

**GRADUATE CERTIFICATE in
Consolidation of Social Work Practice
LEVEL 6 - 60 Credits**

**LEARNER PORTFOLIO
(PORTH AGORED and UWTSD)**

Learner's name: Sharon McManus

**Learner's University Registration Number:
1602956**

**WALES INSTITUTE for WORK-BASED LEARNING
2016-2017**

Portfolio Guidance

Please read these notes carefully. They provide essential information. The documents you will use in developing your portfolio are on the following pages.

What is the portfolio for?

The purpose of this portfolio is to enable learners to demonstrate and provide evidence of how they meet the learning outcomes set by the Care Council for Wales, for the Consolidation programme, including:

- Applying analysis in assessment to inform intervention;
- Intervention and application of professional judgement in increasingly complex situations;
- Working collaboratively with service users, carers and other professionals.

Learner and employer learning agreement

At Section 9 of the Portfolio, you will find a blank copy of a learning agreement that you need to read, discuss and agree with your mentor, manager and training manager/coordinator. Once the agreement has been signed replace it in Section 9 of the portfolio.

How should the Portfolio be presented?

The material you write to include in the portfolio must be typed. Information about this can be found in the Programme Handbook. The whole portfolio must be submitted electronically. Portfolios must be complete at the point of submission.

How is the Portfolio assessed?

During the programme, advice and support about the development of your portfolio will be provided as part of four, mandatory Consolidation workshops, and by your mentor. Feedback on all aspects of the work you are undertaking to develop the portfolio will be provided as part of these workshops. Neither your mentor nor training staff you may have seen as part of the Consolidation workshops will be involved in marking your portfolio after submission. Portfolios are marked by appropriately qualified staff outside of your own employing organisation.

Dates of portfolio submission will normally be made available at induction, at consolidation workshop meetings and posted on Moodle.

Confidentiality

It is important that no individual can be identified either directly or indirectly from the information in the portfolio. You must:

- adhere to guidance in the Programme Handbook about confidentiality;
- not identify your Local Authority/employer by name or by associating any geographical, physical or other feature which might enable it to be identified. This includes reference in the bibliography to policies e.g. please use 'xxx authority policy';
- not identify any individual using services, their family or carers by name. Instead you must use numbers e.g. 1, 2, 3 etc. and **not** letters;
- not write information that enables any individual using services, their family or carers to be identified indirectly through the description you provide. This includes references to names, colleagues, places (including hospitals, schools, town, villages, streets) specific incidents which might enable identification due to past publicity, other professionals or any other personal information including medical or other conditions;
- take personal responsibility for adhering to confidentiality rules. Although consolidation workshops and feedback about your portfolio will provide guidance and feedback, it is the learner's responsibility to ensure the portfolio adheres to the confidentiality requirements stated in the handbook and above.

Remember that the Portfolio is YOUR responsibility you must not rely on anyone else to pick up any confidentiality breaches as this is your work. You must accept full responsibility for confidentiality. Meeting all the confidentiality requirements is very important. Breaches of the confidentiality rules may incur a penalty including a deduction of marks or a fail, please see handbook for details.

Dyslexia and other special circumstances

If you have any condition that you feel may affect your ability to deal with any part of the programme, please contact your training department immediately to discuss any additional support that may be needed. The University has a Student Services Unit that may be able to help but ***It is the learner's individual responsibility to contact them.***

Section 1

Graduate Certificate In Consolidation of Social Work Practice - Learner Portfolio

Guidance:

- Your portfolio must contain items 1 - 9 below (in the order given);
- You should use this pro-forma to insert your text within each section;
- Please make sure the Signatures page at Section 8 is fully completed before submission

Contents

Portfolio Section	Topic	Task no.
1	Contents page	
2	Developmental Review	1
3	Observation and feedback	2
4	Safeguarding and working in complex situations – Case Study	3
5	Safeguarding	4
6	Developmental Review	1
7	Bibliography	
8	Learner details, Signatures and Line manager verification	
9	Learner and Employer Learning Agreement	

Section 2

Developmental review (a)

Guidance: This section should be completed by taking into account the work that you will have done since qualifying, and discussions with your mentor and supervisor/line manager as part of your First Three Years of Practice Individual Plan.

Based on your experience in practice identify and justify your agreed learning needs for the following outcomes:

- Working Collaboratively with individuals who are using services, their families and Carers
Working Collaboratively with Other Professionals
- Applying analysis in assessment to inform interventions
- Intervention and application of professional judgement in increasingly complex situations

500 words (+/- 10%: include your actual word count at the end of each section)

Following discussions with my manager there is an expectation that I enrol on the Approved Mental Health Professional (AMHP) training Course after two years of practice in the team commencing January 2018. Following on from there I will continue my professional development by undertaking the Best Interest Assessor (BIA) course then the Practice Teacher Award. I am aware that the training to attain AMHP, BIA and Practice Teacher will involve an array of learning experiences some taught and some experiential and these will have a significant impact on my professional development and confidence.

Working collaboratively with Individuals who are using services, their families and carers.

The more experience I have with citizens, families, and carers the more developed my practice becomes. I attribute my development to ongoing reflection *in* practice and *on* practice (Schon, 1987), and with the support of colleagues and one-to-one supervision.

Learning Need:

Work with a more complex case load to build on my experience, and increase my professional development.

Development plan:

To work with a protected case load gradually building in complexity and number.

Working collaboratively with other professionals

Mental Health Services are provided in partnership by the local authority and the health board. With the health board taking the lead responsibility. I feel I lack some confidence working in a predominantly medical environment. This is not a reflection of the team in which I practice, it is more a critical reflection of my level of confidence as a Social Worker in a predominantly medical arena.

Learning Need:

Increase self confidence in professional judgment and feel able (with confidence) to apply my professional judgment in the decision making process with other professionals.

Development plan:

Shadow more experienced Social Work colleagues in the team for example, attending tribunals, duty assessments, and ward rounds.

Applying analysis in assessment to inform interventions

I am fairly new to the Mental Health Measure documentation and I would benefit from more experience completing the paperwork.

I don't have a vast knowledge of what interventions/services are available to meet the needs of the citizens/families/carers that we work with.

Learning Need:

Develop my understanding of what is needed in the Measure documents.

Learn more about interventions that can support positive outcomes for Citizens, families and carers.

Development plan:

Draw on colleagues in the team, there is a host of knowledge that other disciplines can offer for example, the Community Psychiatric Nurses, Occupational Therapists, and Consultants.

Browse senior colleagues Measure documentation to gain more insight.

Work in collaboration with the carers support example Hafal.

Intervention and application of professional judgement in increasingly complex situations

As a student I completed my final placement (6 months) in the Child Protection Team; during this time I developed a robust understanding of risk and managing risks relating primarily to children. Having taken on a role in Adult Services I felt I lacked the same clarity in the process of safeguarding adults.

Learning Need:

Develop my understanding of managing risks in Adult Services.

Develop more in-depth understanding of the Mental Health Act 1983/2007 and Mental Capacity Act 2005 and their application in my work.

Development plan

Undertake safeguarding training. Apply for further training if needed.

Utilise Supervision, peer support, and the service team meeting, to make a whole team approach to decision making.

Word Count: 543.

Section 3

Observation from an individual using services, their family and carers

*Guidance: A learner must choose an observation of **direct social work practice** with an individual using services, families and carers, and record it on the following pro-forma. The observation cannot be from giving evidence in court, contributing to strategy group meetings, case conferences or tribunals or any other indirect activity. The permission of the individual using services, their families and/or their carers must be sought before the observation is undertaken. The observation must be undertaken by an observer who is social work qualified and has at least 3 years experience (criteria set out in the Programme Handbook). The observation must be a minimum of 30 minutes long. The observer will gain feedback from the individual using services, their families and/or their carers using the pro forma below at the end of the visit.*

Although the learner can choose to use the proforma provided for gathering feedback, they are encouraged to make this as in-depth as possible, and to use a range of ways to gather it, depending on age, ability, and the needs of the individuals using services, their families or carers.

