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Editorial

This issue of Aotearoa New Zealand Social Work provides an interesting selection of topics and research methods. All the studies were conducted primarily in Aotearoa New Zealand and utilise qualitative and quantitative methods, mixed methods and archival research. The topics demonstrate a wide span of social work concerns: parents of adult children with complex needs, children and young people, Pacific health, cultural support workers in health settings and the long-standing and vexed problem of accessing quality field placements for social work students. The books reviewed in the issue address vulnerability and marginality in human services, integrated health care, and social work practice in health care. The classic book review is a discursive re-examination of a 1979 sociological work, where the reviewer finds much of relevance to child and family policy today.

What this breadth of coverage reminds us is that social work, and indeed social services, is a very broad field of professional endeavour. While child protection is a significant part of social work, it often has disproportionate attention and thus influence on government discourse and policy. Members of the public might be surprised, for example, when they hear that Oranga Tamariki employs less than 25% of registered social workers. Social workers in health, justice, schools, community, disability and mental health make considerable contributions to Aotearoa New Zealand society and should be included in decisions about social work and social work education. Practitioners and researchers from these other fields are making a strong contribution to the journal. While all research is valuable, one often ignored function of social work research and scholarship, is to bring marginalised and less visible fields of practice to the fore. Several of the articles in this issue contribute to that foregrounding. We hope to see more contributions from health, mental health and disability services in future issues.

Hemant Thakkar reports on a qualitative study conducted in Aotearoa New Zealand and India. In “It’s like me leaving a manual of me behind”, parents’ perspectives about succession planning of long-term care and support for their disabled adult children with high and complex needs are explored. Six key components of succession planning were identified: preparing the child; preparing the informal network; sorting out the living arrangements; securing their financial future; creating a life plan and a training manual; and preparing the community. This qualitative study revealed that not all parents have the necessary skills and resources to engage in succession planning and hence it becomes crucial that social workers and other professionals working in social services provide appropriate support to these parents.

Kathryn Hay explores stakeholder perspectives on the growing concern about the availability of quality learning opportunities for students in “There is competition”: Facing the reality of field education in Aotearoa New Zealand. Focus groups and interviews were conducted with tertiary educators and social work students from three Aotearoa New Zealand tertiary institutions. The sector is experiencing considerable pressure on placements due to competition, limited placement opportunities in some locations, high workloads, funding pressures, placement fatigue, and limited space and physical resources. These findings suggest that a comprehensive, sector-wide examination of the social work field education is needed.

The Strengths and Difficulties Questionnaire (SDQ) is an internationally recognised psychometric and behavioural screening tool. The Ministry of Social

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Development in Aotearoa New Zealand has endorsed this tool as the primary behavioural screening and client outcome evaluation tool for the Social Workers in Schools service in 2018. Emma O'Neill reports on a quantitative study which explored two years of aggregated SDQ scores, compiled by youth workers in secondary schools, to understand what client outcomes could be evidenced. The findings suggest that the SDQ as a stand-alone behavioural screening and outcome evaluation tool within social work is limited. O'Neill argues that the use of SDQ in social work requires further examination to test its ability to communicate a client's level of need and intervention outcomes.

Archival research is the method used alongside qualitative interviews in Barbara Staniforth's article "The Auckland MA Sociology (Option II – Social Welfare and Development): A social work qualification gone but not forgotten". Over the period 1975-1979 the University of Auckland MA in Sociology (Option II–Social Welfare and Development) was offered as a qualifying social work programme. Staniforth conducted semi-structured interviews with staff and students who had been involved with this programme. Information was also obtained through exploring archived University documents, reports, and various forms of personal correspondence provided by June Kendrick. There were resource limitations and philosophical tensions within the Department about the qualification. There was little support for its continuation at the end of a three-year grant and after the departure of its main champion. Staniforth notes the contribution of the programme to the profession of social work in Aotearoa New Zealand.

