Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

From the cleaners to the doctors – exploring the dimensions of effective health social work practice in an acute hospital

A thesis presented in fulfilment of the requirements for the degree of

Doctor of philosophy

in

Social Work

at Massey University, Albany, New Zealand

Linda Rose Haultain

2011

ABSTRACT

My thesis reports that since the earliest days of the social work profession the role of science and its relationship to practice has been contested. In Aotearoa this debate has often centred on the relevance of research conducted on distant shores, with populations that were not our own. Social work, by its very nature is interested in context. The absence of local research may have left us bereft of the ability to claim and articulate what it is that does inform us and what it is we aim to achieve in order to legitimately claim our practice as effective. In an effort to begin to understand what may be claimed as effective practice in one particular context this mixed methodology study asked the question: "How are the dimensions of effective health social work practice demonstrated and described within the multidisciplinary team, in an acute hospital setting in Aotearoa?" Beginning with a fine grained case study, the dimensions of effective practice were identified, and then tested across a broader context, with a broader group of participants via an online survey tool. Whilst accepting that at times clear evidence does exist to support particular health social work practices, engaging in this type of interpretive research provided an opportunity to begin to understand the most appropriate practice *in this particular circumstance* (Plath, 2006). Key stakeholders were clear that the dimensions of effective practice in the acute hospital context are made up of a combination of professional activities, behaviours, attitudes and theory-informed practice. The quality of the relationships between the health social worker, their team, patients and his/her whanau members were found to be at the very heart of these dimensions, this is reflected in the title of my thesis ***'from the cleaners to the doctors'***. These dimensions are not confined to specific results, although there are indications that they do support successful outcomes. There is much in the findings to suggest that the vestiges of many of the discoveries made by empirical studies can be found in the dimensions of effective practices that emerged from this study. It is not the remnants of the empirical effectiveness studies that dominate the findings. Rather it appears to be the successful adaptation to the acute hospital environment made by the Health Social Worker that was found to be important. In this context the dimensions of effective practice were identified as those which were best able to support the provision of an efficient, responsive and timely health social work service in a practice context that heavily favours 'getting the job done.'

Acknowledgements

A number of people have contributed to this research and thesis. Firstly I would like to thank the research participants, most especially ‘Kay’ who courageously allowed me to put her health social work practice under the research microscope. Also to those members of the multidisciplinary team who made themselves available to be interviewed, as well as those who completed the online survey, thank you. To my employer, the Auckland District Health Board, I am grateful for access to the research data and the sustained support I have received especially from Janice Mueller and Andrew Thompson.

I would also like to thank Dr Peter Reed and the Children’s Research Centre for their generous support and guidance in the area of survey development and statistical analysis. I am grateful to Dr Barbara Staniforth for her early peer review and editing of the thesis which helped inform the decision to transfer from the Masters to the Doctorate programme.

To my parents Tony and Jane, my friends and family who have unreservedly issued me a ‘leave pass’ while I devoted myself to the long term commitment of completing this academic journey, thank you. I am back now. I also owe an enormous debt of gratitude to my partner Julie. Thank you for your unfailing support, patience and the committed conviction that I would accomplish this goal. I could not have achieved this without your support.

Finally, I would like to acknowledge and thank my supervisors Dr Christa Fouche who boldly and skilfully guided me from Masters to Doctoral research, all the while attempting to contain me and Dr Mike O’Brien; both of whom have provided outstanding guidance, collegiality and support to help ensure the successful completion of this doctoral research.

Dedicated to my dearest brother Mark ‘Bolt’ Haultain who died peacefully and courageously on the 22 October 2011

Table of Contents

Acknowledgements iii
List of Tables viii
List of Figures viii

Chapter 1: Introducing the inquiry 1
Introduction 1
Current measures and changing expectations 2
Bicultural practice imperatives 4
Rationale and aims for this inquiry 5
Research approach 8
Effective practice 13
The multidisciplinary team 15
Auckland District Health Board 16
Language use 17
Reading the inquiry 18

Chapter 2: Social work and effectiveness 19
Introduction 19
A historical standpoint of research, science and social work 20
Deciding on a design 24
First response to ‘nothing works’ 25
Second response to ‘nothing works’ 27
A move towards evidence-based practice 31
The origins of evidence-based practice 37
The broad-stream, narrow-stream metaphor 39
Evidence 45
Effectiveness 47
Post positivism, pragmatism and trade-offs 51
Alternative approaches 52
Reflective Practice research 53
Conclusion 60

Chapter 3: Health social work 64
Introduction 64
The health policy and strategy context 64
The universal theme of change and health social work 70
Social work in a host setting 73

Calls to define the role and demonstrate outcomes ... 77
Broad agreements in the hospital context ... 81
Collaborative team work ... 90
The Paediatric environment ... 91
Outcomes of health social work ... 94
Conclusion ... 101

Chapter 4: Methodology ... 103
Introduction ... 103
Epistemology ... 104
Reflexivity and research practice ... 104
Beliefs about social work ... 105
A situated practice-based inquiry ... 108
The interpretive paradigm ... 109
The research paradigm – mixed methods ... 110
Design ... 113
Ethical issues – being an insider researcher ... 113
Informed consent and potential harm to participants ... 113
Sequential exploratory mixed method design ... 114
The weighting decision ... 114
Step 1: Qualitative data collection – the choice of case study ... 119
Step 2: Qualitative data analysis ... 128
Step 3: Designing the survey tool ... 132
Step 4: Quantitative and Qualitative data collection ... 138
Step 5: Quantitative and qualitative analysis ... 139
Step 6: Interpretations and the combined analysis ... 141
Conclusion ... 142

Chapter 5: Exploratory findings (case study) ... 144
Introduction ... 144
Data analysis ... 147
Introducing *the case* ... 148
Practice context ... 148
The acute environment ... 150
Medical complexity ... 150
Social complexity ... 151
Cultural and ethnic complexity ... 152
Team complexity ... 153
Practice Domains ... 153
Conclusion ... 182

Chapter 6: Survey findings ... 185

Introduction 185
1. Responding to vulnerability and risk associated with interpersonal family violence 188
The Health social work contribution of services to the vulnerable............................... 190
Identification of concerns.. 193
Establishing trust and rapport with patients and families 193
Presence listening.. 196
Assessment of concerns 197
Intervention to reduce concerns 198
Communication and team work 200
2. Practical advocacy and support... 203
Provision of the necessities of life including finances 203
Housing and accommodation.. 204
Transport 204
Context specific needs.. 205
3. Emotional advocacy and support in the medical context.................................... 206
Being non-judgemental, empathic and compassionate 208
The value of listening... 210
Relationships and engagement 211
Being alert to the understanding of the patient and his/her family 212
Supporting patient and family understanding 213
Working *with* the team to support patient and family understanding 214
Supporting patient and family engagement with the health service 215
Responding to distress.. 216
Counselling 218
4. Access to internal and external resources 219
Knowledge of resources.. 220
Using our knowledge of resources to advocate for patients and families..................... 222
5. Cultural advocacy and support... 222
Assessing and responding to cultural needs.. 223
Liaison and referral associated with cultural support 224
Applying cultural and ethnic competencies in the hospital 224
Contributions to the multidisciplinary team.. 226
Ethnicity of Health Social Workers 228
Helping patients understand medical conditions and their consequences 229
6. 'Working the ward' – dependable service delivery 230
Dependable service delivery 232
Social needs met in order to solve problems... 233
The well-organised, proactive and flexible Health Social Worker 237

Provision of a timely, responsive and reliable service 239
Assessment, intervention and activity to support a safe and timely discharge 241
Context specific needs 244
Context specific processes 244
Focus on discharge 245
Psychosocial assessment 247
7. Team work and communication 248
The ability to work in a team and develop excellent team relationships 249
Communication 251
Revision of quantitative data 253
Conclusion 255

Chapter 7: Discussion 257
Introduction 257
Influential messages from the literature 260
Responding to vulnerability and risk 261
Asking our hosts the questions 273
Health social workers' role in supporting cultural responsiveness 275
Supporting patient and family understanding in the medical context 278
Team work and its link with relationship-based practice 290
A rejection of a narrow focus on outcomes 292
Comparison with the health social work literature 293
The research findings and the aims of social work 295
Concluding comments 296

Chapter 8: Conclusion 299
Introduction 299
Reviewing the research aims, motivation and approach 299
The findings 301
Limitations of the inquiry 303
Clinical governance, what is it and what are its aims? 304
Social work and the learning organisation 306
Conclusion 310

Bibliography 314

Appendices 326

List of Tables

Table 1: Summary of survey tool development process 135

Table 2: Contextual Factors and the core dimensions of effective health social work...... 145

Table 3: Personal and professional characteristics.. 172

Table 4: Transition of case study data to combined findings.. 186

Table 5: Dimensions of practice – child protection and family violence (Paediatrics and Women's Health data).. 190

Table 6: Dimensions of practice – Use of self and interpersonal skills 207

Table 7: Dimensions of practice – Communication and personal characteristics 207

Table 8: Dimensions of practice – Cultural responsiveness 223

Table 9: Dimensions of practice – activities that support reliable service delivery........... 231

Table 10: Dimensions of practice – behaviours that support reliable service delivery 231

Table 11: Dimensions of practice – assessment and interventions 232

Table 12: Dimensions of practice – Team work 249

List of Figures

Figure 1: Summary of sequential exploratory mixed method design employed in this study9

Figure 2: Summary of sequential exploratory mixed method design employed in this study 117

Chapter 1: Introducing the inquiry

Introduction

Under increased public scrutiny, with growing professional expectations, practitioners of social work are required to deliver effective services in a wide variety of practice contexts. These contexts are frequently dominated by high risk and uncertainty, coupled with resource constraints; labour shortages; changing expectations and imperfect organisational infrastructure and leadership. These circumstances risk leaving social workers feeling uncertain about what is expected from them in relation to professional practice. In such circumstances, the idea that by simply applying the findings of research one is able to increase positive outcomes, reduce practice risk and survive the public gaze, is a deeply appealing and seductive concept for social workers and managers alike (Trinder, 2000a).

According to Webb (2001), the notion that social work activity can claim the status of 'best practice' by having been informed by evidence fortified by rigorous scientific research methodologies has found fertile ground in our contemporary 'expert' dominated culture. This *practice magic bullet* more and more being required from social workers is most commonly referred to as 'evidence-based practice' that has at its core the concept of effectiveness (Plath, 2006). While the proliferation of evidence-based practice is apparent in all aspects of the health and social service industry (Magill, 2006) social workers are challenged to strengthen ways of usefully and ethically engaging with this concept.

Yet in subscribing to a narrow construction of evidence-based practice there are a number of concerns and contradictions that confront the social work professional in Aotearoa. Matters such as our ethical and professional responsibilities to Maori, our pursuit of social justice goals and models of practice that rely on collaboration with clients clearly require a degree of artistry and flexibility. Without taking into account the contested nature of social work itself; the trials and contradictions inherent in measuring successful outcomes; and an understanding that social workers remain poorly equipped to engage in research activities, there is broad consensus in the literature that the profession *does* remain under increasing pressure to demonstrate its capacity to be effective (Macdonald, 2001; Plath, 2006; Sheldon, Chilvers, Ellis, Moseley, & Tierney, 2005; Thyer, 1996; Trinder, 2000b; Vonk,

Tripodi, & Epstein, 2007; Wandersman, 2001; Witkin, 1998). The question remains however, how do we meet the research expectation and remain true to our social work values, ethics and standards, which by their very nature stand against the imposition of definitive, codified and one-size-fits-all knowledge? We must also consider how effective practice is defined and measured?

Current measures and changing expectations

When we consider how effective we are in achieving positive outcomes in our practice, the measure typically applied, in an 'ad hoc sort of a way' by practitioner, clinical supervisor, and, in the best case scenario, the client/s is *Is this social work activity, or intervention making a difference, is it helpful?* The type of difference one is aiming for depends very much on the practice context and a multitude of other variables. Irrespective it is likely to include considerations of questions such as: Is the situation improving? Is the risk to children reducing and the sense of safety increasing? Is the problematic behaviour, whether it is alcohol abuse, inadequate parenting, family violence or poor health decreasing over the time of the intervention?

These familiar areas of practice reflection and evaluation, many of which are undertaken in the privacy of the supervisory relationship, are no longer sufficient in a contemporary professional environment. In the face of increasing calls for accountability and professionalism (Staniforth & Larkin, 2006) perhaps most evident in the Social Workers Registration Act (2003), social workers in Aotearoa are required to engage in and demonstrate the activities of a more fully professional workforce. Inherent in this expectation is a requirement to engage in social work interventions that have previously been established as more likely to be effective, manifesting in the concept of evidence-based practice. This expectation is implied in the preamble of the Aotearoa New Zealand Association of Social Workers (ANZASW) Code of Ethics which states that "[s]ocial workers are committed to...the growth and disciplined use of all forms of knowledge which inform and enable social workers to effectively carry out their role and function" (1993, p.1). Language such as 'all forms of knowledge' sends an important message to the profession, encouraging us to engage with multiple sources of knowledge including, for example, cultural knowledge.

Some would argue that social workers do not have a choice about which interventions to apply, but have an ethical obligation to utilise interventions that have been demonstrated to be effective through well-controlled and replicated studies (Myers & Thyer, 1997). Others, such as Witkin (1998) make the point that social workers are involved with highly complex and thorny issues and, that in order to do this well, we must be reflective, analytical and compassionate in our approach to human anguish. Maintaining that social workers must choose our interventions on the basis of the information at hand, Witkin challenges practitioners to recognise that we often know scarce details about the lives of our clients, and therefore, we "must listen and learn from them" (Witkin, 1998, p.80). Practice wisdom is also proposed as a concept to guide practice, described in the literature "as a personal and value-driven system of knowledge that emerges out of the transaction between the phenomenological experience of the client situation and the use of scientific information" (Klein & Bloom, 1995, p.799). Ferguson suggests that it is critical best practice that provides a way forward for the profession; his approach determinedly chooses to "focus on the actual critical practices that are 'best'" (2003 p.1005) thereby demonstrating the very specific social work activities and practices that are able to support effective outcomes.

Ferguson's proposition of paying closer attention to practice is supported in the literature under the auspices of practice-based research (Blumenfield & Epstein, 2001; Ferguson, 2003; Fuller & Petch, 1995; Joubert, 2006). This activity is characterised by practitioners being supported to "engage in research that has direct implications for their own practice" (Blumenfield & Epstein, 2001). Advocates of this approach to research suggest that it supports greater practitioner research-mindedness and the increased application of others research findings via a reflective process. This notion of practice-based evidence is increasingly being advocated as an alternative to evidence-based practice (Ferguson, 2003). Citing Plath (2006), Nilsson concurs with an increasingly reflective approach. He makes the suggestion "that future directions for strengthening evidence-based social work practice should include more critically reflective approaches that value interpretive research findings and practice experience in deciding the most appropriate practice in particular circumstances" (Nilsson, 2007, p.40).

A fuller exploration of the various approaches to both social work knowledge production, and how this knowledge can helpfully be applied in practice will be traversed in chapter two. Given the unique Aotearoa practice context, and the professional obligations we carry in relation to Te Tiriti o Waitangi, (see for example the ANZASW Code of Ethics, 1993) the approaches to practice outlined above must also be assessed in regards to their capacity to assist us in the meeting of these obligations.

Bicultural practice imperatives

It is difficult to imagine a Pakeha social work practitioner in Aotearoa who has not been confronted by Maori colleagues, academics and professional commentators regarding the risks to Maori clients associated with the indiscriminate application of imported Western models of practice. This consistent opposition to Western paradigms from those on the margins, combined with a growing multicultural population in Aotearoa increasingly requires practitioners to engage effectively, *and* ethically, across areas of great difference and complexity (Fook, 1996). In this environment social workers are faced with having to make sense of competing versions of events, contradictory expectations, and contested 'claims to truth' (Bird, 2000; Fook, 1996).

Frequently these claims are derived from positivist research inquiries conducted on distant shores which bear minimal resemblance to more familiar constructions of practice imperatives, such as those associated with bicultural practice. An example of one such imperative is the ethical obligation to contextualise interventions involving Maori within their whanau, hapu and iwi (1993, Bicultural Code of Practice of the ANZASW 1.1 p.17). In the absence of what may be considered definitive scientific evidence to support this practice, most Aotearoa social workers instinctively know this to be the right *and* effective thing to do, and to varying degrees practice accordingly.

This resulting contradiction, which must be thoughtfully navigated by social workers, is how to find appropriate ways to engage with the outcomes of research, without contributing to the dominance and injustice reflected in Martinez-Brawley's quote below:

> Women, members of ethnic and racial minority groups, and gays and lesbians have increasingly described how social and behaviour research that developed under the

> dominance of positivism has incorporated and disseminated oppressive ideologies based on race, class, gender and sexual preference (Tyson, 1995, p. 177 cited in Martinez-Brawley, 2001, p. 274).

Highly critical of recent social work paradigms that reflect exclusionary assumptions Martinez-Brawley seeks to reduce their power and open up the way for "…more inclusionary scholarly habits and 'ways of knowing'"(Martinez-Brawley, 2001, p. 271). The purpose of Martinez-Brawley's discussion is to add weight to the notion that there are multiple ways of "…understanding the complex phenomena that surround the practice of social work in a very heterogeneous world" (Martinez-Brawley, 2001, p. 271).

Considering for a moment the number of complex variables that come together at any one time and the huge array of choices regarding the best way to approach the social work intervention, it is little wonder that many practitioners remain firmly committed to the practice of eclecticism. Inevitably the particular variables will have a bearing on intervention options *and this makes sound sense* when you consider how variables will inevitably collide and compete. Consider, for example, the impact on our intervention choice of organisational and practice context, current health and social policy, client and practitioner ethnicity, cognitive ability, and practitioner's preference and competence.

Notwithstanding this range of complexities and tensions, there is no escaping the increasing responsibilities social workers carry to not only apply the findings of research constructively and ethically, but to also find ways of defining, demonstrating, and evaluating effective outcomes in relation to our own practice.

Rationale and aims for this inquiry

I am currently employed by the Auckland District Health Board in a professional leadership role which is primarily oriented toward the clinical governance of health social workers. Fundamental to the concept of clinical governance is the responsibility to safeguard high standards of care, *and* to help create an environment in which excellence can flourish (Braithwaite & Travaglia, 2008). Providing a commentary on the concept of clinical governance in hospitals Edwards makes the point that "[o]ne of the biggest problems in

many health care systems is the gulf between the front line clinical staff and policy makers and managers" (Edwards, 2004, p. 681).

In partial response to the challenge issued regarding my responsibility to engage in effectiveness research, and in an effort to bridge the gulf Edwards has described between leadership and the front line practitioners, this doctoral thesis, undertaken by insider research has multiple drivers. At the very centre however, is a firm commitment to fulfilling both elements of the clinical governance responsibility, first to understand what a high standard of care actually is, and second to help create the environmental conditions in which these standards can flourish.

Ensuring the provision of effective services has been described by some authors as the profession's greatest challenge (Rosen & Proctor, 2003). One way to meet this test is by engaging in *local* practice-based research that is able to reflect the ethical principles and standards of the profession and other situated obligations, while providing an account of what constitutes effective practice within a specific practice context. In questioning effectiveness in my work place, a choice has been made to focus on the "actual critical practices that are 'best'" (Ferguson, 2003, p. 1105) as described by multiple stakeholders, in an effort to understand the day-to-day detail of these critical practices.

The primary aims of this study are threefold and, reflecting the sequential nature of the study, each aim is built on the foundation of the previous one having been achieved. Firstly I ask the question: How are the dimensions of effective health social work practice demonstrated and described within the multidisciplinary team, in an acute hospital setting in Aotearoa? The aim here is to identify what Plath described as "…the most appropriate practice in particular circumstances" (2006, p.68). The data to emerge in response to this first question will enable me to develop an operational definition of the dimensions of effective practice drawn from the perspectives of a range of key stakeholders who construct what constitutes effective practice within this specific context. Achieving this task will allow me to fulfil the final goal of the study, that is to design an intervention which supports health social work leaders to purposefully increase the provision of effective practice.

Over the previous two decades the international and local social work literature has firmly established that the hospital practice environment poses some very unique and powerful challenges for the profession (Beddoe, 1993; Berger, et al., 1996; Judd & Sheffield, 2010; G. Ross, 1990; J. Ross, 1993; Schofield, 2001). One of the dominant responses to these contextual obstacles has been the call to define the health social work role, thereby making it more possible to demonstrate effective outcomes. Here in Aotearoa I have been unable to locate hospital-based research that answers these calls.

This study then will reflect my commitment to local practice-based research, and maintain a fierce concentration on the actual, day-to-day-critical practices that are 'best' as previously described by Ferguson (2003). By taking up this approach I aim to achieve a greater understanding of what Plath, as previously described refers to as "…the most appropriate practice in particular circumstances" (2006, p.68). These circumstances are of course, the multidisciplinary team in an acute urban hospital in Aotearoa. By attempting to articulate 'the best of what is' in this specific practice context, my hope is that this account of the dimensions of effective health social work will provide the foundation for ongoing reflection, discussion and the development of an organisational intervention.

My hope also is that by focusing on the practice itself, by asking health social workers and other key stakeholders what they believe constitute the dimensions of effective practice there will be a greater chance that a shared understanding of these dimensions will emerge. With this shared understanding and the future implementation of the context specific intervention that aims to help transfer the research findings into practice I aim to reduce two of the well- known risks associated with research. Firstly that the findings lack meaning for practitioners and, secondly, that this lack of meaning gets in the way of their capacity to inform practice. I anticipate that these are the collective benefits that can result from conducting insider, practice-based research (Coglan & Brannick, 2005). It is important to note too that I am reviewing 'best practice' as seen through the eyes of professionals; service users may have a different view.

Research approach

While attempting to face up to the 'effectiveness test', this thesis aims to protect as much as is possible, the development of knowledge inherent in research activity, by engaging in a particular type of research that the social work profession has widely come to accept as useful. Qualitative research is seen as having the potential to provide the kind of detailed, descriptive information which has the greatest capacity for understanding and/or assessing practice (Ruckdeschel, 1999).

In light of this a choice has been made to employ a mixed method inquiry that maintains a very direct focus on practice. This begins with a case study design, comprising an exhaustive focus on the professional activities of a practitioner who has been identified by her peers (and other key stakeholders such as nurses and doctors) as a highly effective health social worker. This practitioner is based in a paediatric context. Once the dimensions of her practice are uncovered and described via this first phase of the research project, they will inform the second key phase of the research. This second phase, a survey which includes quantitative and qualitative data will involve a broader participant group involving the paediatric, women's health and adult acute hospital services of Auckland District Health Board.

This second phase of the research provides an opportunity to control and expand the case study findings. Appendix 1 provides a detailed map which illustrates the phases, process and outcomes of the sequential exploratory mixed methods (Creswell & Plano Clark, 2007) design employed in this study. A summary of the process is included here as a point of reference to help support the readers' orientation to the design.

Design (sequence from right to left) →					
Step 1	**Step 2**	**Step 3**	**Step 4**	**Step 5**	**Step 6**
QUAL data collection – case study in hospital paediatric ward	**QUAL** data analysis and findings (Case study)	Use case study findings to design survey tool	**Quan** and **QUAL** data collection – survey tool applied across three hospital populations	**Quan** and **QUAL** analysis (survey)	Interpretations **QUAL** findings (case study) **QUAL** and **quan** findings (survey)

Figure 1: Summary of sequential exploratory mixed method design employed in this study

By taking up a heuristic approach to the research, one that accepts that reality is highly complex and uncontrollable and not something that can be accepted as universal, this inquiry is unashamedly situational and context specific in its application. Full details of what is informing this approach and the methodology applied in this inquiry will be described in chapter four.

The very heart of this study is focused on the dimensions of effective health social work practice within the confines of the multidisciplinary team in the acute hospital environment. The social work activity is therefore appropriately examined within the broader expectations of effective social work practice. This occurs in relation to the empirical literature, and more specifically in relation to health social work literature. In order to orientate the reader to the constructs central to this inquiry I begin by briefly outlining the important elements of social work, and the practice setting of the hospital. This is followed by a brief exploration of the concept of effectiveness and a description of the multidisciplinary team. The International Federation of Social Workers (IFSW) to which social workers who are members of the Aotearoa New Zealand Association of Social Workers (ANZASW) are affiliated provides the following definition of social work:

> The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work (International Federation of Social Workers, 2005).

In the hospital context, the majority of health social workers are registered and we are therefore subject to the standards and expectations of a registered workforce. Many are also members of the social work **A**ssociation and are guided by the ethical framework and practice standards of the Aotearoa New Zealand Association of Social Workers (ANZASW) who state clearly that in relation to practice in Aotearoa,

> ...unique models of practice have been developed as Social Work has matured in the context of this particular bicultural society. These models take into account ...most importantly the requirements of Te Tiriti O Waitangi, the founding document of this country. Social workers in Aotearoa New Zealand are challenged to identify and

express the distinctly indigenous components of social work practice (Aotearoa New Zealand Association of Social Workers, 2010).

Those social workers who have gained registration status via the Social Work Registration Act (2003) are also obliged to comply with the Code of Conduct guidelines for social workers. Within these guidelines the requirement to provide services at a competent level of professional practice is outlined, which the code maintains is dependent on a mix of:

- an individual social worker's skills, knowledge, experience, ethical value base and competence
- the involvement of other providers and professions as necessary
- responsiveness to the client's individual circumstances (e.g. supporting a client's cultural identity)

"Maintaining and developing skills, experience and competence relies, in turn, on ongoing professional development and supervision, combined with an open and reflective approach" (Social Work Registration Board, 2008, p. 7).

Explaining that human health and wellbeing is an increasing concern for social workers, the IFSW website devotes a substantial area of text to outline their policy statement regarding health. Covering topics such as settings, values, policy, delivery, the knowledge base and responsibilities of social workers, whilst maintaining a holistic view of the person they provide the following definition of health:

> ...social workers view health as defined by the World Health Organization (WHO), namely as a positive state of physical, mental and emotional well-being. Illness is seen as the converse of health and includes suffering from sickness and disablement, contagious diseases and diseases of deprivation that involve the lack of food, of clean water, of pure air, of safe shelter, of health services, and of social services (International Federation of Social Workers, 2008).

In relation to the specific responsibilities of practitioners in the health environment they invite social workers to "work for the extension of knowledge of social work and health, through systematic evaluation and research" (International Federation of Social Workers, 2008).

Throughout the study I have chosen to refer to social workers in the hospital as health social workers. This is a purposeful addition to what we are commonly referred to, which is simply social workers. The justification for this choice is to begin to differentiate health social workers as a group of professionals who work in a particular context, and benefit from having a particular set of skills.

Hospitals are described as complex organisations because “they have a complex division of labor and several functions, which sometimes are subdivided into multiple-service units” (Cowles, 2003, p.25). Reasoning that this complex division of labour means that multiple personnel can be delegated various duties and responsibilities Cowles maintains that health social workers must know our organisation well in order to develop their own roles (Cowles, 2003). Although the literature does signal a shift away from a preoccupation with acute care towards primary health care initiatives (Mizrahi & Berger, 2005) the role of the health social worker in a hospital remains central in the health environment.

There are a number of core concepts that bind the practice of health social work in hospitals, and serve as the foundation upon which social work services are based.

> The unifying theoretical perspective…is the view that people can best be understood and helped in the context of the conditions and resources of their social environment. Social environment refers to the quality and characteristics of one’s life situation including interpersonal relationships, resources for one’s needs, and one’s position, roles and participation in society (Cowles, 2000, p 10 cited in Beder, 2006, p.4).

Within the hospital environment, and more specifically within the multidisciplinary team, the unique contribution that health social workers make is the application of a biopsychosocial approach to practice. Described as providing a carefully balanced perspective the biopsychosocial approach ensures a multidimensional assessment of needs taking into account the entire person in their environment (Beder, 2006). The biopsychosocial framework will be outlined in greater detail in chapter three of this thesis.

Having undertaken a thorough biopsychosocial assessment, the experienced health social worker has a number of areas in which to focus her practice, relying on a variety of skills and experiences. These include the capacity to work with individuals, whanau, families and

groups; the ability to respond appropriately to a patient's recent trauma and assist in the adjustment to debilitating medical conditions. Practitioners in a health environment also require skills in crisis intervention, interdisciplinary and multidisciplinary team work, counselling and client advocacy. The capacity to understand the precise processes related to the specific illness, injury, or disability that the patient and their whanau are experiencing is highly desirable (Schofield, 2001).

Effective practice

It is not feasible to narrowly define effective practice in relationship to the professional activities or the outcomes of social work activity. This view is informed by experience, and the reading of the effectiveness literature. In any practice situation there will be a range of desirable outcomes, a diversity of points of view and variables, and a multiplicity of contexts which must be taken into account in any evaluation of effectiveness. This position is supported by Cheetham, Fuller, McIvor and Petch, who maintain that "[a]ny worthwhile research approach to the effectiveness of social work is likely to have to live with various kinds of imprecision or elusiveness in some of its key terms" (1992, p.16). Despite much seemingly uncomplicated use of the word 'effectiveness', it is not something which is easily defined with an object-like reality, just sitting there waiting to be discovered, observed and measured (Cheetham, Fuller, McIvor, & Petch, 1992).

As previously indicated this inquiry attempts to understand what I describe as *the dimensions of effective health social work practice*. By dimensions I am referring to any professional activity, behaviour, attitude, personal characteristic, competence or skill that key stakeholders collectively and consistently rely on to describe "the actual critical practices that are 'best'" (Ferguson, 2003, p.1005) in the hospital context. In so doing there remains a very broad focus, which allows these multiple dimensions to emerge, including participant's beliefs regarding their possible impact on outcomes.

The hospital practice environment has been, and continues to be subjected to unprecedented change (Gauld, 2003) including a change to the roles of health professionals (Dziegielewski, 2004). Some authors argue that these changes "have required social workers and the services they provide to continually prove that evidence-based services are

truly necessary, effective and cost-efficient" (Mitchell, 1999, cited in Dziegielewski, 2004, p 3). Dziegielewski (2004) stresses that in this practice arena it is critical to note that measures of effectiveness must be extended beyond simply helping the client. Citing DePoy & Gilson, 2003, Dziegielewski (2004) maintains that therapeutic gains, accessed via validated measures, must also be achieved with the least amount of professional and financial input.

The concept of effectiveness is central to evidence-based practice. The simple questions of 'Does it work?' and 'How much did it cost?' however are unlikely to be acceptable or adequate questions in relation to health social work practice. In attempting to discover and articulate a fuller understanding of the concept of effectiveness Cheetham and her colleagues propose that the practitioner must ask a series of other, much more finely detailed questions. In order for effectiveness research to be helpful social workers need to know, What parts of this practice worked well? Which parts worked less well? Why might this be the case? For whom did it work well? What were the central factors influencing the situation? and so on. Naturally, when a clearly defined and discernible outcome is the goal of the practitioner, having been clearly negotiated with the client, with agreed measures in place, then the effectiveness of the particular intervention is more easily determined and defined (Plath, 2006).

Within the context of the multidisciplinary team, which has a number of participants, the concept of effectiveness becomes even more challenging to establish, as each profession's values, ethics and standards are likely to impact on their assessment of an acceptable patient outcome (Cheetham, et al., 1992). The following definition, provided in an allied health management text, demonstrates how effectiveness and efficiency are often linked, and are seen to be a core component of the role of the allied health manager who, in Aotearoa hospitals, is often responsible for the operational oversight of health social workers:

> Effectiveness and efficiency are two quite different though related concepts. Effectiveness relates to the clinical outcomes of service provision taking into account evidence-based clinical practice whilst efficiency is concerned with maximising the outputs from a given set of inputs and is linked to the necessary

> balance between resources needed to achieve the aims and objectives of the service (Jones & Jenkins, 2007, p.10).

Of interest here is the link being made between effectiveness, evidence-based clinical practice, and outcomes. This link between social work effectiveness studies and evidence-based practice, along with an extended exploration of the issues of defining and assessing effective practice will be explored in greater detail in chapter two of this thesis.

The multidisciplinary team

Teams and teamwork in particular have become increasingly popular because of their capacity to influence organisational effectiveness (McCallin, 2006). In a contemporary health system McCallin makes clear the growing expectation that health professionals work together, in team working relationships, in order to deliver client-centred care (McCallin, 2006). In this context collaborative team practice is critical for patients requiring the services of many disciplines to aid them in their recovery or rehabilitation. There is widespread acceptance that effective team work requires collaboration, which is understood to be a complex and dynamic process that occurs when two or more health care practitioners cooperate and assist one another in the service of a patient or their family member (Beder, 2006; Dziegielewski, 2004; McCallin, 2006).

Many of these health care teams have a label, sometimes referred to as multidisciplinary, at other times, interdisciplinary teams. What is clear is that terminology has been inadequately defined, and regularly terms are used inaccurately (McCallin, 2006). It has been firmly established however that a team's practice is able to influence the quality and effectiveness of the care provided (McCallin, 2006) and is therefore an important aspect of clinical practice. For the purposes of this inquiry the term multidisciplinary team will be used as this is the dominant description applied by team members at the sites of the inquiry. Broadly then, for the purposes of this study the multidisciplinary team is defined as a team of health professionals who share information and work together in order to provide coordinated and quality patient care.

Auckland District Health Board

A district health board (DHB) is responsible for the provision of health and disability services within a particular district. They may either provide the services themselves or fund them. “The statutory objectives of DHB include:

- improving, promoting and protecting the health of communities
- promoting the integration of health services, especially primary and secondary care services
- promoting effective care or support for those in need of personal health services or disability support”(Ministry of Health, 2011).

As reported on the Ministry of Health’s home page District Health Boards carry an expectation to demonstrate an awareness of social responsibility, to encourage communities to participate in health improvement, to maintain the type of quality and ethical standards one might expect from a public sector organisation, and a provider of health services (Ministry of Health, 2011).

The population size of Auckland District Health Board (ADHB) makes it one of the fourth largest District Health Boards in Aotearoa with annual revenue of approximately $1.3 billion dollars. Of this approximately 76% of this budget is spent on hospital and related services. Auckland City Hospital provides acute medical and surgical services. Auckland City Hospital is inclusive of services provided by Starship Children’s Health and National Women’s Health services. The combined services provided at Auckland City Hospital include:

Children and young people’s service
Women’s health

Surgical services

Cardiothoracic

Clinical support

Laboratory

Radiology

Across these services 27 full time equivalent (FTE) health social workers are located in Adult Services, 15 FTE in Women's Health Services, and 13 FTE in Paediatric Services. Health social workers are typically operationally accountable to a Team Leader who is an allied health professional, and professionally accountable to the Social Work Professional Leader. The allied health teams they are affiliated to are service based and multidisciplinary in nature. These teams are made up of a combination of physiotherapists, occupational therapists, speech language therapists, health social workers and play specialists.

The population of ADHB is made up of European 65.7%, Maori 8.4%, Pacific Peoples 13.7%, Asian Peoples 18.7% and other nations 1.6%. English is the most common language spoken followed by Samoan, Yue, Maori, Northern Chinese, Tongan, French and Hindi. Seventy percent of Auckland District Health Boards population are adults of a working age (15-64). One third of the Maori and Pacific peoples are aged under 15 years, described as a 'young population.'

A range of key socioeconomic factors make up the data which forms the basis of The New Zealand Deprivation index which estimates an overall score of deprivation for an area. The range is from 1 (least deprived) to 10, most deprived. Ten percent of people across Aotearoa live in each decile. In the Auckland District Health Board's catchment a slightly higher percentage of our population live in deciles one and two, and in decile ten (Auckland District Health Board, 2011).

Language use

Throughout this thesis the country of Aotearoa New Zealand will simply be referred to as Aotearoa. This is an acknowledgement of Maori as the indigenous population of this land. In a similar vein, the word 'whanau' will be used intermittently to describe those people who are significant to the patient in the hospital setting and is intended to emphasise a practice context that is both local and inclusive of diversity. When 'whanau' sounds awkward because of the context in which it is used or, or the participants use of the word 'family', then 'family' will also be relied on to signify loved ones, friends and significant others, including same sex partners. Health social workers will be referred to as 'she', because in my experience we most often are females, and clients, customers and service

users will be referred to as ‘patients’, merely because it is familiar and not cumbersome. When referring to social workers who practice in a hospital context I will most often refer to us as Health Social Workers but from time to time will also refer to as ‘practitioner/s’ simply for the sake of providing some variety.

Reading the inquiry

Chapter two provides a brief historical examination of the relationship between social work and science, exploring the notions of effective practice within the empirical tradition up to and including the contemporary viewpoints. The application of evidence-based practice and its relationship with critically reflective research and practice will provide the bridge into the next chapter. Chapter three is intended to firmly situate this study within a hospital practice milieu, providing an account of the particular organisational challenges, and the efforts that have been made to engage in outcome studies. Chapter four, written in the first person to support a reflexive researcher position provides an outline of the methodology and design of the study, prior to the case study findings being presented in chapter five. The survey findings are reported in chapter six, followed by the discussion and conclusion chapters, seven and eight. These final chapters provide an opportunity to reflect on the findings in relation to the issues covered in chapters two and three, particularly as they relate to the provision of effective health social work practice a public hospital in Aotearoa. The proposed intervention plan and a brief account of what is informing it are outlined in the concluding chapter.

Chapter 2: Social work and effectiveness

Introduction

My literature review has provided an opportunity to more fully explore a range of ways the profession has engaged with the thinking and concepts associated with social work effectiveness, adding greater depth and detail to the definition of effectiveness that was outlined briefly in chapter one of this thesis. As in many other disciplines within the health environment, social work as a profession has been under increasing pressure to demonstrate the value of its contribution to effective patient outcomes (Auerback, Rock, Goldstein, Kaminsky, & Heft-Laporte, 2000; Cleak, 2002; Joubert, 2006). This emphasis is evident in policy documents, an expansion of evidence-based language and the growth of quality initiatives (Joubert, 2006). Despite extensive criticism of social work's poor record of research activities, and an overall suspicion of evidence-based practice expressed by many of my colleagues, these increasing research initiatives have not come forward into a methodological or research vacuum. In fact social work can demonstrate an extensive chronicle of effectiveness research throughout its history, albeit one that is highly contested.

My study must then be understood within the context of effectiveness research which already exists, and the recurrent competing and contested research history and conventions which could broadly be described as falling into two main traditions (Gibbs, 2001). In this review of the literature, after a brief examination of the earliest annotations on the clash between science and practice, including Reid's (2001) analysis of the various ways science can be applied to practice, the positivist tradition in relation to social work will be examined. Here reference to the early experimental work, with particular emphasis on large scale effectiveness studies will be undertaken, primarily drawing on meta-analysis or systematic reviews.

Over time this positivist position has been consistently championed in the social work literature by a number of commentators such as Sheldon (Sheldon, 1986; Sheldon, et al., 2005), Macdonald (Macdonald, 2001; Macdonald, Sheldon, & Gillespie, 1992), and Thyer (Thyer, 1996). Collectively these authors argue for the right of social work recipients to

only be offered interventions empirically proven to be more likely to be effective. An exploration of the naturalistic interpretive approaches located in the qualitative research and evaluation framework will follow, including a critique of the positivist paradigm, and its limitations in the messy, multidimensional, highly complex world of social work practice. Drawing on the voice of indigenous peoples and feminists**,** who have effectively questioned the very nature of knowledge and how it is constructed, this part of the review will introduce critical reflection and the influence of postmodern approaches to research with particular reference to the work of Fook and co-authors (Fook, 2000, 2002, 1996; Fook & Askeland, 2006; Fook, Ryan, & Hawkins, 2000).

A historical standpoint of research, science and social work

It was not until the Enlightenment of the 17th century that an interest in social reform was able to question the belief in a divine order, and that science was able to expose and illuminate the "Truth" and apply it to the reduction of social problems (Fraser, Taylor, Jackson, & O'Jack, 1991). Clearly the leaders of the charity societies were impressed with the value of science as is evidenced by Josephine Shaw Lowell's 1884 quote: "The task of dealing with the poor and degraded has become a science and has its well defined principles recognized and conformed to closely by all who really give time and thought to the subject" (Kirk & Reid, 2002, p.27).

Religious and philanthropic movements of the late 19th century in Western society were concerned with social problems such as poverty and it was out of these early movements that the profession of social work began. The social workers of the 19th and early 20th centuries are reported to have lacked the ability to work systematically with their clients, or to have gained professional status (Fraser, et al., 1991).

There was not unanimous agreement about the value of science in the charity movement, the alternative case being made that the altruistic spirit of alms-giving and the detached objectivity of science were clearly incompatible (Reid, 2001). Citing Sheffield (1937) Reid provides us with a compelling quote made in earlier times by John Boyle O'Reilly, who believed that having science inform the activities of charity societies was offering assistance in the name of a "cold statistical Christ" (Reid, 2001, p.273). Others were highly

mistrustful about the value of science being able to provide a foundation for practice, some expressing scepticism that the results of casework could ever be quantified (Kirk & Reid, 2002).

Despite some opposition, Mary Richmond, one of the earliest founders of the social work profession, advocated the application of science, now likely to be referred to as qualitative research, in *Social Diagnosis* (1917), the first published attempt to record the practice of casework (Gibbons, 2001). Demonstrating the methodical care with which she approached her work, Richmond wrote that "serious omissions in the social evidence...could result in an incomplete, unscientific and distorted diagnosis which might, in turn, lead to ill-conceived treatment" (Woodroofe, 1962, p.111 cited in Gibbons 2001, p.5). Here, the beginning influence of a medical paradigm can be seen, with Richmond explicitly making the link between evidence, albeit social evidence, a diagnosis, and subsequent treatment.

In their research on the history of science and social work, Kirk and Reid (2002) make the important point that the concepts presented in Richmond's work raise another weighty issue. Richmond's practice framework required practitioners to be scientific in so much as science is "[a] rational, systematic, problem-solving activity involving methods of data collection, attention to the quality of evidence, effort to be objective and unbiased...and so on" (Kirk & Reid, 2002, 30). They go on to outline that although these activities are those of a good scientist, they are also the activities of a good journalist, detective or lawyer and they question "when a rational, systematic, problem-solving activity becomes a use of the scientific method" (Kirk & Reid, 2002, p.30). This question succinctly expresses the tension encountered throughout the literature, both historic and contemporary regarding the relationship between science and social work.

Plotting the influence of science on social work practice, Reid (2001) tells us that although the collection of scientific knowledge relevant to social work was accumulating both in the UK and the USA in the late 19th century via the studies of the poor and the working classes, little of it was directly useful in the day-to-day activities of practice.

Knowledge that was able to be applied usefully to practice began to emerge as a result of the psychoanalytical movement and despite its dubious scientific credentials social workers began to incorporate personality theories and behavioural interventions into their approaches to social problems (Gibbons, 2001; Reid 2001). In the 1930s the experimental tradition began, with a significant study being undertaken in relation to the prevention of delinquency (Trinder, 2000a). Later, in the 1950s a further push to a 'scientific' experimental approach occurred, with the application of findings from randomised control trials beginning to be applied to practice (Trinder, 2000a). Regardless of the fact that this methodological technique was far from unanimously accepted, the substantive findings came to be highly influential as a string of research studies reported that social work was ineffective (Trinder, 2000a).

One of social work's earliest effectiveness reviews begins with the statement, "[t]he core of professional practice is a commitment to competence – a commitment that most directly refers to a concern with the effective carrying out of professional services" (Fischer, 1973, p. 5). This declaration reflects the primary thesis of Fischer's paper, namely that the question of *the effectiveness* of social work practice must be of principle concern to the profession and cannot be ignored. Asserting that no previous comprehensive review of evaluative research on the effectiveness of casework existed in the literature, Fischer set about providing such a review. Fischer's review is noteworthy as it identifies and describes three of the most important challenges associated with effectiveness research which could best be described as being informed by positivist approaches.

The first critical point that Fischer's review highlighted was the understanding that in order to draw conclusions about how effective casework was one first needed to define what casework consisted of *precisely*. Acknowledging that caseworkers do many things in many ways, all of which could legitimately be called casework, Fischer relied on the work of Raimy who was grappling with similar issues in relation to psychotherapy. Paraphrasing Raimy's (1950) work, Fischer "...points to a view of casework as a set of undefined techniques, applied to unspecified problems, with unpredictable outcome. For this approach, rigorous training is recommended" (Fischer, 1973, p. 6). For the purposes of

reviewing previous studies then, this definition of casework explicitly linked the professional activity of casework with the practitioner's professional qualification.

Maintaining the view that defining social workers' activities was less important than defining their educational qualification, Fischer chose a specific professional qualification as the inclusion criteria, along with the success or failure of the intervention having been established by the study. Fischer's first trial then, that of *defining casework,* brings to our attention to one of the most significant challenges associated with this type of effectiveness research. That is, the explicit *defining of the intervention* which is then subsequently linked to outcome. This is commonly described as cause (intervention) and effect (outcome) research.

The second challenge Fischer (1973) identified associated with research of this nature, that had effectiveness as a central focus, was the difficulty of *defining what is meant by effectiveness*. Accepting that the effects of intervention could be demonstrated in a number of ways, from the more observable measures such as improvement in school results to the more subtle measures of psychological changes, Fischer had to rely on general conclusions of the effectiveness of casework. He also raised the issue that given the scope of the change that can potentially result from casework intervention, the development of varying types of criteria may well have resulted in more confidence about the conclusions drawn from the studies.

Fischer highlighted the third difficulty associated with effectiveness research, that of *What counts as evidence*? and how this should be determined. He advised that outcome indicators must be determined in advance of each study. Consequently for Fischer, this review was constrained by the results that were reported in relation to the measures included in the initial investigations, despite the fact that there may well have been other less visible but none the less significant effects of the service (Fischer, 1973). This raises a significant limitation associated with systemic reviews, or meta-analysis, in that the reviewer (Fischer in this case) only had inclusion and exclusion criteria by which to manage the data.

Deciding on a design

One of the central inclusion criteria of Fischer's review was the use of a control procedure which he maintained would minimise alternative explanations for the changes which have occurred. Citing Nagel (1959), Fischer expressed the view that:

> ...data must be analyzed so as to make possible comparisons on the basis of some *control* group, if they are to constitute cogent evidence for a causal inference. The introduction of such controls is the minimum requirement for the reliable interpretation and use of empirical data (Fischer, 1973, p.7).

Fischer's observation brings our attention to the fourth trial that although not specific to positivist- informed effectiveness research, has been identified as posing a considerable challenge; that of *designing an appropriate research or evaluation methodology* which was capable of providing reliable *and* meaningful data.

A careful examination of one of social work's earliest reviews of casework effectiveness provides us with a sequence of significant issues that emerge from effectiveness studies of this nature that are worthy of further emphasis. Fischer identifies the trials associated with defining the three central concepts integral to effectiveness research of this nature, those of intervention, effectiveness and evidence. These challenges continue to be present in the debates surrounding evidence-based practice. The fourth vital issue that Fischer brings to our attention is that in order to produce reliable, valid and meaningful research findings, an appropriate methodological design is required. He does acknowledge that contextual factors must be taken into account for research to be reliable. Specifically in Fischer's review the overwhelming number of service recipients were impoverished, with a subsequent likelihood of this having a bearing on outcomes. One of Fischer's final observations and perhaps one of the most critical for those charged with the provision of social work services, is the need to continue to make judgements in the face of uncertain knowledge. Fischer may well have made this comment assuming that increased certainty was imminent, as my literature review will demonstrate however, as a profession we are perhaps less close to certainty of knowledge than ever before.

First response to 'nothing works'

According to Trinder (2000) the reaction to the 'nothing works' message was varied. For the empirical practice movement, that is, those who relied on experimental approaches, the response was to work harder at proving that the *right* things did work, at least if carefully measured. This movement placed significant emphasis on encouraging social work practitioners to evaluate their practice in an exact way; most particularly through the use of single-case designs, see for example (M. Bloom, Fischer, & Orme, 2003). Simultaneously, a new wave of group experimental designs started to report more hopeful findings about social work's ability to be effective. This was particularly so when practice was based on more structured methods of intervention, such as task-centred practice and cognitive behavioural therapy, rather than the more difficult to define casework approach (Reid & Hanrahan, 1982; Rubin, 1985; Thomlison, 1984; Videka-Sherman, 1988; Wood, 1978).

Reid and Hanrahan (1982, p.328) provided reassurance that "...earlier pessimism about the effectiveness of these methods is no longer warranted." Yet, despite a number of reviews counteracting Fischer's findings, social workers remained under growing pressure to increase the empirical base on which practice knowledge could be developed. In a reassuring tone others proclaim that "[t]he controversy of the seventies, fuelled by incongruent findings between practitioners and researchers and overstated conclusions that 'nothing worked' has been resolved" (Thomlison, 1984, p.51). Regrettably Thomlison's proclamation that these controversies have been resolved was premature as the debates about 'what works', and how to demonstrate effectiveness continue to rage to this day (Shaw, 1999; Sheldon, 1986; Sheldon, et al., 2005; D. Smith, 2004b; S. Smith, 2002; Thyer, 1996; Trinder, 2000b; Webb, 2001; Witkin, 1998).

In spite of their obvious limitations there is some clear value in some of the earliest effectiveness reviews. Of particular interest in Wood's 1978 review was the commitment to analysing the research literature from the standpoint of social work practice, and the social work practitioner. Wood was clear that global questions such as 'Is social work effective?' make little sense as a research activity and merely result in confused and defensive reactions from the profession. As a counter to previous global approaches Wood was interested in questions with a much sharper focus in the hope of discovering what

practitioners could usefully learn from research. Wood believed that questions such as ‘Why was the intervention successful?’ and ‘What prescriptions of practice theory have been validated?’ would not only better meet the needs of practitioners, but would also constructively inform researchers and social work educationalists more than previous reviews had been able to (Wood, 1978).

This study’s primary interest was to determine to what extent the research ventures had added to (or taken away from) the theory that informs practice. Consequently Wood was highly critical of studies that failed to provide the reader with “...specifics about the clients, conditions, interventions, and changes” as in her view “[s]uch research can give little information about whether practice is effective, or how to make it more effective” (Wood, 1978, p.451). Although these concerns are similar to those raised by Fischer, Wood’s review was centrally focused on how best research could serve practice, whereas Fischer’s critique was concerned with the overall validity of the practice.

Wood approached the literature quite differently to the previous reviews. By grouping the studies into particular groups of clients, and the outcomes of particular models of intervention, Wood was able to extract what she described as six principles of ‘quality practice’. These principles were: accurate definition of the problem; analysis of the problem – factors creating or maintaining the problem and factors that can help resolve it; assessment of the problem’s workability and setting of goals; negotiation of a contract with the client; planning a strategy of intervention and lastly, practice evaluation that involved the client’s experience of the intervention (Wood, 1978, p.451).

The emphasis Wood places on practitioner evaluation that seeks to include the service-users’ experience of the intervention is interesting. This may reflect the quality of the relationship between client and practitioner which has consistently been identified as central to effective outcomes (Poulin & Young, 1997; Young & Poulin, 1998).

Wood also made the case that these aspects of quality practice were not new but had in fact been reflected in social work practice theory over a substantial period of time. Asking serious questions about the competency of practitioners she noted that “[t]hey skipped or

carried out inadequately one or more of the crucial steps in the practice process and instead imposed on clients their preferred ideology of intervention" (1978, p.455). Somewhat contradictory to this point she also declared that different theories were useful for "...some people, with some problems, in some situations" and emphasised the fact that these "techniques were merely tools, good only for the job for which they were fitted" (Wood, 1978, p.455).

At the conclusion of her review, Wood made a plea for a more integrated approach between practice, research and education, challenging each section of the professional community to take more account of the other. The specific advice to practitioners was to apply more thought and methodological rigour to their practice, whilst advising researchers to produce studies that focus on process as well as outcome. Her advice to educators was to "...improve their teaching of research and make it more relevant to the needs of students of direct practice" (Wood, 1978, 456).

In summary, Wood, like Fischer makes an important contribution to the development of effectiveness studies and draws attention to a number of critical issues that also have an alarmingly contemporary ring to them. When writing thirty years ago Wood is clear; research is best designed in order to support the standpoint of practice and practitioners. In doing so she highlights the gap between research and practice. She also outlines six broad principles of quality practice, in place of definitive models or theories. Wood is unequivocal regarding the social work practitioner being a "craftsman [sic] – an expert in helping people to solve problems in living – not a priest or a guru attempting to impart his or her own theoretical 'religion' on the unsuspecting clients" (1978, p.454).

Second response to 'nothing works'

Acknowledging the controversy that has been raging in the social work literature for the previous two decades regarding the capacity of social work to demonstrate effectiveness, Reid and Hanrhan's 1982 review (referred to above) aims to set an optimistic tone by declaring that "...earlier pessimism about the effectiveness of these methods is no longer warranted. A brighter picture is emerging, based on the development of new forms of practice and better designed experiments" (Reid & Hanrahan, 1982, p.328). Like Wood and

others before her, these authors emphasise that from a research perspective, global questions which ask ‘Is social work effective?’ are almost meaningless and are of little value in any well-informed inquiry related to the methods of the profession. Instead they were interested in “[h]ow effective is a particular program with a particular type of client?” (Reid & Hanrahan, 1982, p328).

Reid and Hanrahan suggest that these questions about the effectiveness of social work interventions remained critical to the profession’s struggle to survive and grow. Stressing that these unanswered questions were a source of professional controversy they also name a number of other significant parties, such as policy makers and funding bodies, and members of other professions who may also “...be troubled by the fact that wide-ranging questions about effectiveness have been raised and not satisfactorily answered” (Reid & Hanrahan, 1982, p.328). Claiming that whether the question has substance or not, it has “worked itself into the intellectual life of the profession” (p.328) and consequently they contend that in order to reduce the risks of it culminating in a lack support for social work, it requires a satisfactory answer.

Advising that in order to satisfy the profession’s constituents it is critical to provide “respectable scientific evidence that programs carried out by social workers do achieve results” (p.328), they claim that controlled experimental studies have traditionally been viewed as able to provide “[t]he most definite evidence on the effectiveness of service...” (Reid & Hanrahan, 1982, 329). Whilst acknowledging that previous designs had been justifiably criticised on a number of grounds these authors “...were interested to see what evolution, if any, had occurred in the kinds of experimental designs customarily used in rigorous tests of the effects of service” (Reid & Hanrahan, 1982, p.328-329). It appears then that out of the numerous possible responses to the failure of previous reviews to demonstrate effectiveness these authors chose to look for improvements in a specific type of design, as the most appropriate way to demonstrate social work’s capacity to be effective. This has some obvious consequences, as clearly some interventions, for example, behaviour modification, are going to be better suited to this type of design than others, as is readily conceded by the authors.

Reid and Hanrahan emphasise that the new forms of practice that dominate the review will influence everything that they are able to reveal. An examination of the interventions applied being the essential starting point to this particular review; they outline the following significant trend,

> ...one is struck by the dominance of structured forms of practice in these experiments – that is, of practice that takes the form of well-explicated, well-organized procedures usually carried out step by step and designed to achieve relatively specific goals. The influence of the behaviour modification movement is apparent and pervasive (Reid & Hanrahan, 1982, p.329).

This discovery is in stark contrast to the earlier reviews in which the interventions were more broadly described as 'professional casework' and to the degree that this practice was theoretically influenced; the orientation of psychodynamic thinking had been evident (Reid & Hanrahan, 1982).

Elaborating on the impact of these more recent types of well-structured and well-illuminated studies the authors explain that it was relatively clear – especially in relation to previous experiments – the exact nature of the experimental variables and what they consisted of. By way of example the experiments provided descriptions of particular procedures, such as assertiveness coaching, to support a specific change in client behaviour. They argued that this is easier to comprehend than something merely described as 'intensive casework'. Despite this improvement in the provision of practice detail however, they also note that these experiments continue to fail to provide enough specificity regarding *how* the intervention was actually carried out, thereby preventing a direct impact on future practice via attempts at replication of the intervention.

The range of service-users involved in these studies was described as 'traditional clientele' by the authors, for example, children with behaviour problems. The other important point these authors make however is that only *one* of the studies provided interventions to service-users who were in receipt of 'public assistance'. In doing so they are acknowledging that these studies did not involve services to people impacted by the effects

of poverty. It is hard to imagine then, that these service users would in fact be traditional clientele of social work.

The other substantial differences identified in these more recent experiments related to matters of design, specifically the targets being measured; the smaller sample sizes and the degree of control over service-related variables. The outcome measures often relied on the performance of behaviour change in simulated situations as opposed to 'real life'. The fact that the researchers were largely based in schools of social work and had not only planned the interventions but had also taken responsibility for their implementation and measurement was recognised as a risk of bias (Reid & Hanrahan, 1982).

The large majority of these studies were able to demonstrate positive outcomes, and yet whilst acknowledging this as heartening, the authors caution against complacence. Recognising that the studies did produce results which were statistically significant, Reid and Hanrahan also concede that "...the practical significance of the effects in many appeared to be limited" (Reid & Hanrahan, 1982, p.331) and that data collected immediately after the termination of the service, and demonstrated via activities such as role play, are less reliable than other outcome measures.

Reid and Hanrahan offer us tentative conclusions from this review, claiming that interventions offered by social workers can be effective and that "...these small successes of the present are better than the grand failures of the past" (Reid & Hanrahan, 1982, p.338). One thing that particularly stands out is their statement that:

> [a]t least the weight of recent evidence should give pause to social work's detractors, reassure its supporters, and, *above all*, provide added justification for its existence (Reid & Hanrahan, 1982, p.338 emphasis added).

As an outcome of this review they tell us that structured approaches to practice, designed to address specific problems, *are* able to support constructive changes. They also acknowledge that the practical implications of these changes and their durability require further evidence to be convincing. Lastly, the authors ponder whether the greatest significance of this review was "...the evolution that has occurred in the methodology of

experimental social work" (Reid & Hanrahan, 1982, p. 338). Given the tentative nature of the outcome of their review is seems rather a stretch to claim, as they have, that these findings provide further justification for social works existence.

Striking then, in Reid and Hanrahan's review, is the articulated association between the need to provide *definite evidence on effectiveness* and *respectable scientific evidence*, in order to reduce the perceived vulnerability of the profession by *providing justification for its existence*. It is also significant that these requirements are being authoritatively linked with controlled experiments and a positivist research paradigm as superior to any other possible methods of demonstrating effectiveness. This review signals the considerable shift towards more structured forms of practice, coinciding with an evolution in experimental research design – resulting in an advantageous match between method of intervention and research design.

In light of the findings outlined above we may ask if what we are seeing in Reid and Hanrahan's (1982) review is the profession of social work succumbing to the pressure to demonstrate effectiveness at any cost. Not only are the clientele involved in these studies significantly different to the subjects of study in previous reviews, the actual focus of the interventions and the long term practical application of the changes achieved result in a sizeable doubt about the overall value of these findings and their relevance to the day-to-day reality of practice.

A move towards evidence-based practice

Reid and Hanrahan's review signals the emergence of a significant move towards the contemporary evidence-based practice movement with its reliance on a particular type of evidence as being of better quality than other forms. Significant in this is an ever increasing emphasis on the employment of a particular scientific paradigm, without concurrent consideration being given to what this might mean for the profession's aims and values. Most particularly deficient is the traditional area of focus for social work practice, namely that of furthering the aims of social justice. The absence of any consideration being given to alternative research paradigms, which may well be able to demonstrate effectiveness whilst also furthering the wider objectives of the profession is also notable. The substantial

critiques and limitations of these designs will be explored more fully in the current debates surrounding evidence-based practice. Prior to moving into this wider area of debate however, the most current social work effectiveness meta-analysis will be reviewed.

Reid and Fortune (2003) provide social work with one of the most contemporary reviews of effectiveness studies in a book devoted to the subject of practice guidelines. Perhaps one of the most potent symbols of evidence-based practice, they propose that "insofar as possible, practice guidelines in social work should be based on interventions of demonstrated effectiveness" (Reid & Fortune, 2003, p.59). The ultimate aim of this type of science then is its capacity to produce robust scientific outcome findings in order that they may subsequently inform the development of practice guidelines (Reid & Fortune, 2003).

Reviewing empirically tested social work intervention programmes that were published in the USA for the decade of 1990–1999 these authors maintain a focus on the intervention programme rather than the individual study. Describing a relatively inclusive definition of what makes up an empirically tested intervention; these authors include both experimental and quasi-experimental designs. They confined their review to programmes reported in the literature that had at least one social work author, or were directed by a social worker. Programmes were defined as being of social work in nature provided they involved direct work with clients, including caregivers, in order to bring about changes, or improve problems in their lives (Reid & Fortune, 2003).

In total, 130 programmes were identified, with the majority of programmes having been evaluated by the practitioners who designed and implemented them. The programmes were subsequently coded on the basis of the multiple characteristic of each programme, and the methods used to evaluate them. The reviewers also sent out a questionnaire to the principal author as they were interested in knowing if the practitioner carrying out the intervention had access to, and made use of practice protocols, or guidelines. They were also interested in whether these guidelines were available to others wanting to implement the programme. Their response rate, boosted by telephone follow up, was 80 percent (Reid & Fortune, 2003).

Because of their interest in forming a foundation for practice guidelines, these reviewers targeted programmes that were able to demonstrate effective outcomes, *and* were able to be replicated. Achieving effectiveness criteria were defined as the programme having realised a positive outcome for a minimum of one tested variable. A positive outcome was defined as a statistically significant difference, on the variable, between those who received the intervention and those who did not. 'Replicability' was defined as there having been evidence that practice guidelines were available or that the programme was described in enough detail in either the evaluation report or the literature for others to implement it subsequently. Of the 130 programmes 107 met these criteria (Reid & Fortune, 2003).

These authors tell us that they were able to meet a higher rate of replicability because of their personal efforts to contact the writers, and concurred with Rosen, Proctor and Staudt's (1999) findings that interventions were often poorly described by those that were evaluating them, thereby limiting their subsequent replicability. In this review however, 63 percent of the programmes were able to meet replicability criteria. As well, 46 percent of authors were able to claim that their programmes had been put in place after testing, with approximately one-third being able to claim that practice guidelines had been used in at least one of these implementations (Reid & Fortune, 2003).

Reassuring the social work profession, Reid and Fortune tell us that the good news is that in a large proportion of the programmes' guidelines were available, and were used to support implementation. Reid and Fortune tell us the bad news is that they are still talking about a very small number of effective programmes in which practice guidelines were actually used to guide interventions (Reid & Fortune, 2003).

Although claiming that the problem areas covered by the review spanned the major areas of social work practice, the majority of the programmes involved clients with serious mental illness with a lesser focus on substance abuse, and child/youth behaviour. They also identified a focus on primary prevention (12 programmes) with the focus on substance abuse. The majority of health studies related to the area of HIV and AIDS, and working with the aging population. The authors make particular note of the lack of attention to health issues (Reid & Fortune, 2003).

A total of 58 percent of these interventions employed small group programmes, with only 20 percent of the sample centred on services for individuals; another nine percent focused on family interventions. The vast majority were short-term programmes, with 62 percent reporting the duration of 12 weeks or less and 12 percent of the programmes lasting longer than one year. Every programme was developed to attend to very specific problems, for example, the prevention of unsafe sex by drug addicts. Interested in whether common elements existed in the intervention programmes, the researchers employed a coding system in order to capture this information. The authors only coded a particular technique or approach if the authors of the study mentioned it explicitly, with 'use of relationship' only coded if it was included explicitly in the published description. Although they acknowledge the limitations of such an approach, they also claim to have captured the distinctive aspects of the programmes (Reid & Fortune, 2003).

Although many programmes drew from a variety of intervention approaches, often combining them, such as social networking, and cognitive-behavioural skills, it was cognitive-behavioural interventions and approaches related to this modality that dominated the review. These 'action-oriented' approaches (54 percent) included "cognitive-behavioural, learning theory, problem-solving, and task-centred practice" (Reid & Fortune, 2003, p.65). The next most frequently cited approaches were psycho-educational, being applied by 21 percent of programmes. These had been combined with individual support, and the development of coping skills.

In summary, the most common interventions relied on in this study drew heavily on cognitive-behavioural approaches. The authors comment that "[p]sychodynamic and other humanistic approaches play only a very minor role in this set of programs, in stark contrast to their popularity in the world of social work practice" (Reid & Fortune, 2003, p.66). They also observe that various approaches that are emphasised in social work education are underrepresented, such as empowerment and generalist approaches. Lastly they suggest that the focus on group interventions is less characteristic of much social work practice (Reid & Fortune, 2003).

Almost a quarter of the programmes relied on a highly structured format including the use of lecture-like presentations, reading material and/or videos. The next most represented (43 percent) were programmes with significant structure but which included an expectation of individual difference. Few of the programmes used a loose structure, with a reliance on participants to dictate the direction. In summary, the cognitive-behavioural approaches tended to be very structured, with more case management type programmes being much less structured. In 60 percent of the programmes, formal instruction, such as education and training modules were relied on. Primarily some version of cognitive-behavioural skills training was employed by the programme, for example problem solving. They also established two clusters of combined interventions. These included "case management, concrete services and the use of relationship" and "group approaches that made use of skills training, education and group processes" (Reid & Fortune, 2003, p. 67). The authors argue that this level of reliance on structure is another significant difference between the empirical world, and the ordinary world of social work practice (Reid & Fortune, 2003).

A selection of experimental designs was relied on, which these authors maintain were categorised by a number of strengths. Sixty percent relied on randomised designs, with a further eight percent relying on strong quasi-experimental designs. Sixty-three percent of studies had sample sizes larger than 50, with a total of 43 percent receiving follow-ups of at least six months.

Reid and Fortune are encouraged by the great majority of programmes having been able to demonstrate positive outcomes, stating this result is "a far cry from the generally negative findings in the experiments of a generation ago" (Kirk & Reid, 2001 cited in Reid & Fortune, 2003, p. 69). They are clear however that their optimism remains tempered by a number of cautions: firstly, 90 percent of the effective and replicable programmes were evaluated by the practitioners who developed them, or by evaluators that appeared supportive of the programme; secondly, the majority of the designs (41 percent) employed some version of no-intervention control, claiming the limitations of such studies relate to their inability to control for common factors, such as attention. They consider that a superior design would include the use of a no-intervention control and alternative interventions which were only employed in 17 percent of evaluations; and lastly, there were

almost no replications of studies undertaken by independent investigators, a practice which is considered necessary to reduce doubts about bias (Reid & Fortune, 2003).

Reid and Fortune advise that the positive findings suggest that the social work profession has made progress regarding the ability to identify effective interventions. They were encouraged that the majority of these evaluations did rely on protocols which would subsequently be made available to others. In conclusion they propose that the review relates to the “two overlapping worlds of practice” (Reid & Fortune, 2003, p.70), defining one of these worlds by the experimental programmes they have presented, and the other being made up of “the kind of practice in which social workers ordinarily engage” (Reid & Fortune, 2003, p.70).

Although acknowledging areas of similarity, these authors also make the point that these ‘two overlapping worlds of practice’ move away from each other in important areas. Essentially this divergence relates to the world of experimental practice where interventions are highly structured, are likely to employ group approaches informed by cognitive-behavioural theory and with a focus on primary prevention. On the other hand, the world of everyday practice is likely to employ a variety of approaches that rarely manifest in the tested programmes, such as ecological or generalist approaches. They make these generalisations on impressions from the literature arguing a lack of hard data to refer to, at the same time claiming “they are not inconsistent with what meagre information exists on what social workers actually do” (Reid & Fortune, 2003, p.70). In their final paragraph these authors argue that the best way to resolve the current disparities between the two worlds of practice is by more rigorous appraisal of social work approaches which may well be of value, but to date remain under evaluated. They make this plea on the basis that until such an undertaking is achieved, practice guidelines based on empirical findings, for the full range of interventions social workers undertake, remain out of the profession’s reach.

I have undertaken a thorough examination of Reid and Fortune’s (2003) systematic review of social work effectiveness studies. The hope is that by engaging with this contemporary review in detail, we are able to consider what progress the empirically based practice movement has made over the previous three decades since Fischer’s 1973 review and

identify the persistent themes, challenges and limitations associated with this approach to research.

The origins of evidence-based practice

Hanrahan's 1982 review signalled a move towards evidence-based practice and since that period social work practitioners have been increasingly encouraged to engage in research and evaluative activities in order to justify services, and demonstrate effectiveness (Auerback, et al., 2000; Blumenfield & Epstein, 2001; Christ, 1995; Dziegielewski, 2004). They are also increasingly required to base the interventions, and programmes they provide to service users, on sound evidence. This move towards practice being increasingly informed by research and its evidential findings is commonly referred to as evidence-based practice, empirical practice, or evidence-led practice. For the purposes of this review, I will use the term 'evidence-based practice'.

Although not widely acknowledged in the social work literature, the success of the evidence-based movement in medicine has been limited, with the main opposition to it being centred around the "[c]onflict within medical practice between 'art' and 'science', 'practice' and 'evidence'" (Pope, 2003, p.267). In spite of its limited uptake by the medical fraternity, evidence-based practice in social work is founded on the transfer of the same concepts, namely those of the explicit use of evidence to inform practice, and the development of a hierarchy to rank the particular forms of evidence one should be relying on, to inform practice decisions (Bilson, 2005; D. Smith, 2004a). Although social work can clearly demonstrate a history of concern with effective outcomes that dates back to its earliest origins, (Gibbons, 2001) the evidence-based practice movement is more readily associated with the British modernisation agenda attributed to the New Labour governments of 1997 and 2001 (D. Smith, 2004a).

This commitment to supporting evidence-based practice in the areas of both health and social care is demonstrated in the 1999 funding of the National Institute of Clinical Excellence (NICE), and in 2001, the Social Care Institute for Excellence (SCIE) (Fisher, 2002) both in the United Kingdom. The timing of the establishment of these 'institutes of excellence' reflects the social work pursuit of evidence-based practice having been strongly

influenced by our colleagues in medicine. It was hoped that this excellence would be achieved not only by the development of knowledge about best practice, but also the careful dissemination of that knowledge (D. Smith, 2004a).

Claimed as "generally agreed upon" (Plath, 2006, p.58) this definition is relied on by Plath as she reflects on the current and future directions of evidence-based practice in social work:

> Evidence-based practice is the conscientious, explicit and judicious use of current best evidence in making decisions regarding the welfare or care of individuals, service-users, clients and/or carers (synthesised from Gambrill, 1999; Gibbs & Gambrill, 2002, p. 452; Millen, 2002; Centre for Evidence Based Social Services (CEBSS, 2003, cited in Plath, 2006, p.58).

Plath argues that "[i]nformed decision making by practitioners is central to this definition of evidence based practice" (Plath, 2006, p. 58) stressing the view that clinical decision making is a *process* and that this *process* allows room for a multiplicity of practitioner responses to particular issues. Conversely we can see by Macdonald's definition below, that few loyal supporters of evidence-based practice centralise practitioner choice as Plath has done.

Geraldine Macdonald is probably one of social work's better known advocates of evidence-based practice. Writing about effective interventions in child protection practice Macdonald (2001) challenges practitioners to consider the effects of their actions on the children they serve, pointing out that good intentions alone risk causing harm rather than good. Macdonald provides this definition of evidence-based practice:

> Evidence-based practice indicates an approach to decision making which is transparent, accountable, and based on a careful consideration of the most compelling evidence we have about the effects of particular interventions on the welfare of individuals, groups and communities (Macdonald, 2001, p.xviii).

These adaptations, with their various inclusions, and exclusions and their particular emphasis provide us with important insights as to the various manifestations of evidence-

based practice. These manifestations fall broadly into two versions of evidence-based practice, one relying heavily on a scientific and evidential paradigm, and the other more inclined to an artistic, reflective or practice-based paradigm.

The broad-stream, narrow-stream metaphor

Shaw provides us with a useful metaphor to help develop our understanding of the various manifestations of evidence-based practice, having described them as the broad- stream or the narrow-stream approach. He asserts that the broad-stream version is primarily practice driven and maintains a focus on accountability, partnerships between practitioners and researchers, and a broad obligation to base practice decisions in evidence (Shaw, 1999). The broad-stream version of evidence-based practice includes a programme to support easier access to data, the promotion of the dissemination of research findings in easy to understand formats, and a focus on outcome issues in practice. A combined emphasis on incremental and achievable practice development is also maintained. According to Shaw these commitments are taken up by the majority of educators associated with social work in the United Kingdom, the United States, and Australia (1999).

This broad-stream approach to the use of evidence in practice reflects a shared responsibility between practitioner and the organisations we work in. In the current context, after the introduction of the Social Work Registration Act 2003, this commitment is embedded in policy that dictates the amount of hours registered social workers must engage in continuing professional development activities, such as participating in a journal club.

On the other hand, Shaw described how the narrow-stream variety of evidence-based practice has been primarily driven by academia, and maintained a powerful association with the empirical practice movement originating in the USA. Engaging in a more confined use of the term evidence-based practice, these commentators take up many of the aspects of the broader stream, but are also strident supporters of particular interventions. They support those based on behavioural and cognitive theories, particularly those that have been demonstrated to be effective via the application of experimental and quasi-experimental research methodologies (Shaw, 1999), see for example Reid & Fortune, 2003 cited earlier.

Brian Sheldon, one of Britain's most staunch advocates of evidence-based practice and director of the Centre for Evidence-Based Social Services (CEBSS), is responsible for the adaptation of Sackett and his colleagues' definition relied on by Plath (2006) and sited earlier in this chapter (page 37). In their Editorial in the British Medical Journal Sackett and his co-authors define evidence based medicine as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett, Rosenburg, Muir Grey, Haynes, & Richardson, 1996). Maintaining that evidence based medicine relies on the integration of best available clinical evidence *and* clinical expertise they are clear that patient choice must also be taken into account resisting the notions of "slavish, cookbook approaches to evidence based medicine" (Sackett, et al., 1996).