In completing this section, you should watch the 4 video clips of 'More than just words' on Moodle as these should help you think about your own experiences and to reflect on why language should be an integral part of assessment and service provision.

Observation Summary

Please include name of the expert witness observing in section 8.

Date of observation: 16th January 2017

To be completed by learner

Set out the social work objectives and give a brief description of the situation including geographical and legislative contexts and any relevant cultural, ethnicity and language issues.

300 words (+/- 10%: include your actual word count at the end of each section)

The Regulations made under Part 2 of the Mental Health (Wales) Measure (2010) are clear that discharge from Secondary Mental Health Services is a formal and important event. I recognise that for some citizens, discharge from the Mental Health Service can be a time of increased anxiety and concern. I felt she was ready to disengage with the

service; I wanted to ensure that the process was one of collaboration and promote a positive sense of achievement for her. The purpose of today's session is to provide an 'ending' to our work together (we have worked together for 16 months).

This session is being held at the Community Mental Health Services building. The Community Mental Health Service has its own building that is not shared with other services. The building is centrally located in the county and 1 is happy to make the short journey to get here. The room used for the observation was a room that we had used for some of our previous sessions so it was a familiar environment to 1. The room is conducive to hold a confidential conversation, and offers sufficient space for 1 and I to sit comfortably with the observer just out of our eye line.

The Objectives:

- To act in accordance with the Care Council for Wales Code of Practice.
- To use language, skills and techniques appropriately to facilitate an open and honest conversation,
- To manage the session in a timely manner,
- To adequately assess/review the Care and Treatment Plan and Risks identified, in light of the plan to discharge today,
- To ensure 1 understands her rights to request a reassessment of her needs under Part 3 of the Mental Health (Wales) Measure (2010).

Total Word Count: 283.

Critically reflect on your communication methods and skills during the observation including how you identified whether you had the necessary communication skills to work with the service user, families and/or carer. Show how you adhered to social work values using a person centred approach, Code of Professional Practice for Social Care Workers, cultural sensitive practice, language preference including the "Active Offer" principle, and ethical practice.

1300 (+/- 10%: include your actual word count at the end of each section)

The 'Active Offer' principle (Welsh Government, 2016) was adhered to when 1 and I first met; this reflects the core values of the Social Services and Well-being (Wales) Act (2014). 1's only language is English so there was no identified need for an interpreter or an alternative worker. My first and only language is English and I am aware that this is a potential barrier in my work with citizens in Wales who's chosen language may be Welsh. I have worked with citizens whose chosen language is not a language I can speak; I worked with a citizen who is first language British Sign Language, and also a citizen whose first language is Bulgarian, in these cases I arranged an interpreter through the Wales Interpretation Service who can offer support with over 80 languages (WITS, 2018).

On her arrival I met 1 in reception and carried out introductions with the observer, I clarified that 1 was still in agreement for the observation to go ahead. When we initially sat down I felt nervous about my practice being 'observed'. Rather than allow it to be at the forefront of my mind (which would have impeded my thoughts) I mentioned what I was feeling. Theories around emotional intelligence tell us that practitioners need to make sense of not only the meaning of emotions in others, but, equally, the meaning for emotions in themselves, (Mayer, Salovey and Caruso, 2004).

1 and I had been collaboratively working toward discharge over the past few months. 1 had worked rather intensely and at a particular point in time she was working with three different service interventions. The British Association of Social Work (2014) states social workers should support people to reach informed decisions about their lives and promote their autonomy and independence (p.12). 1 had requested a 'step down from

support' and up until today we had not met for approximately six weeks. The reason behind the 'step down' was to allow 1 time to acclimatise to having no intervention from Mental Health Services. The person-centred approach requires that ending involvement is given significant emphasis if the work undertaken is to be consolidated (Tolan, 2003 cited in Miller, 2012).

The Code of Professional Practice for Social Care (2017) says Social Care Workers 'must' work with individuals in person centred ways using this as the basis for social care and support (Welsh Government. 2017). Social Work Practice aligns itself to a 'person centred' philosophy; a philosophy originally founded by Carl Rogers (1967). Murphy et al. (2013) argue that while Social Work might value the relational qualities of empathy, unconditional positive regard and congruence, it is theoretically misleading to refer to these relationship qualities as person-centred. Murphy highlights that both the policy and professional context require Social Workers to act instrumentally on behalf of the state and this is not in keeping of principled non-directivity advocated by the person centred approach.

Having established a professional relationship with 1, I was able to evaluate changes or differences in her presentation to aid my assessment. For example during times of crisis, 1 would misuse alcohol as a maladaptive coping mechanism, she would neglect to maintain a personal hygiene routine often presenting as dishevelled having unwashed hair and dirty clothes. On one occasion during the depths of her alcohol misuse 1 experienced 'alcohol hallucinosis'; a rare complication of chronic alcohol abuse characterized by auditory hallucinations that occur either during or after a period of heavy alcohol-consumption (Bhat *et al*, 2012).

Over the past few months I have become fairly attuned to 1's non-verbal responses and body language, Beesley et al (2017, p46) refer to this as 'communication cues'. Other less obvious behaviours for example, would include agitation (rubbing her arms) and shifting between elation and tearfulness, on occasions she would use very little eye contact; these behaviours would indicate she was struggling in some way. If/when 1

was struggling she would more often than not use alcohol as a maladaptive coping mechanism which would escalate the risks posed to self and others.

I began by asking 1 how she has been over the past few weeks; this was an open ended question intended to give her as much scope as possible to put her thoughts and feeling into her own words (Harris & White, 2013). From the outset I was covertly assessing to see if there was any indication of relapse in her mental health and any indication that she was misusing alcohol (misuse of alcohol would escalate risks). The mental state examination (MSE) is the primary type of examination used in Psychiatry. It is a structured way to observe and describe a citizen's current state of mind, under the domains of appearance, behaviour, attitude, mood, affect, speech, thought process, thought content, perception, cognition and insight (Trzepacz, 1993). 1 presented as dressed appropriately for the weather in clean clothes. Her speech was clear and she conversed coherently. She kept good eye contact throughout and there was use of appropriate humour. There appeared to be no signs of anxiety or agitation (displayed by rubbing her arms) which was often seen when she was misusing alcohol. She had a calm and amiable demeanour. There was no reports of auditory or visual hallucinations since she has been sober and she was future orientated.

1 stated 'things were different' and she felt ready to be discharged. Active listening is 'proactive rather than passive'; it is about listening to and understanding both what is said and what is not said (Cournoyer, 2013). Rather than simply accepting that 'things are different' I wanted to facilitate her to consider how, what and why things were different. I asked open ended questions for example: how are you managing difficult emotions now? In the past 1 sought alcohol as a way to manage her emotions. By asking open ended questions 1 was able to clarify what skills she was utilising to manage her emotions more effectively. This enabled her to consolidate her thoughts on emotional regulation into a more practicable action plan for the future. She was able to clearly identify triggers to her mental distress and state the support she would draw on if she felt she was struggling.

I believe I demonstrated a person centred approach during this observation. For example: 'empathy' requires an understanding of the other person's world and their values (Rogers, 1967). I asked 1 a pertinent question; I asked if a specific close friend was supporting her sobriety. 1 had spent time during our sessions talking about a particular close friend and how 1 'feared' she would lose that friendship because she no longer drank alcohol. The act of asking the question demonstrated an empathic understanding of her 'internal frame of reference' (Carl Rogers 1980, p. 140). Moreover, it facilitated my assessment of her by clarifying how she was managing the emotion 'fear' that she had spoken about in our sessions. 'Fear' had, in the past, been a trigger to her using alcohol as a way to manage.

1 and I agreed there were no current significant risk factors, she is consistent with medication, and is able to attend the GP surgery for reviews. 1 and I reflected on her relapse signatures and looked at current coping mechanisms in place. 1 is continuing to work with the Substance Misuse Service twice weekly and has regular contact with her key worker from the Rehabilitation Team. 1 is pleased that her child is no longer on the Child Protection register and she is having regular unsupervised contact. 1 had made the decision that she was ready to be discharged from the service and she has the 'qualified' right to respect for private and family life in accordance with the Human Rights Legislation, (1998). The Code of Professional Practice (Welsh Government, 2017) states as a Social Care Worker you must: Support individuals to maximise their decision making and control over their lives (1.3) and work with individuals to balance rights, responsibilities and risks (4.1). The outcome was that discharge will go ahead today.