Margaret Pack reports on an exploratory mixed methods study which was a component of a larger evaluation of the primary health care strategy (PHCS) in Aotearoa New Zealand. The aim of the qualitative phase of the research was to explore the extent of use and satisfaction about service provision and delivery with the PHCS through the operation of Pacific-led Primary Health Organisations (PHOs). The study was conducted using a case study design and in-depth interviews with service managers and health providers at six Pacific-led PHOs. The study reveals tension between the business model, government reporting requirements, and the more altruistic values of those at the front line. Increased uptake of services was attributed to wrap-around, holistic, accessible services delivered by culturally responsive health providers who "go the extra mile" for their service users. Pack discusses the implications for health social work.

In another health context, this issue's research brief by Maree Goh reports on a small qualitative study of cultural support workers in Aotearoa New Zealand in "Exploring the role of cultural support workers in the New Zealand healthcare setting". Goh notes that as Aotearoa New Zealand becomes increasingly ethnically and linguistically diverse, the use of cultural support workers will become a much greater integral part of healthcare services. However, very little is currently known about the needs of these workers – the challenges of the role; their needs for appropriate training, support and supervision; and, how these can be met. Goh identifies significant challenges for the role but is optimistic about their ability to make a positive difference within the healthcare setting.

Editorial Collective
August 2018

ORIGINAL ARTICLE
QUALITATIVE RESEARCH

"It's like me leaving a manual of me behind": Parents talk about succession planning of long-term care and support for their disabled adult children with high and complex needs

Hemant Thakkar

ABSTRACT

INTRODUCTION: A question that concerns most parents of disabled adults with high and complex needs (HCN) is: "What will happen to my child when I am no longer alive?" One of the factors that could assist these parents in securing a better future for their children beyond their own lifetime is timely succession planning.

METHOD: Semi-structured interviews were conducted with 14 Aotearoa New Zealand parents and 18 Indian parents with a view to understanding their wishes and worries concerning the long-term care and well-being of their adult children with HCN. This article focuses on the parents' views on their own role in succession planning.

FINDINGS: Based on parents' responses, six key components of succession planning were identified: preparing the child; preparing the informal network; sorting out the living arrangements; securing their financial future; creating a life plan and a training manual; and preparing the community.

IMPLICATIONS: The study revealed that not all parents have the necessary skills, resources or even desires to engage in succession planning and hence it becomes crucial that professionals working in the social services sector provide appropriate support to these parents.

KEYWORDS: high and complex needs; succession planning; disabled adults; parents of disabled children

INTRODUCTION

What will happen to my child when I am no longer alive? Whilst this question often troubles many parents of disabled children, for a majority of the ageing parents of adult children with high and complex needs (HCN), this is perhaps the most worrisome question as, even within the disability population, people with HCN are considered to be the most vulnerable group. Their increased vulnerability compared to other disability groups could be attributed to the nature of the support they require (including intimate personal care) associated with deficits in cognitive and communication abilities to speak up and fight for their own rights. Milner and Mirfin-Veitch (2012) argued

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that the total reliance of people with HCN on others for most aspects of their everyday lives also makes them more susceptible to various kinds of abuse and neglect. Therefore, in most cases, the parents of children with HCN end up assuming multiple roles in their children's lives including being their primary carer, their friend/companion, their interpreter, their advocate, their welfare guardian, and their financier or finance manager. However, playing such multiple roles often has a negative impact on the mental and physical health of the parents (Morgan, 2009). In addition to spending a significant amount of time attending to the needs of their children with HCN, these parents might also have other children requiring their attention. This leaves them with very little time and energy to do anything for themselves and their life becomes captive around their children (Bray, Moss, Forrester, & McConnochie, 2005; Vorhaus, 2014). However, given the vulnerability of their children, despite the personal toll caring takes on them, facing the prospect of leaving their children under someone else's care, becomes a matter of great concern for the parents of children with HCN.

