Social Work Focus

AUTUMN 2016 — VOLUME 1, ISSUE 1

SOCIAL WORK PRACTICE IN THE HEALTH SECTOR

PAGE 9

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Australian Association of Social Workers
70 Year Anniversary
1946–2016

AASW
Australian Association of Social Workers

2016
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Presented by Dr Leah Giarratano

Leah is a Sydney based doctoral-level clinical psychologist with 20 years of clinical and teaching expertise in CBT and traumatology

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No withdrawals are permitted in the seven days prior to the workshop; however positions are transferable to anyone you nominate.

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Cover image:

Guest editor for this issue of *Social Work Focus*, Lynette Joubert, Professor and the Director of the Practice Research Program in Health and Mental Health in the Department of Social Work at the University of Melbourne.

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Social Work
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NEXT EDITION

Contributions for the Winter 2016 issue will be accepted until 6 May. The theme for articles will be **social work practice and management**

2016 ASWEAS REVIEW
PRESERVING EXCELLENCE IN SOCIAL WORK EDUCATION AND PRACTICE

KAREN HEALY
AASW PRESIDENT

This year the AASW, as the national regulator of social work education, will review the Australian Social Work Education and Accreditation Standards.

The Australian Social Work Education and Accreditation Standards (ASWEAS) outline the content and length of Australian social work education programs, field education requirements, and the obligations that educational institutions have to ensure that social work programs are adequately staffed. Since 2010, they have also included specialised knowledge and skill requirements in child protection, mental health, working with cultural diversity and practice with Aboriginal and Torres Strait Islander people.

As well as setting and monitoring educational standards in social work education programs nationwide, ASWEAS is also linked to the levels of funding available to social work programs and the capacities, employment and career opportunities of graduates.

While government in Australia is involved in setting educational standards for the Australian Health Practitioner Regulation Agency (AHPRA), the regulation of these for social work, speech therapy and dietetics and other related professions is managed by professional associations. This differs to most other countries – in the United Kingdom, for example, the government sets and monitors social work education; in Singapore the standards are overseen by a government appointed accreditation board, and in the US programs are accredited by an independent council.

In Australia, the AASW's role is to make sure that social work programs meet agreed minimum standards, are sufficiently flexible to encourage diversity, respond to the local needs of education providers and graduates, and consider the growth of online technology.

We must also ensure our qualifications meet or exceed international standards. To do this, social workers need a sound understanding of social work values, human behaviour, health and welfare systems, a range of health and wellbeing challenges and core skills for working with individual, families, groups and communities. Our responsibility as the assessor of overseas-trained social workers wanting to practice here helps us establish these standards; it also contributes to the quality controls that make members' qualifications transferable.

Another strength of the AASW's role as education regulator is the extensive experience of our members. The profession influences the Australian social work curriculum and helps us align the Standards with your social work values.

While Australian governments do not monitor the social work profession, they have a keen interest in ASWEAS. The Standards are considered during tertiary social work program funding assessments. They are also relied upon to demonstrate that social workers have the foundational education that makes them eligible, as accredited mental health social workers, to become Medicare providers. Government agencies also rely on the Standards to provide expertise in particular areas of practice, for example, child protection.

The review of ASWEAS will ensure they remain aligned with international standards and the educational standards of other allied health professionals, such as those within the National Alliance of Self-Regulating Health Professions.

The review, which will invite feedback from practitioners, employers, educators and students and service user representatives, will also make sure that graduates have an understanding of the history of the welfare state in Australia, including the legacy of its involvement in the forced removal of Aboriginal children. We will post information about the review process on the AASW website, including when there are opportunities for members to have a say.

Turning to other news: I want to thank the many members who contacted me following the announcement of my appointment as a Member of the Order of Australia (AM). I was really pleased to accept the honour and I hope that it will bring some attention to the contribution of the social work profession in Australia and the value of social work higher education and research.

This year we mark the 70th anniversary of our professional association. I know that many branches are organising exciting activities to celebrate this milestone and encourage you to get involved. I hope you also enjoy Jane Miller's history of the AASW on page 9 in this issue. It will take you on a fascinating journey through our foundation and the other milestones that have made us the association we are today.

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GROWING OUR MEMBERS FOR AN EVEN STRONGER AASW

AASW CEO
Glenys Wilkinson

This year, the Australian Association of Social Workers (AASW) is celebrating 70 years of representing the social work profession and to make us stronger than ever before, we've developed a strategy to grow our membership to 10,000 by 30 June 2016.

Ten thousand members will give us more strength to advocate for the regulation of professional social workers, better social justice policies and legislative change; deliver ongoing professional development, networking and mentoring opportunities; provide our ethics and complaints management service and collective trademarks, and oversee the Australian Social Work Education and Accreditation Standards (ASWEAS), as well as assess Accredited Mental Health Social Workers to enable them to apply for a Medicare Provider Number, support research and promote employment opportunities.

Our plan to grow includes reducing our new graduate membership rate to just $10 between now and 30 June. In the new financial year this annual rate will be reduced to $180, from $330. We are also talking to the employers of social workers about our services and the new graduate rate and to let them know that their social workers can claim their membership fees as a tax deduction.

Undergraduates who are not yet members of the AASW are also in our sights. This time we are talking with university social work schools with low membership uptake and identifying champions in each one as well as established student network groups.

As a current member, you can also help us build our professional association. Imagine what we could achieve if every member recruited one new member between now and 30 June? As an incentive, we will enter your name into a draw to win one of three prizes valued at $500.

Another way you can help us is by working with your local branch to grow membership locally. The branches are contacting non-renewed members and expired members from previous years and exploring adding 'introduce a new member' events to their calendar – opportunities for current members to bring a new member to their branch, highlight the professional networking benefits and make them feel welcome. If you have any questions about how you can help us meet our 10,000 member target by the end of the financial year, please phone the freecall number, 1800 630 124. You can also send us an email to membership@aasw.asn.au

At 70, the AASW is older than our counterparts in the United States and the United Kingdom. As you will see, in Jane Miller's article on page 9, its foundation was due to the determination of a small band of women, and later men, to provide Australian social workers with one professional association. Their aim was to develop professional social work education and practice throughout Australia, and represent the social work profession internationally. They succeeded and paved the way for us to do even more – now we represent yours and your clients' interests, monitor quality education and play a key role in the development of policies that meet our members' social justice objectives.

After you have read Jane's article, please visit the AASW's 70th anniversary pages on our website – they include short biographies of our founding executive, messages from members about why they became a social worker, reading lists to inspire you to continue to capture our history and a link to the definitive book by John Lawrence, *Professional Social Work in Australia*.

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Meet our Board of Directors

National President, Professor Karen Healy AM (seated), with from left to right: Josephine Lee, National Vice-Presidents Cindy Smith and Christine Craik, Barbara Moerd, David Gould, Brenda Clare, Maria Merle, Anita Phillips and Helen Hopper.

LETTER TO THE EDITOR

Dear Editor,

Firstly, I would like to congratulate the Board on the decision to offer social workers practicing in health the opportunity to contribute to the autumn 2016 issue of Social Work Focus. I see this as the first step of a number that need to be taken to encourage practitioners to contribute to the body of knowledge about Australian social work practice.

The National Bulletin is a good opportunity for social workers to contribute articles but it does not afford their work the same status as being published in the AASW's journal, *Australian Social Work*. However, despite its aims and scope to promote the development of practice, policy, and education, and publish original research, theoretical papers and critical reviews that build on existing knowledge, the journal carries few papers related to social work practice.

The journal's international recognition and rise in status in the last decade is a testament to the work done by the Editorial Board and reviewers. And it offers Australian researchers the opportunity to be peer-reviewed and many articles are co-authored with the principal author listed as being an academic rather than a social work practitioner. The journal is, as editor Mark Hughes notes in the October 2015 issue, a publication that 'reflects the greater pressure on social work academics to publish in highly ranked journals.'

Mr Hughes goes on to cite Christine Bigby's concerns that 'with this increased academic profile the risk to the journal and the profession is that it may lose some of its relevance to practitioners'. And I have to agree. The articles and research within them are interesting but largely offer no new knowledge or theoretical concepts relevant to social work practice. Nor do they capture how practicing social workers grapple with, and overcome, a multitude of challenges and dilemmas when they endeavour to integrate existing theory, knowledge and skills with emergent thought, and the lessons they learn – which we know as 'practice wisdom'.

Without a perceived accessible forum for Australian social work practice, knowledge and skills, we risk not growing or even contributing to two of the AASW's core objectives: to contribute to the development of social work knowledge and research, and to promote and facilitate members' professional development and lifelong learning.

I wonder how many practitioners are aware that they can contribute to the journal under the 'Practice, Policy and Perspectives' section? Or how many have the confidence to submit an article for publication? And are these submissions reviewed in the same way as a research paper? If they are, how does the journal identify the practitioners who are capable of reviewing/commenting on practice-based articles? Can it help non-academic practitioners by providing guidelines that will enable them to develop the skills and knowledge required to write for a professional peer-reviewed journal?

In summary, I commend the initiative that has seen this issue of the AASW's quarterly magazine dedicated to social work practice in the health sector, and I look forward to participating in other activities that encourage practitioners to develop their writing skills, which will enable the sharing and furthering of Australian social work knowledge and practice.

PAMELA TROTMAN

AASW Reconciliation Ambassador & Accredited Mental Health Social Worker

REPLY FROM JOURNAL EDITOR

MARK HUGHES

Editor, Australian Social Work

I agree that it is excellent that Social Work Focus is providing more space for practitioners to write articles on important topics for the profession, and I thank Pamela Trotman for her feedback on Australian Social Work.

As mentioned in my editorial last October (*Australian Social Work*., vol. 68, no. 4), I'm very conscious of the need to strike a balance between the interests of the practitioner and academic readerships. And yes, most of the articles are first authored by academics. Even as I write this though, I question this sort of practitioner/academic dichotomy which is reflective of the (from my perspective, unhelpful) theory/practice divide.

Most of the people who write articles for the journal are social workers. Yes, many of them are employed in universities and are supposed to write articles as part of their job, but many are also involved in social work practice – sometimes in clinical work – but often in community development roles either as part of their university 'service' or in a voluntary capacity.

Many of the people who write articles are postgraduate students, but most of these are also social workers and involved in practice. And there are many examples of practitioners and academics co-researching and co-writing articles published in the journal.

Continue reading >

Reply from Mark Hughes, Journal editor continued

More important though is the question of whether the journal publishes papers related to social work practice. In this respect I must disagree with Pamela Trotman. Have a look, for example, at the April 2015 issue (ASW, vol. 68, no. 2). In it, evidence was provided on the effectiveness of family meetings to improve outcomes for patients, carers and health systems. There was a collection of articles that looked at the experiences of people with life-limiting conditions, including an evaluation of an online writing group for people affected by cancer. Another paper looked at how culturally and linguistically diverse people with dementia may revert to their first language and explored the impact of this on families and the service implications. Another examined the ways in which homeless men took control their identities in the face of enormous social stigma.

It is true that the journal does not publish as many discursive 'practice reflection' pieces as we have in the past. Nonetheless we are creating a space – through the Practice, Policy, and Perspectives (PPP) section – to publish papers on small-scale practice research or case studies of innovative programs or policies.

> **What those working with the journal are trying to do is generate and publish high quality Australian and international social work scholarship and make this accessible to all social workers.**

Strong research foundations are vital to the ongoing growth and development of the profession. We are still on that journey, and I welcome the contributions of colleagues, such as Pamela Trotman, in helping us along the way.

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Australian social work owes a debt of gratitude to the small band of women and later men who worked with extraordinary commitment and intelligence to found this national body.

JANE MILLER AM

THE PEOPLE AND THE TIMES

Founding of the Australian Association of Social Workers in 1946

JANE MILLER AM
AASW Honorary Life Member

To mark our 70th anniversary, Jane Miller AM, outlines the events leading up to the foundation of the Australian Association of Social Workers and its early years, and profiles the people who shaped the course of our history.

The 14th of December 1946 was a memorable day for Australian social work. On that day, in the offices of the Royal Society for the Welfare of Mothers and Babies in Sydney, the Australian Association of Social Workers' first Federal Executive Committee was elected. Norma Parker (NSW) became the inaugural President; Vice Presidents were Lyra Taylor (Vic.), Kate Ogilvie (NSW), Dorothy Sumner (NSW/USA) and Amy Wheaton (SA). Margaret Grutzner (Qld), was elected Honorary Secretary with Viva Murphy (NSW) as Assistance [sic] Secretary.

These seven women, mainly ranging in age from mid 40s to mid 50s and most already respected public figures, went on to make extraordinary contributions to the social work profession (see 'Our founding executive' profiles online). Alison Player, one of the Victorian representatives who voted at the 14th of December meeting, was to take over the presidency seven years later, with Parker becoming Vice-President. The new association had approximately four hundred members (AASW Qld, 1947). This achievement had not come about overnight.

Social work's international context

Social work had become an international phenomenon well before it started in Australia. Professional education had started in England and the USA in the late nineteenth century. When the first International Conference of Social Work was held in Paris in 1928 it was attended by 2,481 delegates from countries as diverse as India, Japan, Russia and Chile (ICSW, 1928, p. 6).

An American Association of Social Workers was founded as early as 1917 and by 1955 (Social Welfare History Project, n. d.) it joined with other professional social work groups to form the National Association of Social Workers, which now has more than 130,000 members (NASW, n. d). In Britain a comparable national social work association was not established until 1971, well after Australia, when the British Association of Social Workers was formed. The BASW currently has approximately 14,000 members (Hitchcock, 2011).

The AASW's first president, Norma Parker, aged 25, photographed in 1931 after gaining her American social work qualification and before moving East to find work. (The West Australian July 1, 1931:16, National Library of Australia. http.nla.gov.au/nla.newsarticle32530361)

Early professional organisation in Australia: Almoners and generic social workers

Fortuitously social work training started almost simultaneously in Sydney and in Melbourne in 1929 (Miller, 2011). In Melbourne a course in 'almoner' (medical social work) training was started at the Melbourne Hospital and in Sydney a general social work course was established. Laurie O'Brien and Cynthia Turner (1979) and Elspeth Browne (1996a) have written accounts of early almoner education. Interestingly the AASW was not the first national social work association in Australia. The Australian Association of Hospital Almoners ran from 1934 to 1959 (Lawrence, 1965) when it closed its doors and amalgamated with the AASW. By early 1940 it had approximately forty members. The majority of almoners belonged and in the view of John Lawrence, it was a tightly-knit group (1965).

Isabel Hodge, who was in the first group of Victorians to complete the local almoner training and founded the Almoner Department (now a large and thriving social work department) at the Children's Hospital. She is pictured with polio patients during an epidemic in the 1930s. Almoners played an important role in following up discharged children in their homes, monitoring ongoing recovery and ensuring families had what was needed for the care of the child. (Royal Children's Hospital Archive)

Lawrence's recently re-published history, *Professional Social Work in Australia* (1965) summarises the way in which Australian social workers had started to organise professionally in the 1930s. While the Victorians concentrated on forming their professional almoner association (founded in 1932), New South Wales social workers formed the first association of general social workers in Australia, the Social Workers' Association of New South Wales. In 1935 Victoria followed along the same lines with the Victorian Association of Social Workers. These associations met regularly. Lawrence concludes:

> *The social work associations at this time were embryonic full professional associations. Their sole income was the few shillings of each member's subscription, the numbers were small, and their officers had little time to give to association affairs, but they were important. They set a pattern of educational activity and at least some social action, and they assisted the community's acceptance of trained social work. Perhaps most important of all for the recognition and development of a responsible new occupational group, they held together the products of the Australian training movement. (1965, p. 81)*

Why was there a move to form the original state-based social work organisations at this time? John Lawrence considers that the reason was that local social workers found they were facing similar problems across various fields of practice and a formal association offered opportunities for communication, joint educational activities and social action (1965).

Moves to co-ordinate education

Interestingly the three Australian schools of social work of the time, Sydney, Melbourne and the smaller Adelaide, also saw an urgent need to take a national rather than state-based approach. In a three-day meeting convened by the University of Sydney in 1938 (Miller, 2015), attended by representatives from Sydney and Adelaide as well as distinguished American academic Gertrude Vaile, an Australian Council of Schools of Social Work was established. As its first chairman, Melbourne's Dr John Newman Morris candidly remarked to The Argus newspaper this association would 'be able to ensure common methods of training [and] guard against the risk of reduced standards' if the smaller states started social work education (Miller, 2015, p. 149). This was a prescient remark and eventually it became the job of the AASW to attempt to ensure these uniform Australian standards. Unfortunately this council did not survive the war. After the war, and the formation of the AASW the association's national conferences provided a convenient opportunity for the three schools of social work to meet.

The Second World War: The young profession had arrived

By the beginning of World War II (WWII) the three schools of social work had been taken over by their local universities (Sydney and Melbourne in 1940 and Adelaide in 1942). The war provided great opportunities for professional social work to demonstrate its worth on a national stage. The universities of Sydney and Melbourne made a significant contribution to the war effort by providing, at the request of the Commonwealth Department of Labour and National Service, a number of intensive six-month welfare training courses (a truncated social work education) to people who already held university degrees.

These industrial welfare officers played an essential role on the home front through their support of the women forced to put aside their domestic obligations and go to work in factories (such as the munitions and clothing factories) so that Australia could keep up essential war production. In 1942, R. Baxter, Director of its Industrial Welfare Division, wrote:

> *It is clear that the industrial welfare supervisors [trained by Sydney and Melbourne universities] are playing a most important part...Without trained people the situation will probably get worse each month...we should have successive drafts [of industrial welfare officers] emerging as rapidly as possible (Baxter, 1942).*

Then, as part of the post-war reconstruction strategy, Dr H. M. L. Murray, the controller of the Factory Welfare Branch, started negotiations with the University of Melbourne for establishment of 'some kind of industrial welfare training course especially designed for ex-servicemen and women to undertake after war service...giving them a chance to adjust to civilian life' (Murray, 1944). Social work had come to the attention of the national government which was very keen to harness and extend its expertise. But this did place a heavy burden on a very small profession. The profession's resources were to be further stretched towards the end of WWII when the Australian Red Cross Society (ARCS) demanded a large cohort of social workers to staff its new rehabilitation hospitals nationwide, and not only in the three eastern states where social work was taught.

Red Cross social workers in Victoria in the 1940s, Margaret Grutzner second from left. Red Cross played an important role in the national dissemination of social work. (Author's collection)

ARCS provided a considerable number of scholarships both to enable people to undertake the qualifying social work courses. It also sent four social workers to Britain to undertake specialist psychiatric social work training at the London School of Economics and Politics (LSE). ARCS also recruited more than a dozen social workers from Britain and the USA to strengthen the small Australian workforce (Miller, 2015). Of equal importance to the introduction of social work in all Australian states was the national social work service established towards the end of the war by Lyra Taylor in the Commonwealth Department of Social Services.

One other arena in which Australian social workers made a significant contribution was to post-war Europe, with several Australian social workers going to Europe to work for UNRRA (United Nations Refugee Relief Administration). The story of these women, which included Betty Dow and Nancy Vercoe (Miller, 2015) among others, is yet to be told. However, once again this demonstrated the esteem in which Australian-trained social workers were held internationally as well as at home.

Founding the national association

Today's social workers would scarcely recognise the Australia of 1946. Looking back when the AASW reached its fiftieth anniversary in 1996, Elspeth Browne wrote an evocative article for *Australian Social Work* (Browne, 1996b), in which she recalled the Australia of 1946 immediately after WWII. Australia was a parochial country that was yet to be enriched by massive post-war migration from Europe. There was a housing shortage and petrol rationing; the life expectancy for men was 66 years and for women 77. Infant mortality was 29 per thousand. At the time of the 1946 election a referendum was held. The 'yes' vote resulted in the Commonwealth Government taking over 'much of the social security system and federal funding of health care...' (Browne 1996b, p. 57) which had previously been state concerns. Of interest to the social work profession was the fact that at last the beginnings of our national income safety net, which we take for granted today, could be put in place. As part of this change it became necessary for there to be national provision of social work services in Commonwealth Government departments, which was spearheaded by Lyra Taylor.

