THE ROLE OF THE SOCIAL WORKER/ThERAPIST IN INPATIENT SETTINGS

The role of the social worker/therapist on an inpatient psych unit can never be understood apart from comprehending the overall goal of the unit, understanding the clients served and a good sense of what the outpatient landscape looks like. With the above knowledge, it should be clear what the goals and direction of therapy/case management should be.

1. The role/goal of inpatient psych is a very narrow one.
   - Crisis Stabilization
   - Safety
   - These two goals are met with the following services: medication management, therapy (individual, group and family), and case management. All of these services are initiated within a very structured environment.
   - Average length of stay is approximately 7 to 10 days

2. Demographic reality of this patient population. Clients who are admitted to our unit suffer with a number of deficits/issues that affect the care that can/needs to be provided:
   - Educational deficits: most have dropped out of school before the 10th grade
   - Relational deficits: most have burnt every significant relationship or at least severely exhausted them.
   - Legal issues: this population cannot operate without often interfacing with the legal system: mental health court, criminal court, fines, probation/parole issues
   - Drug abuse/dependency issues: upwards of 70% have issues with drug/alcohol issues or medication abuse issues.
   - Medical issues: their physical health is compromised because it is disregarded by the client and professionals alike
   - Economic issues: Finances are consistently a concern. Trying to live off of a disability check or less, struggles with housing and transportation
   - Social issues: they seldom fit in with other social groups due to ADL issues, thought processes or personality issues
   - Spiritual issues: the struggle often with issues of shame/guilt, hyper religiosity, misguided religious beliefs

3. The current lay of the outpatient psychiatric landscape:
   - Lack of continuity of care. A very haphazard system of services that are not coordinated. There is no umbrella organization on the state, county or local level that coordinates care across the spectrum of needs.
   - Significant decline in resources available in the community mental health system
   - Lack of psychiatrists to meet needs of population
   - Not one stepdown unit in the state of Arkansas (think crisis units or partial hospitalization programs)
   - Almost non-existent long term care programs beyond Birchtree and Pathfinders
   - Confused/confusing legal system. Pulaski County has the only mental health court in the state.
   - Best practice theory indicates that dual diagnosis programs best meet the needs of mental illness/substance abuse clients. Not one dual diagnosis program in the state.
4. The Role of social work/therapist in inpatient psych unit:

- The need to be a great **BIographer**: getting the client’s whole story in context. Not just why the client is here but who is this client, who are his/her social connections, what is his/her mental health history, what is his/her baseline, what are his/her strengths/weaknesses, what are roadblocks/obstacles to recovery, legal standing. It is so easy for the client to get lost in a shuffle of symptoms. The above role is driven by the Systems Theory/Person-in-Environment model that challenges that a patient/client cannot truly be known apart from the environment in which he/she operates.

- On the unit the therapist/social worker is the **EDUCATOR**: therapists conduct groups to communicate information, to help clients gain insight into destructive/sabotaging/self-defeating behaviors, to give clients a language so that they can explain themselves to others, to instill hope. The therapist/social worker should be educating other staff as to why the patient/client might be exhibiting the unhealthy behaviors that they are.

- Therapists should always be **ADVocates**: what will be in the client’s best interest in terms of the care provided on the unit. What is the client’s legal status and what needs to be done with the client in terms of mental health legal status, or criminal status or does the client have a guardian who needs input into the situation. Is the patient on disability or does he/she need to begin the process of applying while on our unit.

- The therapist needs to be a **CASE MANAGER**: what is discharge going to look like? What follow up treatment would be most appropriate? What about issues of housing? How will the client get home, who is going to pick him/her up? Is the purchase of medications going to be an issue?

- Lastly therapists always serve as **LIAISONs** to the rest of the hospital. Our expertise always gets called upon for consults around the hospital, to help the emergency room with a quick assessment and coworkers who want help for themselves or family members.
Barriers to Maintaining Stability in an Outpatient Setting

1. No crisis/step-down units in the state of Arkansas
2. Lack of adequate housing
3. Lack of transportation: inner city bus lines as well as state wide bus services.
4. Lack of necessary benefits provided by Medicare for day treatment services
5. Lack of financial resources
6. Inability to afford/purchase medication
7. No ongoing continuity of care between inpatient and outpatient, nor between outpatient agencies.
8. MHC's not being able to provide expedient outpatient appointments with a doctor.
9. Staffing shortages at MHC's. Lately there has been no doctor available at a local mental health center.
10. Few resources to prevent hospitalization on the front end.
11. There are no dual diagnosis programs in the state to address substance abuse/mental illness issues
12. No long term facilities in the state for the chronic mentally ill who use inpatient as their treatment option
13. Lack of a more sophisticated and individualized Mental Health Law
14. Lack of any real accountability to mental health court orders that allow for consequences for violating the court order.
15. Lack of homeless shelters to adequately deal with mentally ill clients
16. Lack of specific programs that would allow church based programs to provide other resources and care to the mentally ill.
17. Lack of coordinated care between jails/prisons and mental health centers.
18. Lack of understanding by law enforcement to the needs and issues of the mentally ill. Lack of understanding by Law enforcement and providers of the benefits of 911 program.
20. Lack of general knowledge of mental illness, mental health treatment, and mental health law.