms of his perception of potatoes. Rather than disregard them, I believed I needed to work towards meeting his wishes in order that he might perceive me favourably. Furthermore, in order to be perceived as a "good person" to the multi-agency group, I believed it was important to communicate to them the
significant energies that I had employed attempting to integrate the various opinions about Mick's future care, while trying to keep him at the heart of my undertakings. [Editorial note: the following was noted as evidence of the ‘Intervention & skills’ domain]

Once a suitable placement had been found and Mick had moved (to accommodation much closer to my locality), it was necessary to work with him and his new care provider to develop a care plan that accurately reflected his needs and promoted his independence. Given Mick's previous conviction, the care provider and I shared significant concerns regarding Mick having access to lighters and combustibles. Determining levels of risk, however, was particularly difficult given the length of time since Mick had had this level of independence, coupled with the need to support Mick to safely manage his mental health needs. I believe a significant factor influencing our approach to risk was the negative identification and perception of individuals who have experienced criminal justice processes.

I have very little experience of having met "criminals" and perhaps display limited insight into the social construction of deviancy and criminality (Fionda, 2005). Having lived in The Netherlands for around 10 years, I was aware of the arguably "leftist" approach its government has to criminal rehabilitation and have always felt this to be a progressive approach that is perhaps more aligned to social models of human wellbeing, rather than a more right-wing punitive approach that identifies individual or biological pathology. [Editorial note: the following was noted as evidence of the 'Rights, justice & economic wellbeing' domain] My work with Mick tested these values for the first time as I found myself placing greater emphasis on risk minimisation through intervention, rather than perhaps espousing a framework of human rights, as enshrined in law by The Human Rights Act 1998, and statement principles (BASW, 2012) which could include positive risk-taking (Department of Health, 2007). I also found myself rationalising, and seeking re-assurance with other stakeholders in Mick's care, that this risk-averse approach was appropriate. This perhaps indicated, upon reflection, that I was not subconsciously satisfied that the risk management plan was entirely justifiable. As Mick had indicated that he preferred face-to-face contact, and now that he was living closer to me, we agreed on fortnightly visits where risk management plans could be reviewed and amended if necessary with Mick and his care provider. This enabled me to review my misgivings about the initial risk plan and through consultation with agency policy coupled with advice gained through formal supervision, I was able to develop positive risk-taking strategies that Mick and his care provider were agreeable to.

During one of these visits the care provider indicated they were also concerned about Mick having access to his significant savings, and potentially spending it "frivolously". They requested I initiate Appointeeship or Court of Protection procedures to ensure Mick's monies were safely managed. Again initially I was inclined to proceed with a risk minimisation pathway. Perhaps I was also influenced by some feelings of unfairness or jealousy that Mick, a "criminal" should have so much money at his disposal. However, I recalled a previous case that had needed Court of Protection input, and remembered the grounds with respect to mental capacity that had needed to be satisfied.
Discussing the relevance of this previous case during supervision helped me recognise the principles of The Mental Capacity Act 2005, and how they could be applied to Mick's situation. Staff at Mick's care provider appeared unsure about using The Mental Capacity Act 2005 and so I agreed to offer information leaflets and advice during my next visit. I felt satisfaction that I had been able to promote Mick's wishes, while also being able to combine positive risk-taking strategies with effective leadership with respect to explaining why statutory guidance suggested Mick should be supported by his care provider to manage his finances. Again, an appropriate management plan was agreed upon that offered support and transparency to Mick and his care provider.

Conclusion
That I was able to identify a suitable placement that had a self-contained flat and kitchen for Mick to prepare meals was a point of satisfaction. I also believe that by finding a practical solution to Mick's needs, within the context of his diagnosis of paranoid schizophrenia, I was able to develop my knowledge and skills from a point of understanding delusions and how they might present in a clinical manner, to understanding the impact that individuals' beliefs can have on their everyday lives and, furthermore, identifying social care processes that might support them. I believe I was also able to highlight the institutional limitations of sister professions in meeting individuals' needs, with the consequence of perhaps cementing my previously ambivalent relationship with social work. My work with Mick enabled me to more clearly identify the distinct role that social work has within mental health services, as well as reinforcing my motivation to work in an ethically robust manner that valued human dignity, rights and choice.

Upon reflection I was surprised, however, by my conservative approach to risk management. Arguably, this was due to a limited or solely theoretical insight into my perception of individuals who have experienced criminal justice processes. I also believe I had perhaps not maintained sufficient focus on Mick's feedback regarding looking after his own finances. When confronted with these considerations, it took an active commitment to reflection (particularly through supervision) to develop a more holistic approach involving positive risk. I believe the feedback from Mick also helped me to develop my understanding of the importance of building relationships with service users (Ruch et al., 2010). It was through acting on his preference for regular, face-to-face contact that the care provider and I were able to review his care plan appropriately. It was also through his desire to remain in control of his finances that I was forced to reflect on my approach to risk management and positive risk-taking. This examination has given me a better understanding of my own motivations and values with respect to individuals who have experienced criminal justice processes and highlighted the need for me to continue to develop in this area. I am sure that Mick's feedback has significantly improved my confidence as a practitioner and will enable me to exercise similar skills with service users in future.

References