The level of concern felt by the individual parents would, though, depend upon their perception of how well their children will be supported in the future when they are no longer there to care or advocate for them. For most parents, irrespective of where they live, the support network that they would rely upon to look after their children when they are no longer alive would comprise of both formal (publicly funded) support and informal support (provided voluntarily by family, friends and others). Whilst in some cases, the support provided by family and friends could also be publicly funded, for the purposes of this study, informal support is defined as the support provided without any monetary compensation. The availability of, and access to, both formal and informal support, however, differs for parents living in different parts of the world. For example, in India, state funding in the disability sector is very limited and, as a result, disabled people and their families are generally more reliant on their friends and extended family members to meet their care and support needs (Pinto & Sahur, 2001; Rehabilitation Council of India, 2014). On the other hand, the New Zealand government has made significant financial investment in the disability sector in recent years and as a result there is reasonably well-established disability support structure in Aotearoa New Zealand (Ministry of Health, 2016). Thus, India and Aotearoa New Zealand represent those countries where disabled people and their families are generally more reliant upon informal and formal support, respectively.

Further, the literature suggests that, despite the efforts of the policy makers to provide better services that align with the rights of the disabled people under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), the prevalent support models such as "direct payments" or "individualised funding" have been unsuccessful in meeting the needs of the end service users (Larkin & Mitchell, 2016). It has been argued that one of the key reasons for even the contemporary models of delivering disability support failing to adequately meet the support needs of all service users is that there is little policy consideration of family voice and choice (Larkin & Mitchell, 2016). To find any workable solution towards bridging the gap between ideal and affordable support, it is important in the first instance to get a real understanding of what kind of supports disabled people and their families value as being useful. Policy makers can gain such real understandings by consulting with the people whose lives it might impact before making crucial policy decisions. However, the literature suggests that the support needs of adults requiring ongoing care and support and their ageing parents have been poorly studied (James, 2013; Shaw, Cartwright, & Craig, 2011; Wong & Wong, 2003). Thus, there is a lack of focused discussion in the international disability discourse on the specific support needs of the people with HCN and their families. A doctoral study (Thakkar, 2017), the relevant findings of which are discussed in this article, was conducted with a view to making its own contribution towards this identified need for further research and also towards bringing the voice and concerns of the parents of adults with HCN to the forefront.

One of the crucial components of the study was to explore the parents' views on the changes required in their then existing support system that could help in fulfilling their wishes and reducing their worries concerning their children's future. The changes proposed by the parents primarily included either the actions they needed to take themselves during their lifetime and/or the actions they wanted the government to take. This article focuses on what the parents shared about the actions they needed to take themselves as part of succession planning.

Literature review

Parenting a disabled child is reported, time and again in numerous studies, to be far more complex and stressful than raising a non-disabled child (Bennett, 2002; Harrison, Henderson, & Leonard, 2007; Read, 2000; Wills, 1994). The issues faced by parents in raising a disabled child as reported in the literature include:

- difficulties in managing work–life balance;
- feelings of losing their own identity other than being a parent of a disabled child;
- stress in relationship with their partners/other family members;
- loss of friends and feelings of isolation;
- poor health outcomes; and
- worries about, if something happened to them, what would happen to their child.

Further, disabled adults, in general, require more support services involving more government agencies than those required by younger disabled children. However, even within the population of disabled adults, the needs of adults with HCN are even higher as they often have other associated health-related conditions and behavioural issues requiring constant care and supervision, including attending to their intimate personal care (Hewitt-Taylor, 2008). Consequently, as the parents get older and their adult children become physically bigger and stronger, caring for them becomes increasingly difficult. Thus, for the parents of children with HCN, the impact on their lives of raising a disabled child (as reported above) continues beyond their children's childhood and right up to their adulthood. Parents of children with HCN often do not get to do things for themselves that others can, such as taking vacations and pursuing hobbies that require time away from home; and their lives can become captive to their disabled children's needs.

Maintaining resilience in the face of such multiple complexities is not an easy task. It is only natural then for the parents of adults with HCN to be concerned about what would happen to their children if something happened to the parents. Unfortunately, some parents get so concerned about their children's future beyond their own lifetime that they "often express the hope to survive the child by at least 5 minutes, so it won't be a problem. Some parents have actually taken tragic steps to assure they survive their child" (Morgan, 2009, p. 20). However, most parents of adults with HCN manage to do the job of caring and advocating for their children tirelessly and with as much grace as is humanly possible.