One author expresses suspicion about Sheldon's adaptation, making the point that "[w]hat has disappeared from the original definition is as significant as what is retained" (Smith, 2004, p.8). Drawing on Taylor and White's (2002) remarks, Smith highlights the fact that Sheldon's adaptation fails to mention or acknowledge either the skills or the experience of the practitioner. Worthy of consideration is their reflection that "[e]verything that counts as evidence comes from outside rather than from within the practitioner's own experience, and there is no mention of the individual skills and qualities of the worker" (Smith, 2004, p.8). Macdonald's definition also fails to acknowledge the skills and qualities of the worker, and in fact places emphasis on 'the most compelling evidence'. One can assume, given Macdonald's partiality towards randomised controlled trials, that this is a reference to evidence acquired via this methodology.

Sheldon, well known for his strident opposition to the social workers' predilection for 'fads and fashions', argues that social workers must not base their decisions on "subjective preferences or 'favourite ideas and theories'..." but rather "to choose 'helping recipes on best available evidence' and to apply them 'cautiously and within their known scope'" (Sheldon, 1998, p.16 cited in Smith 2004, p.8). Reassuring is Sheldon's acknowledgement that they should be applied within an appropriate setting, and with caution, an aspect of Sheldon's position that is rarely mentioned by his critics, (see for example Witkin, 1998). It

is Sheldon's use of the recipe metaphor that has invoked strong criticism from opponents to the 'narrow-stream' version of evidence-based practice.

Despite this criticism Sheldon and his largely positivist adherents have expressed little doubt up to now that *it is* possible to definitively establish particular interventions as more effective than others, and he could therefore be described as occupying the narrow- stream position in the evidence-based practice debate. Arguing that once the efficacy of particular intervention has been established to a high enough standard in scientific terms, these enthusiasts believe that social workers are obliged to offer these interventions as *first choice treatments* to their clients (Thyer, 1996, p.179, emphasis added).

Thyer, through the late nineties, as a sole author or in collaboration with colleagues, produced a series of articles related to the issues surrounding empirical practice and the 'rights' of clients to be offered effective treatment (Gorey, Thyer, & Pawluck, 1998; Myers & Thyer, 1997; Thyer, 1996). These articles represent the extremes of the debate, and although the empirical practice movement remains a minority voice in the debate, it is none the less a well-organised (Trinder, 2000a) and articulate voice. In the 1996 article Thyer reviews 40 years of progress towards empirical practice and, although he does acknowledge previous challenges associated with establishing an empirical base for social work, he maintains that these challenges have been largely overcome. On this basis Thyer cites four reasons as to why social workers are now able to engage more fully with this empirically driven or narrow-stream version of evidence-based practice: firstly, the emergence of hundreds of rapid assessment tools "covering virtually every client problem and situation likely to be encountered by social workers" (Thyer, 1996, p. 79); secondly, the development of single-system designs which allow social workers to "empirically evaluate the outcome of their work with clients" (Thyer, 1996, p. 79); thirdly, the existence of a significant body of evidence that has successfully demonstrated the effectiveness of particular psychosocial interventions, with certain types of problems; and lastly, what he refers to as "an increasing respect for the principle of 'accountability'" (Thyer, 1996, p.79).

Engaging in a meta-analysis of social work research undertaken through the early nineties, in the 1998 article, Thyer and co-authors discuss the differential effectiveness of prevalent

social work practice models (Gorey, et al., 1998). There are three points of particular interest in this article: firstly, the explicit acknowledgement that cognitive behavioural studies largely outnumber studies undertaken in relation to other models of practice, "yet no substantive evidence for their greater effectiveness was observed" (Gorey, et al., 1998, p. 279); secondly, the respectful invitation to their researcher-practitioner colleagues who are employing models less well represented in the literature to customarily report what they are learning with their clients; and thirdly, that practitioners employing "a person-in-environment framework do very effective work, particularly when the problem is defined as one that transcends the individual – that is, the problem does not reside somewhere "under the client's skin" (Gorey, et al., 1998, p. 275).

In the1997 article, Thyer in collaboration with his doctoral student, Myers, asks the question 'Should social work clients have the right to effective treatment?' and then proceeds to mount a vigorous argument, on ethical grounds, that such a right exists. Their line of reasoning begins with the scenario of a medical doctor and his/her patients' right to validated treatments, as opposed to "other treatment based on his or her own interests, training, or beliefs" (Myers & Thyer, 1997, p. 288). Curiously, their case is based on the assumption that the answer to the question is so obvious it barely requires an answer. As outlined earlier in this chapter however, there is by no means unanimous agreement amongst the medical fraternity about the exclusive application of evidence in medical decision making. In fact, just as in the social work literature the position has been taken by medical commentators that "the complex and dynamic nature of everyday medical work means that it is vital that evidence is balanced with practice" (Pope, 2003, p.279).

The narrow-stream advocates of evidence-based practice such as Thyer, Sheldon, MacDonald, Bloom and Fischer as cited in my review, are strongly committed to a 'scientific' paradigm both in relation to research and practice. This of course, carries a number of risks, including the omission of all evidence that has not been acquired via what they consider to be acceptable scientific methods. There are numerous critics of this paradigm, maintaining that it rests on a deep-seated misconception of the nature of both social work and the social world (D. Smith, 2004a).

Clearly many do agree that evidence-based practice is an appealing prospect (Plath, 2006) and there are few who would quarrel, from a moral perspective, on the need for evidence of effective interventions, particularly in the highly fraught areas of practice, such as child protection (Pritchard, 2004). There is also vast agreement that it is possible to generate results that do count as evidence and that social work practitioners ought to make ourselves aware of, and attend to these findings, using them to inform practice interventions in order to support more effective outcomes. In summary then, the evidence-based practice movement is founded on three central concepts; those of interventions, effectiveness and evidence. These concepts will be examined in order to expose the misconceptions referred to above and highlight some of the specific difficulties encountered when we attempt to apply the narrow-stream construction of evidence-based practice to the activities of social work and social work research.

Clearly the day-to-day activities that many social work practitioners engage in are difficult to describe and define in terms of discrete interventions (Plath, 2006). Plath expresses the view that it is unlikely that a practitioner, upon receiving a referral and undertaking an assessment, will make a straightforward choice based on the evidence she has at hand regarding the effectiveness of intervention A or intervention B. Rather, the social work practitioner is required to engage with the client and assess his/her needs, and appropriate interventions, whilst taking into account various contextual and client circumstances. The primary consideration in making intervention choices is rarely what has been established empirically to be effective (Plath, 2006).

Expressing discomfort with the products of reductionist experiments and noting the challenges of undertaking experiments on people outside of laboratory conditions, Gibbs refers to Goldstein's contention that: "[b]y design, the scientific method must either ignore the tender qualities of moral, spiritual, imaginative, creative and other subjective experiences, or painfully distort them into quantifiable variables" (1998, p. 3 cited in Gibbs, 2001, p. 696).

These experiments, often carried out in laboratory type conditions, with practice that takes a highly structured form (Epstein, 1990) are difficult to translate into skilled social work

interventions at the front line. Cheetham et al (1992) also note that experimental designs are best suited to an evaluation which maintains a focus on very specific, self-contained interventions more readily than on the entire complexities of a multifaceted service. These authors have highlighted the limitation of such narrowly defined interventions, and the versions of evidence that Reid and Hanrahan's 1982 review revealed were dominating the published literature.

As a counter to these approaches Shaw and Lishman, in their book on the evaluation of social work, asked contributors to maintain a focus on evaluation that included the examination of how effective social work is experienced by users, including both clients and carers. They argue that in order for examinations such as these to be useful they need to take account of contextual limitations including, economic, political, social and legal factors. They also advocate that matters such as available resources, and the specific roles and responsibilities of the social workers, be taken into account when evaluating the effectiveness of particular interventions (Lishman, 1999).

Another significant challenge associated with establishing the effectiveness of a particular intervention is the capacity to separate the outcome from the process. David Smith (2004) asks the question, 'If a social worker is able to demonstrate a successful outcome with a service user, is this supporting evidence for the theory, framework or intervention she has employed, or is it evidence that she is a skilful, empathic and effective worker?' Selena Smith, on the same subject tells us that much of the emphasis in social work literature has been on *if* interventions are effective with minimal attention being paid to *why* the intervention works (S. Smith, 2002). In the face of this lack of attention to why interventions are successful Smith's 2004 question above remains difficult to answer.

Having outlined the complexities of defining an intervention, taking account of the contextual factors, and considering both the *if* and the *why* of the effectiveness of a particular intervention, it is little wonder that a number of authors are cautious about the compatibility of the narrow-stream version of evidence-based practice, with the ways that many practitioners approach their practice (Shaw, 1999; D. Smith, 2004a; S. Smith, 2002; Trinder, 2000b; Webb, 2001; Witkin, 1998).There is disquiet that within this version of

evidence-based practice those approaches which could be described as more discrete, treatment-oriented methods will be given an elevated status. Hence the reductionist, rationalist, mechanistic style of practice is being favoured (Plath, 2006; Trinder, 2000b; Webb, 2001) over the less tangible tasks and activities relevant to social work, such as advocacy or achieving the aims of increased social justice.

This tendency to privilege particular interventions over others is demonstrated in the first chapter of O'Hare's book as he describes a 'comprehensive strategy for conducting assessment, intervention, and evaluation' for evidence-based social work practice. In the preface he acknowledges that "*...no single practice theory provides a sufficiently comprehensive and valid foundation for understanding and treating the full range of serious human problems confronted by social workers*"(O'Hare, 2005, p.4). In his description of an evidence-based strategy he encourages social workers to give priority to those interventions proven to be effective in controlled trials. This is a clear example of not only favouring particular interventions over others, but also elevating particular types of evidence over others.

Evidence

The literature provides multiple accounts of what constitutes evidence, and more specifically 'best' evidence. Within the social work literature these differences regarding the type of evidence believed to be legitimate or of value are influenced by the various researchers' ontological and epistemological positions. These differences and the debates that rage around them have been referred to as the 'paradigm wars', (Lishman, 1999; Trinder, 2000a) and of late, it seems that there is less tolerance for engaging in such dichotomies (Gibbs, 2001; Lishman, 1999). Lishman helpfully points out that engaging in such debates prevents us from participating in a realistic consideration of both the strengths and the weaknesses of particular methodologies and the evidence these methodologies are able to produce.

Gibbs makes the case that effectiveness in social work is best represented by the outcomes derived from both quantitative and qualitative studies; producing both 'hard' and 'soft'

evidence; featuring the detail of process and meaning, as well as bare statistical description. Her description of evidence is as follows:

> 'Evidence' must be viewed as a social construct and reflect the many meanings that practitioners and service users may put forward to indicate success. Concepts like culture, spirituality, warmth and empathy are difficult to measure as evidence yet they are clearly linked to effective social work (Hodgson and Heckbert, 1996; cited in Gibbs, 2001, p.10).

There is acknowledgement in the literature that social work has led attempts to involve service users in the research agenda, none more so perhaps than in the disability, feminist, multicultural and indigenous movements (Shaw, 1999). Taylor's research involving children in care not only highlights how critical it is to define what is to count as a positive outcome, she also emphasises the value of attending to those whose voices that have often been ignored, particularly in the area of policy development and the allocation of resources (Taylor, 2004).

In setting out to appraise the evidence for what is effective social work practice with people who experience disability, Sapey begins by posing two important questions. The first "...Is it possible to determine what evidence there is for effective practice without first gaining agreement on what the aims of providing social work services are?" and secondly, "How should evidence be produced – by disabled people, social workers or academic researchers?" (Sapey, 2004, p.143). Sapey's questions are important as they highlight the fact that there are risks inherent in failing to make available for review our taken-for-granted assumptions regarding what does in fact, constitute an effective outcome.

Unlike commentators who are inclined towards definitive outcomes, proven by science and assessed on the basis of evidential hierarchies, Sapey proposed that it is people who experience disability that are in the best position to describe effective outcomes, and that any descriptions of outcomes will inevitably be influenced by the assumptions, beliefs and word views, held by those posing the questions.

As stated in my review, evidence-based practice in social work has been strongly influenced by the medical discourses and as such, the favouring of the evidence produced as a result of randomised control trials is still described by some as the 'gold standard' in evidence (Gueron, 2007; Tanenbaum, 2005). The influence of the positivist paradigm in social work research is most evident by a demonstrated preference for experimental methods, single-system designs, randomised control trails and systematic reviews of research (Macdonald, et al., 1992; Myers & Thyer, 1997; Reid, 2001; Sheldon, 1986) which abound in the literature and have been cited in my review.

Advising on the subject of assessing the level of evidence required for the purposes of selecting appropriate interventions, Vonk et al (2007) suggest that the level or strength of the evidence is based on the methodological quality, on which any knowledge claims are made. These 'levels of evidence systems' favour evidence (at level 1) that has been deduced via a meta-analysis of randomised control trials and reduce rapidly to level 4, the lowest level of reliability, which include opinions based on untested theoretical hypothesis or clinical practice (Vonk, et al., 2007). Not everyone agrees with this hierarchy however, with some researchers such as Fook (1999) stating outright that approaches to knowledge that reflect this scientific paradigm are not congruent with the kinds of practices social workers take up in order to respond to the various situations they face in day-to-day practice.

Effectiveness

As outlined in chapter one, the concept of effectiveness and for the purposes of this study, effective practice, is difficult to define, assess, evaluate and research. Much has been written about the concept; perhaps one of the fullest explorations being provided by Cheetham and her colleagues in their 1992 book dedicated to evaluating social work effectiveness. Here they devote an entire chapter to helping the pitiable researcher who is plucky enough to traverse the complex terrain of such a contested and elusive concept, in an attempt to support our greater understanding of the issues and concerns associated with effectiveness research.

Cheetham and her colleagues begin by telling us that effectiveness is not something that has an 'object-like' reality, just sitting out there waiting to be discovered. As with any other data, evidence about the effectiveness of social work practice and programmes is produced via data collection activities and the assumptions on which they are based. Put simply, these evaluators maintain that "[t]he concept of effectiveness derives from particular ways of thinking and makes sense only in relation to its context" (Cheetham, et al., 1992, p.9).

Cheetham and her co-authors then provide us with a concrete example of how these particular ways of thinking, and various contextual factors may be experienced in practice. In the hospital, the personnel managing bed occupancy may have a measure of effective practice which is closely connected with the length of stay of the patient. The finance officer is likely to be interested in the cost of the bed night, and the social worker is likely to be interested in the effect that her intervention is having on the overall wellbeing of her patient. They also suggest that effectiveness is not a term likely to be employed by clients themselves, who perhaps are more likely to ask the question: "What am I getting out of this service; is it any practical help or comfort to me?"(Cheetham, et al., 1992, p.10).

The various parties' values, personal experience, previous professional knowledge and their social and cultural context will influence their descriptions of effectiveness. Cheetham and her co-authors make the point that this reflects something greater than different people or professions having different expectations. "It implies that effectiveness derives from a variety of perspectives and assumptions, and itself forms part of one or more of a range of different rhetoric – the language of value for money, say, or that of professional accountability, meeting customer demand, or maximising satisfaction" (Cheetham, et al., 1992, p.10).

These various positions are fundamental to the understanding of how concepts of effective practice are being employed, and what and whose purpose they may serve. Given this need to remain alert to whose purposes are being served, Cheetham and her co-authors recommend that these issues must be taken into account when decisions are being made about the focus of the inquiry, and therefore how data will be collected, and the methods employed in pursuit of that data. They then suggest that they are put aside, whilst the

effectiveness researcher gets on with the task. According to them, the next challenge is "... to arrive at working definitions of effectiveness in specific situations, and hence of methods of studying it, which do not permanently lose sight of its conceptual context (Cheetham, et al., 1992, p.10).

They provide us with one working definition, which they say has been usefully applied by managers, researchers and practitioners alike: "social work is effective in so far as it achieves intended aims" (Cheetham, et al., 1992, p.10). This is an important point that has been explored in the discussion chapter of my thesis in relation to the multiple aims the health social worker is trying to achieve in the acute hospital environment.

Sheldon (1986) is less sympathetic to the 'supposed difficulties' regarding the task of defining satisfactorily exactly what effectiveness is. He maintains that many social workers consider this question as if it assumes a fixed and total state of epistemological grace – somewhat like 'truth' – in which all hopes are satisfied, all potential points of view taken into account, and all possible protests overcome. Sheldon suggests that little of what we do is like that and very few of our measures of it occur in such a form. Preferably he tells us he has in mind a much less elaborate affair which

> ...implies describing carefully the nature, extent and implications of any problems prior to intervention; saying what you might do to alter these and why it would be beneficial to try; describing how best this might be brought about; saying in advance what kinds of public test might be applied to support the view that something worthwhile has been achieved; pursuing a solution, and then defending the results against criticism from peers... (Sheldon, 1986, p.224).

Sheldon goes on to argue that "[w]ithin this definition, effectiveness is whatever those involved say it is" (Sheldon, 1986, p.224).

Although initially it may appear that Sheldon (1986) and Cheetham and her co-authors (1992) are making the same point, essentially that effectiveness *can* and must be defined by those involved, Sheldon's description fails to acknowledge that our focus, and subsequent

methodology, will have a significant impact on *what is possible* to include in these descriptions. Sheldon's definition is also disappointing as it neglects to take account of a number of well-articulated challenges associated with the fundamental question of whose voices are more likely to be heard over others in what counts as effective.

Whilst writing about effectiveness in the context of evidence-based practice Plath (2006) cites both Cheetham and her co-authors work, and that of Sheldon. Somewhat surprisingly it is Sheldon's concept of effectiveness she relies on. Plath recognises that there will be conflicting notions of effectiveness within organisations especially when there is an obsession with efficiency and costs. Perhaps as a counter to Sheldon's absence of acknowledgement of the power relations inherent in research processes, Plath does challenge social workers to actively engage in debates to make certain that social work values, and specifically the experiences of clients, are centralised. She also cites Cheetham and her co-authors 1992 contention that when social workers do convincingly argue alternative descriptions of effectiveness "...it is not necessarily the case that policy makers will choose the cheapest option" (Plath, 2006, p. 62).

The literature abounds with a number of critiques made in relation to narrow-stream thinking such as Sheldon's. Largely these arguments are made in relation to who gets to decide what counts as an effective outcome (Taylor, 2004); the power differences in gender, race, class, sexuality and physical disability and the impact on voice (Lishman, 1999; Martinez-Brawley, 2001; Tuhiwai Smith, 2005) and finally the capacity of an agreed outcome measure that is able to capture all the elements of change (Trinder, 2000a). Some of these ideas will be explored briefly in relation to the failures of positivist science later in the chapter.

In regard to establishing the effectiveness of social work, Sheldon (1986) concedes that social work clients rarely have problems that are one dimensional in nature, and that because of the range of problems which fall into its scope, it is a complex business establishing effective outcomes. He continues to maintain that 'too much' has been made of these complexities and is adamant that social workers and researchers must simply continue to grapple with the associated complexity (Sheldon, 1986).

Post positivism, pragmatism and trade-offs

Beginning with the failure of positivism, Lather (1991) suggests that an authoritative critique of positivism has been well established and that the challenge we face is to engage in the opportunities offered in the post positivist era. Put simply Lather posits that in the face of human complexity positivist assumptions have proven to be inadequate. Lather's view is particularly relevant when considering research that involves Maori, given that a number of highly regarded indigenous researchers make a strong plea that the construction of research methodologies must be able to take account of a uniquely Maori world view (Cunningham, 2003; Durie, 1998; Jahnke & Taiapa, 2003; Tuhiwai Smith, 2005) and be able to provide "[a] distinctively Maori way of organising knowledge" (Jahnke & Taiapa, 2003, p.41).

Supporting the view expressed by Lather, Shaw tells us that positivist approaches have been on the wane over the past 50 years and that aside from Thyer (1989, 1993) there are few social work commentators who would support the idea that there are absolute justifications for scientific assertions. He stresses however that "[a]lthough there are no *absolute* justifications, this does not mean there are *no* justifications" (Shaw & Lishman, 1999, p.19). This means that while it may well be appropriate to hold a particular view, it is unrealistic to claim that it is *the truth*, and that this truth is sacrosanct or forever fixed. Shaw names this position 'post positivism' and maintains that those that employ this research paradigm actively employ partial trade-offs. Shaw describes these trade-offs as being between "...rigor to gain relevance, precision to gain richness, theoretical elegance to gain local applicability, and measures of outcome to promote inquiry into process, meaning and local context" (Shaw & Lishman, 1999, p.19).

This notion of trade-offs is also articulated by Trinder (2000) as she extends the debate on effectiveness and pragmatism, noting that in the UK the majority of effectiveness research design is established on technical, rather than ontological or epistemological grounds. These researchers are more likely to employ non-experimental quantitative designs utilising non-randomised samples, and from time to time supplement their studies with qualitative methods in an illustrative role. Referring to these researchers as pragmatists, Trinder (2000) identifies a significant degree of commonality between them, including their broadly held

views on practice, similar research designs, and the employment of particular methods and epistemology. Within this realist epistemological framework Trinder claims that both grand science and grand experimental studies are cut down to size. To further this idea she cites Fuller, who expresses the view that "...the suspension of not-to-be-resolved philosophical conundra in the interests of getting on with the job, leading to a trade-off between what is desirable and what is feasible, and abandoning the search for irrefutable scientific proof (Fuller, 1996, cited in Trinder, 2000, p.143).

Clearly there have been substantial arguments made in relation to the limitations inherent in employing positivist approaches to social work research practice, not least of them associated with the risks of imposing practice theory inappropriately, for example, Western constructions of family, on Maori whanau, or same-sex relationships. Having abandoned the search for irrefutable scientific proof then, what other kinds of inquiry become possible for the social work researcher?

Alternative approaches

Over a significant period of time Fook and her colleagues (Fawcett, Featherstone, Fook, & Rossiter, 2000; Fook, 2000, 2002, 1996; Fook, et al., 2000; Pease & Fook, 1999) and more recently Ferguson (Ferguson, 2001, 2003) offer alternatives to evidence-based practice that has been dominantly influenced and constructed by the empiricist movement. Two central aspects of this alternative approach are of interest in my literature review; the first relates to the nature of the research practices we employ; and the second to how practitioners apply research to practice in order to increase effective outcomes. Relying on these authors and other significant theorists and researchers (Gibbs, 2001; Gould, 2000; Gould & Baldwin, 2006; Joubert, 2006; Lather, 1991; D. A. Schon, 1983; Shaw & Lishman, 1999; D. Smith, 2004a) these central features will be explored with an emphasis on the concepts of reflective practice and research, critical thinking and Ferguson's (2003) concept of critical best practice.

Gibbs assures us that "social work research can embrace reflection, intuition and practice wisdom in order to understand effectiveness" (Gibbs, 2001, p.697). Previously in this chapter Shaw (1999) has suggested that relevance, richness, local applicability and

measures of outcome that support an inquiry into process, meaning and local contexts are central. White is clear, "[t]he efficacy of interventions is clearly crucially important, but an exclusive focus on narrow outcome indicators can lead to a conspicuous neglect of other areas of professional activity" (2006p.xii).

Reviewing the changing nature and context of social work research Gibbs (2001) makes the case for the increased participation in research by both service recipients, and social work practitioners. This call for increased practitioner involvement is supported by others such as (Fuller & Petch, 1995; Joubert, 2006; Shaw, 1999; and Fook, 1999). Questioning the practice of treating the social work environment as a site for "experiment, measurement and quantification," (p.688) Gibbs argues that social work research in the 21st century should be able to reflect the social work principles and values that underpin social work practice. Claiming that equity, social justice, self-determination and empowerment are critical to the research process, Gibbs supports reflective research practices that maintain a focus on process, as well as outcome. She challenges us to move away from the easily researchable toward "...the challenging complexity of everyday social work" (Gibbs, 2001, p.700).

Proposing that heuristic research practices allow social work to describe itself in the rich detail that Shaw (1999) has suggested is possible, Gibbs recommends that this research paradigm is more likely to be able to take account of, and give meaning to the multi-faceted problems that many recipients of social work services face. Supporting its capacity for discovery and the ability of people to learn for themselves, Gibbs advocates the heuristic approach provides the foundation for reflective methods in social work research (Gibbs, 2001) and poses the question "[c]an the reflective and research minded practitioner undertake rigorous, well rationalized research?" (Gibbs, 2001, p.688).

Reflective Practice research

Gibbs relies on Fook's (1996) identification of the key features of reflective research as "intuition and creativity; evolving framework and theories that can be applied to complex issues; the influence of context is seen as critical; the acceptance and valuing of unintended outcomes; the researcher's lack of control is accepted; and the integration of theory, practice and research" (Gibbs, 2001, p.697). Not reliant on exclusive methodologies or

techniques, practice research is described by Fook as "...research which is directly about practice..." (Fook, 1996, p. xiv) and suggests that by adopting a reflective approach we are better able to discover, develop and articulate the unspoken assumptions that make up practice wisdom. Rather than engaging in research that aims to develop theories for generalisation across varying contexts, Fook supports the development of context specific, local knowledge (Fook, et al., 2000) and offers practice based research as one solution to the research-practice divide (Fook, 1996).

In order to act more relevantly, Fook (2000) suggests we need to develop a greater understanding of the *complexity* of our experiences and that one way we can do this is by increasing the number of prisms we rely on to develop understanding. Reflective approaches to research are able to acknowledge "the importance of experiential and interconnected ways of knowing the world" (Fook, 1996, p. 5) thereby taking on a more holistic perspective. Fook promotes the concept that researchers should be able to "appreciate the situation in ways which are congruent with the perspectives of the players we believe are important, be they marginal or ostensibly dominant groups" (Fook, 1996, p. 5). This capacity to capture multiple perspectives in the construction of practice is supported by Ferguson, who employs a critical best practice case study approach in order to establish "the deeper meanings of practice from the perspectives of professionals and service users" (Ferguson, 2003, p.1013).

In 2003 Ferguson outlined a perspective which he named *critical best practice* in the hope of offering an alternative to what he experienced as the dominant deficit approach where the focus of research and reviews appeared to be on what fails to get done, or is not done well by social workers. Maintaining that social work has been under a 'negative sign' evident by the "vitriolic treatment of social work in the media" (p.1007) Ferguson's approach determinedly chooses to "focus on the actual critical practices that are 'best'" (p.1005) thereby demonstrating the specific practice that is able to support effective outcomes.

Ferguson's aim is to employ critical theory as an interpretive framework to provide accounts of best practice in order for them to be made available to support learning.

Elaborating on this aim he explains that a central purpose of the critical best practice analysis is to discover how practitioners work creatively both with and within various structures. In doing so he means to support their engagement in the actual practices that make a positive difference to the lives of the recipients of social services. Recognising the urgency with which evidence-based practice is being promoted in both health and social services, Ferguson identifies the increasing dominance of public and professional discourses related to 'excellence' in social work practice. He also recognises the challenges and uncertainty associated with such discourses, particularly related to how concepts such as 'best practice' become embedded across various contexts (Ferguson, 2003).

The other fundamental aim that Ferguson identifies is the need "to broaden the agenda of critical social work and conceptualizations of both 'evidence' and 'practice' in social care" (Ferguson, 2003, p.1006). Hence one of the underpinning dimensions of Ferguson's critical best practice is "the inclusion of 'practice-based evidence' which relates to experiential knowledge and the social actions and processes that go to make up the very nature of social work in practice" (Ferguson, 2003, p.1006-1007). By doing so Ferguson is privileging the development of best practice standards from 'the bottom up', whilst also recognising that because notions of best practice are socially constructed they are continually open to debate and revision.

It is beyond the scope of my review to provide a full account of Ferguson's research; but what remains central is the notion of a solution-focused approach to research that "attempts to be strategic in terms of identifying ways of working that offer positive resources to professionals in guiding their work" (Ferguson, 2003, p.1010). In order to produce accounts of practice that are well rounded, the "subjective experience working within a narrative or meaning framework" (p.1011) is essential. By relying on evidence of effectiveness in samples of everyday work, the 'practice-based evidence' approach is offered in order to complement the more dominant approach of evidence-based practice. In so doing Ferguson believes that "[c]ompared to the deductive reasoning assumed in positivist experimental research approaches, this is a more inductive process of knowledge building in which practice theory is developed out of the everyday experience of professionals" (Ferguson, 2003, p. 1011).

Attributing this commitment to the day-to-day processes of professional activity and an engagement in 'critical reflectivity' to the activities associated with critical social work, Ferguson also relies on theorists such as Fook (1999), maintaining that this type of knowledge production has the dynamic potential to both promote learning and reconstitute practice. He argues that not only do we need practice-based research that values experiential knowledge, but alongside this we require an unambiguous commitment to investigating the 'felt lived experience' of practice that could be described as *best*. Importantly Ferguson makes clear that understandings of best practice can develop and evolve out of what, in the strictest scientific terms has not actually resulted in a good outcome, as in his view an enormous amount of social work is simply directed at preventing further harm.

Ferguson's reliance on the belief that practice theory can be derived from the day-to-day activities of social workers and that this type of knowledge building requires an engagement in critical reflectivity requires further examination. The application of critical reflectivity to the activities of social work research and practice are central to this thesis in that this thinking provides a realistic alternative to both positivist research practices *and* the narrow stream version of evidence-based practice. Fook is the most prolific writer in both these areas, and it is to her we turn now in order to develop a deeper understanding of these reflective activities informed by critical theory.

Relying on the feminist theorist Swigonowki, Fook outlines how the feminist critique of positivist approaches broadly fall into three areas: firstly, the belief that it is possible to engage in value free scientific activity; secondly, the separation of subject and object; and finally, the notion that there is an objective reality waiting for the researcher to discover it (Swigonowski, 1994) cited in Fook 1999. In the taking up of this critique we are required to recognise the critical nature of subjectivity in every aspect of research and social work practice. This reflective practice is termed reflexivity (Stevens, 1993) and requires that researchers give attention to recognising how their individual awareness impacts the situation, most especially regarding specific interpretations and/or constructions of meaning.

Fundamental to this reflexive approach are questions of power (Fook, 1999). In accepting the concept of reflexivity, social workers acknowledge that the research procedures we employ construct reality just as much as they produce accounts *of* that reality. Highlighting this point Taylor cites Atkinson (1990) who suggests:

> [T]he notion of reflexivity recognizes that texts do not simply and transparently report an independent social order of reality. Rather, the texts themselves are implicated in the work of social construction (Taylor, 2006, p.75).

Ferguson's work relies on the process of critical reflexivity, and this requires the addition of 'critical' in the reflexive process. When these two concepts are combined the activity of reflection is undertaken through the lens of critical theory. Critical theory informs the *direction* of the reflection (Fook & Askeland, 2006). Both critical theory and the process of reflection require further development in an attempt to establish a solid understanding of these concepts and their origins.

In an effort to support our understanding of critical theory, Fook and Askeland (2006) propose that at its most basic, it is a series of social theories that stand against the positivistic conception of the world, and of society. "Critical theory results from processes which reveal contradictions in the rationality and the arguments for social actions" (Carr and Kemmis 1986, p.144). The central idea is that the new insight and knowledge gained through reflection would result in societal changes" (Fook & Askeland, 2006, p.42). It is the resulting change that is at the core of critical theory, and the way that Ferguson employs this theory, is regarding a change in the way that *best practice* is discovered and articulated. The second central concept is that of reflection, and in order to understand this idea in relation to social work research and practice, Fook turns to Schon (1991).

Although it may be argued that we engage in the practice of reflection day in and day out, Schon situates his theory in the professional domain and applies it in a conscious way in order to create new meaning when something is unfamiliar, problematic or surprising (Fook & Askeland, 2006). Focusing on the crisis in confidence Schon believed professionals were

experiencing, he claimed that “professional knowledge is mismatched to the changing character of the situations of practice – the complexity, uncertainty, instability, uniqueness, and value conflicts which are increasingly perceived as central to the world of professional practice” (D. Schon, 1995, p.14).

Schon’s theory then, is developed on the basis that he recognised the gap between what practitioners said they did – ‘espoused theory’, and what they actually did – ‘theory in action’(D. Schon, 1995). Schon was interested in the kind of knowing that competent practitioners engaged in and believed that they usually knew more than they were able to say. He called this “knowing-in-practice” (p.viii) most of which he believed was tacit knowing (D. Schon, 1995). Schon tells us that “[s]ocial workers have produced multiple, shifting images of the nature of their practice” (D. Schon, 1995, p.17). It is these multiple images that pose a predicament for practitioners who reject positivist approaches, because we are then charged with making choices about which approach/s to adopt, or alternatively to engage in the development of our own approach to practice.

According to Fook and her co-author, Schon’s reflective model does provide a way for practitioners to distance ourselves from the notions of objective science and engage in a process of developing our own practice theory. At its simplest the model provides social workers with an opportunity to engage in a comparison between our espoused theory, and our theory in action and by so doing “are able to compare the theory we actually enact with the theory we may wish to believe we are enacting” (Fook & Askeland, 2006). In effect what this does is provide an opportunity to identify the gap, and adjust either our practice, to bring it into line with our theory, or adjust our theory to bring it into line with our practice. Local authors, also relying on Schon’s theory maintain that when a practitioner is reflecting in action we are able to become “...a researcher in the potential context” (Lunt, Fouche, & Yates, 2007, p.10). By doing so we are “not dependent on the categories of established theory and techniques but construct a new theory of this ‘unique case’” (Schon, 1983, p.68 cited in Lunt et al., 2007, p.10).

Encouraging this concept, Fook suggests that rather than supporting the increased conscious use of espoused general theory *deductively,* there may be some benefit from a

more *inductive* approach whereby a more general theory of how to act might be developed from a series of specific experiences (through a process of articulating the implicit theory). In this sense then, the model Schon provided has enabled both the development and improvement of practice (and theory) but it also supports the creation of theory directly out of the practice experience.

In this approach then, the reliance on intuition may well be significant in recognising the critical factors in particular situations and making connections between what may initially appear to be logically unrelated experiences. Fook tells us that "[t]his reaffirms the *artistry* of professional practice involved in the ability to make judgements to act in situations which are often unpredictable, complex, changing and uncontrollable" (Fook, 1996, p. 4). Given that many practice situations are beyond our control and invariably involve a number of different participants and perspectives, an understanding and acknowledgement that no single universal framework can be considered relevant in all situations is critical. Rather we come to know that in any circumstance, a number of valid perspectives may apply. Central then, is the recognition that in order to develop a fuller understanding of any situation, including of the concept of effectiveness, is an appreciation of the context in which it occurs.

As this literature review reveals, social work as a profession can demonstrate a sustained interest in evaluating the effectiveness of the professional activities it engages in, and yet despite this history, many practitioners continue to have what has been described as an ambivalent relationship with research (Everitt, 2002). Having also noted that practitioners are challenged to incorporate research findings into their practice, Fook suggests that this is difficult as many approaches and methods have limited relevance to the demands of the workplace (Fook, 1996). This lack of relevance and the shortcomings of the evidence-based practice movement are also highlighted by Plath (2006) who suggests that "[w]hen the professional, organisational and political contexts of social work practice are considered, barriers and limitations to the use of research are confronted (Plath, 2006, p.63).

The fervent association of evidence-based practice with the positivist paradigm is likely to result in tension for those practitioners who value a more reflective, humanist and

interpretive response to social work practice (Plath, 2006). This tension is likely to be fuelled by the debates in the literature which may in turn result in practitioners being at risk of engaging in a binary description, with research and evidence-based practice on one side of the divide, and critically reflective practice on the other. I believe a broad-stream version of evidence-based practice, or rather practice-based evidence as in Ferguson's earlier discussion provides practitioners with an opportunity to combine the very best of both approaches. In so doing I would argue that we have the opportunity to undertake practice-based research ourselves, and to engage critically with multiple outcomes of research.

Conclusion

My literature review began with a brief exploration of the origins of science in social work and explored a number of effectiveness studies approached from a largely positivist standpoint. These studies were largely quasi-experimental and maintained a focus on discrete interventions, and measurement of outcomes. Matters such as practice context, practitioner expertise, cross-cultural concerns and process activities do not feature in this approach. The chapter subsequently made the links between this empirically informed approach to research, and the evidence-based practice movement. The literature then canvassed the central critiques of the approach, and provided some alternative paradigms which are perhaps more in keeping with social work values. The final part of this chapter concludes with connections being made with key ideas from the literature, and their application to this research endeavour.

"Critical reflection addresses the question of the justification for the very premises on which problems are posed in the first place" (Mezirow & & Associates, 1990, p. 12). It is this critical engagement with research that allows us to ask questions such as, What counts as knowledge? What is evidence of an effective outcome? Who gets to decide? Is it possible to apply the findings from one context successfully into another? and What part do service users play in deciding which intervention is best for them? These are some of the questions I have grappled with when deciding which approach to take in this research activity. Whilst the service users' voice is one amongst many in the first phase of the data collection, other significant stakeholders are given an opportunity to express multiple accounts of what constitutes effective practice.

No matter how devoted to the principles of applying evidence to practice, many argue that some will always be better at this than others. At the very least, the decisions related to what evidence is relevant to each particular case and context, and its subsequent application in practice will inevitably be impacted by the practitioner's skills, experience, and competence. Social work authors such as Gould (2006) are emphasising the role of social work leadership and organisational structures in practitioners' ability to access, reflect on and apply the findings from research. This emphasis is evident in the final aim of this research inquiry, namely the development of an organisational intervention which aims to support an increased engagement with a variety of knowledge sources, including outcomes derived from research.

It is Gould who most recently articulates the recognition that learning is experiential and contextually embedded. In doing so he makes the connection between the concept of the learning organisation and reflective practice. He proposes that the basic premises of reflective learning emerge from three critiques of technical-rational models of problem-solving (Gould, 1999). The first is that expert practitioners, whilst likely to draw on the findings from formal research to inform their practice, nevertheless find that their problem-solving strategies are acquired through experience. Citing researchers such as (Benner, 1984; Dreyfus & Dreyfus, 1986; and Fook, Ryan and Hawkins, 2000) Gould is clear that with the development of expertise, "practitioner knowledge typically becomes more tacit, demonstrated and communicated through the practice itself" (Gould & Baldwin, 2006, p.4).

This raises an important question for health social work leadership, specifically, How do we hold a space in an acute environment for practitioners to extend and embed the learning it is possible to achieve through experience? I argue that activities such as clinical supervision, continuing professional development, reflective learning groups, and practice-based research groups and journal clubs are a few examples of the type of activity which would enable this reflection to occur. These types of activity will be outlined in the concluding chapter of my thesis in relation to the organisational intervention plan which forms the final aim of this inquiry.

Gould's point regarding how practitioners engage in problem-solving also raises an important question for researchers, namely how best to explore this 'tacit practitioner knowledge that is communicated via the practice itself'? The methods and focus maintained in this research activity aim to maintain this focus on the practice itself, first by exploring how it is demonstrated and described, and secondly by asking multiple stakeholders to add a further layer of description of the practice that counts as effective in this context.

The second point Gould makes is that the traditional understanding of practice as the application of formal knowledge, fails to appreciate the context of practice as a determining influence in both the use of knowledge, and the creation of knowledge by practitioners (Gould & Baldwin, 2006). The approach adopted in this inquiry aims to highlight these contextual influences, and to explore what tactic knowledge exists amongst multiple stakeholders regarding what constitutes the dimensions of effective practice.

The final point Gould makes is that what represents a problem is in itself a matter of construction and interpretation within a particular context. Arguing that cook-book type approaches to practice rely on the assumption that it is self-evident that practitioners will recognise specific types of problems to which preordained solutions can be applied (Gould & Baldwin, 2006). Gould, informed by Schon (1983), relies on the swamp metaphor which proposed that this rationalistic standpoint of problem-solving: "…is typically from the high ground occupied by managers and academics, while practitioners are situated in the swampy lowland having to negotiate from a complex and confusing plethora of circumstances an understanding of what constitutes 'the problem'" (Gould & Baldwin, 2006, p.4).

My research is situated within the 'swampy lowlands' of practice in order to explore what these circumstances actually constitute, and what types of day-to-day activities support a particular way of engaging with them that is likely to result in descriptions of effective practice. Just as Ferguson (2003) has suggested, a solution-focused approach to the research is being adopted with the aim of producing positive, contextually informed and relevant resources to help guide health social workers' future practice. This contextual relevance is reflected in the following literature chapter which provides an opportunity to more fully

explore the world of hospital health social work and its challenges, the foremost approaches to practice, and the attempts of the profession to engage in outcome studies.

Chapter 3: Health social work

Introduction

In an effort to firmly situate this research project within the hospital practice environment an analysis of the contemporary health social work literature will be undertaken. Spanning almost two decades, and relying on journals such as *Social Work*, *Social Work in Health Care*, and Aotearoa New Zealand's *Social Work Review,* seminal articles and international trends will be highlighted. The consistent issues being experienced both nationally and internationally by health social workers during this recent practice history will also be described, including introducing the concept of the hospital being a host organisation for the profession of social work. An exploration of others' efforts to define the role, an account of key activities such as undertaking the biopsychosocial assessment also feature as does a brief exploration of the paediatric hospital context. The literature will then turn to the efforts health social workers have made to research the outcomes of our practice. Beginning with a brief exploration of the national health policy context and then broadening the contextual scope to include international subject matter as described above, the health social work practice canvas on which this inquiry builds is explored.

The health policy and strategy context

The health system in Aotearoa has been described as being in active transition since the early 1980s and has had four different organisational structures for the delivery of health care since the late eighties. This has resulted in it being described as the most restructured health system, for this period of history, in the world (Gauld, 2003). These changes in structure have occurred as a result of health reform, described as the reconfiguration of the main structural aspects of a health system which includes funding, provision and regulation on a national level (A. L. Bloom, 2000). Explaining that historically social policy has maintained a focus on health care because of the 'public good' aspect of health, Cheyne, O'Brien & Belgrave rely on Baume (1995) to explain that public policy in relation to health care is:

> ...the determination of who shall live and who shall die, of who shall suffer and who shall be relieved, of who shall find care and who shall miss out – at public expense. All of these decisions will be made in situations where, in a

> technical sense, the care could be given, or the procedures could be performed, if the public resource available was great enough (Cheyne, O'Brien, & Belgrave, 1997, p.219).

This explanation illuminates the social justice implications inherent in health policy. It is therefore appropriate to spend some time outlining contemporary policy and some of its impacts on the preoccupations and activities of health social work.

Claiming a similarity to the issues impacting in many Western economies, the forces driving health reform nationally during the 1980s and 1990s were limits on the amount of funds the government was prepared to spend on health, coinciding with an increased demand for health care (Bloom 2000; Gauld 2003). A number of factors have been attributed to the rising demands on health care resources. These include a belief that ageing populations were taking up unsustainably escalating quantities of health resources; changing technologies; growing consumer knowledge and continuously rising expectations regarding the outcomes health care could produce (Berkman, 1996; Blank, 1994; Bloom 2000).

Although there are any number of rationales for health reform, in Aotearoa one of the primary drivers of reform has been a desire for what Bloom (2000) describes as technical and allocation efficiency, and the resolve to not only preserve, but improve equity in health status, access to health care and accountability to consumers. According to Cheyne and her co-authors the key elements of recent health-care policy include: large and growing health expenditure; increased access to effective pharmaceutical and technological interventions against ill-health; significant challenges associated with the delivery of health services, for example, extensive waiting lists; and the ongoing nature of ill-health among certain population groups such as Maori (Cheyne, et al., 1997).

Questioning whether health reforms would ever be able to achieve the stated aims, Cheyne maintains the overall emphasis reflected the increasing prominence in social-policy reform of public-choice theory and managerialism (Cheyne, et al., 1997). Relying on Clarke and co-authors (1994) definition of managerialism Schofield describes it as “a view of management as the fundamental coordinating force in organisations” (2001, p.149).

Schofield explains that "[t]his perspective challenges professional structures as well as professional capability to identify the needs of client groups" (Schofield, 2001, p.149–150). The similarity of the outcomes of managerialist approaches in British social services is claimed by Schofield in relationship to health social work practitioners in Aotearoa. Schofield describes these outcomes as reduced training opportunities and diminished career pathways**;** services centralised back to hospitals; an added emphasis on discharge planning**;** and an obligation from staff to protect managers at the possible expense of clients (Schofield, 2001).

Clearly Schofield is describing the negative outcomes of reform for the profession. There does, however, appear to be agreement in the literature that governments are reviewing the taken-for-granted assumptions about health systems and how health care should be delivered (A. L. Bloom, 2000). This has positive potential for those groups who are currently not served well by the health care services. This will be considered more fully later in the section exploring our most contemporary health strategy.

Here in Aotearoa an explicit argument has been made by Treasury that despite increasing spending there has not been an equivalent improvement in health outcomes (Cheyne, et al., 1997). This trend is also evident in the US where Berger claims that "[d]espite twenty years of vigorous efforts to control health care costs, expenditures continue to escalate without commensurate improvement in health outcomes"(Berger & Ai, 2000, p.101). In comparison to other Western nations however, Aotearoa has not been assessed by experts as spending excessive amounts of Gross Domestic Profit on health, and in fact, eight percent is considered to be both reasonable and adequate, resulting in what is described by Bloom (2000) as an impressively high standard of health care.

In the face of this analysis it is interesting that the fear of increasing costs has been one of the main drivers of reform (A. L. Bloom, 2000). Offered in partial explanation for these phenomena is the notion that there are also other powerful forces driving reform. These include a scarcity of investment capital for the development of infrastructure, growing technical efficiency and the need to develop increased quality. Relying on a number of theorists who describe different phases and approaches to reform, Bloom articulates the

Aotearoa themes of "micro-efficiency and responsiveness to users" as being dominant. But beginning to take root are the notions of "public health, primary care, evidence-based medicine, and managed care ..." (2000, p.4).

Aotearoa has a unique ethnic composition, with 14.5 percent of the population identifying as Maori, and 5.6 percent identifying as being from the Pacific Islands. It has been established (Gauld, 2003) that the structure of the population will change rapidly over the next 25 years due to the large numbers of Maori and Pacific populations being under the age of 25 years. In comparison, the Pakeha population of 'baby boomers' born in the 1950s, are rapidly approaching retirement age and are being described as an ageing population (Gauld, 2003).

There are also significant differences in the health indicators of various populations in Aotearoa, with Maori faring poorly. This is evident by reduced life expectancy, an infant mortality rate twice that of Non-Maori[1], and rates of hospitalisation for conditions such as stroke, pneumonia and influenza being as much as four times higher among Maori, than Non-Maori (Gauld, 2003). The desire to reduce inequities is said to be one of the drivers of health reform and this is reflected in current health policy and strategy.

In December 2000 the Minister of Health, Annette King released the New Zealand Health Strategy which set the foundation for the then Labour Government's action on health for the next decade (Ministry of Health, 2000). This strategy identified the priority areas with the overall aim of ensuring that health resources were directed towards improving the health of the entire population. This strategy had a particular focus on reducing inequalities in health and was underpinned by seven fundamental principles which have been expected to be reflected in practice across the entire health sector. Some of the principles particularly relevant to health social work include an acknowledgement of the relationship between Maori and the Crown under the Treaty of Waitangi; an improvement in the health status of disadvantaged groups; collaborative approaches with a focus on health promotion and disease prevention; timely and equitable access to health services and an expectation

[1] Use of the term Non-Maori in the research cited above refers collectively to all those in Aotearoa who are not Maori, for example Pakeha, Pacific peoples and Asian populations

regarding a high-performing system with active involvement from consumers and communities (Ministry of Health, 2000).

Although the New Zealand Health Strategy referred to above remains in place, since the National Government came to power in late 2008, the focus of the strategy has shifted markedly. In the Statement of Intent 2010–2013, the Minister of Health, Tony Ryall described the statement as "an important junction for the planning, funding and delivery of health and disability services" (Ministry of Health, 2010, p. iii). As Aotearoa is not in a position to afford uncontrolled costs that continue to grow, or poor decision making, the emphasis was on how best to utilise the limited health resource.

> We need a health system that does the right things in the right order, has tightly focused roles that eliminate duplication, and has people with the right knowledge, skills and incentives to do the job (Ministry of Health, 2010, p. iii).

While the strategy lays claim to ensuring the same opportunities for good health are afforded to all people living in Aotearoa, and a clear commitment to supporting the Whanau Ora[2] programme, at the coal face the overwhelming experience is one of extreme fiscal restraint and a primary focus on 'better value for money'.

Unashamedly beginning yet another round of reform, "the focus is on reducing waste, and improving systems, processes and culture, in order to:

- support greater clinical leadership and integration of services
- improve the focus and coordination of services
- put the wellbeing of New Zealanders at the centre of decision-making" (Ministry of Health, 2010, p. 1).

Family violence has been recognised in Aotearoa as having a negative impact on the health and wellbeing of the populations experiencing it and is described "as a preventable public

[2] Whanau ora reflects the aspirations of whanau to be self-managing and take responsibility for their social, economic and cultural development. a whanau ora approach will allow providers to work flexibly with whanau through coordinated and aligned service settings and priorities of government agencies and Non-Government Organisations (NGOs)

health problem" (Koziol-McLain, Garrett, & Gear, 2009). In light of this the reduction of interpersonal violence has been identified as a key objective in the New Zealand Health Strategy (Glasgow & Fanslow, 2007). In an effort to help reduce the health impact of family violence the Ministry of Health has published two key guidelines to assist health professionals in the early identification, assessment and referral of those people identified to be experiencing family violence (Fanslow, 2002; Glasgow & Fanslow, 2007).

The Child and Partner Abuse Guideline whilst more widely implemented and recently evaluated (Koziol-McLain, et al., 2009) has been a more familiar document to those of us working in the hospital, applied less frequently but also important are the Elder Abuse and Neglect Guidelines. This guideline presents a six-step framework for health care providers to assist us to identify and respond to elder abuse (Glasgow & Fanslow, 2007). Taking into account the ageing population and the increased awareness of issues such as elder abuse, I suggest that the ability to provide effective services to vulnerable adults *and* vulnerable infants will become an increasingly important Health Social Work competence.

Health strategy is subject to the changing ideology and priorities of the government of the day. One example of changing ideology and its impact on policy is evident in the increased focus on interpersonal family violence which has had a significant impact on the day-to-day practice of health social workers**.** This focus is associated with the introduction of clinical guidelines established at the Ministry of Health level referred to above. In our hospitals, the policy that derives from these guidelines demands that disclosures of family violence as a result of the answering of screening questions require patients who are identified as potentially high risk, have access to risk assessment and safety planning interventions. Most frequently these interventions are required to be conducted by health social workers. This type of policy dictate raises the importance of maintaining an adaptable and flexible workforce, who are well supported to develop the skills and competencies required to meet the changing expectations of governments, and their policies. It also demands that adequate human resources are available to meet these changing requirements.

The universal theme of change and health social work

The numerous waves of change in hospitals that have occurred since Ida Cannon first defined the role of the medical social worker in 1905 are clearly articulated by Neuman (2000). One way this evolution in hospital services can be demonstrated here in Aotearoa is via the advent of medical social work, first provided as a post graduate nursing course in 1940. The role was focused on the knowledge that "personal and social factors can affect the onset of many types of illness and disease, as well as the course and outcome of treatment" (Wright, 1957, p.193). Reflecting on the historical background to hospital social work, Judd and Sheffield describe how with the advent of social workers in the acute hospital setting, "the needs of patients moved beyond interventions for immediate medical issues to include addressing aspects of the larger ecological system impacting health outcomes" (Judd & Sheffield, 2010, p. 857).

In spite of the consistently changing practice environment, one author maintains that this person-in environment approach to health social work practice has remained an exceptionally consistent focus, regardless of the changing nature of the practice environment. (See for example, Volland, 1996). Conversely over the last two decades, health environments and hospitals in particular, have been described as the sites of unprecedented, rapid and unpredictable change (Cleak, 2002; Globerman, 1996, 1999; Pockett, 2003; Rock & Cooper, 2000; J. Sulman, Savage, & Way, 2001).

In the early nineties hospital restructuring, the dismantling of numerous health social work departments, a reduction in staffing levels and changing health care paradigms were established as significant concerns for the profession (Beddoe, 1993; Berger, et al., 1996; G. Ross, 1990; J. Ross, 1993). Indicating the sense of uncertainty this change evoked in Aotearoa, the Chief Social Worker in a small rural hospital proposed that "[h]ealth care delivery is at present in such a state of flux that it is hard to say what it will look like, which social and health care services people will require, and from whom they will seek them by the end of the century" (G. Ross, 1990, p.24).

More recently Bronstein and her colleagues described some of the critical challenges providers of health care face, including the increase in terminal and chronic illness. They

also describe an increase in socially linked health conditions such as HIV/AIDS, drug and alcohol abuse, teen pregnancy and violence (Bronstein, Kovacs, & Vega, 2007). Having argued that these changes have resulted in increasing complex treatment decisions, and a greater participation from health care consumers and service providers in these decisions, they identify the profession needs to be prepared to integrate and employ knowledge and professional roles in order to respond effectively to these increasingly complex health care situations (Bronstein, et al., 2007).

Clearly this consistently changing practice environment has had significant implications for those charged with forward planning and decision making in relation to service development, workforce strategy and the adoption of appropriate models of care. Academic-practice partnerships would serve us well to help develop these responses, but the literature identified serious concerns about the growing gap between the practice and academic communities (Bronstein, et al., 2007).

Mirroring international trends here in Aotearoa, with the focus on cost-containment and an increasing emphasis on minimising the length of hospital stay, Ross (1990, p.25) predicted that "...there will be an increased demand made on social work services to document the effectiveness of its services to gain more widespread acceptance". In 1993 another local author and hospital employee mourned the decline of the professional culture of health social workers and making a plea for a national professional voice she cautioned that "[h]ealth social work is in danger of becoming a ghetto... Pay, conditions, professional development and career structure have deteriorated to such an extent that it does not surprise me that it is becoming hard to recruit staff" (Beddoe, 1993, p.30). One year later this senior social worker lamented that "[t]he melancholy truth is that social work has lost out professionally, and its role in the health services is even less secure" (Bobbett, 1994, p.15). This feeling of insecurity, and the sense that "the reductionist approach of the 1990s New Zealand health reforms left health social work undervalued, under resourced and marginalised as a profession" (Briggs & Cromie, 2001, p.1) has continued into the 21st century.

Throughout the nineties and persisting to the present day, the literature continues to highlight the many waves of change (Rock & Cooper, 2000); the shift in focus towards

managed care (Berger & Ai, 2000); ongoing technical and medical advances (Globerman & Bogo, 2002; Mizrahi & Berger, 2005); increased consumer involvement (Davis, Baldry, Milosevic, & Walsh, 2004); better informed consumers (Davis, Milosevic, Baldry, & Walsh, 2004); the ageing population and a shift to home care (Zimmerman & Dabelko, 2007); an increasing incidence of diseases which could be socially linked (Volland, 1996) and changes to accountability standards and professional roles (Judd & Sheffield, 2010). These shifts in focus has been described by one author as a new health care paradigm, arguing that previous models of care are no longer appropriate for the treatment of chronic conditions. She explains that because:

> [c]hronic illnesses are determined by many factors, such as an individual's social, psychological, and physical environment; genetic makeup; and health care accessibility factors, the hospital, once the dominant organization in health care, must become part of a primary care network of community-oriented delivery systems focused on chronic disease management (Berkman, 1996, p.541).

This paradigm shift is evident in the New Zealand Health Strategy (2000) as described above, with its focus on – among other things – improved access, primary health and more recently the advent of integrated family health care centres.

The ever increasing costs associated with health care, and the related need to limit resources and engage in cost effective interventions continue to dominate the contemporary literature (see, for example, (Auerback, Mason, & La Porte, 2007; Berger & Ai, 2000; Bjorkenheim, 2007; Cleak, 2002; Zimmerman & Dabelko, 2007). According to Auslander, this worldwide escalation of costs of health care has taken a particular toll on social work as "[n]ew organization structures, political philosophies and economic priorities have resulted in the dismantling of social work departments in some countries" (Auslander, 2001, p. 204). This state of affairs has been attributed by Auerback (2007) to hospital administrators' view that health social workers are nonessential in a hospital environment that is constantly concerned with cost cutting. The view that health social work is expendable is also expressed by Wimpfheimer (2004). This is particularly concerning given the profession's poor record of articulating what we do (Rock & Cooper, 2000), and what

has been described as the invisible nature of health social work in a hospital (Wimpfheimer, 2004).

This commentary leads us to two specific challenges identified in the literature that the profession has faced associated with contextual variables: firstly, the concept of being in a host environment; and secondly, the specific difficulties the profession has faced which have been linked to working in what continues to be a predominately acute medical setting.

Social work in a host setting

A number of authors have proposed that health social work faces some unique challenges in a practice context which is described as a 'host setting' or 'host organisation' (Auslander, 2000, 2001; Mizrahi & Berger, 2005; Neuman, 2000). Cowles (2003) has named the health service environment a 'secondary setting' for social work practice because the organisation's main function is the provision of medical services. In Cowles' construction, health social workers are described as *auxiliary*; playing a supportive or supplementary role; and *ancillary* in that she maintained the profession is subordinate to the services of the nursing and medical teams (Cowles, 2003). Neuman (2000) expressed a similar view arguing that by the very nature of its location in a hospital, health social work is vulnerable because the primary task of the hospital is not to attend to the psychosocial needs of its patients.

Auslander argued in 2000 that when health social workers are attempting to determine outcomes for interventions, we must first consider the organisational context in which these interventions occur. Having proposed that expectations and outcomes are not only the business of the health social work department, Auslander maintained *that* they will inevitably be powerfully influenced by organisational imperatives. Referring to health social workers as 'institutional guests', Auslander was clear that health social workers must demonstrate what we contribute to the hospital in order to have our stay extended. Issuing the strong challenge that it is insufficient for health social workers to be successful on home ground, we "must be willing to assess the relationship between our achievements, our outcomes, and the goals of the host organization" (p.35). Auslander was clear that health

social work would do well to demonstrate effective outcomes at the organisational, as well as departmental level (2000).

Relying on the host metaphor, Volland has repeated the call for a proactive approach, placing the responsibility for adjustment to the host setting firmly on the health social worker. “The practitioner is required to know how to enter the host setting most effectively and work with the health care team on behalf of individuals and their families” (1996, p.44). Whilst acknowledging that the sense of lack of control has emerged for the profession, she assertively challenged this by relying on Carleton’s 1989 quote: “...the fact that we are accountable for helping the organization achieve its goals and objectives is indicative of the fact that we are components of these structures, not guests in them” (Volland, 1996, p.44).

Cowles (2003) has provided health social workers with a clear set of directions in order to be fully accepted and successfully utilised in this secondary setting:

> (1) be considerate and respectful of the primary service providers and their work and responsibilities; (2) be mindful of the fact that medical and nursing staff view the patient as “their patient” and will appreciate the social workers keeping them informed of any developments concerning the patient and family; and (3) keep in mind the primary and priority functions of the organization, as well as the associated perspectives and concerns of the primary service providers (Cowles, 2003, p.23).

Cowles goes on to argue that problems do arise in this environment if social workers become too engrossed in their own work and therefore neglectful of this caveat.

Other trials unique to this environment have been identified in relation to the health social workers reliance on members of the multidisciplinary team for our referrals, (Globerman, 1996) where roles are often blurry, contested and evolving (Davis, Baldry, et al., 2004). One example of these shared roles identified in the literature regards discharge planning. In an article in the *Journal of Advanced Nursing* it’s claimed that “[d]ischarging patients from hospital is a key component of the nurse’s role in acute health care settings” (Atwal, 2002).

I think that the majority of health social workers would also claim this as a key component of their role, highlighting the point that Davis and her colleagues make above. Some argue that these trials have been compounded by the discovery that health social work is only valued in pockets, is often invisible, has varying status, and "[c]ompared with other professions, social work seemed 'vague, uncertain and the role is unclear'"(McMichael, 2000, p.176).

Highlighted as one of the challenges associated with the reliance on referrals from the multidisciplinary team described above, Payne cites a study which found that multiprofessional ward meetings were not a reliable source of health social work referrals with only the most serious cases picked up (Payne, 2000). This finding may well be correlated with a regularly cited concern in the social work literature that the health social work role remains ill- defined in many hospital environments (see, for example, (Auerback, et al., 2007; Globerman, 1999; Volland, 1996). Schofield, a local author offered a word of caution in relation to this matter, inviting us to note "that those professions with a firmly established base and status are more able to resist and negotiate change" (2001, p.151).

Describing the hospital as a professional organisation because most members of the primary staff are highly trained members of a profession, Cowles (2003) went on to explain that hospitals are a highly complex organisational context for health social workers. This idea was also referred to in allied health literature by Boyce (2001). Here Boyce maintained that this organisational complexity is evident in the provision of numerous services and functions combined with multiple roles and positions (Boyce, 2001). As outlined in chapter one this has resulted in what Cowles refers to as "a complex division of labor" (Cowles, 2003, p.25). According to Cowles this has meant that that assignment of tasks, labour and responsibilities are often divided among multiple personnel and professions.

In this setting Cowles has maintained that roles are not always firmly established and defined by the professional group itself; rather that they must be 'won'. Relying on Bucher and Stelling's description of this process she explained that this is "kind of a political process in which *turf* (domain) is negotiated with other professionals in an ongoing fashion" (Cowles, 2003, p.24). In this context Cowles has argued that health social workers

are unable to simply apply our practice frameworks and interventions. As an alternative we need to be aware that our role definition is highly reliant on the tacit consent and cooperation of the other professionals in the team. By way of example, Cowles has cited her earlier research (Cowles and Lefcowitz, 1992) claiming that where once the psychosocial domain was perceived as primarily a health social work function, increasingly both nurses and physicians are considering this appropriate to their professional domain (Cowles, 2003). This commentary highlights how the profession has clearly faced substantial challenges related to the hospital context, and to its professional standing in this highly contested medical environment.

The literature has indicated that social workers undertake a wide variety of professional tasks with the vast majority of their time spent with service users (Globerman, 1996). This finding has been more recently confirmed in two Australian studies, also based in the hospital context (Davis, Baldry, et al., 2004; Davis, Milosevic, et al., 2004) and more recently by Judd and her colleagues study published in 2010. This leaves very limited time for professional development (Globerman, 1999); undertaking research (McMichael, 2000); or attending to the specific needs of the discipline (Berger, et al., 1996). Not only has the profession been identified to suffer from a lack of outcome research (Nilsson, 2007; Wimpfheimer, 2004), and an inability to demonstrate, or articulate the value of the role, (Rock & Cooper, 2000) health social workers in hospitals also have a limited record of undertaking research and subsequently few studies to draw on when making service development decisions (Berger & Ai, 2000).

The Judd and Sheffield (2010) study referred to previously, based in American hospitals, identified that the primary focus of health social work practice was discharge planning, with much less time spent on responding to emotional distress, including supporting patient and family adjustment to a new diagnosis. Somewhat concerning was the finding that almost no time was spent on practice research activities (Judd & Sheffield, 2010), particularly given the increasing pressure on the profession to engage in evidence-based practice.

In summary, health social work has faced almost two decades of substantial challenges, both locally and internationally. The most significant challenges have been described as the changing practice context; cost saving and subsequent restructuring; new health care paradigms and changing expectations, and the unique difficulties associated with the profession's location in a host setting. The literature maintains that practitioners undertake a wide variety of tasks, spend the majority of the working day with service users, engage in limited professional development, and have meagre outcomes studies to draw on in making practice decisions. The attempts the profession has made to respond to these challenges will now be described.

Calls to define the role and demonstrate outcomes

Writing about redefining the health social work role as far back as 1993, Ross asked a series of questions in her efforts to explore the contribution of health social work in the hospital environment. Her first question "[w]hat has been social work's main contribution to health care?" (Ross, 1993, p.246). The subsequent answer has provided some insight as to the thinking of the day. Here Ross claims that:

> Among health providers social workers have the training, knowledge base, and skill to best understand the particular psychosocial and economic needs imposed on a patient by illness and the changes and adjustments demanded of the patient and his or her family, to assess the interpersonal and instrumental resources that will be required to treat them, and to assist with these adjustments through counselling and referral. All this we accomplish within extremely compressed time limits. Much is lost in translating these activities into language that has meaning to non-clinicians and into figures that demonstrate fiscal necessity (J. Ross, 1993, p. 246).

Whether or not we agree with Ross's faith in the profession's abilities, it is striking that she made these claims without having cited a single piece of evidence; instead her article was in fact almost entirely a commentary (which may reflect its era.)

Ross's quote also highlighted the perceived challenges associated with health social workers demonstrating outcomes. More recently "[s]ocial workers practicing in a health context have been encouraged to identify the characteristics of their expertise and to name profession specific roles (Pecukonis, Cornelius, & Parrish, 2003, p. 111). These themes remain doggedly persistent throughout this literature review; (see for example (Judd & Sheffield, 2010; Nilsson, 2007). Two studies, both published in 1996, have provided us with a fuller appreciation of the efforts that have been made to seek solutions and develop strategies in the hope of overcoming the contextual challenges health social workers were facing.

A small exploratory telephone survey was undertaken by Globerman and co-researchers (1996) with the aim of better understanding how health social workers could meet the challenges associated with health reforms and the restructuring of hospitals. Twelve senior health social workers based in Ontario hospitals participated, which at the time were undergoing significant change processes. The study was qualitative and relied on a series of semi-structured interviews as the method of data collection; the analysis was largely interpretive (Globerman, 1996).

Back grounding their research, these authors rely on extensive literature to describe the motivation for health service restructuring. Although there was clearly a focus on cost control, economics and fiscal restraint, the concept of patient-focused or patient-centred hospitals also dominated. The third category of rationale came out of the organisational and management literature which maintained an emphasis on empowering workers; shared governance; increased control of their workplace, and the need to "…re-evaluate assembly-line thinking" (Globerman, 1996, p. 178). This is broadly reflective of the increased focus on clinical governance in our own context, evident in the proliferation of articles associated with shared governance. See for example, (Braithwaite & Travaglia, 2008; Degeling, Maxwell, Iedema, & Hunter, 2004; Perkins, Pelkowitz, & Sedden, 2006).

One of the three central themes identified by Globerman and her colleagues involved the health social work role, and specifically concerns regarding role changes; a lack of control regarding the role; and the absence of a thorough understanding of the role among their

medical colleagues. These authors made the argument that disciplines such as health social work are required to pay “thoughtful attention to the greater social, psychological and spiritual needs of patients” (1996, p.8) and citing Purtilo (1994) suggested this was ‘moral work’. According to these authors our contribution in the hospital setting was consequently likely to be less visible and more difficult to measure, thereby being disadvantaged in a system that relies heavily on quantitative measurement to demonstrate a profession’s worth.

The social workers Globerman and her colleagues surveyed, recognised and articulated a number of strategies to deal with the perceived threats to the health social work role. These strategies focused on the need to define the role; to develop a strategic plan; to systematically deconstruct health social work practice; to engage in critical evaluation regarding what we do, and examine what we would choose to do in an ideal world. A consistent strategy described in their findings was the opportunity this critical evaluation process would afford practitioners to claim the best of what we currently provide, and to distinguish new areas of expertise. Their proactive descriptions included the concepts of innovation, being on the cutting edge and creating new enterprises “in an effort to establish and define a place and role for social work” (Globerman, 1996, p.7).

Supporting the proactive position as articulated by Volland (1996) earlier in this chapter, was the unambiguous acknowledgment from participants that the challenge of defining the health social work role rests fairly and squarely on the profession’s shoulders. Strengthening industry and university partnerships to facilitate increased evaluation of practice and engage in outcome studies was encouraged. Respondents consistently expressed trepidation about how to articulate and demonstrate the distinct health social work domain in the hospital environment, and their lack of capacity to engage in outcome studies. Regardless of these expressed misgivings, the need to meet the challenge of proactively defining the health social work role remained a central strategy to assist practitioners to respond effectively to the changing practice environment (Globerman, 1996).

Responding to numerous requests from practitioners regarding how to deal with the changing scene of social work in hospitals, a report prepared by The Society for Social

Work Administrators in Health Care and the National Association of Social Workers of America was published in 1996 (Berger, et al., 1996). Similar to Globerman and colleagues' study cited above, these groups joined forces in order to undertake a large-scale study of the changes taking place in hospitals, and the impact of those changes on health social work practice. A standardised, self-administered survey instrument was developed, and a sample of 340 hospitals, drawn from the member list of the American Hospital Association participated in the study.

Identifying a need to create a balanced view of what was occurring in hospitals, an important finding from their study was the need to contextualise changes in social work, to the overall changes in the health care industry. Claiming that health social work was not being subjected to, or singled out for, greater demands for change, they cautioned against health social workers taking up a stance as victims (Berger, et al., 1996). They expressed the belief that associated with this stance was the risk of powerlessness, inevitably leading to behaviours that would increase, rather than reduce the problems the social workers were facing. If this powerlessness was to take hold, they suggested that practitioners may well become engaged in turf wars, and efforts to resist change. These authors advised that this was a time to participate in, embrace and lead change, to become the architects of the change process, not the helpless victims of it (Berger, et al., 1996).

Predicting that the waves of change would continue until the health system was able to comprehensively address the basic inequities and inconsistencies that currently existed, Neuman (2000) proposed that health social work will continually face the challenge of having to redefine our role. Some of the suggested responses to the challenges outlined above have included, an imperative to remain relevant and adaptable (Kossman, Lamb, O'Brien, Predmore, & Prescher, 2005); the ability to become the architects of change (Berger, et al., 1996; Neuman, 2000); a willingness to develop innovative approaches to changing environments (J. Sulman, et al., 2001); a commitment to making the practice and the role more visible (Berger, et al., 1996; Berkman, 1996); the skill of consistently educating others about the role (Subramanian, 2000); finding ways of making evaluation workable (Wade & Neuman, 2007); maintaining and developing clear practice standards (Auerback, et al., 2000; Berger, et al., 1996); the capacity to reflect on and test

interventions (Blumenfield & Epstein, 2001); and lastly to engage in an examination of health social work decision making in order to state clearly and strongly the basis of health social work knowledge (Kitchen & Brook, 2005).

Broad agreements in the hospital context

It is appropriate to consider the evidence found in the literature regarding the advancement the profession has made by facing up to the described challenges. This advancement includes the international research efforts which have been able to articulate the unique contribution we make in the hospital environment by providing examples of effective health social work practice. In an effort to add finer detail to the health social work practice context in which this inquiry occurs these issues have been examined in the literature to which I now turn.

Despite what appeared to be a lack of evidence, there has been substantial agreement that social workers have played a significant role in hospitals throughout the 20th century (Beder, 2006; Cowles, 2003; Dziegielewski, 2004; Rock, 2002). It is Rock (2002) who articulated the vision for the first medical social worker developed in 1908 by Cabot and Cannon in the Massachusetts General Hospital. Outlining the medical social worker's essential functions Rock maintained that the role was comprised of:

> "(1) understanding the patient in his/her environment, especially; (2) the importance of family and the community, including community resources; (3) compliance with medical treatment plans; (4) discharge planning and follow-up; and (5) research, especially, in community needs" (Rock, 2002, p. 11).While acknowledging the multiple revolutions that have occurred in health care during the subsequent hundred years, various authors agreed about the enduring nature of these key health social work functions in the hospital environment (Beder, 2006; Berkman, 1996; Cowles, 2003; Dziegielewski, 2004; Rock, 2002).

Rock continued his account of the health social work role by contrasting the dominant medical ideology of the 20th century, the biomedical worldview, with the preferred health social work worldview, described as a biopsychosocial approach. The former is focused on

disease, the reductionism of complex phenomena, a mind/body dualism and a lack of acknowledgement of the social, psychological and behavioural elements of illness. In contrast, “the biopsychosocial model attempts to integrate a vision of a patient as a person, in-situation, not unlike the social work concept of person-environment fit” (Rock, 2002, p.11) referred to earlier in this chapter.

The biopsychosocial model, whilst recognising the importance of biological factors, has maintained that these are inadequate for understanding a person’s situation in a social world. Rock cites Engle (1977/1992) who highlighted the distortions emulating from the narrow construction of the biomedical model. Rather he proposed that the patient has a lot of ‘data’ to impart to the physician, but the restrictedness of the biomedically focused practitioner is not able to ‘hear’ that data. Described as ‘the more enlightened approach’ this is precisely the data that health social workers *are* occupied with. Rock concludes by stating “[t]he scientifically measurable existence of *disease* does not explain the subjective, human experience of *illness*” (Rock, 2002, p.11-12).

Dziegielewski (2004) identified a core concept and the foundation on which all health social work services are based, as she elaborated Rock’s description of the biopsychosocial model by outlining the three overlapping elements of a service user’s functioning. ‘Bio’ referring to the medical and purely biological aspects of health; ‘psycho’, to their psychological function, such as self-esteem; and lastly ‘social’, which reportedly encompasses the social environments and their influence on the wellbeing of the service user. When all these aspects of a service user’s experience have been assessed and attended to, the biopsychosocial model of practice is said to be in place (Dziegielewski, 2004). Mason Durie has developed a local model metaphorically representing the four sides of the house, or ‘whare’. This model articulates a Maori approach to assessment. Durie’s framework invites health social workers to consider ‘taha wairua’ (the spiritual dimension); ‘taha hinengaro’ (the mental dimension); ‘taha tinana’ (the physical dimension) and lastly ‘taha whanau’ (the social/family dimension) (Durie, 1994) when assessing the needs of patients and their whanau.

Clearly the application of the biopsychosocial approach to practice forms the foundation on which health social work practice is built; however in order to more fully understand how this approach manifests in practice it was necessary once again to explore the health social work literature. Three texts and one book chapter all published in the 21st century, provide us with a basic outline (Beder, 2006; Cowles, 2003; Dziegielewski, 2004; Schofield, 2001), with published research from social work journals providing additional confirmation of the core skills, functions and roles of the health social worker. By highlighting and extracting the consistent accounts of health social work practice, we are provided with a basic framework of activities that the health social worker is reported to regularly rely on in this practice context.

