
Resuscitating health social work

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Abstract

This article explores a definition of contemporary health social work and presents an overview of an initial assessment process developed by the author and general health social workers in the Capital and Coast District Health Board (CCDHB). Health social work is a significant field of practice in New Zealand social work but is often not well understood. The author notes that social work documentation in clinical settings often focused on a brief social history and tasks required. The evidence of fuller social work intervention is sometimes completely missing. An approach to assessment in health settings is presented within a broader discussion of the role of health social work to demonstrate the context and thinking that informed it.

Introduction

Health social work is one of the largest social work groups in Aotearoa New Zealand, and also contributes to a significant proportion of the allied health professional workforce. A report on the allied health workforce employed in district health boards (DHBs) states that there are over 1,100 (893 FTE) social workers working for DHBs (DHBNZ, 2007, p.7). However, unlike most other allied health professional groups, social work does not have a primary institutional setting, and is not confined to the health field.

A consequence of this is that social work must quickly adapt to the health environment, especially within hospital settings, and shape itself to what is often very medically task-focused and diagnostic-centred work. Giles (2009) suggests the bio-medical model is often accused of failing to connect with the individual meaning and experience of health and illness, and can have a denial of the social causes of illness. To counter this, health social work brings a wider bio-psychosocial perspective but this can be diminished to a task centred approach within the demands of busy general medical wards with a current emphasis on reducing 'bed block' due to less inpatient beds available.

In some areas of the hospital, requesting a professional social work service involves a referral based around undertaking a specific task, for example: supplying a medical alarm form, home help or benefit information. Social workers will often accept such referrals as a way of doing further exploration of the person's world, but I found this fuller involvement was not always documented. Frequently social work documentation showed a brief social history (that can be taken by any number of medical personnel and often is) and then required interventions based on tasks to complete. The evidence of social work analysis was sometimes completely missing, suggesting task-centred work that did not involve exploration

of the wider context of the person's social, emotional, psychological and spiritual world. New roles have also emerged in the hospital such as patient care coordinators and discharge planners whose boundaries with social work appeared to be blurred at times.

In my experience, a narrow task-centred approach to social work and role confusion can impact on job satisfaction and result in poor social work staff retention. Limited assessments also do not ascertain the wellbeing, coping and safety of the people to whom we have a duty of care, nor highlight wider social disparities or community issues. Often these types of task-related referrals are shaped by a lack of understanding of the role of social work in health settings and instead on the task-focused aspects of the medical systems. Giles (2009) talks about the need for health social work to challenge barriers and structural factors to good health outcomes, and facilitating individual and community access to healthy active lives. It is not possible to do this if social workers are not engaged in assessments that reveal this type of information.

I believe social work in health settings, especially hospital-based practice, needs to articulate its role and purpose and be able to explain this clearly in often very large, rapidly changing organisations struggling with limited budgets and complex systems. The risk of not doing this may mean the health social work role becomes shaped by others who do not understand its function, leading to confusion and a sense of being the 'designer' rather than the 'designer'(Globerman 1999). The Canadian Association of Social Workers had this to say about the changing face of health:

In many ways it is like our society is wandering through a large sprawling building complex, opening doors and exploring as we strive to understand what it means to be 'healthy'. For years the medical model has remained and practised in those rooms where they have been most comfortable. Now there are new doors opening. As social workers do we sit in the corner and hope to be recognised, do we wait to be asked to participate? Or do we greet them at the door and lay claim to our place in an evolving healthcare system? (Canadian Association of Social Workers, 2003).

Exploring the role of health social work

The World Health Organisation defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' Social environmental, cultural, emotional, psychological and spiritual factors must be considered if people are to recover from or at times live with ongoing health challenges. In turn these can highlight wider social inequalities and disparities that impact on the health of key population groups. A fundamental feature of any social work is the dual consideration of individual well being and social context. This is especially important in relation to health. Many of the barriers that prevent people seeking services may be rooted in their social conditions or cultural traditions, and social workers are formally trained to anticipate, recognise and address such barriers (Darnell, 2007, p.83). By offering comprehensive bio-psychosocial assessments, social workers can identify internal and external barriers and also the strengths that will enable better recovery. Social work is uniquely placed as the profession that can bring the emotional, social, spiritual, and psychological aspects of a person's world to the multi-disciplinary team. If we do not bring these factors together we only treat one symptom, treatment which may not make a long-term difference if all components of a person's world are not considered.