Research suggests that timely succession planning on the part of the parents can help alleviate some of the worries that they have concerning their disabled children's long-term future (Hatton, Akram, Shah, Robertson, & Emerson, 2004; Redmond & Richardson, 2003; Taggart, Truesdale-Kennedy, Ryan, & McConkey, 2012). Unfortunately, however, the same studies have also reported a lack of planning on the parents' part or even a reluctance to engage in planning. For example, during their review of the relevant literature, Taggart et al. found that:

> Carers may not make plans as a result of denial about the inevitability of their own mortality and the realisation that they will not be able to provide care indefinitely. Moreover, they have difficulties in letting go of their loved ones as it may mean increased loneliness for them and an end to their role in life… They find the subject too painful to broach and do not make firm plans until it becomes unavoidable. (Taggart et al., 2012, p. 219)

Thus, many parents avoid future planning as it is a very sensitive topic that might force them to face a lot of their own insecurities, anxieties or inhibitions. Whilst a reluctance towards planning on some parents' part might be understandable, the literature, nevertheless, suggests that it is certainly neither advisable nor desirable to delay the planning until it reaches a point of crisis. The potential dangers of a lack of timely planning include the adult child not acquiring the necessary functional skills to be independent (Shaw et al., 2011); the child being forced to move to an institution and/or live a diminished quality of life (Broadbent, 2003); emotional trauma and unexpected dilemmas for the family and a sudden demand placed on the formal support system (Taggart et al., 2012). Timeliness is crucial— if the parents do not make their and their children's wishes explicit to others in a timely manner, the future decisions taken by others might not be in the best interests of their child.

Method

The primary aims of this study were to:
a) understand the wishes and the worries of the parents of adults with HCN concerning their children's future; b) understand the support mechanisms (both formal and informal) that they consider and value as being useful for their children's future; and c) make useful recommendations for design and delivery of disability services catering for the specific support needs of adults with HCN and their families.

With the above aims in mind, the following two key research questions were identified:

1. What are the wishes and the worries of the parents of adults with HCN concerning the long-term care and well-being of their children?

2. What type of supports (both formal and informal) do parents consider as being crucial for their children's future, especially when they are no longer there to care and advocate for them?

Given the sensitive nature of the topic, a qualitative methodological approach was considered appropriate for this study. Using purposive sampling, 14 parents from Auckland, Aotearoa New Zealand and 18 parents from Delhi, India were selected as the participants for this study. The primary purpose of choosing the participants from India and New Zealand was to provide a unique insight into what influence does living in countries with varied levels of formal and informal support have on the wishes and worries of the parents of children with HCN concerning their children's long-term future.

It was considered that, in addition to interviewing parents in the two geographical contexts, interviewing key informants would be valuable particularly for developing robust recommendations from a service delivery perspective. A total of 13 key informants were interviewed – six in Auckland and seven in Delhi. The key informants were chosen from the researcher's professional network and represented a mix of disabled people themselves, academicians, government officers, service providers and the NGO sector. All the participants were provided with a Participant Information Sheet (PIS) and an Informed Consent (IC) form approved by the University of Auckland Human Participants Ethics Committee (UAHPEC). Other ethical issues that were considered to be of special significance for this study included *social and cultural* *sensitivity* and *minimising harm*. These were addressed appropriately by approaching interviews with great respect and sensitivity towards individual participant's cultural norms and emotional state of mind, respectively.

Personal interviews were conducted with all the participants using a semi-structured interview schedule. All the interviews were audio recorded and transcribed by the researcher. Finally, thematic analysis of the transcripts was conducted to generate meaning from the data. As part of this process, the transcripts were first auto-coded using NVivo™, a qualitative data analysis software, based on the broad questions used in the interview schedule. Each auto-coded question was then reviewed line by line to identify the emerging key themes based on the participants' responses. A combination of *Axial* coding, *In-vivo* coding, and *Open* coding was used to identify themes and sub-themes.