It is Schofield in Aotearoa who explained that "[c]ontemporary health social work practice encompasses work with individuals, whanau, families and groups in hospital and community settings" (Schofield, 2001, p.152). Dziegielewski (2004) proposed that this is what sets the profession apart from other disciplines and is the most important aspect of the profession of social work. She proposed that in its most simplistic form, it is the recognition of the 'person in the environment' or the 'individual in the situation' that remains critical to social work practice, and has provided us with a unique capacity in the contemporary health environment. As well as the provision of standard concrete service, she emphasised the value of health social workers also aiming to address a number of other areas which include restoration and prevention, and increased wellbeing (Dziegielewski, 2004).

The people who receive services from health social workers are reported to have often experienced recent trauma or are trying to cope with and adjust to a debilitating medical condition. Relying on Poole (1995) Schofield emphasises that the aim of health social workers is to "...enable clients to improve their social functioning and to maintain this at its highest possible level" (Schofield, 2001, p. 153). She maintains that on top of general social work competencies, health social workers "...require specialist knowledge and skills in crisis intervention, multidisciplinary teamwork, and client advocacy" (Schofield, 2001, p. 153). These skills also feature in Cowles' list of health specific knowledge along with grief counselling and case management (2003).

Asserting that the role of health care social workers has been clearly established, an extensive list of core services is outlined in Dziegielewski's (2004) book. Although it was aimed at practitioners working in a managed care environment, many of the activities appear to be consistent with the Aotearoa context which may be associated with the increasing emphasis on cost containment and the ability to demonstrate effective outcomes. Dziegielewski's list included case finding and outreach; pre-service planning; assessment; concrete service provision; psychosocial evaluations; identification of goals and objectives; clinical counselling; assistance with short term and long term planning; information and health education; assistance with wellness training; referral services; continuity of care and client advocacy (2004).

Focusing exclusively on the hospital Emergency Department, Dziegielewski also highlighted the ability to respond to trauma and abuse as core skills. This included the assessing the vulnerability of adults and children in the areas of drug and alcohol abuse; domestic violence and risks associated with mental health concerns such as suicideality (2004). With a focus on Emergency Department practice, Beder (2006) has outlined the need for health social workers to engage in a thorough risk assessment when patients present who have suffered domestic or sexual abuse. She maintains that this must consider the frequency and severity of the abuse, and current or past injuries, and the legal ramifications inherent in such situations.

It was notable that there were very few detailed accounts of health social work activities or core skills related to the ability to respond to patient vulnerability and risk associated with interpersonal violence. Although, as outlined above, there were some references made to this in relation to Emergency Department work, only one minor reference to elder abuse was found (Dziegielewski, 2004). The chapter on paediatric health social work in Beder's (2006) book titled *Hospital Social Work* made no explicit mention of the need to respond to issues of vulnerability and risk in the infant and child population. This absence may reflect the era in which the texts were published**.**

Cowles (2003) stated that health social workers, practising in a medical context, required the following additional knowledge: the nature of the health problem and the characteristics

of the client population; the nature of the organisational context and what this implies for health social work practice; a robust knowledge of the particular characteristics of the communities we serve, and appropriate community resources; specific intervention modalities taking into account the above considerations; and lastly high standards of documentation, and the capacity for research and evaluation. Suggesting that health social workers were at a disadvantage if we were unfamiliar with medical jargon, this need for a well-developed understanding of medical conditions and terminology highlighted by Cowles above was also confirmed in Dziegielewski's text. Here she has provided health social workers with a list of medical terminology to emphasise her point (Dziegielewski, 2004, p. 111).

Having made the assertion that in the current context traditional health social work activities are being questioned, one recent study aimed to develop a set of clinical priorities for health social workers. Relying on the numerical ranking of two sets of client scenarios this research process relied on coding and the cognitive mapping of the declarations health social workers made in order to explain the rationale underpinning their priority ranking of the various scenarios. Three clear themes emerged from the data; safety and risk, social/psychological support and access to resources (Giles, Gould, Hart, & Swancott, 2007).

Within the first theme, that of safety and risk, health social workers identified specific social issues such as homelessness, the use of alcohol and drugs, domestic violence and child abuse and mental health issues such as depression and suicide. In combination with naming these specific social issues as motivation for the ranking, practitioners also relied on language denoting levels of risk, for example, 'high risk' and particular obligations such as a 'legal obligation' or a 'moral obligation' (Giles, et al., 2007). The centrality of issues associated with safety and risk was supported by data from Miller's internal survey situated in a major Australian paediatric hospital. This survey revealed that a third of the teams cases involved issues of abuse or neglect (Miller, 2001).

The social/psychological support theme was demonstrated by language describing the psychosocial and emotional issues in connection to the patient and his/her family's

adjustment to a new situation. These descriptions included matters such as patients and their families experiencing loss and grief responses, isolation, relationship difficulties, family breakdown, and the levels of service support. These authors also noted that the practitioners relied on language to represent the social and psychological implications of these particular phenomena, for example, that parenting were affected by the hospitalisation of a child (Giles, et al., 2007). Evidence of the predominance of psychosocial issues in the hospital social work literature has been reflected in this sample of articles (Lechman & Duder, 2006; Miller, 2006; Nilsson, 2007; Zimmerman & Dabelko, 2007)**.**

The third and final theme of access to resources was demonstrated by health social workers naming the situations in which service users required information and assistance in gaining access to particular services. These included services such as housing, interpreters, finances, and counselling. In the accounts that represented this theme health social workers also described resource issues in regards to their own resources such as time, and also their capacity to be effective (Giles, et al., 2007).

In 2001, relying on the findings from a Delphi exercise, Auslander has provided us with a list of 20 central collective accomplishments of health social workers. Having relied on a team of academics and expert practitioners from a variety of countries to explore these achievements, Auslander declares that they are consistent with the literature. Two of the achievements that rated particularly highly are: having an effect on changing models of health and illness and that of achieving recognition and legitimacy. A further three, those of knowledge development, the expansion of culturally appropriate interventions, and the provision of direct interventions with service users, also received very high ratings (Auslander, 2001).

It is interesting that the incorporation of the biopsychosocial model and other similar holistic approaches into mainstream medical services is claimed to be health social work's most significant achievement. Having promoted an increased awareness of the critical influences that emotional, social, family and cultural factors play in a patient's health, social workers believe that they have encouraged "physicians in particular, to take these factors into account in diagnosis, treatment and prevention" (Auslander, 2001, p. 201). The

other 14 achievements included interdisciplinary and multidisciplinary team work; advocacy of patients' rights; linking illness to other social problems; increased professional autonomy; management and organisational development; gathering empirical evidence; involvement in health policy; service user self help and empowerment; dissemination of knowledge; inclusion of families; quality assurance; training medical personnel; the establishment of social work departments in hospitals; the provision of services to other members of the team, such as debriefing; and finally the ability to specialise (Auslander, 2001).

Overall it was found that three activities of the hospital social worker dominate the literature: the psychosocial assessment and interventions; discharge planning; and collaboration and team work. There are a number of other key activities, such as grief and loss work, (Schofield, 2001); crisis intervention (Miller, 2001) advocacy and liaison (Davis et al, 2004) and knowledge of community resources,(Hall, et al., 1996). Within the limits of this inquiry however, a choice was made on the basis of prevalence. Each of these three core activities has been examined in more detail, once again situating the practice within the hospital context. A brief examination of paediatric health social work follows; this is included as an acknowledgement of the case study context, prior to a brief examination of two hospital and one primary health based outcomes studies.

Completion of the psychosocial assessment has been identified as the beginning point for numerous significant interventions within the hospital environment (Beder, 2006; Cowles, 2003; Dziegielewski, 2004; Giles, et al., 2007; Lechman & Duder, 2006; Miller, 2006; Rock, 2002; Schofield, 2001; Subramanian, 2000). These assessments have been outlined by Dziegielewski, (2004) as the gathering of information on the service user's biopsychosocial, financial, cultural and other specific circumstances and situational factors used to inform the basis of a formal psychosocial report and/or plan. Cowles described psychosocial problems as "...problems with both psychological and social environmental components, which reflects the inevitable influence each arena has on the other" (Cowles, 2003, p.69).

The literature identified that the psychosocial assessment is undertaken prior to medical interventions such as organ transplant (Beder, 2006); kidney dialysis (Dziegielewski, 2004); and cancer treatments (Cowles, 2003). In an Australian study psychosocial assessments were indicated by participants in a study which aimed to define the health social work role as "their main tasks undertaken daily and formed the basis of their work" (Davis, Milosevic, et al., 2004, p. 291). The psychosocial assessment provides the foundation of successful discharge planning (Kitchen & Brook, 2005); is considered an essential skill for all contemporary health social work practitioners (Berkman, 1996); and having been successfully implemented, solid psychosocial plans have demonstrated cost savings in primary care environments (Rock & Cooper, 2000); and hospital contexts (Auerback, et al., 2007).

Upwards of 30 percent of discharges from hospital are delayed as a result of non-medical reasons according to Boutin-Foster and his colleagues. Reasons identified include matters such as lack of availability of equipment and nursing home beds and an inability to access home health care (Boutin-Foster, et al., 2005). Whilst these matters are not the sole responsibility of health social workers, their article proposed that early identification of patients who need a health social work evaluation is fundamental to effective discharge planning.

Exploring the role of hospital social workers, an Australian study demonstrated via a thematic analysis of the research transcripts that discharge planning was the all encompassing aim of the health social worker. Relying on this participant quotation they explain that "discharge planning...is just such a broad umbrella that it covers everything that we do from counselling, assessment...advocacy, everything as part of liaison and management" (Davis, Milosevic, et al., 2004, p. 291). This finding was supported in Beder's hospital social work text where she ascertains that "[e]very social worker interviewed for this volume identified discharge planning as a defining task of their work in the hospital" (Beder, 2006, p.10).

Relying on the American Hospital Association's 1984 definition of discharge planning, Beder proposed that this is essentially an interdisciplinary process which is guided by the following fundamental elements:

1. "Early identification of patients likely to need complex post-hospital care
2. Indication of patient preferences for post-hospital care
3. Patient and family education
4. Patient and family assessment and counseling
5. Planning, development, and coordination of community resources needed to ensure continuity of care after discharge
6. Post-discharge follow-up to ensure service and plan outcome"(Beder, 2006, p.11).

Beder suggested that in the majority of hospitals these specific activities fall within the domain of the health social work department and this was reflected in the importance this subject is given in the health texts (Beder, 2006; Cowles, 2003; Dziegielewski, 2004). Sulman's 2001 study argues that with the current trend of shorter lengths of stay, and much higher patient volumes, social work services should be oriented towards maximising interventions in the pre-admission phase. They provide the example of a social worker in the oncology service beginning their intervention at the pre-admission assessment unit "to begin pre-admission discharge planning, to identify pre-existing social issues and provide information to the team prior to treatment" (J. Sulman, et al., 2001, p.323). These same authors suggest that "[t]his relatively brief pre-admission contact paves the way for effective, time-efficient interventions during hospitalization" (J. Sulman, et al., 2001, p.323).

A more recent article devoted to the contemporary roles and professional responsibilities of health social workers who work in hospitals confirmed that discharge planning remains a highly relevant skill for our profession. Reinforcing its value this article highlighted that in American hospitals respondents identified discharge planning as a *primary role* (Judd & Sheffield, 2010). Adding final emphasises to the role that discharge planning can play in curtailing ever increasing health care costs by reducing length of stay; planning the patient's discharge from hospital was described as an increasingly critical activity by these Israeli researchers (Soskolne, Kaplan, Ben-Shahar, Stanger, & Auslander, 2010).

Collaborative team work

Teams of various types, both multidisciplinary and interdisciplinary have become increasingly popular in a modernising health system (Beder, 2006; Cowles, 2003; Dziegielewski, 2004; McCallin, 2006). Teams and teamwork have been found to be a key factor in organisational effectiveness, and whilst the above terms remain loosely defined, this may simply suggest that "labels may be less important than the challenges of working together" (McCallin, 2006, p.6). In essence, members of these teams collaborate and cooperate to varying degrees in order to provide effective and coordinated hospital care for the patient and their whanau. For the purposes of this literature review the term 'multidisciplinary' has been used whilst acknowledging that the key concepts of collaboration, cooperation and shared decision making were identified as central to both interdisciplinary and multidisciplinary teams.

In 1993 Ross argued that any claim health social workers have to membership of the health care team must be based on expertise, not merely a shallow grasp of the biopsychosocial aspects of illness (J. Ross, 1993). Citing Ruster, (1995) Cowles (2003) has promoted the notion that the ability to cooperate and collaborate with our medical colleagues in a way that complements, rather than competes, has been a key to the survival of health social workers. This view is supported by Beder (2006) who proposed in her text that this type of collaboration requires a great degree of cooperation in order to be successful, with each member of the team knowing that what they contribute *will* be taken into account when shared decisions are being made about patient care.

Team work was identified by a local author as a key factor affecting organisational effectiveness; however she suggested that it was not yet clear if any specific form of team working is better than another (McCallin, 2006). What was clear in McCallin's research however was the concept that teams can only become skilled at working as a team once colleagues were confident that the particular team member was competent. In short her research found that "individual practitioner competence was critical" (McCallin, 2006, p.7) to effective multidisciplinary team work. Exploring the concept of dialogue in relation to effective teamwork McCallin argued that it was more than simply communicating; rather it meant talking something through to the extent that a change of thinking and/or practice

occurs (McCallin, 2006). Having signalled the centrality of this information exchange McCallin suggested that "[m]ore than ever before, the individual's capacity to exchange information about complex tasks, goals, and client progress is critical" (2006, p.8).

This need has been reinforced in another locally based study which aimed to identify how many health professionals a patients sees during an average hospital stay (Whitt, Harvey, McLeod, & Child, 2007). This study, based at Auckland City Hospital found that in medicine the patients saw an average of 17.8 health professionals, and in surgery they saw an average of 26.6 health professionals during their admission. In their conclusion these authors emphasised that in a context where many different health care professionals were involved in a patients care "the importance of effective communication both between health professionals and patients" and "between health professionals themselves" (Whitt, et al., 2007, p.7) is vital to the provision of quality health care.

Beder (2006), extending the discussion to the concept of collaboration, described this as "a complex and dynamic process that occurs when two or more health care providers cooperate and assist one another in the service of a patient or family member" (p.5). The rationale for this type of collaborative team work is that multiple skills and knowledge sets are required to fully meet the needs of service users and their families. The function of such teams includes the multidisciplinary assessment of a patient's need with subsequent interventions designed to address the specific problems identified (Beder, 2006).

The Paediatric environment

Miller, an Australian social work leader based in a paediatric teaching hospital very similar to the practice environment in which the case study occurred described the essential knowledge, skills *and* qualities needed within this context (Miller, 2001). She placed great emphasis on the need for strongly consolidated ethical practitioners with a sophisticated level of ability to work in a large bureaucracy. Stressing as essential the capacity for teamwork and the specific ability to communicate with the multidisciplinary team in order to gain their support for intervention plans, Miller also highlighted the skill of working within and between systems (2001).

Beder suggested that the illness of a child is likely to pull at the emotional wellbeing of families, and in the paediatric environment "consistent with the social work systems orientation, the patient is the sick child *and* the family members who care for him or her" (Beder, 2006, p.69). Depending on the severity of the illness or condition, she proposed that parents are at risk of becoming overwhelmed themselves. Often finding themselves in a strange environment with little warning, they were identified as vulnerable to feeling torn between remaining with their ill child, and the external responsibilities they carry. It was described as the health social workers' job to orientate parents to the hospital environment, described as going into 'intro mode', they are required to help acquaint family members with the hospital routines, and assist them to be as comfortable as possible under very trying circumstances (Beder, 2006).

Based on interviews with 11 paediatric social workers, Beder (2006) stressed the importance of health social workers in this environment assuming a crisis orientation to their work, particularly if children had arrived in hospital unexpectedly. Adding weight to this point Beder relied on Dungan and co-authors 1995 work focused on the challenges paediatric social workers can face in this context:

> [C]ontaining the crisis, enabling the mastery of tasks, differentiating between past and current sources of stress, validating the family's efforts, being sensitive to cross-cultural issues, tolerating strong affect (emotions usually run high), and supporting bereaved parents as needed. In efforts to contain the crisis of the hospitalization and illness, the social worker has to balance the needed emotional expression of feelings for the parents and family with the need to help the family keep functioning (Beder, 2006, p.169-170).

The need to deliver services with a family-centred orientation was also stressed in the literature, with all three authors emphasising the role the paediatric health social worker plays in ensuring that appropriate information and dialogue occurs between the family and the medical team (Beder, 2006; Dziegielewski, 2004; Miller, 2001). In order to engage in this activity the need to understand medical diagnosis and language is also stressed as described previously. Some weight was also placed on the need for "sensitivity to different approaches to illness and health in our multicultural society" (Miller, 2001, p.4).

This ability to work cross-culturally is emphasised in the literature repeatedly, albeit briefly. Beder (2006) is especially clear that the health social worker needed to be well informed about the specific cultural practices and beliefs of family members, and to be respectful of them at all times. Emphasising the task of advocacy in relation to rituals that fall outside of the dominant culture, Beder (2006) proposed that the health social worker is often required to undertake this advocacy activity with members of the multidisciplinary team.

Miller (2001) noted that paediatric hospitals do not have the luxury of an intake system; rather the health social worker is allocated several wards from which she either accepts or declines referrals at her own discretion. Miller is clear that the social worker needed to be highly competent in the area of rapid assessments, and has the ability to undertake appropriate, but brief interventions, and emphasises the timeliness of responses given the brief length of stay for many child patients. The appropriateness of brief interventions is also described by Beder (2006) who encourages a focus on helping parents adjust to and deal with the present stage of their child's illness.

This concept of adjustment has been identified as significant in the study by Nilsson and Fitzgerald, (2001) who found that the indicators for social work intervention, *adjustment to hospitalisation*, and *adjustment to health condition* accounted for 47 percent of all referrals. More recently Nilsson's 2007 study, which was co-located in a paediatric hospital conceptualised *adjustment* issues identified in a health settings "as a complex, multi-dimensional process including the key inter-related themes of *coping, emotion, subjective meaning, adaptation, support, family-focus, and process orientation*" (Nilsson, 2007, p.21).

There were very few studies focused on outcomes in relation to health social work intervention in a paediatric hospital and Nilsson was particularly cautious regarding the timing of outcome measures in relation to concepts such as adjustment. He argued that because adjustment has been conceptualised as a process, and the consistent feature of social work in health care has been "...its fluidity in responding to the often rapidly changing needs of clients" (Nilsson, 2007, p.40), precise outcome measures could prove

limiting. Other researchers have taken on the challenge of outcome studies in the hospital and it is to these that our attention is now turned.

Outcomes of health social work

Having examined the concept of outcomes, and been clear that the results of health social work intervention must be linked to organisational imperatives, Auslander asked that practitioners consider the motive for including social work departments in hospitals in the first place. Consequently she grouped outcomes into two categories: (a) departmental or psychosocial outcomes, directly related to the well-being of the service user; and (b) organisational outcomes, related to the improved functioning of the hospital as an organisation (Auslander, 2000).

Expanding on the first category of results, Auslander explained that psychosocial outcomes originate from a direct connection between the psychosocial state of the health social work client, and the conditions being addressed by the hospital. This approach acknowledged the fact that for many hospital patients, the medical condition that they are dealing with exposes them to increased risk of particular psychosocial problems. The aim of the health social worker is therefore to assist them in the resolution of these problems in order to improve their situation (Auslander, 2000).

Whilst having acknowledged that certain medical situations, such as the birth of a premature baby, may be expected to exacerbate psychosocial problems, the actual care provided by the hospital may in itself lead to psychosocial problems according to Auslander. For example the low birth weight of the preterm baby may well lead to anxiety, marital stress, and the breakdown of normal family relationships (Auslander, 2000). Treatment regimens may require behavioural changes; dietary demands may force changes in the eating habits of entire families hereby demonstrating that the hospital can itself have wide-ranging psychosocial implications for service users. Accordingly she argued that it is both realistic and necessary to provide health social work services within that arena. It was Auslander (2000) who clarified that the presence of a health social worker on the hospital ward provides an opportunity to advance interdisciplinary cooperation and teamwork in an effort to reduce or prevent these difficulties from manifesting.

The second area of results Auslander identified was that of organisational goals that she breaks down into three areas: firstly, *the mission-oriented outcome*, the mission being the overall goal or vision of the organisation. For instance the Auckland District Health Board's vision, established in 2001 is Hei Oranga Tika Mo Te Iti Me Te Rahi, Healthy Communities, Quality Healthcare (ADHB Health Improvement plan). Auslander argued that achieving the hospital's mission can often be achieved via successful psychosocial intervention as these factors are regularly part of the aetiology of various diseases. By way of demonstration "[p]sychosocial and socioeconomic factors such as poverty, overcrowding, and poor sanitation are related to the spread of infectious disease" (Auslander, 2000, p.37). By attending to the psychosocial difficulties the service user was experiencing, the expectation is that health social workers are able to contribute to the recovery, maintenance, and rehabilitation of physical health. Health social workers therefore apply the biopsychosocial model of practice as a standard response to the achievement of the organisation's mission.

The second set of results Auslander was able to articulate within the organisational category was that of *enabling outcomes*, those activities that the health social worker undertakes to assist their medical colleagues to provide services. She cited as an example, an intervention designed to support a service user's adherence to complex treatment regimens. The final area of results Auslander (2000) identified for our profession is that of *maintenance outcomes*. These related to the hospital's ability to continue operations with improved resource utilisation and overall efficiency. To demonstrate the health social worker's contribution to such an outcome Auslander called on the examples of reduced use of prescription drugs, and effective discharge planning (Auslander, 2000).

This framework of four social work outcome-types, psychosocial, mission related, enabling and maintenance have provided health social workers with a conceptual map. Application of this map may support health social workers to demonstrate the unique influence our profession is able to have in the hospital environment. Auslander (2000) set out to do just that and made some significant discoveries. Focusing on the professional literature in a

number of specialist and non-specialist health care journals, she was able to unearth the following findings.

The most commonly reported outcomes fell within the psychosocial domain, via the resolution of psychosocial problems. Within this domain the most commonly reported results were described as problems solved and plans completed; improved coping; successful adjustment to chronic and/or serious illness such as cancer and improved well-being and quality of life. Other outcomes in this category were related to improved relationships; reduced pressure on caregivers, and positive impacts on families receiving intervention (Auslander, 2000).

The second category of most reported outcomes were identified as falling within the maintenance field, for example, reduced length of stay, frequency of admissions and readmissions, and the costs and time spent per case. Auslander (2000) noted with interest that none of these studies made the connection between the psychosocial outcome and the maintenance outcome. This could be done for example, by firmly establishing a link between the work health social workers undertake to support appropriate adjustment, timely discharge and reduced readmissions.

Auslander was further encouraged by the discovery that two studies were able to make a fundamental link between the health social work interventions and enabling outcomes; both these studies related to service user's adherence with medical treatment plans. Another three studies found that social work intervention resulted in a better understanding of the illness, and its related treatment. This was particularly reassuring given the relationship that has been established between the patient's feelings of control, participation in decision-making and subsequent adherence to treatment plans (Glajchen and Moul, 1996 cited in Auslander 2000).

Lastly Auslander identified a very small group of six studies which were able to demonstrate a link between the social work intervention and the service user's health status. Although most of these studies had non-physiological measures, there were also some, such as the study completed by Auslander and colleagues they conducted in 1998 which were

able to demonstrate reduced cholesterol levels in a group of women who received health social work intervention.

Overall Auslander's review of the health social work literature in 2000 was able to show that psychosocial outcomes predominate, but there is also increasing evidence of health social work researchers being aware of how critical it is to expand the research boundaries by exploring the relationship between specific health social work interventions, and outcomes that were crucial to the achievement of the goals of the wider organisation. To demonstrate the profession's ability to respond to these research gaps, a small sample of these studies has been described.

Rock and Cooper's study, despite its location in a primary health setting, has been included because it was able to demonstrate the clear benefit of having social workers attend to the psychosocial and environmental aspects of illness. This has clear relevance in a hospital environment. The study aimed to demonstrate the value of health social work in a primary health care setting and via a student unit, support social work students' increased engagement in research by utilising practice research approaches (Rock & Cooper, 2000). The literature indicated that service users with high levels of psychosocial stress placed increased demands on primary care facilities, including diagnostic and laboratory resources (Rock & Cooper, 2000).

Applying a single subject design, the students objectively determined what problems should be targeted with the use of a screening tool, the Global Screening Inventory. The initial results of this screening indicated that most of the service users who were referred to the social work students were suffering from depression and anxiety. Subsequently "The Hudson Measurement Package" with standardised measure was selected as they were short, easy to administer (10 minutes) and easy to score (five minutes). According to this literature these rapid assessment tools were valuable in that they could be used over time in order to obtain repeated measurements, providing data about the status of the service user's condition; with either an improvement or deterioration. This process was able to guide the social work student, providing a clear indication of the present interventions efficacy (Rock & Cooper, 2000).

This study demonstrated validation of effectiveness as issues such as anxiety, depression and adjustment reactions were decreased as a result of social work input. These interventions were reported to result in fewer visits to the physician, improved compliance with diet/nutrition and with medical regimens (Rock & Cooper, 2000). There were other benefits to the study identified, including increased referrals to social work; a greater awareness among medical staff regarding the mental health symptoms of depression and anxiety as important co-morbidities with acute medical illness and increased social work productivity. The authors recommended randomised studies as a follow up, with a greater sample in order to demonstrate that the study is able to be replicated, and generalised, demonstrating the cost effectiveness and quality of social work services in primary care (Rock & Cooper, 2000).

In 2006, Lechman and Duder undertook a study that was able to demonstrate a direct link between psychosocial severity, length of hospital stay, and the role of the health social work service. Their sample of 2,642 cases was drawn from three acute care hospitals and data collection focused on excess length of stay, the difference between actual length of stay and target length of stay. They discovered that 29.2 percent of all hospital days were in the category of excess days for patients in receipt of health social work services. For a sample of 176 health social work cases, a stepwise regression was able to yield two statistically significant predictors of length of stay, namely, firstly the medical problem and target length of stay, and secondly, the severity of the psychosocial problem (Lechman & Duder, 2006).

This data from Lechman and Duder's study was able to demonstrate three things very clearly. They discovered that as many as 43.7 percent of service users admitted to hospital, and 32.2 percent of typical cases admitted to hospital and in receipt of health social work services, exceeded the target length of stay which had been based on the diagnosis and severity of the medical condition. They also found that health social work cases were associated with a disproportionate number of these excess days, and that for these cases the severity of the psychosocial problems was not only a significant predictor of excesses

length of stay, they also consumed the highest amount of health social workers time (Lechman & Duder, 2006).

These authors maintained that two notable issues arise from this study; citing Njomo's (1996) research they claimed that since health social workers provide interventions to service users who remain in hospital the longest, we risk being seen as a redundant service unless our unique role in working with the most serious social problems can be clearly articulated and understood (Lechman & Duder, 2006). Psychosocial severity was the specific service user factor that was able to be directly linked to the use of health social work services. Given this finding they argued that health social work interventions would benefit from being specifically articulated as a critical activity to support the most complex cases requiring discharge planning. Subsequently this may result in the development of a unique role for the health social worker on the multidisciplinary team, in that we are the practitioners who specialise in interventions targeted at psychosocial problems.

Claiming that the contribution health social work practice was able to make in the medical/surgical units of the hospital had been subjected to ongoing debate, this final study published in 2007 aimed to provide evidence that was able to support the value of social working these areas of the hospital. Arguing that in the current system health social workers may share case management and discharge planning tasks with nurses and other health professionals, they suggested that it proves difficult to demonstrate the unique contribution health social work was able to make in this environment. The authors also maintained that "[a]nother consideration is that social work education and the profession's basic values, which emphasize treating clients within environments, client advocacy, and empowerment can run counter to a hospital's priority of discharging patients quickly" (Auerback, et al., 2007, p.19).

Again this study originated in America where the managed care environment is said to place enormous demands on hospital staff to discharge patients within the allocated length of stay guidelines, provided by the insurance industry. If the patient runs over this time, the cost is incurred by the hospital, thereby creating a situation where health social work, with the assistance of an appropriate data base, is able to demonstrate its contribution to timely

discharge. The authors argued however that "in order to sufficiently appreciate the value of social work services in hospitals, the complexity of the discharge process must be fully understood" (Auerback, et al., 2007, p.23).

The sample consisted of 'med-surg[3]' patients admitted to the hospital between January 1, 2002, and June 6, 2004, a total of 64,722 patients. Of this total 15.7 percent had health social work involvement, with a substantially higher mean age of 68.8 compared to those who were not in receipt of health social work services, which had a mean age of 53.8 years. Over 60 percent of the patients health social workers provided service for were over the age of 70 with these patients having an increased length of stay, 11.4 days as opposed to 4.3 days of the non-health social work patients.

The authors were at pains to point out that age is strongly associated with length of stay, which dramatically increase as patients get older. The data was able to demonstrate that the majority of health social work discharges were to an institution, for example, a nursing home and that these patients typically presented with a range of complex issues including frailty, to bed availability, all contributing to increased length of stay. The findings suggested that health social workers in this acute care hospital were referred the most complex cases, and that health social workers are significant providers of patient assessment and discharge services (Auerback, et al., 2007).

In conclusion these authors have stated that "[s]ocial workers who often are trained in the psychosocial biological model of practice are well suited to resolving these complex combinations of discharge issues" (Holliman et al, 2003, cited in Auerback et al. 2007, p.29). They also pointed out that medical information and diagnosis, whilst clearly important, are not adequate for planning for the post-hospital needs of the elderly and other high risk groups and citing Rock (1996, p.32) make clear "[i]t is not so much the acute illness itself, but its consequences that matter..."(Auerback, et al., 2007, p.29). Their final plea is that departments of health social work develop computerised tracking systems that allow us to provide empirical data about the specific and unique contribution we are able to make in the hospital (Auerback, et al., 2007).

[3] Medical-surgical wards

In summary these three studies have been able to demonstrate the health social work contribution to the often complex psychosocial challenges that users of health services present with, both in primary and secondary services. Subsequently they were able to make the important link between the health social work intervention, and effective outcomes, many of which were associated with resource use, length of stay, and appropriate discharge. These studies were able to demonstrate that with careful planning, appropriate data collection and considered research design, health social workers are able to explore the relationship between specific health social work interventions, and effective outcomes which are crucial to the achievement of the goals of the wider organisation.

Conclusion

This chapter has provided an opportunity to explore the health social work practice context of the acute hospital. The policy and strategy context was briefly described, with a focus on the changing demands inherent in this context and the expressed desire to reduce health inequalities. One way the policy requirements manifest is in the current interpersonal family violence policy which has a significant impact on the organisational expectations of and demands on, the health social work workforce.

A chance too was taken to highlight the professional challenges unique to this environment, and the research activities that have grown out of the *particular contextual variables* inherent in the acute hospital environment. Over the previous two decades, what I have come to think of as the international research trajectory has progressed from defining the health social work role and functions, to identifying key achievements and clinical priorities through to developing categories of outcomes. The most recent development by researchers in the field has been to extend this trajectory to explore the link between social work interventions and effective outcomes that are able to support the achievement of broader organisational goals.

Despite these research efforts I believe that health social workers in Aotearoa have continued to experience the sense of vulnerability, and doubt regarding the wider organisations understanding and valuing of the health social work role that has been a

theme in this literature. It is likely that the more pressing the focus on reducing resources and saving money, the stronger this sense of vulnerability becomes. Having situated my research within the shared international understandings of the challenges facing health social workers my aim is to gather foundational data in order to begin to articulate local accounts of what constitutes the dimensions of effective practice in this highly contested and increasingly financially focused context. The next part of this thesis outlines the research methodology I have chosen in order to make a contribution to our understanding of the important dimensions of health social work in a local context.

Chapter 4: Methodology

Introduction

In chapter two of this thesis the literature explored social work and effectiveness written by empiricists such as Fischer (1973), and authors informed by a more interpretive approach, such as Fook (1999). These authors agreed that context *is* vital to helping us understand notions of effective social work practice. Despite being on what may be considered opposite ends of the research continuum these authors understand that social workers must be supported to make sound decisions in the face of uncertainty, and that this uncertainty is influenced in part by context. The methodology taken up in this inquiry aims to capture this contextual data, and the dimensions of effective health social work practice which have evolved in this particular practice environment.

This sequential exploratory mixed method study (Creswell & Plano Clark, 2007) began with the detailed case study which sought to *explore* the dimensions of effective health social work practice in the paediatric hospital context. Once the dimensions were identified they were used to inform a survey tool that was designed to check their relevance in a broader hospital context. The survey tool also provided an opportunity to expand and compare the dimensions, across this wider context. In so doing the distinct practices and/or behaviours (that may have developed in the hospital context to support the provision of health social work practice), described by key stakeholders as effective health social work were delineated.

The aim was to 'unpack' the dimensions over time. To observe them, read about them in the literature, to hear and read them being described by multiple stakeholders, disciplines, and service areas, thereby increasing the lenses through which effective practice was able to be experienced and written down as text. They were then grouped together into key practice domains. From these emerged the operational definitions developed to represent these domains, the dimensions of effective practice were consequently articulated. The final task was to develop an organisational intervention with the goal of more purposefully embedding the dimensions of effective practice across the broad physical health acute hospital context.

As a profession that carries a commitment to social justice, social work has wrestled with the role of scientific inquiry and an appropriate epistemology. Having largely rejected logical positivism long ago (Wells Imre, 1984) social work has more recently faced up to the realisation that we must use research to examine the outcomes of practice (DePoy, Hartman, & Haslett, 1999). Complicating matters "[i]n the past fifty years, the term research itself has come to be imbued with so much mystique that social work scholars have often forgotten it should simply refer to ways of studying and analysing what professionals do" (Martinez-Brawley, 2001, p.272). Nonetheless it is these very *ways*, the actual *approach* we take to this process of study that are so numerous and varied that substantial efforts are required to clarify our choices and to make transparent what drives these choices in order to support an understanding of the phenomenon under study (Patton, 2002).

The approach we take to research activity inherently reflects the beliefs we hold about the world, and the world we want to live in (Lather, 1991). Concurring with Lather's view the first duty of this methodology chapter is to articulate the beliefs I hold about the professional activity of social work, the ambitions I carried for the construction of local knowledge and the important influences that have had a bearing on these beliefs and aims. The relationship between the beliefs, the ethical responsibilities and the aims of the inquiry are reflected in the methodological choices I have made. A thorough description of the sequential exploratory mixed method design, which reflects the flow of the design, follows. Reflecting the weighting decision I have applied to the research design, the qualitative and interpretive elements of the research methods, including the choice to employ a case study for the first phase of the research will be described in some detail.

Epistemology

Reflexivity and research practice

A number of authors recognise the value of adopting a reflexive approach to research practices, such as (Etherington, 2004; Fook, 1996; Gibbs, 2001; Lather, 1991; Lees, 2001). "Reflexivity can simply be defined as an ability to recognise our own influence – and the influence of our social and cultural context on research, the type of knowledge we create,

and the way we create it …" (Fook, 1996b, cited in Fook & Askland, 2006, p.45). Outlining some of the fundamental conceptual issues in qualitative inquiry Patton (2002) explained that the notion of reflexivity is a way of highlighting the importance of maintaining self-awareness, a political and cultural consciousness and ownership of the perspective one brings to the research task. He proposed that to be reflexive requires us to engage in the ongoing consideration of '*what I know*' and '*how I know it*' (Patton, 2002, p.64).

Patton (2002) maintained that in the postmodern context, the very idea of claiming the mantle of objectivity is embarrassingly naïve; rather "qualitative research in recent years has moved toward preferring such language as *trustworthiness* and *authenticity*" (Patton, 2002, p.51) to support the credibility of the research endeavour. Not discounting the concept of neutrality entirely however, Patton proposed that we aim for neutrality with regard to the phenomenon under study by not setting out to prove a specific point or influence the data to arrive at a preconceived position. Patton (2002) suggested that by its very nature the reflexive process requires that a level of self-awareness is maintained and recommends that one way of supporting this self-awareness is by writing in the first person.

The writing style I have chosen does however run counter to one of the assumed hallmarks of scientific writing with its notions of objectivity and neutrality, an expectation with which Witkin (2000) explained authors are expected to comply. He proposed that writing as a cultural activity inevitably does express values and therefore there is no 'pure' way of characterising the world. "[O]ur choice of words, emphases, or literary tropes tend to generate one picture, whereas other, but equally legitimate, choices may generate another picture" (Witkin, 2000, p.390). The hope was that the writing style adopted in this thesis reflects the tentative nature of one picture of the dimensions of effective practice and is therefore respectful of the *numerous* possible ways effective practice can be experienced and described by others.

Beliefs about social work

"There is no one right way to do social work" (Nash, Munford, & O'Donoghue, 2005, p.9); however there does appear to be wide consensus amongst numerous social work authors

regarding the social work profession's responsibility to pursue the aims of social justice and specifically to engage in anti-oppressive practice (Clarke, 2003; Cooper, 2002; Gray, 2004; Nash, et al., 2005; Van Heugten, 2001). Clarke (2003) proposed that fulfilling our obligation to anti-oppressive practice demands far more from us than simple compliance with a fundamental values stance. Instead she has invited us to engage in a "…radical rethinking of historic, time honoured theories and concepts and a critical re-examination of taken-for-granted assumptions about the helping process" (Clarke, 2003, p. 247).

In support of Clarke's proposition, I have engaged a research methodology that aims to bring forward local accounts of the dimensions of effective practice. In doing so this inquiry privileges a more egalitarian approach to the development of professional activities which could be described as 'best practice'. This is in opposition to the top down imposition of codified best practice knowledge, which may have been informed by research undertaken in a distinct and distant context.

As described in chapter one, in Aotearoa, Maori and Pacifika practitioners have consistently challenged dominant assumptions regarding appropriate social work practices. One of the ways this has been evident is by the development of their own social work theories and models derived from research they have undertaken for themselves, for example (Mafile'o, 2005; Pohatu, 2003; Ruwhiu, 2005). I wholeheartedly support these efforts and in no way intend that the findings of this inquiry, undertaken by a Pakeha woman, are imposed in a definitive way on Maori or Pacifika whanau or practitioners.

This consistent challenge to Western paradigms by those on the margins demands that all researchers find ways to engage ethically in research activities across areas of difference in complex environments (Mutua & Swadener, 2004). Believing the proposition that social work "[p]ractice is more situated, and theory less generalisable than allowed for in 'scientific formulations'" (Fook, 2000, p. 115) the methods taken up in this inquiry are charged with reflecting this situated practice, with a limited expectation of creating generalisable knowledge beyond these particular hospital walls. Fook also suggests that the outcomes of social work practice are less rigid or clean than may be suggested with more

expert, or technocratic perspectives and again, this research aims to capture this flexibility, messiness and uncertainty that Fook (2000) alludes to.

Throughout my adult life I have been strongly influenced by both feminist and anti-racist thinking as expressed by such authors as Awatere (1984), Bird (2000, 2004, 2006), Fook & Askeland (2006), Rich (1980), Stanley & Wise (1983), Tamasese & Waldergrave (1993), Tuhiwai Smith (2005) and Walker (1971). Over the years while attending university, various conferences and workshops I regularly experienced a sensation of discomfort which was associated with a feeling of exclusion, a sense that something vitally important was missing. I noticed a variety of dominant ideas being described that did not reflect a multiplicity of worldviews or experiences, some of which were my own.

My experience as a lesbian who has a construction of whanau that sits outside of mainstream thinking is one such example. I have also been aware of Maori expressing their unease with Western constructions of whanau and how these have impacted on their (Maori) ability to engage with health and welfare services effectively. The personal experience of having been raised alongside Maori, and later, having practised social work with Maori colleagues and whanau in rural Aotearoa I came to some understanding that Maori have a worldview that is often vastly different from my own. These experiences, supported by a feminist analysis which understands and articulates the concept of power relations and dominant discourses, has generalised into an understanding and valuing of difference.

It was this understanding of difference that attracted me to a research methodology that was able to demonstrate the capacity to reflect and honour difference ethically and respectfully. This was imperative given my responsibilities as a Treaty partner to Maori and Maori calls to develop their own practice theory. Maori have also consistently asked to have indigenous frameworks and worldviews validated, for example Cunningham (2003), Durie (1998, 2001), Henry & Pene (2001), Ruwhiu (2005) and Tuhiwai Smith (2005) rather than accepting the imposition of others frameworks.

It is postmodern ideas as described by Foucault, (Foucault, 1977) which have provided me with language to articulate this feeling of disturbance I experienced when confronted with certainty claims that risk excluding those of us on the margins. It is postmodern or social constructionist ideas and theory that have challenged the notions of totality, or as Lather (1991) describes them a "lust for absolutes" (p.6). Rather this approach to research has supported the philosophy that: "nothing is fixed; knowledge can only be partial and built upon the culturally defined stocks of knowledge available to us at any given time in history; reality is socially and personally constructed; there is no fixed and unchanging 'Truth'" (Etherington, 2004, p.27). It is these influences that have continued to support a reluctance to engage wholeheartedly with rigid theoretical constructs and models derived from positivist research approaches. Bird recommends a tentative approach and suggests that "positioning ourselves for discovery and review" protects our practice from the imposition of dogma (Bird, 2000, p.xix). Lather asked the question "[W]hat kinds of practices are possible once vulnerability, ambiguity and doubt are admitted?" (1991, Lather, p.47). I suggest one response to this question is to engage in research activity that aims to identify these ambiguities and doubts, to adopt an approach that allows for the discovery and subsequent review of practice as proposed by Bird (2000).

A situated practice-based inquiry

Essentially this thesis attests to the abiding professional commitment I have to supporting the delivery of an effective health social work service in my current area of leadership practice, the acute hospitals of the Auckland District Health Board. This commitment is also fuelled by an ethical obligation "...to the growth and disciplined use of all forms of knowledge which inform and enable social workers to effectively carry out their role and function" (ANZASW 1993, p.1).

The inquiry has been situated within my immediate practice context for a number of reasons: firstly, the firmly held belief that academic undertakings are made more meaningful and useful by being situated in the day-to-day challenges of direct social work practice; secondly, the hope that the leadership position I hold can be enhanced by the development of a more in-depth understanding of the organisational, contextual and practice challenges encountered by the practitioners and clients we aim to serve; and

thirdly, a notion associated with practice-based research which promotes the idea of the contribution such research endeavours can make to "...the forging of a genuinely indigenous (local) theoretical base..." (de Vos, 2005, p.42 brackets added) for health social work in Aotearoa. Devotees of practice-based research pay particular attention to the value of research being conducted from the inside, suggesting that a partnership between "systematic intellectual enquiry...and the tough-minded realities of life in social agencies" (Fuller & Petch, 1995, p.3) has the potential to contribute significantly to the developing body of social work research. There are however some unique challenges associated with undertaking research in your own organisation and these will be explored to a greater extent later in the chapter.

Fook has told us that the act of exposing practice to reflection supports the processes of inquiry, criticism, change and accountability (Fook, 1996). By taking up a reflective approach, this research aimed to avoid some of the basic flaws inherent in positivist research approaches. A reflective approach endeavours to affirm and reinforce the significance of interconnected and experiential ways of knowing the world. By engaging in a reflective style the aim was to blur the more traditional boundaries and separations between what Fook refers to as "'knowing and doing', 'values and facts', 'art and science', 'theory and practice', 'subjectivity and objectivity'" (Fook, 1996, p. 5). According to Fook this approach acknowledges that many of these categories have been artificially constructed in opposition to one another, with one being given more value than the other. Rather than engaging in such binary thinking, this research aimed to establish a more holistic and multifaceted understanding of what constitutes the dimensions of effective practice in one local context. This has allowed the inclusion of the more emotional and subjective elements of practice such as intuition.

The interpretive paradigm

The choice of paradigm a researcher takes up is a crucial first step in the research process as it provides a particular frame of reference and ultimately the way in which the study is organised and reasoned (Sarantakos, 2005). Paradigms are described as fundamental orientations that assist us in conceptualising the research process and reflect an underlying set of beliefs and assumptions regarding such matters as the nature of reality, the

connection between the researcher and the subject of study, the part values play in the study, and the design, or methodology the research relies on (Delport & Fouche, 2005).

Outlining what they describe as a paradigm framework, Grant and Giddings (2002) maintain that the interpretive paradigm aims to get back to "the things themselves" (Husserl, cited in Farber, 1943, p.568, cited in Grant and Giddings, p.16). Those of us applying the interpretive paradigm attempt to understand what meanings people may attach to the events of our lives; essentially we aim to understand what it means to be human (Grant & Giddings, 2002). Within this research domain the emphasis has been on "...the production of meanings and to learn the special views of actors, in other words, the local meanings" (Pfeifer, 2000, cited in Sarantakos 2005, p.40). This approach has been able to reflect my own beliefs, leaving room for multiple accounts and interpretations of the same event, experience, activity, feelings or values.

One of the key points of difference between positivist and post positivist approaches is the value system concerning what counts as evidence. In applying an interpretive paradigm, research is conducted that looks for interpretations of the social life that are both culturally derived and historically situated (Sarantakos, 2005). The task of the qualitative researcher engaging an interpretive paradigm is the development of greater understanding, rather than one of greater explanation. It is the opinions, views and the perceptions of the participants, which they describe in everyday language as their experience of effective practice which I have valued as evidence. Rather than aiming for objectivity, it is these subjective accounts, the way people both make sense of and ascribe meaning to their lived experience that this inquiry has sought to discover (Sarantakos, 2005).

The research paradigm – mixed methods

For the purposes of this study I have relied on Creswell and Plano's definition of what constitutes a mixed methods study, evolved over many years and described in their 2011 text. Reflecting their belief that a definition of mixed methods research is best to include a diverse range of views they describe a number of core characteristics inherent in this approach. Their effort to define the approach incorporates elements of a research design orientation, a philosophy and methods. It has also emphasised the key elements that make

up the design and implementation of a mixed method study (Creswell & Plano Clark, 2011). They proposed that a researcher employing a mixed method research design will:

> Rigorously and persuasively collect and analyse qualitative and quantitative data based on the research questions
>
> Build on the data by mixing, integrating or linking it together in some way
>
> Choose one or both sets of data to prioritise
>
> Employ this set of procedures in either multiple phases or in a single study
>
> Rely on and describe the theoretical lenses and philosophical worldviews that frame the procedures
>
> Direct the plan for undertaking the study by combining the methods into a specific research design (Creswell & Plano Clark, 2011)

The central foundation of mixed methods research is a belief that by employing the use of both qualitative and quantitative data we are able to reach an enhanced understanding of the research question than if we were to employ either method in isolation (Creswell & Plano Clark, 2007). These authors persuasively maintained that quantitative approaches lack the ability to understand the context in which people are speaking, resulting in voices not being directly heard. They highlighted the quantitative researcher's propensity to background themselves by not acknowledging or discussing their biases which includes their role in interpreting the data. On the other hand they named the limitation of qualitative research being associated with the personal interpretations made by the researcher and the bias that arises from this. The other significant limitation they identify in relationship to qualitative studies is the inability to generalise the findings. Creswell and Plano argued that the strengths of one approach is able to offset the deficits of the other (Creswell & Plano Clark, 2007).

Two primary goals drove my decision to employ a mixed method study. Foremost was my commitment to the practice of health social workers and the urgent need to achieve an enhanced understanding of the research question. Secondly I considered that it was important to take up a methodology which would be assessed as credible in a hospital context which largely favours quantitative data. This mixed method approach has allowed

me to honour my professional roots, orientation, values and standards by seeking to explore the contextual detail of the practice. Further it has allowed these detailed dimensions of what constitutes effective health social work practice to be tested and verified across a broad group of stakeholders, who in the near future will no doubt examine the methods, in order to assess the validity of the findings.

Tashakkori and Teddlie have told us that some authors caution against the combining of approaches to protect the strengths of the paradigmatic position, for example positivism or constructivism, being taken up by the researcher. Others propose however that neither qualitative nor quantitative paradigms are 'pure' and researchers have little to lose by mixing them up in a creative way (Tashakkori & Teddlie, 2003). The findings from this study will attest to the value of having followed this creative research pathway.

As an alternative to the paradigm wars where one methodology is said to be superior to another, pragmatism is proposed as an alternative (Grant & Giddings, 2002) . Pragmatism features in a number of key texts associated with mixed method research, (Creswell & Plano Clark, 2007, 2011; Hesse-Biber, 2010; Tashakkori & Teddlie, 2003). Collectively these authors proposed that pragmatism is a useful paradigm for justifying the use of a mixed method study. Tashakkori and Teddlie elaborate by explaining that pragmatism rebuffs the incompatibility thesis and supplants it with the notion that at the heart of decisions regarding methodology must be the research question at hand. They refer to this as the "dictatorship of the research question" (2003, p. 20). Cresswell and Plano Clark supported this approach suggesting that a variety of forms of data collection are able to inform research questions and therefore taking up a mixed method approach is "…pluralistic and oriented towards 'what works' and practice" (Creswell & Plano Clark, 2007, p. 23). I chose to adopt this sequential exploratory mixed method design because I aimed to first explore the detail of the dimensions of effective health social work practice via the case study, and then expand these descriptions across a wider context, via the administration of the survey tool.

Design

Ethical issues – being an insider researcher

Ethical approval for the study was sought and gained from the Northern X Ethics committee in July 2007 (Appendix 2) and updated to include the survey in November 2009 (Appendix 3). As this inquiry was undertaken within my own organisation, I undertook what is often referred to as *insider* research which poses some specific ethical challenges (Coghlan & Brannick, 2005). Coghlan explains that when one is undertaking insider research you are required to balance the day-to-day role you hold with that of the researcher role. Given the close scrutiny of *the case* being undertaken by a researcher with a dual leadership role one of the specific issues that required ethical consideration was what would occur if any poor practice was uncovered. It was agreed with the ethics committee that any situations of this nature would be brought to the attention of *the case's* Team Leader, in order that they be investigated and responded to outside of the research process.

Goghlan (2005) also identifies a number of other specific ethical considerations related to undertaking insider research. Those that I gave particular consideration to were negotiating access with authorities and participants; ensuring participants' right not to participate and/or to withdraw from the research without fear of negative consequences; keeping good faith by demonstrating I was trustworthy; and taking care with the writing up of the study in order to protect ongoing relationships. This proved to be a significant issue for one participant in particular who 'sanitised' the transcript of her interview in order to protect ongoing relationships with agencies such as Child Youth and Family, and the NZ Police.

Informed consent and potential harm to participants

Aside from the issue identified above regarding the possibility of exposing poor practice, risks to participants in this study were considered to be very low, particularly in light of the inquiry being directed towards positive accounts of practice. Nonetheless all interview participants were provided with an information sheet (Appendix 4), and were required to sign a consent form prior to the interviews occurring (Appendix 5). Written consent from colleagues during the observation of *the case* was not sought; rather people were made aware verbally of the research activity being undertaken as the observations comprised ordinary daily practice activities and were primarily focused on what *the case* was doing.

Use of the survey tool was also assessed as low risk by the Northern X Ethics committee with approval given to provide an incentive to participate by way of the food hamper for which all participants were eligible to go into a draw. The information sheet preceded the survey, and completed the survey was considered adequate proof of consent.

Sequential exploratory mixed method design

Keeping in mind that the phases of research are rarely a series of lock-step processes, but rather a general framework (Creswell & Plano Clark, 2007), this next part of the chapter describes the mixed method design relied on to inform my own design. This was selected from the range of designs described by these authors. This study started with a qualitative phase in order to explore the details of the dimensions of practice in a particular context. The use of this design is based on the notion that exploration is necessary for one or more reasons. Such as in this instance where exploration is driven by the absence of the dimensions of effective health social work practice being previously described and the lack of a guiding framework (Creswell & Plano Clark, 2007). The goal of the two stages of data collection is that the results from the exploratory stage (in this case the case study) have been used to help develop and inform the second stage of the data collection (in this case the survey tool which includes quantitative and qualitative fields). As introduced in chapter one a full illustration of the design, the procedures used, and the outcomes of each research phase has been illustrated in Appendix 1. Figure 2 has been included below to provide a shortened version of this appendix, illustrating the sequential nature of this research process.

The weighting decision

As has been argued consistently throughout this research report a number of authors, including Creswell and Plano Clark (2007) recommend that researchers select a design that is best able to answer the research question at hand. They argue that in doing so, the researcher is provided with a framework, and that this framework provides a logical guide to the implementation of the research design (Creswell & Plano Clark, 2007). Taking a pragmatic approach these authors also invite us to consider matters such as the time we have available to conduct the research; our expertise and skill in a particular field of research, and finally, the research audience and what they place value on (Creswell & Plano Clark, 2007).

It has been acknowledged in the literature that there is a divergence of views regarding the need to identify the priority, dominance or weighting of the qualitative or quantitative approach being taken by the mixed methods researcher (Tashakkori, 2009). In this research a choice was made to make what Morgan (1998) cited in Cresswell and Plano Clark (2007) refers to as the "priority decision" (p.81).

As described previously multiple issues may be considered when making this priority decision. Morse (1991) cited by Creswell and Plano Clark (2007) suggests that "the theoretical drive, or worldview used to drive the study determines its weighting" (p.82). Revisiting the quantitative, qualitative debate in relation to mixed methods research, these authors are clear "… that methods are shaped by and represent paradigms that reflect a particular belief about reality" (Sale, Lohfeld, & Brazil, 2002, p. 46). They also maintain that the emphasis or focus of qualitative research is on meaning making, and process. Alternatively the quantitative paradigm, informed by positivism, is interested in establishing 'the truth,' which relies on all phenomena being reduced to empirical indicators which represent this truth (Sale, et al., 2002).

As a substitute to this positivist approach, ontologically speaking, I subscribe to an interpretivest view that there are multiple truths and these truths are in a constant state of evolution and change. This view is represented via the choice to engage in methods which are informed by a qualitative paradigm. Clearly the choice of paradigm a researcher takes up reflects a particular view, and our beliefs about reality (Sale, et al., 2002). Given this Sale et al. argue that "…the qualitative paradigm are based on a worldview *not* represented by the quantitative paradigm (Sale, et al., 2002, p. 46).

As stated previously Creswell and Plano Clark propose that it is the research question and the method most suited to answering that question is what drives the weighting decision (2007). In this research project a naturalistic or interpretive approach has been chosen as the most appropriate way to explore and report the dimensions of effective health social work practice. Given the epistemology informing this research activity, it is qualitative approaches which have been assessed as best able to meet the aims of this inquiry. This

weighting choice is signalled in table one below via the use of capital letters (QUAL= qualitative), or lower case letters (quan= quantitative).

Exploring issues associated with the integration of data during the analysis phase, one author maintains that by definition, mixed methods studies attempt some manner of integration of data to help inform their conclusions (Bazeley, 2009). Although there may be a temptation to be influenced by the paradigm wars when making decisions regarding how data is integrated and reported, Bazeley suggests this is unproductive. Rather arguing from a pragmatic perspective she encourages the researcher to "…determine what data and analyses are needed to meet the goals of the research and answer the question at hand" (Bazeley, 2009, p. 203). This view reflects Cresswell and Plano's (2007) belief referred to above.

In making the weighting decision I have been informed by the considerations outlined above. Of primary importance was the belief that a qualitative approach, which privileged the reporting of qualitative data, would best illuminate the dimensions of effective health social work practice. In so doing I aimed to report the meaning, based on the lived experience of the participants, which they attributed to these dimensions. This was in preference to a choice which could have been made to analyse and report, for example, inferential statistical data. Finally when we consider the health social work practitioner audience, the primary audience of this research, my belief is that this choice reflects a social work worldview and is therefore more likely to be experienced as accessible, meaningful and relevant to this audience.

Design (sequence from right to left) ⟶

Step 1	**Step 2**	**Step 3**	**Step 4**	**Step 5**	**Step 6**
QUAL data collection – case study in hospital paediatric ward	**QUAL** data analysis and findings (Case study)	Use case study findings to design survey tool	**Quan** and **QUAL** data collection – survey tool applied across three hospital populations	**Quan** and **QUAL** analysis (survey)	Interpretations **QUAL** findings (case study) **QUAL** and **quan** findings (survey)

Figure 2: Summary of sequential exploratory mixed method design employed in this study

This sequential exploratory design has been found to be useful when a researcher wants to generalise the results beyond the initial study site, in this case paediatric hospital wards. It may also enable the researcher to test an emerging theory or hypothesis which again resonates with this study. This design has the ability to explore the phenomenon, in this case the dimensions of effective health social work practice in one context, and then check their relevance across a broader context (Creswell & Plano Clark, 2007), the wider hospital including further paediatric wards, women's health and adult wards. Because in this design the sequence began with a qualitative approach, it is this approach that receives the greater emphasis, most evident in this chapter via the detailed account of the case study methodology, and also reflected in how the findings are analysed and reported.

As stated the data is collected in stages when a sequential design is relied on, with one set of data collection following another. In a sequential design such as this one, the qualitative and quantitative collections are related to one another as opposed to being independent of one another (Creswell & Plano Clark, 2007). According to these authors sequential data collection is helpfully conceptualised as having three distinct but connected phases. When a choice is made to apply the sequential exploratory design the first phase is qualitative in nature with data collection and analysis reflecting this research paradigm. In this inquiry the first stage of data collection forms the case study. In the second key phase of the research process decisions are then made about *how* the results will be used to inform the third phase of the research process. The development of a survey tool or instrument is inherent in this overall design (Creswell & Plano Clark, 2007). In this research project I chose to use the case study findings to help inform the development of a survey tool.

This survey tool provides the mechanism for undertaking the third key phase of the design, the collection of quantitative *and* qualitative data that *builds on* the phase one findings. A process of combined analysis and interpretations form the final phases of the research process, each of which will be described in some detail. Once again each step of the research activity is illustrated in figure 2 which includes five distinct, but connected steps (collectively they reflect the three phases of research as described by Creswell & Plano Clark, 2007). Reinforcing this sequence and step by step process, the next part of the

chapter describes the choice of a case study approach, the first data collection phase of the inquiry.

Step 1: Qualitative data collection – the choice of case study

The utilisation of a case study approach allows for a concentration on the experiential knowledge of the particular case and the careful attention to the influences of social, political and organisational contexts (Stake, 2005). A case study design allows the researcher to look for the detail of interactions within a specific context, and to study the particularity and complexity of the case, allowing us to come to an understanding of the case's activity within important circumstances (Stake, 1995). It is the exact nature of these important circumstances which this inquiry aimed to explore for the reasons outlined above. It is the complexity of the experience, the contextual variables, and the specific circumstances that impact on, support or disrupt a health social worker's engagement in practice that could be described as effective, which this inquiry hopes to begin to understand.

There are a number of examples of the case study methodology being applied in both social care, and health contexts to good effect (Atwal, 2002; Ferguson, 2001, 2003; Trotter, Cox, & Crawford, 2002). The specific choice of employing a case study approach has been influenced by the writing of Ferguson (2001; 2003) and his attempts to develop a more positive perspective on the practice of social work. Ferguson proposes that by engaging in research activities that focus on accounts of social work practice that could be described as 'best' the researcher is able to reach an operational definition of 'excellence'. Drawn directly from the perspectives of a range of stakeholders who construct effective practices within a specific context, this inquiry aims to begin to articulate these practices.

A leading proponent of case study design (Yin, 2003) suggested that this approach to research is appropriate in particular circumstances, which include the answering of 'how' or 'why' questions; when the researcher has limited control over events, and when the primary focus of the study is on a present-day phenomenon within its day-to-day, or real-life context. This is the focus in this study. A leading advocate of the value of the case study explained that the specific value of this approach is its ability to capture the

complexity of a single case. We choose to study a case when it is of very special interest (Stake, 1995). “The case is a specific, a complex, functioning thing”; it is “a bounded system”; it has “working parts”; and in human services “is likely to be purposive...The case is an integrated system...Thus people and programs clearly are prospective cases” (Stake, 1995, p.2). In this inquiry, *the case* is a health social worker who has been identified as an effective practitioner by a range of stakeholders. This approach reflects Ferguson’s recommendation above, namely to focus on the positive, or ‘best’ aspects of practice in order to use these accounts to develop operational definitions of excellence.

In order to optimise our understanding of *the case*, meticulous attention to its activities is required. Four central features of case study methodology are outlined by Stake (2005) in support of this aim; they include issue choice, triangulation, interactivities and experiential knowledge. Issue choice and triangulation will be examined in relation to the initial identification of the issue under study, and the evidence relied on to demonstrate this issue. The second elements of interactivities and experiential knowledge of the case will be outlined later in the chapter, in relation to the data analysis process.

Issue choice – a feature of case study

Employing an *instrumental case study* is recommended by Stake (1995) when the researcher has a specific question or an interest in developing a general understanding regarding explicit issues which will be assisted by the study of *this* particular case. In this scenario the case itself becomes secondary, it merely plays a supportive role, and ultimately it facilitates our understanding of something else. So although *the case* is still studied in depth, its context is still examined and its ordinary activities outlined, this is completed because it helps with the pursuit of the external interest. In *this case* the external interest is the nature of the dimensions of effective health social work practice in the context of the multidisciplinary team in an acute hospital. With an instrumental case study what remains dominant is the issue, whilst recognising of course that issues are not stable, but are inevitably linked to political, social, personal and historical contexts (Stake, 1995).

Stake advises that issues are inevitably complex and context specific with problematic relationships and that this is what makes them issues. Stake (2003) outlines that the purpose

of the issues chosen is to draw attention to ordinary experience, and to what could be considered discipline-specific knowledge, such as is the case in this inquiry. There are two questions that are important in establishing issues: firstly, which issues were central to the planning and activities of the inquiry; and secondly 'What is it that can be learnt here that a reader would benefit from knowing?' (Stake, 2005). The central issue in question here, the primary research question, is 'How are the dimensions of effective health social work practice described and demonstrated within the multidisciplinary team in an acute hospital environment?'

Reflecting Stake's guidance in relation to the planning and activities of the inquiry my study was firmly situated within its contextual boundaries of the ward, the multidisciplinary team, and the organisation. Participants were observed undertaking various activities of interest on the ward; several different professional disciplines were interviewed; clinical notes were studied. Professional and organisation documents outlining expectations, such as job descriptions, policy guidelines, particularly those related to interpersonal family violence, ethical responsibilities via the ANZASW Code of Ethics, and contemporary health strategy were also relied on as data sources. The impact of these data sources can be found in the case study findings, the descriptions of context, and in the discussion.

Triangulation – a feature of case study

At its simplest, triangulation involves the process of using multiple data sources and perceptions in order to clarify meaning and to verify the repeatability of any observations or interpretations that result from the inquiry. Acknowledging that it is unlikely that any observation or interpretation is exactly repeatable, triangulation also serves to clarify meanings by identifying the different ways that the case is being seen (Flick, 1998; Silverman, 1993, cited by Stake, 2005). Yin, a champion of case study expresses the view that one of the primary strengths of this approach is the chance to use multiple sources of evidence (Yin, 2003). A number of approaches have been employed in order to support data triangulation, some of which have been described above; further sources of triangulation will be expanded under the heading of data collection later in the chapter.

Recruitment: choosing the case

The initial design for identifying *the case* was based on an iterative process. In the first step senior members of multidisciplinary and health social work teams throughout the three service areas were invited to nominate an effective health social work practitioner, thereby identifying the health social work participant (*the case*) via purposeful sampling (Patton, 2002). An e-mail was cascaded via organisational contact lists and people were invited to nominate the health social worker that came to mind when they read the words 'effective social work practice in the context of the multidisciplinary team'. This proved a successful way to get nominations; 19 initial responses were received. One practitioner received four nominations; two received three nominations, three received two nominations and three received one nomination. This resulted in a total list of nine names provided out of a potential pool of approximately 70 health social workers.

The next step was a direct approach to the practitioner who had received four nominations, but she declined to participate and in line with ethical considerations this was not pursued. The second approach was made to one of the practitioners who had received three nominations. I approached this potential case quite simply because the opportunity arose, and this was done very casually, literally in the corridor. She also declined to participate. At this point I engaged in further research consultation and agreed on two actions: firstly, to discuss the best way to approach the third potential participant with her Team Leader; and secondly, to seek her assessment of the three most nominated staff members, all of whom were in her team.

In choosing exactly which case to study, Stake (2003) emphasises that the first criterion must be to maximise what we can learn from the case. Given the primary aim of this inquiry I had considered the question 'Which is the case that is most likely to lead to the greatest understanding of what constitutes the dimensions of effective health social work practice?' Prior to beginning this stage of participant recruitment I had thought the answer to the question was 'the practitioner who is identified as most effective by receiving the largest number of nominations'; it became apparent however that because of the case study design, *access* to the data was central – a concept Stake (2003) refers to as a case being 'hospitable to our inquiry'. Therefore locating a *hospitable* primary participant, nominated

as an effective health social worker became the essential challenge. Somewhat naively I had failed to consider the possibility that this research process would not be welcomed, and that the practitioner's sense of pride at having been nominated, and her research-mindedness, would have been enough to bring forward a positive response to the request to participate. After the first two refusals and some considered research supervision a further attempt was made to identify a suitable *and* hospitable participant.

My next step was to engage in consultation with the Social Work Team Leader as agreed with my research supervisor. She had not made a nomination prior to this time; but she did provide an unreserved endorsement of the three practitioners in her team who had received the most nominations as highly effective practitioners. She also provided a fourth endorsement for another staff member she considered to be highly effective. The Social Work Team Leader provided her endorsement of the second practitioner who had received three nominations, bringing her total to four. She also agreed to make an initial approach to request her participation in the research. It was decided that it may be more appropriate for her to make the initial approach for two reasons: firstly, their well-established relationship; and secondly, in order to provide some reassurance in relation to how any potential ethical concerns would be managed. This proved to be a successful approach with the practitioner agreeing to participate.

My contact with the newly identified practitioner was tentative, with discussion occurring at the first meeting regarding how she could be adequately supported to participate as *the case*. This process of negotiation proved successful and the case study could begin. How much her agreement had to do with additional care that was taken with her recruitment is doubtful in that the practitioner stated clearly she was motivated by 'a willingness to do anything to help the profession'. This willingness to participate reflected Stake's description of a hospitable case, which proved to be enduring throughout the length of the study, with her interest in the progress of the research continuing to this day.

***Participants and sampling around* the case**

Once *the case*, the central participant whose practice would be 'under the research microscope' had consented to be studied subsequent recruitment of the participants who

worked alongside her proved to be largely uncomplicated. This began with people who made the nominations and provided the endorsement – three senior nurses, and one social work team leader. An additional member of *the case's* multidisciplinary team, a paediatric surgeon also agreed to be interviewed along with two other health social work participants. The four social work participants, all Pakeha females included *the case* Team Leader and her previous Practice Supervisor. A social work student who had recently completed a three-month field education placement with *the case* also agreed to be interviewed, and *the case* herself. Their agreement to participate resulted in nine interviews being conducted in total, one of whom was a family member of a child patient.

The social work student participant had not been part of the initial design. Stake (2005) emphasises that case study design is flexible by nature, with opportunities for learning more about *the case* being pursued whenever possible. The whanau member of a child patient also agreed to be interviewed and did so willingly on the basis that *the case* practitioner had been 'very helpful'. She was an aunty living in Aotearoa having recently migrated from the Cook Islands.

Prior to undertaking the study a decision to choose *a case* that involved a Pakeha practitioner was made in consultation with the ethics committee, an internal Maori research review committee and various individual cultural mentors including senior Maori and Pacifika health social workers. This decision was based on an appreciation of the cultural limitations I have as a Pakeha researcher, and a view that the most could be learnt from studying the practice of someone with a similar cultural and ethnic background as my own. In light of the decision to focus on a Pakeha practitioner, a verbal commitment was made to support a similar inquiry being undertaken in relation to Maori and Pacifika practice, by someone culturally competent to undertake such a study.

Interactivity – a feature of case study

By employing a case study design I wanted to understand the day-to-day 'nitty-gritty' functioning of *the case* (Stake, 2005). Given this intention I observed as much as I could, I asked others for their experiences and gathered relevant materials in order to support my understanding of how *the case* operated. By way of example, the practitioner being studied

in providing a health social work service is required to observe guidelines and policy, take account of ethical and professional accountabilities, and adapt to various constraints and contextual variables. Describing and interpreting these day-to-day activities makes up a large part of the case study findings.

As I believed that these activities were compellingly influenced by the context, this also required illustration. Qualitative researchers have an expectation that the reality identified by the people both inside and outside of *the case* will be influenced by contextual factors; I therefore aimed to describe the interactivity of functions and contexts in detail. To protect the study from a one-dimensional account of the context, each interview began with the participant's description of the context. The contextual themes to emerge will be described in the case study findings and include elements such as the acute nature of the hospital, the complex nature of the team environment, and the medical, cultural and social makeup of the patients and their needs.

A large amount of data for this study was collected via nine semi-structured interviews with the participants as previously described. Additional data of observational activity was collected over three days; the method I employed for this observational activity will be expanded later in the chapter. This observation involved attending nursing handover, multidisciplinary team meetings and case planning meetings, the study of clinical case notes and statistical data sheets. This activity provided an opportunity to look for correspondence and patterns in the data, a concept that will also be explored more fully later in the chapter.

Observations of *the case* working with the family member who was subsequently interviewed also took place. A less structured interview with the family member of a child who had been a recipient of social work service from *the case* practitioner was also undertaken. As the inquiry developed it was this particular participant who became most accessible for a conversation, which developed from my having met her on one occasion during observational activities and the establishment of some rapport during an extended waiting time. A subsequent meeting and telephone call occurred with this participant which

provided further data for the inquiry, including her account of what she considered to have been effective *helpful* practice.

Patton (2002) tells us that cross-cultural differences add a layer of complication to the already complex activity of interviewing participants. Given that the client participant was from the Pacific Islands I sought cultural guidance from one of my Pacifica mentors regarding an appropriate interview format and language use, and explored the issue of how to ethically undertake the informed consent process. Written consent was gained. As a result of advice from a Pacifica colleague a short fairly informal interview was undertaken than had been originally planned with an uncomplicated focus being maintained on 'what was helpful?'

The interviews

The purpose of interviewing is to allow us, as best as we are able, to gain and enter into another person's perspective. Qualitative interviewing is built on the assumption that the people interviewed have a meaningful contribution to make, that what they contribute via interview is knowable and is able to be made explicit (Patton, 2002). I interviewed members of *the case's* multidisciplinary team because I believed that their narratives, the accounts of effective practice that they were able to contribute would provide a rich layer of meaning to the observational and documentary data.

All the interviews were conducted on the hospital wards prior to the observations taking place. They were conducted in the private office of the person being interviewed; they were digitally recorded and subsequently transcribed. Each interview lasted approximately one hour. The transcripts were then provided to each participant for checking and revision.

Having engaged in social work interviewing for a period of over 20 years my interviewing skills are well developed and have been supported enormously by the mentorship of Johnella Bird from the Family Therapy Centre in Auckland. Over many years Johnella has encouraged me to engage in a "style of inquiry that brings forward what is known but often unspoken" (Bird, 2000, p. 6). It is impossible to do Johnella's work justice within the limitations of this chapter; more than anyone else it is she who has supported my ongoing

engagement in the practice of *presence listening*. Johnella tells us that “[t]his depth of listening involves our emotional, intellectual and physical selves. It is listening beyond the everyday” and “[i]n this listening place we make ourselves available to have our life knowledges overturned, added to and/or confirmed” (Bird, 2000, p. 14).

It was the known but unspoken accounts of effective practice that I was specifically aiming to elicit, by assisting members of the multidisciplinary and health social work teams to ‘language into existence’ (Bird, 2000) their experience of the dimensions of *the case’s* effective practice. Although I relied heavily on an interview guide which had been previously reviewed by a peer (Appendix 6) there were two questions, one at the beginning of the interview, and phrased differently but repeated at the end, which aimed to capture the constructions of effective practice which were most valued.

The first question was, ‘When you think about effective social work practice, within the context of the multidisciplinary team, what words, thoughts, memories or examples come to mind?’ and once again towards the end of the interview, ‘If you had to bottle and sell the qualities that support effective health social work practice – if you had to name the essence of these qualities, what would you call them?’ This open form of narrative interviewing, (Sarantakos, 2005) is designed to support and encourage the participants to give an account of effective practice in their own words. Once these accounts were given in an uninterrupted way, the various descriptions those interviewed relied on, such as ‘good communication’ were extended with the use of a series of smaller questions such as, ‘and what does this good communication sound like and look like in this context… and how might you know it if you heard it?’ These additional questions aimed to protect the interviewer from making an assumption regarding what ‘good communication’ consisted of. Instead this interviewing style provided an opportunity to develop a deeper understanding and shared meaning of good communication within the boundary of the case. Consistently this style of interviewing bought forward additional layers of meaning. For example in relation to good communication narratives came forward such as ‘clear, accurate, timely, verbal, written’ etc. which helped develop the ‘fine weave’ descriptions that Stake (2005) describes as fundamental to the case study approach.Observational activities – as a data collection measure related to the case

In the context of this inquiry what I was most interested in was *the case's* activities 'on the ward' and this is where the majority of observation occurred. This series of observational activities was assisted by the development of what Patton (2002) describes as a 'sensitising framework'. He reminds us that "...observers do not enter the field with a completely blank slate" and that while the primary intention in qualitative research is to remain open to what comes, "some way of organizing the complexity of experience is virtually a prerequisite for perception itself" (p.279).

In light of this a sensitising framework, a tool that assisted me to break down the complexities of the observed activities into "distinguishable, manageable, and observable elements" was developed to guide initial observations (Appendix 7). Patton (2002) does offer a word of caution regarding the use of sensitising concepts explaining that if they are 'overused' they risk becoming desensitising. In light of this caution I engaged in the activity of developing the conceptual list after completing two observations without one, thereby orientating the formal list on beginning observations, the literature, and the research questions.