Why a national association was needed

In 1961 Sydney's Kate Ogilvie recalled that, 'First tentative moves towards forming the Australian Association were discussed in Adelaide during the war, at an interstate refresher course in Social Casework arranged by Mrs Wheaton and the South Australian Social Workers'. She goes on to add, 'Our contribution was a little blurred by the effect of sitting up for two nights in a war-time train, fortified by one precious bottle, which we managed to procure in Melbourne', giving some picture of the difficulties under which the pioneers laboured as well as Ogilvie's dry sense of humour (Ogilvie, 1961, p. 1).

Apart from the value of coordinating efforts, the driving forces for establishing a national professional association at that time were the need to be able to negotiate with one voice with the federal government and the need for international representation.

In relation to the first point, Browne (1996b) points out social workers from the state associations and the Australian Association of Hospital Almoners had made representations to the Commonwealth Joint Parliamentary Committee on Social Security, established in 1941, but were hampered by the lack of a unified national approach. It was clear that for social workers to have a significant say in national policy they had to have a single national association (Browne, 1996b). They were aware that negotiations with ARCS and the Commonwealth Government's manpower planning authority during WWII had been unduly cumbersome as these national organisations had to deal with six state representatives individually.

The second important concern was Australia's formal connections with social work colleagues internationally. In correspondence with Member of Parliament, Dame Enid Lyons, Norma Parker discussed a need for a national body to advise the Australian government on welfare representation in the United Nations Organisation (1946).

A national association would also facilitate communication with international colleagues, such as the International Conference of Social Work (Lawrence, 1969). At the first meeting of this international conference held after the war in Brussels, Jean Robertson (a Scottish social worker who had been the second staff member appointed in the University of Melbourne social work course (Miller, 2015)) represented Australia. Later Amy Wheaton and Helen James represented the AASW at discussions regarding the International Federation of Social Workers which took place in Paris. In addition to discussing the above, in her President's Report in 1950 Norma Parker also alluded to the interest of Australian social workers in welfare programs in South East Asia and expressed a hope that the AASW would be able to send 'a large contingent' to the next International Conference in India (Parker, 1950). By 1950, the establishment of a single national social work association was bearing fruits in international communication.

By December 1946 there had been several drafts of the constitution and it had been agreed that it would not be finalised until 1948. At the meeting where the first Federal Executive Committee was elected, two representatives voted from each of the states that had existing state social work associations. The early constitution of 1946 listed the objects of the Association as:

Unknown social workers in Paris in late 1940s/early 1950s. Australian social workers were keen to learn from the practice of colleagues overseas. England was a popular destination in the 1940s and 1950s despite the major influences on Australian social work being American. (Author's collection).

1. To promote and develop professional Social Work throughout the Commonwealth;
2. To act in a representative capacity for the Social Work profession in matters pertaining to the Commonwealth as a whole;
3. To educate and inform public opinion as to the aims and objects of social work;

4. To promote and maintain standards of professional training and practice;
5. To promote professional status and ensure good conditions of employment;
6. To co-ordinate the activities of Social Workers' Associations in the various States of the Commonwealth and to facilitate the exchange of information and ideas between them. (Draft Constitution of the AASW, n. d.)

In 1946 there were associations of social workers in all states except Tasmania. It was to be many years before branches were established in the Northern Territory or the Australian Capital Territory. When the national AASW was formed the state associations became its branches. Four years after the commencement of the AASW, in her 1950 Presidential report to the Federal Council of the AASW, Norma Parker explained that:

> *The states gave up to the federal body the power to determine membership of the association and to act on behalf of the social work groups in the Commonwealth in relation to social work, in the federal and international spheres. Otherwise they retained complete control of their constitutional change. (Parker, 1950, p. 142)*

The early association's model was very much that of a federation of state associations, not as today a centrally driven national organisation with major policy making and fee-setting powers.

Parker went on to explain that 'Membership of the Association is now limited to persons holding a professional qualification in social work from an approved School of Social Work or equivalent training body' (1969, p. 142). She elaborated the difficulties faced by the young association. The high cost of travel around Australia was a problem; planning at a federal level was complicated by the different stages of development of social work in the various states; the turnover of office bearers, partly due to the movement overseas of experienced social workers to further their education and experience, added to their woes; and lastly, there was an 'overwhelming' volume of work for the voluntary office bearers.

The appointment in 1949 of a paid secretary 'made all the difference to the effective working of the Association' (Parker, 1950, p. 144). In her report Parker referred to the 'enthusiastic interest and support of the Director General of Social Services (F. H. Rowe) and the 'keen interest' of the Minister for Health and Social Services (Senator McKenna) and the discussion and consultation of these men with Lyra Taylor, the chief social worker of the Commonwealth Department of Social Services (Parker, 1950, p. 144). She noted the work of the Association in relation to the government's (post-war) migration program and the pleasure of the association with the appointment in 1948 of a social worker to organise a Social Welfare Service in the Department of Immigration.

Another initiative of note had been work with the Commonwealth Employment Service and the establishment of a social work program in its Physically Handicapped Division (Parker, 1950). The early AASW leaders were well connected in senior government circles, working effectively on a range of fronts and clearly carried an immense burden of work in addition to their demanding jobs.

Amy Wheaton with Dr H. V. Evatt, Labor Leader, and Judge and Dr. G. V. (Jerry) Portus, Academic and ABC Broadcaster, undated, 1940s. Like Lyra Taylor and Norma Parker, Wheaton rubbed shoulders with national leaders. (Courtesy Archives, University of Adelaide).

The first object of the AASW, according to the initial constitution, was to 'promote and develop professional social work throughout the Commonwealth'. The first four schools of social work collaborated with each other and ran courses of similar standard. For this reason a formal standard-setting function was not required of the AASW – this matter came to a head in the 1970s with new courses in South Australia and Western Australia (Lawrence, 1976). However, there was a major emphasis on improvement of social work standards through education, particularly through the national conferences and, to a lesser extent, the Association's journal.

Achievements of the first decade

The AASW immediately set about providing education and networking for its members through the establishment of a national conference and a national journal.

National conference series

Less than a year after its founding the AASW held its first national conference in Sydney, 5–7 September 1947. It was attended by over 200 social workers (Lawrence, 1976), representing 50 per cent of the membership. As its title 'The Place of Social Work in Australia Today' suggests, this conference outlined the state of play of the profession at that time. Norma Parker said in her presidential address:

> *Social work has developed so quickly in this country that it has been impossible for us to keep pace with happenings... We think we have a great deal to gain from meeting together, sharing our thinking and experience and viewing together problems common to all. This clarification of our own ideas is a necessary preliminary to getting together with other groups. Later conferences will cover a wider field. (Parker, 1947, p. 7)*

In addition to Parker, the keynote speakers were Lyra Taylor (Vice-President) who spoke on 'Social Work and the Statutory Agency'.

Taylor counselled that in the new statutory sector:

> *At the moment, a decent humility, a playing down of too-ambitious claims for social work, and a steady getting on with the job as we see it, is called for rather than much talk about what has been effected or what it is hoped to accomplish. (Taylor, 1947, p. 28)*

She emphasised cooperation between sectors, the chronic problem of under-supply of qualified social workers and she also tackled some prejudices such as: 'Of course you can't do real casework in a Government Department' or 'Government Departments are all festooned with red tape' (Taylor, 1947, p. 34).

Dorothy Sumner (Vice-President), an American social worker who was a personal friend of Norma Parker and was then working at the University of Sydney, spoke on 'Social Work in the Voluntary Agency'. She began ironically talking on the motivation for becoming a social worker,

> *Is it the great prestige which the profession confers upon members? Possibly the handsome salaries are a drawing card. Perhaps we need to expiate our own guilt about something, or we enjoy seeing that there are others suffering more than we are? (Sumner, 1947, p. 46)*

She went on to discuss various social work methods and the common base of social work in different fields. These papers were followed up by presentations on social work education from the heads of the three schools of social work: Amy Wheaton (Vice-President) from Adelaide, J. A. Cardno from Sydney and Ruth Hoban from Melbourne. The discussion of the papers was recorded in full. Recurring themes that resonate today are the need for research, for prevention rather than cure and the need for cooperation between sectors and for social work unity.

Conferences continued biennially. The Second Australian Conference on Social Work was held in the Braille Hall, Tyrone Street, South Yarra, Melbourne on 26 and 27 August 1949 attracting approximately 200 social workers (Lawrence, 1976). Of particular importance was a post-conference 'refresher course' on casework run by Norma Parker (AASW, 1949).

SOCIAL WORKERS URGED TO STUDY THE INDIVIDUAL

Social workers attending the Second National AASW Conference in Melbourne, August 1949. The photo depicts visitors to Victoria from the five other Australian states. Life was much more formal with hats, gloves and 'costumes' as women's suits were then known. (*The Argus*, Melbourne Monday 29 August 1949: 6, Trove, National Library of Australia)

The third conference, held from 24 to 28 August 1951 in Adelaide, was entitled 'Social Work at Home and Abroad'. It was attended by 90 social workers (Lawrence, 1976). Back in Sydney in October 1953 with 145 attendees the fourth conference title was 'The Contribution of Social Work to the Study and Meeting of Family Needs' (Lawrence, 1976).

The fifth conference, held in Victoria on 12–16 August 1955, had 174 registrants (Lawrence, 1976) and was titled 'The Contribution of Social Work in the Field of Mental Health'. The sixth national conference held in Adelaide, was attended by 86 (Lawrence, 1976) social workers and had as its theme 'Education for Social Work' (AASW, 1957).

These early conferences had a strong emphasis on discussion groups, sharing of ideas and discussion of AASW issues as well as issues related to professional service. It was the AASW rather than the universities that took the major responsibility in the provision of continuing professional education. Because the AASW at that time ran on a federation model, each state took major responsibility for its conference – all work was done by members on a voluntary basis. The report of the planning committee of the 1955 Victorian conference explained this voluntary commitment, which included hospitality and home stays with members. It suggested that in future at least out-of-pocket expenses for activities such as meeting overseas visitors or the use of social workers' cars to take visitors on picnics could be reimbursed (AASW, 1957).

These national conferences played a crucial role in welding together the small number of social workers who were scattered across Australia. They promoted the development of professional networks, offered professional development, disseminated knowledge about social work and were valuable forums for sharing ideas. The development of a national journal was to play an equally important role in the creation of a strong profession.

National social work journal

In 1951 *Forum*, which had started life as a Victorian social work journal, expanded to become a national publication. In her foreword to the first national edition Norma Parker remarked on the 'solid achievement' of Australian social work (Parker, 1951, pp. 1-2).

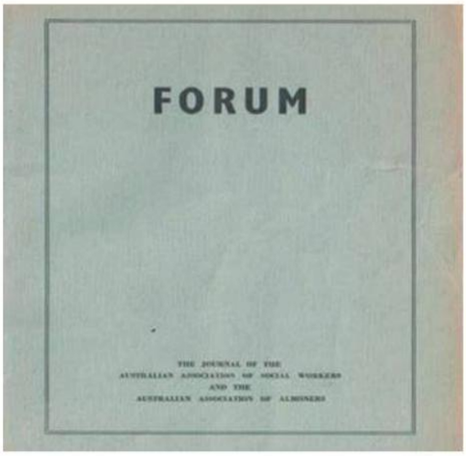
Parker also threw out a challenge to members in the foreword:

> *Is our professional thinking keeping pace with all this activity? Are we giving enough attention to careful evaluation of what we are doing and to the continuous appraisal of changing needs? Are we devoting sufficient thought to the contribution we should be able to make from our experience to community planning and organization? ... Are we adding anything to the general store of knowledge about life and people in Australia to-day? (p. 1)*

She goes on to challenge members:

> *When we look at that aspect of particular interest to us here, the written record, we find that there is not a great deal to show; in fact there is an almost complete absence of anything which might be called professional literature. A few papers written for special occasions and published in pamphlet form, a few projects undertaken in the Social Studies Departments of the various universities, an occasional article in a general publication... (p. 2)*

These remarks have an oddly contemporary ring. Finally she exhorted members to provide 'a keen and critical body...willing to participate in written discussions and to help the Editorial Committee with ideas' (p. 2).



The national journal, *Forum*, 1954, no. 2. This issue had 45 pages, was roneoed and bound with a printed cardboard cover (Author's collection).

Forum promoted international and interstate networking, ran articles about innovations, discussed social work practice, carried news on staff changes and the travels of individuals, as well as book reviews and job advertisements.

It was a lively little journal, more like a newsletter. It was not printed but typed and roneoed and cost four shillings per year (post free), to be paid for in addition to membership. Fortunately the journal has now been digitised and these early Forums can be accessed *Australian Social Work*.

New social work courses

The national AASW and a handful of members of its Queensland branch (initially seventeen members in all (AASW Qld, 1948)) worked hard to establish the first social work course at the University of Queensland, which commenced in 1956 and was the fourth school in Australia (AASW Qld, 1947). While on visits to their Queensland offices Lyra Taylor, Chief Research Officer in the Commonwealth Social Service Department, and Marion Urquhart, National Director of Social Service with the Australian Red Cross Society, offered support and advice. In 1951 Lyra Taylor discussed training for social work with the University of Queensland on behalf of the branch (AASW Qld, 1951). By 1954 the Annual Report of the Training Sub-Committee was able to advise members that 'the long arduous task of this Committee' appeared at last to be nearing completion, when the University decided to establish a Department of Social Studies (AASW Qld, 1954, p. 3). In 1956 the Annual Report announced the appointment of Hazel Smith, the Branch President who was to start the social work course (AASW Qld, 1956). Clearly the national AASW and a committed local branch played a key role in establishing the course at the University of Queensland.

It was not until 1964, beyond the scope of this article, that the University of Western Australia started social work education. But the value of the opportunity for discussion on a national level afforded by the biennial conference is illustrated by a paper presented at the 1955 conference by E. Williams (1955), President of the Western Australian Branch, on 'Developments in Thinking of Those Concerned with the Subject of Professional Education in Western Australia'. After outlining the urgent need for trained social workers in the West and efforts made to establish training at that stage she concluded,

> *It is our desire to establish on a firm footing, a University post graduate course. It seems to us the need requires our urgent attention, for we may otherwise find that Social Workers will be trained to a professional status, whether we agree that the desirable standard is maintained or not, if in reasonable time we cannot do something about it ourselves. (Williams, 1955, p. 32)*

Registration under the Arbitration system

Another important matter which the AASW addressed was a serious undersupply of social workers coupled with inadequate wages and conditions (possibly a circular situation). To solve this problem, the Association started a campaign to register itself under the arbitration system to achieve an industrial award for social workers. It was decided that rather than split the membership by creating a separate union the AASW should become a registered body in the Arbitration Court (Parker, 1950). Not all social workers agreed with this move (some being uncomfortable with the idea of being trade unionists), but ultimately it was agreed by a 93 per cent vote to go ahead with this approach (Ogilvie, 1961). In Kate Ogilvie's words:

> *The Association had achieved legal status as the body representing Social Work in this country; members were formally recognised as a distinct professional group and protected from compulsion to join other unions, though they might still choose to belong to more than one. (Ogilvie, 1961, p. 4)*

Thus a very important step in improving social workers' wages and conditions had been achieved. It probably also strengthened the profession's sense of identity. Social workers interested in knowing more about the early industrial situation should read John Lawrence's (1976) introduction to *Social Work in Australia*: Responses to a changing context, edited by Phil Boas and Jim Crawley of the Preston Institute of Technology in 1976. While Lawrence found that twenty years later a federal award had not been sought for a range of reasons there was positive industrial activity in the 1960s.

While this falls outside the timeframe of this article, it is of interest that an industrial case:

> *…pursued through the Commonwealth Professional Officers' Association, but with active AASW assistance was seen as an industrial milestone. The starting salary of a male social work graduate was better than that for an engineer; the salaries for higher grades were clearly aligned with other professional salaries and were shaken clear of their previous alignment with so-called medical technologists such as occupational therapists, physiotherapists and radiographers; and equal pay was to be phased in by January 1972. (Lawrence, 1976, p. 30)*

In 1976 the handing of the hard-won industrial function of the AASW to the newly created Australian Social Welfare Union (ASWU), which it was hoped would then represent both social workers and the emerging associated welfare professions industrially, was agreed to by a narrow majority of members and is still a matter of controversy. Ultimately social work wages and conditions lagged under the management of the new union. This is one of many professional issues that would benefit from further historical study, particularly while some of the protagonists are able to give their versions of events.

Where to now?

Looking back, one advance seems to neatly follow another but on many occasions the cards could have fallen another way. Choices were made for better or worse and battles were won or lost. For example, we might ask what would have happened if the Almoners had refused to cooperate with the general social workers and there had been two associations claiming to represent the profession? There were many turning points of this nature.

The Australian Association of Social Workers has had many ups and downs since 1946, and doubtless not all its decisions have been perfect. Overall it can be said that the basic model for a national association put in place by the founders has provided a guiding light for the profession in Australia. The national communication strategy from the earliest days has ensured a unified understanding of the profession and its key tenets. Australian social work owes a debt of gratitude to the small band of women and later men who worked with extraordinary commitment and intelligence to found this national body.

Understanding our history is essential in helping us to understand the profession in the present day. The same issues arise over time. Past debates can throw light on present dilemmas. In doing the research for the writing of this history, it has been disturbing to find how difficult it is to locate primary source material. For example, the minutes of the AASW's federal executive committee appear to be unavailable. We do not have a listing of all the national presidents, the state presidents, the honorary life members and so on. Because of the dearth of archival material, I could not have written this article without the assistance of John (R. J.) Lawrence, Honorary Life Member and distinguished social worker, who guided me through his extensive personal archive.

Nevertheless, the AASW is to be congratulated in this seventieth anniversary year on its historical initiatives including re-printing Lawrence's *Professional Social Work in Australia* (1965) and commencing work on a project to compile profiles of its Life Members. But we cannot rest on our laurels. Far more needs to be done to preserve the archival documents that remain and we need to urgently undertake concerted historical research on Australian social work.

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In contemporary health social work, we continue to confront the challenge of maintaining our professional identity, sense of social justice and theoretical perspectives.

LYNETTE JOUBERT

SOCIAL WORK PRACTICE IN THE HEALTH SECTOR

PROFESSOR LYNETTE JOUBERT
Guest editor

Social work services within health care settings are secondary to the primary focus on health and providing health care.

Ida Canon, who is acknowledged as establishing the first organised hospital social work department within the health sector, first used the term 'host setting' to describe organisational relationship and its impact on the identity of social work as a discipline. She was acutely sensitive to balancing professional values and perspectives with the demands of the hospital. Today social workers in the health sector face the many challenges of being within a 'host' setting. Some of these challenges relate to shifts in focus toward secondary risk prevention, recovery rather than rehabilitation, and moving from infectious disease treatment to self-management of chronic disease.

This special edition of the AASW's new newsletter, Social Work Focus, describes a range of projects, analysis of current issues and innovative social work practice within the health sector across Australia. Issues such as perinatal counselling, the experience of abuse, policy directives for elder abuse and aged health care issues, and 'end-of-life planning' are described alongside exploratory and rigorous descriptions of innovative practice. These articles include working with vulnerable children, cost effective relational educational group work for rehabilitation patients and a trauma-informed model of care for women and children in emergency. Combined, the submissions highlight the diversity and complexity of health social work interventions that are grounded in social work theoretical paradigms but aligned with developments in the health system.