I explained 1 of her rights under Part 3 of the Mental Health Measure (2010). As a 'Relevant Patient' she is entitled to self-refer within three years of her discharge date. I stated that in line with the Mental Health Measure (2010) the Local Authority is under a duty to provide written information including the reason for her discharge from secondary mental health services and I will forward this on to her in the post.

Total Word Count: 1409.

Feedback and comments from an individual using services, their family or carers

This section of the Observation should not be done in the presence of the learner.

Some or all of these questions may be used by the observer (who should re-phrase and add explanations and prompts as required). Alternatively, the learner is able to design their own method of obtaining information for the Observer to use if this is more suited to the needs of the individual. The observer should record responses below or by using the alternative method from the individual using services, their family or carers.

Before asking the questions, the observer must explain to the individual using services that their comments will be shared with the learner. It may be useful to explain that it is used as a learning tool for the learner to develop their own practice.

If the observer is unable to gain feedback, they should briefly say why.

Was the social worker on time? Or if delayed did he or she contact you?	Yes – usually on time for all appointments
Did the social worker get your permission in advance for the observer to be present? Did they explain why they were being observed?	Yes – I was asked on the phone and Sharon said I could say 'no' if I wanted. I didn't have to do it.
Were you clear why the social worker met with you today?	Yes
How well prepared do you think, the social worker was for his or her meeting with you?	Very prepared, Sharon usually is organised, she always has her pen and her diary with her.
How has the social worker listened to you and respected your views and wishes?	Yes always. Sharon has been very supportive over the past ten months, she has been very 'human' and has gone over and above in helping me.
Did the social worker talk to you in a way that you understood? Did you understand the language they used?	Yes, with the MIMs assessment Sharon explained it to me, Sharon explained the jargon that children's services use. Sharon didn't use jargon.

How has the social worker's involvement met your expectations for this visit?	Yes, did everything I thought we would do.
Are there any other comments or suggestions that you would like to make?	No for me Sharon has done more than she needed to – has been a massively supportive. Sharon (and SMS) have been the one constant as I have been very unwell, Sharon has got me the help I needed.

Section 4

Safeguarding and working in complex situations – Case Study

Complete a critically reflective case study based on an assessment, undertaken with others (In your own area of work) concerning the safeguarding of either an adult or a child. Demonstrate how the case relates to safeguarding legislation and your Safeguarding Boards safeguarding policies, strategies and procedures. Ensure that you cover the learning outcomes, National Occupational Standards, legislation (domestic and international), the specific dimensions of working in Wales and relevant social work theories. Please find list of learning outcomes in the handbook

4000 words (+/- 10%: include your actual word count at the end of each section)

This case study will highlight the complexity of social work practice; documenting a case where I had to manage the safeguarding of both a citizen and her young child simultaneously. I have tried not to focus on the child in this piece of work as the case study criteria asks for 'either an adult or child', but I think it demonstrates that often social work is complex and cannot be compartmentalised.

The Mental Health Measure (2010) requires initial referral to Mental Health Services be made through GP surgeries. Following consultation with a GP a decision is made as to whether an assessment is required by Primary Care Mental Health Services. Part 1 of the Mental Health Measure (2010) requires that, amongst other things, the local Primary Mental Health support services 'support the onward referral and co-ordination of next steps with Secondary Mental Health Services, where this is felt to be appropriate for an individual' (p.4). Secondary care Community Mental Health provide a service for citizens who are considered to have a serious mental illness/disorder that have longer term needs. It is important to note that some citizens with a serious mental health diagnosis will choose to just have contact with their GP. However for others who have active symptoms it may be that they want/need to have contact with the secondary care service.

I first met 1 during a 'transfer of care' meeting with the Local Authority Home Treatment Service. 1 had recently been discharged from a mental health hospital following an assessment and treatment under a Section 2 (S.2) of The Mental Health Act 1983. An

assessment under S.2 will consider whether a person is suffering from a mental disorder, what type of mental disorder it may be, and whether any treatment is needed. A S.2 is used if a person has not been assessed in hospital before, or for quite some time, and if a person is unwilling to go into hospital for assessment 'informally'. An Approved Mental Health Practitioner (AMHP) or a 'Nearest Relative' must make the application for hospital admission (Section 26 of the Mental Health Act 1983 sets out who will be a Nearest Relative. The list is in strict order and the person who is highest on the list is your Nearest Relative). When making an application for a S.2 the person must have been seen within 14 days of making the application, and seen by two separate doctors (one of whom must be specialised to undertake the role), the doctors must have seen the person within five days of each other, and hospital admission must be arranged within 14 days of the last medical examination. A person can be held up to 28 days, but the stay does not have to be that long if unnecessary. The S.2 cannot be renewed but can be transferred on to a Section 3 if warranted. A person detained in hospital has the right to appeal at a tribunal in the first fourteen days of detainment. A person also has the right to appeal at a Managers Hearing, and has the right to and Independent Mental Health Advocate who can support them to raise any issues with their care and treatment. If a person is being detained under S.2 they cannot refuse treatment except electro-convulsive therapy (ECT) which requires consent (Mental Health Act, 1983: S. 58A). A person can only be discharged from a S.2 by the Responsible Clinician, The Mental Health Act Managers, The Tribunal, or the 'Nearest Relative' (the Responsible Clinician can overrule the Nearest Relative).

Whilst 1 was in hospital she was diagnosed with a mental health disorder compounded by additional factors such as 'alcohol issues'; 1 accepted the mental health diagnosis but disputed she had 'alcohol issues' describing recent events as a 'blip'. 1 was prescribed medication to support her mental health recovery and she was currently consistent with the medication prescribed. The Home Treatment Team were requested as part of 1's aftercare treatment. The Home Treatment Team (HTT) provide a service in a crisis situation, whereby without intervention, acute psychiatric hospitalisation would be the likely outcome. The HTT also serves to prevent the need for readmission as an

inpatient, or to facilitate early discharge from inpatient services. The service offers a 7 day week service intervention for citizens.

The Mental Health Code of Practice states 'service providers should have robust procedures in place to support the timely and effective transfer of care between services' (Welsh Government, 2010, p.40). 1 had been under the care of the HTT for approximately 2 weeks following her discharge and the team felt a transfer to Secondary Care was appropriate. Secondary care services are a 9am-5pm Monday-Friday service that cannot provide the same acute care as the HTT, so it was important to assess the suitability of a transfer at this point in 1's recovery. An important factor to be considered during a transfer of care are the 'risks' posed. When assessing risk there are fundamental aspects to consider: 'probability, severity, and imminence', (Mental Health (Wales) Measure, 2020). The areas of risk in this case included: 'risk to self' (risk of suicide, self-neglect), 'risk to others' (risk of neglect to her child, making allegations against members of the public), 'vulnerability' (promiscuous when under the influence of alcohol), 'health and safety' (smokes in the home and this can be a fire hazard, heightened risk if 1 consumes alcohol), and 'environmental risks' (if 1 was to drive whilst she was under the influence of alcohol),

The current risks posed in this case were assessed and the outcome was that there remained a 'medium' risk; with the potential that the event is unlikely to happen 'unless circumstances change', (Mental Health (Wales) Measure, 2010). The circumstance 'change' that could potentially escalate the risks was identified as the misuse of alcohol, something 1 had done in the past which had resulted in her requiring acute care services. It has been highlighted that the misuse of alcohol escalates the risk of 1's mood dipping and in turn increases the probability of suicidal ideation. 1 had recently been through a detox programme and there was no current evidence of alcohol use. The collaborative assessment concurred that the risks posed at this current time were manageable by 1 being supported by the secondary care services (1x weekly visits) and the transfer of care went ahead.