Step 2: Qualitative data analysis

Experiential knowledge – a feature of case study

The essence of qualitative understanding is experiential knowledge and it is the task of *the case* findings to convey and draw forth this essence (Stake, 2005). There are two aspects to this experiential knowledge: firstly, that of the participants and stakeholders (such as clients); and secondly, the experience of studying *the case*. The aim of a carefully written case report is to enhance the reader's *experience* of the case so care was taken to choose quotes, and write observational accounts with this aim in mind. Stake maintains there are three ways this is achieved "...with narratives and situational descriptions of case activity, personal relationship, and group interpretation" (Stake, 2005, p. 454). Stake contends that experiential descriptions and subsequent assertions are easily incorporated into memory and use by the reader. He argues that when the researcher's account makes available an opportunity for vicarious experience, the reader is able to extend their perceptions of what has occurred. Stake then goes a step further, developing the proposition that naturalistic case materials, to some extent, are able to parallel actual lived experience, thereby feeding

into the most basic processes of awareness and understanding. Coining a term for this process he and his colleague (Stake & Trumbull, 1982) have named this 'naturalistic generalisation', whereby people are able to construct generalisations wholly from personal and/or vicarious experience.

This process rarely occurs in isolation; rather it takes place in social processes involving others. In these circumstances we often come to know what has occurred, at least partially, via the accounts others reveal as their experience. For the case study researcher, this means moving from one social experience, the observation or study itself, to compose another, the case report, or findings (Stake, 2005). Believing that knowledge is socially constructed, the method of assisting readers in their construction of knowledge is through the experiential and contextual accounts provided in the findings and discussion chapters to follow.

There is little doubt that the case study researcher relies most heavily on subjective data in the empirical study of human activity, whether it is the activity itself, or accounts provided by participants. Whilst the beliefs I have already expressed are clear about the limitations associated with the very notion of objective data, there is a desire to protect this research process from an unbounded subjective approach. In order to support this attempt at some resemblance of objectivity, the process of replication, falsification and triangulation of methods has been relied on (Stake, 2005). In my study this effort at objectivity included activities such as looking for consistent behaviour, such as how the clinical records were maintained. Seeking multiple examples of the same behaviour, consistent descriptions, and congruence across various data sets also supported this aim.

On the important subject of data analysis Stake lets us know that there is no special moment that data analysis begins, rather it "...is a matter of giving meaning to first impressions as well as to final compilations" (Stake, 1995, p.71). He makes clear that in qualitative inquiry we are able to capitalise on ordinary ways of making sense of what has occurred and that "there is much art and much intuitive processing to the search for meaning" (p. 71).

On the subject of interpretation, case study relies on two methods: firstly, the use of direct interpretation of an individual instance; and secondly, through the aggregation of a number of instances until something can be said about them as a category. In an instrumental case study, Stake assures us that some critical features may only occur on one occasion and that this is not a reason to exclude them from our findings. He is clear however that because the study is undertaken to help us to understand a phenomenon or particular relationships within it, the need to develop data categories and measurements is greater. He maintains that we are able to sacrifice "...attention to the complexity of the case to concentrate on the relationships identified in our research questions" (p.77). In an inquiry such as the one I have undertaken, the character of the study, the specific questions and particular interests of the researcher are able to determine what analytic strategies will be taken up; categorical aggregation or more direct interpretation. As described previously there was no desire to unearth 'the truth' about the dimensions of effective health social work practice, rather an approximation of the practice was all that was aimed for. Given this aim a focus on correspondence and patterns was applied to all data, including the interview data, clinical records, observational sheets, and policy documents.

Correspondence and patterns – coding procedures

Following Stake's (1995) guidance the majority of the interpretation in this inquiry is supported by multiple accounts and/or observations which rely on the same or similar use of particular descriptions. In our search for meaning, we search for patterns and consistency. A general inductive approach was taken to analysing the typed interview transcripts (Thomas, 2006). Thomas describes inductive analysis as a systematic process whereby the detailed reading of raw data enables the researcher to derive particular concepts, themes and models to emerge over time. This process relied on the reading and highlighting of phrases, and content into categories, each of which was identified by a different coloured highlighter pen.

There were occasions, as Stake suggested, where something significant happened only once, for example the disclosure by a father that he had hurt his baby; however as Stake further explains, "important meanings will come from reappearance over and over" (p.78).

Again by way of example, when the accounts participants provided relied on language such as fun, playful, jokes a lot, sense of humour, laughter, an upbeat manner, they were coded and subsequently aggregated into a pattern category – humour. When a number of pattern categories emerged, for example, those of being open, reliable, honest etc., they became a theme which was named personal characteristics. Themes such as this have provided the headings in the findings chapter, with a heavy reliance on participant quotations to provide supporting examples of the elements of each theme.

"Keeping in mind that it is the case we are trying to understand, we analyze episodes or text materials with a sense of correspondence. We are trying to understand behaviour, issues, and contexts with regard to our particular case" (Stake, 1995, p.78). When Stake talks about correspondence I understand that to mean the relationship between these various aspects of the case, with the aim being an attempt to understand this relationship. By way of example in this inquiry the relationship between the use of humour (behaviour), being approachable (behaviour) the volume of child protection cases (contextual complexity) and effective health social work practice (issue) is able to be explored. This results in an assertion being made that effective social work practice in this context is supported by a good humoured, approachable social work practitioner. "[F]or more important episodes or passages of text, we must take more time, looking them over and over again, reflecting, triangulating, being sceptical about first impressions and simple meanings" (Stake, 1995, p. 78).

Taking up this advice, the assertions made in the discussion chapter of my thesis are most often based on themes which have been developed from the coded interview transcripts and subsequently confirmed by both observational data and further validity being provided in the clinical notes and finally the survey data. The case study findings chapter was also confirmed by *the case* practitioner as an accurate account of her practice and expert comment, gained from experienced practitioners in this context, was also sought as a further act of checking and reinforcing. Extensive reflection, both solitary and via supervision processes was also undertaken throughout the data collection process, and prior to writing the findings and discussion chapters of the thesis.

Step 3: Designing the survey tool

In the employment of the exploratory design with the requirement to develop a survey tool to help check, reinforce or discredit and expand my understanding of the dimensions of effective practice across the wider hospital context the question arose as to exactly which data would be most useful to incorporate in the survey. In this phase of the research process I needed to consider which information was most helpful in the design and development of the survey tool, and also what procedure I should use when making this choice. The second significant area to consider was how best to design and administer the survey with the aim of gaining maximum responses. The next part of the chapter explores both these issues relying primarily on the theoretical guidance of Cresswell and Plano Clark (2007;2011) and Dillman, Smyth, & Christian (2009).

The case study findings were used to inform the development of a survey tool which incorporated both quantitative and qualitative fields. The quantitative fields represented the 40 key elements of effective practice identified via the case study data and confirmed in the literature. These elements of practice were grouped together into logical clusters of activities, or characteristics which appeared to be naturally connected. By way of example, listening skills; developing rapport and engaging people; the ability to adjust communication style; helping to manage complex situations on the ward, and the ability to work with people from different backgrounds constituted one cluster of skills. These particular activities were combined into this cluster because they were often described together by participants and seemed to be linked, i.e. the ability to establish rapport and engage people was linked with the ability to help manage complex situations on the ward. This set of skills was located in the question related to social work skills, whereas 'having a stable centred demeanour' and 'a good sense of humour' were clustered with other personal characteristics, rather than with skills.

In retrospect the grouping of skills, characteristics, traits, activities and competencies that constituted the dimensions of effective practice proved challenging in some instances. This became evident after the combined analysis where the volume of data was able to provide increased clarity regarding more appropriate clusters. For example the quality of being reliable was found to be very much connected with the provision of a dependable service,

whilst the trait of being non-judgmental was found to be more appropriately connected with relationship-based practice. This is therefore identified as a limitation of the survey tool.

The quantitative ranking and rating activity was a two-step process. Firstly participants were asked to rank each dimension of practice numerically in order of importance; they were only allowed to use each number from 1–5 once. The second step involved using a word rating employing a Likert scale with word choices ranging from extremely important to not important or extremely valued, to not valued. This scale was developed on the basis that five options were offered to participants, two that were above average, one that indicated the middle ground, and two which signalled a below average, nutral or not applicable rating. This scale was assessed as offering a sufficient variety of choices to participants, enabling an authentic account to develop regarding their assessment of each dimension of practice. Following each set of quantitative fields participants were also afforded an open ended question. This provided them with the opportunity to offer further examples of effective practice which they assessed as relevant to the dimensions of practice in each cluster under study.

The ranking and rating was relied on for two reasons. Primarily the ranking was included to help prioritise the subsequent intervention activities, and the rating activity was designed to check and reinforce the dimensions of effective practice identified in the phase one data. The open-ended questions also served to reinforce and extend the phase one findings and identify potential areas of difference across the three practice domains. Two areas of the survey were qualitative in nature; an exploratory question related to the provision of effective health social work for vulnerable adults experiencing interpersonal family violence, as I did not have prior qualitative data from an adult context on which to base a quantitative question. Second, reflecting the case study data, a series of four qualitative questions sought further examples of the dimensions of the advocacy and support health social workers provided, which this new wider group of participants valued. I included these open ended questions because I wanted to compare and contrast a range of examples across the hospital context with the data gained from the paediatric context.

The procedures that were relevant to the development of this survey tool (Appendix 8), along with literature related to survey development (Dillman, 2009) and specifically online survey development (Fielding, Lee, & Blank, 2008; Lumsden, 2007) have been incorporated into the table below. The research activity I undertook has been described in the right-hand column, in relation to the theory I most heavily relied on which is located in the left-hand column. Given that the primary purpose of the survey tool was not intended to validate findings using complex statistical measures no emphasis has been placed on correlations, item variance and reliability. Because of the centrality of the influence of tailored design theory (Dillman, Smyth, & Christian, 2009) in the development of the survey, this approach will be explained in some detail directly after Table 1.

Table 1: Summary of survey tool development process

Instrument development and online survey theory relied on	Research activity
1. Define the research questions (Lumsden, 2007). 2. Establish what you want to measure and ground yourself in the findings, constructs and theory to be tackled (Creswell & Plano Clark, 2007).	• Read literature • Data analysis and writing up of qualitative findings – identified forty key dimensions for checking • Presented findings to practitioner audience (x2)
3. Surveys are an efficient and useful tool to enable us to learn about people's behaviours and opinions (Dillman, et al., 2009) 4. Create a pool of short items, check reading level, keep questions simple (Creswell & Plano Clark, 2007). 5. Identify subcategories and divide research question into them. List and organise items in a logical order (Lumsden, 2007) 6. Keep questions to a minimum (Lumsden, 2007) 7. Keep open ended questions to a minimum (Fielding, et al., 2008) 8. Write introduction including ethical considerations, consent, confidentiality of data etc (Lumsden, 2007)	• Developed compulsory first word question • Decided on demographic data fields • Grouped items into 7 themes • Wrote qualitative questions x 5 • Designed survey on Survey Monkey – applied tailored design theory • Included information sheet and explained consent
9. Settle on the scale measurement and the item and the physical construction of the instrument (Creswell & Plano Clark, 2007) 10. Decide target audience and profile (Lumsden, 2007) 11. Employ a tailored design (Dillman, et al., 2009)	• Developed ranking system • Developed rating system - Likert scale questions, with clear instructions as to how respondents were to indicate their answers (Lumsden, 2007) • Identified survey population • Designed survey tool, consultation with research peer, supervisors

Instrument development and online survey theory relied on	Research activity
12. Ask experts to review item pool (Creswell & Plano Clark, 2007)	• Presented item pool to key stakeholders, research peer and senior colleagues
13. Locate other survey tools, scales or validated items and consider for inclusion (Creswell & Plano Clark, 2007)	• No suitable tools, instruments located
14. Burdensomely long surveys reduce participation and risk roll-off (Fielding, et al., 2008) 15. Administer the survey to a sample (Creswell & Plano Clark, 2007)	• Piloted survey with social work group • Piloted survey with key stakeholders, i.e. Charge Nurse, Doctor and Allied Health Team Leader • Items evaluated, some language changed to clarify meaning • All data was reviewed to reduce size, front page reduced to cut down reading time
16. Administer survey, attached link to e-mail to make it easy to respond (Dillman, et al., 2009) 17. Incentives increase response rate (Dillman, et al., 2009) 18. Sending the link via e-mail allows for random samples of known populations, supports anonymity and increases instrument design options(Fielding, et al., 2008)	• Identified sponsors and requested they send out survey to key stakeholders via their distribution lists i.e. Senior Doctors, Midwives, Nurses, Allied Health and Social Workers (Populations sample approximately 647) • E-mail invitation included the ability to influence the provision of effective practice in their hospital • Incentive to participate offer by way of participants going into the draw for a hamper

Tailored design

Dillman (2009) explains that a tailored design requires the researcher to employ multiple motivation features in mutually supportive and compatible ways to encourage a high quality and quantity of responses. This approach is based on what he describes as the "social exchange perspective on human behaviour…" (p.16). This theory "suggests that respondent behaviour is motivated by the return that behaviour is expected to bring…" (p.16). This approach is built on the assumption that if the respondent trusts that the anticipated rewards will offset the anticipated cost of responding this will support a greater and more accurate response to a self-administered survey (Dillman, 2009).

Three fundamental considerations form the foundation of this general approach. To begin with the tailored design is based on a scientific approach to conducting sample surveys which maintains a focus on reducing the four primary sources of survey error; these include coverage, sampling, non-response and measurement (Groves, 1989, cited in Dillman, 2009). The steps I have outlined in Table 1, and the procedures that follow, collectively aim to reduce these primary sources of error.

The second consideration requires the development of a set of survey procedures, which includes such things as e-mails or contact letters, that act together to persuade the maximum number of responses. Therefore it requires the researcher to pay attention to all elements of contacting and communicating with respondents. Efforts to reflect this advice were extensive, with the use of established relationships, contacts and careful use of language applied to all aspects of communication.

The final consideration relates to the development of the survey procedures. Tailoring is about building positive social exchange and promoting maximum response by considering matters such as survey sponsorship, the nature of the survey population, and the content of the survey. The efforts I made to apply the tailored design method have been outlined in the table above. Survey sponsorship by way of an endorsement from the most senior professionals in each set of participants, language use, and ensuring the survey was tested, and language appropriate provide further support of the tailored design method, in practice.

Step 4: Quantitative and Qualitative data collection

Population and sampling

Traditionally it is recommended that the participants in the first stage of data collection are different to those who participate in the second round of data collection. In this study however phase one participants were not excluded from participating in phase two for the following reasons: the time lapse between the stages of data collection (two years), staff turnover (five of the phase one participants were no longer employed), the number of participants in each stage (10 in stage one and 191 in stage two) and the desire to check and extend the findings across all practice contexts, including the original study site.

Because of my insider researcher status and the ability to rely on established relationships and networks I was able send the survey link to key Senior Administration staff in Nursing, Midwifery, Medicine and Allied Health for distribution. They sent the survey link in the body of an e-mail via their e-mail distribution lists for senior members of staff (Appendix 9). The subject line said, “An opportunity to inform ADHB social work service – please complete this survey – great prize to be won!” In the body of the e-mail a brief outline of the purpose of the survey, encouragement to ‘have your say’ and a description of the prize, a gourmet food hamper valued at $500 provided additional incentive to participate.

As referred to above many of the senior leaders in the organisation, such as the Nurse Director in Adult Health included a line of encouragement to participate, for example “Please take time to complete Linda’s survey; it will help ensure that the social work service in this hospital is responsive to your clinical area’s needs.” This is an example of the social exchange perspective in action, referred to previously and as described by Dillman (2009).

Because of repeat postings, and the cascading of the e-mail it is difficult to be exact about the sample size, but approximately 200 senior nurses in Adult Services; 300 senior nurses in Paediatrics; 59 Senior Doctors; 59 Senior Midwives and Obstetricians from Women’s

Health and 29 Senior Allied Health Practitioners received the e-mail with the survey link attached, a total of 647.

The survey respondents represented the Nursing, Medicine, Allied Health, and Midwifery Professions with a total sample size of 191 (N=191), an approximate response rate of 30.4 percent. The nursing participants (N=92) occupied roles such as Charge Nurse Managers, Charge Nurses, Nurse Educators, Nurse Advisors, Nurse Specialists and Clinical Nurse Specialists. The Doctors (N=42) were representative of a variety of specialism's and service areas, for example, Paediatricians; Anaesthesia, Ophthalmology, Neurology and Psychiatry Consultants; a Neonatologist, Cardiologist, Surgeon and Geriatrician were identified as part of the sample. The Midwives (N=21) also represented a number of specialty areas and held senior roles, for example Professional Leader, Clinical Charge Midwife, Midwife Specialist, Foetal Medicine Midwife Specialist, Clinical Midwife Advisor, Midwifery Educator and a High Risk Midwife.

The Allied Health disciplines were also well represented with participants from a number of disciplines represented (N=35). This group was made up of Health Social Workers (N=13), Physiotherapists (N=9), Occupational Therapists (N=4), Speech Language Therapists (N=4), Dieticians (N=3), Psychologists (N=2) and Child Psychotherapist (N=1). Again roles were of a senior nature including Professional and Team Leaders, Practice Supervisors and an Allied Health Practitioner. The average length of service in health was a period of twenty-one years, with the shortest length of service being four years, and the longest 50 years.

Step 5: Quantitative and qualitative analysis

Quantitative analysis

Guidance regarding what would constitute an appropriate numerical rating to establish that a dimension of practice would be carried forward into the final operational definitions was provided by the Starship Foundation Children's Research Office statistician, Peter Reid. Given the five-point Likert scale, with the middle choice constituting an average rating, the top two choices represented the above average rating positions. In these top two positions of the rating scale participants were given the choice to rate each dimension of practice as

either extremely important or very important, or highly valued, or very valued. The choice was made to add these top two ratings together to give a combined percentage of these above average ratings.

By way of example, 87 participants (N=90) rated the ability to identify and assess child protection concerns as extremely important whilst 82 participants (N=90) rated it as very important. Combined, the overall percentage of participants who rated this dimension in the extremely important or very important range of the scale totalled 94.3 percent. These percentages are reported in the survey findings in a series of tables. Each table lists the dimensions of practice in the left-hand column, and the top two percentage rating, as described above, in the right-hand column.

A choice was made to not report the ranking choices participants made. This choice was made because I assessed this data as not adding any particular value to the overall findings; rather it provided reinforcement and clarification of the other data. As indicated this data will however be usefully applied when prioritising occurs in relation to the intervention activity, particularly as they relate to choices regarding which dimensions of practice require an early, or concerted focus.

Qualitative analysis

The account provided early in the chapter regarding the qualitative analysis which occurred in the case study, has also been applied to the qualitative data received via the survey responses. Broadly an inductive approach for analysing the qualitative data was adopted as described by Thomas in relation to evaluation data (Thomas, 2006). This process included a focus on correspondence and patterns, with themes being identified via the coding and counting of patterns, words and subthemes evident in the text**.** The descriptions survey participants provided of effective practice largely mirrored and therefore reinforced the case study data and were seamlessly sorted into the same subthemes and themes identified during the case study.

This method of analysis has relied heavily on a process of interpretation. Fundamental then, is the notion that there may well be different and at times competing viewpoints that may

come into play when attempting to interpret a situation. In light of this proposition any interpretation of a situation, in this study the dimensions or elements of practice that collectively applied constitute an effective health social worker, is my own viewpoint, on the practice described and demonstrated, and therefore can only be considered an interpretation, or attempt at describing reality, rather than reality itself (Fook, 1996).

"A reflective approach in this sense recognises that 'reality' merely consists of the extent and ways in which the different players share an understanding of the situation" (Fook, 1996, p.4). As a researcher, by accepting Fook's proposition it became critical to attempt to appreciate and describe these accounts of practice in ways which were highly congruent with the perspectives of the participants. Fook's approach emphasises the importance of a holistic perspective which aims to take account of the entire situation and context and the ways in which various perspectives relate and connect to one another.

The process of research has provided an opportunity to establish that numerous different players, across multiple specialisms, disciplines and service areas for the most part articulate a consistent account of the dimensions of effective health social work practice. In this analysis of the text accessed during in-depth interviews, and afforded by participants across the three service areas surveyed are remarkably congruent. Consistent and powerful links have been made regarding the psychosocial needs that arise for patients and their families in the hospital context, and therefore the skills and competencies required to meet these needs. This congruence and consistency provide solid support for the extent to which as shared understanding of the situation, as described by Fook, has resulted from this reflective research process.

Step 6: Interpretations and the combined analysis

In making decisions about how the survey data, and the combined data have been analysed it is helpful to review the purpose of the survey, and how it relates to the overall aims of the inquiry. My study aimed to identify the dimensions of effective health social work practice via the case study activity, the first exploratory stage of data collection. These dimensions were then tested across a wider context via the survey tool. The combined data was used to develop operational definitions of effective practice. The final aim of the study was to

develop an intervention plan which is able to support hospital social work leadership to purposefully increase the provision of effective practice in this context.

The case was a health social worker in the paediatric context and therefore this is the context in which the dimensions of effective health social work practice emerged. In order to explore this data more extensively across a broader audience a survey was designed to check and reinforce that the dimensions were accurate and relevant across the more expansive context of the three service areas. These included the Paediatric, Adult Services and Women's acute hospital inpatient services of Auckland District Health Board. The choice to test the dimensions across a wider contextual landscape was motivated by a desire to understand the similarities and differences across the organisation. The final aims of the study were to develop operational definitions and an intervention to support their implementation.

In light of these multiple aims the stage one and stage two combined data were analysed on the following basis.

- For congruence i.e. were the examples given in stage one, similar to those given in stage two?
- For extension i.e. were any new dimensions of effective practice identified by stage two participants?
- For difference i.e. were things that were valued in one practice context not valued in another?
- For checking and reinforcement i.e. did the stage two participants identify that the dimensions of effective practice identified in stage one achieve a 60 percent rating of extremely important or very important or highly value or very valued?
- To help provide guidance in relation to the focus of the intervention, i.e. which dimensions of effective practice were ranked by most participants as most important?
- New qualitative data was analysed using the same framework as described for the case study data i.e. a reflective approach which aimed to identify correlations and patterns.

Conclusion

This methodology chapter has aimed to make transparent critical matters which have informed the design, implementation and analysis that are the foundation of this research inquiry. Beginning with a description of my epistemological influences and position, the

focus then shifted to the various stages of the research activity. Having employed a mixed method methodology, namely a sequential exploratory design, the chapter structure has aimed to reflect the sequence of the study. Honouring the weighting decision I made, a central focus of the chapter has been on the development of the case study. Reflecting the sequence of the research design the following chapter reports the phase one case study findings.

Chapter 5: Exploratory findings (case study)

Introduction

In the contemporary practice environment, with the increased demand to take up evidence-based practice and to develop more sophisticated systems of audit and accountability Parton (2000) maintains we are at risk of losing sight of one of social work's core strengths, the concept of ambiguity, indeterminacy and uncertainty. In supporting Parton's call for the 'rehabilitation of the idea of uncertainty' it is essential that this account of what constitutes the dimensions of effective health social work practice described in the case study is not taken up as an account that aims to establish any particular 'truth'. Accepting instead that social work, by its very nature is "not amenable to or reducible to authoritative definition or measurement" (Parton, 2000, p. 460) this description of effective practice aims to showcase one possibility amongst many. This record is merely an approximation of the practice, a snapshot that is able to reveal what is in the frame on the day, and like any snapshot, it is likely to have left out as much as it has been able to include. Stake, on the matter of writing up the case study confirms this idea of *a partial telling* by claiming that "...the whole story exceeds anyone's knowing and anyone's telling" (Stake, 2005, p. 456).

This first chapter of findings provides a detailed account of the dimensions of practice that emerged from the exploratory phase of this research. This begins with a brief revision of the data analysis actively relied on to identify these dimensions and then moves to introducing *the case* herself. The first substantial section of findings will describe the acute paediatric hospital environment. The key issues to emerge in this context, those of the client and the multidisciplinary team are illustrated in some detail. It is out of this particular practice context that the central descriptions emerge as to what is effective health social work practice. This contextual account is not repeated in the following chapter findings, rather it is intended that the reader is able to generalise the relevant contextual variables across the broader context.

The largest part of the findings chapter will provide an account of the dimensions of practice which were found, upon analysis, to constitute a number of key areas of practice focus. I have called these 'practice domains'. To help orientate the reader to the structure of

the chapter, these domains, and examples of the practice that supports them are provided below in Table 2.

Table 2: Contextual Factors and the core dimensions of effective health social work

Core domains	Summary of practice responses
Practical advocacy and support in response to acute admission and social complexity	Timely provision of advocacy to help meet needs such as; transport, accommodation, finances, milk powder and nappies
Emotional advocacy and support in response to acute admission and complex medical issues	Brief interventions (informed by strength-based theory) that support the patient and whanau adjustment to new diagnosis and experiences of distress, grief and loss
Medical advocacy and support in response to complex medical conditions and team complexity	Clarifying issues for whanau (in consultation with the MDT) who need help to understand what is occurring medically; this includes clarifying issues associated with diagnosis, medical terms, time frames and treatment regimes
Cultural advocacy and support in response to multicultural patient mix and the multidisciplinary teams identified need for guidance	Provision of prayer, facilitating the input of cultural services, providing advice, guidance and support regarding cultural matters, and role modelling empathy to increase patient and whanau engagement
Interpersonal family violence – responding to vulnerability and risk	Assessing and helping to manage situations following a disclosure of family violence, non-accidental injuries, medical neglect, complex family dynamics which impact the wellbeing of the child or the families ability to engage with the health system
Problems solved in a reliable and timely way	Early identification of social issues and same day response in order to reduce their impact on the patient, family and the MDT

Core domains	Summary of practice responses
Brief assessment and intervention skills (average length of stay 2–3 days)	Biopsychosocial assessment and brief task centred interventions
Professional skills and theoretical influences	Biopsychosocial assessment Task centred practice Strength-based solution focused brief interventions Crisis intervention Grief and loss counselling (containment) Conflict resolution and de-escalation Organise and facilitate family meetings Organise and facilitate inter-professional and interagency meetings
Personality traits – personal, professional	Open, non-judgemental, kind Friendly, sense of humour Reliable, approachable, diplomatic
Assisting to manage complex	Cultural competence and

Core domains	Summary of practice responses
situations on the ward	understanding De-escalation Crisis intervention Visibility and presence on the ward
Communication	Open, timely, written and oral
Team relationships	Open Well known and trusted
Team work	Being part of the team Collaboration and consultation
‘Working the ward’	Proactively identifying patients who require social work etc.

Data analysis

In the writing up of the case study my aim is to describe the significant dimensions of practice, and the characteristics of *the case* that the participants expressed in an effort to articulate their experience of effective health social work. Frequently these descriptions have been confirmed during my observations, via analysis of the clinical notes and case load records, and in the accounts of the practice that *the case* herself provided. As described in the methodology chapter the key strategy for data analysis was the use of codes, counting and patterns. An inductive data reduction process was employed which involved numerous readings of the data, highlighting of patterns, establishing linkages and eventually creating

meaning from the complex raw data through the development of summary categories and themes.

By way of example, in this context a number of consistent variables appeared to impact on a patient's need for health social work input. These included any combination of social, medical, cultural and practical elements, all of which required an acute response within the confines of what was often a large and complex team. Out of this consistent pattern of need, a consistent pattern of practice was found to emerge reflecting a causal relationship between need and practice. I have called these practices *the dimensions of effective health social work* practice which tend to be relatively discrete. For example if a patient's parent is hungry the health social worker finds a way of ensuring they are fed. When a number of needs, and therefore the dimensions of practice which are required to meet these needs were found to link together they become a domain. Again by way of example the need for food, transport and accommodation have been grouped together into the domain of practical advocacy and support.

Introducing *the case*

This part of the chapter begins by introducing Kay (not her real name) the health social work practitioner who was identified by her peers and her colleagues as someone they considered to be an effective practitioner. Kay brings a wealth of professional and personal experience to her role as a health social worker, often described in the research interviews as a ward social worker. She has raised a family of her own, has lived in rural and urban environments, and has spent significant periods of her life living and working among marginalised groups. Her *experience, maturity and the fact that she has growing children*[4] are said by Kay to contribute to her effectiveness. Kay is a registered social worker, her formal qualifications comprise of two Diplomas, in social work and counselling. She also has a certificate in supervision.

Practice context

For the period of this inquiry Kay was providing a health social work service to the general medical and surgical wards in a large paediatric hospital in Aotearoa. As it is a tertiary

[4] Quotes relied on in this chapter are attributed primarily to participants in the case study, either by name or by title, short quotes will be indicated by italics rather than quotations marks

service the catchment is large, serving the upper half of the North Island. These wards are consistently described by members of the multidisciplinary team in language that exemplifies the acute and complex nature of the service being provided to child in-patients and to their family members who are accompanying them.

At the time of the case study health social workers were allocated to a specific ward or wards but were located in a social work team away from the ward. Within the social work team structure staff recruitment, orientation, provision of continuing professional development activities, performance appraisal, objective setting and supervision are undertaken. These activities have occurred largely independently from our multidisciplinary colleagues on the hospital wards. By way of example, Charge Nurses are not involved in the recruitment of health social workers, or in the decisions regarding the movement of staff away from their wards.

The development of a comprehensive understanding of the practice context is critical to this case study as thematic analysis highlighted the link between the practice context and the precise nature of what is valued as the dimensions of effective practice. With the aim of situating the practice most powerfully within its context an attempt has been made to describe the multi-faceted components of this complexity in some detail.

During the research process it became evident that there were multilayered contextual elements that directly impacted on the needs of patients and their families. These elements included the acute nature of the environment, the medical and social issues they were facing, team size and patient cultural and ethnic complexity. Responding to patient vulnerability and risk was also found to be a key feature. At times these elements manifest singularly, and at others, in combination. This quotation from the Charge Nurse of the medical ward demonstrates this concept of multilayered complexity:

> You can get huge medical complexity with some of the conditions that will come in and perhaps have not yet been diagnosed. Such as children who might have been deteriorating neurologically and complexity can also be measured in social circumstances. The last couple of weeks we have just been inundated with a volume of Child Youth and Family (CYF) related cases. So sometimes even though the

> patients on the ward can be quite stable, and we may refer to it as the acuity (acuteness) being manageable, what is taking up a lot of our time and resources is working with families and supporting the social dynamics going on in the family and liaising with obviously our Ward Social Worker, Te Puaruruhau (the specialist child protection service based at Starship Children's Hospital) and CYF as well.

The acute environment

The concept of *acute* is summed up by a participant who explains "... it is all the very short term, brief crisis intervention. People are in and out within a week..., if they are any longer than that you notice it!" This pace is supported by another member of the multidisciplinary team who emphasises *a very high, fast patient turnover*. Kay herself maintains that "it's a luxury having them (patients) for a week and it's a super-duper luxury to have anyone for a month, mostly it's three or four days". The Charge Nurse on Kay's ward described the context this way:

> We have a very high, fast patient turnover and the average length of stay is approximately 2.7 days. We take everything from your respiratory-style illness, skin infections, complicated infections and obviously infectious diseases. We also take children with child protection issues which is part of our work and young ladies with eating disorders such as anorexia nervosa. So we take quite a wide spectrum of acute medical problems.

Medical complexity

The medical accounts of complexity, invariably relate to the type of conditions, illnesses, accidents and trauma that resulted in an admission to hospital, often with minimal warning for the family. Some of the language used by members of the multidisciplinary team which hinted at this medical complexity were *rare, unusual, undiagnosed, complex infections, palliative, technology dependant, and only in this hospital in New Zealand*. One senior member of the multidisciplinary team outlines the situation of constantly needing to respond to rare conditions. She explains that: "It is very complex. There are a lot of specialities. More often than not when we have the multidisciplinary meeting we will have some sort of condition that none of us have ever heard of before and we might even .... go to the books and have a look up because there is something we haven't heard of."

During the period of observation a number of complex conditions were noted.
A sample of these include a ten-month-old baby and twelve-year-old child, both with large tumours in their stomachs; a ten-year-old boy who has been run over by heavy machinery resulting in complicated internal injuries and numerous broken bones; a newborn infant with her stomach on the outside of her body; a one-month-old baby with no anus which required urgent remedial surgery in Aotearoa having been born in the Cook Islands and a six-year-old who fell from a climbing frame, badly damaging one of her kidneys.

Social complexity

It was evident that often the medical conditions that brought children into hospital were intensified by the social and/or cultural circumstances surrounding the child and their family. As this Paediatric Surgeon explains,

> ...often patients are from out of town, Northland and all sorts....we are always getting rare and unusual things ...With the social issues, a lot of them are multicultural. You don't really often get that many social problems with your white middle class, central city kid who has broken his forearm, like you might with someone from South Auckland.... And in terms of the Social Work issues there are the various family issues, family stresses, and broken families. …And then there is a big Pacific Island population and a variable demographic in terms of the patients we admit, so there are financial issues as well which are dealt with.

There did appear to be common agreement about the nature and frequency of particular psychosocial issues which are likely to result in a referral to the Health Social Worker. As outlined above these are likely to reflect the low socioeconomic demographic of some of the paediatric hospital population. These social concerns are made up of any combination of housing, accommodation, food, employment, financial, income support, legal issues, immigration, out of town issues, family stress, lack of family support, isolation, refugee and new migrant issues, mental health issues, and domestic violence and child protection concerns. Due to the recurring theme of child protection and interpersonal family violence issues which became apparent during the study this aspect of practice will be explored in more detail later in the chapter.

Cultural and ethnic complexity

Cultural and ethnic complexity first emerged via the identification of children and whanau from a diverse range of cultures. Kay's statistical summary sheet provided a breakdown of the ethnicity of patients she had seen during a 14 week period. These include people described as Chinese, Cook Island Maori, Fijian, and Indian, Middle Eastern, Niuian, Samoan, South-East Asian, Tongan, other European and New Zealand European. Over this period Kay saw a total of 468 patients, 177 of whom identified as Maori.

It was evident that cross-cultural factors had the potential to add to the involvedness of a medical situation in any number of ways. These included matters such as the need for Health Social Workers to work effectively with an interpreter and relevant cultural support workers. It also required an ability to maintain awareness and knowledge of cultural constructions of health and illness, and take account of access, engagement and compliance issues. Cultural beliefs related to body parts and medical procedures, issues of cultural isolation and cross-cultural communication were also evident.

An example of the cultural and ethnic challenges a Health Social Worker can be required to respond to is outlined by this Paediatric Surgeon. "There is a guy from the Middle East, whose son was run over by heavy machinery and he went off his face on the ward and started punching another father..." Kay wrote about this incident in the clinical notes explaining that "Dad became very distressed earlier when he heard they had removed some bone. Culturally this is really bad to have body parts removed. We have assured him they can keep the piece of bone for burial." When we consider the multiple ethnicities that present for care at the hospital, it is clearly a significant challenge to maintain cultural competence in relation to their rituals, customs and belief systems, and how they may impact their comfort and safety in the hospital context.

This statement from a Charge Nurse colleague demonstrates the proactive approach Kay took to involving cultural support in a situation which was likely to be volatile.

> Kay actively engages the Pacific Island Family Support Unit or Kia atawhai (Maori cultural support) if needed. …For example if CYF have come in to uplift the child, Kay will always ensure that the right cultural support is in there and she will often be

> the person initiating it before anyone else has actually thought to do so….whatever the situation is it has been handled correctly and with the appropriate level of support for the family.

As these comments clearly demonstrate, the day-to-day contribution Kay made to ensure cultural needs and issues were responded to appropriately is a core dimension of effective practice in this context.

Team complexity

The final significant factor which adds to the construction of a complex practice context was the number of health professionals involved with a child and their family. Speaking about the size of the team, this multidisciplinary team participant illustrated that,

> [t]he team is large, depending on the specialty often there are numerous consultants but generally there would only be one on for that service for the week ... There would be a Registrar and a House Surgeon and generally there will be some sort of therapy services involved. So it might be the whole raft of them, depending on the child or it may be just a Speech Language [therapist] or it may be an Occupational or Physiotherapist...A lot of the specialties have Nurse Specialists attached to them and the Nurse Specialists work closely with the team to manage the care of those children whilst they are in hospital...and the Social Worker, sometimes there might well be a Child Youth and Family Social Worker or the Child Youth and Family ADHB Liaison Social Worker or a Community Social Worker all involved as well. Or even a community worker – there have been a few cases where we have had a Maori worker involved too.

In this team environment it became obvious that a commitment to the development and maintenance of effective working relationships was observed to be a central focus for the Health Social Worker.

Practice Domains

Five consistent fields of client need were identified which required health social work input, four of these have been described under the rubric of the provision of health social work advocacy and support. Each of these activities constitutes a practice domain. The fifth

core domain is the need patients have in relation to interpersonal family violence. In a paediatric context this primarily involved child abuse, child neglect, medical neglect and the impacts of interpersonal family violence. Give this need the capacity of the health social worker to respond to vulnerability and risk was also found to be important.

1. Practical advocacy and support

An essential task for the health social worker was the ability to respond quickly to the numerous practical tasks associated with a child's admission to hospital. This was particularly evident when the child was from 'out of town' and the admission occurred with little warning for the family. The tasks requiring attention appeared to fall broadly into two psychosocial categories; one associated with matters at home, the other centred on the admission itself. This example, recorded in the clinical notes by Kay provides a representative sample of this type of practical need. This intervention plan or list of tasks Kay committed to undertaking relates to the child who was badly injured by the heavy machinery and is therefore in hospital for an extended period of time.

1. Taxi for mum
2. Food parcel
3. Contact police
4. Letter to lawyer to defer court appearance
5. Telephone boss to clarify leave entitlement

Representative examples of the need for practical support include advocacy regarding the provision of meals on the ward, assistance with income support applications, letters to Housing New Zealand either for accommodation, or to have accommodation improved (for example the addition of carpet), applications to trusts for financial support, liaison with the Ministry of Health regarding various payments, and the provision of milk powder and nappies for children on the ward.

The account below, of a recent assessment Kay had undertaken, demonstrates the focus on the immediate, or acute needs of the family, whilst also remaining conscious of the broader emotional issues associated with previous loss, and the precise medical situation the child and family are facing. In this situation Kay has demonstrated an incremental approach to

the assessment of need, beginning with the immediate crisis (brief initial assessment) and progressively responding to new issues if the length of stay permitted it (fuller assessment). Kay refers to this incremental assessment process as assisting the whanau to take action in *manageable chunks.*

> There are several things you are taking into account – one is what has brought the child into hospital, which could be anything from standard pneumonia to some horrific car accident. Like this girl this morning, not only has she got a dreadful medical condition ... and Mum's known for six weeks that something has not been right, and no-one has listened, she also has all this other stuff with her own Mum just dying. So you are taking into account levels of anxiety or understanding around the medical side and then assessing what their immediate needs are on the ward. If they are from out of town we need accommodation for other family members. How are we going to feed them? What supports have they got to help them through the admission up here? If none, what can we provide? And then you start casting the net out a bit wider to find out what else is going on behind the scenes – are there other children at home that need to be looked after? They might have housing issues or other stresses that they are facing as a family.... then you start moving it out. Like this morning, what can we do today to make today better, because they don't know it yet but I know that they have like a year of this. So it is to keep them focussed on today – who can go round to the house in Whakatane and feed the animals, get the parents into 'The House', make sure they have a good understanding of where the Doctors are up to now and what is going to happen in theatre today. What are they going to do in the two hours she is in theatre? So giving them some options around that, because this is going to be the longest two hours of their lives. There are tasks I need to help them with when I leave here, Dad needs to do some e-mails, and I need to show him where the Post Shop is. We need to get Mum's asthma medication, take them to the chemist then move them down to The House. And it is all about today, and then by the end of the day I will talk about the weekend, then come Monday we will talk about the next few days, then extend it out. So put it (the assessment) in to manageable chunks.

This long quotation has been included in the findings because it demonstrates how Kay engaged in an initial assessment, and the subsequent provision of immediate practical support. This was clearly the first step in helping a family adjust to this new and foreign

environment. By meeting their urgent external needs Kay is able to begin to establish a relationship which may serve them well in the time ahead when they are likely to experience more challenging emotional needs.

2. Medical Advocacy and support

Closely aligned with the provision of emotion support, and often time involving a cultural element, this dimension of practice appeared to rely on a set of skills evolved over time in this context. The families need for accessible information regarding their child's medical situation, and the Health Social Worker's advocacy role in order to achieve this was evident. This call for information often involved the activities and interventions of the wider multidisciplinary team in either the diagnosing or treatment of the child's condition. One example of this, provided by Kay, was the provision of support to enable a child to ask her own questions of the Surgeon.

> She is twelve, and an only child. First I went out with the Surgeon ...and went through all the scans with them – the x-rays... and got heaps of information. Mum had a really good cry and Julie was able to ask me lots of questions which I then got her to ask the surgeon.

Rather than an imposition of the seeking, or giving of information, Kay seemed to negotiate this on a case by case basis as described below:

> …or I have had other families where they don't want to talk about it (so I start with) 'what do you want to know?'... It is all checking out and engaging all along the way. What are they comfortable with? What do I need to know? There are a lot of things we don't need to know. Families are stressed, worried, tearful and they are sitting with a lot of anxiety so your purpose is to bring those stress levels down, not add to them.

This practice reflects Kay's stated commitment to containing the emotional work and protecting family members as much as possible from the risk of intrusion associated with the 'public living' which inevitably occurs during extended lengths of stay on the Paediatric ward.

The other key aspect of the advocacy role in this context may involve expressing a view on behalf of a family member, or patient which was contrary to the views of the medical team, or in some cases, other professionals outside the hospital, such as Child Youth and Family personnel. Here a senior member of the multidisciplinary team draws attention to the respect Kay has gained from the wider team in relation to this particular role.

> Speaking out is important and giving a voice to the family or the parents or the child – being an advocate. And sometimes going against what the rest of the team have in mind, just because they (the social worker) have that insight (***Linda:*** and is there a particular way that they do that speaking out?) My perception is that once the social worker gains confidence in being accepted as part of the team they feel comfortable to voice their concerns and that their voice is respected by the team because we know that they have the knowledge and the skills and that is their specialty (***Linda:*** What kinds of things are they likely to be involved in with advocacy?) Well, first of all are patient rights and the code of rights ... and then the rights of children in regards to basic needs like food and a bed and basic needs. Advocating for people who don't have the voice to speak up for themselves, so being the voice for them and relating that voice as accurately as they can...adjusting it if necessary. Sometimes advocating for the child sometimes against what the parents might feel is best for their child, so being that patient or child advocate.

The final element of medical advocacy and support has strong links with cultural and emotional advocacy and support and involves the ability to communicate with a wide array of people. This ability was confirmed by a family member who played a significant part in supporting her sister-in-law, a Cook Island caregiver of a seriously ill child, who had English as a second language.

> We understand her (the child's) situation and condition now and it's not as scary as we thought...at first she (the caregiver) lacked understanding, she misinterprets everything...her (Kay's) talk was good and easy and slowly and in plain English so that my sister-in-law could understand....she was explaining it because she didn't understand what was happening.

This ability to explain things in 'plain English' and the impact this clearly had on reducing the family members feelings of fear and worry was an important professional activity and appeared to be highly valued by this service user.

3. Emotional advocacy and support

The ability to respond to the child patient, their parents and extended family members' emotional reactions to a child's hospitalisation was a strong feature in the data although it did appear to take a slightly secondary role to responding to the more practical concerns. This impression may have been created because the clinical record often relied on language like 'continue to support' without providing the exact nature of that support. It may also relate to the acute nature of the admission and the brief length of stay. Again it is Kay's description of the assessment she undertook just prior to this interview occuring that provides valuable insight regarding the cautious approach she took to this emotional work.

> Well, you are listening and watching for receptiveness from the families and you can tell if something is not working for them...Like this family this morning – terrible, terrible circumstances. The girl has come in and has such a massive tumour in her stomach... Grandma died the night before last having been diagnosed with cancer two weeks ago. They have all kinds of issues – houseful of pets and no-one there to look after them. I open the curtain and Mum is very teary...they knew I was coming which was helpful, but you have to find a way in. How am I going to start? How far does this family want to go with me that is not going to be too painful and is going to be helpful? Not all of them will let you listen to their grief ... And then you have to delicately assess saying 'I need to ask you a few questions. And I need to ask you, Julie, a few questions. Shall we do it altogether? Or shall we start doing it together and see how we go?' You have to set the scene.

This account which Kay provides of her practice demonstrates the respectful and tentative nature of the initial assessment which involves emotional elements. Evident in this account is a willingness to negotiate with the family how this may occur and consideration of how best sensitive issues may be approached.

Another element of emotional support is the concept of 'just being there' as was highlighted by this senior member of the multidisciplinary team.

> Sometimes it might just be that sitting there and maybe a little bit of chit-chat about nothing – about what's in the newspaper or something, *just being there* as a support to people and that makes a big difference. It might just be holding their hand and saying nothing or it might be *just being there* whilst life goes on around that sick child and what's going on and people rushing in and out. Saying 'yeah, this is where you are' and 'I'm here too – I see it – I see it... and I can see what you're experiencing and how you're reacting and I'm here.'

The containment and support offered to the child's parents during a hospital stay, and the willingness and capacity to be available, to sit and listen, and to talk about the small things with a family is what dominated descriptions of what appeared to be of value in this context. These descriptions tended to be relied on rather than more formal concepts such as grief or trauma counselling.

4. Cultural advocacy and support

An awareness of the cultural diversity of the population we serve, and the need for sensitivity and respect was recognised as a valuable contribution that health social workers, and in particular Kay, was able to provide in this multicultural practice context. This advocacy took various forms as described below:

> I think that there is a respect for cultures. For example if we are having a meeting, they (the social worker) may well be the people who look around and maybe even approach someone and say "do you want to do a little introduction?" or "do you want to do a powhiri[5]?" They often think about what the most appropriate time to have a meeting will be for that family and they will have an input into that. They may even advocate for who might be best to be at that meeting. They may think that there are too many people or not enough people or they may even suggest that we need some male presence for some of the Muslim people. And I feel fine about that. They may be the ones who suggest the interpreter. They will often sit close to the person that is

[5] Traditional Maori welcome

> coming to the meeting – the care giver, and so giving that non-verbal support. They have the knowledge of what some of the different cultures need. They may even do the organising amongst the different cultural supports. They are available to make sure that the issues that need to be teased out are teased out and decide who is going to do that teasing out and how that is going to be fed back or dealt with.

This extensive quotation devoted to the role of cultural advocacy has highlighted a number of skills that were valued by a variety of participants in the case study. These skills involve competencies such as the ability to work with an interpreter; to advocate for cultural rituals such as prayer, welcomes and introductions; to maintain an understanding and awareness of specific cultural needs and to refer on to; or ensure by other means the provision of appropriate cultural support.

This capacity Kay demonstrated to understand cultural issues and concerns is further reinforced by the Paediatric Surgeon who maintained that:

> [s]he just seems to have a good grip of the whole cultural thing. I don't know if she has a bit of a tangata whenua[6] background or whatever, I don't know…She has just a natural understanding that comes from that. That whole natural understanding of what's going on seems to help. A lot of us might react and say 'oh that jolly Syrian guy', but she would just have an understanding of where they are coming from which makes a huge difference.

What is evident in the statement above is an acknowledgement of the value of what is described as the *natural understanding* Kay demonstrated which has been attributed to contributing to making a huge difference to the family wellbeing.

5. Interpersonal family violence – responding to vulnerability and risk

The requirement for the health social worker to be involved in the investigation, assessment and ongoing management of child protection cases were central to accounts of Kay's practice. Whilst some of these situations were co-worked with health social workers from the specialist child protection unit which is charged with responding to the most serious and

[6] The term tangata whenua means indigenous to this land, i.e. Maori

complex child protection problems it was evident at the time of this inquiry that Kay played a key role in the identification and ongoing management of these situations on the ward. As the Charge Nurse explained where once the health social worker was there to assist with housing or a food parcel, in a contemporary environment “there are so many uglier things that they have to do…”

The situations encountered reflected a wide variety of scenarios ranging from the late presentation of injuries such as broken limbs; the alleged repeated holding of a baby underwater by her father; a disclosure by a mother that she had abused her newborn baby by shaking her; the ability of parents to undertake the medical treatments their children required upon discharge and the neglect and abuse which can be associated with parental substance abuse and mental health issues.

The tensions associated with the dual role of participating in the investigation of child abuse, and then being required to provide support and guidance for the family when or if the statutory child protection agency became involved was well described by this Charge Nurse:

> ...sometimes with some of the families they take it pretty hard. They get pretty upset. And then I see over time the Social Worker is trying to breakdown those issues. Initially the family may refuse to see the Social Worker again, or they might want a different Social Worker.... they (the Social Worker) may actually see those patients several times a day. And they may actually just go in and have a social chit-chat. A social talk, they might not even talk about all the bad things, or the issues or the nitty-gritty. They just go in to break down the barriers to be a friend and gain that trust. And re-establish their role as the Hospital Social Worker.

The increasing prevalence of these cases, associated partially with changes to Ministry of Health policy regarding Family Violence Screening is given consideration by this senior member of the multidisciplinary team. In response to a question regarding her view of the level of knowledge required by the social work in this field of practice she explains that it is:

> Hugely (important)! Because I wouldn’t want to say it is our bread and butter, but at the moment, for example, this morning I had 32 patients on the ward and I would

> have had seven children with significant child protection issues. So that is a good chunk of our work at the moment....(*interviewer:* and have you noticed that change over the years?) ... I guess now with mandatory training for Family Violence Screening and also for child protection training which became mandatory a few years ago, it is certainly more prevalent and we are talking about it more openly.

The increasing prevalence of the challenges facing children in Aotearoa is reinforced in the following excerpt from a *New Zealand Medical Journal* article exploring the issues of child health and human rights. In this article the authors maintain that:

> There continues to be widespread belief that New Zealand is a child-focused and "child-friendly" society. The reality, however, is that for many children it is a harsh and brutal environment with high levels of stress, illness, anger and violence. In addition many New Zealand institutions, and traditions, are tolerant of children rather than engaging directly with them (Turner, Hoare, & Dowell, 2008, p. 8).

The degree to which this work impacted on Kay is reflected in this account that she provided a few days after one of these situations came to light:

> I stumbled across a dreadful child abuse case. The boy had come in for pneumonia and the family ended up disclosing all this stuff to me. Horrific stuff and then that night I was mulling that over and thinking "oh my god, I wonder if we should get a whole lot of medical stuff done, like a bone scan .... And I bet you the paediatrician hadn't thought of that. And I thought of that all night and first thing in the morning I rang her and said "look I don't want to tell you how to do your job but while we have him in do you think we should do a bone scan and an MRI and all that?" And she said "oh, that is such a good idea, I will ring the specialist and double check", And of course they did....and then the next night a mother had disclosed to me that she had abused her child and I had never[7] had that happen to me before ever. And so I took that home too because I was quite shaken by that, I was really shaken. And the police

[7] This parent admitted shaking their child to Kay, while the NZ Police were trying to establish 'who had done it.' I believe in this circumstance it was a situation of a parent never having made an admission such as this before.

> said they weren't going to come over and interview her straight away – they were going to leave it until the next day and I was terrified she would change her mind, which she did.

Again in the verification of findings process Kay emphasised how important she felt it was to engage respectfully with whanau members no matter what the circumstances, and attributed this mother's disclosure of having shaken her child to the respectful way Kay had treated her over the previous ten days of her child's admission.

The disclosure that Kay refers to above is also mentioned by another participant and perhaps somewhat surprisingly it was this member of the multidisciplinary team with a medical background who provided this insight regarding the value of clinical supervision in relation to this area of practice:

> ... I think the other thing that is interesting with the social work service is the supervision and the debriefing which they routinely have which I think is really important. Because I can't imagine some of the stuff that over the years Kay has had to walk around with. Just the day before last she had a huge disclosure on the ward.

I have reported these findings, and the role Kay played in the ward environment in an effort to demonstrate the complexity of the day-to-day practice many health social workers have to deal with. In this data set it was evident that from time to time, (even in a hospital with a specialist child protection unit), health social workers *are* required to significantly contribute to the containment and management of complex child protection situations on the ward. In my view these examples demonstrate the level of competence and emotional resilience required by health social workers who practice in this context and the level of practice oversight and support required to help ensure that children and families are appropriately supported, risk is appropriately managed, and practitioner wellbeing is properly attended to.

Making the link between practice context – patient needs – and what is valued as the core dimensions of effective health social work practice

> Problems solved in a reliable and timely way

A number of phrases are used in an attempt to portray the multidisciplinary team's experience of Kay's work and what they valued about it. Consistently words like *responsive, helpful, hardworking, well organised* and *industrious* are provided in relation to what constitutes effective Health Social Work in this acute work environment. The ability to sort out and solve problems in a *timely* and *reliable* way was the overriding narrative used by members of the multidisciplinary team to describe the approach to, and subsequent outcomes of, Kay's interventions. Not only were the problems sorted, but as this Paediatric Surgeon described, they *were almost sorted out before we knew it*.

He goes on to provide an example of a situation that Kay played a central role in resolving referred to earlier in the findings. "There was a little boy with quite nasty injuries in hospital for a long time who is a classic example of difficult social issues we deal with. The situation involved his Dad being under stress and reacting badly and behaving dangerously on the ward". This behaviour included assaulting the parent of a child in a neighbouring bed, the Paediatric Surgeon described Kay's contribution and attitude in the following way,

> I guess it really shows Kay's understanding. Most of us would just say he was acting like a complete idiot and get him out, but she actually understood the stresses he'd been under, he'd been tortured back in the Middle East ... She just knew the reason he was acting that way (***Linda***: and what difference does that make?) The difference it makes is that she gets it sorted out in an effective manner because she understands the background to the way people behave. Whereas if it was left up to us we would probably just get Security or the Police in and issue a trespass order or something like that which would probably become counterproductive because the little boy is probably close to his Dad and his Dad is reacting in a dysfunctional, but understandable way.

The clinical notes written by Kay after this incident provide some clues as to how she achieves these reportedly *timely* and *reliable* outcomes. In order to get a psychiatric assessment of the father's suspected Post Traumatic Stress Disorder she "goes to see the psychiatrist, books the interpreter, attends the assessment and then maintains regular liaison with the practitioner responsible for providing coping skills to Dad." Kay also visited the Dad on the ward on two occasions the following day and whilst expressing understanding

and compassion is also very clear that this behaviour is "unacceptable and could result in a trespass order".

This ability to *get through the work* and *be efficient* is also highlighted by a senior member of the social work team:

> In this context for me it (efficiency) means being able to get through a work load, being able to manage a work load, being able to identify when you need help, being consultative and open and being aware of resources. It also means being aware of models of intervention so you know how to intervene in a useful and efficient way. I suppose it also means to a certain extent what we also have in our objectives about realising the financial impact of every clinical decision that we make. And that is not just about how much photocopying paper you use, but about how much time you spend with each client. If you are seeing yourself as a resource or the social work team as a resource, (and asking) 'how can I best make this available to the neediest people?'

The Social Work Practice Supervisor who provided the clinical oversight and support for Kay on a day-to-day basis provided this account of what she considered constituted effective practice.

> It [effectiveness] means more than one thing. Initially it means process, what process Kay would use when a situation was referred to her. It means her ability to assess the situation, her assessment skills, her interventions and rationale for intervention, her method of interaction with the client, her method of interaction and consultation with those required to either give knowledge, have knowledge of the situation or be informed of the situation… I am talking about both a social work process and the process of communication [with the interdisciplinary team] … and even a theoretical process which is involved in that whole issue.

Of interest in these comments is the sense that somehow Kay has been able to develop a particular *process* of engaging in Health Social Work practice, and providing a service that has been experienced as effective because it meets the needs of multiple stakeholders including families, multidisciplinary team members and Social Work clinical and operational leadership as described above.

Brief assessment and intervention skills

The vast majority of social work activities that Kay spent time on, outside of the child protection work, were directed towards ensuring the hospital stay ran as smoothly as possible for the child, family *and* the multidisciplinary team. As outlined earlier in the chapter much of this activity occurred in the early days of admission, with a more substantial assessment being completed if the admission lasted for an extended period of time, such as the one involving the child injured by heavy machinery. An example of this type of early rapport building and beginning assessment is reflected in this observation which took place on the paediatric surgical ward.

Researcher observation

Entering their single room the first thing that is evident is the confines of the space, the hospital smells, the proximity of the couple, the baby, the Grandma. The cot sits squarely in the middle; to the far side a hospital bed where a young Pakeha couple lean *with backs against the wall*. The once bright curtains, having long since faded, hang limply from the windows facing the atrium, muted sounds of children playing down below drift up and echo quietly around us. Grandma sits against another wall, perched on the chrome bench stool, a part of hospital furniture for as long as I can remember. At the base of the cot, the table on wheels, covered with magazines, filled rolls, a handbag. Against the inside wall a sink, antiseptic hand-wash, paper towels, the plastic rubbish bag, *hospital rubbish* blazoned across it. Lastly the back wall, with the bell call attached and the outlets for oxygen. Baby moves around the cot gooing and garing, smiling at Mummy she looks well and despite being 'nil by mouth' for some considerable time, appears content. The only clue that something is amiss, the luer[8] in the back of her hand.

Kay begins her casual patter, "hello I'm the ward social worker, ok for a chat now? And you must be Grandma, first Grandchild is she...I see you've been at the hospital canteen, its not cheap, you can spend a fortune on food in here...you'll need to do a grocery run...you're in the best hospital in the country...waiting for histology due on Wednesday, that's going to be a long wait....and where are you from?" Dad pauses to change a

[8] A luer provides ongoing intravenous access

nappy... "Whose looking after the farm... you must be right in the middle of it...good support from Granddad, that's great and your sisters are coming up in the weekend.... this time next week you'll know your way around...I'll show you where the lounge is on level 3, you don't want to get cabin fever....and how did you get to be here? The GP didn't take you seriously...you can't beat parental instinct; parents always know...you'll be wanting to get home as soon as you can I suppose...she is so cute, look at her beautiful smile for Daddy...must be spoilt being the first grandchild...all those aunties to fuss over her ...there are a couple of tricks I can tell you I've learnt from other parents. Sometimes in a situation like this one of you will want to talk about it and the other one won't, that's ok, just let each other have the space...and how many cows are you milking....do you know the Rogers from down that way...yeah they're from my family...you do...oh been there for years...you must be a physical person, have you found the gym yet, it's up on Douglas Street, and the guy there does a cheap deal if he knows your child is in here..." A nurse comes in to take baby' temperature, "what are you doing in here, pretending to work I suppose!" and "will you take a sample from that nappy, it needs to go to the lab, third smelly one today and Mum and Dad are getting worried there might be a bug....and have you got anything to read...magazines are good... by the time you leave here you'll know what all the Hollywood stars are doing...any questions? Is there anything I can help you with...you ok with what the doctors are doing? Just yell out if there's anything you need a hand with...or a chat...I'm always around; just let the nurses know..."

This beginning conversation, where Kay made herself known to the family demonstrated a number of professional skills. These included rapport building which included engaging in whakawhanaungatanga (the process of establishing connections in order to support the relationship) and adjusting her language and topic of conversation, i.e. farming, to engage Dad. Preparing the family for some of the emotional challenges ahead, the provision of practical information and support, checking in and explaining her role and how to access her if required and the use of humour and team work were also evident. Matters such as informed consent or the employment of a formalised assessment framework were not evident during this introductory visit.

This first encounter appeared to be a ‘taking the social temperature type activity’ with Kay providing basic information to assist the family with their initial adjustment to the hospital environment, and providing clues as to what her role in the future may be, should the family require an ongoing service.

Professional Skills and theoretical influences

Various other activities such as discharge planning, the organising and facilitation of family, inter-professional, and multiagency meetings, and referral on to various agencies in the community also featured during the inquiry. The primary focus of Kay’s work however was on professional activity best described as brief psychosocial assessment and task centred interventions, and responding to vulnerability and risk primarily involved with child protection situations.

The theoretical ideas and practice models that were observed and described in her work with clients included task-centred practice; the provision of strengths based, solution focused emotional support; ecological and systems theory; crisis intervention and the use of counselling skills, particularly related to supporting parents adjustment to their child’s health condition, and grief and loss work. These descriptions were relied on by the four Health Social Workers who participated in the inquiry, including Kay herself. They were also verified via the clinical notes, and during the observations.

An adapted version of task-centred practice dominated, with tasks being negotiated and divided between parents, family members and Kay. These tasks were often identified on the day, or day after admission, with a series of ‘ticks’ in the clinical notes indicating when they were completed. This demonstrates a typical plan:

<u>Plan</u>

1. Phone call home (Cook Islands)
2. Show lounge
3. Baby clothing
4. Meals (ticked)
5. WINZ consult re emergency benefit

6. Continue to support

This emphasis on activities directed at supporting the admission or in preparation for a safe discharge is also evident in this account provided by the family member of a child who spent over a month in the surgical ward.

> She (Kay) was very helpful giving us lots of information about the hospital and meals and stuff like that...she lets you ring home (the Cook Islands) and she did her best, my partner was the only one working so she helped out with food parcels and stuff....and a few days of milk and nappies while we were waiting. She gave us lots of info about Housing New Zealand trying to help her (the child's caregiver) get a place because they're too expensive....

A fourth-year graduating social work student, having recently completed an academic assignment regarding the practice models demonstrated in the fieldwork placement context provided a particularly clear account of the influence of theory on Kay's practice.

> .. she is very, very good at using the whole systems and the ecological model, she bases her assessments around what's happening in the environment and in the home and in the community and the extended family and the close intermediate family and that person and their job, so her entire assessment is focused on what else is influencing this family or this individual. And also very good at explaining to the families why suddenly one day they will be fine, they are in hospital and they're fine with their kids here, and the next week the stress just escalates, and she's very good at explaining to families that things accumulate and that outside factors have huge influences in here, it's definitely a key ... And I think she practices in quite a narrative style as well and because it's all about ...she wants to understand what emphasis that client places on their own experience... she gets them to talk about their life or what has lead them up to here and tries to understand what the important events are... It works along side with the strengths based, if they have a negative view on themselves as parents or on their extended family she will turn it around and use it as a strength ...She kind of makes them work...they all work along side of each other and as cliché as it sounds it is very strengths based because she always reinforces what the good things are that they are doing. ... or building on the family's own resources and their

> own reserves but it’s also very task orientated, she will go into parents and say to parents, ‘are you sleeping and are you eating?’, and ‘are you showering?’ And just, the simple things, and of course crisis intervention that’s when they’re in crisis, i.e. their kids been in hospital, that she does ensure that they are looking after themselves and ‘are the bills being paid?’ Because that of course goes in with the systems thinking, because if the bills aren’t being paid they’ve got increased worries, it’s just using all of those theories to make sure that every aspect of their life is actually ok.

This takes us to the next important dimensions of Kay’s practice, which involved the development and maintenance of relationships. This will be explored first in regards to relationships with patients and their families, in relation to team work, communication and relationships, and in finally in relation to how Kay engages in the work.

Relationship-based practice

Thematic analyses and observations identified a number of specific skills and strategies that Kay applied day-to-day in her delivery of Health Social Work practice which has been described as effective. These professional activities fit within a category of skills and attributes which could appropriately be described as supporting relationship-based practice. Of interest is the notion that they rely *on* relationships, but also support the development *of* relationships. These skills and strategies were observed to be applied in relation to members of the immediate team, the wider team and to the patients and whanau. This capacity to be in relationship with families, and members of the team is summarised powerfully as follows:

> She is a truly dedicated, extremely personable person who I think could get on with anybody and who I have seen develop a relationship with some very difficult families and who can not only work closely with families (and every member of the family) right through to Consultants, Charge nurses and Duty Managers…So just an absolutely crucial member of the team …

The multidisciplinary team descriptions of the practice skills Kay relied on included listening skills, the ability to engage people, develop rapport and extract information. One

skill that was emphasised and described by a number of participants as significant was the ability to *adjust her style of communication* in order to work effectively with a wide variety of people. Another participant described this as being *not too Government* explaining that *if you were dressed up in a suit you probably wouldn't get anything out*.

Engaging in the concept of whakawhanaungatanga also featured, somewhat clumsily explained by the Paediatric Surgeon with whom Kay worked:

> … I don't know how to explain it. She knows where people are from and she will often talk about patients (I can't give you an explicit example), but she would say they are from such and such a place. She seems to know people's backgrounds pretty well.

Routinely engaging in this professional activity, by actively making the link between people, places and herself as a shared point of connection is also demonstrated during the observation described previously in the chapter, and in the way Kay managed to help facilitate a time for an interview with this extremely busy Paediatric Surgeon for me, partly assisted by the fact that we were from the same small town.

Personal attributes, for instance, having a good sense of humour, and professional attributes, such as being reliable and enthusiastic consistently came forward as central dimensions of the provision of effective practice. Because of the volume and centrality of these descriptions they have been recorded in the table below. These attributes and behaviours have been grouped into four somewhat arbitrary categories, the first three focused on how Kay interacts with patients, their family and members of the multidisciplinary team. The fourth category which I have described as the 'dependable work ethic' reflects *how* Kay undertook the practice. The more often a description is relied on by participants the nearer the top of the table it appears.

Table 3: Personal and professional characteristics

Temperament	Humour	Communication and attitude	Dependable work ethic
Demeanour never changes	Laughter – jokes	Honest, challenging and upfront	Reliable
Even	Great sense of humour	Open	Responsive
Centred	Playful	Non-judgemental	Approachable
Level	Fun	Diplomatic	Timely
Stays calm	Friendly		Problems solved
Relaxed	Sociable		Enthusiastic
Balanced	Upbeat manner		

The importance of the ability to speak up, whilst maintaining positive working relationships is illustrated in the following quotation. Interestingly this participant alludes to the complex power relationships in this practice context and the navigation skills required to effectively advocate on behalf of patients and family.

> Well, first of all she has to have a very clear understanding of her role and where she is willing to bend or negotiate on issues, but she has to also have the belief and the ability to speak up for herself and for her profession and sometimes that can be quite challenging when you are dealing with doctors or people that don't sometimes view you as being on the same level. You have to be able to say to them, 'no', or 'yes', or challenge them. First of all you need quite a thick skin. Whatever they think about you actually has to just roll off you like water because if you listen to everything people say, you are not going to get anywhere. So she does have a very good ability to have a relationship with people – she makes a working relationship with them. So that whether or not they agree on something or whether or not she is actually having a head butt with the Doctor over a child, she still finds a way to make it work for both of them.

As described by the Charge Nurse in the following comment, this ability to maintain relationships extended to patients and their families in situations that were clearly very

challenging and confronting. This was particularly evident in situations involving vulnerable children, and the need to challenge adult behaviour whilst maintaining an effective working relationship with them.

> I never had a parent ever come to me and say 'I don't wish to work with your ward social worker'. So her style of handling those situations was always extremely effective and ultimately it was a win/win situation. The families were supported and we worked through issues with them and the damage control or situation was settled and the nurses didn't have to go in and deal with the hostile situation.

The combining of these personal and professional qualities and their impact on patient wellbeing, team relationships and the overall smooth running of the ward were integral to multiple accounts of the dimensions of effective Health Social Work practice. These qualities seemed to assist Kay to make a number of significant professional contributions, such as helping to manage highly volatile situations on the ward, which clearly alleviated pressure on other members of the team.

The consistent work habits which I have collectively described as 'the dependable work ethic' was another key feature in accounts of how Kay responded effectively to the acute demands of the ward. The significance of the timeliness and reliability of Kay's response is evident in the way the Charge Nurse described her contribution as *crucial*.

> If there was ever a situation that needed addressing on the ward quite smartly, not only was Kay crucial to our service, but she was incredibly dedicated and very reliable. She was also an excellent communicator and if we needed her on the ward we could call her and basically she would come straight up. She would see the need and she would come up.

This participant went on to explain that she had *never* had to chase up a referral made to Kay and that her routine of regular telephoning, and attending daily updates was a crucial element of team work.

> Again eleven o'clock updates when we all meet again as a team which is really, really crucial. Not only to the Nurses, the Nurses I feel need to know what's happening on the ward, they can't work in isolation – they have got to be aware that we work in a team and know what's happening for all the patients. It is also crucial for me, the Play

> Specialist, the Nurse Educator and Social Worker. She was always here at eleven o'clock or before eleven and if she wasn't she would ring and leave a message. 'I'm in a case conference I won't be there at eleven but I will be up at twenty-past.' It was always so reliable…

This quotation sums up four elements of the dimensions of effective Health Social Work practice which were consistently described and observed throughout this inquiry. They include regular attendance at nursing handover; team work, good communication and being reliable.

Assisting to manage challenging situations on the ward

The role Kay played in helping to respond to challenging situations, which seemed to be a regular feature of Paediatric ward life, proved to be a consistent theme. One of the explanations for some of the outbursts of aggression and strong emotions which occurred on the wards was provided by Kay who attributed them to "children being bumped off surgical lists because something more critical has come in". Another violent outburst was specifically attributed in the clinical notes to the child's father becoming increasingly distressed over his child's level of pain. More generally these situations were represented in the following way; *violent outbursts; tempers frayed; aggressive and violent; a code orange called; being rude and obnoxious and behaving dangerously on the ward*".

An example of this ability to diffuse difficult situations offers further insight into the challenging nature of the situations that can occur in this context.

> I remember one day, probably about a year ago, we had a baby [on the ward] and the mother had some mental health issues and I was in the room explaining to Mum that we couldn't get her home on the flight in the morning. It was going to have to be in the afternoon, and before she did it I had a vision that she was going to throw the baby at me and sure enough she did. So I rang for help and Kay was on the ward and Kay could see where the bells were coming from and she was almost the first person in the room. And she was able to help me defuse that whole situation which was rather unpleasant. I am just glad I caught the baby!

Kay's ability to respond effectively to these situations to help achieve calm and some measure of resolution were portrayed by a variety of participants positively as, *de-escalates; defuses; facilitates; mediates; conflict resolution*; *gets alongside the family* and *an innate ability to handle literally any situation*.

Communication

Kay's sophisticated, well-developed ability to communicate orally and in writing with members of the multidisciplinary team, the social work team, managers and clients was evident throughout the duration of this study. It became apparent that verbal reporting back of critical incidents, progress updates, her whereabouts and intentions, were highly valued and central to the provision of effective Health Social Work. At times during the study it appeared that verbal communication took precedence over the clinical notes, although Kay did consider it a high priority to record her actions in the clinical record in a timely, brief and accurate way. The notion of good communication was expanded by this Charge Nurse:

> Keeping us in the loop, telling us what we need to know and sometimes keeping back some of the stuff that we don't actually need to know....good communication is regular and thorough so it covers the points that need to be covered. It is good verbal as well as written communication and there are good notes that anybody can refer to and know what is going on and what the plan is...

It was difficult to fully appreciate how vital this standard of communication was to the overall functioning of the ward, and the part it played in supporting safe and effective multidisciplinary team practice. A number of illustrations were provided regarding its significance and the reliance other members of the team had come to place on it.

> She is either talking to me, she is ringing me or she is writing very, very clear notes in the patient's record. So if something happened at four-thirty the day before and I wasn't here, I can go to the notes and see that she has been in and spoken to the mother and xyz is going to happen the next day.

The accuracy of the communication and a level of collaboration also featured "…it is incredibly accurate. It is pretty much 'this is what I have been discussing with the family,

this is what I have uncovered, and these are what my concerns are, and this is how I am going to address it – do you agree?"

This level of communication and collaboration with other members of the team appeared to have important implications for families too. For example Kay was able to facilitate things like the provision of meals on the ward for family members. She did not do this in isolation, rather, as explained by the Charge Nurse, "she would always come out and consult and run it by me and I don't think I ever said no". Maintaining this standard of communication seemed to rely on Kay's understanding of the value of it, and an absolute firm commitment to it, which will be described in greater detail in relation to the concept of 'working the ward' later in the chapter.

Team relationships

The nature of the team relationships and the association they had with Kay's ability to carry out the Health Social Work function effectively is compellingly put by this participant in response to a question regarding what advice she would give someone who was beginning a career in the acute hospital environment:

> I think the first thing would be to form relationships with all the people in the multidisciplinary team and to make relationships with them, ***from the cleaners to the doctors***, get everybody on your side...because no matter what happens you will always have the support of your team.

This capacity to *be in relationship* with all members of the team is supported by another participant, who described Kay's behaviour around the ward. She is "very friendly… anybody can talk to her about anything they want. She is like a jolly good person when she comes to the ward, she says hi to everybody."

Approachability and openness also feature in relation to *just being able to check things out* and *talk things over* when there was a slight worry or concern. The casual, low-key approach Kay appeared to maintain in these random encounters with multidisciplinary team members is summed up in this account.

> Approachable – that goes with the communication thing. But a personality that people can actually sound things out with and say 'what do you think about that?'

> Often it is not necessarily something you can put your finger on but you have a feeling...

Given the key role the health social worker has been found to play in relation to helping identify vulnerability and risk in relation to interpersonal family violence and other concerns of a sensitive nature, this approachability is likely to be particularly important.

The capacity to develop and maintain team relationships appears to be at very centre of this inquiry, and was particularly evident during the observations. One of the most striking manifestations of the relationships, and the regard in which Kay was held, was demonstrated by the multidisciplinary team's willingness to participate in and contribute to this inquiry with most people needing to give up an hour of busy clinical time to be interviewed. It was also evident in the good humour, social chit-chat, cooperation, willingness to help, and mutual responsiveness to requests for assistance that was observed.

The interconnection between relationships, humour and 'favours' that enabled Kay to get the job done is reflected in this account:

> ...definitely a sense of humour, she has a great sense of humour and I think she will often use that to lighten the mood, so whether or not she is having negotiations with somebody or she's having to sort of ask someone to do a favour for her...there is always an element of humour (*Linda*: what kind of favours might she be asking for?)...if it's a Doctor she might be asking for them to let a child stay one more night, or asking the Nurse if the mother and child can have a single room so Mum can sleep or asking the nursing staff to call her when Mum comes to the ward or to be present...or to get an interpreter or call in cultural support for her...