For instance, if someone is to recover successfully from surgery then addressing the family violence that they live in will make a difference. If someone is living in an isolated world with little social and emotional supports no matter how physically well they are when they leave the ward, they are likely to return. They are also more likely to have a longer length of stay without attendance to the spiritual, social, emotional and psychological factors that need to be unpacked to support recovery (Lechman, Duder, 2006). This type of bio-psycho-social and systems analysis combined with skills of facilitation, advocacy, team work and negotiators position social workers to function well in multi-faceted complex organisations such as tertiary hospital settings (Globerman 1999). Davis, Baldry, Milosevic & Walsh (2004) sums up the role of health social work to include functions such as psychosocial assessment, education, discharge planning, advocacy, counselling, case conferencing, crisis intervention and community outreach.

In 2001 Auslander identified five top priority areas of what had been achieved in health social work. These included:

1. Changing models of health and medical care by including the incorporation of bio-psycho-social and other holistic approaches into mainstream health care.
 2. Establishing social work as a legitimate discipline in health settings.
 3. Enhancing knowledge development through carrying out research into the psychosocial aspects of health and illness.
 4. Applying direct practice, psychosocial interventions through intervening in the social aspects of health and sickness.
 5. Developing culturally specific, culturally appropriate and indigenous models of health and social services.
- (Auslander, 2001, p.207).

It is essential that we continue to progress these key areas in the work that we currently do in health social work. The health sector is also moving from a tertiary focus to that of a primary health service, with an emphasis on promoting wellness and disease prevention (rather than just treatment) evidenced by population health thinking. Social work is well equipped to notice and work with key health determinants that are evidenced in population health and public health work, including:

- Income and social status,
- Personal health and coping skills,
- Gender,
- Social supports,
- Culture (including ethnicity and religion),
- Physical environment,
- Working conditions and employment,
- Biology and genetics,
- Available education and health services.

Health social work can provide insight into such determinants to higher levels of policy and decision making, and develop initiatives and resources that support change. We have skills such as networking and working in partnership with others, with considerable scope to develop the range of effective partnerships wider than immediate individual work (Wh-

iteside, 2004, p.386). This provides another key way for social work to show how it adds value, by having health social workers present on committees, projects and steering groups, addressing key health determinants within population groups.

In Aotearoa New Zealand along with trying to address nationwide disparities impacting on the health of Maori, Pacific populations and children, the field of health is now more strongly recognising other key social issues that carry significant health impacts. These include family violence (encapsulating partner abuse, elder abuse and child abuse) and also depression rates and the increased risk of suicide.

Family violence

In 1979 Gelles and Straus argued 'with the exception of the police and the military, the family is perhaps the most violent social group and the home the most violent setting in our society' (Gelles & Straus, 1979, p.15). In policy documents and consultations with health consumers, family violence was consistently ranked as one of the top priorities for health care providers to address (Fanslow, 2002, p.6). People experiencing violence will suffer health consequences both acute, and chronic, physical and mental, emotional and spiritual, and hence are more likely to seek health services.

In Aotearoa New Zealand we have an ageing population which increases the likelihood of Elder abuse and neglect. Elder abuse is defined as 'A single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person' (Action on Elder Abuse, 2004 World Health Organisation, International Network for the Prevention of Elder Abuse, cited in Glasgow & Fanslow, 2006, p.11). As with child and partner abuse, health social workers are in an ideal position to engage in early identification, support and referral of older persons experiencing abuse.

At the 2008 International Society for the Prevention of Child Abuse and Neglect conference Hong Kong there was discussion about whether we need to move from child welfare-based systems to health-based systems as a response to child abuse. It was felt it is time to build the capacity of the health and mental health systems to that of social/welfare/legal systems as a way of responding to child abuse. This includes the need for advanced health and public health research and programmes for abused and neglected children and their families. Overall we must start viewing family violence as a health issue, to which health social workers take a lead in recognition and response within the health system.

Depression and suicide

The Western world including New Zealand is also seeing a significant increase in rates of depression. Fergusson, Blakely, Allan, & Collings (2005), noted that New Zealand's suicide rates do not compare favourably with other OECD countries. They found the female and overall rates are roughly in the middle of the OECD range but the male rate is among the highest of the selected OECD countries. They also noted that in most developed countries suicide rates peak for men in old age and in women during late old age. New Zealand suicide rates, however, do not follow this pattern. Since the 1980s New Zealand has consistently had one of the highest youth suicide rates (especially for young males) in the OECD. It is

critically important that health social workers are trained to screen for low mood, depression and the risk of suicide.

Defining health social work

After consideration of these issues and noting the struggles experienced with other health professionals understanding the social work role at Capital Coast District Health Board, I decided with the help of social work staff to construct a definition for health social work. Such a document did not exist in the organisation, and my purpose was to ensure a solid foundation for all practice to be built from. Without a strong defined foundation it is difficult to ensure consistency of service delivery and articulate the contribution social work offers.