The Mental Health Services adhere to the 'recovery model'; providing support and building the capacity of citizens to take responsibility for their own health and wellbeing, to live well despite symptoms of mental illness (Hafal, 2009). Social Work in mental health includes enabling people to take 'positive risks' to promote their recovery, supporting autonomy, choice, social inclusion and self-determination for longer-term recovery (Allen, 2014). Part 2 of the Mental Health (Wales) Measure requires that all citizens receiving secondary care mental health services in Wales receive a care and treatment plan (CTP). The Mental Health (Wales) Measure Code of Practice (2010) Parts 2 and 3 clearly state that assessment of risk forms a part of the necessary first step to setting outcomes and formulating the care and treatment plan (p. 13). A CTP takes into consideration all aspects of a citizen's life from a holistic viewpoint. Categories including: 'finance and money, accommodation, personal care and physical well-being, education and training, work and occupation, parenting or caring relationships social, cultural or spiritual, medical and other forms of treatment including psychological interventions', (Welsh Government. 2010, p.12). Wherever possible care plans should be produced in consultation with the citizen. Where a decision in the CTP is contrary to the wishes of the citizen or others the reasons for this should be transparent, explained to them and fully documented, (Department of Health, 2015).

In line with the Mental Health (Wales) Measure (2010), I compiled 1's risk documentation which incorporated any current as well as historic risks such as alcohol misuse. As a matter of course 1 had signed to say she had read and understood the boundaries of confidentiality sheet which stated there are a number of exceptions when confidentiality will be broken; if I believed 1 was likely to harm self or attempt suicide, likely to seriously harm somebody, if I believe the welfare or safety of a child or vulnerable adult are seriously at risk, and where there is statutory obligation to do so. From the outset 1 made it clear to me that her 'only' protective factor against her harming herself was her young child. I was mindful of what she had told me and it was documented as a 'potential' risk factor in her documentation that if for 'any reason' her child was removed from her care then the risks to self would be increased.

As the professional overseeing 1's care I began to understand the complexity of this case; I knew I was duty bound (by the Children Act 1989/04) to share any concerns for the safeguarding of her child and I knew that any referral to Children's Services would escalate the risks 1 posed to herself. I was open and honest with 1 from the outset stating I would share any concerns with Children's Services if they arose. This was a tentative conversation that I felt duty and morally bound to have with 1. The British Association of Social Workers (BASW, 2014: 2) and the Welsh Government, 2017. P.8 states that social workers should be prepared to account for and justify their judgements and actions to people who use services..... work in a way that is honest, reliable and open, clearly explaining their roles, interventions and decisions and not seeking to deceive and make judgements based on balanced and considered reasoning. By informing 1 of the boundaries of confidentiality it facilitated her to take some responsibility for her actions for example; *if* 1 was to begin using alcohol again she was aware that I would be concerned for the wellbeing of her child and I would be duty bound to share that with Children's Services, moreover in my professional opinion *if* 1 was to begin using alcohol again she would be making an informed decision based on what I had explained to her.

1 requested, due to work commitments and childcare issues that I visit her at home and I agreed to that request. (I followed the Local Authority lone working policy protocol). The initial sessions involved the formation of her CTP. During the sessions I would communicate understanding, provide encouragement to reach her goals which included referrals to outside agencies, and I supported her to manage her anxiety by offering therapeutic techniques for her to utilise. In line with Social Work values I was open about being newly qualified; if I did not know an answer to her questions I would explain that I would get back to her, and I would.

Over the subsequent weeks it became evident that a professional rapport had developed, this was demonstrated in her willingness to be open and honest with me. During the sessions 1 would share some of her innermost thoughts and feelings around her mental health. She described having often thought of suicide but the protective

factor was her young child. During our sessions I would always be assessing Citizens 1's mental health using the mental state examination process (see page 12). As part of that process I would clarify if there was any plan and/or intent to harm herself or others. I was always mindful of the wellbeing of the child in this case and I would always ask about the child; The Children Act 1989, 2004 and the Social Services and Well-being (Wales) Act 2014 clearly states there is a 'duty' to report if a child is 'experiencing' or is 'at risk of' abuse, neglect or any other kinds of harm.

Having met with 1 several times I felt I had a better understanding of her as an individual. For example I began to notice certain traits in her behaviour that would indicate to me when she was feeling low or anxious; this benefited our work together and in many ways it developed a more trusting relationship; having developed a level of understanding I was able to identify when there may be problems occurring that she was not necessarily outwardly sharing with me. For example there came a point where her interaction changed somewhat, I noted over a matter of days that she had called me several times and in spite of offering to visit her at home, she refused; I began to wonder if she was struggling. It was clear from what she had shared with me that at times she was feeling 'overwhelmed'; she worked full time, was raising a child on her own, she had mounting debts, a fractured relationship with her family, little in the way of support, and she was experiencing anxiety attacks on a regular basis. Although these issues were in the process of being addressed, 1 was nevertheless on occasions feeling it was too much to cope with. I was mindful to respect 1's 'right to a private life' (Human Rights Act 1998; Article 8) and I did not want to disrespect the fact she had said she did not want a visit, on these occasions I would highlight the benefits of her keeping in touch with me.

On the next visit it transpired that 1 had forgotten I was visiting. It became evident that 1 had been drinking alcohol. I could smell it on her and there were several empty wine bottles in the kitchen. The house looked unusually untidy with discarded food wrappers, a full ashtray, and clothes and make up on the floor. 1 looked tired and had been crying. 1 explained to me that she had had an argument with her mother and this had triggered her to 'have a drink'. 1's child was not home, he was staying at his fathers

which is something he did once a week. The Code of Professional Practice for Social Care states: you must respect the rights of individuals while seeking to ensure that their behaviour does not harm themselves or other people (4: 2017). After some initial consoling, having checked with her that there was no intention to harm herself. I was open and honest with 1 that if she was to drink to such an extent when her young child was in her care I would be concerned. 1 was very upset having heard what I said and stated to me that if her child was 'taken off her' she would 'kill herself' and she inferred that I would be to blame. I was mindful that 1 may feel angered by what I had said after all we had developed quite a rapport up to this point; by stating to her that I would be concerned she understood I would refer to Children's Services and she felt judged by me. This was a clear indicator of the 'power' difference in our relationship, something that had not been clearly displayed before today.

Raven's Power Theory (2008) listed five types of power in a relationship: legitimate, expert, reward, referent and coercive. Power can hinder effective social work relationships because of the implied imbalance. The power types relevant to this case are coercive power and legitimate power. Coercive power is based on the ability to apply sanctions (Maclean and Harrison, 2011). Legitimate power is that which is invested in a role for example a legal action to control behaviours of others. As Birkenmaier and Berg-Weger say 'this should be exercised only as absolutely necessary to fulfil that role' (2017, p.89). I would not be exercising 'legitimate' power because my professional role does not hold that power. However I was mindful that a referral to Children's Services may result in her child being removed from her care if she was to be deemed not to have the parenting capacity to safeguard her child.

1 assured me that she would not drink to that extent if her young child was in her care and I had no reason to doubt that (I had visited on occasions when her child was present and there had been no indication of her using alcohol at that time). She was very remorseful having worked through a recent detox programme; she acknowledged that although alcohol had at times been her way of coping, she was not going to allow

herself to relapse. I reiterated to 1 that there was support available to her such as the local drug and alcohol team (it's a service she was aware of and it had been offered as a follow up from the detox programme) but she declined the offer of the service and was adamant she would not drink again. I was not so convinced and I suspected that she was struggling to manage her emotions and using alcohol as a maladaptive coping mechanism, albeit when her child was at his fathers. I wanted to support her but at this point in time she appeared to be resistant.

Prochaska and DiClemente's (1983) Cycle of change theory says that there are 6 stages of change: Pre contemplation. Contemplation. Preparation. Action. Maintenance. And Relapse. Considering this theory and applying it to 1, in my professional opinion she is in the first stage of pre contemplation. At this stage Citizen1 is not thinking about changing her drinking behaviour. She does not see it as a problem, and she thinks that in some way I am exaggerating the problem when I express my concern.