Social workers who have participated in research projects with either qualitative or quantitative research methodology have described not only their understanding of the research process but also how health social work can contribute to favourable outcomes for patients. Many of these practice research studies have evolved from practice-based research initiatives in partnership with university departments that offer the opportunity to extend and deepen practice through collaborative and meaningful research activity – all of which contribute to social work in the health setting. The shift to person-centred care clearly fits with social work's perspective on social determinants, while holistic health care emphasises the importance of families, communities and the person-in-social context. In addition, social work can align with the need for health care to be collaborative and culturally sensitive and its practice can be holistic in the prevention, treatment and management of chronic diseases. Care should become proactive, rather than reactive, with a target of early prevention. Social work clearly has a major role to play in these policy and service provision shifts.

In contemporary health social work, we continue to confront the challenge of maintaining our professional identity, sense of social justice and theoretical perspectives. Health care systems assume the importance of individual, family and community issues, but do not assume social work ownership of this. The articles in this special edition celebrate health social workers' response to these current challenges. The wisdom of Ida Canon persists but competencies and skills described in these articles demonstrate the ways in which social work is establishing its place as an important and effective deliverer of patient-centred health care.

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About the author

Professor Lynette Joubert is a Professor and the Director of the Practice Research Program in Health and Mental Health in the Department of Social Work at the University of Melbourne. She is a research mentor at Northwestern Mental Health and the Peter MacCallum Cancer Centre and has a particular interest in the development of academic practice partnerships in supporting social workers' engagement with practice research. Lynette is the AASW's guest editor for this special issue of Social Work Focus which explores social work practice and research in health.

BENEFITS OF AN EARLY BREAST CANCER SUPPORT GROUP

ROSEMARY ARIAS

Rosemary Arias explores the power of shared experience and the therapeutic value of a support group held for women with early breast cancer at St Vincent's Public Hospital Sydney. She draws on social work practice experience, research literature, and on her experience of facilitating the support group.

Breast cancer is the most common cancer diagnosed in Australian women and the leading cause of cancer deaths (Beacham et al., 2005). The decision to initiate and facilitate a breast cancer support group was based on the high incidence of breast cancer and a belief that women diagnosed with it would benefit from meeting other women in a similar situation. It was felt that they would feel supported by each other, realise they were not alone and be empowered by information and knowledge to feel more in control of their situation, and learn coping skills from each other.

Research shows that the experience of living through the diagnosis and treatment for breast cancer is a major life transition, the distress may be long-term and there is a degree of uncertainty regarding survival. It also shows that there is a need for support and for women to have an opportunity to talk about their experience. An increasingly common way women with breast cancer seek to cope with their illness is participation in social support groups (Han et al., 2008; Smeardon, 2001).

Support groups can provide a safe forum for the expression of emotions and give and receive support. The group may help women face difficult issues by drawing attention to similar experiences or difficulties (Beacham et. al., 2005). Information, emotional and social support from peers and from health professionals are the major components of cancer support groups (Zeigler, Smith, & Fawcett, 2004).

The mutual aid model of group work, as described by Moyse Steinberg (2004), is the theoretical basis for our support group for women with early breast cancer at St Vincent's Public Hospital in Darlinghurst, NSW, as we believe this approach best reflects social work values. The essence of this model is that the facilitators attempt to bring out the potential of the helping relationship between participants, thereby enabling mutual support and demand. The aim is to provide an opportunity for people in similar circumstances to learn from each other and share their experiences. The mutual aid model reflects a strengths approach. Norms crucial to mutual aid are related to collaboration, authenticity, use of self, use of co-members as helpers, decentralised authority and free-form interaction.

Undergirding the leadership practice model used by the facilitators is a feminist perspective that fosters an egalitarian, non-hierarchical group environment with minimal intrusion by facilitators. Each person who participates in the group is equal. All participants are engaged in a common journey of careful listening to each other and sharing knowledge and experiences. The feminist perspective directly addresses the issue of power by promulgating an egalitarian environment for the group (Zeigler et al., 2004).

The breast cancer support group was started in July 2011, and meets each month. The meeting begins with a speaker on a topic chosen by the women. Speakers have covered a wide range of topics, such as treatment, surgery, the side effects of hormone treatment, menopause, reconstruction surgery, health anxiety, communication, exercise, emotional issues, and new research. Following the speaker there is a discussion on whatever issue the women raise and we encourage them to address their questions or issues to each other, not the staff. Recruitment has been primarily through the support of the breast care nurses.

About the author

Rosemary Arias completed a Bachelor of Arts (Community Social Services), a Bachelor of Social Work (Hons) (1991) and a Master of Social Work at the University of Sydney. At the Department of Community Services (Disability) Rosemary soon recognised the benefits of group work as opposed to individual casework with mothers of children with disability. Working in a health care setting for the past 13 years, the latter five years with women with breast cancer, she again recognised the value of people with similar issues supporting and learning from each other.

It is an open group and women can attend at any time during their treatment or after it finishes. There is no obligation to speak or to attend both parts of the meeting and no time limit as to how long they can continue to come to the group. They are asked to register beforehand to assess whether they fit the criteria of early breast cancer and to make a connection. The women are also given an explanation as to how the group works so they know what to expect. We hold the group in a function room of the hospital's cancer centre, a private, non-clinical space that looks out onto a garden with water features. The Tea and coffee offered on arrival acts as an icebreaker and a light lunch after the group provide women with an opportunity to mingle.

There have been a number of common themes to come out of discussions in the support group, such as the impact of breast cancer on relationships. Women in the group report that often when they try to discuss their innermost thoughts and fears with others it can result in platitudes that lead to a sense of isolation and not being understood. Conversely, group members report a sense of liberation that comes with being able to speak openly and freely in our group, and to feel heard, supported and understood. There can be tears and laughter as the group process unfolds. Members often speak about how the group frees them from isolation and shows them that they are not alone.

The sense of isolation and reduction in support that may often colour the feelings of relief and accomplishment of finishing treatment is another theme that has arisen within the group. Women can feel lost and the reaction of others, although well-intentioned, can invalidate anxiety and feelings of uncertainty. Appearances can belie inner feelings – for or example when a woman's hair grows back, or she has returned to work, there is an expectation that everything is back to normal.

Other themes are dealing with side effects of chemotherapy and long term (10 years) hormone treatment such as hot flushes, neuropathy, joint pain, insomnia, fatigue and fertility. Issues around sexuality, body image, breast reconstruction, and menopause, for many at an uncommonly young age, are some of the weighty themes discussed.

Key comments made in annual evaluations on the benefits of the group are very positive and include terms such as: empowerment, sharing, acceptance, comfort, healing, bonding, safety, understanding, and openness.

Our experience of the support group aligns with literature findings about the value of a support group for women with breast cancer. The therapeutic benefit is the provision of mutual support and realising that they are not alone. The discovery that similar feelings are shared by other members of the group can often be the beginning of freeing a person from the power of that feeling and can be one of the most powerful forces for change resulting from the mutual aid process. Our experience demonstrates the importance of having support groups available for women with breast cancer.

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BUILDING SOCIAL WORK FAMILY VIOLENCE COMPETENCY IN HEALTH

JENNY CHAPMAN

The Royal Women's Hospital in Melbourne has been addressing family violence and the role of its social workers which is critical to providing the hospital's frontline specialist response.

Family violence is a serious social and health issue for women and children and the need to recognise and address it, particularly primary prevention strategies, has gathered momentum in recent years. This has seen the development of several important initiatives, including the commencement in 2011 of the intergovernmental National Plan for the Prevention of Violence Against Women (PVAW), the appointment in Victoria in 2014 of a Minister for the Prevention of Family Violence, and in 2015, the Victorian Royal Commission into Family Violence, as well as more intensive media reporting of family violence and its impacts.

The Royal Women's Hospital (the Women's Hospital) is committed to a social model of health care and a leader in gender-specific health care. It is Australia's first and largest specialist public hospital for women and newborns and has long recognised the impact of gender-based violence on a woman's health and that of her children. The hospital's approach to family violence is based on a gendered framework and, as a result, its internal training and service responses reflect the experiences of intimate partner violence without discounting the fact that men, children and the elderly also experience family violence.

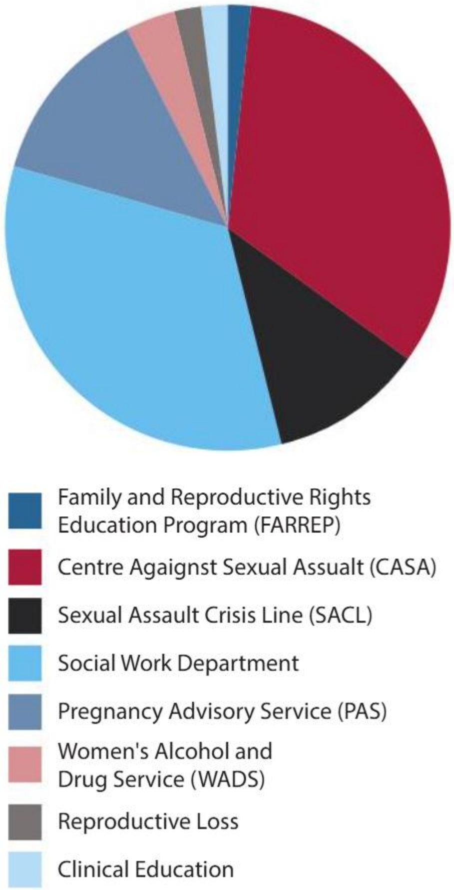
As women often make their first disclosure regarding family violence to a health care professional, social workers in a health setting are critical to identifying and responding to family violence. They are integral to providing support, assessing risk, and planning for safety and making the appropriate referrals that support women to make decisions. Conscious of this role, the Women's Hospital Social Work Department reviewed the capacities of its staff in this field. For this reason, quality specialist training of hospital social workers is fundamental to achieving better outcomes for women and children experiencing family violence.

In 2015 the hospital's review of training programs, conducted as part of the Department of Health and Human Services-funded Strengthening Responses to Family Violence project, revealed a gap in advanced family violence training for social workers. Despite accessing external specialist training in the Integrated Family Violence Sector, the review found workers felt this was not meeting their professional development needs. Feedback indicated that the training was not specific to the hospital context and generally taught at a level below workers' capability and experience, and this led the research team to initiate a survey of all the hospital's social workers so it could identify social work family violence training needs. Specifically, the team sought to determine the social workers' current experience in this complex area, perceptions of their own competency and expectations of what an advanced training package might look like. Capturing this data would inform the development of such a training program.

Collection of the data commenced in June 2015, and initial results suggested some key avenues for further analysis. The Women's Hospital employs 54 social workers in a diverse range of program areas (see Figure 1) and the invitation from the project to participate in an anonymous online survey achieved an impressive 75 per cent response rate. Analysis of this data revealed an experienced workforce frequently engaged with issues relating to family violence in their clinical practice.

The majority of respondents have Bachelor of Social Work (47.5 per cent) degrees and the remainder higher-level degrees. They reported that they had also undertaken ad hoc undergraduate and employer training. Respondents' social work experience was predominantly between 5 and10 years (38.5 per cent). Importantly, 88 per cent also indicated that they frequently engage with issues relating to family violence in their clinical practice.

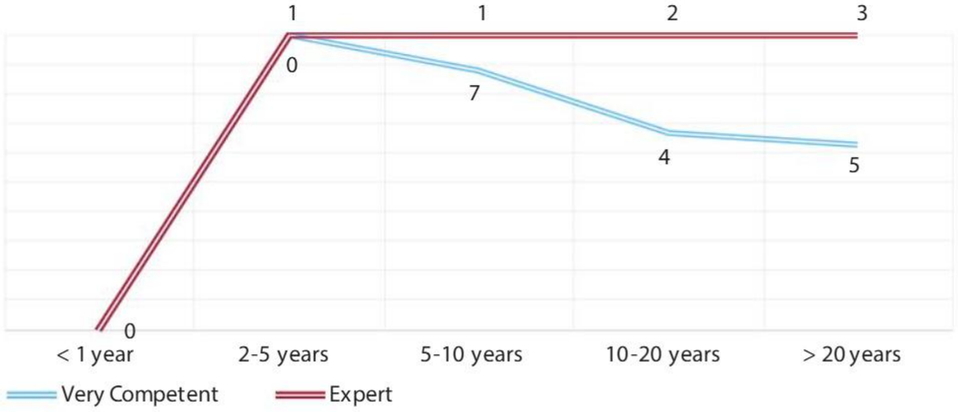
Figure 1: Social work program areas at the Royal Women's Hospital



A key part of the survey was the invitation to social workers to rate their own perception of their competence with managing family violence issues. In social work literature, Marian Bogo defines competence as "an individual's ability to use or translate the knowledge, skills, attitudes, and judgment associated with a profession into a set of complex behaviours, and perform effectively within the scope of professional practice" (Kane, 1992; Whitcomb, 2002, as cited in Bogo 2013).

Continue reading >

Figure 2: Social worker's years of experience and perception of competence

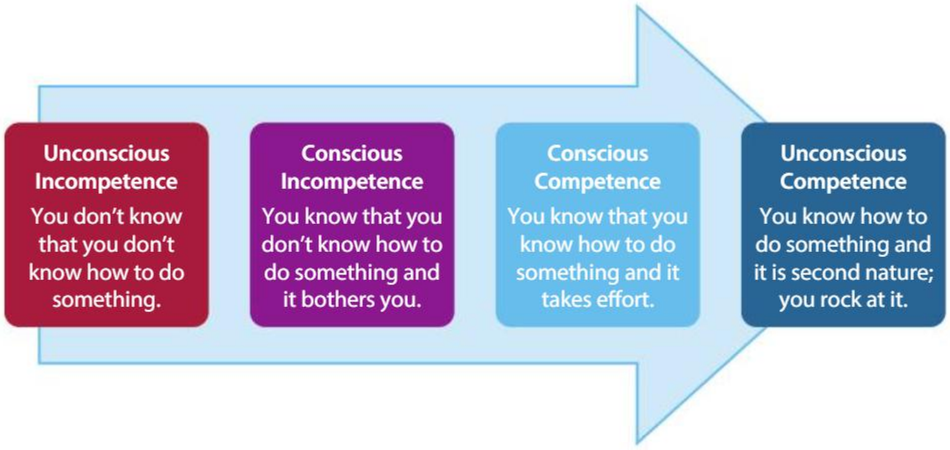


Staff at the Women's Hospital were asked to rate their level of skill as not competent, somewhat competent, competent, very competent or expert. Analysis of this data has produced a particularly interesting initial finding (see Figure 2).

When respondents' years of experience were cross-referenced with their self-rated competence, it was revealed that the peak rating of their competence was made during the first five to 10 years' of their post-qualification experience and that this decreases as their experience grows (see Figure 2).

This suggests that social workers' self-perception of family violence competence changes over time, and is not necessarily contingent on their years of experience. It has been noted that while performance is directly measurable, competence is an inferred quality (Epstein & Hundert, 2002). Competency-based assessment and models have been utilised in professional learning and development in multiple disciplines, although this remains contested territory. While it is acknowledged as being 'critical to self-regulation of the profession and public protection' (Birnbaum & Silver, 2011 as cited in Bogo, 2013), competency-based assessment has also been criticised as an "uncritical tick box approach to practice" (Aronson & Hemingway, as cited in Bogo, 2013). Making use of these initial findings therefore requires a considered approach to understand how competency is achieved. Epstein and Hundert (2002), when defining and assessing professional competence in the medical field, noted that it "is developmental, impermanent and context-dependent".

Figure 3: Maslow's Four Stages of Learning Model



Abraham Maslow's Four Stages of Learning Model (Figure 3) is also helpful when exploring this finding (Maslow, as cited in Crosbie, 2005). Maslow's model is often used in psychology to determine when and how a person acquires a skill. It suggests that as a person progresses, competence goes through phases of conscious and unconscious learning (see Figure 3).

Unlike the Four Stages of Learning diagram, our research suggests that skill attainment is not necessarily a linear process and that implicit attributes of professional competence development in relation to family violence needs to be viewed as much more nuanced and complex, and one which requires particular support and training.

The Royal Women's Hospital is one of two specialist tertiary maternity hospitals in Melbourne and this research demonstrates its social workers are highly likely to encounter family violence issues in their day-to-day practice. The hospital has an executive and workforce that are committed to ensuring appropriate identification of, and responses to, family violence as an important women's health issue and its social workers are experts on family violence and provide women and children experiencing it with the hospital's service response. Therefore it is important to further explore social workers' perceptions of competence and develop sophisticated and responsive training models that are for the complex and changing practice environment of family violence as well as support the critical reflection crucial to ensuring social workers' competence in this area of practice.

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AN EMERGING PROFILE OF COMPLEXITY IN HEALTH SOCIAL WORK

DR HELEN CLEAK AND GLENDA KERRIDGE

The Australian health care system is facing increasing pressure and consumer demand on its services, due to an ageing population and a changing burden of disease, coupled with technological developments in medicine, which has seen life-threatening illnesses transformed into chronic conditions.

The case complexity associated with serious medical conditions, along with an array of chronic social issues, can result in extended hospital stays and this can be further complicated by uncertainty around prognosis, and the influence of existing or acquired disability on people's potential to resume their previous lifestyle (Redfern, Burton, Lonne, & Seiffert, 2015). Additionally, the range of available community services does not always meet these complex needs and consequently, their discharge needs and level of post-hospital support is high, often necessitating long hospital stays. Others are discharged without the required level of support, placing them at risk of failed discharge and re-admission (Cleak & Turczynski, 2014).

The recurrent fiscal pressure on hospitals has generated a drive for efficiencies in patient care and patient flow, while the range of challenges for clinicians continues to expand. Additionally, the emergence of risk assessment to minimise poor outcomes for health organisations as well as patients (Scott, 2010) has led to social workers spending ever-increasing amounts of time with patients and their families, assisting them to negotiate the health system and in mediating conflict situations.

Social work has a long tradition in health in Australia, but within this increasingly complex and tightly constrained economic context, the need for health social workers to articulate their clinical contributions to patient care and interprofessional teams has intensified. Social workers have often expressed that their particular expertise is in their ability to deal with 'complexity' (McAlinden, McDermott & Morris, 2013), but this does not provide a clear or common definition of what it means. Allied health teams are also moving towards interprofessional practice models (Australian Institute of Health & Welfare, 2010) and with this is an impetus to more clearly articulate the evidence-based interventions that social work practice contributes.

One way that social work professionals are beginning to research and define the notion of working within these complex personal, social and organisational systems, is by investigating the experience and perceptions of health social workers in these settings This knowledge can enable us to come closer to an understanding and definition of complexity. Understanding complexity is also important for planning workload allocations and the prioritisation of urgent and multifaceted cases as it has often been difficult to predict the variables that will influence the need for social work activities and give meaningful explanation to variances in workload. Defining and measuring the variables that form complex cases can also contribute to risk assessment and screening tools for use in ensuring that these cases are identified and supported adequately.

The concept of complexity has been explored by a number of authors, who have particularly utilised a sy stems-and-person-in-environment perspective to highlight the complex nature of clients' issues (Sommerfield & Hollenstein, 2011). In 2013, McAlinden, McDermott and Morris undertook a study of a Victorian sub-acute service, in which 11 social workers were interviewed about their definition of complexity. The results highlighted five key inter-related themes defining complexity: multiple competing demands; uncertainty; patient and family characteristics; pending breakdown; and systems challenges. More importantly, there was a correlation between the worker's years of experience and seniority and their perceptions.

A more recent study was undertaken at a major Victorian health service which replicated the methodology used by McAlinden et al. (2013). Thirty-one social workers from both acute and sub-acute sectors were interviewed and asked to define what a complex case meant to them, and then to discuss current cases, describing them in detail and commenting on the impact of these on themselves. This qualitative study provided a rich narrative to advance our understanding of complexity.