In terms of the process used, I informed the social workers across the eight teams I cover about my thoughts and observations and what I'd like us to achieve. We met and I went over a presentation I developed using literature referred to in this paper to help get people thinking and talking about their roles and what they felt they did well. There was a tremendous amount of positive energy in the room, and people expressed how good it was to talk about their role. Finally with a lot of robust debate by 25 social workers across acute inpatient, community, rehabilitation and Whanau Care Services, this is the definition Capital Coast DHB general health social work reached:

Assessing, supporting, and strengthening social, emotional, spiritual, and psychological wellbeing to ensure best possible health outcomes, interdependence, autonomy, and dignity of life for individuals, families and whanau, and communities. (Capital and Coast DHB Policy Document, 2009).

In our next meeting we went on to identify key goals that general health social workers would aspire to in order to address and carry out the role of health social work, aligning this to addressing the individual and the communities they live in. These are:

1. Provide analysis, assessment and awareness of the social, emotional, cultural, spiritual, and psychological components of a person's world, in order to support the achievement of best possible health outcomes. This includes evaluation of service need, psycho-social strengths and barriers to treatment, and high risk screening.
2. Deliver proactive, effective, efficient, social work interventions (provide supportive counselling to manage change, locate and arrange resources and advocacy) which respond and adapt to changing needs and demands.
3. Work in partnership with individuals and families and whanau, and in consultation and collaboration with other health professionals, to support a successful return to the community, and to ensure people remain well at home.
4. Provide analysis of socioeconomic factors that generate disparities in health and wellbeing status within population groups within the CCDHB region, and to promote strategies to reduce such disparities.
5. Work collaboratively with Public Health Organisations, statutory agencies, non government organisations, community nursing, allied health teams and other service providers to improve health outcomes.
6. Engage with people of culturally diverse backgrounds and work in partnership with

community groups and agencies to best support their health maintenance and wellbeing aspirations.

7. Be an integral participant of the health multidisciplinary teams, modelling competent and confident practice in all settings.
8. Engage in professional development activities, consistently applying knowledge and skills to develop innovative practice strategies.
9. To be a leader in the provision of social work services by exploring and developing cutting-edge approaches to social work discourse and practice.
10. Always evaluate and review practice through client service user feedback and efficacy outcomes.

Finally we named the skills required to reach these goals and fulfill the definition and purpose:

- a. Engage and develop rapport to build relationships in highly pressured situations
- b. Interview, assess, facilitate family and other group meetings, de-escalate, and advocate on behalf of individuals and family and whanau
- c. Develop and manage multiple relationships
- d. Provide systemic analysis of people's social, emotional, cultural, spiritual and psychological strengths, resources, and measure changes within these. Support people to manage the emotional, psychological and social impact of changes to health status
- e. Articulate a holistic picture of health to other professionals
- f. Work within legal and governance, social policy and CCDHB's policy frameworks
- g. Undertake balanced risk assessments to determine safety
- h. Identify and respond to child and elder abuse, family violence and protection issues
- i. Work with trauma and undertake crisis intervention to support the beginning of recovery
- j. Work with grief, loss and bereavement
- k. Demonstrate excellent personal and professional management skills including the ability to prioritise, apply acuity measures and provide high standards of documentation
- l. Articulate and apply theoretical frameworks to inform practice and demonstrate clinical reasoning.

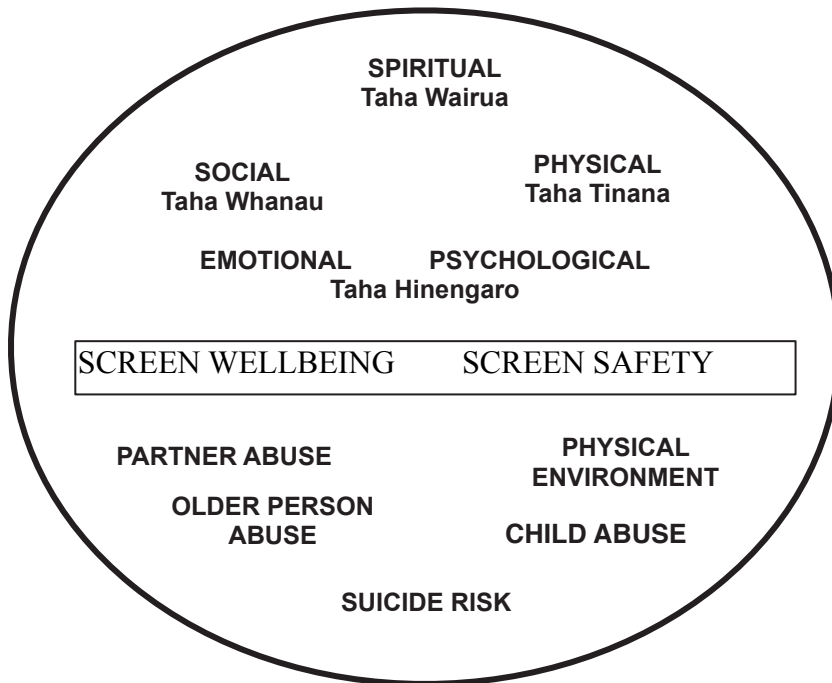
Undertaking the definition, goals and skills work was not to suggest social workers were not doing it already, but rather that it had not been formally articulated. This process not only created exploration and discussion but also ownership as work was undertaken by all available social workers and thoroughly debated. In summary we now have a one-page two-sided document that provides us with the foundation to base our work on, and to build resources, tools and competencies from.