Considering the potential risks posed to 1 and her young child I would regularly discuss the case at our service meeting (to gain support and direction from the team). The local authority has in place a 'protocol for supporting children when working with parents with severe mental illness and / or substance misuse.' The framework provides a holistic assessment tool for use by adult mental health and substance misuse services to assess parenting capacity (Local Authority Protocol, 2009), my manager and I completed the assessment tool and I shared it with Children's Services. My concern was that 1 was misusing alcohol and I could not be certain that this was not in the presence of her son; he was potentially a 'child at risk' (Social Services and Well-being (Wales) Act 2014; S130). The outcome from Children's Services at that time was 'no further action'. A Child Protection referral does not require I inform or seek the permission of the parent, but out of respect I always inform parent/s if I am making a referral.

Over the following weeks things appeared to snowball; during a meeting with her Consultant concerns were raised and the Consultant made the decision to share these

concerns with the DVLA, this led to 1 having her driving licence revoked. The revoking of her licence made it difficult for her to travel to work and 1 handed in her notice, this put a further strain on finances and subsequently her mental health deteriorated. 1 began cancelling appointments and not answering my calls. I was growing increasingly concerned so I made an impromptu visit to her home. There was a note on the door (written by 1) saying that her and her child had gone away for a few days. A neighbour had heard me knocking and recognised me from recent visits, she said she had heard 1 in the home that morning, this led me to believe 1 had not gone away as stated in the note. (With respect to confidentiality; 1 had given permission for me to speak to the neighbour and this was a signed document held in her file. 1 had stated in the same form that the neighbour had a key to her property and it could be used by secondary care staff *if* there were any concerns for safety). The neighbour provided me with the key and it became evident that the front door was locked from the inside. I was mindful that this was a day when her young child would be in her care and not at the fathers or nursery. I feared that she may well have relapsed and had been drinking to excess and this was the reason for her recent withdrawal from the service. In my professional opinion this shifted the potential severity and imminence of risk and I was duty bound to share my concerns.

The Police have a positive duty to protect life under article 2 of the European Convention on Human Rights, and I contacted them to request a 'welfare check'. Given the information that 1 had mental health problems, a history of alcohol misuse and may have a young child in the home, the police agreed to attend immediately. Just as the police approached the property 1 answered the door to me, she was extremely distressed and crying, and it was evident she had been drinking to excess. She requested the police did not come into the home, and she agreed for me to contact the father to pick her child up (which I did). The police left.

Section 1 of the Mental Health Act (1983) states that dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for the purposes of the definition of mental disorder in the Act. 1 has a mental health diagnosis and under definition of the act she was requiring hospital admission on the grounds of 'health and

safety' because she was imminent risk to self: 1 had clearly stated to me that she had active thoughts to harm herself by taking an overdose. On mental state examination (Trzepacz, 1993) (see page 12) it was clear that 1 needed inpatient care; she looked dishevelled, her mood was depressed, she had thoughts of suicide with plan and intent (brought on by the thought of her young child being removed from her care). It was evident that she had been drinking for a matter of days; there were empty bottles of alcohol strewn about the living room and kitchen. There was opened packets of medication about the kitchen and left over bowls of food that she must have prepared for her young child. With hindsight I should not have gone in the house alone and I should have requested the police attend with me. If 1 had refused to go into hospital and not agreed for the father to be contacted I could have found myself in a difficult situation. In private residence Police have powers to enter your home, if need be by force, under a Section 135 warrant. If 1 had refused care the Police could have taken her to a place of safety for an assessment by an Approved Mental Health Professional (AMHP) and a doctor. Section 46 of the Children Act (1989) empowers a police officer, who has reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to remove the child and if needed they could have informed the child's father without permission from 1.

Had 1 not agreed to go into hospital 'informally' I would have requested a Mental Health Act Assessment to be carried out. An AMHP would have been requested as they are the mental health professionals approved by the Local Social Services Authority to carry out duties under the Mental Health Act 1983. Two doctors and an AMHP decide when a person is put on Section 2 or Section 3. Under S2 of the Mental Health Act (1983) an application for admission for assessment may be made in respect of a patient on the grounds that she is suffering from mental disorder of a 'nature or degree' which warrants the detention for assessment, and ought to be detained in the interests of his own health or safety or with a view to the protection of other persons. Under S3 a patient may be admitted for treatment to a hospital and detained there for the period of 6 months but may be discharged before this time is up. The S3 can be renewed for a further 6 months and after that renewed for a further 12 months. There is a right to appeal against the detention and this can be done at tribunal once during the first 6

months and then once during each 12 month period. Appeals can be made to the Mental Health managers at any point during detention. An Independent Mental Health Act Advocate can assist with any appeals or issues with care and treatment.

1 agreed to go into hospital 'informally' and the Liaison Team managed to get a bed in the local Mental Health Hospital which was fortunate. I don't use the term 'fortunate' flippantly; the lack of inpatient beds has been widespread concern for some time. With citizens having to travel out of area to receive the care and treatment they need. This has been documented in a report by The Commission on Acute Adult Psychiatric Care (CAAPC, 2016). Salman (2016) stated that 'transferring patient's long distances for acute care is bad for patients and their families, bad for the system and very expensive.' In accordance with the Mental Health Measure (2010) and Health Board Transfer and Discharge of Care Protocol (2015) relevant documents were provided on point of admission including:

- Part A assessment
- Risk Assessment
- Formulation and review of identified needs, strengths, risks
- Care and treatment plan
- Case notes
- Medicines.

I kept in contact with 1 during her stay at the Mental Health Unit; attending ward rounds every week. Before her discharge I was able to encourage 1 to accept support from Substance Misuse Service and a referral was sent; this became part of her discharge plan. The Welsh Government has established a 10 year strategy plan for Wales; the 'Working Together to Reduce Harm' (2008-2018) and a 'Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem' (Welsh Government, September 2015) these documents reinforce the importance of services working together to treat people who have both substance misuse and mental health issues, recognising how substance misuse can lead to

extended mental health problems and accepting that those presenting with mental health problems are susceptible to misusing legal or illicit substances.

I want to note that at point of admission I had sent in no less than four referrals to Children's Services with my concerns; on 1's discharge I was reassured to hear they were now opening the case and would be involved with safeguarding the child (the father of the child became temporary primary carer). Aware of previous threats to harm herself (*if her child was removed from her care*) I increased my visits temporarily to every other day (there were no current identified risks to self); 1 welcomed the support, Substance Misuse Services agreed to carry out joint visits with me which limited the amount of appointments 1 attended in any given week. Suffice to say it was a difficult few months for 1, and I am pleased to report that there was a positive outcome. 1 worked well with Substance Misuse and the Mental Health Team, and had support from Advocacy in the Child Protection Procedures. 1 is now having regular contact with her child (who is no longer under Children's Services), she had her driving licence reinstated and has since found a job.

Total 4528 words.

Section 5

Safeguarding

Guidance: The Care Council for Wales require newly qualified social workers to provide evidence of their understanding of safeguarding work with adults and children. The assignment below will enable you to show this. N.B. if your normal area of work is with children please write about adult safeguarding. If you normally work with adults then write about child safeguarding.

In an area that is not your main focus of work (see guidance above), explain the relevant legislation, and the national, local and organisational policies and procedures for safeguarding.

500 words (+/- 10%: include your actual word count at the end of each section)

This piece of work will focus on Safeguarding Children.

The United Nations Convention on the Rights of the Child (UNCRC, 1989) states

Governments must:

- do all they can to ensure that children survive and develop to their full potential (Article 6)
- do all they can to ensure that children are protected from all forms of violence, abuse, neglect and bad treatment by their parents or anyone who looks after them (Article 19)
- provide a child who is seeking refuge or has refugee status with appropriate protection and assistance (Article 22)
- help families who cannot afford to provide a standard of living that is good enough to meet a child's physical, social, and developmental needs (Article 27)
- protect children from all forms of sexual abuse and exploitation (Article 34)

The Rights of Children and Young Persons (Wales) Measure 2011 made Wales the first country in the UK to incorporate the UNRC into its domestic law.

