Social Work: big ratios, small funding

As a Social Worker on an adult mental health inpatient unit in Victoria, I am writing a formal submission to advocate for consumers and Social Workers engaged with acute mental health because I believe that current service provision in acute mental health can be much improved. Social Workers are key players in acute mental health precisely because we focus on the psychosocial stressors that have triggered relapses, first episodes or crises leading to admission. The role of Social Workers on the ward is to support individuals to overcome some of their major psychosocial stressors by advocating for them and supporting them to navigate other systems (Centrelink, housing) to move towards an improved quality of life outside the ward. Allied health – contained to Social Work for this discussion – struggles to provide sufficient support to individuals purely due to the impossibly large ratio of Social Work staff to consumers. On our ward we have 1 full-time graduate Social Worker and 1 part-time senior Social Worker for 25 consumers. The medical model and the role of medication is indisputably important, however the funding of public mental health facilities needs to be more balanced across disciplines to allow for holistic, ethical treatment and to further enable consumers' recovery in the community.

Psychosocial Stressors and Social Work

Firstly, there is always psychosocial stress that has overwhelmed the individual to the point that it manifests as a struggle with symptoms of a mental illness – rarely is there an organic relapse of mental illness isolated from psychosocial stress. Psychosocial stressors commonly experienced by mental health consumers in our area include Child Protection involvement, family violence, forensic and legal issues, trauma, seeking asylum and migration, neighbourhood safety, substance use, homelessness (or risk of), unemployment, Centrelink and other financial stressors.

Psychosocial stressors define the role of Social Work on the ward. For example, amongst other interventions and supports, we will often advocate for consumers' rights on and off the ward, support people who are experiencing homelessness (or risk of same) to engage with a housing support worker and find them crisis accommodation; involve Child Protection services when there are children at risk; for those experiencing family violence we will create safety plans and refer them to family violence support services; for those trying to navigate the Department of Home Affairs to stabilise visa issues we will provide support letters and facilitate their liaison with the Department, and for those with Centrelink complications we often escort and support people at Centrelink, and/ or provide advice on payments, then support them to make the claim. Often this task falls to Social Work in the instances where the person has limited social supports or their supports are unable to take time out of their work or commitments.

A commonplace example is an individual who experiences a relapse of depression when they have a history of trauma, are struggling to pay rent, are eligible for more Centrelink but they don't know how to make a claim, they have complex family dynamics and occasionally self-medicate with substances. Amongst the chaos, they then forget to take their medication, possibly self-harm or

attempt to take their own life and come into hospital. Due to bed pressure, Social Work may not be able to meet with them and support them prior to discharge. This means that they are discharged once medication has reduced the severity of their symptoms and they no longer pose a risk to themselves or others being out in the community. However the core reason they came into hospital in the first place preceded medication complications – it was psychosocial stress. Had there been more Social Workers on the ward, perhaps support to navigate Centrelink for Rent Assistance could have been achieved, or other housing options explored, or a referral could have been made for a housing worker. Further, family work, psychological support for their trauma and perhaps a safety plan for their mental health could have been looked into also. But the main reason they experienced a relapse of their mental illness remains unaddressed, reducing the sustainability and integrity of the discharge for the individual, thereby compromising their recovery from this episode.

These tasks may not seem time-consuming, but because services like Centrelink and housing are understaffed, complicated, and require lengthy application forms, practical tasks such as escorting and supporting someone with Centrelink claims can take altogether up to 4 hours on one day, not including the hours spent supporting them to complete claims afterwards. Further to this, the fast-pace of the ward and the nature of bed-pressure (consistently 2 discharges per day, including the weekend) means that sufficient support is sometimes not provided before the individual is discharged.

It is well known that psychosocial stressors cannot be fixed with medication. Medication can often enable a person's symptoms to reduce to a point where they can navigate the stressors themselves, however we are in a society where – cruelly – the most disadvantaged and impoverished people are often engaged with and have to navigate the most complex and under-resourced services that exist, for example Centrelink and Office of Housing. These stressors do not disappear when they are in hospital – they simmer in the background creating only more stress.