Findings

Note: To protect the identity of the participants, pseudonyms are used for the parents as well as their children throughout this section including in the parents' quotes where they refer to their children.

In addition to asking parents about their wishes and worries concerning their children's future, this study also explored parents' views on the changes required in their then-existing support system that could help in securing a better future for their children beyond their own lifetime. Many parents seemed to have given it serious thought and offered a lot of ideas and suggestions including on what succession planning they needed to do to secure their children's future. However, in line with what literature suggested, there were also some parents who had not thought much about the future as they intended to carry on their role for as long as they could. Donna (Auckland parent) felt that it was too early for them to start planning and suggested that, "to a certain extent there are things that can't be decided right now. I am not dead yet". Kanchan (Delhi parent), on the other hand, had left things to destiny: "I allow the universe to unfold. I can't plan too much because I have realised that the best plans get made somewhere else."

The changes proposed by those parents who had started to think about the future, primarily included either the actions they needed to take themselves during their lifetime and/or the actions they wanted the government to take. Thakkar (2017) provides a detailed account of the suggestions Auckland and Delhi parents had for their respective governments to improve the lives of their children. This article reports the findings on the actions that the parents felt that they needed to take themselves as part of succession planning.

The key themes that emerged from the parents' suggestions around succession planning include: preparing the child; preparing the informal network; sorting out living arrangements; securing the child's financial future; creating a life plan and a training manual; and preparing the community.

It should be noted that, in addition to the parents' ideas on what they would do for their own children, the discussion here also includes their suggestions for other parents of adult children with HCN. In other words, the headings below could also be read as the key messages from the parent participants of this study to other parents in a similar situation to theirs.

Prepare the child

In most cases, people with HCN living at home are completely reliant on their parents for every aspect of their lives and hence they share a unique bond with each other. Given the closeness of their relationship, it would undoubtedly be extremely difficult for these children to live without their parents. Hence, it is not surprising that many parent participants of the study suggested that, first and foremost, what they would need to do is to prepare their children to live apart from them. Perhaps recognising the difficulties with mentally preparing their children with HCN to live without them, many parents felt that they could at least start preparing their children in such a way that they gradually become less dependent upon them for their various support needs. Several Auckland parents and many Delhi parents talked about training their children, where possible, to look after their own personal care needs and doing some household chores. They used terms such as their child being "self-dependent", "successful", "cognitively able", "alright", or even "fully cured" so that they can manage their own affairs. For example, Hema (Delhi parent) mentioned that "I would like to see that Jitesh becomes alright. If not, at least he should be self-reliant like in the areas of personal care and household work."

Some Auckland parents also talked about increasing the frequency of sending their children to a respite care home so that they gradually get used to the idea of not having the parents around all the time. Further, given their grave concerns around potential abuse, some parents also talked about somehow helping their children understand what abuse looks like and what to do if it ever happened. Finally, some Delhi parents talked about sending their children to a day centre where they could learn some useful social, artistic or vocational skills with a view to helping them to build relationships with others and also potentially earning some income and reducing their financial dependency on the parents.

Prepare the informal network

In addition to preparing the child, many parents also talked about preparing their informal network of family and friends in supporting their children after the parents' death. As previously discussed, parents play multiple roles in their children's lives and when parents are no longer there, it might be desirable or even necessary to share those roles between different people. In this regard, the parents identified a need for talking to their immediate and extended family, friends and relatives at an early stage about a) who would play what role in their child's future; and b) what support they would need in carrying out their respective roles. In terms of concrete actions, the parents' suggestions around preparing the informal network included identifying potential successor/s (to take primary charge of welfare of the person after the parents); appointing welfare guardian/s; creating a circle of support; and providing training to all concerned.

Identify potential successor/s

The parents were asked to talk about the top three changes that would help them die peacefully in relation to their worries concerning their children's future. In response, finding someone who could take over the direct care or the oversight of the formal care of their children was reported by many parents of both groups as one of the top three changes. Whilst a majority of the parents expected their other, non-disabled, children to be their successors, some Delhi parents suggested that their own younger siblings might take over that role. Several parents, however, held the view that ideally the parents should hand over the reins to someone of more-or-less similar age to their disabled child for long-term continuity of care.