Initial assessment guidelines

The definition enabled us to build a set of guidelines for initial assessment work to help evidence the social work role and demonstrate our work through a consistent documentation process. Following a referral from any health professional (usually ward staff), the social worker undertakes an initial assessment which in part also informs the worker what their role will be (if any) with the family. By combining this with 'screening-type' thinking to reduce possible time, social workers can quickly ascertain the wellbeing and safety of the person

and their family and whanau. Not only does this ensure that all people seeing a hospital social worker received a consistent approach to ensure best health outcomes, but that each time there would be a clear message of the role and focus of a health social worker. With this type of approach in mind I created the following summary diagram, social workers follow when beginning their involvement with an individual and their family and whanau.

Figure one. Wellbeing and safety screen.



Social work in health settings needs to explore both wellbeing (given health is defined as physical, social and mental wellbeing) and safety in order to undertake a comprehensive and balanced assessment. By only looking at danger and harm factors we can miss what may be working well, and likewise by only looking at strengths/safety we may not pay attention to possible negative impacts on a person's health. Social workers should consider all information they receive to determine how it supports or impedes wellbeing, and strengthens or threatens safety. The Wellbeing and Safety screen captures the concept of screening wellbeing in five ways (social, physical, spiritual, emotional and psychological functioning and quality – Taha Tinana, Taha Whanau, Taha Wairua, Taha Hinengaro – Te Whare Tapa Wha – Durie, 1998) and then where indicated, screens safety also in five ways (partner abuse, child abuse, elder abuse, physical environment and suicide risk).

A number of enquiry questions are provided to explore wellbeing and safety and these are further supported by internal policies, procedures, protocols and guidelines. The social worker then takes time to form their assessment by reflecting on and identifying these key areas:

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- Existing social, psychological, spiritual and emotional strengths and resources to manage/adapt/adjust to health and related social situation.
 - Wellbeing areas that need strengthening and further support, and any safety issues related to this including risk of self neglect, and vulnerable other people in household.
 - Individual, caregiver, family and whanau goals and hopes for the future (immediate and longer term) and any required resources to support these.
 - Is ongoing health social work involvement required?
 - Key contacts identified and consent obtained to make contact with others involved.

Finally the social worker documents their initial assessment summary in the person's clinical file under the following headings, with entries dated, timed, named and with contact details:

1. Reason for referral,
2. Current situation/background,
3. Individual, family and whanau goals,
4. Social worker assessment (of strengths/needs/safety),
5. Interventions/actions,
6. Plan/next steps.

Although only having been in use for a short time, I have already noticed a positive change to the documentation I audit through social workers applying the initial assessment guidelines. Notes are easier to follow, and clearly show the social worker's analysis. I have also had feedback from other health professionals that the definition work and initial assessment guidelines have helped them to understand the social work role. I circulated the two documents to all team leaders and discussed with the Director of Allied Health, all of whom have been very positive and supportive. Social workers have also been positive about the new guidelines; as reported by a social worker undertaking an initial assessment with an older woman on an inpatient ward:

And as I was doing my initial assessment checks around her wellbeing I got a sense something wasn't ok at home so I decided to weave a family violence screen into my questions to check out her safety. She found it really difficult to say but eventually she told me her adult son who lives with her is abusive and controlling toward her. I'm so glad I asked, otherwise maybe we would never have known. I could then go on and do a fuller assessment to help identify ways to increase her safety.

Conclusion

This article has sought to explore and define social work in a hospital-based setting. Social work in health must stand up, define and clearly identify its place in the changing world of health. In order to do this we must firstly be able to clearly articulate our role, purpose and goals. We must be able to name the skills we use, along with tools and resources that strengthen and evidence our work. We must be able to confidently discuss and document our assessments and advocate for people's wellbeing and safety. If we do not stand up and state our role we may be reduced to people who fill out the forms and hand out information brochures until it is realised anyone can do this. This may require a letting go of some tasks and embracing a more in-depth bio-psychosocial focus to our work. It may mean stepping up more strongly into the work of child protection and other forms of family violence. We

need to deconstruct our work, explore, write up, research and share our stories of success and of what we do. It is time to take our work out into wider medical forums and clearly show what our job is and how it supports improved health outcomes for individuals, families and whanau, and communities.

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