Many consumers enter and exit the hospital doors having never met with Social Work when, regardless of context, everyone can benefit from Social Work input. As long as the ratio of Social Workers to consumers on a ward is 1.8:25, acute mental health service provision and recovery for consumers will be significantly compromised and discharges will be less sustainable. Community mental health is managing to harness the focus on the link between psychosocial stress and mental health well, however acute mental health lingers in the medical model.

Stigma within the Medical Model

It is well known that mental health treatment needs to be holistic – aside from medical treatment it needs to consider trauma, stress, grief, connection, resilience and coping across all life systems. Historically, treatment was medical because the understanding of mental health was that it was merely a chemical imbalance unrelated to the persons' context and systems. This understanding of

mental health has also flavoured its stigma – that mental health is a sign of weakness and there is no hope of recovery. The disproportionate focus on the medical model relative to the systems approach in acute mental health (which is evidenced by the skewed staffing across medical and Social Work) reflects the archaic understanding of mental health – that medical treatment is absolutely paramount to any other treatment. Through insufficient funding for Social Work roles, the system has created barriers for staff to providing holistic treatment to consumers. Staff are forced to represent a system that is inherently stigmatising its own consumers, which in turn enables consumers to develop or reiterate their own internal stigma.

Another avenue to fight mental health stigma is to increase Social Work in acute mental health as it will enable treatment to become what everyone believes it should be – holistic and focused on the individuals' life systems.

Contradictions within service KPIs

A well-known KPI of the service is the "28 day readmission" target. This indicator tracks individuals who return to the ward within 28 days of the discharge from their previous admission. This can happen for a multitude of reasons, but often relates to substance use and/ or an itinerant lifestyle. By virtue of having a role that focuses on peoples' lives outside of their mental illness and the hospital, Social Work has a key role in discharge planning regarding housing, family supports and finances amongst others. For a service to authentically and strategically commit to keeping this KPI low thereby improving outcomes for consumers, it logically follows that more Social Work is required.

Homelessness, Discharges and Social Work

Currently, no one is ever discharged into primary homelessness such as unsheltered, improvised dwellings. Short-term crisis and transitional options are always accessed which constitute motels and rooming houses with referrals in place to housing access points. However this accommodation is unsustainable. If there were more Social Work on the ward, perhaps engagement with housing services could be facilitated prior to discharge so the consumer has a relationship with the service before leaving hospital. Further, due to the risk between the walls of rooming houses and some motels, better crisis options could have the secondary impact of for example supporting the consumer to remain substance free. This would have a major impact on readmission KPIs, but first and foremost it would reduce the consumers' risk profile and improve their recovery.

For those consumers who don't already have a mental health case manager, they are often discharged with support from the community Rostered Function/ Crisis Assessment Teams with a plan sometimes to be allocated a case manager. However allocation for case management can take up to 2 weeks, sometimes more. There are supports in the community for consumers so not every

issue requires follow-up on the ward. However the more that can be followed up with on the ward, the more holistic the treatment is at the most acute point in their recovery. This enables them to engage meaningfully with services or their own recovery journey upon discharge.

It is negligent and ignorant to provide mental health treatment that is seriously lacking Social Work input. For a sustainable and ethical approach to treating consumers in acute mental health, and to act on the commitment to consumers and to a best-practice recovery framework, more funding for Social Work on wards is vital.

Staff in Acute Mental Health

The current system has repercussions for consumers but also staff. The rate of burnout in mental health is notoriously higher than other sectors. This can be partially attributed to moral injury: defined as acting in a way (whether by choice or not) that digresses from ones moral compass resulting in feelings of guilt, shame, anger and frustration. Working in a tightly woven bureaucratic system that struggles with resourcing and funding can allow for instances of moral injury for staff. For the benefit of consumers, Social Workers and other staff the aim should be to reduce the rates of incidence of moral injury, and where they inevitably occur, create proper support systems to minimise the adverse impact on staff. Discharge KPIs will be improved, consumers' recovery will be better supported, but mostly everyone needs a system that enables us to act to the same degree that we care.