This larger study suggested key defining themes of complexity that included multiple, complex medical conditions; interprofessional and team issues; psychosocial problems; mental health issues; personal (patient or family) behaviour/issues; and systems issues. A common theme was the interplay of a combination of several of these factors at once, leading to an intricate overlay of interfacing challenges, and the presence of conflict, both within the family system and the hospital system.

In contrast to the McAlinden et al. (2013) study, the results showed a consistency in the perception of complexity across the age, grades and years of experience of social workers.

The second interesting finding was that most social workers reported that, although complex cases were often seen as stressful and demanding, they energised and enriched their work and allowed them to use the full extent of their knowledge and skills. These findings seemed to support anecdotal evidence that the referrals to which social workers respond, are becoming increasingly acute and higher in risk, and indeed, are the only cases they can now respond to in acute and subacute health settings.

The future direction of health care is towards a patient-focused, coordinated and interprofessional team approach to service delivery but provided within a climate of dwindling resources and increasing drive for efficiencies. Complexity is a recurring theme in describing the work that social workers undertake in these settings, so it is therefore timely that they are looking more closely at professional and theoretical perspectives of complexity in order to build a comprehensive account of its impact on workload planning.

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WORKING WITH VULNERABLE CHILDREN IN THE PAEDIATRIC HOSPITAL ENVIRONMENT

Approaches to continuing professional education

SARAH CONNOLLY

An ability to identify and respond to children who are vulnerable or at risk of harm is a central aspect of paediatric health care and is imperative for social workers. This article describes a suite of continuing professional development initiatives at the Royal Children's Hospital, Melbourne and the annual credentialing requirements that have been designed to strengthen social work practice with vulnerable children in hospital.

The stakes are high; failing to correctly identify risk to vulnerable children can have devastating consequences for the child, siblings and family system. It is imperative, therefore, to ensure that all paediatric social workers have sufficient skills, knowledge and experience to undertake this work.

The social work department of the Royal Children's Hospital (RCH) is responsible for the delivery of high quality care to children and families experiencing diverse medical conditions. Like many tertiary teaching hospitals, it promotes a culture of excellence and values learning and professional development (Royal Children's Hospital, 2014). Its social work department offers regular, structured professional development sessions on a broad range of clinical issues such as bereavement care, trauma practice and cultural competence and this continuing professional education complements external training, conferences and seminars as well as paid study leave for staff members undertaking higher degrees.

To ensure high quality practice that emphasises child wellbeing and safety, RCH social workers are required to demonstrate specific competence in working with vulnerable and at-risk children as part of annual departmental credentialing requirements.

It is clear both from the literature and practice experience that working with vulnerable children presents unique challenges and dilemmas and requires ongoing professional development (Mildon & Shlonsky, 2011; Searle & Patent, 2012). Failure to correctly identify when a child is at risk can have disastrous consequences (Benbenishty & Chen, 2003; Munro 1996) and the work is demanding, stressful and confronting. Social work intervention is, at times, investigative and perceived as intrusive or unwanted by parents and carers. Cases frequently involve legal action and staff may be required to give evidence in court of their intervention and assessment.

So, what continuing professional education is provided by RCH to social work staff working with vulnerable children?

Because failure to identify and intervene when children are at risk can have dangerous consequences, all new social workers at RCH are provided with a comprehensive orientation program. An online learning module is used to teach staff about the identification of and response to vulnerable children in a hospital setting (see http://vulnerablechildren.e3learning.com.au/). Staff are required to undertake specified reading and receive individual instruction from a senior clinician on practical aspects of risk assessment and engaging vulnerable families. In addition, they receive formal training to participate in an after-hours on-call roster that can include crisis response to vulnerable children.

Competent practice requires also ongoing opportunities for professional development (Mildon & Shlonsky, 2011). and therefore education and training for RCH social workers comprises a number of elements. All receive regular individual supervision that encourages critical reflection on practice (Beddoe, 2010; Fook & Garder, 2007; Maidment & Beddoe, 2012).

About the author

Sarah Connolly works as Chief Social Worker at the Royal Children's Hospital, Melbourne. She holds a Masters of Social Work and Masters of Human Services Management and has a background in child protection and healthcare settings in Ireland and Australia. Sarah is passionate about services to vulnerable and at-risk children and has served on both the AASW's International Qualifications Committee and National Ethics and Professional Practice Standards Committee.

The social workers also have access to departmental clinical practice guidelines for working with vulnerable children and to consultation with a senior clinician to discuss all aspects of practice with vulnerable children. Monthly discussion forums provide an opportunity to examine practice issues, hear about the work of colleagues and identify areas of difficulty. Social workers are also required to maintain a continuing professional education record (the AASW's standard continuing professional development or CPD logbook).

Demonstrating ongoing competence and maintaining high standards of practice with vulnerable children is a priority for the RCH Social Work Department so all social work staff, regardless of role or level of experience, are required to participate in an annual credentialing exercise. This demonstrates knowledge and understanding of working with vulnerable children.

Currently this is undertaken using a peer review model of learning. Social workers present examples of practice with vulnerable children in small peer groups and the peer group reviews the worker's practice by offering comment and constructive criticism to assist learning and reflection. Drawing on Fook's approach (2004) this form of professional development emphasises critical reflection, articulation and evaluation of practice. This learning approach offers an opportunity to share experiences with colleagues, clearly articulate assessment findings, reflect on practice, receive constructive feedback and share dilemmas and issues with others. While reflection alone does not lead to improved clinical practice (Fook, 2004), supporting reflective practice is linked to a culture of excellence, accountability and a strong sense of professional purpose (Blumenfield & Epstein, 2001, p. 11).

The specific challenges of working with vulnerable children necessitate ongoing professional development, critical reflection and staff support. Organisational structures and culture can help promote learning, ensure high quality clinical service delivery and enable social workers to meet credentialing requirements. Tailored, in-house continuing professional education has been presented as practical and feasible in a busy inpatient setting alongside external training and conference attendance if it is underpinned by high quality professional supervision.

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HOSPITAL SOCIAL WORK AND PERINATAL FAMILY CONFERENCING

Pathway to working collaboratively to address child protection issues

CECILIA CORREY AND CHRISTINE CANTY

Every public patient that receives antenatal care at Royal Prince Alfred Hospital has a booking visit with a midwife in which they are asked a number of psychosocial questions.

These questions cover areas including: mental health; drug and alcohol use; domestic violence; housing issues; history of abuse/neglect; criminal and juvenile justice history; previous child protection involvement; and any other practical or emotional stressors.

If issues are identified, the patients are then referred to social workers and other appropriate clinicians from the multidisciplinary team. This process is based on the NSW Health Safe Start Strategic Policy 2010 and, at RPA, the referral process is outlined in the Sydney Local Health District Perinatal Psychosocial Guidelines.

The social worker's role is to complete assessments, provide counselling, advocacy, make appropriate referrals and write child protection reports. They also liaise with child protection caseworkers and other services to address any concerns and organise post-natal follow up and support.

Each year, hundreds of women are referred to RPA women's and babies' social workers in the Young Parents, Perinatal and Family Drug Health and Midwives clinics, the Foetal Medicine, Medical and Obstetric clinic, Gestational Diabetes Clinic as well as through the Neonatal Intensive Care unit.

The perinatal and family drug health social worker receives referrals for women who identify substance use in pregnancy or have a history of problematic substance use. In the period of June 2014 –July 2015, approximately 94 women were referred to this service.

The Young Parents and Antenatal social worker receives referrals for women attending the young parents' clinic and a variety of other antenatal clinics. In the period between June 2014 and July 2015, approximately 75 women were referred to the Young Parent service.

Perinatal Family Conferencing addresses the child protection issues of a very vulnerable group of children. The child death review in 2014 recognised that the majority of children (61 per cent) who died in circumstances that were reviewable were infants who were less than 12 months of age.

A pilot project between the Sydney District Family and Community Services and the Sydney Local Health District, Perinatal Family Conferencing promotes early engagement and interagency planning with families with identified child protection issues.

The program is offered to women receiving antenatal care at RPA Hospital and Canterbury Hospital and is now in varying stages of implementation across several metropolitan local health districts. A full-time coordinator is currently employed to continue to evaluate, train facilitators and improve on the program. It is a voluntary program made up of three meetings in which the pregnant woman and other family members or supports, health workers and Family and Community Services Caseworkers meet to discuss the child protection issues and implement a case plan to address concerns. If a Risk of Significant Harm (ROSH) report has been received in pregnancy, hospital social workers or Family and Community Services caseworkers will discuss Perinatal Family Conferencing with clinics. It is explained to clients as a way in pregnancy to address and minimise risk. An independent facilitator runs the meetings and meets with the families beforehand to provide information on the process. The facilitator also provides support around the meetings.

Perinatal Family Conferencing is a structured way of working with families throughout the pregnancy period. It explores any risk of significant harm and the goal is for agencies and families to work together to minimise risk. Conferencing allows any complex psychosocial concerns and ROSH issues to be discussed outside of a crisis response, allowing agencies and families months to address child protection concerns. Historically,

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Christine Canty is a social worker at Royal Prince Alfred Hospital Women's and Babies Antenatal clinic. She is in the multidisciplinary Perinatal and Family Drug Health Team. Prior to working at RPA she has worked with vulnerable families in various agencies as a family support worker, caseworker, sexual assault and domestic violence counsellor, and youth worker.

Three Houses Model

families with ROSH issues in pregnancy may only meet Family and Community Services workers on the ward once the baby is born. Perinatal Family Conferencing allows for community services workers to engage with families during the pregnancy and this is a potentially better relationship because it has time to work on reducing risks for the unborn baby. Using 'The Three Houses Model' – a visual tool used to help families identify their own strengths, hopes, dreams and vulnerabilities – Perinatal Family Conferencing can be really empowering for the families that we work with and the model can act as a motivation to address worries.

The tasks that are set in the conference meetings include follow-up by Sydney District Family and Community Services and other agencies and a timeline for this to take place. This makes agencies accountable in the conferencing process. If goals from the first meeting prove to be unattainable, the second meeting allows for the case plan to be updated and the goals adjusted. Another benefit is that they provide an opportunity to assist and support families in addressing longstanding psycho-social issues that may have been present long before pregnancy.

While Perinatal Family Conferencing is an excellent tool to work collaboratively, and it empowers families to be involved in decision making to addresses issues as early as possible prior to the birth of baby, participation does not guarantee that parents will take their baby home after it is born. Many of the families that we work with have had previous children removed, ongoing drug use issues and other complex psychosocial concerns. The main purpose of the conferences is to support the family to identify and address the child protection issues so that they are more able to care for their baby when it is born. But with such complex situations (and sometimes very little time), this is not always realistic.

In situations where there is a planned assumption of care, conferencing allows for dialogue around this decision. Families can nominate potential foster or kinship carers so they can be assessed prior to the birth and this can minimise the time that the babies are in temporary foster care. The meetings also help facilitate ongoing relationships between women and families and we have seen that this, in turn, means that they often continue to accept support from a hospital social worker after their child is placed in care. Prior to the birth, the families are able to better prepare because they know that care is assumed, and they can start working towards restoration. Additionally, some women choose to engage in intensive support, such as drug rehabilitation, even though they are not able to be the primary carer for their child.

Antenatally, the families often establish strong links with intensive support services and this can help support them in the incredibly difficult and trying time after their child is removed from their care. Given the vulnerabilities of these women (such as domestic violence, drug use, trauma histories and minimal supports) these relationships can provide a potential safety net at a time, historically, when this group often disengages.

Looking into the future we want to build on the work that has already been done. Through the ongoing collaboration of Sydney Local Health District, the Perinatal Family Conferencing coordinator and the Sydney District Family and Community Services, we aim to increase the numbers of families participating in Perinatal Family Conferencing and the skills and knowledge of the services that are involved in the conferencing process. We also hope to look for gaps in systems and services, and to advocate for these to be addressed. We know that a great start has already been made by working collaboratively with agencies and families to address issues and we are looking forward to continue to do this rewarding and challenging work.

The Royal Prince Alfred Hospital is located in the inner-city and inner-west area of Sydney. The traditional owners of the land within the boundaries of this local health district are the people of the Eora Nation and a high proportion of patients are Indigenous. The population of the district is socio-economically diverse, with sections of both extreme wealth and extreme poverty and almost half the population speaks a language other than English at home.

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Pregnancy Family Conferencing Annual Report 2014 – 2015

PSYCHOSOCIAL ASPECTS OF THE LIVED EXPERIENCE OF MULTIPLE SCLEROSIS

DR CHRIS COWAN

Chris Cowan provides a synthesis of her recently completed and unpublished Doctorate of Public Health thesis that explores the psychosocial aspects and difficulties faced by people living with multiple sclerosis when they are discharged from an inpatient rehabilitation unit.

I have 20 years' experience as a social worker in the health care sector with expertise in neurological rehabilitation. My interest with undertaking this piece of research was sparked through anecdotal evidence in relation to the psychosocial aspects and difficulties faced by people living with multiple sclerosis (MS) and also varied hospital experiences (both positive and negative) of patients who had multiple hospital admissions over a period of time.

The goal of the research is to contribute to current evidence-based practice and provide advocacy in relation to living with chronic illnesses such as MS and inpatient hospital experiences, with the findings having the potential to inform clinical practice within inpatient rehabilitation as well as health care provision generally and broader policy formulation.

Multiple sclerosis is a chronic neurodegenerative disease that affects the central nervous system. It usually negatively impacts many of the functions of daily life, and these impacts become increasingly severe as the disease progresses. While the aetiology of MS remains unclear, it is known that it is a chronic autoimmune disease that affects the central nervous system (Compston & Coles, 2002) and results in permanent neurological damage and degeneration (Bates, 2011).

The PhD study explored several research questions that included: psychosocial aspects of the lived experience of multiple sclerosis; the factors that participants regarded as facilitating or impeding adaptation and adjustment post-discharge from hospital; personal perspectives on rehabilitation, and strategies and supports that were considered to be beneficial following discharge from inpatient rehabilitation.

Data was collected via face-to-face in-depth semi-structured interviews with 15 study participants approximately six weeks after they were discharged from hospital. Each interview was audio-recorded and transcribed verbatim, and a thematic analysis was carried out on the transcripts. A qualitative methodology was undertaken in order to obtain rich and detailed data of the lived experience of MS along with participants' rehabilitation experiences.

The analysis of the transcripts yielded rich and detailed data on the psychosocial aspects of living with MS. Six major themes emerged through the thematic analysis and these included: fatigue; independence and dependence; relationships; loss; provision of care; and perceptions of care. Each of the major themes contained a series of sub-themes, 17 in total. Surprisingly, diagnosis experiences were a standout within the 'perceptions of care' theme and this will be outlined in future publications.

The role of social work was highlighted as being beneficial not only by providing practical assistance, but also over half of the sample highlighted that supportive counselling helped the participants cope with being in hospital and adapting and adjusting to the progression of the disease.

I did see the social worker, which was good…to discuss some of my issues, to discuss dealing with the progression of my illness…it was more around giving me the information and the tools to deal with that. There was this incident at work, I'd gone to the loo, I know it sounds strange but I couldn't put my latch on my pants. For 10 minutes I struggled [emphasis added] and I was so frustrated and I thought to myself why do I have to be disabled, why am I disabled…I closed the door in my little office and I felt sorry for myself, and to come to terms with that and having that psychological assistance…helped me to deal with that.

About the author

Dr Christine Cowan is a social work senior clinician and team leader at the Royal Melbourne Hospital's Royal Park Campus inpatient rehabilitation unit. She has more than 20 years' experience in the health sector, specifically in sub-acute care. Her speciality is working with patients who have neurological conditions such as stroke and multiple sclerosis. Christine completed her Doctorate of Public Health in 2015.

The dissemination of the findings from the study aims to contribute to current evidence-based practice with MS care, specifically the impact on all activities of daily living, and also rehabilitation experiences, in order to inform the interdisciplinary team of the aspects of care that the participants felt were important; and aspects of care that facilitated and impeded the transition from hospital to home.

A series of recommendations have been developed from the research findings and plans are underway to disseminate these within the thesis to future publications and conference presentations. Undertaking this piece of research has been an enriching and rewarding experience and I am indebted to the 15 participants who provided open and heart-warming accounts of living with this chronic degenerative illness. My goal is to highlight the patient's voice – the experiences of living with a debilitating illness like multiple sclerosis –and to provide advocacy and education around hospitalisation.

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WHAT'S IN A WORD?

The complex language of suicidology

DR NICOLE HILL AND LYNETTE JOUBERT

The language of suicide is complex. In a field where clear definitions and standardised terminologies remain elusive, the importance of understanding the meaning of self-harming and suicide-related behaviours from an individual's perspective is critical.

In a recent Australian Research Council Linkage Grant that examined a social work intervention for the prevention of suicide for people presenting to hospital emergency departments with suicidal crises, the complexity of language and the importance of understanding the personalised meaning of these behaviours were exemplified. On the specific domain of suicide assessment in emergency, this research postulated the importance of utilising strengths-oriented language to ensure that risk assessments capture not only a person's intent to die via self-harm, but also their passive lack of desire to live.

The language that defines suicidology is a complex phenomenon. Suicidal thoughts occur on a continuum from vague and non-specific ideas that life is no longer worthwhile, through to detailed thoughts and plans for death (Lakeman & FitzGerald, 2008; Maris, 2002). When thoughts progress to intentional self-harming behaviours, these behaviours are similarly complex and diverse, and differ in their levels of severity and intent.

To manage such variance requires clear definitions and standardised terminology to understand, identify, and classify these thoughts and behaviours. However, this is one of the many challenges facing the field of suicidology – clear definitions and standardised terminology remain elusive (Butler & Malone, 2013; De Leo et al., 2006; Fiske, 2008; O'Carroll et al., 1996; Royal College of Psychiatrists, 2010; Rudd, 1997). In the absence of universally accepted definitions of key suicide-related constructs (Clarke & Whittaker, 1998), the outcome is a field plagued by inconsistent and confusing terminology, covering a spectrum of behaviours from suicide to episodes of self-harm without suicidal intent (Butler & Malone, 2013; Skegg, 2005).

This variance in terminologies was somewhat addressed by the nomenclature proposed by O'Carroll et al. (1996) and later revised by Silverman et al. (2007), who strove to provide a meaningful and common set of nomenclature for researchers and suicidologists to adopt. Despite this work, definitions of suicide-related and self-harming behaviours have continued to change.

In recent literature, terminologies are still commonly, interchangeably, and at times controversially used to describe non-fatal self-harm episodes (O'Connor, Platt, & Gordon, 2011b). These include 'intentional/deliberate self-harm', 'non-suicidal self-injury', 'suicidal behaviour', 'attempted suicide', 'non-lethal attempts' or 'failed suicide attempts'. 'Suicide', 'lethal suicide attempt', 'successful suicide', 'completed suicide' and 'deaths by suicide' are terms used interchangeably with varying degrees of controversy to reflect episodes where a suicide attempt results in death.

People presenting to hospital emergency departments after episodes of self-harm are characterised as having psychosocial difficulties, comorbid mental health problems, and are at significant risk of further self-harm and eventual suicide (Mitchell & Dennis, 2006). Whereas acts of self-harm represent a maladaptive form of coping with overwhelming emotional states and distress, a suicide attempt is indicative of action to escape an insoluble problem and end one's life (Butler & Malone, 2013; Kapur et al., 2013). Others dispute that this distinction. Kapur et al. (2013) discuss that self-injury as a whole is largely characterised by multiple concurrent motivations. In light

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that self-harm can increase the risk of eventual suicide (American Psychiatric Association, 2012; Andover et al., 2012), all self-harming behaviours demand recognition and treatment.