The acute nature of the environment, and the collective pressure all members of the team seemed to be placed under on a consistent basis appeared to be alleviated by team relationships and a high level of reciprocity and co-operation to which Kay made a regular and consistent contribution.

Team work

Attempting to demarcate the difference between team work, team relationships and Kay's personal characteristics given that they were often described and observed as interwoven components of her personality and practice has been a challenging element of writing up *the case*. Whilst describing the contribution Kay makes to the trauma team, this link between attending regular meetings, being approachable, and being a team player is made.

> In the trauma side she is at our team meetings on a regular basis, plus she will catch me or Tama...if there are any problems and she is really approachable so if you ever have any problems you can just chat to her (***Linda:*** so being approachable?) yes, it is part of being a team player...(***Linda:*** do you think that's something critical here?) Absolutely, yes! Being complex patients in a tertiary hospital then it is all about multiple teams being involved in a patient's care and so on the simpler scale it is Doctors, Nurses, Therapists and the Social Workers all working together, but then there can be other teams – there might be Neurosurgeons or Orthopaedics and other teams as well.

The link between the maintenance of team relationships and the contribution relationships made to team work appears to have contributed significantly to the provision of effective practice in this environment. This capacity to maintain relationships while also challenging behaviour which impacted on patients and their wellbeing was something Kay was able to achieve by keeping patients at the centre as described below.

> Kay was always part of the team and would never come into the office and say "oh, the nurses overnight did this....she was never anything more than supportive and praising of nursing staff and I think that is pretty important because then as a Charge Nurse you can be a bit biased toward your nursing team." (***Linda:*** and does she ever give critical feedback?) I think her tack is always from the family's tack so again she is very diplomatic. If she did need to give feedback it would be as an advocate for the family.

Kay was described as a *crucial part of the team* an element of which involved an *excellent working relationship* with the Charge Nurse. Describing how this teamwork manifested in

practice the Charge Nurse described how she and Kay can *stand in a room talking to the families side by side and we are on the same page*.

‘Working the ward’

‘Working the ward’ provides a description of a number of activities Kay relied on in order to access patient situations quickly that would benefit from her input, thereby enabling her to provide a highly reliable and timely service to the patients and the ward. In the methodology chapter it was Stake (1995) who proposed that a case study allows us to come to an understanding of the case’s activity within important circumstances. These circumstances were found to be busy, acute, hospital wards staffed by medical colleagues with an incomplete understanding of the psychosocial issues facing patients and their families. This circumstance is also described and acknowledged in the health social work literature (see, for example, Cowles 2003).

Stake also explained that interpretation of events is supported by multiple accounts and/or observations which rely on the same or similar use of particular descriptions. In this instance I observed these behaviours, heard them described by Kay, and three of the Charge Nurses who were most familiar with her work habits, and saw the outcomes recorded in the clinical notes. This provides an example of triangulation of data which supports the concept of trustworthiness and authenticity as described by Parton in regards to qualitative analysis (2000).

Lastly Stake (1995) outlined the notion of correspondence which he described as “trying to understand behaviour” (in this case the behaviour of Kay); issues (in this case what are the dimensions of effective practice) and context (in this case an acute hospital ward where medical staff rely on health social workers to respond quickly and efficiently to the psychosocial issues of their patients). The development of this ‘working the ward’ concept then provides an example of the relationship or linkages between these particular behaviours, issues and contextual variables.

This concept developed over the course of this inquiry and I have come to think that it reflects a successful *adaptation* having been made, by Kay to this environment. Key to this adaptation are a number of practices which demonstrate the dependable work ethic referred to earlier in the findings. I consider 'working the ward' to be one of the many standout features of Kay's practice. The importance with which Kay treated some of these activities provided some inkling as to their significance. It was not until I considered the practice in its entirety that their collective worth became more apparent. These activities, or work habits included:

Telephoning the Charge Nurse every morning at 8am to get a "heads up" on the ward

Attending nursing handovers diligently in order to get "verbal referrals"

Using the ward list to highlight patients of priority and to systematically work through them

Maintaining a highly visible presence on the ward every day

Listening, watching and proactively responding to 'clues' regarding patients in need; referred to by Kay as *using my radar* and *trawling for trauma*

Maintaining an awareness of the wards needs and expectations

Continuously coaching staff regarding the nature of the health social work role

Being available to members of the multidisciplinary team *to talk about the sad things that happen*

Being approachable to talk about worries or concerns *that you can't put your finger on*

Learning about medical conditions, asking questions and showing an active interest in the specific patient population of each ward

Responding to her pager 100 percent of the time

Using her personal characteristics and professional skills to maintain relationship

Maintaining an attitude of service, and loyalty to *her wards*

This account provided by a Senior Nurse, of the value of Kay's regular attendance at nursing handover is a typical example of one of the activities Kay engaged in on a routine basis that other health social workers don't appear to prioritise.

Senior Nurse: She [Kay] is a very good person to deal with and we love to work with her. We really missed her because she was the Social Worker on 25B, she has to go and work in Children's Emergency now … but we really miss her because we can feel that loss on our Ward. She was a good team player and she comes for the Ward update [Nursing handover] and she gets all the information during the ward handover itself and she knows who she has to go and see.
Linda: Is that important for you, a Social Worker coming to handover?
Senior Nurse: Yes, definitely, especially down in 24B because we have lots of social issues happening and they need to know the child. Today we only have three or four children who need to be assessed by a Social Worker but most of the time I could say that if we had 15 patients in nearly ten of them would need to be seen by a Social Worker. So if she is there [at handover] she knows the child's condition and what's happening with her.
Linda: The new person that you have, are they coming to handover?
Senior Nurse: Not always like Kay used to come. So that is a real loss for us. And then when she is at the handover we can tell her what she needs to know, all the staff can see her and tell her.
Linda: So if the person doesn't come, what does that mean in the ward environment?
Senior Nurse: Because it goes through the Manager, the staff member has to go and tell the Nurse Manager and then the Nurse Manager will inform back to the staff saying they need to call the Social Worker. It is just like another call and waiting for the call back.
Linda: It just makes another job for you?
Senior Nurse: Yes, and then the Social Worker might feel frustrated because she is getting frequent calls but if she is there at the update she gets all the information at one time.

Applying Stake's (1995) concept of correspondence as described previously these activities, including attendance at nursing handover contributed significantly to a health social worker who was highly visible, well known, reliable, organised, efficient,

personable, and *extremely proactive* in her efforts to search out, and respond to the social, cultural, emotional and medical needs of patients on the ward. What this meant in practice was that problems were identified, assessed and responded to in a way that reduced their overall impact on patients, their family and multidisciplinary team members, and helped to contribute to the smooth overall functioning of the ward and an efficient discharge.

It appeared that it was this *proactive behaviour*; the ways that Kay had found to identify and respond to the needs of the patients and their families *before we even knew there was a problem* which seemed to have motivated her colleagues to describe the practice she provided as effective. Given the acute nature of the environment and the complexity of the issues and needs which required this timely response it is little wonder that this has been identified as one of the core dimensions of the provision of effective health social work practice in this context.

Conclusion

Multiple stakeholders, including a child patient's family member, senior members of the health social work and multidisciplinary teams and a social work student have provided a series of accounts of what they believe constitute the dimensions of effective health social work practice in this particular context. Observations and analysis of clinical records were able to confirm many of their descriptions, providing first-hand demonstrations of many of the practices, behaviours and attitudes stakeholders described as highly valued. The findings appear to demonstrate that a series of relatively consistent needs grow out of an admission to hospital. These needs are made up of a collection of practical, emotional and cultural concerns, powerfully influenced by the medical context in which they are occurring. The impact of interpersonal family violence also emerged as a key concern in this context.

This case study found that the health social worker, who has been described as providing an effective social work service, has developed a framework of professional activities and behaviours that allow her to access and respond to these needs in a timely and reliable way. Relying on Stake's (1995) notion of correspondence a hypothesis emerged which suggests

that these behaviours and activities collectively constitute a successful adaptation having been made by Kay, to the acute hospital environment.

The practice both observed and described bears some resemblance to Reid's task-centred practice however the process and behaviours Kay relied on in order to identify the patients who needed her input were also found to be central to the dimensions of effective practice. As Gould (2006) suggests it seems that the application of formal knowledge has been influenced by the context both in the way Kay applied this formal knowledge, but also in the way she appears to have created knowledge. This appears to demonstrate Kay having made a successful adaptation to what others have described as a host environment for the profession of social work. This context specific collection of the dimensions of effective practice have enabled Kay to develop solutions to what were often complex and multilayered organisational, professional and psychosocial problems, in the swampy lowlands of practice (Schon, 1983).

The first four domains of practice are associated with the patient's social, emotional, cultural and medical needs and have been described in practice terms as the ability to provide health social work advocacy and support in order to respond to these needs. The ability to take action in response to interpersonal family violence concerns constituted the fifth significant area of need, which included the capacity to assess issues and intervene in order to help increase the safety and wellbeing of patients. Problems were solved in a reliable and timely way with a primary reliance on task centred practice. The professional skills and theoretical influences to emerge were also described, as were the significant personality traits such as the warmth, compassion and empathy Kay relied on in order to maintain relationships with patients and their families, in what were often complex and trying situations.

The ability to help solve problems on the ward, to engage in a high level of communication, team work and team relationships were also found to be central elements of effective health social work. Lastly the concept of 'working the ward' emerged which was made up of a collection of behaviours and activities which enabled Kay to access and respond to patient,

whanau and ward needs in a timely and reliable way, resulting in patient needs being met efficiently.

The key elements of practice that have been described in this chapter have been synthesised via the data analysis process. This process has identified a number of dimensions which have been grouped into a number of domains. The next step in this sequential exploratory design was to use these dimensions and domains to help inform the development of a survey tool which aimed to check their relevance across the broader context of the wider paediatric, women's health and adult services. Chapter six will report the findings of how this larger sample of 191 senior health professionals assessed these dimensions, and then added a further layer of explanation regarding what they valued as effective health social work practice in the acute hospital environment.

Chapter 6: Survey findings

Introduction

The primary purpose of the survey was to check and expand the case study findings across the wider context of the acute hospital environment. This provides the second significant phase of data collection in this sequential exploratory mixed method design described in the methodology chapter. I was interested in knowing if the core dimensions of practice identified via the case study and summarised in the previous chapter were relevant beyond the paediatric context. Administering the survey tool across the three acute hospitals of Auckland District Health Board provided an opportunity to check the case study findings for congruence, extension and expansion. Employing a survey tool with quantitative and qualitative fields, administered to a wider participant group, across this broader context, the opportunity was provided to examine the dimensions of practice identified in the case study for reinforcement or revision. As described in the methodology chapter participants were asked to rank 40 dimensions of effective practice in order of importance, and rate them using word choices such as 'extremely important' or 'very important', 'highly valued' or 'very valued'.

This quantitative survey data will be reported via a series of eight tables, numbered and also named according to the case study dimensions of practice they were assessing. The raw quantitative data is available for review in Appendix 8. A large volume of qualitative data was also provided via the survey and this has been reported in relation to the domain of practice it has been analysed as most relevant to. The 14 primary domains of practice reported in the previous chapter are represented in the left-hand column of the table below. Having combined quantitative and qualitative data these 14 domains have been extended, interpreted and distilled, resulting in seven primary clusters of practice. These seven domains of practice are numbered in the right-hand column of the table below. Each cluster is made up of a group of activities, skills, competence and personal attributes that collectively represent my analysis of participant's accounts of the dimensions of effective health social work practice in the acute hospital context. The dimensions of practice which make up these domains will make up the bulk of this chapter with each domain being reported following its domain name and number.

The seven domains or clusters of practice reported in this chapter have been developed via the same process of analysis employed during the case study phase, namely the qualitative data was coded in order to identify patterns and correspondence, themes and subthemes. The desire to enrich the data by engaging in a combined analysis of the quantitative and qualitative findings, as advocated by some mixed methods authors (Andrew & Halcomb, 2009) has proved to be beneficial. The data have been combined in order for final interpretations of the all the material gathered during this sequential study to be reported in a coherent, accessible and substantive manner. Once again Stake's (1995) notion of correspondence has been applied to the two sequences of data collected resulting in the original 14 case study clusters reported in the previous chapter being extended, refined and synthesized further.

The primary purpose of the survey was to check and expand the qualitative case study findings. In light of this the use and reporting of extensive quantitative data from the survey is minimal and reflects the weighting decision which was made, and described in some detail in the methodology chapter. In each of the eight tables reported the top two value/ importance rating have been added together to give an overall percentage of value/importance rating given by participants to each practice dimension. This provides the reader with a clear account of how many participants attributed a high value/importance rating to the dimension of practice identified in the case study. Whilst a choice could have been made to report the data differently, for example via the use of greater statistical analysis, it is my belief that this choice of reporting is able to support the overall aims of the research.

Table 4: Transition of case study data to combined findings

Case study domains (phase one data)	**Combined interpretation – extended domains (phase one and phase two data)**
Interpersonal family violence – responding to vulnerability and risk	1. Respond to reduce vulnerability and risk associated with interpersonal family violence
Practical advocacy and support	Provide practical advocacy and

	in response to acute admission and social complexity	support
	Emotional advocacy and support in response to acute admission and complex medical issues Medical advocacy and support in response to complex medical conditions and team complexity	Provide emotional advocacy and support in the medical context
		Access internal and external resources
	Cultural advocacy and support in response to multicultural patient mix and multidisciplinary teams identified need for assistance	Provide cultural advocacy and support
	Problems solves in a reliable and timely way Brief assessment and intervention skills (average length of stay 2–3 days) Professional skills and theoretical influences Personality traits – personal, professional	'Working the ward' in order to provide a dependable service

Assisting to manage complex situations on the ward 'Working the ward'	
Communication Team relationships Team work	Engage in team work and communication

Each of these combined domains has been reported under the cluster headings above, with sub-headings identifying the finer dimensions of practice which emerged as key themes. Each section begins with a section which 'introduces the data' to help orientate the reader to the data source. Because of the nature of the qualitative survey data, (typed postings) much of it being single words or short phrases as opposed to well-constructed sentences, or the type of extended dialogue you may expect in an interview situation, the words of the participants have been identified by italics; only complete sentences and the more substantial quotations have been indicated via quotation marks.

1. Responding to vulnerability and risk associated with interpersonal family violence

Introducing the data

This section of findings reports the quantitative data from the Women's Health and Paediatric participants (N=88) and the qualitative data from across all service areas. Analysis of the case study data revealed four primary areas of practice relied on by the Health Social Worker in order to identify and respond competently to child protection and family violence concerns. In the Paediatric context this vulnerability and risk was primarily as a result of suspected child abuse and neglect, and the impact on children of being exposed to interpersonal family violence. This need was identified as a vital component of the provision of effective health social work practice in the Paediatric context. It appeared from the case study findings that Health Social Workers were required to make a particular

and unique contribution to this area of practice. Because of this finding I wanted to know what this may mean in the Adult Service.

The inclusion of a qualitative question about interpersonal family violence, its manifestations in Adult Health and the health social work skills adult service participants identified as important was therefore included in order to extend my understanding of this area of practice across the wider context. The question explores the possible needs these participants may have in relation to elder abuse, unsafe care arrangements, and caregiver stress in patients and their family members presenting for care in the Adult Service. For the purposes of this section of findings, vulnerability and risk refers to patients, and/or their family members who are experiencing interpersonal violence which may include psychological, physical, sexual, financial or emotional abuse, neglect or harm.

Multiple comments were posted (N=84) in response to this question, many of them substantial in nature. Participant responses focused almost entirely on the vulnerable older adult population. Despite the primary focus on the older adult, descriptions of the dimensions of effective health social work practice central to the provision of services for populations experiencing vulnerability or risk proved to be largely consistent across the acute environment. Whether a Health Social Worker was responding to a vulnerable child experiencing child protection concerns, or a vulnerable older adult experiencing elder abuse or neglect, the core elements of practice were strikingly similar.

This section of the findings begins by illustrating the unique contribution that health social workers have been acknowledged, and are therefore anticipated to play, in the provision of services to those people who are experiencing vulnerability and risk associated with interpersonal violence. Relying on participant quotations and comments, the key themes have been articulated in order to explore how these practice expectations are anticipated, expected and, in some cases, clearly achieved in order to make this contribution. The core dimensions of effective practice seem to be made up of a complex interplay of professional competencies and personal attributes applied in combination with accomplished communication and team working skills. Each of these elements is explored in some detail in order to demonstrate the complex nature of the practice.

Following the exploration of the role Health Social Workers are reported to, or are anticipated to be making in this context, a summary of the dimensions I have described as 'professional skills' such as identification, assessment, intervention and planning are summarised. Some dimensions of practice which have been reported extensively in the later sections of the chapter more generally are also reported here specifically in relation to their contribution to responding to vulnerability and risk. This is because they have been extensively described in relation to the specific part they play in this particular area of practice.

Because of the highly charged nature of this work, the personal characteristics of empathy and the ability to be non-judgemental are also reported with particular reference to the association they appear to have with the professional skill of establishing trust and rapport with patients and family members. This choice was made because the data was provided explicitly in relation to Health Social Workers' ability to effectively carry out our duties in relation to responding to vulnerability and risk.

Table 5: Dimensions of practice – child protection and family violence (Paediatrics and Women's Health data)

Ranking	Importance Rating Top two percent[9]
1. Identify and assess child protection concerns	92.0
2. Assess and respond to family violence concerns	87.5
3. Assist with the management of child protection and family violence concerns over time	80.7
4. Maintain constructive working relationships with family members in child protection and family violence situations	80.4

The Health social work contribution of services to the vulnerable

As can be seen from the data reported in Table 5 a range from 92 percent to 80.4 percent (N=88) of participants across the Women's Health and Paediatric context rated the four

[9] Top two word ratings added together, i.e. extremely important and very important

core competencies in this field of practice extremely highly or very highly. Twenty-eight comments were also posted by survey participants in the Women and Paediatric service areas which add further detail to these findings. These comments have been included in the combined qualitative analysis reported below.

More than 80 percent (N=88) of participants in the Women's Health and Paediatric contexts rated the importance of Health Social Workers being able to assist with the *management* of child protection and family violence concerns over time as extremely important or very important. The combined qualitative and quantitative data from across all areas of the hospital revealed that Health Social Workers are required to be *highly competent* in this area of practice and that this competence is profoundly relied on by other members of the medical team. This was particularly evident in the Paediatric context. This Paediatrician maintained that "child protection is a very important role for social work especially in paediatrics. Social workers should be competent in this area to be employed in paediatrics." Further comments, both contributed by Nurses with upwards of 17 years of experience give some hint of the value they placed on this area of practice and the importance of health social workers being competent. *A great Social Worker in the hospital saves lives* and *this would be the most important aspect in my view of social work practice.* Focusing on vulnerability and risk the *distinct* contribution Health Social Workers are making in the multidisciplinary context is outlined by a Nurse in the Adult Service who explained that "[t]he ability the Social Worker [has] to identify issues that the patient and family are uncomfortable to talk about with other members of the health team" was important to her. The valued role Health Social Workers play in Women's Health was also affirmed by this Midwife with ten years of practice experience. "A very valued member of the team in helping staff with any vulnerable patient especially at times when staff feel out of their depth, having the Social Worker to advise [and] assist you with the case is invaluable."

The professional contribution Health Social Workers are able to demonstrate in this context is also described by a Nurse in Paediatrics who states that "the ability to respond to staff concerns re family violence is extremely important. The Social Worker has the professional skills and knowledge to deal with this area of expertise." Alluding to the challenges

inherent in the field of practice, this posting is clear about the contribution Health Social Workers are required to make for families *and* for staff. “It is essential to provide support both for the family and the staff, as these situations are often fragile, stressful and complex.”

Providing further reinforcement of the role Health Social Workers have taken up on behalf of our medical colleagues for the benefit of patients and their families, this Nurse explains that she values the ability we have *to hear staff concerns and to clarify and talk through their concerns and to advise appropriately*. The willingness to *help other staff negotiate outside services such as Child Youth and Family service so that we can assist our patients better* is also identified as a valued skill. Specific professional knowledge which includes knowledge of the law also features in the data as described by this Paediatric posting. *Important that the Social Worker is trusted and impartial [and that they] can be available to support the team and give correct legal advice*.

This final confirmation of the competence Health Social Workers have demonstrated or are anticipating as needing in the hospital context is evident in this contribution, again posted by a Nurse in the Paediatric environment. By relying on *experience and intuition to pick up underlying problems in families that other staff may not notice, such as the potential for neglect of a child with medical problems*, Health Social Workers are able to respond to vulnerability and risk in a unique and significant way. Taken as a whole, these postings appear to confirm an observation posted by a Social Work Practice Supervisor, highly experienced in this field of practice. She proposes that because “[t]here is limited knowledge of child protection issues and an understanding of the dynamics of family violence within multidisciplinary teams I believe that Social Workers have a responsibility to be well informed on current research and practice guidelines for intervention”.

Based on the data reported in Table 5 and the qualitative data reported above, the following section of findings builds on the assertion that the ability to respond to vulnerability and risk has been established as a vital area of practice for Health Social Workers and is a core function of the health social work role. Therefore the particular personal and professional skills practitioners depend on in order to make this important contribution to health care is

described. Beginning with the identification of concerns and moving through the various phases of activity, the detail of this critical area of practice is explored.

Identification of concerns

Confirmed as a core dimension of the provision of effective health social work, 92 percent (N=88) participants from the Paediatric and Women's Health Service *rated* the ability to identify and assess child protection concerns as extremely important or very important. This skill is also *ranked* number one out of all the skills in this practice domain. The significance of Health Social Workers as being competent in identifying patients who are at risk or vulnerable as a result of interpersonal violence is also affirmed by the participants in the Adult Service. A quarter (N=25) posted comments about the value of Health Social Workers being able to identify concerns associated with vulnerability and risk. Having *a sound understanding* and *a working knowledge* of the issues was recognised as central to reducing the likelihood of *indicators being missed.*

The data associated having *a deep understanding* of what is required in this area of practice with the capacity to *routinely recognise* and identify potential risk factors in situations where it was *hard to get people to admit* there was a problem. Being *confident*, *perceptive* and *having the ability to see beyond the obvious* enables Health Social Workers to respond in sensitive and complex situations where there are often only subtle indicators that a patient or their caregiver may be vulnerable. Having identified the potential problem, the ability to assess the extent of the concern relies on the ability to establish trust and rapport with both the patient and their family. This capacity is looked at in the next section of findings.

Establishing trust and rapport with patients and families

The importance of Health Social Workers treating parents experiencing child protection concerns in ways that demonstrates respect and establishes trust was first described in the case study data reported in chapter five. This compassion and respect was found to extend to parents who were suspected of being responsible for the abuse. Reinforced as a core dimension of the provision of effective health social work, 80.4 percent of participants (N=88) from the Paediatric and Women's Health Service rated the ability to maintain

constructive working relationships with family members in child protection and family violence situations as extremely important or very important.

Confirmed by the survey data, my contention is that this ability to maintain constructive working relationships is supported by particular behaviours and attitudes. It is these dimensions of practice that are consistently described as central to the provision of effective health social work practice associated with risk and vulnerability. These behaviours include *the ability to appear non-judgemental and confident in very difficult situations*, the ability *to be sensitive to the needs of patients and families who are part of a vulnerable group* and the *capacity to remain calm and provide reassurance.*

Described by one participant as *excellent skills in building a trusting relationship* in order to *provide the therapeutic help that is needed,* contributors consistently privilege the value of Health Social Workers being able to demonstrate *empathy*, *understanding*, *care* and *sensitivity*. A significant number of participants describe the capacity to be *non-judgemental*, while others rely on concepts such as *confidentiality* and *trust* as important dimensions of effective practice. The importance of *developing a trusting rapport with the patient and their family* was bolstered by this participant who linked it to the ability *to assist them* [patients and family] *to come to a decision that is acceptable to all parties involved.*

Central in the Adult context is the ability to be *patient*, *respectful* and *sensitive* towards the older patient in order to gain their trust. Adding weight to the case study findings participants observed that is was crucial to gain the trust of family members before they would disclose sensitive information. *The ability of the Social Worker to gain the trust of the patient experiencing domestic related issues, to feel they are safe to ask for help* or to *open up and share their concerns* is clearly an important dimension of practice.

The ability to establish and maintain trust and rapport is not confined to the patient experiencing the risk. Rather it appears to extend to the way Health Social Workers conduct ourselves with family members and relies on multiple competencies. These include *de-escalation skills*, *conflict resolution* and *negotiation skills* and *family meeting facilitation*.

Reflected in the follow posting contributed by a Nurse in the Adult Service with over 20 years of experience the link between attitude and outcome is evident. "Empathy, non-judgemental, excellent listening skills…The ability to deal well with patients [and] carers who are possibly extremely stressed and may have potential for aggression (good de-escalation skills). Effective communication skills, [a] friendly [and] approachable manner…."

The skilled Health Social Worker is clearly an important professional asset in this context as there is some evidence that by applying these skills in a proactive and thoughtful way, potentially difficult situations can be avoided. This capacity for preventative work is reflected in this posting from Paediatrics: "the Social Worker can observe situations and engage in a responsive manner that prevents escalation of parental concerns avoiding security calls." Reinforcement of the preventative value of engaging with families with sensitivity and respect by "getting involved in a way which supports the patient and avoids further conflict" provides further clues about the value of this approach to practice. Clearly there appears to be some evidence that the effective Health Social Worker is able to contribute to reducing risk in the hospital environment by behaving in particular ways with patients and family members.

The final element of care that sits within this set of practice dimensions is identified in the Adult context. Here the willingness to *understand barriers and stresses* is expressed, alluding to the value of patients and their families having their needs responded to in order to reduce vulnerability and risk. Further to this, the ability to be *seen as a person who cares* while at the same time being able to show *awareness of a person's situation or problem* is articulated. These comments appear to reinforce other commonly described dimensions of effective practice with vulnerable groups, the *ability to stand back from the situation and be impartial,* while balancing this with *being a patient advocate.* This balance of *standing back* in order *to make professional, not personal judgements* while engaging in patient advocacy is well described by a number of participants. The last contribution to this section of findings adds weight to the concept of *the delicate balance* and the value of engaging in open communication which this participant describes as vital. "The ability to have open communication with clients involved is vital, so that the person reporting the abuse etc. is

not at risk or feels they have placed themselves at further risk. This is a delicate balance as clients/family members are often reliant on the person abusing them." This ability to *speak out for those in need*, to provide *advocacy for the vulnerable* while maintaining this *delicate balance* emerges as an important element of practice when working to help manage vulnerability and risk in the hospital context.

These dimensions or elements of practice that constitute the provision of an effective health social work service do not occur in a linear fashion. Rather they ebb and flow, interrupting and looping back on one another, rising and falling depending on the individual circumstances and practitioner. I have chosen to report the element of as 'presence listening' (Bird, 2000) and its contribution to responding effectively to vulnerability and risk in the following section of findings because this best reflects where this particular data was posted in the survey. I suggest this skill is likely to have an association with the ability to establish trust and rapport, as it is improbable that one could occur in the absence of another. The contribution careful listening plays to identifying issues and concerns determine the value of reporting these findings next.

Presence listening

Beautifully described by this participant from Adult Services as "good listening skills and a *quiet* approach to encourage patients to talk", the capacity to engage in a particular quality of listening is evident in the data. Connecting with the ability to employ intuition, as described earlier in this section of findings, is the notion that "listening skills and the ability to 'read between the lines' to interpret the risk for patients" is an important element of health social work practice. Emphasising the value of Health Social Workers engaging in a particular quality of the listening was evident by 20 percent of survey participants from Adult Services mentioning *listening* in various forms, in their responses to this section of the survey. Whilst one person mentions the importance of *listening* and *believing* the patient most participants simply describe *excellent listening, good listening, listening respectfully, the ability to listen* and *even efficient listening*! This leads us to the next significant element of responding to interpersonal violence, the capacity to contribute to an appropriate assessment.

Assessment of concerns

Supported as a core dimension of the provision of effective health social work 92 percent (N=88) and 87.5 percent (N=88), respectively, of participants from the Paediatric and Women's Health Service rated the ability to *assess* and respond to child protection and family violence concerns as extremely important or very important. This capacity was reinforced by participants in Adult Services by postings which reflect the importance of Health Social Workers being able to provide *timely*, *accurate*, *effective* and *comprehensive risk assessments* in situations involving vulnerability and risk. Working in close consultation with the multidisciplinary team is a critical competence when assessing vulnerability and risk, particularly when it is associated with interpersonal violence. Clinical questions such as *checking [the patients] cognitive and memory function with the medical team* are identified as important when working with older adults.

Having the competence to undertake the assessment while remaining cognisant of the patient condition is emphasised as a valued skill for Health Social Workers to demonstrate: "the ability to gain an understanding of the patient condition and the care needs as the complexity of the medical condition will have an effect on whether the patient can remain in the care of the same people as before." Having a sound knowledge of the clinical environment and the health condition a patient is experiencing, with the capacity to take these into account when assessing patients and their family situations is reinforced by a Senior Midwife from the Women's Assessment Unit. "Vulnerability in the high-risk patient on Women's Assessment Unit takes many forms, and may be due to a chronic disease or pregnancy process. An awareness and insight into how these processes and diseases may impact on the woman, baby and family is vital."

The capacity to *deal with issues around appropriate child care where compliance around treatment at home is in question* is a further example of the need for Health Social Workers to be able to combine clinical knowledge and knowledge associated with the appropriate management of vulnerability and risk. This is likely to have implications for Health Social Workers professional development needs to ensure we are able to consistently provide competent services across the acute environment.

One participant reveals that she values *the Social Workers' perspective on the bigger picture* while others highlight the importance of gaining an *early assessment* of the *home situation.* Relying on competent interviewing skills and a sound knowledge of the field this participant recognised the significance of the *ability to ask the 'right' questions* in order to *accurately assess circumstances*. This takes us to another critical phase in the process of responding to vulnerability and risk, the capacity to intervene appropriately.

Intervention to reduce concerns

As described in Table 5 the ability to assess and *respond* to family violence concerns is rated by 87.5 percent (N=88) participants from the Paediatric and Women's Health Service as 'extremely important' or 'very important.' This highly valued ranking supports the case study finding that this is an important dimension of the provision of effective health social work in the acute hospital environment. The ability to respond across the hospital has been confirmed by the qualitative comments posted by participants in Adult Services, reinforcing a consistent need across the hospital for Health Social Workers to be competent in the provision of interventions that support a reduction of the risk vulnerable patients are experiencing.

Once again participant quotations and key themes have been relied on to demonstrate concepts. The ability to respond to situations where patients were assessed as being vulnerable by intervening appropriately was made up of five primary dimensions. Central to this area of practice was the ability *to act to improve patient safety*; knowledge of the legislative and policy frameworks; having a sound knowledge of and relationships with appropriate support agencies; communication and team work.

A large number of participants in the adult domain relied on generic descriptions of interventions such as the ability to *respond effectively*; *respond appropriately*; *intervene appropriately*; *take action*; *provide appropriate action* and *solve problems*. This may reflect a lack of knowledge regarding more specific professional language which may have been able to reflect the detail of the interventions. What is clear however is that the intervention, in order to be described as effective, *must* increase patient safety. A sample of participant comments reflects this practice imperative, for example, *safe practitioner*

providing a safety-net for our patients; *safety issues addressed first and followed up*; *knowing what plan to put in place for prevention*; *the child can't be discharged into an unsafe situation*; *find a safe place for those people to be looked after well*; *be able to provide a constructive and protective environment for the client* and lastly, *taking action to resolve the situation for the benefit of the person/s under stress.* This focus on *taking action* in order to help increase safety, even when that action is complex and difficult, is unfailingly privileged as a core health social work skill by a wide variety of participants.

As this participant from Adult Services explained "recognition that maintaining the status quo is not always an option, or wise, for example sending a patient home to an ongoing abusive situation" was identified as an important element of practice. Of equal importance to this contributor is the ability to "offer alternative discharge thoughts – or pathways that staff should take, i.e. call for assistance from other groups such as the police, Child Youth and Family, psychiatry or community services". This participant is clear that having an "attitude and view of addressing and considering needs proactively and over time is important with this population – versus shifting concerns..." I suggest that these findings leave Health Social Workers in no doubt that this is an area of practice responsibility we are required to embrace.

This brings us to the next key dimension which supports the provision of effective interventions to reduce vulnerability and risk; knowledge of networks and functional relationships with community support services. This was a strong feature in the data, being described by over a quarter of the survey participants in Adult Services. It appeared that our multidisciplinary colleagues have an expectation that Health Social Workers are able to provide guidance regarding *community resources*; *monitoring services and processes for implementing protective services*; *knowledge of supports available to patients and their families*; *knowledge of support people*; *correct referral routes*; *alternative options and where to go for guidance and support.* Integral to these accounts is the sense that Health Social Workers would know *what to do next* and by *having good relationships with outside sources* would be in a better position to *make referrals to agencies that are qualified to deal with these issues.*

The need of Health Social Workers to have a sound knowledge of legislation and policy is described by a small proportion of participants, but this does not, in my view, reduce its fundamental value. Two participants mentioned the importance of hospital policy whilst a further 10 percent in the Adult service described various legislative domains relevant to this area of practice such as The Protection of Personal and Property Rights Act (1988); mental health law; knowledge of welfare and property management legislation and the protection of dependants. Integral to a successful approach to the reduction of risk by responding to patients identified and assessed as vulnerable is the fundamental importance of excellent communication and team working skills which includes the provision of a dependable service. Once again it is important to note that these descriptions came forward specifically in relation to this area of service delivery, which is why they have been described twice, once in this domain, and again later in the chapter more generally.

Communication and team work

The importance of good communication with the patient his/her family *and* the multidisciplinary team when Health Social Workers are responding to patients experiencing interpersonal violence or neglect was evident**.** Over half of all participants in Adult services describe the importance of the provision of timely communication and feedback with the multidisciplinary team and this was corroborated by comments from the Women's Health and Paediatric Services. Clear communication involves a number of key elements, all of which reinforce the case study data. They include the features of *timely* and *reliable verbal* and *written communication*. Verbal communication is variously described in the following ways; *explain what you will follow up*; *communicate well with all involved parties*; *feedback information to the team*; *discuss concerns with the wider team*; *communicate clearly*; *voice concerns* and *ensure ongoing communication* of *factual information.* This participant draws our attention to the value of *communicating this information verbally to the clinical team – don't assume that they have read the notes*, is a confirmation of a somewhat surprising case study finding,

Alongside the clear value of verbal communication, it is also evident that Health Social Workers must also maintain timely, accurate, reliable and accessible clinical records. The vital importance of this dimension of practice is evident by postings such as; *maintain clear*

communication and record appropriately to ensure confidentiality; *good writing skills and the ability to document facts properly*; *documentation of relevant conversations within the patient file*; and the *clear documentation of decisions and plans.* This contribution from Women's Health combines the notion of timely assessment and clearly recorded plans by explaining that it's "really important that when there are care and protection issues the assessment is made in a timely manner and the plan is clearly documented".

An important element of communication and competent documentation in this field of practice is the timeliness of the communication, and the completion of electronic clinical alerts as described by this Senior Midwife: "Timely relaying of information, up-to-date legal requirements and most of all ELECTRONIC ALERTS to ensure that patients do not slip through the system unnoticed." The particular responsibility Health Social Workers have to complete clinical alerts is also described in the Paediatric context. "The Social Worker is the key person in identifying the child protection alerts are in place when appropriate." The contribution good documentation plays in helping to reduce risk for patients is evident in this posting from a Paediatric Nurse Specialist. "Good documentation is essential to ensure that information is available if the patient presents again to another area."

The final dimension of the provision of effective practice, when working to increase safety by reducing risk, is the ability to work as an integral part of the multidisciplinary team. The value of collaborative team work cannot be underestimated when Health Social Workers are responding to situations which have been described as *fragile*, *stressful*, *complex and highly charged.*

One participant argues that Health Social Workers *need to report child protection and family violence concerns to the MDT* while another suggests *this is a specialty area and requires support from a wider multidisciplinary team.* The importance of coordination is highly rated by this Midwife who asserts that *the safety of the child is paramount – timely and effective planning and follow up in a coordinated way*. A posting from Adult Services makes the link between effective team work and risk reduction; making an important point

she recommends that we *work effectively with MDT and social work team – to reduce the risks around working in isolation.*

The value of *engaging with key players to get information which is accurate and timely* is described which emphasised another important reason to undertake our professional activities in consultation with others. This posting reminds us of the value of consultation with our community colleagues recommending a *linkage with community to ensure continuity, and to ensure that community key workers are aware of the patient's admission.* Reminding us of the importance of communication between teams and the value of engaging in activities that help *prepare* a family for a referral to the statutory child protection service this contributor reminds Health Social Workers to "ensure there is clear communication between teams within the hospital and that families are well prepared if there is to be a referral on to another agency such as CYF".

The final dimension of practice which will be expanded in greater detail under the title of Health Social Workers providing a *dependable service* is the emphasis participants have consistently placed on what I have come to think of as ATAA when responding to situations involving vulnerability and risk. This is an acronym for the combined concepts of approachability (A), timeliness (T), availability (A) and accessibility (A). To highlight the important of timeliness in this field of practice participants describe the need for Health Social Workers to provide: *timely council and advice*; *timely assessment*; *timely referral and time available to spend time with clients.* Reflecting the acute environment and the need for timely resolution these participants describe the *ability to build rapport quickly so that information can be gathered quite quickly as interventions may be brief* and to *move quickly and take action to resolve the situation for the benefit of the person/s under stress*. The last comment of this section of findings reflects the multilayered dimensions of personal and professional characteristics which have been identified as central to the provision of effective practice when helping to respond to patient vulnerability and risk. It is the ability of Health Social Workers to *come across as a strong person but gentle and approachable.*

This report of a substantial component of the survey findings is found to be largely congruent with the case study findings. The survey which includes Adult Service data has allowed me to affirm the value of establishing rapport, presence listening, team work and communication as vital dimensions of practice, specifically described by participants as integral to effective practice with responding to patient vulnerability and risk. The next section of findings explores the provision of practical advocacy and support. Whilst seemingly a more straightforward element of practice in the hospital context and fundamental to health social work practice, when we apply Maslow's hierarchy of needs we are reminded that this next section of findings is critical to the provision of effective health social work.

2. **Practical** advocacy and support

Introducing the data

Examples of practical advocacy and support were provided by the majority of participants (N=157) and fall into four primary themes. The first three areas of need involve the most regularly described elements of this dimension of practice, namely the ability to provide help with finances, accommodation and transport. The fourth theme is the capacity to respond to the context-specific demands present in each service area, for example, nappies and milk powder in Paediatrics, and electronic alarms and parking permits in Adult Services. Each of these themes has been briefly explored with the contextual differences highlighted as appropriate.

Provision of the necessities of life including finances

Across the three practice domains knowledge of services from Work and Income New Zealand (WINZ), and assisting patients and their families to access the *full range* of entitlements is consistently described as a core dimension of effective health social work practice. The provision of advocacy in relation to accessing appropriate payments, including those from Accident Compensation Corporation, Child Disability allowance and from people's employers is also identified as very important. A fundamental element of this practice is the activity of assisting patients complete forms, make telephone calls, attend appointments and gain timely access to the WINZ worker located in the hospital.

The ability to help respond to the more extreme financial hardship that some patients and their families experience by providing the very basic necessities of life such as *food on the ward*, *food parcels*, *milk powder*, *nappies* and *clothing* is also highly valued in this context.

Housing and accommodation

Support and advocacy in matters regarding housing and accommodation were identified as a need across the hospital with Housing New Zealand featuring consistently. In the Women's Health context *Housing New Zealand for vulnerable pregnant women*; *help to access Women's Refuge* and other *emergency housing* is described as valuable. In the Paediatric context *improvements to housing to impact child health, i.e. damp home* is clearly a central focus. In all service areas assistance to find accommodation for family members needing to stay close by, during a period of hospitalisation of a loved one also featured.

In the Adult Service, advocacy to ensure a *safe* and *warm home* also featured as did *support to give up a home*. An increased focus on helping to achieve a safe and timely discharge for adult patients and the provision of home help is a feature in Adult Services only. The ability to provide support and advocacy regarding residential placements including rest homes and private hospitals is also significant in this service area. Activities associated with housing and accommodation in Adult Services included *taking a patient with no family to view a rest home*; *coordinating voluntary assistance for a major domestic clean up*; *arranging caregivers for an elderly person living alone* and *finding accommodation for someone after hours.*

Transport

A consistent theme in Adult and Paediatric services is the capacity to provide support regarding the Ministry of Health's (MOH) transport and accommodation subsidy. The provision of assistance which will allow family members to visit, and for patients to attend clinic appointments is also regularly described. *Taxi chits, petrol vouchers, assistance with parking costs* and using other resources such as those from the church, or the non-government organisations to enable patients to attend follow up appointments were central to accounts of this element of practice. Assistance with travel arrangement for patients and family members living outside of Auckland is regularly described as a valued skill.

In Women's Health a willingness to home visit pregnant women is described, and in this context the role of assisting women to attend outpatient clinic appointments is a core dimension of practice which is clearly highly valued by a number of participants.

Context specific needs

The fourth and final theme related to context specific needs of a practical nature which emerged from the data and the effective Health Social Workers' ability to meet these needs, at times by engaging in activities which are clearly of great importance to the patient and their family, but are unlikely to require the service provider to have a professional qualification. This includes activities such as driving someone home, making provision for their pets, accessing warm clothing, making phone calls and helping with the filling out of forms.

In Women's Health a Midwife described how she valued the Health Social Worker "providing a grieving family with information post the loss of a baby, like legal obligations regarding registering birth/death and funeral arrangements" as an element of practical support. Whilst we may consider this falling outside the realm of practical support, this is the context in which it was described and has therefore been reported in this section of findings. In Adult Health the ability to help access personal alarms, hearing aids and assistance to get prescriptions filled was described.

The ability to provide practical support for patients and their families, particularly those experiencing hardship has been confirmed by the survey data, reinforcing the case study findings. An extension of the findings is an understanding that while the vast majority of practical needs are consist across all service areas, there are some context specific needs that the effective Health Social Worker must be able to meet. Of interest to many Health Social Workers will be the finding that whilst this is clearly an important and valued element of practice in a hospital, it is by no means the only focus. Achieving a much greater focus in participant's first word descriptions of effective ward social work is the more complex dimension of the provision of emotional advocacy and support, within the

context of a complex medical environment. It is to this subject that the next section of findings will now turn.

3. **Emotional** advocacy and support in the medical context

Introducing the data

The following section of findings is informed by extensive data from various sections of the survey. It draws on analysis of the qualitative data associated with the provision of medical and emotional advocacy and support, and quantitative data associated with personal characteristics and professional skills associated with the ability to form relationships and engage patients and clients. These elements of practice were found to be integral to the provision of emotional and medical advocacy and support and therefore have been reported together. Participants were asked to provide examples of the emotional advocacy and support (N=154) and medical advocacy and support (N=146) that they valued. Participants were representative of all service areas.

This analysis identified nine primary themes and as has been the case previously, the themes are not entirely discrete; rather they have multiple intersections and overlaps. Each of these themes will be described in the next part of the chapter, the themes identified included:

The capacity to be non-judgemental, empathic and compassionate
The value of listening

The importance of relationships and engagement

Being alert to the patient and their families understanding of what is occurring in the medical context and taking action to support their understanding

Working in consultation with the multidisciplinary team to support patient and family understanding

Supporting the patient and families engagement with the health system

Responding to distress and the provision of counselling

Knowledge of resources and the ability to effectively engage appropriate support post discharge

It became apparent during analysis that there was a strong association between the dimensions of practice that emerged in relation to the provision of medical and emotional advocacy and support, Health Social Workers' personal characteristics and the elements of practice associated with developing rapport and engaging people. In keeping with the commitment to the combined analysis and interpretation, this has resulted in substantial survey data being reported together, from multiple tables. This provides a further example of correspondence (Stake, 1995) having been established via the combined data analysis process. In light of this correspondence these dimension of practice have been reported and examined, and connections made with the quantitative data in Table 6 and 7. The quantitative data reported in Table 6 below associated with communication skills and style will be reported later in the chapter under the heading 'communication'.

Table 6: Dimensions of practice – Use of self and interpersonal skills

Ranking	**Importance Rating Top two percent**
1. Developing rapport and engaging people	89.9
2. Listening skills	89.4
3. Helping to manage complex situations on the ward	73.8
4. The ability to work with people from different backgrounds	71.8
5. The ability to adjust communication style	72.7

Table 7: Dimensions of practice – Communication and personal characteristics

Ranking	**Importance Rating Top two percent**
1. Open 78.3	
2. Honest/challenging/up front	72.3
3. Stable centred demeanour	70.7
4. Good sense of humour	39.4

Being non-judgemental, empathic and compassionate

As can be seen from the data reported in Tables 6 and 7 above the case study findings have been confirmed with the exclusion of the need for a good sense of humour. In keeping with the correspondence (Stake, 1995) established between these behaviours the capacity to be non-judgemental reported in a later table is included in this section of findings. As can be seen in Table 10, later in the chapter, 88.7 percent of participants (N=150) rated the capacity to be non-judgemental as highly valued or very valued. This quantitative finding is reinforced by 19 qualitative postings, excluding those specifically made in relation to responding to vulnerability and risk which have been reported above. Whilst there is an acknowledgement that *we use our judgement all the time to keep us safe* what dominated participants accounts is *the need to be accepting and non-judgemental* and able to *adjust their approach depending on the cultural and personal needs of the patient and family.* The capacity to be *deeply honoring of people and their life journeys and worldviews* and to have *a non-judgmental disposition* is clearly valued. In Women's Health it is particularly important to be "a person who is not going to judge before seeing her (a pregnant woman) and who is not going to already have an opinion of her because of the history she may have". This sample of contributions from across the service provides us with an illustration of the importance participants consistently place on this professional quality.

Participants (N=32) across the service felt it was important to describe the practice dimension of being empathetic. Survey contributors relied on phrases such as *empathic and caring*; *having empathy with your clients*; *works with empathy and compassion* in order to describe this fundamentally important element of practice. Twenty contributors also posted comments regarding the human quality of compassion; once again these are representative of all three service areas. It is common for participants to link *empathy*, *compassion* and *understanding*, or *compassion* and *care* together. Many others rely on language such as *kind, friendly, warm, understanding, caring, respectful, sincere, genuine, patient* and *supportive* in an effort to articulate the human qualities associated with the provision of effective health social work practice.

It is important to note also that many participants appreciated what this person has described as *sincerity, easy engaging demeanour, a sympathetic but practical attitude*.

Others described *caring but common sense, agree need to question things and not accept at face value what patients/people say* and *someone who is kind but not a pushover.* Expressed by this participant as *tolerant yet firm, with a caring calm voice,* the need for Health Social Workers to show sympathy, compassion and care, while also getting the job done is well understood and frequently articulated by contributors. This supports the quantitative data also reported in Table 10 later in chapter where 74 percent of participants (N=150) ranked the ability to be diplomatic as highly valued or very valued.

A huge variety of other descriptors are relied on by participants to express the type of personal qualities and characteristics they appreciate as an important dimension of the provision of effective practice. The capacity for calm is relied on by some participants (N=11), such as *stays calm under pressure* and the *ability to remain calm when emotions are high*; this supports the quantitative finding reported in Table 7 above. This Table reports that 73 percent of the participants (N=190) who completed this question rated a stable, centred demeanour as extremely important or very important. Other descriptions such as *patient, perceptive, mindful, tactful* and *rational* all contribute to the sense of value attached to the ability of Health Social Workers to conduct ourselves in a way that reflects the calm centred demeanour.

The capacity to *act with integrity*, *honesty* and trustworthiness is also described; for example "honesty is important so that interventions are as they should be – no waffling or stalling when issues arise". Four participants value the ability of Health Social Workers to take on constructive criticism while this participant describes the value of being "able to see the point of view of others, able to admit that others may be right or have a better way to work…able to be challenged about their practice".

A number of comments also made reference to the challenges associated with practice in the hospital context, for example the need *to have big shoulders to carry a large caseload and all the responsibilities that go with it* and "confidence in own professional value even if it is not the popular stance (i.e. does not fit neatly within the medical model being used)". The importance of *enjoying their work* and *passion for their role, profession and work* is also described.

The final aspect of findings associated with personal characteristics is those associated with having a good sense of humour. Despite the centrality of humour in the case study, when tested across the wider context this did not prove to be an important dimension of the provision of effective practice. Only 39.4 percent of participants (N=190) who rated it, gave it a rating of extremely important or very important (see Table 7). This is further reinforced by only five comments being posted about its value over the entire survey.

The value of listening

We are left in no doubt regarding the value of listening when we combine the quantitative and qualitative findings. In Table 6 above, just over 89 percent of participants (N=190) rated listening skills as extremely important or very important. The value of listening is also expressed by a quarter of participants (N=50) making a variety of comments about its importance. These varied from single words such as *listener*, to two words such as *good listener*; *listens well*; *excellent listener*; *active listener*; *really listens* to more detailed accounts such as this one from Women's Health: *A person who is going to sit and listen to the women, about the issues, concerns and the support that is needed.* The value of listening in Women's Health is a consistent theme; this is reflected in comments such as *allowing them to talk*; *giving them the space to talk*; *setting time and appropriate space aside*; *listening allow family to arrive at own solution if possible* and *lastly listening and been non-judgemental*; *not speaking down to the patient.*

The types of situations participants felt Health Social Workers should make ourselves available to listen to include hearing about *the impact of hospitalisation*; *the effects of a sexual assault*; *a family member identifying their greatest priority*; *their fears and concerns*; *the new diagnosis, especially about ongoing coping*; *bad news*; *patients stories* and *providing a listening service to patients with chronic conditions or long-term hospitalisation.* The data provides a clear message that listening to family members is as important as listening to patients. It is also evident that many participants felt that Health Social Workers were better placed than others to engage in this type of listening activity. This is illustrated in the following sample of postings. "Sitting down and listening – it is often easier to talk to a 'non-medical' person especially if the stress is caused by another

factor than the actual medical condition" and "reassuring patients, listening to complete conversations and allowing them to verbalise complaints and assisting with formal complaint procedures".

The importance of *taking the time to listen* and *allowing a patient to feel heard* was expressed repeatedly, as was the ability *to sit and listen*, as described above. The way that participants relied so heavily on language associated with time, such as *allowing time*; *taking time*; *setting time aside*; *time spent* and *having time* gives the impression that perhaps Health Social Workers are perceived to be in a better position to make time available to listen, in a way that our medical colleagues are less able to. This posting from Adult Services reinforces this hypothesis: *Spending the time to listen to them when everyone else is too busy or too close to the situation to do so.* As described in the findings associated with responding to vulnerability and risk, many participants placed great value on *sometimes just being there is enough and sitting quietly* and *listening will help in many situations* reflect and reinforce this sentiment.

This description from Adult Services makes the link between listening and communicating at the right level by explaining that "a good listener and able to hear what a client is trying to communicate, the ability to use the right level of language according to clients' ability and the ability to come across as present and not rushed". This leads us into the next dimensions of findings, a theme which I am describing as relationships and engagement.

Relationships and engagement

The ability to develop rapport and engage patients and their families was rated the highest out of the practice dimensions described in Table 6 and was rated by almost 90 percent of participants (N=188) as extremely important or very important. As explained in the findings associated with responding to vulnerability and risk, there were clearly intersecting dimensions associated with the practitioner themselves and practice activities associated with establishing rapport and engaging people. These included the capacity to be non-judgemental, empathic and compassionate as described previously, and the ability to make yourself available to listen carefully, and respond to patient and family concerns.

Nonetheless, the capacity to develop a relationship and engage patients and families did emerge from the data in its own right, and on that basis it has been reported here.

Having a relationship with patients and families was described by participants as beneficial because it allowed Health Social Workers to engage with clients at a greater depth, particularly during times of distress. Once again a reliance on a sample of postings from across the three services provides evidence of the consistent value participants placed on Health Social Workers developing relationships and engaging patients and families. This participant from Adult Services explained that "giving the patient time to allow opportunity to get to know them, therefore encourages greater depth of conversation to understand, trust and to help problem solve". Reflecting a similar need in Paediatrics this Nurse tells us that "when a patient and family receive distressing news about their child, having a Social Worker who has a relationship with the family and can help them to develop coping strategies" is important. In Women's Health the provision of emotional support is valued, as explained here. "I value the emotional support and engagement skills Social Workers demonstrate when working with vulnerable pregnant women who have suffered multiple abuse, trauma and oppression." The capacity to provide support *on a regular basis*, to *visit daily* and develop the relationship in order *to provide support during difficult decisions and situations*, formed the essence of this data.

Being alert to the understanding of the patient and his/her family

An important dimension of practice to emerge from the Adult and Paediatric context was the Health Social Workers' ability to identify the times when a patient or their family was struggling to understand what was occurring in the medical environment. This ability relied on *spending time with the family*; *listening to and assessing where the family was at*; *checking understanding*; *identifying when the family had the wrong idea* and *interpreting the families understanding of the clinical setting*. Time featured once again in these postings from Adult Services *taking time with families to help them talk through issues and identify any further questions* and *time and patience to go through medical issues*.

Proactively looking for clues that someone may need our help has been a consistent and important finding in this inquiry. Firstly identified as an element of effective practice in the

case study findings, and again in the data associated with responding to vulnerability and risk it also appeared in relation to patient and family understanding, as explained here: *fostering a level of inquiry on behalf of the patient when non-verbal clues indicate the patient does not understand.* Having established that the patient or family member was having difficulty understanding, the dimension of effective Health Social Work practice which dominated the medical advocacy and support findings was the professional activities practitioners engaged in that were associated with increasing patient and family understanding.

Supporting patient and family understanding

A consistent activity for Health Social Workers in the Adult and Paediatric Services, was the ability to arrange and facilitate professional and family meetings. Having established what questions the patient or family may like to ask, other important behaviours have been identified that Health Social Workers engage in *during* the meeting. These included *sitting alongside the family during meetings*; *repeating and simplifying information*; *asking 'lay person type' questions*; *clarifying families' questions*; *staying after Doctors have gone to ensure patient and family understanding*; *informing the medical team when the patient didn't understand*; and *acting as a voice for the family*. The capacity to provide patient advocacy was an important skill in this domain of practice as described in Paediatrics. *Stand up for the patient if they are feeling vulnerable and require support* and "helping by advocating for the family should they not understand fully what is going on for the child patient, this may include having another meeting with the Doctors".

Another dimension of practice which featured here was the Health Social Workers *knowledge of health conditions and patients ongoing needs*. This has been explored in some detail in relation to assessment activity later in the chapter but because it was described in relationship to supporting a family's understanding, it was worthy of mention here also. In the Paediatric context "maintaining an excellent understanding of medical conditions and an ability to articulate the families' perspective regarding how they understand the child's condition" was important.

The other key element of practice connected to medical advocacy and support involved the provision of information. This was explained in a number of ways including: *providing written information at the right level*; *providing resources about the medical conditions*; *helping people access relevant information about their illness* and *together with the client, finding out about medical conditions.* In Women's Health one participant appreciated the Health Social Worker's ability in a situation involving pregnancy loss to *explain through the grief the more specific details as appropriate.*

Only six participants provided examples of Health Social Workers engaging in activities that directly involved explaining medical details. These included *explaining what a heart attack is*; *explaining why a patient is unable to return home due to being unable to manage medical conditions*; *explaining the need for enteral*[10] *feeding with end-stage liver disease*; *explaining the effects of cognitive impairment*; *explanation given to patient about drinking habits and implications on their health* and *explanation about post-operative management after a liver transplant.* The vast majority of contributions emphasised the value of Health Social Workers working alongside our medical colleagues to support understanding and it is to this element of practice that the findings will now turn.

Working *with* the team to support patient and family understanding

A more widely articulated view about how Health Social Workers were involved in the detail of medical conversations was by working alongside our medical colleagues to help facilitate an increased understanding on behalf of clients *and* the medical team. Explained by this participant from Adult Services as "advocacy is order for the medical team to understand where the patient was, and also for the patient to understand the medical team's point of view". The concept of Health Social Workers providing an important communication pathway between patients, families and the medical team was a strong theme to emerge from this data set as explained here in Adult Services: "liaising between the family members and the rest of the team, the Social Worker can talk to the staff about what is happening and then go and explain this to the family in simple terms." This theme will be explored in greater detail in the last section of the survey findings under the title 'Team work and Communication'.

---

[10] Feeding via a tube, either through the nose, or directly into the stomach.

Other examples of this important dimension of practice included *identifying how a family want to be communicated with about the medical condition*; *paraphrasing the plan and allowing the patient to ask questions*; *sharing information with the multidisciplinary team that the patient feels unable to give; promoting teamwork between the team and the family*; *finding the right person to respond to a family's questions* and *advising staff when there is a lack of understanding and promoting the family's wishes to the multidisciplinary team.*

In Women's Health the importance of *translating medical language into everyday speech*; *supporting the clinical staff to inform a woman about her condition, helping clarity complex issues of care and engaging in effective communication with the team so that the Social Worker is able to pass on correct information to patients* were identified as valuable.

These findings appear to be consistent across all service areas and reinforce the case study findings which described two important dimensions of practice associated with relationships and engagement. These were included in the survey for checking and reinforcement and are reported in Table 6 above. They describe the ability to work with people from different backgrounds, and the ability to adjust communication style. Both these dimensions of practice were rated by over 70 percent of participants (N=189) as extremely important or very important.

Supporting patient and family engagement with the health service

A small but important theme emerged within this data set associated with Health Social Workers' contribution to supporting a patient and their family's engagement in and with the health service. Whilst clearly the ability to support their understanding is likely to increase engagement, other activities were also identified that had both an emotional and practical element. Firstly the capacity to back up information with patients who are non-compliant with medications, *encourage correct use of medications* and *reinforce information and the need for follow-up* were described. Of a more practical nature was *assistance if a patient is unable to afford medications; assisting patients to attend outpatient clinics* and *endorsing treatment adherence by organising community support.* This leads us into the final elements.

Responding to distress

In the acute environment the effective health Social Worker was described as being able to provide emotional support for patients and families experiencing a number of distressing events. These varied across the hospital settings, but common themes which were contextually consistent did emerge. These include all aspects of bad news likely to be frequently occurring in the hospital context, death, including sudden death, neonatal death and foetal death. In Women's Health the ability to *help support the women when a baby dies or there is a bad medical outcome with baby* was described. In Paediatrics the capacity to *work with parents and siblings to help them cope with death and dying* was valued. Similarly in the Adult Service a willingness to "be there for families in the event of the death of their loved one" was described as important.

Distress also featured in relation to the hearing of *bad news.* This was once again a consistent feature of practice across the hospital, with only minor contextual differences apparent. Much of the data was associated with patients and family members receiving a poor diagnosis and or prognosis and included a variety of health social work responses which were clearly valued and relied on during these emotionally distressing times. In Adult Services the ability to *attend a histology meeting was* mentioned, and in Paediatrics the value of *providing support following news of a brain tumour.* In the Women's Health context the capacity to provide the "initial support and response to a woman and her partner and family after being told bad news re a severe foetal outcome like congenital abnormality or probable foetal brain damage" was also described.

Postings suggested that sometimes these situations were particularly complex. For example in Paediatrics support was needed "to deal with imminent death, recent bereavement, changing family dynamics, carer stress and stress related to chronic illness". In Adult Services the ability to *assist a spinal injury patient come to terms with his long-term disability* and *discuss the possibility of returning home and the reasons was this might not be safe* were other examples of the types of situations requiring the input of Health Social Workers. Again from Adult Services this posting from a Maori Social Worker suggests the value of humour by explaining that *empathy*; *being able to be alongside whanau [using]*

humour: 'breaking' the edge of grief. Assessing a *patient's level of readiness and insight* in relation to an adverse diagnosis was also described as important.

Being present when a patient is given a poor diagnosis as support for the patient and family and *making sure the right people are there for family when bad news was given* were identified as two other important elements of practice associated with bad news. The capacity to *provide support to the patient and their loves ones during the last stages of a terminal illness* was identified as a valued skill, as was the ability to *provide support for patient's children who are in crisis.* The competence to *counsel a patient and their whanau who have to make a life altering decision, such as amputation* and "explaining to a patient who required amputation of his leg…helped him to see how saving his life was more important than saving his leg, and helping him come to terms with it" was also highlighted.

Participants posted a number of other examples of practice that related to the ability of Health Social Workers to be available to patients and their families during highly emotional and challenging times. The ability to be *a stable container for emotions…* and *acknowledging their sadness or anger and letting them demonstrate this in a safe or confined way* were two of the skills named. The capacity to *respond to a family in crisis*; *to delayed or cancelled surgeries and patient transfers* and *helping with the grief process, such as death but also loss of roles and income* provides further examples of this element of emotional and medical advocacy and support.

Participants also described the value of the health Social Workers' skills associated with *defusing or calming situations*; *helping de-escalate heightened emotions* and the provision of *support for behaviour de-escalation* which reinforced the quantitative finding reported in Table 6. Here the contribution practitioners make by helping to respond to complex situations on the ward is acknowledged by 73.8 percent (N=187) of participants who rating this skill as extremely important or very important.

Providing a central point of contact for patients and families was also a dimension of practice which was well described. This included providing support to family *by being a point of contact*; *liaising with other family members who don't attend*; *touching base with a*

family each day and *keeping in contact with family members of complex patients to avoid multiple sources of communication.*

The last key dimension of this practice was the provision of emotional support that Health Social Workers seemed to offer in a variety of situations. In Adult Services a Nurse explained that she *highly values that they offer to stay with the patient and family at times of stress* while in Paediatrics *Social Workers will often stay behind after bad news has been given to offer emotional support*. Again from Paediatrics the ability to *help helpless patients to cope with the sometimes huge task of going home* and *supporting distressed parents and helping them solve organisational problems* was highlighted as valuable.

In the Women's Health context one participant explained that "I value the emotional and therapeutic support Social Workers provide to women and their partners during and following pregnancy loss and still births" and another reported how she appreciated Health Social Workers *supporting a mother after her baby has been uplifted by Child Youth and Family Service*. Again in Women's Health the ability to give time was described as a particular contribution practitioners make. "The ability to give the client time to express concerns and debrief, not always something the midwifery and obstetric staff can provide." This capacity to provide support for bereaved mothers provides us with a good example of a contextual difference which emerged during the study, a subject which will be explored more fully in the discussion.

Counselling

As is evident above, the capacity of Health Social Workers to listen, provide emotional support and help contain strong emotions is a key dimension of effective practice in this context. Overall ten participants described the provision of counselling being of value to them. This was most evident in Adult Health where the ability to "be available at times of crisis for families – like trauma or diagnosis and being able to provide initial crisis counselling and support" was described by seven participants. Counselling was described as *bereavement counselling; grief and self care counselling skills*; *process loss and adjustment skills,* and *counselling skills in regard to a new diagnosis*. In Women's Health, a previous employee who specialised in the provision of counselling in relation to

pregnancy loss was named, highlighting the value this Midwife placed on her practice. "Especially think of the wonderful work I saw JC doing with pregnancy related trauma. Absolutely inspiring to see her in action....firm, empathetic and a rock....but also helping managing the day today things that needed to happen."

This participant in the Paediatric context expressed the view that it *would be really beneficial if Social Work could be utilised for grief counselling* while another in Adult Services said that "counselling and listening is very helpful, unfortunately the Social Workers are often too committed to be able to spend much time on this". While some participants appreciated the skills of Health Social Workers in this area of practice, others identified the value of referring on to other services and this will form the next section of findings.

4. Access to internal and external resources

Introducing the data

Analysis of the case study data revealed that in the acute Paediatric context the ability to access community resources was not identified as a strong dimension of the provision of effective health social work. As stated in chapter five, this may have been a result of the rapid pace of those particular wards, and the primarily internal focus of the particular practitioner studied who readily acknowledged this was an area of practice she would have liked to develop. This survey data supports her contention that this *is* a core dimension of the provision of effective health social work practice and is worthy of increased focus and attention.

Across the three domains of the acute environment numerous references were made to this set of skills, indicating that it is likely to be a core function of the effective Health Social Worker. The data reported below has been drawn from multiple locations in the survey, including first word responses, and the domains of advocacy and support in the medical and emotional support arenas. I have also chosen to report the dimension of practice which emerged specifically in relation to cultural advocacy and support under that heading as this was a substantial theme in that practice domain.

Two consistent dimensions of practice emerged from the data, beginning with the value of Health Social Workers having an excellent knowledge of internal and external resources. Using this knowledge in order to effectively refer, liaise and advocate on behalf of patients was the second important dimension of health social work which was consistently described across the acute environment. Of note was the need to be familiar with mental health issues and the resources available to support people experiencing mental health challenges. Relying on participant quotations and highlighting consistent contributions, the key themes will be articulated and demonstrated in order to explain and explore the dimensions of effective Health Social Work practice in relation to accessing resources.

Knowledge of resources

Analysis of participant responses across the acute environment detected language that implied the value of Health Social Workers having a high degree of familiarity and knowledge associated with the resources that were available to support hospital patients and their families. Approximately 20 percent of participants made some comments about this ability in their first word responses to the question regarding effective social work practice in the acute hospital. To articulate this proficiency, participants relied on words such as Health Social Workers having *broad knowledge*; *comprehensive knowledge*; *excellent knowledge*; *a very good understanding and a wealth of knowledge* about resources. Effective practitioners were also described in terms of being *resourceful*; *someone who has experience*; *and being aware* of resources.

Described as paramount, this Midwife explains that in Women's Health the "[a]bility to access information… to refer, link-in with other services and therefore have a good knowledge of the services and assistance that women and her whanau can receive is paramount". The value of this skill is reinforced in the Adult context with an emphasis on the Health Social Worker understanding patient entitlements by being *supportive and knowledgeable about what entitlements patients may have*. Further reinforced in the Paediatric context, and again with a slightly different focus this participant highlights the value of Health Social Workers being able to work the system: "Social Workers need to

know what services are available and how to access them and how to work the system to the advantage of the patient."

The types of resources participants mentioned were many and varied and included internal and external professionals, social services, support groups, government and non-government agencies. Having detailed knowledge of significant agencies, which allowed practitioners to engage in successful advocacy of agencies such as Child Youth and Family, and crucial services such as Taikura Trust[11] were consistently mentioned. In relation to medical advocacy and support there was a consistent focus on the importance of Health Social Workers knowing about the various specialist support services and groups for people experiencing specific medical conditions such as Heart Kids and the Child Cancer Foundation.

Knowledge of services related to mental health concerns was a central feature, with many participants describing the need for help to access mental health assessments, support, drug and alcohol services and counselling services. As illustrated by this posting from Paediatrics *listening to patient's concerns and being able to direct or find relevant mental health help, like counselling* is important. This focus on mental health was also evident in Adult Services with this contribution alluding to post discharge activity: *promoting the use of organisations outside the hospital to improve mental health and widen social support structures*. Lastly this contribution from a Midwife in Women's Health appears to confirm the consistency of the need for Health Social Workers to be familiar with mental health services and resources, again with a focus on post discharge activities. "Service offered over a period of time for example, after discharge, phone calls for support and to provide referral to appropriate service where needed, for example, post traumatic stress, mental health issues." In the same context it was evident that being familiar with services and specialties inside the hospital was also valued. Having knowledge of resources is clearly a valued dimension of health social work; however what is it that is expected of us as a profession in relation to how we *apply* this knowledge?

---

[11] Taikura Trust is the region's single facilitator of support services for all matters concerning disability

Using our knowledge of resources to advocate for patients and families

Knowledge of resources seems to enable the effective Health Social Worker to engage in a number of activities which appear to be core dimensions of practice in this domain. These professional activities include the ability to *explain to patients where they can get appropriate help*; *facilitate transfers*; *promote resources*; *access information* and *resources*; *work alongside*; *refer on if needed*; *link and liaise* and *advocate on behalf of patients and their families.* Again liaison with key agencies such as Child Youth and Family featured strongly in the Women's and Paediatric contexts, as did hospice in the Adult domain.

In relation to advocacy and support of a medical nature, the ability to advocate on behalf of patients and families was a consistently described dimension of practice in relation to medical conditions and concerns. The need for advocacy in relation to the agency that provides resources to patients post discharge was a consistent feature, demonstrated in this posting from the Adult service: *advocating re medical condition to other organisations e.g. Taikura Trust.* Similar postings were received from the Paediatric domain, again demonstrating a consistency of need across these two domains. Advocacy in Women's health included *being present with a woman who baby is being uplifted by CYF* and *assisting to find support groups for a particular condition or child.*

In summary, a key dimension of effective health social work practice has been identified as having a sound knowledge of specific hospital and community resources. Having this knowledge enables practitioners to engage in appropriate referral, liaison, negotiation and advocacy on behalf of patients and their families. The focus on these dimensions of practice lead us naturally into the area of cultural advocacy and support, of which the capacity to liaise, network and refer to appropriate services was a dominant theme.

5. Cultural advocacy and support

Introducing the data

Two primary sets of data have been called on to describe the dimensions of health social work practice associated with the provision of effective cultural advocacy and support. The quantitative data reported in Table 8 below reports the survey findings where the

dimensions of practice identified as important via the case study, have been assessed across the wider context. Further qualitative postings (N=136) have provided examples of cultural advocacy and support participants valued across the broader context. Five key themes emerged from the qualitative survey data, largely reflecting the practice dimensions previously identified via the case study. They include the ability of Health Social Workers to assess and respond to cultural needs; engage in liaison and referral associated with the provision of cultural support; the application of cultural and ethnic competencies in the hospital; the contributions Health Social Workers make to the multidisciplinary team and lastly the value of the ethnicity of some Health Social Workers. These themes have been explored and described in order to illustrate this element of practice which many Social Workers are likely to claim as a cornerstone of ethical practice. A brief exploration of the data reported in Table 8 described as assisting a patient and family to understand the medical condition and its consequences concludes the chapter.

Table 8: Dimensions of practice – Cultural responsiveness

Ranking	**Value Rating Top two percent**
1. Assess and respond to specific cultural needs in order to assist patient and family engagement	84.2
2. Identify cultural support for patient and/or family members	83.2
3. Facilitate effective family meetings across a range of cultures	79.4
4. Work effectively with interpreter	53.8
5. Assist a patient and family to understand the medical condition and its consequences	46.4
6. Support cultural competence in wider MDT	32.4

Assessing and responding to cultural needs

As can be seen from the data reported in Table 8 above, the capacity for Health Social Workers to assess and respond to specific cultural needs in order to assist patient and family involvement in health care was a highly valued or very valued skill according to 84.2 percent of participants (N=187) who rated this set of practice dimensions. This table also reports that 83.2 percent of participants (N=191) rated the capacity to identify cultural

support for the patient and their family as highly valued, or very valued. These elements of practice were ranked highest and second highest out of the six described above, and reinforce the qualitative data which identified that the ability to *respond* to cultural needs was highly valued.

Liaison and referral associated with cultural support

Reflecting a similar pattern to that described in relation to generic resources, the ability to *refer to*, *link and liaise with*, *collaborate with* and *access* internal and external cultural support proved to be a dominant theme in this area of practice. Participants described *referral to culturally appropriate agencies*; *working collaboratively with the Pacific Island Family Support Unit*; *linking with appropriate cultural advisors*; *linking with kaumatua and He Kamaka Oranga*[12]; *connecting with marae or extended family members* and *accessing ethnically* appropriate care as important to them. Contributors to the survey relied on language such as advocacy and empowerment, as illustrated in this posting from Adult Services: "Assist patients with identifying resources and services for future use in order to give them self-determination and independence and empower them by sharing relevant information." The need for advocacy in relationship to *patient's rights for an interpreter's presence* was also described, as was the ability to *provide an interpreter.*

Participants identified two primary areas of need, firstly that of cultural support, and secondly the dimension of religious or spiritual input. The need to be *familiar with multidenominational facilities available and respect for faith* was described, as was the capacity to *facilitate contact with spiritual people important to the family especially if a child may die*. This participant explained what she appreciated about cultural support staff: *particularly appreciate that at any time I can call in Maori or Pacific cultural support and this immediately seems to enhance my relationship with the family as well.*

Applying cultural and ethnic competencies in the hospital

The depth and breadth of cultural and ethnic knowledge required by Health Social Workers and its effective application in the hospital context was quite staggering. Skills ranged from having *knowledge of customs and rituals associated with death and burials*; *creating a*

[12] Maori health services

culturally safe environment; organising family space for cultural practices; *sourcing correct food and identifying culturally appropriate decision-makers.* Illustrating the gravity of this dimension of practice this participant highlighted the importance of "helping to ensure that appropriate family and support persons are involved in family meetings to ensure that a Maori woman returned to her own whanau home to die". Another explained how "starting and closing rituals are important to Pacific and Maori people, and knowledge of the family structure is of great value to cultural needs".

The important contribution effective Health Social Workers made in relation to family meetings was a strong feature of the data. Reflected in Table 8 above 79.4 percent of participants (N=184) rated the Health Social Workers' capacity to facilitate effective family meetings across a range of cultures as highly valued or very valued. The qualitative data reinforce the importance of this area of practice and provide a number of illustrations as to how this knowledge was applied. This activity ranged from *ensuring appropriate family and support persons were involved*; *checking family wishes regarding the use of karakia (prayer)*; *identifying family decision maker*; *the Social Worker often explains what is happening in the family meeting* and *ensuring meetings are culturally appropriate.* This participant explained in greater depth the value of "ensuring the environment feels 'safe' to ask questions in meetings so they can put their own views forward".