While some parents had no idea about who that *someone* could be, the others talked about the potential role of other family members, a trust, a team of guardians, an individual professional, or an organisation taking over the caring role from them:

> Yes, there should be someone to whom we can go and pass it on to, say this is what needs to happen when we are no longer here. (Donna, Auckland parent)
>
> I would like to see Maxine maintain control over service provision and to meet the needs for her care under the guardianship of the shared guardianship team. (Louise, Auckland parent)

> First, the biggest things is that there should be someone – either through a government or an organisation's support – who will look after my child well. (Sunita, Delhi parent)

> That his brother gives us assurance that you don't worry, I will take care of him. (Nita, Delhi parent)

One Delhi parent suggested that, if the parents expect their other, non-disabled, children to look after their disabled siblings after parents die, then they should have that conversation with their children as early as possible and in an open and honest manner.

> In some houses parents don't talk face to face to their other children about the disabled child's future. We motivate our children to have a discussion [with us] and say that "if you don't discuss things with us how would we know that after we die how are you going to look after your brother". (Mrs Sharma, Delhi parent)

Appoint welfare guardian/s

None of the adults with HCN whose parents participated in this study had appointed (or had the cognitive ability to appoint) an Enduring Power of Attorney. Therefore, to support their children with decision making and/or financial management, many parents talked about either setting up a trust and/or appointing someone as a legal welfare guardian for their children. Whilst some parents suggested that their successor would also become their child's welfare guardian, some talked about having multiple people involved in this role. Finding the right people for this role who have a good understanding of their children's needs and preferences could alleviate some of the parents' worries around decision making and potential financial exploitation.

Create a circle of support

Many parents also recognised a need for helping their children develop relationships and widening their children's social network as part of succession planning. The parents' suggestions included gradually increasing their children's social interaction with family, friends, relatives, and wider community; joining family support groups; or starting an informal club in their own house:

> If I could get similar minded interested people who would come with their support workers and come and spend just one hour in his garage where people like him can come and spend a little time. You know just for plain recreation. It's supervised – we are there. Their parents can come, so a little club can start. (Mrs D'souza, Auckland parent)

Creating a circle of support around the child could be helpful in a number of ways including assisting at times of emergency, in keeping the person safe, providing emotional support and avoiding issues associated with isolation and loneliness.

Provide training

Finally, as part of preparing the informal network to provide adequate support to their children, it would become vital for the parents to provide necessary training/guidance to their successors, future guardians and all the other people who become part of their children's circle of support. The successors might need specific training in how to provide personal care and health care related needs, whereas welfare guardians or trustees might need briefing on their children's entitlements to various services and navigating the formal system. Furthermore, where children are unable to effectively communicate their needs and preferences to others, all people in such children's informal network would need training in non-verbal communication irrespective of the role they play. The parents need to train people in how to communicate with their children with a specific focus on the various signs, gestures and behaviours they use for communicating their needs and preferences. The parents are the best experts when it comes to supporting their children with HCN, and hence it becomes vital that, wherever possible, the parents provide this training themselves to all concerned whilst they are still around and able to do so.

Sort out the living arrangements

Sorting out the living arrangements for their children was also reported by a majority of the parents from both groups as one of the three most important changes that would help them die peacefully. In terms of concrete actions, depending upon their preference for future accommodation type, the parents talked about checking out the suitability of the available residential options for their children; buying or renting a house, transferring the house to their disabled child's name or in joint names with their other, non-disabled, children.

> That we have fully settled him into a group home, where he is loved. (Holly, Auckland parent)
>
> That I knew that there was a place where if we did die before him or couldn't look after him that I would feel comfortable about him going to. (Tania, Auckland parent)
>
> Definitely I will be more in peace when I die if I see her happily living with my son's family. (Shobha, Delhi parent)
>
> First, the biggest thing is as I said before, there should be an organisation where our kids can stay safely after us… They should start going there whilst we are still alive so we can be reassured that after us our child will live here for [their] lifetime. (Sangeeta, Delhi parent)

One Auckland parent suggested that, given the shortage of suitable residential options that cater to the specific support needs of their children, the parents need to be a bit more realistic in their search for out-of-home options and that they should also be willing to make some compromises.