In a recent Australian Research Council Linkage Grant (LP0668216) that examined a social work intervention for the prevention of suicide for those presenting to hospital emergency departments with suicidal crises, the complexity of language and the importance of understanding the personalised meaning of these behaviours were exemplified. The research project, entitled Suicide Prevention in the Emergency Department provided social work-based assertive outreach support to people during the high-risk period immediately following discharge from emergency.

In accordance with trends in the literature (Silverman, 2006) and the nomenclature of Silverman et al. (2007), the act of self-harm is acknowledged to be deliberate and purposeful but the word 'deliberate' was not used in the research. 'Deliberate' was seen to have pejorative connotations and to be inappropriately judgemental (Butler & Malone, 2013; Harriss, Hawton, & Zahl, 2005; Kapur et al., 2013; Lilley et al., 2008; O'Connor, Platt, & Gordon, 2011a).

Issues arose with some Suicide Prevention in the Emergency Department research project participants around the use of suicide-related language. The very title of the research project was questioned by some of the participants who were recruited following non-suicidal self-harm. Those participants whose non-suicidal self-harm represented a way of managing difficult or painful emotions by achieving a temporary sense of relief, validation or release, did not initially see how the research was personally relevant because they did not associate their behaviours with being 'suicidal'.

Several participants spoke about the terminology 'attempted suicide' in a sarcastic manner, because they had failed in their own attempt to 'attempt'. Participants primarily used the term 'attempt' rather than saying they were going to 'commit' suicide, however both these terminologies and their limitations are discussed in depth in literature (e.g. 'commit' has the connotation of sin or crime) (Fiske, 2008; Silverman, 2006; Sommer-Rotenberg, 2005).

A number of participants discussed in their interviews a dilemma they faced with language when speaking with emergency department staff about not having a desire to live. They stated that their words were interpreted by staff as being an expression of suicidality. Participants expressed frustration that the true and intended meanings of their feelings had not been acknowledged. These quotations articulate participants' dilemmas.

> “*I've no plan as such to kill myself, but what is the point of living without [my spouse]? At the hospital they kept asking me if I had thoughts of killing myself. I don't, and I won't. What I was trying to tell them, tell anyone, is that my life has no meaning now to keep living, now that my [spouse] is dead. I should be with [my spouse].*”

> “*I'm not going to do something silly, but if I were to have a heart attack and die tomorrow, I wouldn't complain.*”

> “*Yeah I think about it, about... doing something... but how could I? I couldn't actually do something like that to myself. I just know it will get better 'cause one day I'll die naturally.*”

About the author

Dr Nicole Hill is employed in the Department of Social Work at the University of Melbourne. She has academic, research and clinical experience, with a strong history in acute health and crisis mental health work. Dr Hill is continuing the work of her doctoral studies in suicide prevention.

These quotes provide a poignant illustration of the importance of assessing the meaning of an individual's suicidal crisis (Fiske, 2008; Michel, 2011; Michel & Valach, 2011; Suicide Prevention Australia, 2009; Sullivan, 1954) from the individual's perspective (Clarke & Whittaker, 1998; Sullivan, 1954). It could be argued if emergency department clinicians had truly listened to the 'why' of these participants' suicidal crises, these misinterpretations of meaning would have been less likely (Klott, 2012; Shneidman, 1985, p. 40).

Regarding the specific domain of suicide assessment in emergency, the Suicide Prevention in the Emergency Department research project postulated the importance of utilising strengths-oriented language, central to social work professional practice. The inclusion of a strengths-based perspective in risk assessment captures not only a person's intent to die via self-harm, but also their passive lack of desire to live.

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SCOPE OF RENAL SOCIAL WORK ROLE IN AUSTRALIA

DEBBIE FORTNUM, TRISH KINRADE, EMILY MAHONY,
HANNAH BURGESS AND ANNE MAXWELL

In Australia in 2013, there were 11,774 patients on dialysis and a further 9696 with a functioning kidney transplant. Renal social workers support people with end-stage kidney disease (ESKD) who have a life-threatening chronic disease and, if they are on dialysis, a huge burden of therapy.

It is well recognised that social issues play a key role in patients coping with dialysis, with 207 withdrawing for psychosocial reasons in 2013 (ANZDATA, 2014). This group also has a reduced life span and the lifestyle and social consequences of chronic disease that are particularly prevalent and burdensome for chronic kidney disease (CKD) patients.

Kidney Health Australia (KHA) is the national peak health care charity working to save and improve the lives of Australians affected by kidney disease. In 2014, following discussions with some motivated but isolated social workers, KHA facilitated a social worker contact group. This group started interacting by email, and then introduced regular phone conferences and its membership grew by word of mouth. Its key aims were to share experience, knowledge and issues, highlight to KHA where social support gaps exist in practice for those with end-stage kidney disease, and to seek some tangible solutions to existing issues.

The group determined that there would be value in gathering baseline data about the workloads and unresolved social support issues for those with ESKD across Australia and so developed a 21-question survey via SurveyMonkey with input and testing from five social workers and the project manager for education at KHA.

The survey questions focused on the current caseload and priority areas that are managed by renal social work services across Australia. In particular the survey sought to determine where legislative or information/educational support could assist social workers' capacity to support those with ESKD. It was offered by email to the existing voluntary membership network of renal social workers in every Australian state and territory, except the Northern Territory. The results are outlined below.

Demographics

In January 2015, 50 social workers received the email link and 34 responded (68 per cent response rate). Forty-one per cent were from New South Wales, 38 per cent from Victoria, 12 per cent from Queensland, 3 per cent from South Australia and 6 per cent from Tasmania. The ACT and WA did not respond. Eighty per cent operated from a metropolitan centre with all except two centres providing rural and remote support. Twenty per cent operated from a rural centre also providing remote support.

Hours of work and caseload

Of respondents, only 34 per cent worked full-time in the renal speciality with 35 per cent working two days or less. Twenty-five per cent also had responsibility for another speciality. Most social workers were able to quantify how many potential patients were allocated to their caseloads. Nineteen had 50 patients or more who were on dialysis, four with over 200 patients. In addition the social workers were managing on average up to 50 patients with a transplant, up to 50 patients who had chosen supportive care and more than 50 patients who were not yet on dialysis. For comparison, in a study of US renal social workers, Merighi and Browne (2015) reported that on average in 2014, social workers who worked 20–31 hours per week managed 75 patients; 32–40 hours per week, 113 patients and 40 hours per week, 116 patients, similar to the reported Australian data.

In response to a question about how many of their potential patient caseload they were able to review, only five (15 per cent) of the social workers were able to see every patient to establish a relationship. A further 14 (41 per cent) were able to see all of those anticipated to require support. Ten (30 per cent) only saw referrals for identified issues, minor or major, and four (12 per cent) could only intervene for major issues.

Within the caseloads, the number of people from ethnically diverse backgrounds was high. Twenty-six (76 per cent) social workers supported non-English speaking patients who made up, on average, 10 per cent of their caseload (range 1 per cent to more than 75 per cent). Twenty-eight (85 per cent) supported Aboriginal and Torres Strait Islander patients (range 1 to 49 per cent of caseload) and 30 (89 per cent) supported Asian patients (range 1 to 49 per cent of caseload). Fifty-three per cent of social workers had additional non-specified ethnic groups to support.

Referrals and role

Referrals were accepted from a wide range of health professional and even patient self-referrals. Over 80 per cent of social workers accepted referrals from nephrologists, home dialysis nurses, centre-based dialysis nurses and renal ward nurses. More than 60 per cent also accepted referrals from transplant nurses, patient self-referrals and other allied health team members. The palliative care team also referred to 25 per cent of renal social workers.

The role of the renal social workers was extensive (see Graph 1). When asked what their role involved, renal social workers' top responses were: general psychosocial support, carer support, general advocacy and support (part of all the social workers' roles), multidisciplinary meetings, general crisis support (both 96 per cent), end-of-life support, general psychological counselling and internal committees (90 per cent) In addition over 60 per cent managed finding temporary and permanent accommodation, nursing home placement, respite placement, dialysis transport, Centrelink applications, financial counselling, treatment option education, and supporting patients to remain at work.

Most social workers could access Aboriginal health workers (84 per cent), telephone counselling (65 per cent) and an occupational therapist (55 per cent). Forty-eight per cent could access a psychologist and only 38 per cent a psychiatrist or other support for those of alternate language groups.

End-stage kidney disease (ESKD) specific issues

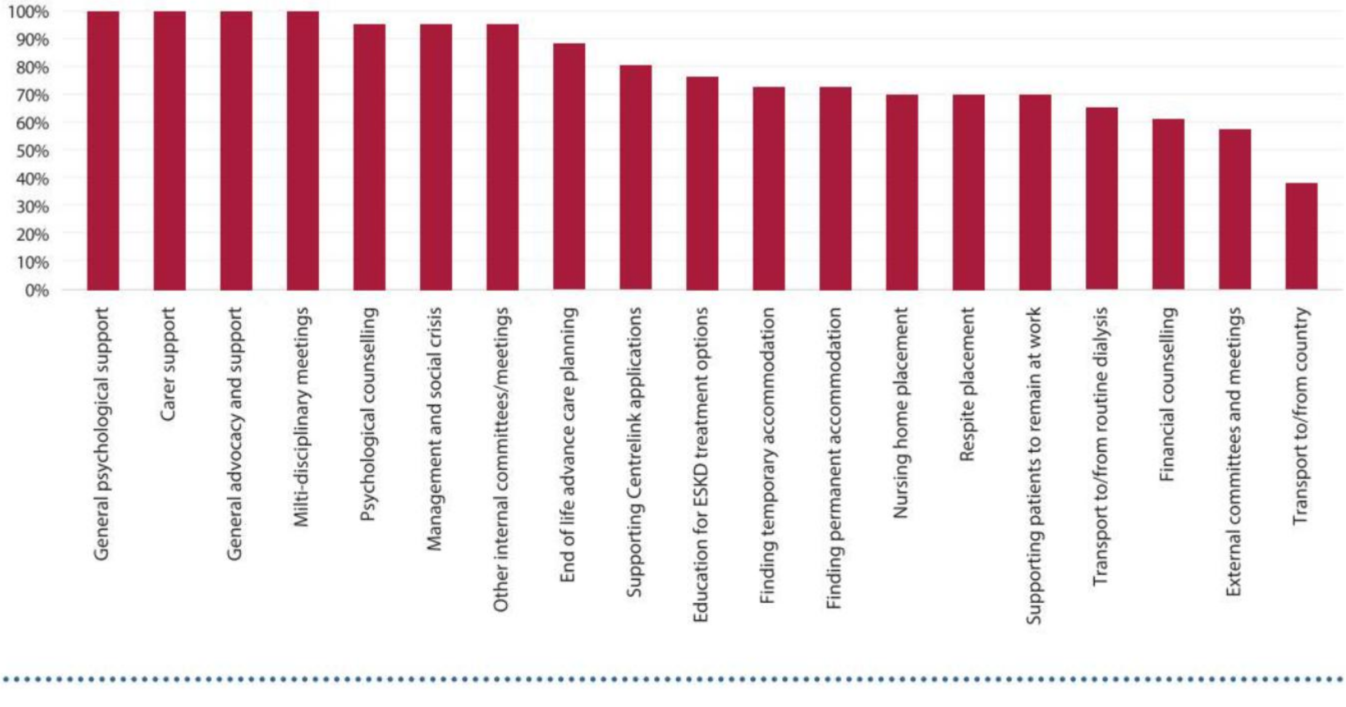
The final survey questions focused on known difficulties for dialysis patients. One of these was access to Centrelink financial assistance for caregivers: the Carer Payment and Carer Allowance. Dialysis patients traditionally need a lot of support but dialysis is not a usual activity of daily living so it is not represented on the standard application forms. Of those social workers who supported patients to apply for the Carer Allowance, only five found it easy to get the allowance and 18 found it difficult. The numbers were similar for the more substantial Carer Payment.

Training for dialysis can take up to 12 weeks, causing financial stress and strain. Ninety per cent of social workers supported a future campaign to obtain a leave payment for those training for dialysis. Transport to and from dialysis was also identified as an issue by 72 per cent of social workers and respite or assisted home dialysis was an identified issue for 50 per cent. Documents have since been developed to help social workers identify the workload associated with being a support person for someone on home dialysis. These documents are now being used by social workers nationally when they are supporting people applying for caregiver allowances and payments with reported success. Kidney Health Australia's advocacy department is completing a submission to government for a leave payment for those who are training for haemodialysis and their caregivers. KHA remains engaged with government reviews of dialysis transport and, in 2015, completed a national survey on transport with the dialysis units.

The social worker contact group has grown to 80 members and continues to have bimonthly phone meetings, sometimes with a guest speaker. A subcommittee is now working with the Australian Kidney Trials Network to establish social research priorities.

Thank you to all of the committed social workers who inspired this contact group, supported and completed the survey and who support the ongoing work of this group, which operates on goodwill and no budget. Those with ESKD would struggle to cope with the daily or intermittent challenges of life on dialysis without you.

Graph 1: Australian Social work role for renal services, 2015



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About the authors

Debbie Fortnum is a renal nurse specialist who works for Kidney Health Australia. She is the facilitator of a national group of renal social workers who dedicate their time to improving the lives and outcomes of people diagnosed with chronic kidney disease.

Emily Mahony is a senior social worker at Royal North Shore Hospital and Sydney Dialysis Centre. She has worked in the field of renal medicine for five years and supports patients and their families at all stages of their treatment.

Anne Maxwell is a renal social worker who works for NSW Ministry of Health in a rural setting. She graduated from Charles Sturt University in 2010 and went straight into private practice. She has been involved in all aspects of renal social work for two years and is an active member of the Renal NSW Special Interest Group and also the Kidney Australia Social Workers group.

Trish Kinrade is a senior social worker at Barwon Health, University Hospital Geelong, where she has worked for 18 years specialising in the areas of renal, Intensive Care Unit (ICU) and trauma social work. She recently completed a PhD investigating the psychological impact of chronic kidney disease on patients and their carers and has also completed a research Masters of Social Work that investigates the needs of families when someone within the family is unexpectedly admitted to ICU. Trish enjoys balancing her clinical work with practice-based research and teaching.

Hannah Burgess has a background in renal social work at St George Hospital, Sydney. She has recently moved into the specialised role of Renal Supportive Care Hub Social Worker. Hannah coordinates the Renal Social Workers of NSW Special Interest Group.

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MENTAL HEALTH AND PHYSICAL DISABILITY ISSUES FOR OLDER AUSTRALIANS

Policy strategies and health promotion initiatives for older adults have focused on maintaining their health in the community and this poses a challenge to the service system as a whole, and social work specifically, about how best to support older people with complex health and mental health issues at home.

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The number of people aged over 65 in Australia is estimated to double by the year 2040 (ABS, 2014). People in this age group have a range of mental health issues, both age-related and lifelong mental illnesses. An Australian population-based survey reported that one in 16 elderly people experienced symptoms of anxiety and depression (Trollor et al., 2007). In addition, dementia was the single greatest cause of disability in Australians over the age of 65 (Alzheimer's Australia, 2015). Older Australians also have a number of co-occurring physical health issues that affect their mental illness and impact upon it.

A clinical data mining (CDM) project in 2014 measured the social, medical and demographic issues for older persons presenting to the Aged Persons Mental Health Program (APMHP) of the Victorian public mental health service, NorthWestern Mental Health (NWMH).

Clinical data mining is a primarily quantitative practice-based research in health and social service setting and is internationally recognised as a research method for social work (Epstein & Joubert, 2010). The rationale for using CDM for the NWMH project is to provide a description of the characteristics and psychosocial needs of elderly consumers and the type of services provided to them.

All new assessments for APMHP were drawn systematically and retrospectively from 31 July 2014 until the final figure of 200 was reached. Electronic copies of the new assessments were located in the APMHP electronic database and retrieved by social work students during their field placement at NWMH.

The new assessments of elderly consumers were carried out by APMHP staff, which included registrars, psychiatric nurses, social workers, occupational therapists and psychologists. The clinical reviews of the services oversaw all the clinical treatment of new consumers; however, they did not ensure the completeness of all new assessment forms.

There were 25 items regarding the demographic, mental health and social aspects on the new assessment forms.

The research project was approved by Melbourne Health Human Research Ethics Committee, the health network overseeing NWMH.

From the 200 consecutive referrals to APMHP, the project will explore the social aspects and the role social workers can play for older people referred with a diagnosis of dementia and with co-occurring physical health needs.

Many older people have both mental health and physical health needs that see them engaging with and moving between these service systems. This has the potential to increase the stress of the older person as well as their family members or carer.

Of the 200 people assessed by APMHP, 50 per cent had a diagnosis of anxiety and depression with 28 per cent living with dementia. In a population bases study, older people in Australia were more likely to experience comorbid physical health disorders and internalising mental disorders such as depression, anxiety and bipolar disorder (Sunderland et al., 2014). Men over the age of 85 committed suicide at a higher proportion than any other age group (NARI 2010).

Over 50 per cent of the total APMHP sample was listed as having a physical disability. Of the 59 clients referred with dementia 48 (81 per cent) had levels of physical illness that were listed to the level of disability (not including intellectual disability). Disability was not defined but professional opinion was made by the person filling out the assessment.

Consequently there were complex physical and mental health needs for clients, with both ongoing and potentially degenerative dementia and physical disability.

Social work can play a vital role in the intervention offered to clients of APMHP and their families. The need to provide appropriate support to clients in their own home is paramount when the majority still live independently or with only daytime care. With most of these having coordinated co-occurring physical health needs, multi-agency communication is very important, as is supporting the family or carers who carry a lot of the burden.

Those clients who had both dementia and physical illness did not necessarily have the appropriate level of support in the community. Seventeen of the 22 people recorded with dementia plus physical disability did not having any links to the community, including primary care, community health and home help meals.

The concept of 'social capital' and other social dimensions and the impact this has on care for older people can guide social workers. The conceptualisation of social capital and other social dimensions has gained international prominence in health promotion over the past two decades.

Definitions of social capital differ throughout international scholarship, with the growing scope of research and evidence linking various dimensions of social capital to positive impacts on mental health (Almedom, 2005; De Silva et al., 2005; Forsman, Nyqvist, & Wahlbeck, 2011; Forsman et al., 2012; Nyqvist, Nygard & Jakobson, 2012; Rowe et al., 2006; Schwarzbach et al., 2014; Stoykova et al., 2011). Putnam's (1993, 2000) conceptualisation of social capital remains the most widely cited definition across international health scholarship. It integrates the structural aspects, such as social contacts and social participation, with the cognitive aspects, such as perceived social support and trust of social capital.

Social work can have a positive impact on the social capital of older people and reduce the negative aspects of their current social situations. Social workers also have the skills and training to support the family relationships. We can improve the social work services in aged care by focusing on the important issues as highlighted by the social capital framework.

Interventions aimed at increasing social support in the elderly showed improvement in their quality of life. A study reported that elderly people with Alzheimer participating in a social support group improved significantly in their quality of life compared to those in the usual care group (Logsdon et al., 2010). Two randomised controlled trials further supported the use of social support interventions for people with early stage dementia as improvements were found in both depressive symptoms and quality of life (Leung, Orrell & Orgeta, 2014).

The positive correlations of social capital on the mental health of older people were studied (Forsman Nyqvist & Wahlbeck., 2011; Forsman, Schierenback & Walbeck, 2011; Nyqvist et al., 2013). It is important to explore the social capital of the aged population, particularly as this group is more vulnerable to decreasing social networks and potentially more dependent on other social resources within their communities (Nyqvist et al., 2013).

More can be done for clients in the early stages of dementia whether they are being treated within the public health or mental health service systems. Social workers in health care need to be aware of mental health issues especially dementia to keep clients at home and plan for at-home care that covers mental health as well as physical illness.