A number of postings illustrated the awareness and competence expected from Health Social Workers in relation to *family structure*, *family decisions makers* and *accessing the right family members* needed during a medical crisis. This participant drew our attention to the advocacy role we take up, explaining that we *allow for large groups to attend family meetings and recognising the role of each within the family*. A specific example of this competence was evident in this posting where a Nurse from Paediatrics explained that "identifying on occasion that in fact the Grandmother may have more influence than appreciated in decision making, than the mother who may be young".

It was acknowledged that *identifying unmet needs* and that *supporting cultural needs goes a long way to reducing stress* and it was evident that Health Social Workers take a lead role,

and have a particularly well-developed set of skills in this area. This Nurse from Adult Services with thirty years of experience is clear about the value she places on these skills. "I enjoy the wide value of their expertise in dealing with many of our clients. They just seem to become aware of such a diverse group of cultures and the outside community. Those Social Workers that I have dealt with in relation to trauma cases from overseas have been superb and the facilitation and willingness to go the extra mile has been superb." This posting, from Paediatrics valued how "the Social Worker bought to our attention that it was actually not appropriate to have a twelve-year old-African girl and her Mum sharing a room with a fourteen-year-old Pacific Island boy". This leads us into the third dominant theme to emerge from the data, that of supporting the wider multidisciplinary team's ability to provide culturally responsive services.

Contributions to the multidisciplinary team

Of some note in this set of data is the finding that 32.4 percent of the 184 participants who answered the question, highly valued or very valued the Health Social Workers' ability to support cultural competence in the wider multidisciplinary team. This may reflect the language I relied on in the survey not adequately reflecting what was clearly found to be of value previously reported in the case study findings. Further this language may also not adequately represent the day-to-day activities that Health Social Workers clearly *do* engage in, and that are valued which is evident as a result of them having been described by survey participants (N=50). Less confronting language may have represented this activity more appropriately, such as 'supporting the multidisciplinary team's cultural responsiveness'.

Relying on language such as *advice to Nursing staff*; *prompting and education of the multidisciplinary team*; *supporting other members of the multidisciplinary team's cultural understanding*; *clarifying cultural needs for the rest of the team*; *being a voice for cultural differences and representing and communicating these to the multidisciplinary team*; *prompts when required, busy unit and easy to overlook* and *preparing the staff beforehand regarding the patients cultural expectations* multiple participants explained the cultural advocacy and support Health Social Workers provide in relation to other members of the team. Once again *knowledge of the family structure* was described, this time in relation to *letting therapists know who they need to contact*.

Equally important was the contribution Health Social Workers appeared to make in relation to supporting a patient and their family's cultural safety, comfort and engagement, as illustrated by this set of examples: m*aking sure a patient feels culturally safe in the hospital*; *letting us know the cultural reason for something the family is feeling uncomfortable with* and *communicating the cultural needs to other health professionals so the patient and family feel safe.* This Allied Health participant clearly valued how a Health Social Worker "helped in understanding why a particular patient was very angry and resentful – very useful in communicating cultural expectations and increase staff understanding and improved patient stay".

The capacity to engage in cultural advocacy was also evident by postings such as *brokering the needs of the family*; *their advocacy for the patient in the situation; letting us know when a family needs an interpreter* and *voicing the family needs to clinical staff when they are too disempowered to do so.* The particular skills we have was acknowledged by this Doctor in the Adult Service who explained *their guidance is particularly needed and valued where cultural aspects could be missed if the Social Worker was not there*. Further reinforcement is evident in this contribution from a Midwife in Women's Health. "The Social Worker may well be more responsive to cultural needs than the medical staff as they are often more focused on practical/medical issues, so any suggestions are always gratefully received. Often the Social Workers will be more involved in ensuring that cultural needs around funerals and bereavement are met."

A number of examples of cultural advocacy and support that were specific to the hospital context were also described. These included *responding appropriately to a patient's request to be showered and dressed by a female Health Care Assistant*; *contacting the minister on behalf of the family when other staff are busy* and *ensuring cultural needs around funerals and bereavement are met.* This need to assist families in the aftermath of a patient's death was a consistent feature across all the service areas expressed by one participant as *ensuring death is handled appropriately.*

Some participants were able to provide examples of Health Social Workers undertaking activities which had a specific medical-cultural component. For example this Allied Health participant from the Adult Service described how "the Social Worker gave me guidance about the family dynamics of a complex medical problem in a Chinese family and a Maori Social Worker provided support for me when discussing nutritional issues after a young patient has a prophylactic gastrectomy".

Similarly, this Doctor from Paediatrics appreciated the Health Social Worker "recognised cultural barriers that may be impairing understanding or acceptance of medical care, for example lumbar punctures." Another quite simply described Health Social Workers *giving advice to clinicians about particular cultural issues for individual patients*. Clearly then Health Social Workers have acted as conduits, providers of advice, support and guidance to members of the multidisciplinary team regarding cultural matters. This brings us to an interesting theme in this important area of practice, that of the ethnicity and particular cultural contribution of Maori and Pacifica staff.

Ethnicity of Health Social Workers

A number of participants (N=20) made some reference to the ethnicity of health Social Workers, particularly drawing attention to Maori and Pacifica practitioners. It was evident in the data that these Social Workers are able to make an important additional cultural contribution in this context which includes their language ability, cultural matching of staff to clients and the provision of a cultural perspective. Taking cultural competence an enormous step further, four postings highlighted the value of Health Social Workers being able to speak the same language as the patient and their family. "It's been helpful having both the Maori and the Pacific Social Workers involved with patients I've been involved with as they can provide a cultural perspective and also by being able to engage in the person's own language this is useful as it helps put family at ease." Another described the value of *the ability to practise culturally appropriate dialogue in sensitive circumstance*, while another described *assisting with interpreting when interpreter is unavailable.*

This participant explains that *Maori Social Workers work with whanau to ensure they are comfortable and understand the hospitalisation process* while another said "cultural

support is valued, in the renal service the Social Workers are ethnically based and the patients love this". In Women's Health the desire to *find a Social Worker or support person of the same ethnicity* was highlighted while in Paediatrics there was a call to *increase the numbers of Maori and Pacific trained Social Workers*. This last posting for this section of findings expressed the view that *Maori Social Workers can be very useful for Maori patients here as would any culture specific Social Worker*.

Helping patients understand medical conditions and their consequences

As can be seen in Table 8 neither working effectively with an interpreter or assisting a patient to understand the medical condition and its consequences has reached the combined 60 percent threshold rating of highly valued or very valued. Both these findings will be discussed in the following chapter. Because of the strength of the qualitative postings which followed this survey question some mention of this is warranted.

What I have been describing in the findings is the capacity to work in partnership with the multidisciplinary team, in order to support the patient and his/her family's understanding of what is occurring in the medical context. This appeared to be a highly valued skill. This included an ability to engage in this activity when there were cross-cultural issues at play. Anxiety about Health Social Workers undertaking this activity in isolation, or taking the initiative without very clear guidance and a significant contribution from the medical professionals is what has been fairly consistently described as unacceptable by some participants (N=19). By way of example this posting from a Paediatrician is very clear. "Explaining a medical condition in simple language should be the role of a doctor or a nurse NOT a Social Worker. As a Social Worker is not trained in medicine this could be confusing and dangerous. A Social Worker could check with the patient and family whether they require any further information to assist them to understand and make sure that this occurs."

In summary then, the effective health Social Worker was described as being able to provide referral, linkages and information regarding internal and external cultural resources such as

Kia atawhai[13] and the Chaplaincy service for patients and their families. We remained alert to the cultural needs of patients and their families and proactively shared this information with our multidisciplinary team members in order to support a culturally responsive health service. It was also identified that we have particular responsibilities regarding the coordination and facilitation of family meetings.

6. 'Working the ward' – dependable service delivery

Introducing the data

The qualitative themes associated with the practice dimensions reported in Tables 9, 10 and 11 below have been reported and explored together in the following section of findings for a number of reasons. The first rationale for reporting these three tables together is perhaps the most important one. It is to support a congruent account of the findings. Therefore when themes develop they were reported together, rather than in a lock-step order following the table they originated from – this reporting structure reflects the concept of correspondence (Stake, 1995) as previously described; and secondly because of the design of the survey where practice dimensions, such as being reliable and being non-judgemental were combined in the same table (see Table 10). During data analysis it became clear that some of these dimensions would have been better associated with personal characteristics while others were more appropriately connected with how the service is delivered, for example, reliably.

The final reason is that once again the qualitative data has been drawn from multiple locations throughout the survey, indicating that participants' descriptions of the dimensions of effective health social work practice did not appear to be confined or prescriptively related to the dimensions of practice they were being asked to rate and rank. In contrast responses seemed to be interlocking and multi-layered, as noted previously.

[13] A Maori health worker based in the hospital whose role it is to provide cultural support to Maori patients and their whanau

Table 9: Dimensions of practice – activities that support reliable service delivery

Ranking	Importance Rating Top two percent
Be highly visible and accessible	79.3
Provide a timely response	88.5
Be proactive about identifying patients who may need social work services	69.8
Attend weekly MDT	55.3
Teach MDT members about the social work role	22.9
Attend nursing handover	12.1

Table 10: Dimensions of practice – behaviours that support reliable service delivery

Ranking	Value Rating Top two percent
1. Approachable	92.0
2. Reliable	98.0
3. Responsive	92.7
4. Non-judgemental	88.7
5. Diplomatic	74.7

Table 11: Dimensions of practice – assessment and interventions

Ranking	Value Rating Top two percent
1. Timely assessment	94.5
2. Clear intervention planning	83.2
3. Accessible record of assessment	73.2
4. Focus on safe and timely discharge	63.2
5. Focus on reducing likelihood of readmission	53.2

Dependable service delivery

One of the most significant case study findings was the concept of *working the ward*, which was made up of a number of behaviours and activities (see chapter five) which enabled the practitioner who was studied to proactively identify patients in a timely way and deliver health social work services rapidly and reliably. A sample of these from the case study included activities such as attending nursing handover, teaching members of the nursing team about the health social work role and proactively identifying patients who required professional input in order to *solve problems before we even knew they existed*.

Reinforcing and extending the case study finding associated with timely problem solving was a similar theme which materialised from the survey data. This was described by one participant in Adult Services as the Health Social Workers' ability to *solve complex socio-environmental problems that patients may face as result of being hospitalised*. Universally accounts of effective practice had at their core the importance of a *timely* and *reliable* response from Health Social Workers. I have chosen to describe the dimensions of practice considered by participants to make up this timely and reliable response as the provision of a *dependable service*. This description provides a further example of Stake's (1995) notion of correspondence where the relationship between the behaviour, issues and context are made sense of. Relying on participant quotations and brief statements, the key themes have been explored in order to articulate and demonstrate how participants have described the detail of the provision of a dependable service.

The delivery of a dependable service appears to be made up of a number of key elements which will be reported in the following order. Firstly as stated above was the capacity to solve problems by acting quickly to meet social needs. The dimensions of approachability – accessibility, visibility, presence and availability – all linked to timely problem solving follows. The capacity to be flexible, well organised and proactive will be reported together, prior to a brief generic exploration of accounts of timeliness. These accounts have formed a solid foundation for a more detailed illustration of how these behaviours were reported to be applied in relation to clinical practice in these particular clinical environments.

Social needs met in order to solve problems

Consistent descriptions of Health Social Workers being able to *identify the problem and find solutions*; *help patients sort out their difficult social circumstances*; *be responsive to patient circumstances* and *deliver results,* dominated accounts of effective practice in this context. It appeared that participants appreciated that this was a challenging task which required more than a wave of the magic wand! Rather it relied on a complex set of practice skills equal to the complexity of the problems. Descriptions such as, *is able to deal with the hard things in life*; *resourceful*; *good problem solving skills*; *capable of handling any situation presented to her*; *trouble-shooter*; *able to think outside the square* and *creative in their approach to problems* all attest to an understanding that the problems Health Social Workers were charged with solving were not simple, or straightforward.

Whilst there was clearly an understanding that many social problems were complex, there was also a very clear expectation articulated that *they would* be solved. These postings, all from Doctors and Nurses in Adult Services provided a clue as to their expectations. *Must actually help*; *the ability to do something – to effect change*, and *ensure help has been given*; *practical and delivers results.* This contribution from a Nurse in the Paediatric Service to the first word's question also had a focus on outcome. "Someone who works on behalf of families in such a way that the family's social needs are met. As a result of this the family is well able to engage in the medical process so that a most favorable outcome is obtained for the child."

Another first word posting, this one from Adult Services introduces the idea that social problems require evaluation and assistance in order to resolve them. She asks that we: *assist patients and medical team to evaluate the extent and complexity of social issues and assist with improving or resolving them*. This concept of evaluation (assessment) and assistance (intervention) will be explored in more detail later in this section of findings. For this part however what was clear is that the effective Health Social Worker is *responsive to the needs of patients, follows through* and is *outcomes focused* in their approach to problem solving activities. This leads us into the dimensions of practice associated with accessibility and presence on the ward.

The dimensions of approachability; accessibility; availability; visibility *and* presence
Substantiating the case study findings, Table 9 reports that almost 80 percent of participants (N=190) rated being highly visible and accessible as extremely important or very important. This dimension of practice was also ranked the highest out of the set of six listed. Being approachable was highly valued or very valued by 92 percent of the participants (N=152) and it too was ranked highest out of the five elements of practice in the set reported in Table 10. The practice element of responsiveness also received a very high value rating with 92 percent of participants (N=150) rating it as highly valued or very valued. Each of these elements of practice will be briefly explored relying on a sample of quotations posted, and themes identified.

Reflecting a common theme in this data set, the actions associated with being visible and accessible were linked with the ability of the Health Social Worker to effectively identify patients who may require their input. This practitioner makes the point that "[i]f you are present and visible on the Ward then you will become aware of social issues such as nurses talking about how stressed a mother is". The value of being present is confirmed by this staff member who suggests that *Social Workers are usually visible and known to the ward team so staff discuss patients with them and seek advice…* Participants frequently prefaced references to accessibility with words such as *readily* and *easy*.

A consistent pattern in the data was the link being made between the Health Social Workers' action and outcomes for patients. For example, being "present is extremely

important – if the Social Worker has a high profile – staff can feel free to run ideas or concerns past them and get feedback from the Social Worker and that has positive outcomes for patients and families". Finally the value of being able to talk something over is reinforced by this contribution from Adult Health who also made an explicit link between actions and effectiveness: "sometimes being available to speak to a Social Worker when referring patients – referral by word is more effective rather than simply completing a referral form."

Availability, whilst clearly having some connection with accessibility was also described as a discrete quality by numerous participants. Multiple references (N=43) were made regarding the importance of Health Social Workers being *available*. This was highly consistent across all three service areas and may indicate that the current size of the health social work resource is not adequate to meet ward demands. This point will be explored more fully in the following chapter. Once again participants were able to provide important pointers about what they valued in this area by posting potent declarations. A sample from across the three domains serves as evidence of consistency: *Easy to contact* and *availability/contact – ability is important* (Adults); *giving a sense of being available even if busy* (Women's); *available to respond to telephone contact ASAP* (Paediatrics). Patients and their families were in the centre of a number of participant's contributions, indicating that the ability to make oneself available was an important element of family centered care, for example, *someone who is available to respond to the needs of the patient* and *readily available to patients and staff*. The sense of fluctuating acuity[14] was evident also as described in this posting. *Availability when patients or families need Social Work input, sometimes it is fairly urgent, sometimes not.*

Providing the last words on availability goes to these Nurses from Paediatrics with 20 years of experience informing their contributions. They represent participants who made an explicit, and in my opinion, a very important link between workload and availability. "Being available is number one. If the Social Worker has an unreasonable amount of work then it is counterproductive and in the end they cannot be reliable" and "being loyal to the ward is not as important as being available to the ward. If they have too much stuff pulling

[14] This refers the level of health or ill-health the patient is experiencing

them off the ward they cannot be effective". A Doctor practicing in the same context supports their view having made this comment in relation to availability. "Availability – there is no point having all of the above skills if the Social Worker is too busy to see the patient or spend the necessary amount of time".

The last dimension of practice that belongs with this set of findings was the capacity of Health Social Workers to be *approachable.* This quality was rated by 92 percent of participants (N=150) as highly valued or very valued. It was ranked the highest in importance in this practice set and attracted 24 direct references from participants. Once again the case study findings are reinforced by this data, indicating that it is an important dimension of the provision of effective social work practice in this context.

As outlined in the introduction of this section of findings, the quality of approachability which is likely to contain elements of personal characteristics is being reported in this section of findings because it was often linked with the notions of availability and accessibility, and appears to be an integral element of the provision of a dependable service. The connection was reinforced between one dimension of practice such as approachability, and effective outcomes, i.e. problems solved. "Our current fantastic Social Worker always takes the time to chat to staff on a 'casual' level, thereby making herself more approachable, visible and often helps solve problems before staff even realise there are problems!"

It is likely that many of the dimensions of Health Social Workers' actions and behaviours described in relationship to the provision of a dependable service were likely to have been impacted by having an adequate staff resource to deploy; however it was beyond the scope of this research to establish this with any certainty. As has been a frequent pattern in the findings the next set of practice dimensions were found to be multilayered, with professional, personal and organisation elements all contributing to the descriptions of an effective Health Social Worker.

The well-organised, proactive and flexible Health Social Worker

It was recognised that in the acute environment there appeared to be a consistent requirement for practitioners to have the *ability to manage competing demands and stress*; *prioritise workloads*; *apply time management skills* and *work systematically.* While some postings (N=14) relied directly on language such as *organised* and *organisation* others were able to articulate some appreciation of the contextual variables, and challenges inherent in these. By way of example this participant invited us to *adapt to changes in the work conditions and effectively prioritise workloads* while another suggests that Health Social Workers are: "realistic about what can and can't be fixed within the acute clinical setting and prioritise the essential problems. Within the Emergency Department setting you will often be required to down tools from the current matter in hand to work with families undergoing extreme trauma in their lives often with no information about the family or patient." Referring to the challenge associated with prioritising tasks in the acute environment this person proposed that *the ability to see the bigger picture, e.g. when to pass a task to community or when it is unsafe to discharge a patient* is a helpful approach.

The capacity to be proactive in the acute environment, as identified in the case study findings, has been affirmed by the survey findings. Seventy percent of responses (N=188) have rated the capacity to be proactive about identifying patients who may need health social work services as extremely important or very important. This quantitative finding is reinforced by considerable qualitative comments that related to proactive behaviour generally, and specifically in relation to what is described in the literature as *case finding*. While Women's Health postings tended to be quite generic, such as *willing*; *helpful*; *committed*; *conscientious* and *involved* descriptions of proactive behaviour from other areas of the hospital were more comprehensive.

This first word response from Paediatrics appreciates the Health Social Worker who *goes looking for the work and is aware of the cases that need social work input – does not rely just on referrals*. Another values the practitioner that was "volunteering to see patients, not waiting for a formal referral – this can be done at multidisciplinary team meeting, handovers or with the Charge Nurse". Yet another suggests *attending multidisciplinary team meetings and handovers and offering social work input* as a way of being proactive.

In Adult Services being *proactive about identifying need* was also valued as was the *ability to keep their eyes and ears open to the environment.* In Women's Health two participants out of 25 posted comments indicating that they thought "staff on the ward generally identified the women needing social work services appropriately… I don't think the Social Worker needs to actively seek referrals". Expressing a similar sentiment this Midwife said, "I don't believe it's up to the Social Workers to identify who would benefit from their input, [rather] may have criteria for referral that is flexible." Apart from this comment, no other data indicates there was support for a heavy reliance on formal procedures such as referral criteria.

Providing us with some insight regarding why formal processes in isolation may not serve the profession or the patients well in the medical environment this Senior Physiotherapist working in Adult Services explained. "It is often difficult for non-social work clinicians to identify social issues with patients and therefore clinicians may not liaise with social work adequately. The most effective Social Workers are proactive on the ward in identifying patients with social needs (i.e. do not necessarily wait for other clinicians to trigger referrals) and attend regular case conferencing where many of these issues will be raised."

This position is supported by a Charge Nurse in the Paediatric context. "An effective ward Social Worker is one who has her 'finger on the pulse'. She is constantly dealing with issues as they arise as well as following up with issues that are in the process of being dealt with, she reacts to her observations and instincts and in doing so works holistically and with the team." Excluding the two postings from Women's Health reported above, a broad consensus was expressed about Health Social Workers engaging in proactive activities that help them identify patients that may benefit from our input. While this needs to be achieved in close consultation with our medical colleagues, too heavy a reliance on waiting for referrals does not appear to be an effective way of identifying patients with social needs.

This leads into the dimension of practice described by many as flexibility. The capacity to be flexible was relied on frequently by some participants with 17 direct references to it. It was often coupled with other abilities such as *the ability to flex when required*, or *flexibility in clinical situations*. The concept of *thinking outside the square, flexibility and*

adaptability were mentioned, as was the capacity to *be flexible and innovative by offering different ideas*. Lastly the capacity to demonstrate *flexibility by providing alternatives*, and *being open to other ways of working* featured.

Three dimensions of practice identified as critical in the case study findings have not achieved the 60 percent threshold. These include attending the weekly multidisciplinary team meeting, teaching members of the team about the social work role, and attending nursing handover. Despite the centrality of these activities to the case study findings, and the strong part they played in the provision of dependable service participants in the survey did not rate them as very important. This may mean they did not make the connection between these activities, and the ones they clearly do highly value, such as being accessible and proactive. This will be explored in more detail in the discussion.

Provision of a timely, responsive and reliable service

Four dimensions of practice directly associated with the provision of a timely and reliable service are reported in Tables 9, 10 and 11 above and include elements described as: provide a timely response; timely assessment; reliable and responsive. All of these dimensions achieved an extremely high rating. Being reliable was rated by 98 percent of participants (N=150) who completed the question as highly valued or very valued. The rating for reliability was the highest rated dimension of practice in the *entire* survey. Ninety-two percent of participants (N=150) rated responsiveness as highly valued or very valued. Also achieving a high rating value was the ability to provide a timely response with 88.5 percent of participants (N=183) rating it as extremely important or very important. Following a report on these first three dimensions of practice, timely assessment will be outlined. These four dimensions of practice were also ranked either first, second or third in order of importance, leaving us in no doubt as to their fundamental value and importance in the delivery of an effective service in this context. These findings clearly reinforce and extend the case study findings.

General descriptions of timeliness and reliability will be explored next, prior to a more direct focus on timeliness in relation to assessment. A number (N=30) of individual references were made by survey participants regarding the importance of a timely and

responsive service from Health Social Workers. A sample of first word responses from across the three service areas attests to the consistent value placed on this dimension of practice by contributors across the disciplines. This response from Adult services describes the effective Health Social Worker as *a person who is available to respond to a referral of a patient who requires input from a Social Worker within 24 hours* and this posting from Women's Health echoes this: *a person who is able to come and see the client the same day as the referral*. Completing the trio, the contribution from Paediatrics asks for *a timely response, able to make immediate decisions*.

A Doctor in Adult Services tells us how important reliability was to them: "[r]eliability is extremely important. I've worked with some Social Workers who promise a lot, but don't deliver. Overall, however, most have been extremely good and dedicated." Others also described the value of *getting through the work load in a timely manner* and providing a *prompt response*. Timeliness also featured as a way of *avoiding duplication*, while someone in Adult Services links it with efficiency by explaining what it means to them: *efficiency, getting the job done with the minimum of fuss in a timely manner*.

A vast number of qualitative comments were posted which relied on language associated with the provision of a timely, responsive, effective, efficient *and* reliable service. These comments reinforce and extend both the quantitative findings reported above, and the case study findings which had at their very core, the value of Health Social Workers being able to solve problems, efficiently and effectively. Whilst a number of references to these elements contributing to the provision of a dependable service were generic in nature, many participants linked these to assessment, intervention and timely discharge.

Once again relying on participant quotations and comments which are able to illustrate the dominant themes, these dimensions of practice will be explored in order to articulate and demonstrate how the participants described the provision of a dependable service in relation to clinical practice. While the previous data were able to provide a solid foundation for the following section of findings, an exploration of *how* the dependable service is applied and described in relation to core health social work activity is also of value. Activities such as assessment, intervention planning and working towards a safe and timely discharge will be

explored relying on both the quantitative data in Table 11 and the qualitative data posted by survey participants.

Assessment, intervention and activity to support a safe and timely discharge

As reported in Table 11 above the ability to provide a timely assessment was ranked the highest in the set of practice activities associated with Health Social Workers clinical practice. It was also rated in terms of its value by 94.5 percent of participants (N=162) as highly valued or very valued. These ranking and rating scores add significant weight to the fundamental importance of the provision of a *dependable service* as described above and makes an explicit link between timeliness and clinical practice. The top four items in this set have all exceeded the 60 percent threshold rating, indicating that they are all important aspects of the provision of effective practice in the hospital context. Notable in this data set is the finding that maintaining a focus on a safe and timely discharge has just exceeded the rating threshold, and is ranked fourth out of the five dimensions. Reflecting the lack of focus on reducing the likelihood of readmission in the earlier case study findings, when checked across the three service domains this dimension of practice did not reach the 60 percent rating threshold. This indicates it is either not a well-understood, well-developed or not a highly valued dimension of effective health social work practice.

The combined qualitative survey data has revealed that Health Social Workers benefit from having a substantial amount of what I have chosen to describe as clinical competence. This competence is likely to support our ability to make the *contextually informed and relevant* professional contributions that have been described by participants as important dimensions of effective practice in this environment. Four interconnected dominant themes emerged from the data. We needed to know about specific medical conditions, the disease processes and *how* these impacted on the patient and their family. Secondly, it appears to be beneficial if Health Social Workers understand the service area and the unique demands associated with it, which included our ability to keep up with and contribute to organisational innovations such as the recently introduced *rapid round* in Adult services. Once we understand the nature and extent of these variables and the challenges they present to patients, families *and* the organisation we need to be able to act, the third theme. This

action is oriented towards the fourth theme which has been described previously as the ability to reliably help to solve complex social problems for patients and their families.

These four dimensions of practice will be explored in the following section of findings in the context of assessment and intervention, including their relationship with the contribution Health Social Workers were reported to be making to the safe and timely discharge of patients. The fourth theme that was identified in the analysis was the need to be familiar with ward dynamics and the roles and responsibilities of each discipline.

The findings suggest that Health Social Workers need more than a cursory understanding of the clinical environment. Analysis indicated that a sound degree of knowledge about the health condition a patient is experiencing and its consequences for the patient and family was a crucial skill. Comments such as Health Social Workers having *a realistic understanding of patient progress*; *an understanding of the disease process that the patient is experiencing* and an *understanding of current trends and health issues* provides some indication as to the depth and breadth of knowledge that may be required. To support the development of this knowledge Health Social Workers are asked to *demonstrate an active interest in the wards specific population* (Adult Service); be able to show *insight into how the health issues of children affect the psychosocial wellbeing of families and children* and to *adjust to the health care setting, [understanding] that it is a different environment from for example, Child Youth and Family.* This notion of adjustment, or successful adaptation to the host environment as I have described it, will be explored in the discussion chapter, particularly in relation to how health social work leadership may engage in activities which more purposefully support it.

This clinical knowledge extended to the ability to *articulate the families' perspective regarding how they understand their child's condition*, and from Adult Health having a *knowledge of medical conditions and what this means for the patient*. This data supports the case study findings regarding the value of the Health Social Worker engaging in proactive activities which helped ensure she was familiar with medical language, conditions and terminology. It also offers a critical link with the issues associated with Health Social

Workers providing competent cultural and medical advocacy to support patients and their families understanding of medical conditions as reported earlier in the chapter.

Being able to adjust our assessment process and framework to take into account the clinical circumstances is also encouraged as explained here: “the area you work in will dictate the type of assessment you do, such as Emergency Department patients as opposed to long-term chronic illness wards.” Two experienced Health Social Workers contributed insightful comments in relation to the effective application of this medical knowledge. The first one illustrates how “an understanding of the medical conditions that frequently come to your work area allows the Social Worker to identify which patients would benefit from Social Work”. This posting from a Health Social Worker practicing in a Medical Specialties ward in Starship Children’s Hospital has put it all together by explaining the linkage between clinical knowledge and overall service delivery. “The Ward Social Worker needs to have an understanding of the type of conditions and treatments the children on their Ward are admitted for. The severity of the condition, the outcome of treatment, the long-term prognosis, the treatment plan, and level of care required at home – all impact on the child and the family. If the Social Worker has this knowledge they can assess the level of stress the family will be under, the supports they may need, and what type of discharge planning is required.”

Reinforcing this link between the nature of the diagnosis and its social significance this Nurse with 40 years of practice knowledge behind her made this point: “it is important that with a chronic illness, the Social Worker makes an effort to understand the social significance around the diagnosis.” This Nurse from Adult Services also wanted Health Social Workers to *think about the wider implications of social situations such as that of [a families] ongoing adherence and long term engagement post transplant* while this staff member from the Emergency Department asked that we are able to *connect and communicate difficult concepts in a crisis situation*. As a final reinforcement of the need to *understand* in order to manage the complexity inherent in this environment this participant made the following request: *an ability to grasp the complexity of the problem and understand it not just manage it.*

Clearly the value of the theoretical framework of the biopsychosocial model as articulated in chapter three and its considered application in the hospital context has been confirmed. By accepting the apparent consensus that an important competence which underpins the provision of effective health social work practice is a robust understanding of the medical condition, an ability to articulate it and engage in assessment and discharge planning that takes them into account consideration must be given to *how* health Social Workers acquire this knowledge.

Context specific needs

The importance of having a well-developed understanding of the specific ward or clinical area the practitioner was servicing, for example, the Emergency Department, also emerged as a key finding. Once again participants made clear the value of staff being able to apply this knowledge in order to provide an effective service. This posting described the need to *understand how the Emergency Department functions and the need to assess patients and families sooner than might be necessary in a ward setting.* Another expressed the desire for staff to *understand hospital constraints [which include] patient flow and issues with capacity.* This participant from the Children's Emergency Department (CED) also highlighted issues associated with service delivery by stating that "understanding the changing dynamics and needs of a service [is important] for example 24/7 service delivery in CED". Once again this finding is congruent with the case study finding and raises questions about how practitioners are supported to remain flexible and adaptive in an ever changing environment.

Context specific processes

Participants also described a number of different multidisciplinary team meetings and discharge planning activities which have been designed to enable team members to work collaboratively to respond effectively to patient needs. If done well, this activity facilitates appropriate care oriented towards a safe and timely discharge. Data indicated that twice weekly discharge planning meetings; rapid rounds; weekly multidisciplinary meetings and white-board rounds are just some of the ward or department processes that are currently occurring in the hospital. The Health Social Workers' capacity to prioritise attendance at these meetings and make an active contribution to them was identified as an important dimension of effective practice. "Currently with the use of Rapid Rounds (where MDT

meet with Charge Nurse Manager for 15 minutes to run through ward needs and discharge planning) this benefits both patients and Social Workers by providing a brief overview of patient discharge planning needs – the Social Worker is able to facilitate smooth discharge where increased level of care or care package on discharge is required in a time efficient manner thus benefiting the patient."

Focus on discharge

Three themes emerged in relation to the Health Social Workers contribution to patient discharge. These included the ability to help people return to their communities by ensuring our gaze extended beyond the hospital walls; to work in consultation with patients, their families and the team to solve the complex problems that can be associated with a safe discharge and to engage in proactive activities throughout the duration of the admission to ensure this occurs *swiftly.* The findings leave us in no doubt that Health Social Workers do have a vital part to play in the safe and timely discharge of patients, but it is not our *only* focus which is sometimes feared by the profession.

The capacity to see beyond the hospital walls was expressed in two ways: firstly, the task for Health Social Workers was described as "a person who is there to help sort out a client's social issues, especially from the point of view when they will be discharged back into the community". It was emphasised that this included the ability to engage in activities which *enable the patient to function in society* and *return to their community*; secondly, it became apparent that practitioners needed a good knowledge of, and sound network with, community services and agencies. For example, it is *important that the community branch is not forgotten*; *cultivate contacts in the community*; *handover care to the community* and *understand the community aspects of discharge.* Clearly the need for a robust understanding of community resources and alternative discharge destinations was an important dimension of effective practice, particularly in the Adult context.

What was described as a *smooth discharge of patient* is supported *where the Social Worker has worked alongside nursing staff to facilitate safe discharge.* Reinforcing the elements of working in consultation this participant includes the value of working with patients and their families by explaining her need for an "excellent communicator who works well with

patients, their family and other members of the health professional team to assist in good care and discharge planning". The value of communication with the team was also evident in this comment from a participant in Adult Services who expressed the value of *talking to the in-charge nurse and talking to other MDT team members who are involved in patient discharge*.

There appeared to be an understanding on the part of our medical colleagues that the challenges associated with the task of supporting a safe and timely discharge were substantial; it was also clear that the effective Health Social Workers were able to overcome these challenges. This first word posting from Adults Services tells us she needs a practitioner, who is, "skilled at assessing patients' needs both in hospital and community, working to help problem solve an ever growing number of social and physical needs of both inpatients and those with imminent discharge".

An Emergency Department Charge Nurse explains "knowledge of alternative discharge destinations and contacts to send referrals for homeless or 'unsafe to return home' situations is also valuable to me". Further signs of the challenges associated with some discharges was evident by the need for a *plan B for those at risk of a failed discharge* and "Social Workers must be able to think outside the square sometimes! Problem solving in order to respond to delays to discharge."

The ability to work under pressure to discharge patients when wards are busy was described by one participant as an important skill, particularly in the Adult Service where most direct references to discharge activity were made. The need to identify *barriers to discharge* and *facilitate swift discharge* was a common theme and participants were clear that this relied on the "identification of issues a patient may have in their non-hospital environment (usually at home) and addressing those issues together with the patient to help their optimal functioning in the community".

The provision of clear intervention planning has attracted an extremely important or very important rating by 83 percent of the 160 participants who completed this question. Qualitative responses were largely related to discharge planning. There was a clear

connection made by a number of participants between effective discharges and early planning; this included the capacity to arrange family meetings in a timely way. The capacity to *provide well-planned (in advance) discharge plans* which were able to support a *smooth discharge* was a key feature of the data. Making the connection between the phases of Health Social Work practice this contributor explained that “their input into safe discharge is valued and timely assessment and intervention planning assists this”.

A number of other skills were highlighted by participants that rightfully belong in the findings associated with assessment, intervention and discharge planning. The ability to *organise and facilitate discharge meetings* was recognised as an important skill. An understanding of the law was mentioned by a number of participants, as was the ability to work in a way that helps to resolve conflict.

Psychosocial assessment

Explored above in relation to the provision of a dependable service there is little doubt that there was high value placed on a timely assessment occurring. Adding further reinforcement to the value of assessment, having an accessible record of the assessment was rated as extremely important or very important by 73 percent of participants (N=160) (see Table 11). Ten participants across all services made various comments associated with clinical documentation. These included a need for *good documentation skills*; *legible handwriting and contact details*; *report writing skills*; *written literacy* and *the ability to obtain and summarise appropriate information.*

Whilst there is clear quantitative endorsement of the value of assessment only three specific comments were posted by survey participants that made a direct reference to psychosocial assessment all of which were posted by Health Social Workers. Being *knowledgeable about psychosocial practice* and being “a responsible individual who is able to act as an advocate for the patient and provide advice and support with psycho social situations which arise as a result of their illness” are examples of these comments. One of the Social Work Practice Supervisors made this contribution in relation to assessment. “Using a framework makes the assessment record clear and gives our multidisciplinary colleagues a clear understanding of what the work is, that Social Workers do.”

Given the absence of direct references to the social work assessment process she may well be right. Overall this is an interesting finding and may reflect a lack of understanding by our medical colleagues regarding the professional frameworks and specific activities Health Social Workers rely on to help inform our interventions. It may also reflect the very recent introduction of a standard biopsychosocial assessment template.

Nine comments overall, a sample of which is set out below, provide evidence of the expectation once again, that the Health Social Worker is able to *solve problems* and *look after the social issues*. "A Social Worker in the hospital setting is someone who will help the family deal with all the issues that are creating problems for them around the admission and diagnosis." One participant shared how she thought this should be achieved by explaining the various steps in the assessment process. "Contacts the Charge Nurse, nurse in charge of the patient and collates information from them about the patient and family concerns, reads the notes, talks to the family after obtaining permission and ensures they are well supported and the social issues are looked after."

The capacity to make the important link between the medical issues and the social ones is one of the key dimensions of the provision of effective practice and is consistently described albeit relying on what may be considered lay persons' language. By way of example this participant values the Health Social Workers' "ability to think about the wider implications of social situations such as that of ongoing adherence and engagement post transplant for the long term". This brings us to the last dimension of practice to be reported in these findings. Appropriately, ending with a fundamentally important area of skill and competence in acute hospital Health Social Work practice, the discussion moves to the ability to work with and communicate with the team.

7. Team work and communication

Introducing the data

The data reported in this section of findings originates from the quantitative survey questions regarding team work and the qualitative postings scattered throughout the survey. Four themes were identified and have been explored and expanded, relying on participant

quotations and comments, as in the previous sections. The themes include being a team player, team relationships, communication with the team, and general communication competence.

Table 12: Dimensions of practice – Team work

Ranking	Importance Rating Top two percent
1. Ability to develop and maintain MDT relationships	82.1
2. Being a team player	79.6
3. Being available to talk things over	69.8
4. Capacity to 'deb rief' MDT m embers after challenging events	42.0
5. Being loyal to the ward	20.4

The ability to work in a team and develop excellent team relationships

Reported in Table 12 above, the ability to develop and maintain relationships with the multidisciplinary team has been ranked the highest in this set of practice dimensions. Just over eighty two percent of participants (N=163) who completed this question rated this skill as extremely important or very important. Being a team player attracted an extremely important or very important rating from 79.6 percent of participants (N=163). Clearly these findings reinforce the value of team work, and the ability to develop and maintain team relationships as a core dimension of effective health social work practice. This has been further reinforced by the volume of qualitative comments made in relation to these skills.

Described as *crucial* and *essential*, the capacity to *develop strong professional relationships with colleagues*; to maintain a *respectful and sensitive approach to colleagues*; *to establish excellent relationships with the multidisciplinary team*, and *have a good understanding of the ward dynamics, with knowledge of each individual staff member*, was well described as a core dimension of effective health social work practice. Having *a good rapport with all the staff including the ancillary staff* was also emphasised, as was the capacity to *get to know* and *listen to other workers*. The capacity to *spend time with staff as colleagues*, and *be there personally and in confidence* was also described.

In general terms the ability to work effectively in a team was described by over 50 participants as *being a team player*; *team member*; *collaborative*; *works as part of a team*; *inclusive of the multidisciplinary team* and *works well in a team.* The capacity to *integrate well within an interdisciplinary team*, to *respect roles and boundaries* and to *engage with other team members, for the benefit of patients and their family* was the essential element of this dimension of practice.

Keeping the patient in the centre of team work was evident in a number of postings across the service areas; in such a way that I was left feeling that patients and family members were often almost considered as part of the team. For example, this participant from Women's Health describes a Health Social Worker who is *inclusive of the multidisciplinary team and whanau*, while this person from Adult Services describes someone who is "able to offer support to both their patients and staff, to be a resource person for staff if they are finding a patient situation challenging". From Paediatrics being a "team member, working for the benefit of patient and family as well as realising the importance of supporting team recommendations and the treatments of the Doctors" was outlined as important.

The importance of working in consultation with others was evident in the findings and this was particularly important in Women's Health. For example this Midwife tells us that "it is important that decisions are not based solely on what the Social Worker thinks" while another emphasises that "plans need to be formulated in partnership with the whole team and in particular, the client. Information sharing is the key to accurate assessments". A further posting from Women's Health leaves us in no doubt that working in isolation was out of the question: "really important that they listen and communicate with the whole team. Often care and protection issues are very complicated and needs the whole multidisciplinary team input."

The capacity to *listen to various professional opinions* and *have confident interpersonal skills with other team members* was also a feature of the data. In Adult Services someone described this as "someone who plays well with others; that is, the work is about the patients not about their views of what the patient should get or need". A common theme

throughout the study has been the Health Social Worker's ability to be an effective conduit between patient, family and team. Here it has been described in Adult Services as someone who is "able to communicate with family and patients –firstly to respond to their needs and to also contribute back to the patients plan in a way that informs the team of the patient and family needs".

This first word contribution, again from Adult Services, poignantly describes the essence of the Health Social Workers need to be an integral part of the multidisciplinary team. "The Social Workers contribution is unique and is an important perspective. To belong to the multidisciplinary team – be part of the team, be seen as a member of the team, a colleague who brings skills, expertise and has a working relationship with other team members." This impact that effective team work has on patient and family care was a consistent theme and it is appropriate that this section of findings ends with a posting from Paediatrics which once again encourages us to *work with other staff to enhance the patient and family experience of a hospital setting*.

Communication

Supporting the case study findings over 60 references were made in the survey related to the practice dimension of communication. These included references to written and verbal communication skills which were applied with the team, patients and their families. Once again it was evident that average or basic skills were not what were being described; rather, exceptionally well-developed communication skills were wanted in this context. To articulate this level of ability participants relied on phrases such as, *a clear effective communicator*; *excellent communication skills*; *highly honed communication skills*; *articulate, concise* and *coherent communication and strong written skills.*

A number of participants also described how these skills would be applied, for example, *provides prompt feedback*; *a good communicator....who can outline what they do so others know what this is* and *someone who has the ability to accurately and effectively communicate back to the client.* A willingness to communicate the mundane, such as *when we are not going to be available* through to the essential such as communicating the needs of a patient back to staff was at the core of this data.

The ability to apply these skills with *all involved, patients, patient's family, nursing, medical and allied health staff was important.* This included activities such as *keeping everyone in the loop*; *keeping in touch with other relevant health professionals*; *having the right information to give families*; *being discerning about how to frame questions to suit the situation* and someone who *has the ability to connect and communicate difficult concepts in a crisis situation.*

The Health Social Worker – the communication pathway between patient, family and team

The capacity *to relate well to a wide variety of people,* the *ability to speak to people from various backgrounds* and be *able to act as a 'go-between' for therapists, families and patients* was at the centre of participants' accounts of effective communication in this context. Described by one participant as someone who is *able to convey information between families and Doctors and Nurses, including organising meetings,* was clearly valued. This particular dimension of practice that the effective Health Social Worker undertook seemed to encompass the ability to provide a communication pathway between key players. This was consistently described as a fundamental skill that was employed in the provision of all key areas of advocacy and support. The consistency of this theme across all service areas, and all key domains of practice demonstrated just how valued this ability was in a highly complex organisation such as the hospital. This first word contribution summed up this role thoroughly. "An effective link between the patient and their family/whanau, the medical staff and the non-hospital groups, organisations and anything/anyone else that may be needed in order to allow the patient to achieve the best possible outcome for discharge from hospital plus during their stay in hospital." The contribution this level of communication plays in improving patient outcomes is evident in this posting, again from an Adult Service participant "someone who helps ensure the best possible outcomes for patients by acting as an effective liaison person between clinical staff and patients/families in both the hospital and home environment'.

Revision of quantitative data

A revision of the quantitative data reported in this survey findings chapter has been provided below. Whilst eight tables of data were reported in the chapter, a further process of data synthesizes, regrouping and interpretation has occurred during the combined analysis process. As was described in this chapter it was recognised that some of the dimensions of practice were more reliably made sense of in relation to similar or congruent dimensions of practice and for this reason they have been reported together below. This further attempt at developing the correspondence between the dimensions has resulted in the dimensions of practice associated with relationship-based practice and teamwork and communication being combined and reported together. The dimensions of practice ranked the highest in each survey cluster have been identified via the use of italics.

Outcome of ranking and rating the dimensions of effective health social work practice

1. Responding to vulnerability and risk
Identify and assess child protection concerns 92 percent

Assess and respond to family violence concerns 87.5 percent

Assist with the management of child protection and family violence concerns over time 80.7 percent

Maintain constructive working relationships with family members in child protection and family violence situations 80.4 percent

2. Relationships-based practice

Developing rapport and engaging people 89.9 percent

Listening skills 89.4 percent

Non-judgmental 88.7 percent

Helping to manage complex situation on the ward 73.8 percent

Stable centered demeanour 73.1 percent

The ability to adjust communication style 72.7 percent

The ability to work with people from different backgrounds 71.8 percent

Having a good sense of humour 39.4 percent

3. Provision of cultural advocacy and support

Assess and respond to specific cultural needs in order to assist patient and family engagement 84.2 percent

Facilitate effective family meetings across a range of cultures 79.4 percent

Identify cultural support for patient and/or family members 83.2 percent

Working effectively with an interpreter 53.8 percent

Assisting a patient to understand the medical condition and its consequences 46.4 percent

Supporting cultural competence in the wider multidisciplinary team 32.4 percent

4. Working the ward – dependable service delivery

Be highly visible and accessible 79.3 percent

Approachable 92. 0 percent

Reliable 98.0 percent

Responsive 92.7 percent

Provide a timely response 88.5 percent

Be proactive about identifying patients who may need social work services 69.8 percent

Timely assessment 94.5 percent

Clear intervention planning 83.2 percent

Accessible record of the assessment 73.2 percent

Focus on safe and timely discharge 63.2 percent

Team relationships, team work and communication

Ability to develop and maintain multidisciplinary team relationships 82.1 percent

Being a team player 79.6 percent

Being available to talk things over 69.8 percent

Open 78.3 percent

Honest/challenging and upfront 72.3 percent

Diplomatic 74.7 percent

Having spent this chapter examining all the data, and engaging in an activity which once again relies on Stake's (1995) description of correspondence the combined quantitative and quantitative data has been reported in Appendix 10. This appendix is intended to be used as a resource which will sits alongside the operational definitions, and the intervention plan intended to support their implementation, which will be described in this final chapter of my thesis.

Conclusion

Undertaking the case study enabled multiple stakeholders to provide a series of fine-grained accounts regarding what they believed constituted effective health social work practice in the Paediatric context. Alongside these accounts non-participant observations occurred, clinical records were examined and a comparison of the findings with key health social work literature was undertaken. Fourteen domains of practice were identified via thematic analysis of this case study data. Four of these domains, namely the provision of health social work advocacy and support regarding social, medical, cultural and emotional support were carried forward into the survey as open ended questions. This choice was made to capture the similarities and differences associated with these domains of practice across the three service areas.

The eight clusters of practice which were tested via the quantitative survey questions were assessed as being amenable to reduction to a one sentence description, (i.e. the ability to adjust communication style) and to be grouped into a series of related practice dimensions. This included sets of skills, such as listening and developing rapport; characteristics, such as having a good sense of humour and a stable centered demeanor; professional activities such as attending nursing handover and the weekly MDT and competencies such as working effectively with an interpreter and identifying cultural support for a family.

Data regarding the dimensions of practice involving cultural competence and skills were tested via a quantitative field and expanded via an open ended question. This reflects the centrality of this set of skills, evident in the initial data. Data associated with the ability to respond to vulnerability and risk were also accessed in two ways, a quantitative question reserved for stakeholders who work primarily with women and children which was based on case study data and an open-ended question which was intended to capture data regarding this domain of practice from adult services. This was an important opportunity to hear from these stakeholders about their specific needs in an area of practice that increasing requires Health Social Workers' input.

While clearly there were a number of limitations in the study which will be described in the conclusion, collectively the mixed method data collection methods have provided sound information. This information has enabled me to reach an operational definition of the dimensions of effective health social work practice in an acute hospital context, within the confines of the multidisciplinary team. These operational definitions, the finer details of the practice which brings them to life in the clinical setting and the interventions designed to support their increased uptake have been discussed in my conclusion, and documented in Appendix 10. As described previously the combined data has undergone a continual process of iterative development and sense making. It has being refined, expanded, unpacked, added to, distilled and articulated according to the patterns of correspondence which were established during this process.

Ten dimensions of practice identified as central to the provision of effective practice via the case study, when checked via the survey did not reach the 60 percent threshold. Five of these dimensions did feature significantly in the qualitative survey data and on that basis appeared to be in conflict with the quantitative data. This apparent conflict between the data and its possible meaning and consequences will be explored in some detail in the discussion chapter to follow.

Chapter 7: Discussion

Introduction

The primary aims of this study were threefold and, reflecting the sequential nature of the study, each aim is built on the foundation of the previous one having been achieved. Firstly I asked the question 'How are the dimensions of effective health social work practice demonstrated and described within the multidisciplinary team, in an acute hospital setting in Aotearoa?' The aim here was to identify what Plath refers to as "… the most appropriate practice in particular circumstances" (Plath, 2006, p. 68). The data to emerge in response to this first question will enable me to develop an operational definition of the dimensions of effective practice drawn from the perspectives of a range of key stakeholders who construct what constitutes effective practice within this specific context. Achieving this task will then allow me to fulfil the final goal of the study, to design an intervention which supports health social work leaders to purposefully increase the provision of effective practice.

These final two aims of the study are reported in Appendix ten and eleven and reflect the iterative process inherent in this design. The choice to report them last is indicative of the need to make final sense of all the findings via this discussion and the concluding chapter, articulating why the choice has been made to include and exclude particular dimensions of effective practice from the final outcome of this research.

A key step in this inquiry has been making decisions about the aims of the research and which research methods to employ; ultimately what won out were those that have been assessed as being most able to meet the aims of the research. A number of factors were taken into account when making these decisions, many of which have been traversed in the previous chapters of my thesis. At the end of the reading, reflecting and discussion with my research supervisors' choices about the research goals and methods were made which have inevitably influenced the outcome of the research. Therefore in an effort to maintain the reflexive approach committed to, this discussion about my research findings begins with a revision the influential messages from the literature, and how these messages have informed the questions, the methodology and the outcomes of this study.

The findings regarding the dimensions of practice associated with our capacity to respond effectively to vulnerability and risk will be explored in the second part of the discussion. This offers an opportunity to expose and describe a number of significant tensions which emerged from the findings, particularly as they relate to the apparent lack of connection between current policy guidelines and the practice itself. A specific critique of positivism and its application to practice via narrowly focused practice guides, described by some as 'proceduralism' is also taken up. Whilst this part of the discussion occurs in the context of interpersonal family violence practice, given much of the findings focus on relationship-based practice (Ruch, Turney, & Ward, 2010), this part of the discussion can readily be generalised to all the domains of practice.

The third part of the discussion provides an opportunity to explore other significant issues to emerge from the findings and makes important links with both the empirical and the health social work literature. As the findings have been reported in some detail in chapters five and six of my thesis, only the results that highlight significant friction between the qualitative and quantitative data will be discussed in detail. A connection is established between the concept of the host environment and a number of the key dimensions of practice identified as central to the provision of effective practice.

In light of this connection having been made the fourth part of the discussion includes an effort at theory building. Here an argument is presented that suggests a successful adaptation to the host environment on the part of the health social worker may well provide a critical foundation to the provision of effective practice, almost if you like, a prerequisite. Following this a concise comparison of the broad findings in relation to what the health social work literature suggests are critical components of practice in the hospital is examined. The last part of the discussion, also brief, makes a connection between the findings of the research and the definition of social work from the International Federation of Social Workers. Headings will be used to help orient the reader to the findings under discussion.

Throughout the discussion Shaw's (1999) broad-stream and narrow-stream approach to evidence-based practice provides a useful framework in which to explore both the findings, the operational definitions to emerge from them, and the final aim of the study, the intervention which seeks to support their organisational implementation. These last two elements will be discussed in the concluding chapter. Because of the substantial influence of this metaphor throughout the discussion, a revision of it is worthwhile.

Shaw's analysis protects us from engaging with the potential binary of the value of evidence over the value of practice wisdom to help us understand the various manifestations of evidence-based practice. He suggests that the broad-stream version is primarily practice driven, as in this study, and maintains a focus on accountability, partnerships between practitioners and researchers, and a broad obligation to base practice decisions in evidence (Shaw, 1999). Included in the broad-stream approach to evidence-based practice is a fundamental understanding that this approach requires a partnership between the organisation, the profession and the practitioner primarily associated with an ease of access to appropriate evidence and a focus on outcome issues in practice. A combined emphasis on incremental and achievable practice development is also maintained. According to Shaw these commitments are taken up by the majority of educators associated with social work in the United Kingdom, the United States, and Australia (1999). I subscribe to this approach to evidence-based practice.

Alternatively Shaw describes how the narrow-stream variety of evidence-based practice has been primarily driven by academia, and maintains a powerful association with the empirical practice movement originating in the USA. Engaging in a more confined use of the term evidence-based practice, these commentators take up many of the aspects of the broader stream, but are also strident supporters of particular interventions. They support those based on behavioural and cognitive theories, particularly those that have been demonstrated to be effective via the application of experimental and quasi-experimental research methodologies (Shaw, 1999). (See for example(Reid & Fortune, 2003) cited in chapter two). These expectations tend to manifest in practice via the use of practice guides, to ensure strict replication of the intervention.

Influential messages from the literature

It is fitting perhaps that the first influential concept has its origins in one of the earliest effectiveness reviews undertaken almost 40 years ago. Fischer (1973) proposed that a commitment to competence is at the core of professional practice, and that central to this is the ability to provide an effective service. Gould and Baldwin (2006) maintain that expertise, and therefore competence is best able to be demonstrated and communicated through the practice itself. Connected to the value of the practice itself being examined in order to identify competence Ferguson invites us to "focus on the actual critical practices that are 'best'" (Ferguson 2003, p.1005). Collectively then, the influence of these ideas is a very clear and direct focus in the research attempting to understanding the "challenging complexity of every day social work" (Gibbs, 2001, p.700), and how practitioner competence, expertise and the critical practices that are 'best', were described and communicated via the practice itself.

These descriptions were accessed via non-participant observations, analysis of clinical records and in-depth interviews with key stakeholders. This made up the first phase of data collection, the outcomes of which are reported in the case study findings in chapter five of this thesis. These core dimensions of practice were synthesised, comparisons were made with the health social work literature and a series of 45 elements of practice were then tested and expanded via an online survey. Forty of these were tested via quantitative methods, and a further five were inquired about via qualitative questions, which aimed to expand my understanding of particular elements of effective practice, in a wider context. One hundred and ninety-one multidisciplinary stakeholders responded. This sequential mixed method design enabled the research question, 'How are the dimensions of effective health social work practice described and demonstrated within the multidisciplinary team, in an acute setting in Aotearoa?' to be answered.

The second set of influential ideas flow out of local and international health social work literature. From here a number of relatively consistent issues concerning the hospital as a practice context for social work came to light. Firstly, the notion that the context is a dynamic one, with the only certainty being that of consistent change (Cleak, 2002; Globerman, 1996, 1999; Pockett, 2003; Rock & Cooper, 2000; J. Sulman, et al., 2001). A

sense of professional vulnerability, and the trials the profession faces practising in what is described as a host setting also dominate (see for example Auslander, 2000, 2001; Mizrahi and Berger, 2005 and Neuman 2005). In response to these contextual challenges health social workers are invited to consider the organisational context when determining and demonstrating outcomes; define the health social work role; and consider the ways we can establish how we add value. Volland (1996) issues us with a clear challenge in relation to working effectively in the host setting. She invites us to take responsibility for finding ways of *effectively entering this environment* in order to work with the health team on behalf of patients and their families (1996).

By engaging in a research project which aimed to identify how key stakeholders described the contextually informed dimensions of effective practice one of my research goals was to respond to the invitation issued by the health social work authors referred to above. The results and benefits of taking up of this invitation are clear in the reported findings. Whilst these findings were never intended to focus on outcomes, inadvertently they have identified what it is that the organisation, represented by key stakeholders, require from health social workers, and therefore value as an outcome when their needs are met.

They also appear to have achieved a clear defining of the role, informed largely by the rich and often complex array of psychosocial concerns which emerge in this context. By providing effective responses to these concerns health social workers have been able to demonstrate our unique and important contribution, and therefore where we add value, in this particular practice environment. Nowhere was this more evident than in the practice domain of responding to vulnerability and risk associated with interpersonal family violence. An exploration of these changing demands, the skills required to meet these demands and the associated tensions provides the next section of the discussion.

Responding to vulnerability and risk

The hospital is a dynamic practice environment in which health social workers are required to respond to changing practice demands. This dynamic environment is evident in a recent adjustment of focus after the change of government in 2008, especially the Ministry of Health's (MOH) imperative to improve the cost effectiveness of health services. Part of this

strategy emphasises the need to ensure health professionals have the right knowledge and skills to enable us to do the right things, in the right order (Ministry of Health, 2010). Recognising that some of the policy was in place before the change of government, it is nevertheless valuable to consider these two variables in parallel, namely the changing nature of the organisation and ministry demands and the need for health social workers to have the right knowledge and skills. By doing so the challenges the profession faces in the hospital context become apparent.

One of the areas in which these rapidly changing demands are most evident is associated with interpersonal family violence. Prior to exploring these findings in relation to the wider literature it is important to provide some background to these changing demands. This background has been included after the literature review as a result of the finding that this domain of practice is foundational to the provision of effective health social work in a hospital.

This approach provides the reader with *one example* of the dynamic nature of the hospital environment, and how the methods relied on in this inquiry have been able to provide a faithful account of the knowledge and skills health social workers do require. A natural extension of these findings includes the organisational responsibilities associated with supporting the delivery of the effective service the organisation and the Ministry of Health are seeking.

Family violence has been recognised in Aotearoa to have a negative impact on the health and wellbeing of the populations experiencing it and is described "as a preventable public health problem" (Koziol-McLain, et al., 2009, p. 1). In light of this, the reduction of interpersonal violence has been identified as a key objective in the New Zealand Health Strategy (Glasgow & Fanslow, 2007). In an effort to help reduce the health impact of family violence the Ministry of Health has published two key guidelines to assist health professionals in the early identification, assessment and referral of those people identified to be experiencing family violence (Fanslow, 2002; Glasgow & Fanslow, 2007).

It is these guidelines that express the broad expectations of the Ministry of Health which each District Health Board is responsible for interpreting in order to develop organisational policy and practice guidelines. These finer detail guidelines describe the organisational expectations regarding practice. To date these are in place at Auckland District Health Board in relation to child abuse and neglect, and partner abuse; guidelines in respect of elder abuse and neglect are yet to be developed.
When the research findings associated with the dimensions of effective practice are considered in relation to the dynamic context, the Ministry of Health's desire for health social workers to have the right skills and knowledge, and organisational guidelines which signal what these right skills and knowledge are, a number of challenges and tensions emerge that warrant discussion. These challenges are compounded by an absence of context specific and local research to help guide our practice, the invisibility of the contribution of health social workers to interpersonal family violence practice in the medical literature and the process of policy and practice guide writing in the hospital and health social workers' participation in this. The culmination of these difficulties is organisational policy that is dominated by technocratic expectations of health social work practice, with a central focus on following the correct procedures. In light of these challenges the final point of discussion is a brief consideration of the organisational responsibilities concerning this domain of practice.

My inquiry confirms the fundamental importance of the health social workers' ability to respond effectively to patient and family vulnerability and risk. Most often this is associated with concerns such as child abuse, partner violence, elder abuse and neglect, and the neglect of children including medical neglect. Collectively these situations, which occur within the boundaries of the family, are referred to as interpersonal family violence.
The finding that these skills are critical to the provision of effective health social work practice is congruent with the clinical priorities study reported in chapter three of my thesis. In this section of the literature review authors identified that health social workers ranked the need to respond to high risk situations as the most important clinical priority in the hospital, driven by both legal and moral obligations (Giles, et al., 2007). Other authors cited such as Miller (2001) highlight the high volumes of cases involving child abuse and neglect in the paediatric environment.

It is significant that two articles published in Australia focused on defining the role of the hospital social worker (Davis, Baldry, et al., 2004; Davis, Milosevic, et al., 2004) make no reference to interpersonal family violence. A recent article focused on contemporary roles and professional activities of hospital social workers in America, whilst acknowledging we are often involved with high-risk groups also fails to describe our responsibilities in relation to interpersonal family violence (Judd & Sheffield, 2010).
In Beder's (2006) work devoted to hospital social work there is also a failure to describe the health social worker's role in this practice domain. Dziegielewski's (2004) work, also focused on health care social work does have a chapter on Shaken Baby Syndrome; there is minimal guidance regarding what health social workers are required to actually do to assist patients and their families. There is no attention paid in the text to partner abuse, and only one reference to elder abuse (Dziegielewski, 2004).

In the absence of health social work literature I am forced to turn to local literature published in Aotearoa by Doctors, particularly Dr Patrick Kelly who is known to work alongside health social workers (Kelly & Farrant, 2008; Kelly & Hayes, 2004; Kelly, MacCormick, & Strange, 2009). In Kelly's articles, despite one of them boasting a co-author who is a social worker (Kelly, et al., 2009), collectively these articles include one sentence regarding the role of health social workers. Kelly and his colleagues do acknowledge the lack of consistent psychosocial data available for research review in one of the studies (Kelly, et al., 2009).

Another local study is also worthy of some reflection given its primary focus on improving the detection and quality of child abuse and partner abuse in an Aotearoa Hospital. These authors, also our medical colleagues, focus on activity aimed to increase the identification of interpersonal family violence. Arguing strongly for the value of having the right people with the right skills this article fails to acknowledge or describe the role of health social workers, focusing primarily on the medical team's partnerships with community agencies when considering interventions (Wills, Ritchie, & Wilson, 2008). This invisibility is somewhat surprising and disappointing given the key role health social workers are found to be playing in this domain of practice, via this inquiry.

In response to the findings that this area of our practice is significant in the hospital I engaged in a further review of the social work literature, particularly as it related to health social work. One exception to this absence of literature focused on the health social work role in relation to interpersonal family violence is a local article published in 2009 and written by health social workers (Todman & Mulitalo-Lauta, 2009). Here the authors describe the introduction of a social work alert system for high risk patients, putting the contribution health social workers are able to make, at the very heart of this practice. Partially congruent with my findings these authors describe the role of health social workers being that of psychosocial assessment, planning referrals, safe discharge planning and liaison with government and non-government departments. There is no emphasis on relationship-based practice, and scant detail of the practice itself; this may be a result of this not being a research article.

A final article, exploring the knowledge, skills, values and beliefs health social workers require to respond to the ageing demographic, written by a local health social worker, makes no mention of the skills or competencies required to respond to elder abuse and neglect (Aldrich, 2010). No outcome studies or studies that defined the role of health social workers in this area of practice were located or cited in the literature review undertaken for my thesis. This confirms Judd and Sheffield's contention that "hospital social workers had not routinely produced evidence-based outcomes that substantiated social work roles and interventions within hospital settings" (Judd & Sheffield, 2010, p. 858).

The discovery of the invisibility of health social workers in the literature written by our local medical colleagues is also significant. It may provide confirmation of the contested professional ground inherent in a hospital context as described in chapter two of this thesis (Davis, Baldry, et al., 2004). It may also provide support for McMichael's (2000) contention that health social work is often invisible, and only valued in pockets. In light of this consistent plea to identify the characteristics of our expertise, and to name the profession specific roles that we carry (Pecukonis, et al., 2003) the findings from this research provide an important opportunity to begin to articulate our contribution to this important area of practice.

The findings of my research clearly demonstrate that health social workers, irrespective of which area of the hospital we are servicing, are required to be highly competent in this domain of practice. The findings indicate that this competence is heavily relied on by members of the multidisciplinary team and yet there is minimal context specific evidence to help inform what we do. Rather the literature particularly that associated with child protection practice originates from the social service arena, or the medical area as described above, requiring a transfer of knowledge in order for it to be applied effectively in the hospital context by health social workers. Herein lays the first tension if we are to subscribe to the narrow-stream approach to evidence-based practice.

I am a health social work leader who is interested in defining, describing and delineating the health child protection social work role. In part because of the increasing desire to have health social workers take up a significant role in assessing and responding to child protection concerns it feels important to be able to differentiate our role for key stakeholders such as patients and members of the multidisciplinary team from the more familiar, Child Youth and Family social work role. I am interested in understanding the specific skills and competencies a health social worker requires in order to respond effectively to interpersonal violence, vulnerability and risk, including risk to infants and children. I want to know what the appropriate expectations should be of a *health* child protection social worker. This desire results in a preference for local context specific research, which will enable us to respond to calls such as those made in the recent government *Green Paper* focusing on services to vulnerable children (Ministry of Social Development, 2011).

My aim is that we are able to define the scope of the health social worker in relation to this important area of practice and contribute actively to the development of national and organisational guidelines which are multidisciplinary in nature, drawing on a number of disciplines knowledge and strengths. For our profession this means contributing practice knowledge that is able to take account of human rights, social justice, ethical principles and *improved* access to health resources for those in marginalised groups. *The Green paper for vulnerable children* (Ministry of Social Development, 2011) talks about local solutions to

local problems and I support this concept. The capacity to contribute to local solutions is fundamentally enhanced by access to local research.

With an increasing desire to have health professionals exercise a more active contribution in this area of practice, as signalled in The Green Paper, it is imperative that the imposition of child protection practice models from disciplines other than social work does not occur. This would be evident by a drive to engage in an overly diagnostic, and or, forensic focus in the hospital, which if poorly executed does risk alienating vulnerable populations further. My concern is that if we engage in this practice in the absence of a clear focus on building and maintaining relationships with patients and their whanau we risk reducing access to mainstream health care for populations which are already known to be disadvantaged.

My findings provide clear confirmation of the health social workers' contribution to interpersonal family violence practice in the hospital environment, and that this contribution has been established as significant. The findings also reveal that the dimensions of effective practice that health social workers rely on that enable us to make this contribution are found to be substantial. While some of these dimensions consist of what may be considered the more obvious competencies, such as the ability to identify, assess and respond to interpersonal family violence concerns, this inquiry found that these competencies in turn relied on a number of subsidiary skills, or dimensions. It may well be that these are the critical practices that are 'best', the concept described by Ferguson previously (2003).

These dimensions of practice are not well described in the health social work or interpersonal family violence medical literature referred to earlier. They are also largely absent in the Ministry of Health guidelines and their subsequent translation into ADHB organisational policy. This may reflect the *process* of development, including for example, the discipline and background of the authors asked to write such documents, who is consulted and how the consultation occurs and which particular literature is relied on. All of these dimensions will inevitably impact on what counts as evidence.

By way of example, focusing on the identification of concerns, this capacity is found to rely on a number of qualities including intuition, confidence, perception, and the ability to see beyond the obvious. 'Presence listening' as defined by Bird (2000), the ability to establish trust and rapport with patients, their families *and* the wider health care team are also found to be critical. Assessment of the identified concerns is found to rely on the capacity to engage with patients and families in a non-judgemental and compassionate way, ensuring trust and relationships are built and maintained over time. This finding is congruent with a comment in the literature made by a parent who explained, "It's all about relationships. We are talking about dealing with people with problems, with painful stuff. You have to know someone, trust them. They must be reliable and be there for you if you are going to be able to talk about the things you don't want to. The things that scare you" (Munro, 2011, p.3). Returning to the family violence guidelines published by the Ministry of Health, and the organisations attempt to interpret these guidelines for day-to-day implementation in the hospital, the primary focus up to now has tended to be on what is described in the literature as technocratic or procedurally driven policy and practice guides (Munro, 2011). This approach is likely to reflect the narrow-stream approach to evidence-based practice, where the inference is that in order to effectively reduce risk, health social workers should simply following a set of clearly prescribed procedures. It was Smith (2004) who identified that this approach risks ignoring the very dimensions of practice which were found to be significant in my findings, namely the skills and qualities of the health social worker. Herein lays the second tension in that it appears that the very skills the effective practitioners are found to be most heavily relying on do not reflect the skills and the standards the organisation has established.

I am forced to move further afield in my exploration of the literature and find support for my results in a body of literature association with the reforming of child protection practice. Reinforcing the value of practice associated with the relational skills and qualities of the practitioner, a number of child protection social work authors also articulate a powerful critique of the narrow-stream, procedurally focused and bureaucratic approach to practice. They maintain that this technocratic approach has been found to be wanting. Collectively they argue that an over-emphasis on compliance to procedures has become the desired outcome, leaving little room for professional judgement, individual practitioner expertise,

or the ability to take account of the real life complexity inherent in human behaviour (Ferguson, 2001, 2003; Lonne, Parton, Thomson, & Harries, 2009; Munro, 2011).

These reflections, whilst expressed specifically in relation to interpersonal family violence practice, are also supported more generally in the critiques occupying the second part of chapter two of this thesis. Here a number of theorists construct substantial arguments against positivist approaches, and their translation into practice via the use of prescriptive practice guides. My findings appear to uphold one of their central arguments, namely that these positivist assumptions in the face of human complexity, have proven to be woefully inadequate.

Procedures such as screening for family violence, completing child protection alerts, undertaking referrals to the statutory agency, and ensuring appropriate documentation are clearly valued by some participants and are, without question, important. What is more frequently described, however, is the ability to develop and maintain a compassionate and empathic relationship with the persons experiencing the interpersonal violence, *and* those perpetrating it. This finding is likely to reflect the dimensions of practice akin to relationship-based practice referred to above and, in my opinion, would benefit from being made more explicit in subsequent guidelines.

A description of the some of the key elements of relationship-based practice is provided by Ruch (2005), who in turn relies on Howe (1998a), Lishman, (1998) and Parton (1999). These authors maintain that "relationship-based practice involves practitioners developing and sustaining supportive professional relationships in unique and challenging situations…and requires practitioners to re-evaluate their styles of practice and sources of professional knowledge in a social work context of complexity and uncertainty…" (cited in Ruch, 2005, p.113).

My finding in favour of relationship-based practice provides support for Ruch's argument that there is a need to re-focus practice associated with social work which aims to respond effectively to interpersonal family violence (Ruch, 2005). Indeed these findings suggest that it is relationship-based practice which is able to provide a valid alternative to the

reductionist accounts of human behaviour and the thinly formulated bureaucratic responses reflected in current practice guides.

This inevitably raises the question of the type of professional infrastructure, models of practice and the professional and organisational support health social worker may require in order to safely engage in these less technocratic approaches to practice. It is authors who support the broad-stream approach to evidence-based practice who are able to provide us with important clues regarding the types of organisational interventions which are more likely to support a purposeful increase in the provision of effective practice in relation to interpersonal family violence.

As my thesis indicates, the dimensions of practice which health social workers were found to rely on were described as a complex array of personal qualities, professional competence and relationship-based practice. Of central importance is the ability to be accessible, visible, approachable and available, all qualities which are likely to depend in part at least on the available human resources and their competence. This is described generically in the study as the provision of a dependable service.

Whilst the Ministry of Health has clearly required District Health Boards to implement programmes such as the Family Violence Screening Programme since 2002, as outlined in the family violence guidelines described previously, they have failed to provide a detailed analysis of what this actually requires from health professionals, or the wider organisation. This includes a lack of attention to the resource implications which inevitably flow on from the implementation of a screening programme such as this one. So far as I am aware no District Health Board has undertaken this analysis either.

When we consider two key findings from this study firstly, the centrality of relationship-based practice and secondly, those elements of practice associated with a dependable service, we find ourselves challenged to consider how these guidelines can more meaningfully and ethically be implemented in the hospital context. It is this test I aim to meet in the development of an appropriate intervention designed to support a purposeful increase in the provision of effective interpersonal family violence practice. Herein lays the

third and final tension. How do health social workers gather the necessary data, participate in the necessary discussions, and inform the necessary people about what it is that we know, and what it is that the profession can contribute?

Whilst much of the attention in the Ministry of Health strategy, and the organisational guidelines focus on the responsibilities and activities of the health workforce, these skills clearly extend beyond the provision of effective services at the coal face. Those of us in leadership and decision-making roles are charged with giving careful consideration as to how we ensure the health social work workforce is properly equipped and supported to undertake these responsibilities. This will inevitably require a focus that reaches beyond the practice itself, although clearly the findings from this study are able to provide an operational definition of these dimensions of practice.
When considering how to support the critical practices which were found to be 'best' I am reliant on both the later part of the effectiveness literature, and those authors who are occupied with reforming child protection practice. Together these authors suggest that technocratic, compliance-driven approaches to practice are based on and provide an illusion of certainty (Lonne, et al., 2009; Munro, 2011 ; Ruch, 2005). As discussed previously the underlying assumption inherent in this approach is the notion that by following a series of lock-step activities health social workers will in fact provide an effective service.

On the other hand however, proponents of relationship-based practice readily acknowledge an absence of certainty, and are therefore in a position to develop organisational and professional responses to support practitioners to operate as safely as possible, in the absence of certainty. Interestingly, it was Fischer (1973) who concluded at the end of his effectiveness review that it has long been a feature of the helping professions to make judgements in the face of uncertain knowledge. What then does the literature tell us about the work conditions health social workers require which are able to take account of the complexity inherent in working with the human condition?

It appears that central to their accounts is the need to offer opportunities for social workers to engage in continuing professional development, reflective learning activities and to have ready access to appropriate clinical supervision (Lonne, et al., 2009; Munro, 2011 ; Ruch,

2005). An emphasis on the importance of cognitive and emotional responses to the work (Ruch, 2005), and access to research (Plath, 2006) are also important. Support to engage in activities which assist health social workers to transfer knowledge from one context, such as Child Youth and Family Service, into a health context will also be crucial. My findings indicate that having adequate numbers and properly resourced health social workers is also critically important. These ideas will be taken up in the final chapter which explores briefly the development of an intervention.

Whilst authors such as Kelly acknowledge the psychosocial determinants associated with child protection, it appears to be the diagnostic process that dominates his research, which given that he is doctor, is scarcely unusual. In light of the high rates of child abuse reported to be occurring in Maori whanau (Kelly, et al., 2009), and health social workers' demonstrated ability to work competently with Maori and other vulnerable populations, it is high time that health social work claimed a place and contributed more actively in this policy and practice arena.

This will require from us an additional and concerted focus to our professional practice which is likely to include activities such as: developing the capacity to research our role and contribution; developing appropriate networks with both the Ministry of Health, our community partners and consumers of health services; developing the ability of our peak groups (such as the national network of health social work leaders) to represent our views *and* more actively contribute to national and local policy development. This will require us to maintain and contribute the social work principles and values associated with human rights, including health consumer rights, empowerment of vulnerable populations, and a focus on social justice. This is after all what makes us *social* workers.