> One of the things that I keep telling myself and my family that initially we were looking for a perfect place for Maria – we let "perfect" get in the way of perfectly adequate. So, if we look for perfect – it won't happen; if we look for something where most of the boxes are ticked – we will find something. So we will have to make some compromises and some adjustments. (Mr Smith, Auckland parent)

Secure the financial future

Some Auckland parents and almost all the Delhi parents felt that, in addition to sorting out the living arrangements, they would also need to do something about securing the financial future of their children as otherwise their children might end up living at the mercy of others or of the welfare state. The concrete actions that the parents felt they needed to take in this direction during their lifetime included preparing a will, putting some funds in the child's name, getting assurance from other family members of their ongoing financial support for their children, setting up a small family-run business in the child's name, or working with the government to ensure that their children would continue to receive adequate lifelong financial support. As previously mentioned, a majority of the Auckland parents (including those who were financially affluent) expected the state to take full responsibility for their children's future financial needs.

Many Delhi parents felt that it might become easier to get informal support if the child was financially secure. They suggested that the parents should either leave enough funds in their child's name or ensure that there would be sufficient ongoing funding from the government to meet all their needs. People then might be more willing to provide support so long as they do not have to spend money.

> If there is some help from the government then even other relatives will be interested in providing some help….

> They will think that we don't need to do much, we just have to take him there and get things done and come back. Otherwise, if they think that I will have to put in money to get it done or run around to get things done then they take a back step. (Mr Sethi, Delhi parent)

Create a life plan and a training manual

Each person with HCN is unique and can function well if his or her unique needs are met in a certain way. Those *certain ways of doing things* become second nature for parents by the time the child becomes an adult; and hence, the parents are the true experts on the support needs of their adult children with HCN.

It, therefore, becomes crucial that the parents share their expertise with others as part of their succession planning. Whilst we touched upon the need for the parents to educate the people in their informal network, a number of parents felt that it would be important for even the support staff from the formal system to have access to their knowledge of their children's needs. Many parents talked about creating a life plan for their children detailing their support needs, likes and dislikes, and goals and aspirations. This would ensure that, irrespective of the changes in who provides the support, their children's needs and preferences would be known to all even when parents were not around to advocate for them. A couple of parents of children with complex medical conditions suggested that, along with the life plan, they would also need to create an instruction/training manual providing minute details of their children's health and personal care needs and how to meet them. Such a manual could also include pictures and/or videos of parents doing the care themselves so that others would know what exactly needs to be done and how; the details around their children's preferred method of communication and what different signs and gestures mean; their memorandum of wishes; a note on their values; and a list of "dos and don'ts" important for ensuring the safety of their children.

> Yeah, it would be like me leaving a manual of me behind [laughs]. So that the next person whoever I would like to take over the guardianship would know my core values. (Louise, Auckland parent)

One Auckland parent had already prepared such a manual and presented a brief description of the manual in the following words:

> There is a fifty-page training manual which spells out how to assist me with my health, how to assist me with my mobility, how to take me out to cafe, it also has a whole lot of background knowledge such as who is who in her family, because being non-verbal often you have to initiate the conversation. Lot of photo books and albums, so people can look through that and say "ohhh, this is so and so" – that sort of thing. (Rosemary, Auckland parent)

Prepare the community

A number of parents from both groups commented that, when it came to their attitude towards disability and disabled people, by and large, the society offered a mixed bag – it had both kinds of people – those who accept it and those who do not. They felt that whilst, in general, the society had become more accepting of disabled people, especially over the last couple of decades, due to increased awareness amongst the general public and the emphasis on mainstream education; there was still a lot of ignorance and lack of awareness leading to a lack of societal acceptance of disabled people.