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HEALTH AND MENTAL HEALTH SOCIAL WORK

Evidencing the complexity of practice

Health and mental health social work managers from across Victoria have been working together since January 2014 to contribute to a multi-site project on social work practice knowledge.

In collaboration with the Department of Social Work at the University of Melbourne, the project has developed an audit tool, coding system, training manual and database and is based on previous audits undertaken by the University with St Vincent's Hospital, Melbourne, the Peter MacCallum Cancer Centre Melbourne and Auckland Hospital, New Zealand.

The project aims to evidence current practice to contribute to the broader debate about the future role of health and mental health social workers in complex service delivery systems and is a response to the lack of rigorous data in current social work practice literature.

ALISON HOCKING
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The health system and social work profession in Australia have undergone widespread change in recent years (Healy, 2010) driven by changes in funding structures and the need to improve patient experience and service delivery. Social work professionals have adapted to new roles, responsibilities, scopes of practice, models of care and organisational governance requirements.

The methodology consisted of an audit of usual social work practice across a single day (24 hours) in 2014. The current sample was recruited from a total of 17 metropolitan and rural, public and private, and community health services, with a total sample of 551 social workers.

Data was collected via a spreadsheet divided into five-minute intervals. These were populated with data codes from a coding sheet. The audit sheet and coding key were developed from previous audits as outlined above.

The audit captured data across multiple domains that included:

- Clinician demographics
- Role description of clinician
- Location of intervention
- Patient/client descriptor
- Primary treating unit
- Intervention issue
- Clinical intervention type
- Theoretical approach
- Community services utilised
- Interdisciplinary practice
- Other clinical activity
- Non-clinical intervention

Students on placement were offered the opportunity to work on a real-time research study. Not only did they contribute to practical data collection activities while on placement, but continued to engage in data entry, database development and data analysis alongside their theoretical studies in the research subject. This offered them a unique opportunity to integrate theoretical knowledge with practice research experience.

The study was screened as an observational–quality assurance study via the University of Melbourne Ethics Committee. Data was entered into a database developed by University of Melbourne students Annaliese McNeil, Sarah Firth and Erin McFadden.

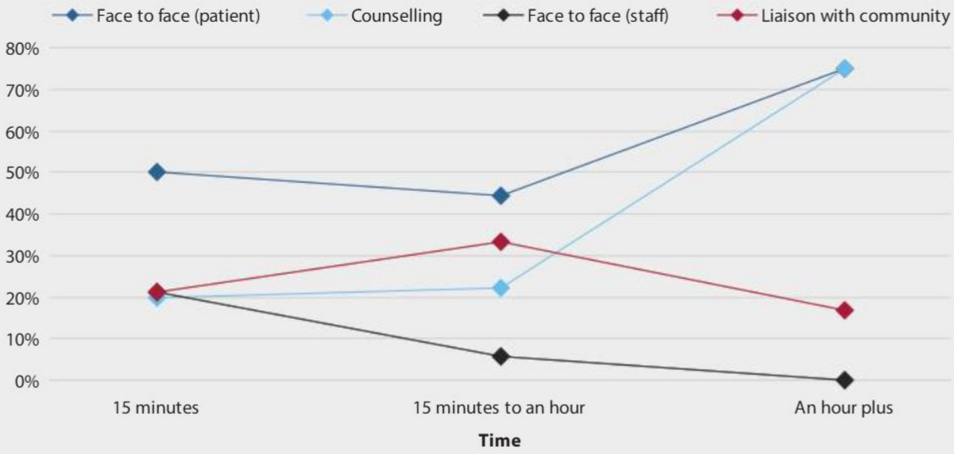
Our initial analysis of the findings highlights a significant issue for health social work. Social work professional time, unlike that of many other health professionals, is not only focused on services to the patient, but simultaneously engages with the social context around the patient; with the health system on behalf of the patient, while linking the patient with significant systems in the community. This is illustrated by the data field item in the audit tool named 'reason for intervention', which has 29 data fields.

The five fields with the highest frequency are discharge planning, care planning, documentation, advocacy and negotiation, and counselling. These data fields can differ in distribution across fields of social work practice, with a few minor differences in oncology. We have been able to compare these across the two University of Melbourne academic practice research partnerships with the Peter MacCallum Cancer Centre and NorthWestern Mental Health. This is demonstrated in Table 1.

Table 1: Frequencies of social work activity

	Total sample %	Mental Health %	Oncology %
Face-to-face (Patient)	20	19	20
Face-to-face (Staff)	16.5	15	18
Face-to-face (Significant other)	8.5	8	8
Community service providers	8	9	8
Telephone	23	24	27
Non-contact file	24	23	17

Graph 1: Sample of interventions in patient-based activities (with contact) by time



It is interesting to note that there is a length-of-time difference in comparing activities with, around and on behalf of the patient, that is, advocacy and community linkage. The length of time spent by the social worker that is 'up to or exceeds an hour' involves contact with the patient alone, that is to say counselling activities. This is demonstrated in Graph 1.

Part of the challenge for Social work in-health is that it is operating as a Social s systemic profession within a very linear medical background. This has been well documented but no one has actually clarified what this means in practice terms.

Our preliminary analysis of the data reflects the symbiotic relationship that is critical in defining the professional role of social work, that is an interaction between hospital need and balancing the professional social work response to satisfying that need. This raises particular challenges for social workers, when formulating their response, to combine their professional training and practice wisdom to develop a therapeutic plan that responds to the problem defined in the referral.

The skills required to simultaneously respond to patient, carer and family needs (while simultaneously being inclusive of the treating team's reason for referral) could range from competency in brief family therapy to ability to liaise effectively over the telephone with a community provider. This approach to complexity of practice can be conceptualised as managing a health service need at the same time as balancing professional standards and promoting patient-centred care. Social work is a consistent advocate for patient and family voice within health care.

This position is reflected in the following quote from the Victorian Health Minister, the Hon. Jill Hennessy MP at the 11th National Allied Health Conference, Melbourne, December 2015:

> People have existing strengths and motivations – we need to listen and respond to these. This means seeking and responding to patient input into service design and delivery, including ensuring that there is ongoing, dynamic patient feedback. It means developing systems to support and nurture patient and community input, including shared decision making and co-design.

Health & mental health service participants

Alfred Health, Alfred Psychiatry, Austin Health, Ballarat Health Services, Barwon Health, Cabrini, Eastern Health, Epworth Health, La Trobe Regional Hospital, Melbourne Health, Monash Health, NorthWestern Mental Health, Peter MacCallum Cancer Centre, Royal Women's Hospital, St Vincent's Hospital, Victorian Rehabilitation Centre, Western Health

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APPLYING CHILD SEXUAL ABUSE ACCOMMODATION SYNDROME TO SOCIAL WORK FOR SITUATIONS OF ADULT ABUSE

PENNY LORDING AND ANDREW BOYLES

While working in adult safeguarding within community and hospital settings in London, Andrew Boyles and Penny Lording were struck by similarities between the five stages of Child Sexual Abuse Accommodation Syndrome described by Roland Summit in 1983 and the responses of adults to abuse and neglect. They believe, if used carefully, Summit's theory may be able to inform and enlighten social work practice with adults who are experiencing abuse or neglect.

Within healthcare, presentations of adults who are victims of abuse and/or neglect are not uncommon. Hospital admissions particularly appear to act as a catalyst for allegations of abuse to be voiced either by adult victims or others. This may be because the adult is removed from the abusive situation and is in a perceived place of safety or may be due to the questions that are asked about the nature and cause their injuries.

Roland Summit's paper (1983) outlining his theory of Child Sexual Abuse Accommodation Syndrome (CSAAS) was an entirely new way to conceptualise the process that children go through when they are subjected to sexual abuse. He made it clear that he was presenting an 'empirically derived non-diagnostic description of behaviour' (Weiss & Alexander, 2013) and, later, felt the need to emphasise this by stating that his model 'is a clinical opinion, not a scientific instrument' (Summit, 1992, p. 156; cited in London et al., 2007) and 'the presence of the syndrome is neither a diagnosis nor an indication that sexual abuse occurred' (Weiss & Alexander, 2013, p. 417). Since 1983, there has been much work done to try and develop an evidence base upon which to understand the process which children go through in situations of sexual abuse (Bradley & Wood, 1996; London et al., 2007; Weiss & Alexander, 2013).

Each stage of Summit's model – secrecy; helplessness; entrapment and accommodation; delayed, conflicted and unconvincing disclosure, and retraction – can be applied to improve social workers' understanding of, and work with, adult victims of abuse or neglect.

In some situations of adult abuse or neglect, secrecy is maintained for a long time. Summit (1983) identifies that implicit or explicit threats to a child about what will happen if the abuse is revealed contributes to feelings of 'intimidation, stigmatization, isolation, helplessness and self-blame' (Summit, 1983, p. 181). These are often felt by an adult victim too. Some adults will be so fearful that they will go to great lengths to hide what is happening from people who are outside the abusive relationship. Victims often express fear that they will be blamed for what has happened or that professionals or other adults will not be able to protect them from retaliation by the abuser.

Expectations around 'self-protection and immediate disclosure [of child abuse, fail to recognise] subordination and helplessness within authoritarian relationships' (Summit, 1983, p. 182). Similarly, it can be easy to underestimate the degree to which adult victims may feel helpless and unable to protect themselves particularly in situations where the adult is dependent on the abuser for all their physical or emotional needs. Adults may feel ashamed and intimidated by their helplessness; the threat of not having their physical needs met, loss of family contact or not being believed may seem worse than putting up with the abuse or neglect.

An adult who is dependent on another person to meet their physical and emotional care needs may feel they have no choice but to accept the abusive behaviour. They may feel (or be told by the abuser) that 'no-one else would want to care for you' or 'anyone else who has to look after you will be the same, or worse' or 'if you want me to get you a drink/take you to the toilet etc. you should stop complaining'. Commonly, children blame themselves for the abuse (Summit, 1983) and similarly, adults may also feel responsible. They may be very fearful of what would happen if the abuse or neglect was revealed and these factors may lead to a feeling of entrapment. Once in this situation, if the adult does not see a way for the abuse to stop, this may lead to them finding a way to accommodate the abuse in order to be able to survive.

Summit (1983) acknowledges that many victims of child sexual abuse never disclose what has happened to them but states that disclosure often happens in response to 'family conflict [and] an eventual breakdown of accommodation mechanisms' (Summit, 1983, p. 188). Often the demeanour of the child is used to undermine, discredit or explain away their assertion of abuse (Summit, 1983). Similarly, aspects of age-related conditions may be used by a perpetrator of adult abuse to undermine allegations made by an adult. For example, a perpetrator may say things such as 'she's always saying that but she's very confused' or 'he's very difficult to care for, always hitting out and hurting himself which is what has caused the bruises'. It is very important that professionals take all steps to properly investigate allegations and avoid unquestioningly being drawn into accepting rationalising behaviour by the perpetrator(s). Perpetrators of adult abuse may go to great lengths to discredit the victim's account of what has been happening.

Summit (1983) describes a process whereby the consequences of disclosure of child sexual abuse can result in such trauma that the child will retract the allegations in order to '[restore] the precarious equilibrium of the family' (Summit, 1983, p. 191). Research undertaken by Bradley and Wood (1996), however, did not find high levels of retraction. In some cases of adult abuse, the adult will retract the allegations they have made or seek to minimise its extent and severity. This may be because the adult is distressed by the consequences of their disclosure (possible anger from the perpetrator, a desire to minimise how bad the abuse was now that he or she has some distance from it, and has feelings of guilt at getting a family member or carer into trouble or is a unwilling to accept a change in accommodation – i.e. a move to a place of safety). Sometimes the reaction to the disclosure may seem worse to the adult than the abuse itself, leading to a retraction or minimisation of the disclosure. Hence it is important to involve them as fully as possible in decisions about the actions that are taken to respond to the allegations and address the abusive situation.

Carefully used, Summit's theory may be used as a model to inform and enlighten social work practice with adults who are experiencing abuse or neglect. There is a need, however, for further research to explore this hypothesis to determine how closely the experiences of adult victims of abuse fits with Summit's (1983) Child Sexual Abuse Accommodation Syndrome model and other research in this area. Another area to explore could be whether there is a correlation between disclosures of abuse and inpatient hospital admissions and why.

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Penny Lording has a Bachelor of Social Work (Monash University) and a Master of Social Work (University of Melbourne). She worked as a hospital social worker before moving to London in 2005 where she managed a hospital team, a community emergency intervention team and an intake team. In 2012, Penny became the first Principal Social Worker in adult social work at Royal Greenwich where she gained significant experience in adult safeguarding before returning to Melbourne in 2014. Penny is currently a social work manager with Monash Health.

Andrew Boyles qualified as a social worker in the United Kingdom in 1997 and worked in child protection and as a hospital social worker and manager until 2007, when he became Specialist Team Manager for Adult Safeguarding at Royal Greenwich. Andrew has considerable experience in risk assessment and management and led numerous complex safeguarding investigations into the alleged abuse of adults at risk. He moved to Australia in November 2014 where he is presently working with the Office of the Public Advocate and refugee children in Melbourne.

A TRAUMA-INFORMED SOCIAL WORK MODEL OF CARE FOR WOMEN AND CHILDREN IN A VICTORIAN EMERGENCY DEPARTMENT

DR ANITA MORRIS AND NICOLE LIND

Western Health is a large public health service located in the western region of Melbourne. Thirty-eight per cent of residents in the catchment speak a language other than English at home and patients presenting to the health service speak more than one hundred different languages or dialects. The region has a diverse socio-economic status and is one of the most rapid growth corridors in Australia.

Early in 2015, a service gap was identified by the social work department. Despite the presence of a multidisciplinary care coordination team in Emergency, the service had not been funded, nor staff adequately trained, to respond to paediatric and maternity patients presenting there. The social work department was also not funded to provide services in Emergency and this prevented adequate risk assessment and intervention for these potentially vulnerable patients, causing distress at times for the patients as well as Emergency staff. A particularly tragic Emergency presentation illuminated the service gap when an ambulance presented to Emergency with a very young child and the ambulance officer called out on arrival for the social worker. The child required intensive staff support, leaving limited resource to assess, support and advocate for the family. As there was no dedicated social worker in Emergency, nor an out-of-hours on-call service, one of the ward social workers was called on to respond when she arrived to work. As such, there was a delay in supporting the highly distressed mother and in facilitating an interpreter for the family.

Along with the clear service gap, this example illustrates potential language and cultural barriers that may be experienced when people have acute health problems and require hospital care. Noting these two issues and more broadly recognising social contexts of adversity that lead to trauma in patients' lives, the social work department investigated the merits of a model of care that would be culturally sensitive and attend to people's lived experience of trauma and its impact on their health and wellbeing.

These combined factors provided the impetus to pilot a social work position in Emergency, which coincided with the Victorian Department of Health and Human Services (DHHS) release of funding to support allied health advanced scope of practice roles. With a grant, the 'Provision of responsive emergency Maternity and Paediatric Social Work Service' (Pre-EMPTS) in Emergency at Sunshine Hospital was established. A Grade 3 Social Worker was appointed to provide a trauma-informed model of care to maternity and paediatric patients presenting to Emergency and their families. Quality assurance approval was granted by Western Health and data is being collected over 12 months about referral type, presenting issue, adverse childhood experiences identified via a brief trauma screen (of patient and primary caregiver), intervention type and the identified referral pathway.

The use of an adapted, brief trauma screening tool was based on groundbreaking research by Felitti and colleagues (1998) into adverse childhood experiences. It was also informed by Kezelman & Stavropoulos (2012) and Bateman, Henderson, & Kezelman (2014) work on trauma-informed care and practice. A working definition of trauma was utilised which describes trauma as experiences that threaten the individual's psychological or physical wellbeing or existence and t overwhelm the individual's coping mechanisms. It represents three types of trauma: simple trauma that is usually recognised as single incidents that are overwhelming and painful; complex trauma, which

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Dr Anita Morris is Manager of Social Work and Pastoral Care at Western Health. She has worked in family violence and public health settings for over 20 years and has a strong interest in trauma informed care. Her PhD is in health responses to children experiencing family violence.

Nicole Lind is a senior social worker at Western Health with a background in women's and children's health social work and child protection investigation and response. She has a particular interest in presentations of paediatric psychosocial trauma in the emergency department and supporting incarcerated pregnant women.

most often involves multiple incidents over an extended period of time, and finally, developmental trauma in which children's development can be slowed down or impaired. Trauma-informed care is a framework that understands the negative impact of trauma on health and wellbeing and provides a strengths-based intervention that emphasises safety and empowerment to facilitate recovery and resilience (Clark, Classen, Fourt, & Shetty, 2014).

There is a strong relationship between higher use of health care and a history of trauma . Trauma-informed models of care are being used in a range of health and mental health settings to ensure early identification and intervention and minimise the transmission of intergenerational trauma (García-Moreno et al., 2014; Jennings, 2004). However an initial search of the literature indicates that there is a dearth of evidence of the implementation of these models of care in Australian public hospitals. Paediatric health in the United States is trialling trauma-informed models of care in outpatient settings and this could guide the way in Australia.

At Western Health, our Pre-EMPTS social worker receives referrals from all clinical staff in Emergency. The role provides referees with a comprehensive psychosocial assessment, trauma screen, psycho-education and appropriate referral pathway for all pregnant women, children and young people. Under the temporary funding model, all out-of-hours referrals are followed up the next business day via a phone call and/or a review clinic appointment. Additionally, the Pre-EMPTS social worker provides education and consultation to clinical staff about trauma-informed care and the indicators that a patient may be experiencing violence or abuse.

The brief trauma screen is completed for each patient and for paediatric patients, their primary caregiver as well. Based on Felitti and colleagues' (1998) model of Adverse Childhood Experiences (ACE), the trauma screen can identify a history or current context of trauma for patients and their family based on three main areas of childhood adversity: family dysfunction, abuse and neglect. This is further broken down into identification of nine adverse childhood experiences incorporating physical, emotional and sexual abuse, physical and emotional neglect, family violence, incarceration of a parent, parental separation or divorce, and household substance abuse (Anda et al., 2006).

The Pre-EMPTS model enables capturing of Adverse Childhood Experiences scores for individuals and patient groups to indicate broader impacts on health and mental health, such as engagement in the risk-taking behaviours associated with early trauma, projected risk of depression, suicidality and illness such as respiratory and cardiac conditions (Felitti et al., 1998). Such vital information can inform preventative health care strategies such as targeted education, health monitoring and referral to appropriate support services. Following the recent creation of an extensive credentialing package to endorse the Pre-EMPTS role as advanced social work practice, Western Health Social Work intends to publish the project's findings with a view to broadening the reach of trauma-informed care in hospital settings.

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FAMILY VIOLENCE AND CHILDREN – TIME FOR A HEALTH RESPONSE

DR ANITA MORRIS, PROFESSOR CATHY HUMPHREYS AND PROFESSOR KELSEY HEGARTY

In a time when the scourge of family violence is finally attracting national attention, health social workers are increasingly expected to utilise their expertise in trauma and respond to the greater numbers of family violence victims being identified and referred in a range of health settings. While the influx of referrals is welcomed – because it reflects growing awareness of the importance of family violence identification and response – knowing how to respond appropriately to women and children experiencing family violence is essential to ensuring adequate risk assessment, safety planning, support and healing for these families.

As the focus shifts to meeting the training needs of health professionals, it is important to critically examine the type of training that is available in order to determine if it accounts for responses to all victims of family violence. Training packages that focus on responding to women experiencing family violence are readily available whereas less attention is given to specific training in responses to children who experience family violence. This significant omission neglects the growing body of evidence on intergenerational transmission of trauma and risk of further victimisation that is associated with family violence (Kitzmann, Gaylord, Holt, & Kenney, 2003; Lieberman, 2007). It also hinders the enormous potential in health settings for early intervention with children and their mothers (García-Moreno et al., 2014; Insetta et al., 2015).