Whilst this exploration of the findings has been extensive, it has provided one detailed example of the tensions which can arise when the findings from research are at odds with the notions inherent in positivist approaches to practice, manifested in this case in the current organisational practice guides. Clearly there is an opportunity to engage in an intervention which aims to develop ethically robust responses to the findings, which must include a focus on the provision of adequate support, human resources and professionally

informed practice guidance. This leads us to another set of significant findings, associated with the delivery of a dependable service and the dimensions of practice which were found to support this.

Asking our hosts the questions

This section of findings begins with a brief revision of the concept of the hospital being a host, or secondary setting for health social workers as described by a number of authors (Auslander, 2000, 2001; Cowles, 2003; Mizrahi & Berger, 2005; Neuman, 2000).These authors suggest that because the hospital's primary function is to tend to the medical needs of patients, the psychosocial needs are rendered secondary. Dominated by the medical model, and our medical colleagues' view of the world, health social workers are described by Cowles as playing a supportive or supplementary role. Clearly this 'round peg-biopsychosocial approach' and 'square hole-medical model' dichotomy brings forward significant challenges for the profession.

In response to these challenges it is Auslander (2000) that suggests we would do well to assess the relationship between the goals of the host, and the profession's achievements and outcomes. Volland (1996) suggests we find ways of effectively entering the host setting, making the adjustment to this context the profession's responsibility. It is this capacity to adjust and adapt, to find ways of reducing the risks associated with the paradigmatic dichotomy described above which appears to play a significant part in the provision of effective health social work service.

I chose to respond to the challenges posed by our international health social work colleagues with a commitment to developing a fine-grained understanding of what it is that a health social worker must be competent to do in the host setting. What is it that our profession can accomplish, that others may struggle with? What might the profession's unique contribution and achievements be, and how is it able to support the aims of the organisation?

By asking the question, 'How are the dimensions of effective health social work described and demonstrated within the multidisciplinary team, in an acute hospital setting in Aotearoa?' this unique and significant contribution *has been described*. Tentative links with

the organisation's aims are also revealed. It is the day-to-day detail, reflected and described in relation to the dimensions of practice themselves, in this particular context which have been able to shed light on how the health social worker demonstrates her ability to contribute effectively in the host environment. This idea will be expanded later in the discussion in relation to the provision of a dependable service.

I held a belief that a multifaceted and authentic description of these dimensions would emerge if I posed this question to experienced representatives of the social work profession *and* members of the multidisciplinary team. I was informed by the notion that our multidisciplinary colleagues in the hospital are our customers or hosts, seeking our professional input in order to address the psychosocial elements of a patient and families hospital experience. By positioning our medical colleagues as customers with important insights to contribute they became sources of vital information, not only about the dimensions of effective health social work practice, but also about their needs and aims.

In asking this question a description of the primary issues, the challenges our medical colleagues experience, and needs they, their patients and families experience have been richly portrayed. This study provided an opportunity for this set of key stakeholders to illustrate and describe their accounts of the dimensions of effective practice which *they believe* enable health social workers to meet these identified needs. Therefore the asking of this question within the boundaries of the host environment, of the very stakeholders who are also our hosts, provides a meaningful response to the challenge posed by our health social work authors referred to above.

Another test associated with working in a host environment is the overriding sense that health social workers hold one view of the role, whilst our colleagues hold a vastly different view. This is manifest in various articles, as described in chapter three of my thesis, for example (Davis, Baldry, et al., 2004; Davis, Milosevic, et al., 2004). It is also evident day-to-day, on the shop floor. It is not unusual for health social workers to express a feeling of being undervalued as simply the providers of discharge plans, practical assistance and referrals to home help. The sense of being misunderstood is at times profound, perhaps associated with the dissonance connected to operating under vastly different paradigms, and

an absence of local research which assists us to define our role. Inadvertently this inquiry has provided an opportunity to assess this perception, by comparing social work accounts of what constitutes effective practice with our multidisciplinary colleagues' accounts.

Given this strength of feeling it is somewhat surprising that the results of my study suggest a largely congruent explanation of the dimensions of effective practice, across all the professions and all service areas. These explanations are also largely congruent with the health social work literature, and the definition of social work. The three key areas of difference materialise from the conflict between the quantitative and qualitative data and provide a useful opportunity to explore what may well be a tension associated with our contradictory paradigms. They relate to what has been identified in the qualitative data as fundamental health social work roles; firstly; that of supporting the cultural competence of the wider team; secondly; the activity associated with supporting patient and family members understanding in the medical environment; and thirdly those results linked to what is described as the provision of a dependable service.

Two other sets of results warrant considered discussion, beginning with those associated with what may be considered organisational outcomes, such as a timely discharge, and reducing the likelihood of readmission. Finally the health social workers' capacity to solve problems by meeting social needs will also be highlighted as this is where the absolute value of multiple paradigms, as indicated by health services being delivered by a multidisciplinary team, becomes evident. These findings will be discussed in relation to the empirical literature, and the notions associated with positivist science. Links with the health literature will also be made.

Health social workers' role in supporting cultural responsiveness

The capacity to provide cultural advocacy and support was initially identified in the case study findings, and was subsequently made available for review in the survey. The quantitative results are reported in Table 8, chapter six of my thesis, followed by the qualitative findings. Whilst many of the findings were congruent with the literature and uncontroversial, the data associated with 'supporting the cultural competence in the wider

team' and 'assisting patients and family to understand the medical condition and its consequences' warrant some discussion.

It is worthwhile focusing for a moment on how others describe the role of advocacy in health social work. Maintaining that the provision of advocacy distinguishes social work from other helping professions a study which aimed to better understand the role provides the following definition: "Advocacy involves deliberately speaking out or taking action to influence others so that psychosocial needs of the client (patient and family) will be recognized and met when they otherwise would not be" (Nelson, 1999, p. 70).

Whilst the combined qualitative data indicate clearly that the speaking out occurs, it is the aspect of influencing others that our medical colleagues appeared reluctant to acknowledge in the survey rating exercise. The need to influence others regarding cultural matters and the value this adds to the patient experience is evident in the qualitative data in two ways: firstly, in the call to provide cultural guidance to our medial colleagues; and secondly, in the clear need to assist patients and their families understanding of matters of a medical nature.

When we consider that the survey findings rated the value of health social workers supporting the cultural competence of the team at 32.4 percent rating, the absence of acknowledgement of this contribution is clear. Appearing to be in conflict with this rating however, numerous contributors *described* health social workers engaging in cultural advocacy aimed at supporting the wider team's cultural competence. As described in the findings these activities were clearly oriented towards supporting the wider team's capacity to provide a culturally safe and responsive environment for patients who were other than Pakeha, thereby fulfilling the second element of advocacy, namely that of influencing others. As one Doctor described it *their guidance is particularly needed and valued where cultural aspects could be missed if the social worker was not there*.

How to account for this conflict in the data is difficult. It may reflect the language relied on in the survey not adequately reflecting the case study findings, or the qualitative descriptions regarding this dimension of practice which our multidisciplinary colleagues

clearly *do* value. Conceivably a less confronting description may have been received more positively, for example 'supporting the multidisciplinary team's cultural responsiveness', as opposed to cultural competence.

What does appear clear from these *combined* findings is that a core dimension of effective health social work is the capacity to assist our multidisciplinary colleagues respond to the often subtle and complex cultural needs of our patients and their families. Clearly this is evidence of our profession making a unique and valuable contribution to the aims of the organisation. Whilst minimal specific attention has been paid to the value of these skills in the health social work literature, the cross-cultural challenges associated with the largely monocultural nature of hospitals, and the health system more widely, have been very well articulated by the Ministry of Health itself.

As described in chapter three of my thesis the link between health inequalities and ethnicity has been firmly established (Gauld, 2003) and the desire to reduce these inequalities is a longstanding aim of the Ministry of Health. This is evident by the numerous strategies, resources and attention which are paid to health inequalities, all accessible via the website of the Ministry of Health. One of the key strategies identified is an effort to provide equitable access to health services and an expectation regarding a high-performing system (Ministry of Health, 2000). Whilst not wanting to overstate our contribution to these aims, it is clear from the findings that health social workers can demonstrate a very active commitment and role associated with this strategy.

A 2009 study is now called on because of the direct link it has with the findings associated with the ethnicity of health social workers, and the advocacy activities a number of practitioners were found to engage in. This report explores the experiences of health services for Maori (Mauri Ora Associates, 2009) in an effort to understand their expectations and preferences. These authors suggest that studies undertaken in Aotearoa have been able to identify barriers to minority patients accessing health resources, and facilitators of access to health resources (Mauri Ora Associates, 2009). Attributed in part to organisational and human resources, their findings appear to reinforce the value of the activities health social workers are found to be engaging in.

The relevant organisational barriers were identified as a Western approach to health care and an under-representation of Maori health professionals. Clearly Maori and Pacifica health social workers are identified by participants as highly valued in this context, recognised as playing a particular role in supporting patient engagement. As described in the findings it is evident that these practitioners are able to make an important additional cultural contribution which includes their language ability, cultural matching of staff to clients and the provision of a deeply authentic cultural perspective. All these are said to support increased comfort, safety and engagement in the health service (Mauri Ora Associates, 2009).

The relevant human resource barriers identified in the report (Mauri Ora Associates, 2009) included non-Maori health staffs characteristics; including our attitudes and perceptions about Maori patients, and the absence of appropriate communication between the patient and the provider. Reinforcing the findings from my study regarding the contribution health social workers are making in this area, the Mauri Ora report claimed that good communication from the provider was one of the most important predictors of patient satisfaction (Mauri Ora Associates, 2009). The identification of this particular contribution is a powerful example of the value of practice-based research and provides foundational data that will enable us to develop and strengthen this role over time.

Supporting patient and family understanding in the medical context

This leads us to the subsequent but connected significant conflict between the qualitative and quantitative data where it is the empirical data which appears to be at odds with the descriptive data. It is difficult to be definitive about the origins of this conflict. Again it may be the choice of language I selected to represent the activity observed and reported during the case study as being of particular value. In the survey participants were asked to rank the importance of the health social workers' ability to 'assist the patient and family to understand the medical condition and its consequences'. This attracted a low ranking with 46.4 percent of participants rating it as highly valued or very valued. Perhaps of more weight is the fierce opposition expressed in some of the qualitative responses, primarily posted by Doctors and Nurses which can be found in the survey findings chapter.

I needed to explore alternative literature in order to help me to understand and contextualise this opposition. The resistance expressed by our medical colleagues coupled with what appears to be an absence of understanding about *why* the health social workers may need to engage in these *sense making activities* was found to stand in stark contrast to what I discovered. In order to contextualise the findings locally, four articles were accessed which pay particular attention to patients' experience of communication in the health service.

The report regarding Maori experiences of the health service cited previously found that when communication was good, participants described feeling more comfortable in the hospital. Uncaring attitudes and a perception of poor communication were reported by some contributors to their study, and this was at times attributed to cultural differences between patients and hospital staff (Mauri Ora Associates, 2009). Along similar lines, an article devoted to improving access to health services for Maori reported that unsatisfactory encounters with health professionals, and particularly experiences of disempowerment, got in the way of Maori accessing health services (Ellison-Loschmann, 2006).

Wilson and Neville's local research focused on nurses' ability to work with vulnerable and marginalised populations. They found not only that nurses failed to identify the patient's understanding of what was occurring for them regarding their health, but also they did not take an interest in their health experience (Wilson & Neville, 2008). But this article did report that Maori women and older people frequently state that they did not understand what health professionals were saying, and that they were not provided with enough time to absorb information and respond to it (Wilson & Neville, 2008).

Finally a study undertaken at Auckland Hospital to determine the adequacy of the informed consent process, arguably one of the most critical areas of doctor-patient communication, was examined (McKeague & Windsor, 2003). Reflecting some of the themes identified above, this study found that a key element of the informed consent process, namely the patient feeling that they understood what was being communicated, was found to require improvement (McKeague & Windsor, 2003).

Collectively this literature supports the finding that there is a clear need for health social workers to pay careful attention to a patient and his/her family's understanding of what is occurring in the hospital environment. Whilst this is unlikely to occur in isolation from our multidisciplinary colleagues, nor should it, the findings suggest that the competence and confidence of health social workers regarding how this activity is appropriately carried out, is a vital dimension of effective social work practice in this context which requires additional attention.

One of the skills this practice is found to rely on is an extensive knowledge of medical conditions, language, treatment regimes and illness trajectories. Noticeably this is not something we learn in our undergraduate degrees, unlike some of our multidisciplinary colleagues. The case study results identified that the health social worker who was studied appeared to proactively seek out this information at every opportunity. Significantly the value of this knowledge has been identified in the literature as enabling health social workers to engage effectively with our medical colleagues and with increasingly well-informed consumers of health care (Beder, 2006; Berkman, 1996; Cowles, 2003; Dziegielewski, 2004).

This leads me to wonder how it is that health social workers learn the skills, scope and professional boundaries that are clearly an important feature of this practice. The health social work literature makes clear references to the role of health social workers advocating for patients by clarifying medical information (Cowles, 2003; Davis, Milosevic, et al., 2004; Dziegielewski, 2004; L. Sulman & Tuzman, 1982). One article argued that we are well placed in engage in this type of activity due to our knowledge of communication theory (Nelson, 1999). But this same author highlighted obstacles to engaging in advocacy which she attributed to a lack of active hospital support, and a lack of appropriate education. Given the tensions associated with this domain of practice evident in these findings, the development of a professional standard is likely to support both health social workers, and our medical colleagues to better understand and value the role. This leads us into the next part of the discussion where a key concept to emerge from the case study findings, *working the ward* and the discovered linkages with the provision of a dependable service via the survey findings is examined.

Dependable service delivery – 'working the ward' and the role of adaptation to the host environment

This section of the chapter begins with a discussion as to why accounts of effective practice benefit from being organisationally embedded. This discussion relies on the specific data associated with the provision of a dependable service because this was found to be connected to the concept of *working the ward.* This is followed by a detailed examination of the third area of findings where there is some dispute between the qualitative and quantitative data, also associated with the provision of a dependable service. It is here that the relationship between the provision of practice described as effective, and a successful adaptation to the host environment is explored. The final part of this section of the discussion explores the health social workers capacity to meet needs in order to solve problems, found to be a major component of dependable service delivery.

The early part of chapter two contains a thorough review of effectiveness studies informed by the empirical tradition, or the narrow-stream approach to evidence-based practice. This is followed by the successive critiques of empirical approaches to effective practice research which primarily surround the issues associated with how knowledge is developed and the subsequent *application* of this formal knowledge in to practice. In this section of the literature review theorists and authors such as (Fook, 2000, 2002, 1996; Fook & Askeland, 2006; Fook, et al., 2000; Gould, 2000; Gould & Baldwin, 2006; D. Schon, 1995; D. A. Schon, 1983) are relied on. As previously stated in regard to how knowledge is developed it is authors such as Fook (1996), Ferguson, (2003) and Gould and Baldwin, (2006) that promote the application of research which is unequivocally about the practice itself.

Having engaged in a study that is focused on the practice itself the discovery of a number of professional activities, attitudes and personal characteristics were identified as important. One of the most significant findings has been conceptualised as *working the ward*, which is made up of a number of particular ways of engaging in and with health social work practice in a hospital. Upon reflection it seemed that *working the ward* relies on a number of

dimensions of practice which are likely to have been developed as a response to the challenges associated with practicing social work in a host environment.

The belief that these activities make up a significant number of the dimension of effective practice described and demonstrated during the case study, and later affirmed via the survey findings, suggests that they may well provide confirmation of a successful adaptation to the hospital. I propose that the provision of effective practice in this context is built on, and is therefore reliant on, the foundation of the health social worker having made a successful adaptation to the host environment. This has significant implications, particularly in relationship to the development of the intervention which aims to support an increase in the provision of effective practice. This relationship will be explored more fully in the concluding chapter.

Prior to examining the tensions which emerged from the data associated with this concept, a brief revision of the behaviours and activities which were found to constitute 'working the ward', and the significance they have to the ability to access early referrals is worthwhile. This provides an opportunity to situate the findings firmly in an organisational context, which ultimately shares the responsibility for the provision of a dependable service between the practitioners and the organisation we work in.

The professional activities that Kay engaged in to *access* the early referrals, which have been largely reinforced via the survey findings, could be described broadly as *process activities* and *relationship skills*, which may have remained invisible and undiscovered if the choice had been made to engage in a narrow-stream, outcome study. As Cowles (2003) describes, within the hospital environment it is apparent that the professional roles and responsibilities were not always firmly established; rather they have to be 'won'. During this inquiry it became evident that Kay had found a way of establishing the social work role, and confirming Cowles' (2003) description of this as a *process*, had developed specific strategies that enabled her to keep proactively accessing, describing, negotiating, claiming and demonstrating the health social work role to her multidisciplinary colleagues on an ongoing basis.

Tables 9, 10 and 11 in the survey findings report many of the behaviours associated with 'working the ward'. They include qualities such as reliability, responsiveness, being proactive about identifying patients who need health social work services and being highly visible and accessible. Given the current organisational model of the allocation of one health social worker to a specific ward or wards, it is likely that the amount of wards and the volumes of work originating in each ward are going to impact on the health social workers capacity to demonstrate the qualities described above.

The other qualities, previously discussed in regards to interpersonal family violence are inherently relationship-based practices, in this case applied to ways of engaging with the multidisciplinary team. The capacity to be approachable, responsive, diplomatic, and non-judgemental and having the ability to make ourselves available to talk something over are found to be central to the provision of a dependable service.

While not in any way wanting to diminish the responsibility health social workers have in relation to all these elements of practice, it is critical the linkages between having the right work load, needing to maintain the right amount of relationships, *and* having the right skills are an organisational responsibility which rests beyond the scope of the individual practitioner. This brings us to the final tension identified in the results, again something that is likely to contain organisational, as well as individual practitioner responsibilities.

Two of the activities which are integral elements of *working the ward* were checked via the survey; regular attendance at nursing handover, and teaching the multidisciplinary team about the health social work role. The results in relation to attendance at nursing handover attracted the lowest rated activity out of the 40 dimensions of practice checked, with 13 percent of participants rating it as extremely important or very important. Similarly, the activity of teaching our multidisciplinary colleagues about our role fared poorly, with 24 percent of participants giving this a high value rating.

The majority of qualitative data which contributed to the development of the overall concept of a dependable service indicated that this concept was highly valued by all professions, across all service areas. Given these disparate results the qualitative and

quantitative data appear to be having an all-out war. These dimensions of practice have been simply described, and are therefore less likely to have suffered the misunderstanding that may account for the previous two points of tension discussed. In these instances currently under discussion I am able to make sense of the conflict. It may be evidence of a lack of understanding, by the majority of stakeholders surveyed, regarding the part these particular activities play in the very qualities many participants described as fundamentally associated with dependable service delivery. It may also signal something about the formal and informal aspects of dependability and how dependability is measured and defined.

These qualities, such as the health social workers' ability to be proactive, reliable, timely, visible, present and accessible were found to be linked in the case study to regular attendance at the nursing handover, and the active teaching of the multidisciplinary team about the health social work role. As described earlier these activities, along with the adaptation of Reid's task centred model (Reid & Fortune, 2002), appear to play a key role in the provision of practice which was identified and described as highly effective. How is it that this practitioner appears to have made these successful adaptations that others are unaware of? Does this mean that some health social workers have made these adaptations whilst others have not? What might it mean in relation to the notions associated with the narrow-stream approach to evidence- based practice and the organisation's responsibility to support this adaptation? In an effort to answer some of these questions I turn to Gould's 2006 work.

Gould's (2006) assertion that learning is experiential and organisationally embedded is based on his critique of the technical rational models of problem solving inherent in the narrow- stream construction of evidence-based practice. Here Gould (2006) made three important points, each of which appear to have been confirmed in this inquiry. Firstly he tells us that whilst practitioners might draw on formal research findings to guide their interventions, their strategies for problem solving are directly attained through experience.

Gould (2006) emphasised that it is novice practitioners who are likely to rely on slavish replications of formal knowledge. Yet with the development of expertise, or increased effectiveness, the very qualities followers of evidence-based practice claim to support, the

knowledge *the case* (Kay) most heavily relied on appears to be knowledge that is best described as 'tacit'. The dimensions of this practice, which taken as a whole constituted the provision of effective practice, have been largely confirmed via the survey data. Just as Gould (2006) forecast, these dimensions of practice appear to be most clearly demonstrated and communicated through the practice itself.

At no time did *the case* herself or any other participant describe the concept of 'working the ward' or 'dependable service delivery.' Rather this concept grew directly out of the observations and accounts of various practice activities, which collectively have been conceptualised as 'working the ward' as a product of the research activity. When one of the activities that contribute to this concept, the teaching of nurses about the health social work role during nursing handover was highlighted in the verification of findings process with Kay, it became apparent that she was *completely unaware* that this was an activity she engaged in, in an ongoing manner. As an alternative she associated this activity with moving into a new area of service provision simply to 'get the nurses up to speed with the role'. This is likely to be an example of what White and co-authors (2006, p.xii-xiii) refer to as "...thoughts and actions that have become so familiar and taken for granted in their everyday practice that they are no longer even aware of them".

What is also of interest is that these very thoughts and actions, which I have come to think of as part of the successful adaptation having been made to the host environment, *were un-named,* and therefore not available to others for reflection, replication or review (Bird, 2000). This provides further reinforcement of one of the potential benefit of practice-based research. Whilst not being a great supporter of the direct replication of practice, I am however interested in how these behaviours, obviously so successful in one area of the hospital, may be usefully transferred to another.

As reported in the findings chapter this proactive teaching of the nursing team about the health social work role attracted a low score from survey participants. Given that the health social work literature is unequivocal about the likelihood of psychosocial needs being missed if the profession is too reliant on our medical colleagues for appropriate referrals, this activity which Kay developed and maintained over time, is particularly significant. As

Kay acknowledged, *literature and policy has pretty well fallen off* which I understood to mean this was not something that she activity engaged in, or currently sought out. Given this finding it is probable that Kay made this apparently unconscious adaptation to her practice in recognition of the nurses' inability to identify psychosocial problems early, rather than as a result of any formal knowledge gained from the literature. This may also be an example of Kay's ability to develop a problem solving-strategy directly attained through experience, as outlined by Gould (2006) above.

Connected to attendance at nursing handover is the activity referred to previously, that of teaching the nurses, on an ongoing basis, about the health social work role. Kay describes this as "having her radar on" and "trawling for trauma", engaging in careful listening during nursing handover for clues that a patient or their family would benefit from her services. In so doing Kay is able to bring to the attention of nursing staff in a particular patient situation, the psychosocial contribution she is able to make for the patient and their family. Likely to be equally important however, is that over time nurses learn what it is that the health social worker actually does, thereby clarifying the role. The combined outcome of these activities seemed to support the timely identification and response to patients and families requiring health social work input. The very thing our multidisciplinary colleagues have told us that they want.

When we examine the combined data it becomes apparent that the ability to proactively identify appropriate patients for health social work interventions is likely to play a considerable role in the practitioner's ability to provide a timely service, and *solve problems before we even know about them*. When we consider the descriptions in the literature of the health social work role being blurry, invisible and contested, it is little wonder that the effective practitioner must find ways of defining her role, day-to-day, providing further confirmation of Kay's successful adaptation to the host environment.

The second limitation Gould (2006) highlights regards the traditional understanding of applied research knowledge which he argues has underestimated the context of practice as a formative influence in the way knowledge is created and applied by practitioners. Here Gould challenges the sense that despite the widespread acknowledgement of skill transfer

as an important social work competence, the empirical evidence indicates that practice knowledge is in fact very context specific, and the majority of learning is not therefore immediately transferable without interpretation and adaptation (Gould & Baldwin, 2006).

The importance of this transferability skill seems apparent in Kay's heavy reliance on a modified construction of Reid's task-centred model (Reid & Fortune, 2002), in which she seemed to have "dropped off" the step of evaluation with the client. This change may reflect the acute nature of the environment (average length of stay being 3.5 days), where perhaps the pragmatic achievement of the tasks is the imperative. Kay's practice did seem to demonstrate a desire to both monitor the achievement of the task, evident in the activity of ticking achievements off in the clinical notes, whilst also providing a shorthand clue to other members of the multidisciplinary team regarding the successful incremental implementation of the health social intervention plan, listed in the clinical record.

Whilst the absolute value of effective communication in the multidisciplinary team is well reported in the health social work texts (Beder, 2006; Cowles, 2003; Dziegielewski, 2004; Schofield, 2001) the results of my research suggest that activities such as ticking the agreed actions off in the plan is likely to be evidence of this formal knowledge being applied in a tacit and unconscious way, because it was reinforced to the practitioner, to be an effective strategy in the acute context.

Similarly the activity of evaluating the success of the plan, as indicated by systematically achieving the tasks as indicated by the tick, is identified as important in a number of effectiveness studies, for instance Wood's (1978) meta-analysis. My research suggests however that it was Kay's *adaptation* of these practices, which serve multiple context specific purposes that are evident in the stakeholder accounts of the dimensions of effective practice.

Consequently the essential nature of this capacity for adaptation and the successful translation of formal knowledge into effective practice in this context is what have been confirmed by these findings, rather than a slavish replication of others' practice. This challenges us to consider how it is that we support this transfer of knowledge and the

ability of practitioners to evaluate their practice. This way we can develop best practices from the ground up. Here there is an opportunity to remain local but also be *informed* by the research literature. A variety of approaches must be relied on to help develop practice knowledge and articulate expectations or the risk is we continue to occupy ourselves with the writing of prescriptive practice guides, which leave little room for adaptation and often fail to engage staff.

A final element of the provision of a dependable service involves the identification of psychosocial problems, and developing appropriate responses to them. Here, with the help of Gould's final point; the capacity to solve problems by meeting psychosocial needs will be explored.

A focus on outcomes or meeting social needs in order to solve problems

The third appraisal Gould (2006) makes in relation to the direct application of positivist science to practice is the nature of what constitutes a problem, which he argues is a matter of interpretation in itself. He proposed that cookery book, or rule-based approaches to practice are based on the assumption that it is possible to recognise problem A, provide intervention B, which results in solution C. It is here that Gould relies on Schon's (1983) metaphor, suggesting that whilst at the university, or within the lofty heights of management, this rationalistic approach to problem solving may well be applicable, down in the 'swampy lowlands of practice' the effective health social worker is identified as being able to *negotiate* the pathway to a solution. This solution must inevitably be constructed amongst a confusing and complex array of circumstances which collectively constitute 'the problem'.

In the paediatric hospital, the family member of a child patient who participated in this inquiry presented Kay with a complex array of circumstances as described in the case study findings. In summary this meant finding solutions to the challenges facing a new migrant family, with limited funds, English as a second language, living in an overcrowded home with a child who had been cared for by her mother, aunty and back to her mother because of the precarious status of her health. In this situation it is unlikely that a practice guideline would be able to provide a step-by-step guide to the solution. Instead it appears that Kay

draws on a variety of theories, life experience, networks, team relationships, and personal characteristics to *tailor make* a solution. This appears to be evidence of the benefits of the very artistry and eclecticism the empiricists, opponents of the broad-stream version of evidence-based practice, have argued against in chapter two.

These solutions described as effective and helpful seem to derive from, and are relevant in this context. As Kay explains it, her practice is informed by a vast array of training, experience, learning from colleagues *and* learning from mistakes, rather than any strict compliance with practice models. One way the influence of what could be described as practice wisdom (Klein & Bloom, 1995) became apparent was when Kay was asked how literature, theory and policy informed her practice. As previously discussed Kay was clear that *literature and policy has pretty well fallen off,* as an alternative she described the unconscious influence of these elements as *it's just a knowing thing*.

The combined results of this study provide unequivocal confirmation of the high value participants placed on the health social worker's ability to meet needs in order to solve complex social problems. This illustrates another example of our profession's ability to demonstrate how health social workers add value in this context. Whilst there may be some lingering perception that health social work is about 'having a cup of tea and a chat', stakeholders in this study are absolutely clear that the capacity to solve complex psychosocial problems is by no means an effortless skill. Rather it is acknowledged that health social workers are required to be resourceful trouble-shooters, able to think outside the square, and be highly creative in our efforts to solve problems. The complex steps involved in such problems solving practice are unlikely to be described via practice guidelines – clearly this would require a guide the size of an encyclopaedia!

This ability is found to be reliant on knowledge of, and relationships with both internal and external services. It is also found to be dependent on the capacity to listen to patients and their families, to engage empathically and compassionately and provide a non-judgemental and supportive service, in the most challenging of circumstances. These are the dimensions of effective practice; these are the abilities that enable health social worker to solve complex social problems.

I turn to contemporary literature regarding relationship-based practice to help me discuss this multilayered finding. It is Ruch and her colleagues that challenge us to avoid the polarised debate regarding evidence-based practice and the risks associated with the dichotomy of task-centred practice verses relationship-based practice (Ruch, et al., 2010). Relying on Trvithick (2003) they suggest that "[w]hat methods like task-centred social work practice offer is a *means* to develop the relationship between service user and social worker, then a structure by which that relationship can be employed to progress the work. This is sometimes described as a purposive relationship" (Ruch, et al., p.207).
It is important not to lose sight of the absolute need for health social workers to engage in rapid assessment, and the focused and purposeful meeting of psychosocial needs in a hospital environment. The *vehicle* for identifying what these needs are, negotiating the primary goals, and purposefully attending to them in collaboration with patients, their families and the multidisciplinary team is found to be the relationship itself. Given this finding whatever guidance is provided to health social workers regarding the expectations of the organisation and the profession, must take account of this relational element. Connected to this relational activity is the value of team work, another key finding in this study.

Team work and its link with relationship-based practice

This ability to get the job done then, not only relies on a number of specific behaviours and activities in order to *access* the work, it also appears to rely on a number of professional behaviours and personal characteristics that fall outside of traditional practice models and are therefore less amenable to prescriptive outcome measures. The central constructs of 'finding ways of getting on with people' and 'solving problems in order to get the job done' are found to be inseparable within this high pressure acute environment. In this context it is apparent that multiple team members collectively rely on each other to respond quickly and efficiently to various patient and family needs.

It is Cowles (2003) who provides health social workers with a clear set of directions which she argues will support our acceptance and allow us to be successfully utilised in the host setting. By way of revision, she suggests respectful and considerate acceptance of the

medical team's work and responsibilities; maintaining mindfulness that patients 'belong to nurses' and therefore nurses must be kept in the loop, and finally to understand the primary functions of the hospital and what these may mean for the concerns of the medical team (Cowles, 2003). These activities bear minimal resemblance to messages from the empirical literature regarding effective practice. Rather they reflect some very specific guidance regarding how to *position health social workers* successfully within a specific practice context, in a way that is more likely to result in positive relationships *and* positive outcomes.

There is reinforcement for the value of Cowles' advice in my research findings. The importance of being responsive to the medical teams calls for assistance, to maintain open and constructive communication, to collaborate and cooperate, to facilitate relationships in order to support a shared understanding between patients and the medical team and to ensure timely and reliable feedback are all examples of Cowles's directions having been implemented. Clearly these dimensions of practice are likely to support solid team relationships, and it is the capacity to work successfully in a team which is highlighted consistently in the health literature (Beder, 2006; Cowles, 2003; Dziegielewski, 2004; McCallin, 2006).

Team work has also been identified in the health literature as a key factor affecting organisational effectiveness (McCallin, 2006). In this study the ability to develop and maintain team relationships *from the cleaners to the doctors* seemed to have multiple consequences. In the case study there is evidence that the trusting relationship between Kay and members of the medical team resulted in staff feeling able to *just talk something over* which was connected to her capacity to engage in an early intervention. Writing about the concept of dialogue in relation to effective teamwork, this local author argues that it is more than simply communicating, it means talking something through to the extent that a change of thinking and/or practice occurs (McCallin, 2006).

What became apparent in this study was that one of the ways this change of practice is evident is in the ongoing and increasingly appropriate and timely (as described by Kay) referrals. What is also significant however is that equally often the situation was established

as *not* requiring an intervention, allowing Kay to focus on those patients and whanau with the most significant need.

These findings suggest that effective social work practice cannot be attributed to one activity, skill, quality or use of a particular intervention that has been tested empirically. The importance of practitioner competence, as described by McCallin (2006) as critical to effective team work is evident in the comment made by the paediatric surgeon Kay worked with when he said quite simply, “it is pretty obvious she is a good social worker because the problems are sorted”. The value of expertise, competence and experience are also powerfully endorsed by the survey findings.

These results clearly signal that the ability to meet social needs, in order to solve complex problems is a highly valued skill, and that the meeting of these needs could be constructed as an outcome, albeit dependent on numerous variables which would inevitably prove an enormous challenge to quantify. As discussed multiple times central to this capacity is the ability to develop and maintain relationships with patients, their families, and members of the multidisciplinary team. What then did participants say about the activities health social workers engage in which may be more amenable to outcome studies?

A rejection of a narrow focus on outcomes

Reinforcing the case study finding of the apparent limited value of what could be considered exacting outcome measures, it is noteworthy that survey participants did not appear to place an extremely high value on health social workers’ contribution to either a timely patient discharge, or reducing the likelihood of readmission. As described in the chapter six, 64 percent of participants rated a focus on safe and timely discharge as extremely important or very important. Even fewer, 58 percent rated reducing the likelihood of readmission as either extremely important or very important. This came as a surprise given the absolute focus on timely discharge apparent in the hospitals.

Whilst it is possible that participants may have felt that health social workers have a minimal role to play in these outcomes they were unequivocal about the activities which may contribute to these outcomes. For example, participants rated reliability highest out of

all the dimensions, with 98 percent of participants rating this as extremely important or very important. Other activities such as clear intervention planning (83.8 percent) and providing a timely response (89.6 percent) also attracted a high value rating, indicated that perhaps the focus on the practice activities and professional behaviours are more important than the outcome itself. This analysis of the findings may well support the view that "[t]he efficacy of interventions is clearly crucially important, but an exclusive focus on narrow outcome indicators can lead to a conspicuous neglect of other areas of professional activity" (White, Fook, & Gardener, 2006, p.xii).

What is evident in the results from this inquiry is that multiple areas of professional activity, such as the ability to listen (89.4 percent); to provide a non-judgemental response (88.7 percent) and to be approachable (92 percent) have been consistently rated as extremely important or very important. Combined with both sets of qualitative data it is evident that participants are signalling their immense significance as core dimensions of effective practice. These finding supports Fook's (2000) contention that in order to act more relevantly we need to understand the *complexity* of our experiences, and that one way we can do this is by increasing the number of lenses, or approaches we rely on to build this understanding. By applying and maintaining the broad stream approach to the research activity, we are better able to apply this knowledge in a broad stream way to practice.

Comparison with the health social work literature

These overall findings appear to be remarkably consistent with the hospital social work literature in a number of significant areas, some of which have already been discussed. The psychosocial assessment and intervention activities described as being highly valued are broadly in keeping with the essential medical social work vision first articulated in 1908, and outlined in Rock's (2002) description of the biopsychosocial model of practice. These activities have endured throughout the various revolutions of health care, and could best be encompassed under the rubric of the biopsychosocial model of care. Within the hospital context interventions informed by this framework have a growing body of evidence to support their efficacy for example (Auerback, et al., 2007; Lechman & Duder, 2006; Rock & Cooper, 2000). They are also described in all the health social work texts relied on for

my thesis, as a fundamental aspect of health social work practice (Beder, 2006; Cowles, 2003; Dziegielewski, 2004; Schofield, 2001).

The findings also align with Sulman and his colleagues (2001) proposition that in the hospital context social work does not just respond to the most complex social situations, but also to the medical situations that could be considered routine but serious. These medical events, with the ensuing hospitalisation of a loved one, are likely to have psychosocial consequences that the effective health social worker is required to respond to. This professional health social work activity is described by Berkman (1996) as enhancing coping with health problems and is said to be reliant on accessing and supporting the provision of both external (practical) and internal (emotional) resources.

The health social work activity described and demonstrated as practical advocacy and support proved to be most central to descriptions of 'helpful' practice, provided by the patient's family member who was interviewed as part of this study. Whilst the critical value of this practical support cannot be overstated, other activities oriented towards the emotional needs of patients and their whanau, also feature strongly. In line with Berkman and her colleagues' findings, participants provided multiple examples of health social work practice primarily directed towards strengthening internal (emotional) resources. By way of example the emotional advocacy health social workers provided associated with grief, loss and bereavement. The practice activities described in the literature as helping to set priorities, education and clarification regarding the individual's illness and its repercussions are also identified as highly valued by participants in this study (Berkman, et al., 1996) as previously discussed.

The practitioner at the centre of the case study was clear that she was not conscious of the influence of research or policy when she reflected on what was informing her practice. At no time during the inquiry was the practitioner observed reading or attempting to access a journal article and yet the professional activities she engaged in could be very directly linked with the hospital social work literature, and to a lesser extent, the empirical practice literature. What stands out in the findings is that the practice models such as Reid's task-centred practice appear to have been *modified* or adapted and that it is these adaptations

which appeared to significantly contribute to effective practice, as opposed to any 'pure' use of interventions, as we would understand them as described in the empirical literature.

The research findings and the aims of social work

In chapter one I included a definition of social work provided by the International Federation of Social Workers and used by the professional association that many of the health social workers employed at Auckland District Health Board are affiliated to. I have assessed the findings of this study in relation to this definition and observe that many of the elements of it are powerfully evident in the accounts of what constitutes effective practice in this context. This is extraordinarily rewarding, and reassuring, particularly given the tensions previously described which are associated with the provision of social work in a hospital context.

The requirement to facilitate problem-solving in human relationships is evident in much of the practice, particularly the provision of emotional advocacy and support and the capacity to provide an effective communication pathway, or bridge between the patient, his/her family and the wider multidisciplinary team. The responsibility to support empowerment is evident in multiple domains, including the practice associated with working with interpersonal family violence, and the provision of practical and cultural advocacy and support. Those dimensions of practice which are oriented towards supporting the patient, and his/her family's views and experience, which are able to support their increased engagement with the health service are persuasively associated with the social work requirement for empowerment, and to help enhance the wellbeing of our patients.

Worthy of celebration and perhaps most important of all are the findings which collectively reflect the principles of human rights and social justice, fundamental to the aims and values inherent in professional social work. The dimensions of practice described as empathy, compassion and the capacity to engage with patients and their families in challenging circumstances such as those associated with interpersonal family violence are particularly noteworthy. Vitally important too, the contribution we are making in the area of cultural advocacy where health social workers are found to be speaking up on behalf of those who are vulnerable to oversight, poor communication and misunderstanding.

Finally the capacity of the health social worker to intervene at the points where people interact, or not, with their environments is evident. Again health social workers are found to be informed by and operating under the auspices of the biopsychosocial model of practice, and therefore are able to add a critical element of care, for those patients facing psychosocial challenges associated with their admission to hospital. It is here that health social workers are able to demonstrate fairly and squarely what is our contribution, where we add value, and the clear defining of our role as the health professionals who attend to the social, in an environment dominated by the medical.

Concluding comments

Perhaps Reid and Kirk's (2002) observation and curiosity, expressed early in chapter two provides some clue as to the profession's appropriate use of what may be described as scientific evidence. To recap, they observe that Richmond's practice framework demanded that practitioners were scientific in so much as science is "[a] rational, systematic, problem solving activity involving methods of data collection, attention to the quality of evidence, effort to be objective and unbiased...and so on" (Kirk & Reid, 2002, p.30). They then tell us that these are the activities of a good journalist, or lawyer, and question "when a rational, systematic, problem solving activity becomes a use of scientific method" (Kirk & Reid, 2002, p.30).

The focus of this research inquiry does not enable me to, nor am I inclined to, respond to this question definitively. It may be that it is the application of common sense and the ability to modify, transfer and adapt practice to a particular context that has won out. Clearly I have argued that adaptation to the context itself is at the centre of health social work practice which can claim the description of 'best'. These abilities, combined with the capacity to notice and respond to individual patient and family needs, situated within a set of particular organisational challenges is likely to have been what supports the provision of effective practice. Given these findings, this inquiry provides further affirmation of the rejection of the imposition of the narrow-stream version of evidence-based practice in this context. Rather it supports professional activities, relationship-based practice and

organisational and professional accountabilities that will enable the successful adaptation of activities and interventions that have proven to be effective in other contexts.

The findings from this inquiry support the rejection of the imposition of increased codified knowledge via practice guidelines as it is the *tailor making* of complex solutions, for complex problems that appear to be central to the dimensions of effective practice, or as described by Ferguson (2003) the actual critical practices that are ‘best’. This ability seems to rely on much more than simply applying an intervention which has previously been established via empirical testing, to be effective. As evident in the results, the ability to access and respond to the health social work client is reliant on a number of interlocking steps, relationships and attitudes which enable health social workers to deliver services which stakeholders describe as effective.

The professional activities that have been conceptualised as ‘working the ward’ and extended to include the concept of ‘dependable service delivery’ have been associated and described by participants as making a significant contribution to effective health social work practice in this context. The explicit naming of these proactive behaviours resulted in a curiosity regarding the absence of these behaviours in others. This absence was confirmed both during the inquiry and subsequently during the verification of findings process with experienced informants. Clearly many of the dimensions of effective practice demonstrate what Klein (1995) refers to as practice wisdom. It was the practice-based research process of accessing, naming and defining the manifestation of this wisdom which appears to have successfully provided the data which will enable the operational definitions of effective practice to be developed and articulated.

Consequently how to increase these effective health social work practices will benefit from well-considered leadership, appropriate clinical governance infrastructure and significant organisational responses. The aim of future interventions would ultimately be to support the appropriate and successful adaptation of formal knowledge to practice in this particular context. These findings suggest that these intervention activities would profit from being embedded in a solid understanding of the organisational imperatives thereby being more

likely to result in increasingly effective practice. Recommendations such as this one will be explored more fully in the concluding chapter.

Chapter 8: Conclusion

Introduction

This concluding chapter provides an opportunity to review the aims, motivation, research approach and findings which collectively constitute the beginning, middle and end of this research endeavour. A frank exploration of the limitations of the research is undertaken, prior to a brief exploration of the theory which has driven the development of the intervention plan. The plan laid out in the final table of the thesis (Appendix 11) includes the operational definitions of effective practice and the intervention activities which aim to support their purposeful increase. This table is designed to be read in conjunction with a summary of the research findings reported in Appendix 10; together they form a summary of the final outcomes and recommendations to emerge from the research. This intervention has been developed for a specific practice context, the Auckland District Health Board's acute hospitals. Whilst some activities may well be appropriately applied in other social work contexts, it should be noted that this plan has been designed on the basis of our particular organisational context and needs.

Reviewing the research aims, motivation and approach

My thesis began with an outline of some of the central challenges social workers face and, in particular, those of health social workers situated in an acute hospital. These include the impact of a negative public gaze as described by Ferguson (2003); the increasing pressure to deliver effective services and provide evidence of outcomes (Macdonald, 2001); the capacity to keep pace with the changing demands of the dynamic hospital context (Berkman, 1996) and the need to define the health social work role (Davis et al, 2004). Health social workers are also required to demonstrate how we add value in the hospital context (Volland, 1996) an environment which is increasingly focused on cost effectiveness and efficiency (Dziegielewski, 2004).

In developing responses to these challenges, one of which has been to engage in this research, I faced another series of hurdles which have required careful navigation. These trials were associated with the contested nature of evidence, or knowledge itself as played out between those who subscribe to positivist approaches to research such as Thyer (1996),

and others aligned to more interpretive, or qualitative approaches as described by theorists such as Fook and Ryan (2000). Connected with how the profession has engaged with the thinking and concepts associated with social work effectiveness my own beliefs required clarification, prior to a decision being made about what research methods to employ in this study.

Being an insider researcher, as described previously by Coglan and Brannick (2005), provided a series of both obstacles and motivations, which I have attempted to engage with reflexively and transparently. I have done this throughout the research process in order to protect the inquiry and its subsequent findings, as much as is possible, from the inevitable bias that is likely to be present when engaging in research which so clearly has significant implications for my own day-to-day practice as a leader.

As described in the introduction of my thesis the leadership role I occupy is primarily focused on the clinical governance of a group of physical health social workers, the majority of whom are employed in a hospital context. Clinical governance referred to earlier, is defined as “safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish” (Braithwaite & Travaglia, 2008, p. 11). These two elements of clinical governance have powerfully informed the aims and therefore the outcomes of this research, including the design of the intervention. It is here that the shared responsibility inherent in the concept of clinical governance manifests in my practice. This is evident in the substantial investment being proposed in the intervention plan which aims to develop the practice environment. This approach is intended to support the provision of the high standards of care being called for.

I have maintained that in order to more fully respond to the first element of clinical governance I was required to develop a sound understanding of what these high standards of care may consist of. Given the dynamic nature of the hospital, the contested character of what constitutes evidence, and a commitment to the knowledge that can be created by local practice-based research, undertaking this research in a particular way was critical. Collectively the key messages I took from the literature culminated in a research inquiry

which attempted to understand the "challenging complexity of every day social work" (Gibbs, 2001, p.700).

My hope has been to bring these standards to life, by consistently focusing on Ferguson's (2003) actual critical practices that are 'best'. I sought to understand what constituted these high standards of care and, in order to answer the research question, I asked key stakeholders, 'How are the dimensions of effective health social work practice described and demonstrated within the multidisciplinary team, in an acute hospital setting in Aotearoa?'

The findings

The data to emerge from this research has enabled me to identify a number of dimensions of effective health social work practice that I believe constitute "the actual critical practices that were found to be 'best'" (Ferguson, 2003) in this environment, at this time. By engaging in an interpretive, mixed methods research inquiry I have achieved the aim that was to identify what Plath described as "…the most appropriate practice in particular circumstances" (2006, p. 68). In light of this aim there is minimal expectation or desire for them to be generalised beyond this practice landscape.

The three dimensions of practice tested via the quantitative method in the survey which were found not to be critical are the capacity to debrief members of the multidisciplinary team after challenging situations; having a good sense of humour; and being loyal to the ward. These elements have not been carried forward because of the absence of significant survey data of either a quantitative or qualitative nature to support them. Whilst working effectively with an interpreter also failed to attract robust support in the findings, because of its contribution to the role of cultural advocacy, and our legal and ethical responsibilities to this practice I do not want to exclude it as a core dimension of effective practice, particularly in light of Auckland's multicultural population.

The combined data has formed the basis of the final description of the dimensions of effective health social work practice. These have been reported in Appendix 10, referred to previously. The 40 dimensions of practice, initially identified via the case study, and

subsequently supported by the empirical survey data (excluding the three which were not supported via the survey data) have been listed alongside a catalogue of dimensions which emerged as a result of the combined analysis of all the qualitative material. The combined dimensions of practice found to be fundamental to each domain have been reported under each domain title, for example *responding to vulnerability and risk* which form the foundation of the final ten operational definitions of effective health social work practice, reported in Appendix 11.

This has met the second aim of the research which was to reach an operational definition of the dimensions of effective practice drawn from the perspectives of a range of key stakeholders who construct what constitutes effective practice within this specific context. These dimensions were found to be a combination of activities, behaviours, attitudes and theory-informed practice. They include what may be described as processors, such as working the ward; theoretically informed approaches such as task- centred practice and the successful ways health social workers professionally position ourselves in the hospital context. The quality of the relationships between the health social worker, their team, patients and their whanau members were found to be at the very heart of these dimensions. These dimensions are not confined to specific results, although there are indications that they do support successful outcomes.

I suggest that these dimensions of effective practice provide a solid platform which is able to support the provision of a high standard of care by health social workers in a hospital. They also appear to enhance the standard of care provided by our medical colleagues, offering confirmation of where health social workers were able to add value in this context. They are not intended to be definitive, exacting or prescriptive; rather I think of them as series of signposts, or touchstones, to help guide and support practitioners in what has been described and established as a complex, dynamic and contested practice environment.

The third and final aim, to design an intervention plan which supports hospital social work leadership to purposefully increase the provision of effective practice is provided in the final table of the thesis. Linked with the first element of clinical governance, these proposed findings provide a starting place for establishing and engaging in a more

consistent standard of practice which is meaningful and relevant in this context. This intervention also provides an opportunity to help fulfil the second element of clinical governance by making a substantial contribution to creating an environment in which excellence in clinical care can flourish. After exploring the limitations of this inquiry, the primary ideas which have informed the development of this intervention will be outlined.

Limitations of the inquiry

The most significant limitation of this study is the absence of the voices of patients and their whanau and family members regarding what they experience and describe as the dimensions of effective health social work practice. Whilst a patient's family member was interviewed during the case study, and her views were incorporated in the dimensions of practice subsequently checked via the survey, this is primarily an effectiveness test which was administered by key stakeholders other than patients and their families. Having patient and family participation would have added an additional layer of richness, quality, and authenticity to this account of what constitutes the dimensions of effective practice.

The next limitation worthy of acknowledgment is that at the design stage of this inquiry as I was identifying *the case* I held an expectation that a variety of disciplines, who were members of the multidisciplinary team would respond to the request for nominations of a health social worker they experienced as effective. In effect, nurses were the dominant professional group to make nominations, with only one physiotherapist making a nomination, and one doctor supporting the nomination from others. The reliance on e-mail cascades through leadership e-mail distribution lists may have reduced the possible responses for a number of unknown reasons; for example, the nurses may have had more up-to-date lists. The result of this is that the practitioner under study in the first phase of the research was predominantly nominated by nursing and social work staff, when the intention was that multiple disciplines had input into this choice.

A further limitation along similar lines grows out of the absence of other allied health voices, again in the first phase of the research. Whilst the assumption that all members of the multidisciplinary team would have a significant contribution to make about the nature of the health social work practice provided, as it turned out it was nurses, a doctor and

health social workers who proved information central to these accounts. This may have been a result of health social workers being in a separate team from our other allied health colleagues, at the time phase one of the inquiry was conducted. What this means is that our senior allied health colleagues had the opportunity to assess these dimensions of practice in the second phase of data collection but were not part of the initial development of them.

A fourth, and also significant limitation is that the majority of participants in this study are Pakeha health professionals, and those that are not, are not readily identifiable.
Although the purposeful choice was made to study a non-Maori practitioner, informed by my beliefs about the limitations of Pakeha researchers, researching Maori phenomena this does mean that the accounts of effective practice primarily reflect a particular world view. Any future inquiries would benefit from a greater inclusion of both Maori and Pacifica accounts of effective social work practice.

The final limitation is associated with the use of e-mail distribution lists which makes it difficult to be precise about the sample size and the response rate. Given the weighting decision regarding the emphasis being on the qualitative data, in favour of the quantitative data the impact of this limitation is reduced.

As an insider researcher the primary driver for undertaking this research was associated with the professional responsibilities I carry. Any ability to generalise the findings must consider the limitations as described above, and the clear contextual focus of the research. Prior to presenting the intervention plan, a brief exploration of the what has informed the parameters and nature of the intervention will be outlined, beginning with the connection between clinical governance, and the concept of a learning organisation.

Clinical governance, what is it and what are its aims?

Clinical governance has been described as providing one of the most high profile means of obtaining culture change in the health service (Degeling, et al., 2004). An accepted definition, more comprehensive than the one relied on earlier in this chapter, of clinical governance is,

> [a] framework through which the NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (Braithwaite and Travaglia, 2008, p. 11).

Whilst obviously we are not talking about the National Health Service (NHS), many of the hospitals in Aotearoa have adopted this concept, which is reliant on the development of a clinical governance framework. This is described as a series of initiatives which are designed with two primary purposes in mind; firstly to enhance the quality of the care provided to patients and their families; and secondly to encourage and support the development of a productive organisational culture and climate, inside which the provision of clinical care can flourish (Braithwaite & Travaglia, 2008).

These authors suggest that at the core of clinical governance strategies sit an explicit commitment to the organisational and professional principles of quality and safety and that these principles inherently rely on mutual accountability being developed between clinicians and hospital management (Braithwaite & Travaglia, 2008). In essence it is a systems approach to quality improvement, which I believe is highly congruent with the social work allegiance to systems theory.

Some authors argue that clinical governance must reach every level of a health care organisation and that in order to be truly effective greater emphasis needs to be maintained on its developmental focus (Degeling, et al., 2004). One of the key elements of this development focus is the concept of continuous education, which is situated within an organisational context (Braithwaite & Travaglia, 2008). Whilst acknowledging that individuals bear some responsibility for engaging in lifelong learning, at an organisational level this is required to be an entrenched cultural characteristic.

This approach to learning, which relies on a shared responsibility between practitioner and organisation, is in keeping with the requirement to engage in continuing professional development as articulated and monitored by the Social Work Registration Board (Social Work Registration Board, 2010). This requires registered social workers to participate in

continuing professional development, signed off by our employer, in order to be eligible for an Annual Practicing Certificate.

This is one of the locations where the connection is made between the individual responsibilities and the organisational ones, namely that in order for high standards of care to flourish, the organisation, in this case the Auckland District Health Board, is required to create a particular type of practice environment. A number of clinical governance structures, which aim to support the development and maintenance of such an environment include measures such as quality assurance, audit, promoting evidence-based practice, setting and monitoring standards, promoting continuous education and maintaining a primary focus on patient safety (Braithwaite & Travaglia, 2008). I have formed the belief that critical to its success will be the ability *to hold a space*, in which health social workers can engage in the type of reading, critical reflection, supervision and practice-based research activities, which are likely to support an increasingly effective workforce.

Many of the concepts and processors inherent in the clinical governance framework have been described in the literature in relation to the medical profession, most particularly doctors. As a leader of social workers I became interested in these ideas and how they may be translated, and applied to our profession. It was here that I turned to the concept of the learning organisation, as articulated by Gould and Baldwin (2006) in their book *'Social Work, Critical Reflection and the Learning Organization'*.

Social work and the learning organisation

Nick Gould and his co-editor Mark Baldwin have provided us with one of the first texts that explore the worthwhile concepts associated with transforming the organisations we work in, to learning organisations. Gould maintains that despite the relatively recent nature of the learning organisation literature, it is premised on an extensive sociological tradition of theory regarding the relationship between practitioner behaviour and the organisational structure in which we work (Gould & Baldwin, 2006). Providing a potted history of the learning organisation theory, Gould quotes Revan's law (1985):

> Revan's 'law' anticipates much of the theory of the learning organisation: For an organisation to survive its rate of learning must be equal to or greater than the rate of change in its external environment (Gould, 2000, p. 586).

According to Gould there are two significant areas of consensus in regards to organisational learning theory. One, that the learning of the individual is necessary but inadequate for organisational learning as the latter requires a collective process. This view appears to have been confirmed in my study, as clearly some practitioners have made various adaptations to the host environment that others of us have not been aware of. I believe this is one of the elements that have hindered a purposeful approach being developed which could aim to hasten and support this process of adaptation.

Secondly, "[l]earning incorporates the broad dynamics of adaptation, change and the environmental alignment of organisations, takes place across multiple levels within the organisation, and involves the reconstruction of meaning and world views within the organisation" (Gould, 2000, p. 587). I suggest that one way this concept is evident in the findings are those associated with health social workers increasing demand to respond to the disclosures which follow screening for family violence. In this domain of practice there is a clear indication that the organisation has paid inadequate attention to the development of the right knowledge and skills, ensuring the appropriate professional infrastructure is in place, or that sufficient human resources are available in order to ensure high standards of care are able to be maintained.

Central to the concept of the learning organisation is its capacity for change and transformation. In order to achieve this, the organisation is required to embed processes that will enable this change, transformation and learning to occur. Inherent to transformation occurring is organisational support for health social workers to reflect on our practice experiences, and the opportunity to discuss and analyse how our practice efforts contribute to the organisations aims (Preskill, 1994). In an effort to determine our ability to effectively meet patients and the organisations needs, current practices and work systems require ongoing evaluation (Preskill, 1994).

Expanding this idea and relying on Watkins and Marsick's definition published in 1992 (p. 128), Preskil proposes that:

> [t]his means that learning is a continuous, strategically-used-integrated with, and running parallel to, work-that yields changes in perception, thinking, behaviours, attitudes, values, beliefs, mental models, systems, strategies, policies and procedures (Preskill, 1994, p. 292).

It is here that the concepts of clinical governance and the learning organisation share a similar premise. This is that in order for excellence, quality and high standards of care to flourish, the organisation is required to create a particular culture, a particular professional environment, which is able to support learning beyond the individual. Having accepted this premise, this approach to practice development has been reflected in the choice of intervention activity I recommend at the conclusion of this chapter.

This intervention aims to support the development of a health social work professional learning culture, in which practitioners are encouraged to take up the activities associated with critically reflective learning. This approach fairly and squarely places the responsibility for safeguarding high standards of care in the shared hands of practitioners *and* leaders, whilst acknowledging that each has a particular role to play. In doing so there is a desire to protect the intervention from the resistance which is likely to follow a top-down, or what may be perceived to be a managerially driven intervention. Rather the aim is to engage health social workers in a process of reflection, learning and practice development.

There is a desire to enrich the findings by providing health social workers who are practicing in the very 'swampy lowlands of practice' an opportunity to interact with the findings, and to engage in further interpretations of the "actual critical practices that are 'best'" (Ferguson 2003, p.1005). There is a desire to support a considered, incremental and meaningful change occurring which continues to be thoroughly grounded in the day-to-day reality of practice.

Clearly the outcome of this practice-based research inquiry is an attempt at knowledge creation. The intervention which follows is an effort to increasingly apply this knowledge

in the workplace, unreservedly in an effort to support the translation of research knowledge into practice. Given the previous critics of the notions associated with a narrow-stream approach to evidence-based practice, this intervention aims to reflect the broad-stream approach of practice-based evidence. As described in chapter two of my thesis this approach includes increasing opportunities for health social workers to engage critically with research. This requires opportunities to access, interpret and transfer research material and to continue to create our own. As in this study, and a previous collective effort undertaken by a team of practitioners based in the same hospital context (Haultain, Thompson, Loli, Herd, & Comber, 2009), the desire is to continue to support local, practice-based research efforts.

Since my early days of academic study I have had a quote on my office wall that asks "What kinds of practices are possible once vulnerability, ambiguity and doubt are admitted?" (Lather, 1991, p. 47). This quote has held a lot of meaning for me and I have tried to reflect this meaning in each step of this research activity. It speaks to me of professional courage, of the willingness to try things out, to keep an open mind, to remain reflective and curious. It invites me to continue to wonder, can I do this differently? Lather's quote leads me to the final point to consider in relation to the development of this intervention. The last word goes to Fischer (1973) who after completing his empirical effectiveness study reminded us that the helping professions must continue to solve problems in the absence of certain knowledge.

I remain committed to these ideas and therefore have considered the kind of activities which will support health social workers to engage in and with these dimensions, without them becoming part of what could be considered 'certain knowledge'. My ambition is that these dimensions of practice which constitute an effort at practice-based research remain uncertain and in the words of an important professional mentor, Johnella Bird, *are held lightly*. If I am able to achieve this aim the opportunity is created for these ideas to be expanded, built upon, challenged, revised and reviewed just as I have been encouraged to engage with all theory, practice, knowledge, and ideas by Johnella.

Conclusion

The empirical literature is unequivocal in its belief that the way to answer questions of effective practice lies in the positivist tradition, where social work interventions are able to be reduced down to quantifiable variables, contained, defined and measured in order to establish their efficacy. Having been definitively established as effective, there is a growing expectation that the appropriate way to achieve increasing effectiveness is by applying the findings of this empirical research via a process of evidence-based practice.

The narrow-stream version of this activity would have social workers applying the findings from research by way of a strict adherence to practice guidelines, which by their very construction are often devoid of contextual considerations. Nor do they appear to consider that it may be the social workers who is effective, rather that the guide they are applying. This approach to practice guidance is presented as a simple A (problem) + B (intervention) = C (solution) equation which takes little account of the multi-layered and complex encounters most health social workers are required to respond to in the messy day-to-day reality of practice in an acute hospital.

Authors such as Witkin (1998) suggest that a more appropriate response to the highly complex and thorny issues of practice require a reflective, analytical and compassionate approach from practitioners and these thesis findings appear to support his view. Emphasising the diverse populations, and situations practitioners face, Witkin endorses a greater engagement with listening and learning from patients and their whanau in order that practitioners are able to develop solutions in partnership with our clients. The findings from my research suggest that this emphasis is entirely valid, with a primary finding, linking the quality of the relationship, with the quality of the outcome.

Both sides of the debate are supportive of social work practitioner's greater engagement with the notions and concepts associated with effective outcomes and the ethical application of evidence; it is *how* this is to be achieved where the paths tend to diverge. As outlined in chapter one, Cheetham and her colleagues propose that in order for effectiveness research to be helpful social workers need to know 'What parts of this practice worked well?' 'Which parts worked less well?', 'Why might this be the case?',

‘For whom did it work well?’, ‘What were the central factors influencing the situation?’ and so on. They also suggest that when the goal of the intervention is clearly defined and discernable, then the effectiveness of that intervention will be more easily determined and defined (Cheetham, et al., 1992).

This research activity has found that health social work practice, conducted within the confines of an acute hospital, does not appear to be amenable to the type of reductionist thinking, manifesting in ‘cook-book type practice guides’ which are primarily oriented towards outcomes. As these empirically informed guidelines appear to place minimal focus on the value of relationships, process, attitudes or values, they are therefore unlikely to be able to support the dimensions of practice identified in this study, as foundational to the provision of effective practice.

By developing an intervention which privileges the critically reflective approach as articulated by authors such as Fook, Witkin and Ferguson, practitioners will inevitably require substantial organisational input to support their ability to respond to the increasing need to improve outcomes for the patients, clients and their whanau in receipt of health and social services.

Based on my 25-year practice history employed in a vast range of government and non-government agencies spanning urban and rural health and social services; community and hospital facilities; mental and physical health; the statutory and voluntary sector; academic and practice contexts, my experience is that this reflective capacity is not well established. As a profession we are not consistently asking ourselves the questions posed by Cheetham and her colleagues as far back as 1992, and this is because at its most basic, the capacity to engage in this type of reflective activity relies on a number of multi-layered and complex variables being in place.

To engage in this type of practice evaluative activity, this attempt at sense making regarding the effectiveness of the service we provide, either as an individual practitioner, as a participant in a team process or as part of a wider organisational activity, a number of contextual variables must be present. For example, the health social worker will have

adequate access to a suitably qualified, experienced and accessible clinical supervisor who is able to assist them to consider these questions; process and develop their responses. To engage in a more formal evaluation of our service we typically rely on external research capacity, the occasional Masters or PhD student, or a rare partnership with university staff.

In order to begin to develop what has been conceptualised as research mindedness, at the very least practitioners require access to resources that will help support and develop our research skills. An example of this support in practice was demonstrated in 2007 via the Growing Research in Practice (GRIP) initiative with those of us lucky enough to participate getting a firsthand experience of the difference this sort of support can make to the development of local knowledge by engaging in practice-based research (Lunt, et al., 2007).

For many of us GRIP provided a first opportunity to have a research informed article published which described local, context specific knowledge that we developed via a practice based research project. This example of practice-based research, undertaken by a group of Maori, Pacifica and Pakeha health social workers employed in the hospital, was published in a local social work journal (Haultain, et al., 2009). Engaging in this project as the coordinator of it, brought home to me the amount of time, commitment and sheer grit required to complete research, within the hospital context and its unrelenting acute demand. Resources that are able to support a greater engagement with high standards of care via the increased translation and application of the findings from research must include ready access to computers, access to electronic journals and library facilities, assistance to identify appropriate research funding, the allocation and protection of non-clinical time for health social workers and research mentoring.

It is clear that health social workers who are curious about what research has to offer their practice, who are able to critique the findings from research and apply what is relevant, who have the capacity to engage constructively with research are rare. Rather they require nurturing in the workplace, and this relies on organisational and leadership insight and motivation and a commitment of time, resources and appropriately qualified personnel. I am fortunate to hold a professional role which has the leadership authority and

organisational backing and infrastructure to help develop this capacity in others. Combined with the professional commitment, networks and research knowledge to put such a framework in place, these elements of professional nurturing will form an important foundation for this intervention.

Bibliography

Aldrich, R. (2010). The aging demographic transition: The impact on elderly and social workers. *Aotearoa New Zealand Social Work Review, 22*(2), 4-12.

Andrew, S., & Halcomb, E. (Eds.). (2009). *Mixed methods research for nursing and allied health*. Chichester: Blackwell Publishing Ltd.

Aotearoa New Zealand Association of Social Workers. (2010, 2010). Social work in New Zealand. Retrieved 22 April, 2011, from http://anzasw.org.nz/sw-in-nz/

Atwal, A. (2002). Nurses' perceptions of discharge planning in acute health care: a case study in one British teaching hospital. *Journal of Advanced Nursing, 39*(5), 450-458.

Auckland District Health Board. (2011, 4 July 2011). Auckland District Health Board. Retrieved 23 July 2011, 2011, from http://www.adhb.govt.nz/

Auerback, C., Mason, S., & La Porte, H. (2007). Evidence that supports the value of social work in hospitals. *Social Work in Health Care, 44*(4), 17- 32.

Auerback, C., Rock, B., Goldstein, M., Kaminsky, P., & Heft-Laporte, H. (2000). A department of social work uses data to prove its case (88-99B) *Social Work in Health Care, 32*(1), 9-23.

Auslander, G. (2000). Outcomes of social work intervention in health settings. *Social Work in Health Care, 31*(2), 31-46.

Auslander, G. (2001). Social work in health care What have we achieved? *Journal of Social Work, 1*(2), 201-222.

Awatere, D. (1984). *Maori sovereignty*. Auckland: Broadsheet.

Bazeley, P. (2009). Integrating data analyses in mixed methods research. *Journal of mixed methods research, 3*(3), 203-207.

Beddoe, E. (1993). Health social work - A brave survivor or a victim? *Social Work Review, September* 30-31.

Beder, J. (2006). *Hospital social work. The interface of medicine and caring* New York: Routledge

Berger, C., & Ai, A. (2000). Managed care and its implications for social work curricula reform: Clinical practice and field instruction. *Social Work in Health Care, 31*(3), 59-82.

Berger, C., Cayner, J., Jensen, G., Mizrahi, T., Scesny, A., & Trachtenberg, J. (1996). The changing scene of social work in hospitals. *Health and Social Work, 21*(3), 167-177.

Berkman, B. (1996). The emerging health care world: Implications for social work practice and education. *Social Work, 41*(5), 541-551.

Berkman, B., Bonander, E., Kemler, B., Rubinger, M., Rutchik, I., & Silverman, P. (1996). Social work in the academic medical centre: Advanced training - a necessity. *Social Work in Health Care, 24*(1/2), 115-135.

Bilson, A. (2005). Introduction. In A. Bilson (Ed.), *Evidence-based practice in social work* (pp. 1-8). London: Whiting and Birch.

Bird, J. (2000). *The heart's narrative. Therapy and navigating life's contradictions*. Auckland: Edge Press.

Bird, J. (2004). *Talk that sings: Therapy in a new linguistic key*. Auckland: Edge Press.

Bird, J. (2006). *Constructing the narrative in super-vision*. Auckland: Edge Press.
Bjorkenheim, J. (2007). Knowledge and social work in health care - The case of Finland. *Social Work in Health Care, 44*(3), 261-278.
Bloom, A. L. (2000). *Health reform in Australia and New Zealand*. Auckland: Oxford University Press.
Bloom, M., Fischer, J., & Orme, J. (2003). *Evaluating practice: guidelines for the accountable professional* (4th ed.). Boston: Allyn and Bacon.
Blumenfield, S., & Epstein, I. (2001). Introduction: Promoting and maintaining a reflective professional staff in a hosptial-based social work department. *Social Work in Health Care, 33*(3/4), 1-13.
Bobbett, M. (1994). Health social work Some thoughts on the changes. *Social Work Review, September*, 14-15.
Boutin-Foster, C., Euster, S., Rolon, Y., Motal, A., BeLue, R., Kline, R., et al. (2005). Social work Admisison Assessment tool for identifying patients in need for comprehensive social work evaluation. *Health and Social Work, 30*(2), 117-125.
Boyce, R. (2001). Organisational governance structures in allied health services: A decade of change. *Australian Health Review, 24*(1), 22-36.
Braithwaite, J., & Travaglia, J. (2008). An overview of clinical governance policies, practices and initiatives. *Australian Health Review, 32*(1), 10-22.
Briggs, L., & Cromie, B. (2001). Editorial - Registration issues for health social work: Will social workers become 'second tier' health professionals? . *Social Work Review, Winter*, 1.
Bronstein, L., Kovacs, P., & Vega, A. (2007). Goodness of fit: Social work education and practice in health care. *Social Work in Health Care, 45*(2), 59-76
Cheetham, J., Fuller, R., McIvor, G., & Petch, A. (1992). *Evaluating social work effectiveness*. Buckingham: Open University Press.
Cheyne, C., O'Brien, M., & Belgrave, M. (1997). Health policy reform: Control or responsiveness? *Social policy in Aotearoa New Zealand. A critical introduction*. Auckland: Oxford University Press.
Christ, G. (1995). Developing a research unit within a hosptial social work department. *Health and Social Work, 20*(1), 60-69.
Clarke, J. L. (2003). Reconceptualizing empathy for anti-oppressive, culturally competent practice. In S. W. (Ed.), *Emerging perspectives on anti-oppressive practice*. Toronto: Canadian Scholars' Press Inc.
Cleak, H. (2002). A model of social work classification in health care. *Australian Social Work, 55*(1), 38-49
Coghlan, D., & Brannick, T. (2005). *Doing action research in your own organisation* (Second ed.). London: Sage Publications.
Cooper, L. (2002). Social work supervision: A social justice perspective. In W. McMahon (Ed.), *Supervision in the helping profession: A practical approach* (pp. 185-195). Sydney: Prentice HallS.
Cowles, L. (2003). *Social work in the health field*. New York: The Haworth Social Work Practice Press.
Creswell, J., & Plano Clark, V. (2007). *Designing and conducting mixed methods research*. Thousand Oaks: Sage Publications, Inc.
Creswell, J., & Plano Clark, V. (2011). *Designing and conducting mixed methods research*. Los Angeles: Sage Publications.

Cunningham, C. (2003). Application of TPK guidelines for conducting evaluation reseach with Maori. In N. Lunt, C. Davidson & K. McKegg (Eds.), *Evaluating policy and practice*. Auckland: Pearson, Prentice Hall.
Davis, C., Baldry, E., Milosevic, B., & Walsh, A. (2004). Defining the role of the hosptial social worker in Australia. *International Social Work, 47*(3), 346-358.
Davis, C., Milosevic, B., Baldry, E., & Walsh, A. (2004). Defining the role of the hopsital social worker in Australia Part 2. A qualitative approach. *International Social Work, 48*(3), 289-299.
de Vos, A. (2005). Scientific theory and professional research *Research at grass roots for the social sciences and human services professions* (Third ed.). Pretoria: Van Schaik Publishers.
Degeling, P., Maxwell, S., Iedema, R., & Hunter, D. (2004). Making clinical governance work. *British Medical Journal, 329*, 679-681.
Delport, C., & Fouche, C. (2005). The place of theory and the literature review in the qualitative approach to research *Research at grass roots for the social sciences and human service professions* (Third ed., pp. 261-266). Pretoria: Van Schaik Publishers.
DePoy, E., Hartman, A., & Haslett, D. (1999). Critical action research: A model for social work knowing. *Social Work, 44*(6), 560-569.
Dillman, D., Smyth, J., & Christian, L. (2009). *Internet, mail, and mixed-mode surveys. The tailored design method* (3rd ed.). New Jersey: John Wiley & Sons, Inc.
Durie, M. (1994). *Whaiora, Maori health development.* Auckland: Oxford university press.
Durie, M. (1998). *Te Mana Te Kawanatanga: The politics of Maori self-determination*. Auckland: Oxford University Press.
Durie, M. (2001). *Mauri ora: The dynamics of Maori health*. Auckland: Oxford University Press.
Dziegielewski, S. (2004). *The changing face of health care social work. Professional practice in managed behavioural health care*. New York: Springer Publishing Company.
Edwards, N. (2004). Commentary: Model could work. *British Medical Journal, 329*, 681.
Ellison-Loschmann, L. (2006). Improving access to health care among New Zealand's Maori population. *Americal Journal of Public Health, 96*(4), 612-617.
Epstein, W. (1990). Rational claims to effectiveness in social work's critical literature. *The Social Science Journal, 27*(2), 129-145.
Etherington, K. (2004). *Becoming a reflexive researcher*. London: Jessica Kingsley Publishers.
Everitt, A. (2002). Research and development in social work. In R. Adams, L. Dominelli & M. Payne (Eds.), *Social work themes, issues and critical debates* (Second edition ed.). Basingstoke: Palgrave in association with The Open University Press.
Fanslow, J. (2002). *Family violence intervention guidelines: Child and partner abuse*
Fawcett, B., Featherstone, B., Fook, J., & Rossiter, A. (Eds.). (2000). *Practice and research in social work. Postmodern feminist perspectives*. London: Routledge.
Ferguson, H. (2001). Promoting child protection, welfare and healing: the case for developing best practice. *Child and Family Social Work, 6*, 1-12.
Ferguson, H. (2003). Outline of a critical best practice perspective on social work and social care. *British Journal of Social Work, 33*, 1005-1024.
Fielding, N., Lee, R., & Blank, G. (Eds.). (2008). *The Sage handbook of online research methods*. Los Angeles: Sage Publications.