The majority of the Children Act 1989 applies to both England and Wales. Part 3 of the Children Act 2004 is specific to Wales. As of April 2016 Part 3 of the Children Act

(1989), which relates to Children and Families support from Local Authorities including 'Children in Need', has been replaced in Wales by Part 6 of the Social Services and Well-being (Wales) Act 2014. Child Protection cases that reach court are dealt with in the same way in England and Wales. It is a 'general duty' of every Local Authority to safeguard and promote the welfare of children within their area who are in need; and so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs (Children Act, 1989., s 17). A key principle of the Children Act 1989 include the 'paramount' nature of a child's welfare. Each professional and organisation must do everything they can, to ensure that children and adults at risk are protected from abuse.

Wales have established a National Independent Safeguarding Board to work with the safeguarding adult's boards and safeguarding children boards across Wales. The board's duties are, amongst other things, to: report on the adequacy and effectiveness of arrangements to safeguard children and adults in Wales. The All Wales Child Protection Procedures (2008) are an essential part of safeguarding children and promoting their welfare. The Procedures inform child protection practice in each of the local and regional safeguarding children boards across Wales. The Local Authority Intake and Interface Team is the service that undertakes initial assessments to determine if child/family meets the threshold for Local Authority Social Service intervention. In some cases the Social Worker may have reasonable cause to suspect that a child who lives, or is found in their area, is suffering, or is likely to suffer significant harm without Social Services intervention, in which case the Local Authority have 'a duty to investigate'. During which investigation they shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare (Children Act, 1989, s 47). One of the most important principles of safeguarding is that it is everyone's responsibility.

Total 542 Words.

Reflect on the difference between safeguarding in adult and childrens work
400 words (+/- 10%: include your actual word count at the end of each section)

One of the fundamental differences between safeguarding in adult and children's services is that an adult with 'mental capacity' to understand abuse, and risk of abuse, has the right to refuse intervention even if this leaves them at risk of significant harm. The Mental Capacity Act 2005 states that an individual has the right to make unwise decisions (Part 1). The Welsh Government defines a 'vulnerable adult', who 'needs' safeguarding or protection, as:

'a person over 18 years of age who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of himself or herself, or unable to protect himself or herself against significant harm or serious exploitation'.

Section 126 of the Social Services and Well-being (Wales) Act 2016 imposes a duty on local authorities to make, or cause to be made, such enquiries as it considers necessary to decide whether a person is an adult at risk; and to decide what action, if any, should be taken. Where an adult's ability to make informed decisions is questioned the principles of the Mental Capacity Act (2005) and Mental Health Act (1983) must be followed (Local Authority 2016).

Safeguarding adults and children at risk is 'everyone's responsibility' in every service within the council (Local Authority Policy and Guidelines, 2013). Moreover some have statutory duties for example: under Section 28 of the Children Act 2004, the Local Authority has a duty to ensure that it undertakes its function in a way that safeguards and promotes the welfare of children. Under Section 17 of the Crime and Disorder Act 1998, it is the Local Authority's duty to ensure that every reasonable step is taken to protect adults and prevent crime and disorder. Under Part 7 of the Social Services and Well-being (Wales) Act 2016 there is an overarching duty in the Act to promote the well-being of people who need care and support. In the Act 'well-being' is defined with eight common features, one of which is protection from abuse and neglect. In relation to

children's 'wellbeing' it includes their physical, intellectual, emotional, social and behavioural development, and their welfare, ensuring they are kept safe from harm.

Any concerns for the welfare or wellbeing of children are to be shared with the Local Authority Family Gateway. Any concerns for the welfare of adults are to be shared with the Single Point of access Team (SPOA). Out of normal office hours there is a designated Social Service out of hour's team. In an emergency the Police are to be informed immediately.

Total words 437.

Developmental Review (b)

Critically reflect on your development including reference to the training, learning, research and use of supervision since completing section 2. Consider in discussion with your mentor/ supervisor/line manager the extent to which those learning needs have been achieved. Identify additional learning needs to support your development in the transition to becoming an experienced practitioner. You will consider here, the feedback you have received from individuals using services, their families and carers, and how this has impacted on your practice.

800 words (+/- 10%: include your actual word count at the end of each section)

Reflecting on section two of the portfolio I can see I have developed significantly as a practitioner. I attribute my development to an array of experiences over the past two years of my practice key elements of which will be mentioned here.

I have attended an array of mandatory training courses for example: (This is not an exhaustive list). Mental Health Act (1983/2007); Mental Health Measure (2002); Social Services & Wellbeing (Wales) Act (2014); Mental Capacity Act (2005); All Wales Safeguarding Awareness; Child Protection Level 2; and the Wales Applied Risk Research Network (WARRN) training. These training sessions were formal lecture style training courses which were very informative but I find my learning is consolidated when I can apply knowledge to practice. I place great importance on informal theory; the opportunity to experience situations at first hand, exploring them with colleagues, and during supervision, this process has supported me to build up my 'practice wisdom' (Doel and Shardlow (1993). The method of 'shadowing' has been attributed to Albert Bandura's (1986) Social Learning Theory (O'Brien (2015; Langer & Lietz 2015; Stone & Harbin 2016) and is an effective way to develop practice. I had the opportunity to shadow an experienced Social Worker in the team who agreed to work alongside me during my first Mental Health Tribunal. I was guided through the process of planning for and attending a Tribunal. I was shown what documentation was required and guided through the process of collating a Social Circumstance Report. I found this extremely helpful and I don't believe I could have gained the same knowledge and practice wisdom if the information had been simply given to me in written form. It confirmed for

me that I learn best from a combination of written information and most importantly 'experiential learning' (Doel and Shardlow (1993).

My case load has gradually increased over the past 2 years and has seen me take on more complex cases. Managing a more complex case load can at times prove challenging but I have welcomed that experience; I have found I have developed skills in managing my time, prioritising cases, and when appropriate delegating some work to other workers/agencies involved. I am on the team's duty rota and this has been an invaluable experience and continues to be so; I have been able to build on my assessment skills and gain more confidence in my professional decision making. I have attended many formal meetings for example, Mental Health Tribunals, Managers Hearings, Child Protection Conferences and these experiences have further developed my practice and confidence, these experiences have also provided me the platform to make links with other professionals. I felt privileged to be asked to take on the role of 'mentor' to a colleague who was new to the team and this facilitated me to firm up my knowledge by highlighting to me key areas I felt I lacked understanding.

An identified 'need' that I had highlighted at the beginning of my development was to feel more confident in applying my professional Social Work judgment in a predominantly medical arena. Ramon *et al.* (2009) note that, in the mental health field, social work perceives itself as less powerful than other professions and this was my perception when I began. Lamb N. cited in Allen, R (2014, p2) states that Social Workers working in statutory mental health services provide a vital counterbalancing view to clinical models of illness and disorder and where this is done well, can have a powerful impact on NHS culture and practice. I found one-to-one supervision with my practice manager is a good way for me to reflect on my practice and develop my confidence. We (Team) are fortunate to have two very experienced Consultants based in the building who value Social Workers professional opinions; working alongside the two Consultants supported me to build confidence in my professional opinions and in turn this has encouraged me to be more confident outside the team.

Supervision has been once a month in line with Social Care Wales guidance (Welsh Government, 2017), in addition I have utilised clinical supervision with the therapeutic team. Supervision is, according to Lord Laming (2009) the 'cornerstone' of good social work practice an opinion reiterated by the Munro Review (2011). I value supervision as a way to step back from my cases and gain another opinion/direction for my practice. Clinical supervision with the therapeutic team gives me an opportunity to acquire therapeutic tools and skills to utilise in my work with citizens. When I consider the feedback thus far from individuals, carers and families using the service, it has on the whole been positive feedback. I am pleased to report that quite often I have been called 'human' and a 'good listener'. At times I have had a duty to take action that has not been agreeable to a citizen, family, and/or carer and during these times feedback was negative in tone. I was such a case (see Case Study page 16) where my actions lead to a significant life change (child being removed), several months on during our 'ending' session 1 thanked me for being 'by her side' throughout the 'tough times' and being 'open and honest with her throughout'. I found what she said to be quite moving because it validated to me that she had felt truly supported in her times of crisis.