A recently completed research project by Anita Morris from the Department of General Practice at the University of Melbourne in partnership with Berry Street, a large child welfare organisation in Victoria, recognised the gap in health responses to children experiencing family violence. More specifically, the research sought to understand children's safety and resilience in the context of family violence and determine health responses that could support them and their mothers. Collaborators included Professor Kelsey Hegarty and Professor Cathy Humphreys, PhD supervisors and Alliance co-chairs of the newly-formed Melbourne Research Alliance to End Violence Against Women and their children (MAEVe)** and an expert advisory panel of policy and practice experts that includes industry partners.

Researching with a primary care sample of children (n = 23) and their mothers (n = 18), families were recruited from GP clinics and a risk assessment undertaken prior to their participation in the project. Ethics approval from the University of Melbourne endorsed recruitment of children aged eight and above (Morris, Hegarty, & Humphreys, 2012). Dr Morris used semi-structured interviews and focus groups to elicit concepts of children's safety and resilience and to determine what children and mothers saw as the role of primary health care professionals in responding to children experiencing family violence.

To guide the research, a working definition of safety drew upon MacMillan, Wathen and Varcoe's (2013) assertion that understanding of children's safety in the context of family violence needs to attend to more than threat to physical safety and to incorporate emotional safety and the child's internal perceptions of safety. A working definition of resilience described a dynamic process in which elements such as emotional intelligence, a sense of purpose and self-esteem may be recognised in children by themselves and others and promoted in a relational context (Rayner & Montague, 2000). These two ideas about safety and resilience reflected a research stance that sought to research with, and for, children.

Accordingly, the study was underpinned by complementary theoretical frameworks of feminist research principles and children's participation rights to inform an ethical, child-centred methodology (Morris, Hegarty, & Humphreys, 2012). Each approach in the research process addresses inequality and enabling of voice. Additionally, the qualitative analysis used the ethics of care and dialogical ethics lenses to give rise to a rich tapestry of insights to awareness and naming of family violence and the concepts of protection, care and trust in relationships.

The findings of the PhD are yet to be published. However they introduce a model of intervention for health professionals which puts children at the centre of family violence responses rather than at the periphery. As Australia awakens to the horrors on our own doorstep, more can be done in health care to ensure that family violence is not a burden that our children will carry through to the next generation.

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A COMPREHENSIVE RESPONSE TO ELDER ABUSE AT ST VINCENT'S HOSPITAL MELBOURNE

MEGHAN O'BRIEN AND SONIA POSENELLI

The Social Work Department at St Vincent's Hospital in Melbourne has responded to the problems of identifying older people at risk of abuse and how best to support them with the development of a Vulnerable Older Persons' Policy and Model of Care.

In Australia there is growing awareness of elder abuse at a time when there are greater numbers of older people, increased longevity and higher rates of dementia (Victorian Department of Human Services [DHS], 2009). Many of the same factors that contribute to family violence contribute to elder abuse, including gender inequality, the use and abuse of power within relationships, a history of family conflict and community attitudes (ageism).

Over the past decade staff of the Social Work Department at St Vincent's Hospital Melbourne (SVHM) have taken up the challenge to demonstrate how we can respond more effectively to elder abuse, including building the evidence base through research partnerships, organisational change, commitment to data collection, practice improvement, effective interface with peak bodies and policy makers, systemic advocacy and establishing new partnerships with external stakeholders.

Elder abuse can be defined as a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person (DHS, 2009). This definition has been heavily influenced by extensive work undertaken in Canada, United Kingdom and the United States. While definitions of elder abuse do vary, Chesterman (2015) suggests that all include, at their core, a breach of trust.

Dong (2015) confirms that older adults who are subject to elder abuse, neglect or exploitation, face a greater risk of being hospitalised than other seniors. Literature further suggests that the hospital provides a window of opportunity, not otherwise available, for staff to respond if they suspect an older person may be at risk of abuse (Joubert & Posenelli, 2010).

Healthcare professionals who routinely interact and assess older people are best placed to identify those at risk of abuse and provide them with support (WHO, 2011). However, lack of awareness, knowledge and skills in relation to the recognition, reporting and effective management of elder abuse have been identified as significant impediments to tackling it for older people (Cooper et al., 2009). Education is a critical strategy to assist in minimising the risk of elder abuse for older people and is essential for understanding and having an awareness of it (Walsh et al., 2007). The importance of providing specific elder abuse education to targeted health professionals such as social workers is becoming well recognised as we become more aware of the impact of elder abuse. (Walsh et al., 2007).

An Australian Research Council (ARC) Linkage Project established in 2009 between SVHM and the School of Social Work at the University of Melbourne has focused on developing a pathway for SVHM health professionals to support older people at risk of harm. The project was completed in three separate but interrelated phases: (1) theoretical work was undertaken to identify the components of effective health education interventions; (2) this information was synthesised to develop an education intervention, and (3) the intervention was tested in a pre–post test design. The Linkage Project has investigated the effect of education on health professionals' knowledge, confidence and competence to improve their responsiveness to act on suspected elder abuse in a hospital setting.

There is currently no recognised best practice elder abuse model for hospital staff in Australia. Each state and territory supports different approaches to responding and managing it when it

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is suspected. A study tour of the United Kingdom as well as extensive review of international models, informed the development of a number of clinical governance initiatives at SVHM to build capacity to respond to increasing incidence of suspected elder abuse presenting to the hospital.

The Australian Council on Healthcare Standards defines clinical governance as 'the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers.' The SVHM approach has focused on key elements of an elder abuse governance framework: culture and leadership; organisational systems and processes; education and training; effective clinical care; risk management; and performance measurement.

The ARC Linkage Project provided a platform for SVHM to establish an evidence-based approach. The involvement of multidisciplinary and multi-program key stakeholders internally led to the establishment of an organisation-wide Protection of Vulnerable Older Persons' Coordination Response and Coordination Group. The group aims to minimise clinical risk and improve safety of care using a systems approach.

The development of a SVHM Vulnerable Older Persons' Policy and Model of Care that is incorporated into the education program, provides staff with a framework and clear pathway to assist them step-by-step in understanding their responsibilities. These important initiatives have fostered a cultural and attitudinal shift to support innovative efforts to prevent harm to older people.

The data collected on notifications of suspected elder abuse reflects the efficacy of our model and framework. In the three year period since the introduction of the new governance arrangements, there have been 182 notifications. This data has enabled SVHM to examine prevalence, types of abuse, risk factors, adherence to policy and pathways of care, to implement safety planning and also to identify opportunities to improve practice, training and processes.

SVHM continues to build capacity to systematically respond to elder abuse in a climate of increased attention to issues of family violence. We continue to strengthen our interactions with peak bodies and policy makers and have expanded our efforts to grow the organisation's policy and advocacy voice in relation to elder abuse. Working closely with our national organisation, St Vincent's Health Australia (SVHA), and sister organisation, St Vincent's Hospital Sydney (SVHS), we made a joint submission to the recent Victorian Royal Commission into Family Violence. The SVHM Social Work Department also gave evidence to the Commission.

Our ongoing interface with the Victorian Department of Health and Human Services (DHHS) has provided an opportunity to develop an elder abuse collaborative pilot project that will enable us to share knowledge, resources and strategies with other Victorian hospitals. Other new collaborations to improve the health and wellbeing of older people at risk of elder abuse include the Seniors Rights Victoria (SRV) funded Health-Justice Partnership between SVHM and Justice Connect/Seniors Law.

The organisation's mission and abiding commitment to person-centred care and social responsibility underpin efforts to improve the care of vulnerable older people and the importance of this should be acknowledged. With organisational support and working on multiple fronts, the Social Work Department at St Vincent's Hospital Melbourne has been able to comprehensively respond to elder abuse through internal collaborations as well as partnerships with academia, government, other health services, statutory bodies and legal and community services.

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REACHING FOR THE STARS LEADERSHIP PROGRAM — A MULTI HOSPITAL COLLABORATION

SONIA POSENELLI, TASS KOSTOPOULOS, PENELOPE VYE AND RALPH HAMPSON

As health care organisations rely on a high quality workforce, the challenge for health service managers in social work and other disciplines is to identify talent, provide enabling learning opportunities and nurture leadership abilities and attributes. Reaching the Stars leadership program was formed after the Health Social Work Directors' Group, a special interest group of the AASW, observed that recruitment to senior level positions could be difficult and that the transition to senior positions often posed significant challenges.

The view of the Health Social Work Directors' Group regarding the difficulty of recruitment to senior positions reflected the findings of Cowan's (2010) study of allied health senior clinicians that highlighted the importance of training to facilitate the transition to senior or team leader roles and the essential role of mentors. Other authors have also highlighted the importance of early career leadership development (Long, 2011; Wylie & Gallagher, 2009).

In 2013, the Health Social Work Directors' Group formed the Reaching for the Stars (RFTS) Working Group. The idea for the title came from the proposal developed in the United Kingdom to develop the best and brightest social workers, following a successful program undertaken with teachers (TeachFirst, 2016; Frontline, 2016).

An online survey (Kostopoulos et al., 2013) was distributed to members of the HSWDG who invited Grade 2 and Grade 3 hospital social workers to respond. The respondents were asked in the survey to provide information on existing leadership programs within hospital social work, self-identified learning needs that could facilitate transition to senior positions, existing in-house opportunities and barriers, and their interest in leadership development.

Forty-one social workers completed the survey, providing the following information:

- 87.8 per cent of respondents stated that there were no current departmental leadership programs in their workplace
- 55 per cent were interested in making a transition from Grade 2 to Grade 3 roles
- 68.3 per cent were aware of the competency differences between Grade 2 and Grade 3 roles
- 95.1 per cent were interested in participating in a HSWDG sponsored leadership program.

Several respondents identified that St Vincent's Hospital Melbourne (SVHM) had developed a Social Work Leadership and Mentoring Program that operated on the view that 'stars are made, not born' (Kelley, 1999). The program focused on nine breakthrough leadership strategies: taking initiative; self-management; organisational awareness ('savvy'); small 'l' leadership; followership; teamwork; making network connections; adopting 'the big picture' perspective; and 'show and tell.'

In 2014, after reviewing the SVHM Program, the Reaching for the Stars Working Group adapted it for a multi-hospital trial that provided a dynamic leadership program that would offer participants important learning opportunities, the opportunity to practice key skills, observational and reflective experiences, and mentoring from senior social work staff. Nine major metropolitan health services supported the inaugural program (see Table 1).

Table 1. Participating health service social work departments

Health services	Senior social work staff
Alfred Health	Bridget Wall, Manager Patient and Family Services
Austin Health	Debra Leahy, Manager Social Work
Eastern Health	Tass Kostopoulos, Associate Director Allied Health, Social Work
Melbourne Health	Georgina Hanna, Workforce Development Manager (Social Work) & Julia Blackshaw, Manager Social Work and Cultural Diversity
Peter MacCallum Cancer Centre	Alison Hocking, Head of Social Work Department
Royal Children's Hospital	Robyn Clark, Social Work Clinical Practice Development
Royal Women's Hospital	Penelope Vye, Chief Social Worker
St Vincent's Hospital	Sonia Posenelli, Chief Social Worker

Social workers were invited to provide an expression of interest to participate in the course; these were then considered by the RFTS Working Group and a selection process was undertaken. The selection process required applicants to:

- Propose a self-directed project aligned to the organisation's or department's strategic directions
- Participate in eight formal training sessions, held in a number of different health service sites. Sessions were facilitated by senior social work leaders and others such as research and quality improvement personnel
- Enter a formal mentoring relationship with an allocated senior social work manager
- Undertake observational experiences such as attendance at management meetings.

Senior social workers within the hospitals provided participants with exposure to key stakeholders and key issues that arose as the program was undertaken.

The eight formal training sessions focused on:

- Quality improvement
- Project development and management skills (getting organisational 'buy in')
- Leadership styles and situational leadership
- Managing people and teams
- Small 'l' leadership, followership and networking
- Lean thinking and redesigning care
- Giving effective presentations.

All costs were met by in-kind contributions. The estimated expenditure for each participant was approximately $5,000, including time spent in program planning and coordination, session attendances, reading, mentoring sessions and the completion of an individual social work project.

The program was evaluated. All participants were asked to complete an online survey after each training session; and invited to participate in a telephone interview at the completion of the program with an independent evaluator. In addition, managers and participants were also invited by email to provide general feedback on the program.

The evaluation confirmed that the program was highly valued by all participants. Knowledge was improved as a result of each session and all sessions were rated between four and five on a five-point Likert scale. Thematic analysis of all data identified key areas where the program had a positive impact on participants.

Networking and peer interaction was highly valued and reported as one of the key benefits of the program. The interaction with peers at a similar career level, allowed for effective networking. Respondents all reported that the project was core to the program and was a key part of their learning. All reported increasing their knowledge and skills in project planning.

Learning about situational leadership enabled participants to think more about their own style, as well as that of their peers and managers. Participants reported using this in their workplaces to increase their understanding and skills in managing relationships in the hospital setting.

Participants gained insight into social work management and the broader organisational context. This resulted in the majority being more willing to volunteer and undertake increased responsibilities, including projects, committee work and supervision.

Context– understanding where the social work 'project' was located within the social work profession and the wider health context was a key learning point for participants. Other positive impacts on participants were that all reported positive behavioural and attitudinal changes, and identified new skills that they had applied to their practice.

Two areas were identified for improvement – greater clarity regarding project expectations and development of a formal mentoring agreement.

Nine participants were followed up twelve months after the program's completion and surveyed on the longer term outcomes of their participation:

- Succession planning – 71 per cent reported that they had undertaken acting Grade 3 roles and one had obtained a permanent Grade 3 position at another health service
- Retention – 66 per cent were still working with the same employer
- Career development – 33 per cent had enrolled in higher degrees
- Presentations and awards – 100 per cent had given presentations on their projects at professional meetings and there were two research 'best poster' prizes and one publication (in an AASW newsletter)
- Capacity building – new projects were in development or the Reach for the Stars projects were further progressed
- Resource and funding impacts – there were three instances of new funding directly related to, or emanating from, Reach for the Stars project work
- Leadership development – qualitative feedback strongly highlighted participants' increased confidence and willingness to 'add value' and take on new responsibilities

Next steps

Recently the Faculty of Medical Leadership and Management and The King's Fund (UK) and the Center for Creative Leadership (USA) published a report (West et al., 2015) summarising the evidence on leadership development in health. The Reach for the Stars initiative resonates with several of the key findings, for instance, the importance of leaders working together, spanning boundaries within and between organisations, supportive and enabling people management and learning from experience as the most valuable factor influencing leadership skill development.

The Reach for the Stars is a dynamic program that is clearly aligned with key directions in leadership development in health. Work is currently underway to develop the program further, including a possible partnership with the Department of Social Work at the University of Melbourne.

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END OF LIFE PLANNING IN HEALTH CARE SETTINGS

MORGANA THOMAS

As the social worker for the St George Hospital liver clinic, Morgana Thomas works with people with advanced liver disease or liver cancer, an irreversible condition with often quite poor prognosis and short life expectancy, and has, over time, identified the need for a space inside the medical model for patients to express and process their feelings around their own death and plan and document their wishes around death in order to ensure they are upheld when the time comes.

A large proportion of people suffering liver disease or liver cancer have a history of alcoholism or injecting drug use (the main risk factor for Hepatitis C, one of the leading causes of liver disease). A large cohort of patients are also from culturally and linguistically diverse backgrounds who contracted viral hepatitis through unsafe medical practices (shared medical equipment) while living overseas. These groups have a higher likelihood of being poor advocates for themselves as they are less educated and have poor English language skills, or of not having an appropriate advocate to act on their behalf because they may be socially isolated and without family in Australia.

For these patients, documentation of their wishes ensures they maintain some control over their lives in a situation where they feel powerless. Some patients have clear ideas about what constitutes a good death. For example, what medical interventions they do or do not want at the end of their life (i.e. resuscitation, intubation), whether they would like to be at home or hospital – it is a common misconception that everyone wants to die at home (Gomes et al., 2013) – who they would like to have around them (e.g. immediate or extended family, religious or community figures), and what extent of comfort measures they would like (e. g. morphine and other pain relief).

Of course, not everyone wants to have these conversations, and it is not a conversation that can be forced. I try to ensure patients and their families are educated about the possible consequences of abstaining from these discussions. For example, invasive interventions could be used that may extend the quantity of the patient's life but not necessarily the quality, and there may be pain or discomfort involved. Similarly, without a plan it may be hard to get the family member or religious person desired to arrive in time. I discuss with patients and their families that for those who have end-of-life planning discussions, there is often a great sense of relief and comfort for the family members who know they upheld the patient's wishes right until the end. This in itself can transform the death into a meaningful, even beautiful experience for those involved.

In fact, I have been struck by how often people want to discuss the meaning, or existential context of their death. For those who are prepared, there is often a reconnection with spirituality that provides great comfort. A framework that encompasses the bio-psychosocial and the spiritual in the assessment can be a good starting point for working with patients at end of life (Kaut, 2006). From this point, I have found many people are relieved to find a space where they can divulge the emotions that are often taboo in the family context: fear, anger, sadness. I never find these conversations easy but attempt to demonstrate to the patient that I am willing to go with them into that space. My aim is to hold them enough emotionally so that they can experience these emotions, rather than repress them.

This was particularly powerful with one gentleman who I will refer to as Anh. Anh was a 56-year-old gentleman who had arrived in Australia thirteen years ago as a refugee from North Korea. He had lost contact with all his family overseas and had made only a few acquaintances in Australia. He had been an alcoholic for many years and lived alone. Despite this, Anh had

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a cheerful disposition and through interpreters and a lot of patience we were able to build a good rapport. When invited, Anh spoke openly about his emotions around death and, over the course of several months, he proceeded through stages that included great regrets, significant sadness over his premature death and an immense sense of gratitude for the good years of his life spent in Australia. He also described a non-defined sense of spirituality and the certainty that after death he would go to a better place. Through these conversations he cultivated a fearless determination to transition with dignity without pain in St George hospital under the care of his treating gastroenterologist.

Anh's wishes were documented in the form of an Advance Care Directive, copies of which were stored in his file, electronic medical record, with his community palliative care team and also the ambulance service. Anh had no advocate to represent him if his health deteriorated and he could no longer make decisions for himself, so he understood the great importance of this document and kept a copy with him at all times. Anh was brought into St George hospital under the care of his preferred doctor, despite being from out of area, and was cared for there for several weeks until his peaceful death. Through these weeks he was visited regularly by myself and a social work student and we provided opportunities for him to tell stories about his work, lovers, home country, and to generally reflect on his life. This biographical approach at end of life is well supported as a powerful way to make meaning out of death (Ando, Tsuda & Morita, 2007).

In terms of patient welfare, end of life planning is arguably one of the most important roles of social workers in health contexts and yet one that is often overlooked or poorly developed. There is currently momentum inside NSW Health to improve the process around Advance Care Directives (the medico-legal element of planning), however, any discussion around medical intervention at the end of life should not be isolated from its associated set of emotions, values and narratives. Social work is uniquely positioned to contribute to this broader discussion as it is on the bridge between the biological and the psycho-social on which the medical social worker stands. Bridging this gap is essential if we are to move towards a more humane and planned approach to death.

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Morgana Thomas is a social worker specialising in the areas of health and mental health who is passionate about social justice issues and cross cultural communication. After graduating from social work in 2009, she worked in California in adolescent mental health before returning to Australia where she has worked in homeless outreach, with newly arrived refugees and in several Sydney hospitals. Morgana's present focus is on end-of-life discussions in outpatient healthcare settings, especially with patients of non-English speaking backgrounds. She has also recently commenced a Masters of Psychotherapy and Counselling at Western Sydney University.