Fischer, J. (1973). Is casework effective? A review. *Social Work 18*, 5-20.
Fisher, M. (2002). The Social Care Institute for Excellence. The role of a national institute in developing knowledge and practice in social care. *Social Work and Social Sciences Review, 10*(2), 6-34.
Fook, J. (2000). Deconstructing and reconstructing professional expertise. In B. Fawcett, B. Featherstone, J. Fook & A. Rossiter (Eds.), *Practice and research in social work. Postmodern feminist perspectives*. London: Routledge.
Fook, J. (2002). *Critical theory and practice*. London: Sage Publication Ltd.
Fook, J. (Ed.). (1996). *The reflective researcher. Social workers' theories of practice research*. St Leonards: Allen and Unwin Pty Ltd.
Fook, J., & Askeland, G. (2006). The 'critical' in critical reflection. In S. White, J. Fook & F. Gardener (Eds.), *Critical reflection in health and social care* (pp. 40-53). Maidenshead: Open University Press.
Fook, J., Ryan, M., & Hawkins, L. (Eds.). (2000). *Professional expertise practice, theory and education for working with uncertainty*. London: Whiting & Birch Ltd.
Foucault, M. (1977). The political function of the intellectual. *Radical Philosophy, 17*, 12-14.
Fraser, M., Taylor, M. J., Jackson, R., & O'Jack, J. (1991). Social work and science: Many ways of knowing? *Social Work Research and Abstracts 27*(4), 5-15.
Fuller, R., & Petch, A. (1995). *Practitioner research: The reflexive social worker*. Buckingham: Open University Press.
Gauld, R. (Ed.). (2003). *Continuity amid chaos*. Dunedin: University of Otago Press.
Gibbons, J. (2001). Effective practice: Social work's long history of concern about outcomes. *Australian Social Work, 54*(3), 3-13.
Gibbs, A. (2001). The changing nature and context of social work research. *British Journal of Social Work, 31*, 687-704.
Giles, R., Gould, S., Hart, C., & Swancott, J. (2007). Clinical priorities: Strengthening social work practice in health. *Australian Social Work, 60*(2), 147-165.
Glasgow, K., & Fanslow, J. (2007). *Family violence intervention guidelines. Elder abuse and neglect*.
Globerman, J. (1996). Social work in restructuring hospitals: Meeting the challenge. *Health and Social Work, 21*(3), 171-178.
Globerman, J. (1999). Hospital restructuring: Positioning social work to manage change. *Social Work in Health Care, 28*(4), 13-30.
Globerman, J., & Bogo, M. (2002). The impact of hospital restructuring on social work field education. *Health and Social Work, 27*(1/February), 7-15.
Gorey, K., Thyer, B., & Pawluck, D. (1998). Differential effectiveness of prevalent social work practice models: a meta-analysis. *Social Work, 43*(3), 269-279.
Gould, N. (2000). Becoming a learning organisation: A social work example. *Social Work Education, 19*(6), 585-596.
Gould, N., & Baldwin, M. (Eds.). (2006). *Social work, critical reflection and the learning organization*. Aldershot: Ashgate.
Grant, B., & Giddings, L. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse, 13*, 10-28.
Gray, M. (2004). Just practice and the beginning practitioner. Unpublished Masters thesis. Massey University, Albany.
Gueron, J. (2007). Building evidence: What it takes and what it yields. *Research on Social Work Practice, 17*(1), 134-142.

Hall, J., Jensen, G., Fortney, M., Sutter, J., Locher, J., & Cayner, J. (1996). Education of staff and students in health care settings: Integrating practice and research. *Social Work in Health Care, 24*(1/2), 93-113.

Haultain, L., Thompson, A., Loli, M., Herd, J., & Comber, C. (2009). Whanau meetings in the hospital: Uncovering the unique role of social workers. *Social Work Review, 21/22*(4/1), 4-14.

Henry, E., & Pene, H. (2001). Kaupapa Maori: Locating indegenous ontology, epistemology and methodology in the academy. *Organization, 8*(2), 234-242.

Hesse-Biber, S. (2010). *Mixed methods research: Merging theory with practice*. New York: The Guilford Press.

International Federation of Social Workers. (2005). Definition of social work. Retrieved 22 April, 2011, from http://www.ifsw.org/f38000138.html

International Federation of Social Workers. (2008, 05.09.2008). International policy on health. Retrieved 22 April, 2011, from http://www.ifsw.org/p38000081.html

Jahnke, H., & Taiapa, J. (2003). Maori research. In C. Davidson & M. Tolich (Eds.), *Social science research in New Zealand* (pp. 39-50). Auckland: Pearson Prentice Hall.

Jones, R., & Jenkins, F. (2007). *Managing and leading in the allied health professions*. Oxford: Radcliff Publishing.

Joubert, L. (2006). Academic-practice partnerships in practice research: A cultural shift for health social workers. *Social Work in Health Care, 43*(2/3), 151-161.

Judd, R., & Sheffield, S. (2010). Hospital social work: Contemporary roles and professional activities. *Social Work in Health Care, 49*(1), 856-871.

Kelly, P., & Farrant, B. (2008). Shaken baby syndrome in New Zealand, 2000-2002. *Journal of Paediatrics and Child Health, 44*, 99-107.

Kelly, P., & Hayes, I. (2004). Infantile subdural haematoma in Auckland, New Zealand: 1988-1998. *New Zealand Medical Journal, 117*(1201), 1-9.

Kelly, P., MacCormick, J., & Strange, R. (2009). Non-accidential injury in New Zealand: The outcome of referal to statutory authorities. *Child Abuse and Neglect, 33*, 393-404.

Kirk, S., & Reid, W. J. (2002). *Science and social work: A critical appraisal*. New York: Columbia University Press.

Kitchen, A., & Brook, J. (2005). Social work at the heart of the medical team. *Social Work in Health Care, 40*(4), 1-18.

Klein, W., & Bloom, M. (1995). Practice wisdom. *Social Work, 40*(6), 799-807.

Kossman, D., Lamb, J., O'Brien, M., Predmore, S., & Prescher, M. (2005). Measuring productivity in medical social work. *Social Work in Health Care, 42*(1), 1-16.

Koziol-McLain, J., Garrett, N., & Gear, C. (2009). *Hospital responsiveness to family violence 48 month follow-up evaluation report*.

Lather, P. (1991). *Getting smart: Feminist research and pedagogy with/in the postmodern*. London: Routledge.

Lechman, C., & Duder, S. (2006). Psychosocial severity, length of stay and the role of social work services. *Social Work in Health Care, 43*(4), 1-13.

Lees, J. (2001). Reflexive action research: Developing knowledge through practice. *Counselling and Psychotherapy Research, 1*(2), 132-139.

Lishman, J. (1999). Introduction. In I. Shaw & J. Lishman (Eds.), *Evaluation and social work practice* (pp. 1-13). London: Sage Publications.

Lonne, B., Parton, N., Thomson, J., & Harries, M. (2009). *Reforming child protection*. London: Routledge.

Lumsden, J. (2007). On-line questionnaire design guidelines. In R. Reynolds, R. Woods & J. Baker (Eds.), *Handbook of research on electronic surveys and measurements*. Hershey: Idea Group Reference.

Lunt, N., Fouche, C., & Yates, D. (2007). *Growing research in practice (GRIP) an innovative partnership model*. Wellington: The Families Commission.

Macdonald, G. (2001). *Effective interventions for child abuse and neglect. An evidence-based approach to planning and evaluating interventions*. Chichester: John Wiley and Sons, Ltd.

Macdonald, G., Sheldon, B., & Gillespie, J. (1992). Contemporary studies of the effectiveness of social work. *British Journal of Social Work, 22*(6), 615-643.

Mafile'o, T. (2005). Community development: A Tongan perspective. In M. Nash, R. Munford & K. O'Donoghue (Eds.), *Social work theories in action* (pp. 125-139). London: Jessica Kingsley Publishers.

Magill, M. (2006). The future of evidence in evidence-based practice: Who will answer the call for clinical relevance? *Journal of Social Work, 6*(2), 101-115.

Martinez-Brawley, E. (2001). Searching again and again. Inclusion, heterogeneity and social work research. *British Journal of Social Work, 31*, 271-285.

Mauri Ora Associates. (2009). *He Ritenga Whakaaro: Maori experiences of health services*. Auckland.

McCallin, A. (2006). Interdisciplinary team work: Labelling is not enough. *JARNA, 9*(2), 6-10.

McKeague, M., & Windsor, J. (2003). Patient's perception of the adequacy of informed consent: A pilot study of elective general surgical patients in Auckland. *New Zealand Medical Journal, 116*(1170), 1-9.

McMichael, A. (2000). Professional identity and continuing education: A study of social workers in hospital settings. *Social Work Education, 19*(2), 175-183.

Mezirow, J., & & Associates. (1990). *Fostering critical reflection in adulthood* (1st ed.). San Francisco: Jossey-Bass Publishers.

Miller, J. (2001). The knowledge, skills and qualities needed for social work in a major paediatric teaching hospital. *Australian Social Work, 54*(1), 3-6.

Miller, J. (2006). Skills, bravery, courage, and foolhardiness: Seventy-five years of social work in health care in Melbourne, Australia. *Social Work in Health Care, 43*(2/3), 173-191.

Ministry of Health. (2000). *The New Zealand Health Strategy*.

Ministry of Health. (2010). *Statement of intent 2010-2013*. Retrieved from http://www.moh.govt.nz/moh.nsf/pagesmh/10104/$File/soi1013.pdf.

Ministry of Health. (2011). DHB Home page. Retrieved 7 August 2011, 2011, from http://www.moh.govt.nz/moh.nsf/indexmh/dhbs

Ministry of Social Development. (2011). Green paper for vulnerable children. Retrieved 11.08.11, 2011, from http://www.childrensactionplan.govt.nz/

Mizrahi, T., & Berger, C. (2005). A longitudinal look at social work leadership in hospitals: The impact of a changing health care system. *Health and Social Work, 30*(2), 155-163.

Munro, E. (2011). *The Munro review of child protection. Interim report: The Child's Journey*. Retrieved from http://www.education.gov.uk/munroreview/downloads/Munrointerimreport.pdf.

Mutua, K., & Swadener, B. (2004). Introduction. In K. Mutua & B. Swadener (Eds.), *Decolonizing research in cross-cultural contexts* (pp. 1-23). Albany: State University Press.

Myers, L., & Thyer, B. (1997). Should social work clients have the right to effective treatment. *Social Work, 42*(3), 288-298.

Nash, M., Munford, R., & O'Donoghue, K. (Eds.). (2005). *Social work theories in action*. London: Jessica Kingsley Publishers.

Nelson, M. (1999). A view of social work advocacy in hospitals in Eastern Ontario. *Social Work in Health Care, 29*(4), 69-92.

Neuman, K. (2000). Understanding organizational reengineering in health care: Strategies for social work's survival. *Social Work in Health Care, 31*(1), 19-33.

Nilsson, D. (2007). Evaluating adjustment to health condition and adjustment to hospitalisation as indicators for intervention in Australia. *Social Work in Health Care, 45*(2), 21-42.

O'Hare, T. (2005). Definitions, processes, and principles *Evidence-based practices for social workers* (pp. 3-13). Chicago: Lyceum Books, Inc.

Parton, N. (2000). Some thoughts on the relationship between theory and practice in and for social work. *British journal of social work, 30*, 449-463.

Patton, M. (2002). *Qualitative research and evaluation methods*. Thousand Oaks: Sage Publications.

Payne, M. (2000). *Teamwork in multiprofessional care*. Basingstoke: Palgrave.

Pease, B., & Fook, J. (Eds.). (1999). *Transforming social work practice*. St. Leonards: Allen & Unwin.

Pecukonis, E., Cornelius, L., & Parrish, M. (2003). The future of health social work. *Social Work in Health Care, 37*(3), 1-15.

Perkins, R., Pelkowitz, A., & Sedden, M. (2006). Quality improvement in New Zealand healthcare. Part 7: Clinical governance - an attempt to bring quality into reality. *The New Zealand Medical Journal, 119*(1243), 1-6.

Plath, D. (2006). Evidence-based practice: Current issues and future directions. *Australian Social Work, 59*(1), 56-72.

Pockett, R. (2003). Staying in hospital social work. *Social Work in Health Care, 36*(3), 1-23.

Pohatu, T. (2003). Maori world-views: Source of innovative social work choices. *Social Work Review, Spring*, 16-24.

Pope, C. (2003). Resisting evidence: The study of evidence-based medicine as a contemporary social movement. *Health, 7*(3), 267-282.

Poulin, J., & Young, T. (1997). Development of a helping relationship inventory for social work practice. *Research on Social Work Practice, 7*(4), 463-489.

Preskill, H. (1994). Evaluation's role in enhancing organizational learning: A model for practice. *Evaluation and Program Planning, 94*, 291-297.

Pritchard, C. (2004). Effective social work: A micro approach - reducing truancy, delinquency and school exclusions. In D. Smith (Ed.), *Social work and evidence-based practice* (pp. 61-86). London: Jessica Kingsley Publishers.

Reid, W. J. (2001). The role of science in social work. The perennial debate. *Journal of Social Work, 1*(3), 273-293.

Reid, W. J., & Fortune, A. E. (2002). The task-centred model. In A. Roberts & G. Greene (Eds.), *Social workers' desk reference* (pp. 1001-1104). Oxford: Oxford University Press.

Reid, W. J., & Fortune, A. E. (2003). Empirical foundations for practice guidelines in current social work knowledge. In A. Rosen & E. Proctor (Eds.), *Developing practice guidelines for social work intervention* (pp. 59-79). New York: Columbia University Press.

Reid, W. J., & Hanrahan, P. (1982). Recent evaluations of social work: grounds for optimism. *Social Work, 27*(4), 328-340.

Rich, A. (1980). *On lies, secrets and silence*. London: Virago.

Rock, B. (2002). Social work in health care for the 21st century: The biopsychosocial model. In A. Roberts & G. Greene (Eds.), *Social workers' desk reference* (pp. 10-15). New York: Oxford University Press.

Rock, B., & Cooper, M. (2000). Social work in primary care: A demonstration student unit utilizing practice research. *Social Work in Health Care, 31*(1), 1-17.

Rosen, A., & Proctor, E. (2003). Practice guidelines and the challenge of effective practice. In A. Rosen & E. Proctor (Eds.), *Developing practice guidelines for social work intervention Issues, methods, and research agenda* (pp. 1-14). New York: Columbia University Press.

Ross, G. (1990). Turf conflict between nurses and social workers. *Social Work Review, 3*(1&2), 24-26.

Ross, J. (1993). Redefining hospital social work: An embattled professional domain. *Health and Social Work, 18*(4), 243-247.

Rubin, A. (1985). Practice effectiveness: More grounds for optimism. *Social Work, November-December*, 469-476.

Ruch, G. (2005). Relationship-based practice and reflective practice: holistic approaches to contemporary child care social work. *Child and Family Social Work, 10*, 111-123.

Ruch, G., Turney, D., & Ward, A. (Eds.). (2010). *Relationship-based social work: getting to the heart of practice*. London: Jessica Kingsley.

Ruckdeschel, R. (1999). Qualitative clinical reseach and evaluation. In I. Shaw & J. Lishman (Eds.), *Evaluation and social work practice* (pp. 182-197). London: Sage Publications.

Ruwhiu, L. (2005). Tangata whenua knowledge and social work theory. Unpublished Study guide and readings. Massey University

Sackett, D., Rosenburg, W., Muir Grey, J., Haynes, R., & Richardson, W. (1996). Evidence based medicine: what it is and what it isn't. Retrieved 14 July, 2011, from http://www.bmj.com.ezproxy.massey.ac.nz/content/312/7023/71.long?eaf

Sale, J., Lohfeld, L., & Brazil, K. (2002). Revisiting the quantiative-qualitative debate: Implications for mixed-methods research. *Quality and Quantity, 36*, 43-54.

Sapey, B. (2004). Practice for what? The use of evidence in social work with disabled people. In D. Smith (Ed.), *Social work and evidence-based practice*. London: Jessica Kingsley Publishers.

Sarantakos, S. (2005). *Social research*. Basingstoke: Palgrave Macmillan.

Schofield, V. (2001). Health social work. In M. Connelly (Ed.), *New Zealand social work. Contexts and practice*. London: Oxford University Press.

Schon, D. (1995). *The reflective practitioner*. Aldershot: Arena Ashgate Publishing Ltd.

Schon, D. A. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic Books.

Shaw, I. (1999). Evidence for practice. In I. Shaw & J. Lishman (Eds.), *Evaluation and social work practice* (pp. 14-40). London: Sage Publications.

Shaw, I., & Lishman, J. (Eds.). (1999). *Evaluation and social work practice*. London: Sage Publications.
Sheldon, B. (1986). Social work effectiveness experiements: Review and implications. *British Journal of Social Work, 16*, 223-242.
Sheldon, B., Chilvers, R., Ellis, A., Moseley, A., & Tierney, S. (2005). A pre-post empirical study of obstacles to, and opportunities for, evidence-based practice in social care. In A. Bilson (Ed.), *Evidence-based practice in social work* (pp. 11-50). London: Whiting and Birch.
Smith, D. (2004a). Some versions of evidence-based practice. In D. Smith (Ed.), *Social work and evidence-based practice* (pp. 7-27). London: Jessica Kingsley Publishers.
Smith, D. (Ed.). (2004b). *Social work and evidence-based practice*. London: Jessica Kingsley Publishers.
Smith, S. (2002). What works for whom: the link between process and outcome in effectiveness research. *Australian Social Work, 55*(2), 147-155.
Social Work Registration Board. (2008). Code of conduct guidelines for social workers. In Social Work Registration Board (Ed.) (pp. 1-10).
Social Work Registration Board. (2010). Continuing Professional Development for Registered Social Workers booklet (V1.1 ed.). Wellington: newzealand.govt.nz.
Soskolne, V., Kaplan, G., Ben-Shahar, I., Stanger, V., & Auslander, G. (2010). Social work discharge planning in acute hospitals in Israel: Clients' evaluation of the discharge planning process and adequacy. *Research on Social Work Practice, 20*(4), 368-379.
Stake, R. (1995). *The art of case study research*. Thousand Oaks: Sage Publications.
Stake, R. (2005). Qualitative case studies. In N. Denzin & Y. Lincoln (Eds.), *The Sage handbook of qualitative research* (Third ed.). Thousand Oaks: Sage Publications.
Staniforth, B., & Larkin, R. (2006). Documentation in social work: Rembering our ABCs. *Social Work Review, Spring*, 13-20.
Stanley, L., & Wise, S. (1983). *Breaking out: Feminist consciousness and feminist research*. London: Routledge & Kegan Paul.
Subramanian, K. (2000). The nature of social work services in a large public medical centre serving an impoverished multicultural population. *Social Work in Health Care, 31*(2), 47-64.
Sulman, J., Savage, D., & Way, S. (2001). Retooling social work practice for high volume, short stay. *Social Work in Health Care, 34*(3/4), 315-332.
Sulman, L., & Tuzman, L. (1982). Discharge planning: A social work perspective. *Quality Review Bulletin, Special Edition*(Spring), 27-82.
Tamasese, K., & Waldergrave, C. (1993). Culture and gender accountability in the "Just Therapy" approach. *Journal of Feminist and Family Therapy, 5*, 29-45.
Tanenbaum, J. (2005). Evidence-based practice as mental health policy: Three controversies and a caveat. *Health Affairs, 24*(1), 163-173.
Tashakkori, A. (2009). Are we there yet? The state of the mixed methods community. *Journal of mixed methods research, 3*(4), 287-291.
Tashakkori, A., & Teddlie, C. (Eds.). (2003). *Handbook of mixed methods in social and behavioral research*. Thousand Oaks: Sage Publications.
Taylor, C. (2004). Social work and looked after children. In D. Smith (Ed.), *Social work and evidence based practice*. London: Jessica Kingsley Publishers.
Taylor, C. (2006). Practising reflexivity: narrative, reflection and the moral order. In S. White, J. Fook & F. Gardener (Eds.), *Critical reflection in health and social care* (pp. 73-88). Maidenhead: Open University Press.

Thomas, D. (2006). A general inductive approach for analyzing qualitative evaluation data. *American journal of evaluation., 27*(2), 237-246.
Thomlison, R. (1984). Something works: Evidence from practice effectiveness studies. *Social Work, January-February*, 51-56.
Thyer, B. (1996). Forty years of progress toward empirical clinical practice? *Social Work Research 20*(2), 77-82.
Todman, A., & Mulitalo-Lauta, P. (2009). The social work alert system: An account of a new initiative in the emergency department at Middlemore hospital. *Aotearoa New Zealand Social Work Review, 21/22*(4/1), 44-52.
Trinder, L. (2000a). Evidence-based practice in social work and probation. In L. Trinder & S. Reynolds (Eds.), *Evidence-based practice. A critical appraisal*. Oxford: Blackwell Science.
Trinder, L. (2000b). Introduction: The context of evidence-based practice. In L. Trinder & S. Reynolds (Eds.), *Evidence-based practice. A critical appraisal*. Oxford: Blackwell Science.
Trotter, C., Cox, D., & Crawford, K. (2002). Family problem solving: A case study. *Australian Social Work, 55*(1), 119-127.
Tuhiwai Smith, L. (2005). *Decolonizing methodologies: research and indigenous peoples*. Dunedin: University of Otago Press.
Turner, N., Hoare, K., & Dowell, T. (2008). Children in New Zealand: Their health and human rights. *The New Zealand Medical Journal, 121*(1271). Retrieved from http://www.nzma.org.nz/journal/121-1271/2980/
Van Heugten, K. (2001). Social work: Its role and task. In M. Connelly (Ed.), *New Zealand social work: Contexts and practice* (pp. 3-17). Auckland: Oxford University Press.
Videka-Sherman, L. (1988). Metaanalysis of reseach on social work practice in mental health. *Social Work, 33*(4), 325-338.
Volland, P. (1996). Social work practice in health care: Looking at the future with a difference lens. *Social Work in Health Care, 24*(1/2), 35-51.
Vonk, M., Tripodi, T., & Epstein, I. (2007). *Research techniques for clinical social workers* (Second ed.). New York: Columbia University Press.
Wade, K., & Neuman, K. (2007). Practice-based research: Changing the professional culture and language of social work. *Social Work in Health Care, 44*(4), 49-64.
Walker, A. (1971). *You can't keep a good woman down*. New York: Harcourt Brace.
Wandersman, A. (2001). Program development, evaluation and accountability. In L. Ginsberg (Ed.), *Social work evaluation* (pp. 178-210). Boston: Allyn and Bacon.
Webb, S. (2001). Some considerations on the validity of evidence-based practice in social work. *British Journal of Social Work, 31*, 57-79.
Wells Imre, R. (1984). The nature of knowledge in social work. *Social Work, January-February*, 41-45.
White, S., Fook, J., & Gardener, F. (Eds.). (2006). *Critical reflection in health and social work*. Maidenhead: Open University Press.
Whitt, N., Harvey, R., McLeod, G., & Child, S. (2007). How many health professionals does a patient see during an average hospital stay? *The New Zealand Medical Journal, 120*(1253). Retrieved from http://www.nzma.org.nz/journal/120-1253/2517/
Wills, R., Ritchie, M., & Wilson, M. (2008). Improved detection and quality of assessment of child abuse and partner abuse is achievable with a formal organisational change approach. *Journal of Paediatrics and Child Health, 44*(3), 92-98.

Wilson, D., & Neville, S. (2008). Nursing their way not our way: Working with vulnerable and marginalised populations. *Contemporary Nurse, 27*(2), 165-176.

Wimpfheimer, S. (2004). Leadership and management competencies defined by practicing social work managers: An overview of standards developed by the national network for social work managers. *Administration in Social Work, 28*(1), 45-56.

Witkin, S. (1998). The right to effective treatment and the effective treatment of rights: Rhetorical empriricism and the politics of research. *Social Work, 43*(1), 75-80.

Witkin, S. (2000). Editorial - Writing social work. *Social Work, 45*(5), 389-394.

Wood, K. (1978). Casework effectiveness: A new look at the research evidence. *Social Work, 23*(6), 437-458.

Wright, N. (1957). Medical social work at Queen Elizabeth Hospital, Rotorua. *The New Zealand Nursing Journal, 50*(5), 193-194.

Yin, R. (2003). *Case study research: Design and methods* (Third ed. Vol. 5). Thousand Oaks: Sage Publications.

Young, T., & Poulin, J. (1998). The helping relationship inventory: A clinical appraisal *Families in society: The jounal of contemporary human services, March-April*, 123-133.

Zimmerman, J., & Dabelko, H. (2007). Collaborative models of patient care: New opportunties for hosptial social workers. *Social work in health care., 44*(4), 33- 47

Appendices

Appendices

Appendix list

1. Sequential exploratory mixed method design
2. Ethics approval – case study
3. Ethics approval – survey
4. Information sheet
5. Consent form
6. Outline of questions and prompts for semi-structured interviews
7. Sensitising framework
8. Information, back ground and consent page and survey (data)
9. Email to participants
10. The dimensions of effective health social work practice
11. Operations definitions and proposed intervention

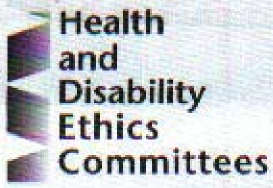
Appendix one: Sequential exploratory mixed method design employed in this study[1]

Design (sequence from right to left)→					
QUAL[2] data collection – case study in hospital paediatric ward	**QUAL** data analysis and findings (Case study)	Use case study findings to design survey tool	**Quan** & **QUAL** data collection – survey tool applied across three hospital populations	**Quan** and **QUAL** analysis (Survey)	Interpretations **QUAL** findings (case study) **QUAL** & **quan** findings (survey)
Research methods and activity (flow down each column)					
• Purposeful sampling • In-depth interviews • Document analysis • Non-participant observation s	• Thematic analysis • Indentify quotes • Identify dimensions and categories of effective practice • Develop hypothesis re adaptation to host environment	• Develop dimensions /categories and subcategories based on findings and health social work literature • Design open ended questions for new practice	• Purposeful sampling via email distribution lists (senior stakeholders: midwives, nurses, doctors, health social workers and other allied health practitioners)	• Report statistical results • Identify quotes that support generalisation and identify areas of difference • Thematic analysis of QUAL survey data	• Interpret and discuss combined findings

[1] Adapted from Plano Clark & Cresswell's Figure 23.0 Visual Diagram of a Sequential Exploratory Mixed Methods Design to Generate and Test a Conceptual Model SOURCE: Based on Richter (1997). p. 551

[2] Use of capitals, or lower case reflects weighting decision (see methodology chapter for fuller description)

	• Present dimensions, categories and hypothesis to practitioners x2	domains			
Research outcomes (flow down each column)					
• X 9 interviews transcripts • X 5 observation sheets • X 10 document analysis	• 10 key themes • Detailed description of dimensions developed • Adaptation to host hypothesis	• Survey tool	• Sample (N=191)	• Summary tables Quan and QUAL	• operational definitions of the dimensions of effective practice • intervention plan



Northern X Regional Ethics Committee
Ministry of Health
3rd Floor, Unisys Building
650 Great South Road, Penrose
Private Bag 92 522
Wellesley Street, Auckland
Phone (09) 580 9105
Fax (09) 580 9001

Email: pat_chainey@moh.govt.nz

4 July 2007

Ms Linda Rose Haultain
32 Nikau Rd
Blackpool
Waiheke Island

Dear Linda

NTX/07/05/046 **Effective social work practice in a multidisciplinary team, a contextual inquiry centred in the multidisciplinary team: a qualitative case study: PIS/Cons V#3, 27/06/07.**

Principal Investigator: Ms Linda Rose Haultain
Massey University, Auckland DHB

Thank you for your letter received 3 July 2007 attaching the Committee's requested changes for this study. The above study has now been given ethical approval by the **Northern X Regional** Ethics Committee. However, the following is requested

- Version no. and date inserted as a footer on both the information sheet and the consent form, i.e. V#2, 27 June 2007.
- Consent Form to be on letterhead.

Please forward a copy of this document to me for the file.

A list of members of this committee is attached.

Approved Documents

- Information Sheet/Consent Form version #2 dated 27 June 2007.
- Outline of Questions Version #2 dated 25 June 2007.

Certification

The Committee is satisfied that this study is not being conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the trial is being carried out.

Accreditation

The Committee involved in the approval of this study is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, April 2006.

Final Report

The study is approved until 31 March 2008. A final report is required at the end of the study. The report form is available on http://www.newhealth.govt.nz/ethicscommittees - Information for Researchers – Progress Reports and should be forwarded along with a summary of the results. If the study will not be completed as advised, please forward a progress report and an application for extension of ethical approval one month before the above date.

Requirements for SAE Reporting

The Principal Investigator will inform the Committee as soon as possible of the following:

- Any serious adverse events occurring during the study which are considered related to the study.

All SAE reports must be signed by the Principal Investigator and include a comment on whether he/she considers there are any ethical issues relating to this study continuing due to this adverse event.

Amendments
All amendments to the study must be advised to the Committee prior to their implementation, except in the case where immediate implementation is required for reasons of safety. In such cases the Committee must be notified as soon as possible of the change.

Please quote the above ethics committee reference number in all correspondence.

The Principal Investigator is responsible for advising any other study sites of approvals and all other correspondence with the Ethics Committee.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Yours sincerely

Pat Chainey
Administrator
Northern X Regional Ethics Committee

Cc: ADHB Research Office A+ 3777

Linda Haultain

From: Pat_Chainey@moh.govt.nz

Sent: Monday, 17 September 2007 4:08 p.m.

To: Linda Haultain

Subject: Study NTX/07/05/046

Effective social work practice in a multidisciplinary team, a contextual inquiry centred in the multidisciplinary team: a qualitative case study: PIS/Cons V#3, 23/09/07

Dear Linda

This email needs to be annexed to the ethical approval letter dated 4 July 2007.

Ethical approval is given to the amended Participant Information Sheet/Consent Form V#3 dated 3 September 2007.

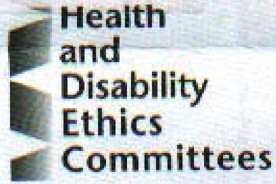
Regards
Pat

Ms Pat Chainey
Administrator Northern X Regional Ethics Committee
Health & Disability Ethics Committees
Chief Advisor Services
Population Health Directorate
Ministry of Health
DDI: 09 580 9105
Fax: 09 580 9001

http://www.newhealth.govt.nz/ethicscommittees
mailto:Pat_Chainey@moh.govt.nz

****
Statement of confidentiality: This e-mail message and any accompanying
attachments may contain information that is IN-CONFIDENCE and subject to
legal privilege.
If you are not the intended recipient, do not read, use, disseminate,
distribute or copy this message or attachments.
If you have received this message in error, please notify the sender
immediately and delete this message.
****

This e-mail message has been scanned for Viruses and Content and cleared by the Ministry of Health's Content and Virus Filtering Gateway



Northern X Regional Ethics Committee
Ministry of Health
3rd Floor, Unisys Building
650 Great South Road, Penrose
Private Bag 92 522
Wellesley Street, Auckland
Phone (09) 580 9105
Fax (09) 580 9001

e-mail: pat_chainey@moh.govt.nz

9 November 2009

Ms Linda Rose Haultain
32 Nikau Rd
Blackpool
Waiheke Island

Dear Linda

NTX/07/05/046	**Effective social work practice in a multidisciplinary team, a contextual inquiry centred in the multidisciplinary team: a qualitative case study: PIS/Cons V#3, 23/09/07: Substudy survey 2/11/09**
Principal Investigator:	Ms Linda Rose Haultain

Thank you for your emailed requests dated 14 September to 2 November 2009

The following amendment was reviewed by the Deputy Chairperson of the Northern X Regional Ethics Committee under delegated authority.

Ethical approval has been given for :

- Addition of a Substudy: On line survey
- Information, background, Consent and Instructions (undated)

Yours sincerely,

Pat Chainey
Administrator
Northern X Regional Ethics Committee

Cc: Auckland Research Office A+3777

Social Work Department
Auckland City and Starship Children's Hospital
Auckland District Health Board

INFORMATION SHEET

INVITATION:

Hello and Kia ora
My name is Linda Haultain and I would like to invite you to participate in some research I am undertaking to help me to understand more about effective social work practice within the hospital environment.

TITLE:

Effective Social work practice, a contextual inquiry centred in multidisciplinary team: A qualitative case study.

INTRODUCTION:
I am currently undertaking a study to enable me to complete my Master's of Social Work qualification via Massey University. Whilst I am a student, I also work for the Auckland District Health Board in the role of Professional Leader for Social Work. If you want to speak to me you can telephone me on my phone number at work, 307 4949 ext 23534.

ABOUT THE STUDY

Since the introduction of the Social Work Registration Act (2003) here in New Zealand there has been an increased requirement for social workers to demonstrate the effectiveness of the social work service they provide to patients, and their families.

The aim of the study is to identify and describe the current social work professional activities that could be described as highly effective, within the multidisciplinary team in an acute hospital setting, in Aotearoa New Zealand.

As a researcher I wish to explore the essential social work practices that both members of the team, and the person receiving the service, believe are essential to achieving effective outcomes. To understand effective practice in detail I will be interviewing a social worker, members of the multidisciplinary team, a service user and some of their family, and appropriate members of the social work profession. I will also review the social work literature that relates to effective practice.

Before asking you to sign a consent form to be involved in the study I will explain the study to you and then give you time to decide whether you would like to participate. It is entirely your choice. You do not have to take part in this study and if you choose not to take part, this will not affect any future care or treatment for you, or your

employment, if you work at the hospital. If you do agree to take part, you are free to withdraw from the study at any time without having to give a reason and this will not affect your future health care. Only families fluent in English will be involved.

Participants for the study have been selected because of their association with the social worker in the organisation who has been identified as providing especially effective social work. I have developed a schedule of questions and participants will be invited to reflect on the social workers practice, and talk about what their experience of the social work practice has been. The interviews will be taped and I will also take notes. All names and identifying information will be taken out of the information I get, before the information is published.

BENEFITS RISKS AND SAFETY

The results of the study will inform the field of effective social work practice, within the multidisciplinary team in an acute hospital setting, and in particular, within the profession of social work. There are minimal risks to participants in the study and a maximum of approximately 90 minutes time is all that is required from most participants.

If during the course of this study poor practice comes to my attention, I will inform you of the appropriate complaints procedures and I will pass on any concerns to your direct supervisor and/or line manager.

CONFIDENTIALITY

No material which could personally identify you will be used in any reports of this study. I will prepare the transcripts myself and no one else will get to read them. Records will be stored in a locked cupboard to ensure details are kept confidential throughout the duration of the study, and will be stored at Auckland District Health Board after completion of the study.

COMPENSATION

In the unlikely event of a physical injury as a result of your participation in this study, you will be covered by the accident compensation legislation with its limitations. If you have any questions about ACC please feel free to ask the researcher for more information before you agree to take part in this trial. There will be no financial costs for participants, and no one will receive payment for taking part.

ADVOCACY STATEMENT

If you have any queries or concerns regarding your rights as a participant in this research study, you can contact an independent Health and Disability Advocate. This is a free service provided under the Health and Disability Commissioner Act:

Telephone (NZ wide): 0800555050
Free Fax (NZ wide): 0800 2787 7678 (0800 2 SUPPORT)
Email: advocacy@hdc.org.nz

If you have any questions throughout or following your participation in the study, you may contact me at the phone number above.

RESULTS

The findings will be available to read by participants and publication of the results will be sought in peer reviewed academic journals. There will be approximately a six month delay between data collection and publication.

STATEMENT OF APPROVAL

This research project and my practice as the researcher will continuously receive mentoring and oversight by an experienced researcher from Massey University, my supervisor, Christa Fouche.

This study has received ethical approval from the Northern X Regional Ethics Committee.

Please feel free to contact me or my supervisor if you have any questions about this study.

Research Contact person:

Linda Haultain
Professional Leader
Auckland District Health Board
Private Bag 92 024 Auckland Hospital
(09) 307 4949 Extension 23534 or e-mail **lindah@adhb.govt.nz**

Supervisor:
Christa Fouche
Associate Professor
School of Social and Cultural Studies
Massey University
Telephone (09) 414 0800

Appendix 5

CONSENT FORM FOR PARTICIPATION IN RESEARCH

Interview

I ……...

being over the age of 16 years hereby consent to participate as requested in the **interview** for the research project on effective social work practice in an acute hospital setting.

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to my information and participation being recorded on tape
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
   - I may not directly benefit from taking part in this research.
   - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
   - I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
   - I understand that participation in the interview or will not impact on my employment or my future health care

Participant's signature……………………………………Date…………………...

I certify that I have explained the study to the participant and consider that she/he understands what is involved and freely consents to participation.

Researcher's name: Linda Haultain.

Researcher's signature…………………………………..Date……………………

NB. Two signed copies should be obtained.

Appendix 6

Outline of questions and prompts for the semi-structured interviews

A. Social work practitioner

1. Within the context of the multidisciplinary team, when you consider effective social work practice, what thoughts, ideas or examples come forward that would help me to understand what you consider to be the most important aspects of effective practice?
2. If we were to explore one of these memories or examples in greater detail which one would provide us with the most clues about what effectiveness means to you?
3. Now that you have chosen an example, could you tell me about this in more detail?
    - how long ago were you involved with this example?
    - who else was involved, in what context and role?
    - what were the identified case work issues?
    - how were these issues identified?
    - how would you describe the relationship you had with the client?
    - how long were you involved with this piece of work?
    - what skills, abilities or knowledge did you bring to bear on the situation?
    - when you think back on it, what is it that you think contributed to the effective outcome?
    - What did you learn from these experiences?

4. You will be aware that a variety of people have identified you as someone who has a capacity to engage in effective practice. What do you think they notice that would lead them to nominate you as an effective practitioner?

5. Who, in your life, either personally or professionally would be the least surprised that this has happened? What do they know about you, the person that you are, the ideas and practices that you engage with that would lead to them not being surprised?

6. What do you think has contributed to this capacity for effective practice? What do you believe is the most essential skills, abilities, ideas or practices that support this effectiveness?

7. In thinking about the case that has been selected for this research project, what are the first things that come to mind when you think about this particular service user and his/her whanau/family?

8. What do think you has been an essential contributor to the effectiveness of this particular piece of work?

9. When you think about the effectiveness of this specific piece of practice;

- can you recall how the issues were identified that required your assistance?
- can you recall how you decided to focus on these particular issues?
- can you remember how the change in situation was reflected on, measured and evaluated in terms of its effectiveness?

10. What ideas, skills or abilities have supported this reflection on effectiveness?

11. Do you remember when/how or with whom you learnt these particular skills?

12. How do you think that ......would describe the involvement you have had with him/her during their time in hospital?

13. If other people were watching/listening to you whilst you were engaged in this type of practice with .... what would they see, here, or notice that you believe has contributed to this effectiveness?

14. When you think about significant moves towards increased effectiveness in your practice over the years, what has supported these moves?

15. When you think about effective practice, what theory, learning, literature or organisational policy comes to your mind which you believe has contributed to this effectiveness?

16. In what forum or locations do you evaluate the effectiveness of your practice?

17. When you want to have a second opinion about the effectiveness of the practice, who do you discuss this with? What types of conversations support this kind of reflection?

18. Is there anything that hinders or hampers a greater engagement in practice that is effective?

19. Have you discovered any skills, thinking or practices that have assisted you to move further towards effective practice?

20. When I inquire with the team what they most respect or value about the social work practice you provide to clients, what do you think they will say?

B. Service user and/or significant member of their whanau/family

1. You will be aware that I am very interested in understanding more about your experiences of the social work service you received from .... I am especially interested in *your* experience of this service. When you think about the time you have spent with .... and the specific usefulness of this time, what thoughts, or memories or experiences come to mind that would help me to understand this experience better?

2. You know that I have a particular interest in the idea of effective social work practice, and for the purposes of this study, I am most interested in effective practice that takes place within a health team of many professionals such as doctors, and nurses and physiotherapists. I wonder if you could tell me what effective practice means to you within this context. When you hear the words *effective practice*, what do you think that is made up of? How do you think about or measure effectiveness when it comes to social work?

3. When you remember the issues you discussed with the social worker, when you think about the things that were important for you to have help with, can you remember how you and the social worker came to agree that these were the issues that needed attention?

4. How important was it for you that these things were agreed to be important?

5. Do you remember if there were times when ..... checked back with you how things were going with........., do you recall how she/he did that? How important was that to you?

6. Thinking about your ...... and what was going on for her when she came into hospital, did you think at the time that it might be helpful to have the assistance of a social worker?

7. What did you know about social workers at that time, did you have much of an idea about what they did, or what kind of help they could offer?

8. Have your expectations of the social workers, the things you thought you would get, and the things you did get, how have they matched up?

9. If you were to name the three most important things that you have learnt, or discovered or remembered whilst being involved with ...... professionally, what would those three things be?

10. When you think about what .... did to assist you, what was it do you think, that made the real difference? What was it she/he said or did, what was it about the way she talked or didn't talk, pushed or didn't push, that made the real difference to you?

11. If someone was to overhear you and .... talking, or if they were to walk into the room when you were together, what is it that they would notice, or hear, that would be important for me to know if I was to understand this idea of effectiveness better?

C. Key member of the multidisciplinary team, i.e. charge nurse, doctor or physiotherapist

1. How long have you been practicing ....., and how long have you been working with ....?

2. When you think back to how many social workers you may have worked along side of, roughly how many do you think it might have been?

3. When you think about effective social work practice, within the context of this multidisciplinary team, what words, thoughts, memories or examples come into your mind?

4. If you were to think about .... practice in relation to effectiveness for a moment, is there anything that stands out about her/his practice that you think it may be important for me to know about?

5. You will be aware that a variety of people have identified ..... as someone who has the capacity to engage in effective social work practice within the context of this team. What do you think these people might have noticed that would lead them to nominate ..... as an effective practitioner?

6. When you think about ...... and specific examples of effective practice that she/he has contributed to, what do you think has been essential to this contribution?

7. You will be aware that I am interested in a specific case has been identified as particularly effective, within this team, and that I understand you were involved in this case too, the case involving....... When you think about this case, and specifically ...... contribution to it, what do you think are the essential elements of her practice/knowledge/skills or personality that have impacted on this effective outcome?

8. What do you believe are the essential attributes, skills and abilities that enhance effective social work practice on a multidisciplinary team, in an acute hospital setting?

9. Have you ever witnessed ..... working along side a client, if so, what have you noticed which you think may contribute to the effectiveness of her/his practice?

10. Have you ever heard clients describing or discussing their involvement with ...., if so what have they said that could be significant to the effectiveness of their practice?

11. What do you know about social work ethics, values or standards which may contribute to the effectiveness of ...... practice?

12. If you think about effective practice in relation to other team members, and the specific contribution she/he makes to their practice, are there any examples that come to mind which may be important for me to understand?

13. If you have to name the essential elements, factors, or signs of effective social work practice, within the context of an multidisciplinary team, what would they be?

C. Key stakeholder from professional community, i.e. long standing member of Aotearoa New Zealand Association of Social work

1. How many years, and in what roles, have you been associated with the association for?

2. And how many years, and in what roles have you been involved in social work practice?

3. In considering the issue of effective social work practice can you tell me what thoughts, examples or memories come to mind?

4. Thinking back to your own professional education, times of training can you think what ideas or theories or practices are dominant in New Zealand and what relationship these may have with the effectiveness of social work practice?

5. Thinking about the best supervisory relationship you have had, can you recall the way that practice was evaluated, what types of conversations or questions or areas of inquiry gave an emphasis to the issues of effectiveness?

6. In considering the issue of effective practice, can you recall what specific association activities or initiatives the have been undertaken in the pursuit of increasing social workers engagement in effective practice?

7. Can you expand on how these initiatives are intended to specifically impact on practitioner’s engagement in interventions that are effective?

8. In thinking about intervention choices for a moment and thinking about people seeking help from a social worker for a condition such as anxiety or depression perhaps, do you think that client has an ethical right to an intervention that has been empirically proven to be effective?

9. I was recently reading an article which asked questions about service user's right to receive interventions that have been proven to be effective. How do you position yourself around this issue? For example, in a New Zealand context, what constitutes valid evidence of effectiveness?

10. Do you think it is reasonable to compare the interventions social workers engage in, with the interventions of other medical professionals, such as doctors and/or psychologists?

11. What changes have you noticed over the years regarding social workers engagement or not with professional matters such as research and evaluation, or evidence, or the application of practice standards, that sort of thing?

12. What do you think the association expects of social workers regarding these professional matters? What clues do the Code of Ethics, or the Practice Standards provide regarding these professional matters?

13. In thinking about effective practice, what do you think the essential elements are that support effective social work practice? What are the first things that come to mind thinking about the effectiveness of specific social workers practice? And thinking specifically about the role of effectiveness within teams, or multidisciplinary teams in particular, what are the critical aspects of this, do you think?

14. What does empirically proven mean to you, what thoughts, ideas or practices come to mind when you consider the matters or evidence, or evidence based practice? Do these things have a direct relationship for you, with effective practice, if so why, if not, why not?

13. What role do you think the association has in supporting these practice activities?

Appendix 7

Sensitising framwork

Sensitising concepts	**date/time**	**data source**	**observation/reflection**
Physical environment • space • noise • furniture • participants • resources			
Professional activities Activities i.e. • responding to pager • ways of speaking • interaction with staff • interaction with patients • following through • keeping in touch			

• being clear about role • use of professional language • use of informal language • tone of voice • pace • use of theory • negotiation of goals • recording of goals • evaluation of goals • evaluated against what? • beginning, middle, end of patient interaction • attend to sequence			
Referral processes • pager • written • explicit • appropriate			

• volume			
Social climate Activities .i.e. • stopping to chat • greetings • personal sharing • bringing/sharing food • warmth/friendliness • informal interactions • what are people saying about each other • what happens in unstructured time			
Meetings Activities i.e. • patterns of interaction • non-verbal clues • frequency of interaction • groupings • presenting sw view			

• who gets to speak • how are decisions made • how are decisions communicated • does the team use ‘native language’? • pace • process • humour • conflict • tension • strengths • use quotes and source • what does not occur			

Appendix 8

Effective Social Work Practice in the acute hospital environment.

1. INFORMATION, BACKGROUND AND CONSENT PAGE

Researcher:
Linda Haultain
Social Work Professional Leader
ADHB
Private Bag 92 024 Auckland Hospital
3074949 ext 23534 or e-mail lindah@adhb.govt.nz

Key Supervisor:
Mike O'Brien
Associate Professor
School or Social and Cultural Studies
Massey University
Telephone (09) 4140800

Title:
Effective social work practice, in the acute hospital environment.

Introduction:
Kia ora, my name is Linda Haultain and I am doing this survey as part of my doctorate in Social Work, I also work for ADHB.

About the study:
This study aims to understand effective social work practice in the acute hospital setting.

Phase one of the data collected for this study comprised MDT interviews, observational activities and literature review (2008). This data identified a number of personal and professional attributes that are believed to contribute to the provision of effective social work practice in the acute hospital environment.

The purpose of this survey is to validate and broaden the findings from phase one. I will use them to develop an intervention that aims to extend effective social work practice in this hospital.

Benefits, risks and safety:
The results of this study will inform the field of effective social work practice, within the profession of social work. There are no risks to participants in the study and there are only 15 questions!

A minimum of 20 minutes and a maximum of around 30 minutes is all the time that is required from most participants.

Confidentiality:
No material which could personally identify you will be used in any reports of this study. All the surveys will be confidential, and I will be the only person that has direct access to the survey material. Records will be stored in a locked cupboard to ensure details are kept confidential through the duration of the study, and will be stored at Auckland District Health Board after completion of the study.

Compensation:
In the unlikely event of a physical injury as a result of your participation in this survey, you will be covered by the accident compensation legislation within its limitations. There will be no financial costs for participants. All participants who complete and return the survey will go into a prize draw for a GOURMET FOOD HAMPER, VALUED AT $500!

Results:
Publication of the results will be sought in peer reviewed academic journals and will be presented at conference and ADHB Grand Round.

Statement of approval:
Mike O'Brien from Massey University has monitored the project in his role as research supervisor. Ethical advice and approval has been provided by the District Health Boards Northern X Regional Ethics Committee.

Consent:
By completing this survey, and returning it via the electronic link, you are consenting to participate in this study. This consent is made on the basis of reading about the study, and understanding that once you have returned the survey, you will be unable to withdraw from the project because your response will be anonymous.

Effective Social Work Practice in the acute hospital environment
Exit this survey

2. Instructions

Survey instructions:
Only the first two questions are compulsory, if you do not answer them you can't continue.

Once you begin the survey you will notice that you are asked to rank each attribute as well as identify how important it is to you. This is a TWO STEP process.

Step one, which element in each set of attributes is most important overall?
Step two, how important are these attributes in their own right?

In other words, if forced to pick only one out of the set, which is THE most important? (step 1)

In step 2 you may decide all of them are extremely important which is fine. In this part of the question you can use the word descriptors as many times as you like.

So when you are answering the questions it is vital that you only use each RANKING number ONCE, this is the only way I can figure out the most essential attribute or skill in each set.

Ranking

1 = extremely important/valued
2 = very important
3 = important
4 = not very important
5 = not relevant

Thank you very much for participating in this study, your contribution is critical to a successful outcome. If you want to be entered into the prize draw, please include your name and a contact phone number at the end of the survey. Remember your name will not be linked to any of the information you have provided, it is simply being sought for the purpose of the prize draw.

Best regards

Linda Haultain

Effective Social Work Practice in the acute hospital environment

1. This question is compulsory; please write a response or the survey format will prevent you from continuing. Please tell me the first words that come into your mind when you are asked to describe an effective ward social worker?

	Response Count
	196
answered question	196
skipped question	1

2. Please provide the following practice location and role details. This information will help me to understand any differences that may exist across the hospital.

	Response Percent	Response Count
Ward	100.0%	196
Profession:	100.0%	196
Role:	100.0%	196
Period employed in health:	100.0%	196
answered question		196
skipped question		1

. Which of these social work skills is the most important to you Please use each ranking
n the how important menu you can use each description as many times as you like .
T T R T 1 most important 2 second most important the middle
very important least important

Ranking

	1	2			
	6. % 69				
	.2%				
				2 . %	
	.9% 6				
					29.6

ow important is this to you

	extremely important	very important	important	not very i
	61. % 116			
	61.2% 11			
		2.2% 9		
	. %			
		. % 1		

answered
skipped

. Please rank these characteristics when thinking a out the effective ward social worker. efore please use each ranking num er C . n the how important menu you can use ea description as many times as you like .

Ranking

	1	2		
	9. %			
		.2%		
				.0% 6
	6. % 0			

ow important is this to you

	extremely important	very important	important	not important	not applica le
	2.0% 9				
		1. % 9			
			. % 6		
		6. % 69			

answered questio
skipped questio

. Please rank these social work activities which help to identify patients who require a soc use each ranking num er C please. n the how important menu you can use each des as you like .

Ranking

	1	2			
		26.6% 0			
					1. %
		1.6% 60			
	. %				
				2 .0% 2	

ow important is this to you

	extremely important	very important	important	not important	
	6. % 6				
				1.6% 9	
			60.9% 109		
	.2% 101				
	. %				
			2.6% 9		

	a

6. n a multicultural ward context please rate the following social work competencies and t value them. Please use each ranking num er C . n the how valued menu you can use many times as you like .

Ranking

	1	2			
				22.2% 1	
	9. % 9				
		.6% 0			
			2 .1%		

ow much do you value this

	highly valued	very valued	valued	not valued	
			1. % 6		
	. % 10				
	0.0% 92				
	. %				
			1. % 6		
			6.6% 10		

	a

. omain . elp of a practical nature for example providing a food parcel or assistance with transport . Please provide one or two examples of practical social work assistance that you value.

	Response Count

answered question	1
skipped question	0

. omain . dvocacy and support related to medical issues e.g. explaining a medical condition in simple language to a patient or family mem er . n the space elow please give me one or two examples of medical social work input that you value.

	Response Count

answered question	1 6
skipped question	1

9. omain C. motional support e.g. listening and responding to a patient s distress or family mem ers reaction to their loved ones hospitali ation . n the space elow please give me one or two examples of emotional social work help that you value.

	Response Count

answered question	1
skipped question	

10. omain . elp of a cultural nature e.g. making sure a family s need for prayer efore a meeting is provided for . n the space elow please give me one or two examples of cultural social work input that you value.

	Response Count
answered question	1
skipped question	60

11. This question is a out social work assessment intervention and planning. Please rank competencies and only use each ranking num er C so that can work out which is the important competence overall. n the how important menu you can use each description as you like . ust a reminder a out the ranking system: 1 most important the middle g important

Ranking

	1	2			
	69. % 11				
		0. % 9			
			.6% 6		
				. %	
					9.1

ow important is it to you

	extremely important	very important	important	not very important	not ap
	6 . % 102				
	. % 0				
	6. % 91				
		. %			
			2. % 2		

answered
skipped

12. When you imagine the C TR T an effective social worker makes to team relatio following attri utes. Please use each ranking num er C only. n the how important me each description as many times as you like .

Ranking

	1	2			
			.2% 61		
	0.0% 2				
				. % 6	
		2. % 0			
					.9

mportance of contri ution to you

	extremely important	very important	important	not important	not ap
		. %			
	.6% 90				
			2.6% 69		
	.9% 9				
			. %		

answered

skipped

1 . Paediatrics and Women s ealth R only: ocial work competence in child protecti violence practice is important want to know which elements of this practice is most impo Please use each ranking num er once only. n the how important menu you can use eac many times as you like .

Ranking

	1	2			
	62.2% 6				
		0.0% 6			
			2 .9% 26		
				6. %	

how important is it to you

	extremely important	very important	important	not important	not app
	9. % 0				
	.0% 66				
	62. %				
	6. % 9				

answered
skipped

1 . dult ealth R only: dentifying and responding to family violence elder a use unsafe care arrangments or caregiver stress are likely to e relevant in adult health. Please tell me what social work skills you identify as important when working with these vulnera le populations.

	Response Count

answered question	
skipped question	11

1 . Please indicate the value you place on the following traits in an effective ward social wo use each ranking num er C . n the how important menu you can use each descriptio as you like .

Ranking

	1	2			
	0. %				
	. %				
	2 . %				
	2 .9%				
					9.1

ow much do you value this trait

	ighly valued	very valued	valued	not va
	9. % 120			
	0.0% 120			
	6 . % 9			
	6 .2% 10			
	.0% 66			

answered
skipped

16. Please enter your name and contact telephone num er if you would like to go into the draw for the R T P R. e in to win all complete responses go into the draw

		Response Count
	answered question	1
	skipped question	2

Linda Haultain (ADHB)

From: [redacted] (ADHB)
Sent: Monday, 14 June 2010 12:58 p.m.
To: Linda Haultain (ADHB)
Subject: FW: An opportunity to inform ADHB social work service - please complete this survey - great prize to be won!

Sent to adult health senior nurses today.

Regards

[redacted]
PA to the General Manager Clinical Services & Nurse Director Adult Health, Margaret Dotchin
and Deputy Chief Medical Officer & Medical Director Adult Health, Margaret Wilsher
Auckland City Hospital

DDI (064 9) 3754396 or int. ext. 23996
Fax (064 9) 6310761 or int. 24490
Mobile 021 492 357
Email SBiddick@adhb.govt.nz

Subject: An opportunity to inform ADHB social work service - please complete this survey - great prize to be won!

Dear Senior Nurses,

Please take the time to complete Linda's survey; it will help to ensure that the social work service in this hospital is responsive to your clinical area's needs.

Regards [redacted]
Nurse Director, Adult Health

Dear Participant

This survey forms the final part of a PhD study aimed at understanding effective hospital social work.

The findings will help me to develop a local intervention that will support improved social work effectiveness in this practice context.

This survey provides a significant opportunity for your experience and opinions to contribute to this intervention so please have your say!

Your opinion and experiences matter a lot to me so please take 20 minutes or so out of your busy day to complete the survey and I promise it will make a difference to ADHB social work practice.

All participants will be eligible to go into a draw to win a $500 gourmet food

hamper which will include New Zealand made wine, chocolates and condiments – all you have to do is complete the survey, include your contact details to be in to win ! Survey closes 30th June 2010.

Please follow the attached link to complete the survey
http://www.surveymonkey.com/s/P7X3T65

Kind regards
Linda Haultain

Social Work Professional Leader
Allied Health Offices
Level 11 Support Building, Auckland Hospital
Private Bag 92-024
Auckland. NZ

e-mail lindah@adhb.govt.nz

Appendix 10

The dimensions of effective health social work practice

Preamble:

1. These dimensions of effective health social work practice in an acute hospital setting are a *representation* of the combined qualitative and quantitative data to emerge from a doctorial research project undertaken at Auckland District Health Board
2. The dimensions of practice which did not achieve the 60% highly valued, or extremely important rating, but did receive extensive qualitative support are included
3. The dimensions of effective practice provide a touchstone that key stakeholders could apply to help inform or support the following operational and professional activities;
   - Recruitment
   - Clinical supervision
   - Continuing professional development
   - Self and peer assessment of skills
   - Orientation
   - Performance Appraisal
   - Objective setting
   - Clinical indicators
   - Practice based research

Domain 1: Responding to vulnerability and risk associated with interpersonal family violence

1.1 Establish trust and rapport with patients and families

1.2 Maintain a non-judgemental attitude and approach

1.3 Take time to listen carefully (presence listening)

1.4 Assess concerns in collaboration with MDT colleagues

1.5 Intervene to meet needs and increase safety and wellbeing

1.6 Develop and maintain internal and external networks

1.7 Communication and team work

1.8 Identify and assess child protection concerns

1.9 Assess and respond to family violence concerns including elder abuse and neglect

1.10 Assist with the management of child protection and family violence concerns over time

1.11 Maintain constructive working relationships with family members in child protection and family violence situations

Domain 2: Provision of practical advocacy and support

2.1 Advocacy re finances, including sound knowledge of all financial entitlements

2.2 Advocacy re accommodation and housing (during hospital stay and post discharge)

2.3 Advocacy re transport (home, to outpatient clinics, to visit loved ones)

2.4 Advocacy re practical assistance of a population specific nature, e.g. food for parents on ward, clothing, nappies, milk powder, personal alarms, care of pet, (relies on sound knowledge of resources)

Domain 3: Provision of emotional advocacy and support

3.1 High value on relationship-based practice and use of self which reflect the human qualities of compassion and empathy

3.2 Presence listening

3.3 The capacity to provide emotional advocacy and support in times of distress, e.g. post a poor diagnosis, prognosis, still birth and bereavement. This practice is likely to be informed by the following theories and models;

- brief interventions
- grief and loss
- crisis intervention
- adjustment, decision making and coping
- relationship based practice
- strengths based, solution focused and resilience theory
- counseling skills
- biopsychosocial

3.4 Developing rapport and engaging people

3.5 Non-judgmental

3.6 Help to manage complex situation on the ward

3.7 Stable centered demeanor

3.8 The ability to adjust communication style

3.9 The ability to work with people from different backgrounds

3.10 Knowledge of and ability to refer on to appropriate support services

Domain 4: Provision of medical advocacy and support

4.1 Maintain an awareness regarding the risk of misunderstandings, or miscommunication between the medical team and the patient and their family

4.2 Proactively engage in activities which support patient and family understanding and engagement in the health service, this relies on a number of skills including;

- Knowledge of medical conditions, language, disease trajectory and possible outcomes
- Communication
- Team work
- Patient advocacy
- Cultural competence, including multiple constructions of health and illness
- Arranging and facilitating family meetings

4.3 Regular liaison with and referral to internal and external services

4.3 All the dimensions associated with the provision of emotional advocacy and support also apply in this domain

Domain 5: Provision of cultural advocacy and support

5.1 Liaison with and referral to appropriate culture support and resources, internal and external

5.2 Assess and respond to specific cultural needs in order to assist patient and family engagement

5.3 Apply knowledge of cultural and ethnic issues, needs and concerns to support patient engagement and comfort

5.4 Support cultural responsiveness in the wider multidisciplinary team

5.5 Assist the patient and their family to understand the medical condition

5.6 Seek cultural guidance from our health social work colleagues with particular cultural knowledge

5.7 (Leadership) Recruit health social workers able to reflect ethnic composition of local population

5.8 Facilitate effective family meetings across a range of cultures

5.9 Identify cultural support for patient and/or family members

5.10 Work effectively with an interpreter

Domain 6: Working the ward – dependable service delivery

6.1 Social needs are met in order to solve complex problems

6.2 Able to 'think outside the square' in order to solve problems

6.3 Proactive and highly organised

6.4 Attend nursing handover when appropriate/possible/relevant

6.5 Highly visible and accessible

6.6 Approachable

6.7 Reliable

6.8 Responsive

6.9 Provide a timely response

6.10 Be proactive about identifying patients who may need social work services

6.11 Teach the multidisciplinary team about the health social work role

Domain 7: Psychosocial assessment with the focus on safe and timely discharge

7.1 Knowledge of medical conditions, disease processes and likely impact on patient and whanau

7.2 Knowledge of how ward identifies patients for health social work services, e.g. rapid rounds

7.3 Knowledge of different approaches to assessment dependant on area of service delivery (informed by biopsychosocial framework)

7.4 Timely assessment

7.5 Clear intervention planning

7.6 Accessible record of the assessment

7.7 Focus on safe and timely discharge

7.8 A focus on reducing the likelihood of readmission

Domain 8: Team relationships and team work

8.1 Ability to develop and maintain multidisciplinary team relationships

8.2 Being a team player

8.3 Being available to talk things over

8.4 Work in consultation with MDT

8.5 Attend the weekly multidisciplinary team meeting

Domain 9 Communication

9.1 Open

9.2 Honest, challenging and upfront

9.3 Diplomatic

9.4 Ability to adjust communication style

9.5 Effective communication

9.6 The Health Social Worker – the communication pathway between patient, family and team

Appendix 11

Operational definition of effective health social work practice (HSW) and the intervention to support its purposeful development

Preamble The dimensions of practice which form the basis of these operational definitions of effective practice are reported in Appendix 10, a fuller account of the details of these dimensions is available in Chapters five and six of this thesis. This list of operational definitions and a series of interventions designed to support them being increasingly embedded across the acute hospital is designed for the context in which the research was undertaken. They will be lead by me, in my role as Social Work Professional Leader, in collaboration with key stakeholders such as Social Work Practice Supervisors, and allied health Team Leaders. The activities reflect the professional responsibility and commitment I have to contributing to the creation of a practice environment in which clinical excellence can flourish. The operational definitions and interventions may be applie din other acute hospital contexts, provided a critical review was undertaken of their relevance, for example, I am aware that a number of hospitals in Aotearoa currently have guidelines in place for the appropriate management of elder abuse. When references are made to 'applying the research data' I am referring to the data to emerge from this study.

Operational definition – effective HSW practice	Examples of practice activities	Clinical governance, and learning organisation informed interventions
1.Responding to vulnerability and risk The effective HSW understands and values the unique contribution we make to identifying, assessing and responding to the needs of vulnerable patients and their families	• HSW engage in careful listening and use our intuition to help us identify patients who may be vulnerable • HSW develop trust and rapport with patients and families when we are intervening in situations involving vulnerability and risk • HSW demonstrate compassionate and empathy when we are responding to vulnerability and risk • HSW have a sound understanding of the policy and practice guidelines relevant to this area of practice	• Undertake a data mining (clinical audit) of the impact of family violence screening on HSW workloads • Undertake a learning needs analysis to establish base line competence across all service areas

in order to reduce risk, and increase patient safety and wellbeing.	• HSW practice reflect the profession's values and standards including our commitment to ethical practice associated with human rights • HSW can apply the principles of patient rights when responding to vulnerability and risk, including a robust engagement in the informed consent process • HSW are proactive about identifying, assessing and responding to patient and family vulnerability and risk • HSW work in partnership with patients and family members to help support an increase in the patient and/or their family members safety and wellbeing • HSW maintain high standards of verbal and written communication when responding to vulnerability and risk • HSW work collaboratively with members of the multidisciplinary team when responding to vulnerability and risk • HSW work in effectively in multidisciplinary and multiagency forums to support an increase in safety and wellbeing for patients and their families • HSW are able to draw on research and practice	• Social work leadership, informed by the data generated from this research work in consultation with hospital leadership and other key stakeholders to identify the impact of the increasing demands on HSW in relation responding to vulnerability and risk • Engage in an analysis of the combined data from the previous activities in order to help prioritise actions, including the opportunity to increase HSW human resources in the hospital • Develop practice guidelines and a clinical pathway for responding to elder abuse and

	knowledge to increase safety and wellbeing, while reducing risk • HSW are able to demonstrate competent and ethical practice for vulnerable patients and their families across all service areas of the acute hospital	neglect • Develop social work informed clinical guidelines for responding to vulnerability and risk that reflect social work values, standards and ethics • Develop an interagency meeting applied practice guide[1] • Develop strategic and practice partnerships with key stakeholders both internal and external • Establish a learning forum which encourages critical reflection and dialogue about the HSW role in relation to

[1] An applied practice guide is one that is developed in consultation with health social workers, combining best evidence and best practice wisdom to support the day-to-day practice of health social workers without being overly prescriptive

		vulnerability and risk • Monitor complaints and develop response to themes • Partner with university to undertake research which explores the unintended consequences of hospitals increasing focus on interpersonal family violence
2.Practical advocacy and support The effective health social worker provides advocacy and support to ensure the provision of the basic necessities of life while people are in hospital, and upon discharge. HSWs have a sound knowledge of resources both internal	• HSWs assist patients with finances issues • HSWs assist patients and their families with housing and accommodation issues • HSWs assist patients and families to resolve transport issues which enable them to attend follow up visits; return to their communities; access health services and visit their loved ones in hospital • HSWs assist patients and their families to access food, clothing, nappies, milk powder and other basic necessities	• Develop applied practice guidelines for four areas of greatest need • Use practice guide to orient new HSWs • Identify key community agencies and support increased knowledge of and liaison with key stakeholders • Develop team resources and incorporate community visits

and external to the hospital and is able to access these to support safe and timely discharge	• HSWs actively liaison with community agencies in order to meet practical needs • HSW apply our knowledge of resources to appropriately support a patient and their whanau post discharge • HSW are able to use knowledge from practice to advocate for effective and comprehensive services	into orientation of new staff • Review use of HSW assistants in relation to provision of practical support • Use data to inform orientation of new HSWs
3.1 Emotional advocacy and support The effective health social worker provides advocacy and support to ensure the emotional distress patients and their whanau experience in the hospital environment is responded to. HSW have the ability to engage with warmth, compassion and empathy towards patients and their whanau. We maintain a	• HSW establish and maintain relationships with patients and their families • HSW make time available to listen to patients and their whanau • HSW demonstrate empathy, compassion and a non-judgmental approach in our dealing with patients and their families • HSW respond to the distress associated with hospitalization including sudden and traumatic death, fetal death and pregnancy loss, and poor diagnosis and/or prognosis • HSW have or develop the therapeutic skills which	• Apply the data to help inform recruitment decisions • Increase opportunities to teach, reinforce and support these qualities including in-service training, clinical supervision, live supervision and appraisal • Increase continuing professional development activities oriented towards the development of these skills • Explore scope and skills prior

non-judgmental approach towards our clients and seek to use our selves, and our relationships with patients and families to help support change	enable us to carry out these functions competently	to developing allied practice guides • Explore ways of researching the outcomes of these interventions • Use research data to inform orientation of new HSWs
3.2. The effective HSW has the willingness, skills and ability to help manage complex situations on the ward, intervening proactively in order to reduce the impact of patient and family distress on them, and the ward, including other staff and patients	• HSW are proactive about identifying potential challenges on the ward and take action to reduce the impact of these problems where possible • HSW have skills that enable us to reduce anxiety, de-escalate strong feelings, and help resolve conflict • HSW maintain a sensitivity and awareness regarding cultural risks and issues and take action to reduce the impact of these on patients, their families and members of the MDT	• Support an increase in skills associated with this area of practice, including de-escalation, containment and conflict resolution • Strengthen partnerships with stakeholders in mental health to support cross service learning collaborations • Use data to inform orientation of new HSWs
4. Medical advocacy and support	• HSWs proactively learn the medical language and consequences of the area/s they are providing services	• Develop practice and orientation guideline to ensure

The effective health social worker is alert to the patient and their families understanding of and engagement with the medical context. We actively seek to notice and respond to misunderstanding in close consultation with our medical colleagues	in • HSWs maintain an awareness of the patient and family understanding of what is occurring medically while they are in hospital • HSWs take action to support patient and family understanding • HSWs work in partnership with the team to support patient and family understanding • HSWs competently plan and facilitate family meetings • HSW's take action to support patient and family engagement in the health service • HSW's adjusts our community style to support patient and family understanding of and engagement with health services	increased practitioner awareness and competence • Provide in-service training based on identified actual practices that are 'best' • Monitor complaints associated with misunderstandings and respond to themes • Write applied practice guide reflecting actual practices that are 'best' as identified in previous research • Use data to inform orientation of new HSWs
5.Cultural advocacy and support The effective health social worker is culturally	• HSW assess and respond to specific cultural needs in order to assist the patient and their families engagement in the health service	• Increase focus on recruiting Maori and other ethnic staff in order to match patient

competent, aware and responsive. We have the ability to apply these personal and professional qualities to support patient's safety, comfort and engagement with the health service. This includes the ability to attend to both patient and family needs. We understand the risks (?demands) associated with cross cultural service provision and actively assist members of the multidisciplinary team to support the provision of a culturally responsive health service	• HSWs have positive and effective relationships with cultural support services both internal and external to the hospital • HSW identify cultural support for a patient and their family members • HSW facilitate effective family meetings across a range of cultures • HSW work alongside the MDT team to ensure a culturally responsive service • HSW maintain an active awareness of the interface between culture and health • HSW apply this awareness to support improved outcomes for patients	demographics • Increase intake and mentoring of Maori and other ethnic students • Continue to develop effective partnerships with internal and external cultural support services • Increase focus of continuing professional development to support HSW's ability to engage in context specific cultural advocacy • Formalise access for HSW to cultural advice and mentoring • Support HSW's 'merit' activities focused on responding to cultural issues

		and needs • Use data to inform orientation of new HSWs
7. Working the ward-dependable service delivery The effective health social worker provides a dependable, timely service. A foundational skill that supports this capacity is the proactive identifying of patients who may require our input. We are able to prioritise competing demands in order to meet patient and family needs. Our professional contribution in the	• HSW are visible and accessible on the ward • HSW provide a timely response • HSW are proactive about identifying patients that may need HSW input • HSW attend ward meetings, i.e. rapid rounds, MDT etc • HSW are approachable, reliable and responsive in regards to indentifying and meeting patient and family needs • HSW have clinical knowledge that assists us to understand and meet patient and family needs	• Develop a process to monitor and evaluate workloads • Evaluate the use of the initial assessment framework and template • Develop a process that will enable us to understand the time between referral and assessment, assessment and intervention, intervention and discharge (clinical indicator) • Develop an applied practice guide to support an increase in proactive case finding • Use data to inform orientation

hospital is oriented towards assessing and meeting needs in a timely manner in order to help solve complex psychosocial problems for the benefit of the patients, their family and the organisation		of new HSWs
8. Psychosocial assessment with the focus on safe and timely discharge The effective HSW undertakes timely assessment of a patient's needs, develops and implements intervention plans and works in consultation with the patient, their whanau	• HSW assess patient needs as soon after admission as possible • HSW undertake a biopsychosocial assessment in order to identify patient and their families needs • HSW provide an accessible record of our assessments • HSW develop and implement plans in consultation with the patient, their family, and the MDT • HSW favour approaches to practice which reflect the acute nature of the environment i.e. brief interventions • HSW are competent organizers and facilitators of family meetings, professional meetings and interagency meetings	• Develop a discharge planning applied practice guide • Develop on-line training resource re clinical documentation • Develop practice guide and other practical resources to assist HSW's to understand their role as facilitators of clinical meetings • Explore ways to research

members and members of the MDT to support a safe and timely discharge from the hospital	• HSW maintain a strong focus on safe and timely discharge while also prioritising other patient needs, such as the need to talk and be listened to • HSW have well developed community networks and engage in active liaison to ensure patient needs are met	outcomes
9. Team relationships The effective HSW has the ability to develop and maintain relationships with the MDT for the benefit of our patients and their families	• HSW maintain effective professional relationships with members of the MDT for the benefit of their patients, and patient care • HSW are visible on the ward, understand the needs and dynamics of individual wards and make ourselves available to talk things over • HSW have sound relationships with members of the MDT which allow us to advocate for patients and their families about sensitive issues such as cultural responsiveness	• Explore the data and engage in dialogue with hospital leadership regarding the risks and value associated with current staffing structure • Develop relationship based competencies in consultation with HSW practice supervisors • Increase focus via in-service, supervision and appraisal
10. Team work The effective HSW understands the value of team work and works in	• HSW understand the difference between clinical areas and their processors and adapt our practice according to need • HSW understand the value of dialogue, collaboration,	• Use data to develop guide for orientation of new practitioners • Continue to develop interdisciplinary training forum

close consultation with the multidisciplinary team to support appropriate patient care and outcomes	consultation and team work to ensure patient needs are responded • HSW make decisions in consultation with team members	for allied health practitioners • Ensure requirement for critical reflection is sought for appraisal and included in portfolio
11. Communication The effective HSW is an open, clear and concise communicator who understands the importance of timely, accurate and professional communication with members of the MDT, patients and family. An important role for HSW is providing an information pathway between patients, their families and the MDT	• HSWs demonstrate the value of regular, timely and accurate communication with members of the MDT, bother verbal and written • HSWs ensure an accessible record of important clinical data is available for members of the MDT • HSWs keep the patient in the centre of all their communication with the MDT • HSWs are open to different professional opinions, roles and expectations and engage respectfully with colleagues to develop a shared understanding regarding appropriate actions and interventions	• Develop communication competencies in consultation with HSW practice supervisors • Increase focus on development of communication skills via in-service, supervision, live supervision and external continuing professional development activities • Develop tools to support and increase communication skills • Apply research findings to inform orientation of new

		HSWs