Total 891 Words.

Please record in the table below the dates of each consolidation programme workshop you attended.

Consolidation workshop	Date Attended
1	10/11/16
2	19/01/17
3	12/04/17
4	16/08/17

Mentor's comments

Please comment fully on the learner's development over the duration of the whole programme. Reflect on information provided by the learner in section 2 at the outset of the programme and the later perspective given at section 6. Where you have seen or discussed feedback from individuals using services, families or carers, you are encouraged to comment on this with regard to the learner's development.

I have noticed significant changes over the course of the programme in Sharon. I asked Sharon to mentor a new member of staff because I was confident that Sharon would give her support and guidance but that guidance would be correct. Sharon is very professional in her approach and has been from the outset of joining the team. Sharon is conscientious and meticulous with her recording which is of benefit to the individual, the team and the service as we share paper records with other parts of the service such as inpatient acute services. This has developed and increased over the duration of her consolidation training and I was keen for Sharon to share her skills with the new social worker to start the new person on the 'correct path' of documentation and recording. Sharon has been very supportive of her colleague and that individual has voiced how beneficial she found having Sharon as a mentor.

Throughout this portfolio Sharon has demonstrated a sound understanding of legislation. This will be further developed and expanded upon as she commences her AMHP training.

Sharon has used reflection appropriately both during supervision and in discussions outside of supervision about specific clients. Sharon is able to be reflective and analytical in discussing her intervention and the outcomes for the person. I supported Sharon in an interview relating to a complaint made about children's services. The professionals conducting the investigation interviews commented on how precise and informative Sharon's documentation was, they also commented on the quality of the support Sharon had provided. The comments made to Sharon reflected well on Sharon and subsequently the team.

I feel Sharon has grown in confidence over the course duration, she has commented on how she has taken more complex cases. These cases she discusses in supervision, MDT meetings, Risk meetings and professional meetings. Sharon's skills in chairing

meetings, presenting at meetings and taking decisions has evidently grown and I have observed Sharon presenting at complex risk meetings and at the end of the meeting outlining outcomes and agreeing actions. All skills that will transfer to her next stage of progression which is the AMHP course.

Section 7

Bibliography

Allen, R. (2014) *The role of the Social Worker in Adult Mental Health Services*. London: The College of Social Work.

Bandura, A. (1986) *Social foundations of thought and action: A social cognitive theory*. University of Michigan: Prentice-Hall.

BASW. (2014) *The Code of Ethics for Social Work*. Birmingham: British Association for Social Work.

Beesley, P. Watts, M. Harrison, M. (2017). *Developing Your Communication Skills in Social Work*. London: Sage.

Birkenmaier, J. Berg-Weger, M. (2017) *The Practice of Generalist Social Work*. 4th ed. London: Routledge.

Bhat, P. S. Ryali, V. Srivastava, K. Kumar, S. R. Prakash, J. & Singal, A. (2012) 'Alcoholic hallucinosis' *Industrial Psychiatry Journal*, 21(2), 155–157.

CAAPC. (2016) 'The Commission to review the provision of acute inpatient psychiatric care for adults. Building on progress: achieving parity for Mental Health in Northern Ireland'. [Online] Available: <https://www.caapc.info/> (accessed 24.10.2017)

Department of Health. (1983) *The Mental Health Act 1983 Code of Practice*. London: TSO.

Harris, J. White, V. (2013) *A Dictionary of Social Work and Social Care*. Oxford: University Press:

Health Foundation. (2014) *Person-Centred Care Made Simple. What Everyone Should Know About Person-Centred Care*. London: Health Foundation.

Human Rights Act 1998. London: HMSO.

Hafal. (2009) *My Recovery, a Step-by-Step Plan for People with Serious Mental Illness* Neath: Hafal.

Hyde, W. Bowles, B. Pawar, M. (2014) 'Challenges of recovery-oriented practice in inpatient mental health settings – the potential for social work leadership' *Asia Pacific Journal of Social Work and Development*, 24 (1-2): 5-16.

Kwantes, C. Glazer, S. (2017) *Culture, Organizations and Work, Clarifying Concepts*. Canada: Springer.

Langer, C and Lietz, C. (2015) *Applying Theory to Genarlist Social Work Practice*. John Wiley & Sons. New Jersey.

Local Authority. (2016) *Safeguarding Board Policy and Procedures to Support People who Self-Neglect*.

Miller, L (2012) *Counselling Skills for Social Work*. London: Sage.

Morrison, T. (2007) 'Emotional Intelligence, Emotion and Social Work: Context, Characteristics, Complications and Contribution' *British Journal of Social Work*, 37, (245-63).

Murphy, D. Duggan, M. Joseph, S. (2013) 'Relationship-Based Social Work and Its Compatibility with the Person-Centred Approach: Principled Versus Instrumental Perspectives' *The British Journal of Social Work*, 43 (4), 703–719.

Mayor, J. Salovey, P. and Caruso, D. (2004) 'Emotional Intelligence, Theories, Findings, and Implications' *Psychological Enquiry*, 15 (3), 197-215.

Mental Health (Wales) Measure (2010) 'Care and Treatment Planning - Mental Health Wales'. [Online] Available: <http://www.legislation.gov.uk/mwa/2010/7/contents/> (accessed 21.10.2017).

North Wales Police, (2017) 'Welfare Check (on behalf of other agencies) Policy and Procedure'. [Online] Available: <https://www.north-wales.police.uk/.../welfare-check-on-behalf-of-other-agencies-policy-> (accessed on 24.10.2017).

O'Brien, E Z. (2016) *Psychology for Social Work: A Comprehensive Guide to Human Growth and Development*. London. Palgrave.

Raven, B. (2008) 'The Bases of Power and the Power/Interaction Model of Interpersonal Influence' *Analysis of Social Issues and Public Policy*, 8 (1), 1-273.

Ramon, S. Lachman, M. Healy, B. Shera, W. & Renouf, N. (2009) 'The rediscovered concept of recovery in mental illness' *International Journal of Mental Health*, 38, 106–126.

Rogers, C. (1980) *A Way of Being*. New York: Houghton Mifflin.

Stone, C. Harbin, F. (2016) *Transformative Learning for Social Work. Learning for and in Practice*. London: Palgrave.

Schon, D. (1987) *Educating the Reflective Practitioner*. San Francisco: Jossey Bass.

Salman, S. (2016) 'Mental health beds shouldn't be so hard to find' *The Guardian*. [Online], Available <https://www.theguardian.com/healthcare-network/2016/may/18/acute-mental-health-lack-beds-nhs> (accessed on 24.10.2017).

Trzepacz, PT. Baker, RW. (1993) *The psychiatric mental status examination*. New York: Oxford: University Press.

The Children Act 2004. London: TSO.

The Children Act 1989, London: HMSO.

Welsh Government (2018) 'The All Wales Child Protection Procedures, Safeguarding Children'. [Online] <http://www.childreninwales.org.uk/our-work/safeguarding/wales-child-protection-procedures-review-group/> (accessed on 24.10.2017).

UNICEF (1989) 'The United Nations Convention on the Rights of the Child'. [Online] http://www.unicef.org/crc/files/Rights_overview.pdf (accessed on 16.03.2015).

Welsh Government, (2017) *Code of Professional Practice for Social Care*. Cardiff: Social Care Wales.

Wits. (2018) 'The Wales Interpretation and Translation Service for the Public Sector'. [Online] <https://www.wits.wales> (accessed 24/10/2017).

Welsh Government. (2017) *A Guide to Supervising and Appraising Well*. Cardiff: Social Care Wales.

Section 8

Learner details, Signatures and Line manager verification

It is the learner's responsibility to ensure that their university learner number is correctly inserted wherever requested within the portfolio

Learner Details

(NB it is essential that you inform your Workforce Development/Training Unit and the University of Wales Trinity Saint David if your name or your address for correspondence changes).

1. Name of Learner: Sharon McManus

2. Learner's University Number: 1602956

Address for Correspondence: 52 Fforddisa, Prestatyn, Denbighshire, LL19 8EB.