HAVING A VOICE

Youth participation in the field of adolescent and young adult cancer care

KATE THOMPSON, CAITLIN OLIVER AND LUCY HOLLAND

ONTrac at Peter Mac, Victorian Adolescent and Young Adult Cancer Service, Peter MacCallum Cancer Centre

Young people are encouraged to take an active role in shaping their own clinical care as well as the policies and decisions that affect cancer services and systems, yet within the adult health service system, where young people are often the minority of service users, their voice and right to participate is often overlooked. Here the authors report on the establishment of the Victorian and Tasmanian Youth Cancer Advisory Board (YCAB) and the role they have undertaken in Victoria to guide health service development and reform.

The field of cancer has traditionally been divided into paediatric and adult care, however in recent years adolescent and young adult oncology has emerged as a distinct field (Ferrari et al., 2010). Each year in Australia, approximately 1,000 young people aged 15–25 are newly diagnosed with cancer, a number approximately 1.4 times higher than those under the age of 15 years. Cancer is now the leading cause of disease-related death among adolescents and young adults, and second overall after injury and poisoning (AIHW, 2011).

Significant improvements in survival outcomes have been achieved across the cancer sector, nevertheless progress in adolescent and young adult outcomes have remained strikingly lower than those seen in children and older adults (Bleyer, 2008; Ferrari et al., 2010; Khamly et al., 2009). Psychological and social factors experienced by young people with cancer during this life stage place them at greater risk of poorer long-term health outcomes than their healthy peers and survivors of childhood cancers (Jones, 2008; Seitz et al. 2010; Shama & Lucchetta, 2007).

In recognition of the unique challenges experienced by young Australians, communities are investing in the development of age-specific services to bridge the gap in care (Osborn et al., 2013). Engaging young people to ensure services are responsive to their particular needs is essential to this process. Youth participation is a fundamental right of young people within the health system and provides them with many benefits.

For young people, being involved provides opportunities to share in decision making, develop new skills, pursue an area of interest and use their skills to effect change. For organisations, engaging with young people can lead to enhanced development as new energy, fresh ideas and enthusiasm are brought to programs. There can also be an increased acceptance of services and the credibility of the organisation may be enhanced.

ONTrac at Peter Mac Victorian Adolescent & Young Adult Cancer Service (the service) is a Victorian Government funded, state-wide initiative aimed at improving the delivery of care to young Victorians diagnosed with cancer. Located at the Peter MacCallum Cancer Centre, the it provides comprehensive clinical care to young people and their families following a cancer diagnosis. A multidisciplinary team within the service provides medical expertise and developmentally targeted psychological, social and emotional support. ONTrac at Peter Mac also provides a statewide secondary consultation service, an health professional education and training program, and engages in research.

ONTrac at Peter Mac is committed to working in partnership with young people. In 2011, with the support of Cancer Strategy and Development within the Victorian Department of Health and Human Services, the Victorian and Tasmanian Youth Cancer Advisory Board (YCAB) was established. It comprises 12 young people aged 15 to 25 who have had an experience of cancer. The members represent young people across the two states and have a range of diagnoses and treatment experiences. YCAB provides advice and guidance about the development of targeted services and initiatives for adolescent and young adult patients across Victoria and Tasmania.

Prior to establishment of YCAB, careful consideration, research and consultation with health and community agencies determined the structure, operation and outcomes for the board. Following this process, comprehensive operational guidelines and a participation plan were developed.

Since its establishment, the Victorian and Tasmanian Youth Cancer Advisory Board has achieved a number of significant outcomes, which include:

1. Participation in raising awareness of cancer in young people through public speaking, community education and media appearances.
2. Curriculum development and content delivery for the University of Melbourne Graduate Certificate Adolescent Health and Wellbeing (Oncology Stream).
3. Participation in the design of a new Youth Cancer Centre within the Victorian Comprehensive Cancer Centre, Parkville.
4. Engagement in the development of position papers.
5. Development of YCAB awareness and branding, including the development of a DVD.
6. Participation and contribution to the development of the ONTrac at Peter Mac 2015–2018 Strategic Plan.

Across the Australian cancer sector, young people are serving in increasing numbers on a wide range of boards and advisory committees. A thorough understanding of youth development and the benefits of engaging young people is required for this to be successful. Youth engagement must be based on the understanding that young people have unique capacity to contribute in creative ways that may often be less constrained by societal norms. Any assumptions about the limited comparative role and capacity of young people must be relinquished, and their value must be recognised as unique and significant.

The significant achievements of Victorian and Tasmanian Youth Cancer Advisory Board to date are the combined result of young people's enthusiasm in participating in the development of services, the organisation's commitment to youth development and ensuring young people's voices are heard and valued.

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HeLP PARTNERSHIP: IMPROVING PATIENT OUTCOMES

Unexpected or traumatic hospital admissions and people with chronic illness or disability are likely to experience a wide range of legal problems – and lower rates of resolution of those problems. Taken together, these issues often lead to spiralling health, legal and social problems, with serious negative personal and family outcomes. In March 2014 the HeLP Patient Legal Clinic was launched, as a partnership between the Alfred Hospital, Maurice Blackburn Lawyers, Monash University and Justice Connect to address all these issues.

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Addressing social determinants of health and an individual's psychosocial needs is increasingly accepted as critical to improving health. A 2012 Legal Australia-Wide Survey revealed that legal issues negatively impact individuals' health. Similar research in the United States has led to the development of a range of medico-legal partnerships, whose results indicate that a patient's health outcomes improve as their legal issues are addressed.

The clinic is an integrated service model and involves legal advisors working with social workers and clinicians, to support patients in ways that improve their access to justice, maximise their health outcomes, and support stronger social connection and inclusion.

Patients and social workers' feedback has been overwhelmingly positive. The HeLP clinic has enabled inpatients to access a lawyer in a timely and familiar environment and, as such, offers a 'one stop shop model' of greater access and support.

By creating a collaboration between clinicians, social workers, and lawyers, the Alfred and its HeLP partners aimed to meet the social, legal and medical needs of patients and their next of kin in ways that are impossible when these problems are tackled separately.

To create the clinic, an Alfred Steering Committee began developing a memorandum of understanding between the Alfred, Maurice Blackburn Lawyers, Monash University and Justice Connect to establish an integrated, pro bono legal and medical service for Alfred patients in 2013. The committee also worked on policies, procedures and processes for the service.

Locating HeLP at the hospital meant that patients could access legal advice quickly as part of an integrated approach that considered their needs comprehensively. Considerable thought went into planning of referral pathways to minimise risks to both patients and the partner organisations. After an initial psychosocial assessment that included an assessment of the legal issue, the Alfred determined that referrals would be most safely managed by its social work team.

Planning for the establishment of HeLP also involved developing inclusion and exclusion criteria, a communication strategy to promote the service, building relationships with key stakeholders and creating risk management processes, along with clear structural, locational and reporting requirements for the clinic.

The co-location of the lawyers in the social work department is an advantage that enhances the collaboration through relationship and capacity building for both professions.

The HeLP program aims to provide seamless, holistic, patient-centred care in an acute setting. Given the very high rate of legal issues and low rates of resolution of legal problems among people with chronic illness or disability and unexpected or traumatic hospitalisation, its primary objective is to provide the most vulnerable patients with free, easy to access, timely legal advice and support.

This means that their legal issues can be resolved quickly so that the patient can focus on their health. Simplifying and improving access to justice also means that patients can work more closely with their clinicians and social workers on other aspects of their wellbeing, including social connection and inclusion.

HeLP was initially introduced as a pilot research intervention. The Alfred led its establishment with social workers facilitating education sessions with HeLP lawyers and Monash researchers, and leading the communication about the clinic within the organisation.

HeLP acts as a referral service, providing preliminary legal advice when required. Where further legal support is needed, its staff refer the patient to other public and private legal services. While many patients are referred to community legal services, some require the services of private law firms – most of whom have been providing some level of free advice and assistance.

The focus has been on making 'hot' referrals, where the clinic calls the community legal centre or firm, gets preliminary advice and arranges the appointment. Patients are much more likely to follow up if an appointment is made for them, rather than just being given contact details to make their own appointment.

Research is currently being conducted to determine whether the intervention was benefiting patients and supporting better delivery of health services. Preliminary results reported here are derived from clinical data, interviews with patients and next of kin, and two focus groups with social workers.

Clients

HeLP clients ranged in age from 26 to 81, with most aged between 50 and 70 years. The majority derived income from a pension or benefit.

Legal matters

In its first year HeLP assisted 238 patients with around 350 separate legal matters. Patients were helped with an extensive range of legal matters and almost all hospital departments referred patients to the clinic. Advice was most frequently requested about:

- end-of-life legal planning, including medical and legal powers of attorney, wills and superannuation
- financially-related legal issues, such as Centrelink debts and outstanding fines
- housing and property
- criminal charges
- family law
- immigration problems.

Feedback

Patients have described HeLP as 'like having a personal support team at the hospital'. They reported that accessing the legal support relieved their anxiety, allowing them to focus more on their health.

Several social workers also noted that patients felt empowered by having a face-to-face conversation with a lawyer in the hospital. Patients also welcomed the support in accessing external services:

> *It was so easy, so simple. Before that I was getting the answering machine. I sent emails but I couldn't get anyone to talk to. One phone conversation with [the HeLP lawyer] changed all that.*

For long-stay patients, the service proved invaluable. Previously, accessing legal advice would have required a temporary discharge. Most patients were more likely to defer or not deal with these issues, and their impact would escalate.

The location of HeLP in the Alfred's social work department enabled lawyers and social workers to forge strong and flexible working relationships when responding to patients' problems and to smooth patients' access to legal advice.

This innovative HeLP service is the first of its kind in Australia. It demonstrates that the early identification of legal issues in healthcare settings can prevent crises and achieve better outcomes for patients and their families.

Addressing a patient's legal problems results in a marked improvement in their health. The benefits are broadly summarised in the words of this patient:

> *A lot of people don't have the money to get legal help when they need it… Legal issues often help with the deterioration of your health. So every bit of help you can get can only help your health.*

HeLP is a collaborative initiative that allowed clinicians, social workers and lawyers to pool resources and expertise and design services around the needs of the Alfred's patients and their families. This approach has meant that the team is able to shift its efforts to early intervention and resolution, rather than crisis management.

The program strongly represents the commitment of all partners to inclusiveness and holistic patient care, and demonstrates how public health services can better support and protect their most vulnerable patients and communities.

DELIVERING A COST-EFFECTIVE RELATIONAL EDUCATIONAL GROUP PROGRAM FOR PATIENT REHABILITATION

MELANIE WELLS, LISA BLOOMFIELD, ANGELA WHELAN AND DR JEANETTE NEDEN

A relational educational rehabilitation group program is currently being delivered by social workers within an acute care setting at Gold Coast Hospital, Queensland. The program integrates theories of relational practice and relationship autonomy (with traditional theories from social work practice.

Historically, individualised case management was the standard practice for responding to the range of social work referrals for adjustment, anxiety, motivation and psychosocial issues generally. However commonly experienced issues and concerns were identified by the program as having a negative impact on the rehabilitation journey and patient capabilities for ongoing recovery. To promote positive change, it was decided to explore a group-work approach that could address these commonly experienced anxieties and motivational issues in a relational context.

Our strong commitment to collaborative ways of working, support for patient autonomy and patient-centred care led us to the relational autonomy literature (The Health Foundation, 2013). An authentic model of patient-centred care underpins this model which encourages capabilities through formation of relationships between patients and their networks, and with clinicians. A relational group work model was developed to encourage patient autonomy, facilitate patient resources and capabilities and enhance positive patient outcomes through engagement in decision making for the rehabilitation journey. We undertook to develop a set of skills to deliver relational group work practice, design and deliver the program. The design is tailored to rehabilitation patients and applies a relational educational group approach (Sands & Solomon, 2003), which fosters relationship building for mutual aid and enhancement of autonomy and capabilities. To achieve this, clinicians are positioned within a relational context to patients who are situated both within group relationships and the wider cultural, linguistic and social contexts of their lives (Entwistle, Carter, Cribb, & McCaffrey, 2010). The specific program aims are: (1) to encourage members to reflect on their illness conditions in the context of the lives they seek to lead; (2) to promote ideas about the various healthy possibilities available during and after recovery; (3) to support, educate, and motivate through patient involvement in the group; and finally (4) to reinforce and expand patients' personal strengths, autonomy and confidence to achieve their rehabilitation goals.

The co-facilitated, open-ended bi-weekly program is delivered on rehabilitation wards. Patients' ages range from 40 years to over 100 with a mix of male and female participants, and the only exclusion criteria being major cognitive impairments. Patients attend between one and eight sessions, subject to the length of their admission, with an average attendance of two to three sessions.

Selection of content topics was based initially on the history of rehabilitation referrals and new topics were identified by the patients. The engagement of patients in selection of weekly topics is crucial to their autonomy and reflects one example of how group intervention can meet a core component of relational autonomy in practice (Entwistle, et al. 2010).

Initial data collected as part of a small quality project to evaluate the effectiveness of the current social work groups shows that a total of 584 patients attended the program at Gold Coast Hospital since its conception. The qualitative questionnaire, devised in conjunction with patients and given to each group participant at the end of their rehabilitation stay, was thematically analysed and the results indicated four main themes: increased motivation; decreased patient isolation' enhanced patient engagement in wellbeing, and positive group experiences. Example responses included: 'The motivation session inspired me…'; 'I loved meeting people and the company', and '….it gave me clues for improved mindset and practical hints'.

The interactive, relational component of the group work processes enabled participants and clinicians to learn and be changed through the experience (Payne, 1991). Patients experienced an enabling context which increased autonomy and capabilities through respectful sharing of ideas, reflecting on positive options and exploring diverse ways of managing their rehabilitation journey. Critical reflection on group work processes during the relational educational rehabilitation group program has led to an increased body of practice wisdom within the social work team, developing a better sense of the wider social factors that give patients their sense of identity, beyond their illness.

We believe that we are able to better focus on patient concerns that arise within the social and family context, together with better appreciation of the wider social structural aspects of rehabilitation to which patients' gave voice. Evidence from the group processes, when shared with the broader multidisciplinary rehabilitation team, make transparent and visible the social conditions that constrain or assist the rehabilitation journey and its impact on health choices, outcomes and patients' resilience when adapting to change. An additional positive outcome has been enhanced skill development regarding the design, delivery and preliminary evaluation of an authentic patient-centred group program.

In keeping with financial accountability, the cost effectiveness of delivering the program at Gold Coast Hospital is clear. On average, we have delivered 114 groups over a two-year period with two co-facilitators consisting of an HP3 (1 hour) and an 003 (2 hour) costing $96 per group, considering preparation and documentation. This contrasts with the same psychosocial support delivered individually for patients from an HP3 costs the health service $270. In effect, the program saves the social work department just under $10,000 per annum. It now needs a systematic evaluation of outcomes, which is in the planning stages.

Opportunities exist in models of this kind to enhance patient capacity to engage successfully in self-directed decision making in order to deliver effective health outcomes for patients, both in hospital and at home. In seeking to develop a new relational group practice model of care within the hospital context two main considerations arose: development of a model that would reflect authentic patient-centred care, and guaranteed cost savings and delivery within existing resources. We believe that social work is well positioned to lead the field in this area with group work programs of the kind reported here.

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About the authors

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HEALTH SOCIAL WORKERS' PRACTITIONER RESEARCH PROGRAM

This article reports on a social work team research program that is exploring a gap in understanding patients' and caregivers' perceptions of the quality of care provided to them by hospital social workers in the General Medicine unit of Monash Medical Centre, and how other multidisciplinary team members view these social workers.

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An increase in age has been linked to increased numbers of patients with chronic illnesses (Clark & McCann, 2004). Hospital admissions for older people reflect the interaction of multiple chronic conditions with social factors, leading to complex treatment processes and higher costs (AIHW, 2007). With the need for elderly Australians to be placed in care set to increase, there will be significant ramifications for general medicine social workers who see a majority of patients aged over 65 years and their families.

A literature review suggested a gap in understanding patients' and caregivers' perceptions of the quality of care provided to them by hospital social workers (Couture, Ducharme & Lamontagne, 2012) and that many of these patients were labelled social admissions, or 'acopic'. In addition, as members of a multidisciplinary team (MDT), we found ourselves wondering how other MDT members viewed us. Recognition of these gaps in our knowledge motivated us to initiate a program of practitioner-driven research.

We are undertaking this research program as part of a social work research team in the General Medicine unit at Monash Medical Centre. Part of Monash Health Network, Monash Medical Centre is a large tertiary care hospital in the southeast suburbs of Melbourne, Victoria, caring for over 3 million Victorians across nine local government areas within a culturally diverse 312 km catchment area.

Commencing in 2011, this program of research has looked at two research questions, and through to 2017 will consider a further three. In undertaking this program of research we have been assisted by social work students on placement, co-researching with them and providing a reference group to supervise their research.

The first step in the research (Question 1) was to identify the characteristics of patients perceived as social admissions and to look into what role general medicine social workers took in their care. In 2012–13 the research team looked at how the role of the general medicine social workers was viewed by the multidisciplinary team members (Question 2).

Inquiry into these questions revealed that the characteristics of older patients admitted with various health and social issues are highly complex and pose challenges for healthcare professionals, which paralleled the findings of previous research. Our research revealed that social work is seen as having a unique but not isolated role within the broader multidisciplinary team, providing psychosocial assessments and interventions, complementing medical, nursing and other allied health input. Social work contributions were highly valued by the MDT.

The next questions formulated by our team are building on those findings, addressing the needs of aged patients and carers and their perceptions of the social work role in the transition to aged residential care. In December 2015, a comprehensive literature review and ethics approval for questions 3, 4 and 5 was completed and data gathering for question 3 commenced. It is planned that this phase will be completed by the end of 2016, with research addressing questions 4 & 5 to be completed in 2017.

The team is employing and proposing to use a range of research methods, including clinical data mining of the medical files of patients referred to social workers who had been identified as 'acopic' or 'social admissions', and survey and focus group discussions with members of the General Medicine multidisciplinary team. Another method used is face-to-face and telephone interviews with patients and carers in order to gain insight into the complex emotions and experiences patients and care givers report in the transition to aged residential care, TCP or palliative care, and how social work might assist.

Much has been written about the difficulties social work practitioners face in undertaking research. Our team has been challenged by many of these, principally lack of time and resources in an extremely busy hospital environment. However, the ongoing commitment of the research team, the support of departmental managers and the possibility of accessing research assistance through our partnership with Monash University social work department have been crucial (Fouché, & Lunt, 2009).

The program of research we have initiated arises from our on-the-ground experiences as practitioners: the findings we have arrived at so far and those we anticipate emerging from the next steps in the research are vital to ensuring that we work from an evidence base and deliver relevant and appropriate services to our patients and their families. Along the way we have developed many skills: how to formulate researchable questions; how to receive ethics approval; how to analyse data; how to supervise research students; how to manage the research process; how to use our findings to inform practice; and how to write-up research. Our research provides us with further evidence-based practice and we look forward to the ongoing research journey.

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The research questions

Question 1:
Who are the general medicine patients who are described as 'acopic' or 'social admissions'? and sub-question: What is the role of the General Medicine social worker in caring for older patients with complex health and social needs?

Question 2:
How is the role of the General Medicine social worker in caring for older patients with complex health and social needs perceived by multidisciplinary team (MDT) members?

Question 3:
What are the psychosocial needs of patients and their carers in the transition from hospital to residential care?

Question 4:
What are the psychosocial needs of patients and their carers in the transition from hospital to Transition Care Program (TCP)?

Question 5:
What are the psychosocial needs of patients and their carers in the transition from hospital to palliative care?

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