Telephone: 07984093190.

E-mail: sharon.mcmanus@btinternet.com

Date of Professional Qualification: 14th September 2015.

Date of registration with Care Council for Wales: 15th September 2015.

3. Name of Learner's Agency: Community Mental Health Service. Denbighshire Local Authority.

Agency Contact details:

Name: Sharon McManus

Address: Beechwood Road Rhyl.

Telephone Number: 01745 443050.

E-Mail address: sharon.mcmanus@denbighshire.gov.uk

4. The evidence I have provided within this portfolio is in:

Welsh only ☐ Welsh and English ☐ English only ☒

Mentor's details

5. Mentor's details:

Name: Karen Danby

Address: Beechwood Road Rhyl.

Telephone Number: 01745 443050.

E-Mail address: karen.danby@denbighshire.gov.uk

6. Observer details

Name: Karen Danby

Work Address: Beechwood Road Rhyl.

Professional Qualification and date of qualification:

Email and telephone number: karen.danby@denbighshire.gov.uk 01745 443050.

Signatures and Line Manager Verification

CONFIDENTIALITY and PLAGIARISM – to be completed by the learner

All information provided in this portfolio complies with guidance on confidentiality. I confirm that all work apart from comments by others (e.g. mentor, an individual using services, their family or carers) is all my original work and has not been copied. I understand that plagiarism is taken very seriously by the University and the programme.

Signed:  (Learner)

Date: 8/3/18

Feedback and comments from an individual using services, their family or carers (Section 3) - to be completed by the Observer

I confirm that I am a registered social worker with knowledge of the learner's area of practice and that the observation summary and the comments from the service users and/or carers above are about the same piece of practice that I observed on the date given.

Signed:  (Observer)

Date: 8.3.18

Line manager verification

Guidance: This section must be completed and signed by the learner's line manager or senior practitioner. He/she should be a registered social worker who is familiar with safeguarding work, can verify that the learner has been involved with the case evidenced in section 4 of the portfolio, and has also met all other required criteria listed.

In this section, please confirm that you have seen sufficient of the learner's work during the period they have been undertaking the Consolidation programme. If necessary, please consult with other managers that the learner has worked for. In signing this section, you are confirming that you are content with the:

- level of supervision and mentoring support received by the learner
- learning and development undertaken

- reading and personal research undertaken
- level of knowledge and skills demonstrated
- understanding shown of the Code of Practice and National Occupational Standards
- core values of the learner
- content of the development plan within the portfolio
- work and commentary referred to within the portfolio, that it is the learner's own work and based on current practice

I confirm that this learner has achieved an appropriate level of professional practice.

LINE MANAGER VERIFICATION:

NAME OF LINE MANAGER: KAREN DANBY

SIGNATURE OF LINE MANAGER.: Km Danby

DATE: 8.3.18

Section 9

PORTH AGORED and UNIVERSITY OF WALES, TRINITY SAINT DAVID

GRADUATE CERTIFICATE IN CONSOLIDATION OF SOCIAL WORK PRACTICE

LEARNER AND EMPLOYER'S LEARNING AGREEMENT

Name of Learner	Sharon McManus
Name of Team/Agency	Hafod Community Mental Health Services, Secondary Care Team. Denbighshire Local Authority.
Name of Mentor	Karen Danby
Name of Line Manager	Karen Danby

Study Duty

The learner will undertake all elements of the Graduate Certificate programme diligently, including mandatory attendance at induction, 4 Consolidation workshops, and participation in an evaluation survey or focus group on completion of the programme.

The learner's full and effective participation on the Graduate Certificate is mandatory given that the Care Council for Wales has made completion of the programme a requirement within the first (three year) period of registration as a Social Worker.

Study Leave

The employer undertakes to support the learner by providing paid leave in full to attend all agreed induction, Consolidation Workshops, programme evaluation meetings or training agreed as required during the programme. In addition, three additional paid days can be approved by managers as a contribution towards the time involved in personal research and developing the portfolio for submission. It is for learners to open a discussion with their manager about when they want to take this leave. The study days can be taken on any week-day (or combination of days) as long this is (i) appropriate to the stage of portfolio preparation at the time, and (ii) agreed with the Team Manager who will take into account team and service needs. The level of paid leave described here assumes that the learner works full-time hours. Where the learner works less than 37 hours a week, paid time will be approved in accordance with the employer's local policies.

Resources

Learners are able to access learning and library materials from their employer's existing resources or as described in the Programme Handbook from the University. The employer understands that the Graduate Certificate is to be completed by newly qualified Social Workers in their first period of registration and will support this timescale. But there is also an expectation that as a professional development programme, Learners take responsibility for their own learning and will also use their own time for personal study and portfolio preparation.

The employer's training department agrees to:

- Arrange for eligible staff to join the programme
- pay course fees directly to the University
- provide additional guidance and support by:
 - a) facilitating access to existing learning materials or library resources
 - b) providing appropriate training opportunities from existing internal training programmes as agreed with the learner and mentor
 - c) providing programme induction and Consolidation Workshops
 - d) providing learners' with guidance and support about programme requirements and portfolio completion
 - e) helping to resolve any programme difficulties encountered by the learner, mentor or service managers

The learner agrees to:

- work actively towards completing the qualification within the agreed timescale of 12 months from the date of registration on the programme
- Identify with manager/mentor appropriate internal training and arrange to attend these courses
- Identify with manager/mentor and Training Manager any special requirements e.g. dyslexia and contact the University's Student Services office directly about additional support that may be required
- attend induction and 4 Consolidation Workshops. These are mandatory components of the programme
- produce work and evidence appropriate to the portfolio and learning outcomes within agreed timescales
- make and keep agreed appointments with mentor/line manager
- ensure they are prepared adequately and obtain all necessary consent for observed practice
- inform mentor/line manager and training department immediately of any problems or changes in circumstances while undertaking the programme, especially where this may affect completion of the programme by the agreed deadline or ability to attend a mandatory workshop.
- liaise with their line manager/mentor to confirm study days and use their own time for self study, research and portfolio preparation
- take personal responsibility for preparing and completing all work necessary to submit their portfolio
- act at all times in accordance with the Code of Practice, the employer's and University's policies, procedures and processes
- ensure they understand the need to complete the programme within the first (three year) period of registration with the Care Council for Wales.

Line Manager/Mentor agrees to:

- attend an induction meeting to become familiar with the requirements of the programme
- provide or arrange to provide sufficient assessment opportunities in order for the learner to evidence competency and undertake required observations. Where opportunities may not be immediately available within the team, arrange to provide these elsewhere within the Service,
- guide and support the learner for the duration of the programme
- release the learner for programme induction and Consolidation Workshops, and any internal training courses agreed as being appropriate to meeting agreed learning needs.

- agree with the learner, use of up to 3 additional paid leave days over the whole duration of the programme, as a contribution towards time needed for personal study, research or portfolio development
- Hold supervision with the learner, ideally monthly, and ensure this incorporates mentoring support and monitoring of the work undertaken and still outstanding. Maintain a full record of supervision dates and record discussions and agreements.

Completion and submission of portfolio

Learners are expected to complete the Graduate Certificate and will normally submit their portfolio within 12 months of attending induction to the programme. Any Learner anticipating any difficulty in meeting this requirement should immediately discuss the matter with their Training Manager/Co-Ordinator

The portfolio submission process and dates for each programme cohort will be published on Moodle. Once registered on a programme, learners **CANNOT** change the due submission date without gaining agreement from the employer and University.

Pressure of work is not regarded as a reason for non-attendance at any Consolidation Workshop.

I understand and accept the terms and conditions of this learning agreement as stated above.

Signed:  Print Name: Sharon Mercer Date: 8/3/18
(Learner)

Signed:  Print Name: KAREN DANCY Date: 8.3.18
(Line Manager/Mentor)

Signed:  Print Name: KAREN DANCY Date: 8.2.18
(Mentor, if different to above)

PLEASE PLACE THE SIGNED COPY OF THIS LEARNING AGREEMENT IN SECTION 9 OF THE PORTFOLIO