> I think people in general just accept but with a "but". I don't think that people really go out of their way to include and they are still – even though attitudes are changing, they still see us as different – them and us. (Donna, Auckland parent)

> Not much [acceptance]. This country is not good for disabled people. It doesn't care about – it doesn't think of the disabled people at all. Because we are so many people. There is no regard for a human life in this country. So where is the place for them? (Manju, Delhi parent)

In the experience of both groups of parents, the attitude of the public towards their children included prejudice or disapproval (expressed through strange stares or avoidance); pity or sympathy; patronising or disrespectful attitudes; or in some extreme cases, the use of insulting or abusive language.

A majority of the Delhi parent participants belonged to the Hindu community. They mentioned that, even today, many people of their community believed that being born with a disability or having a child with a disability was a punishment for one's sinful *karmas* [deeds] of the past life. Due to such beliefs, their attitude in general was not very helpful.

> Their thought is that this is some *upari hawa* [evil power] or this is a fault of the ancestors. They don't believe that this is a medical problem, they just think that this is a result of the sins of the ancestors and these kids are getting punished for that; or they are paying for the sins of their own deed in the previous birth; or you must have done something wrong as a result your kids are like this and so on. (Radhika, Delhi parent)

In relation to changing the attitudes of the community, many parents felt that they themselves needed to be more proactive in preparing the community to accept their children.

> I think we as disabled families can do just as much for the public as expecting it back, yeah. Because we have the benefit of knowing our people. They don't know our people, they don't know how to react. (Louise, Auckland parent)

> I have noted that this depends on you. If your behaviour towards Jitesh is wrong, the people are also going to look at him in similar manner. If you are looking at Jitesh in a nice manner and showing your affection towards him even in front of the public, then people's attitude also changes accordingly. (Hema, Delhi parent)

According to some parents, one of the best ways of educating the community about their children was taking them out wherever they went and approaching members of the public with a positive attitude rather than a feeling of shame or embarrassment. In many parents' experience, the public generally reciprocated the feelings and hence a positive attitude was more likely to be reciprocated by positivity and acceptance in return.

> We go to pools and [the] more times we are out there, [the] more people we are educating. And maybe softening a few hearts out there too. (Wendy, Auckland parent)

Many parents, however, felt that, to bring about a change in community attitudes, it was important that the families checked their own attitude first and changed it, if required. Their suggestions for other parents included accepting their children, believing in their abilities, and loving them for who they are.

Finally, a couple of Auckland parents suggested adopting a cautious approach as, in their views, people could not be forced to accept disability:

> You can't force communities to be accepting of people with disabilities for example. It's a human nature thing, it's a choice and it's about making a right choice or being raised in an environment where disability and difference is accepted. It's an evolution – we are still undergoing that evolution. (Lesley, Auckland parent)

To conclude this section on findings, it needs to be mentioned that the parent participants of the study were aware that doing succession planning is not an easy task and some parents might find it more difficult than others. Recognising this difficulty, one of the messages that the parent participants had for other parents in similar situations to theirs was around looking after themselves and seeking professional help, where needed.

> Don't make a martyr out of yourself. If you need a hand, stick your hand up and say I need a hand, because you are not going to do anybody any favours. (Wendy, Auckland parent)

Discussion and conclusion

This article has discussed the parents' suggestions on some of the actions that they could take themselves to fulfil their wishes and address some of their worries. Whilst some parents had not given much thought to succession planning, a majority of the parents were aware of the mammoth challenge that lay ahead of them relative to preparing for their children's long-term future beyond their own lifespan.

Whilst the themes identified in the findings section represent the views of both groups of parents and largely have common threads, there are a couple of significant differences worth noting. In relation to the potential future role of the non-disabled siblings in their disabled children's lives, most Indian parents expected them to be their potential successors. On the other hand, most of the New Zealand parents were of the view that their non-disabled children should be able to live their own lives and it was not fair to expect them to have to look after their disabled siblings. Similarly, in relation to securing their disabled children's financial future, whilst most Indian parents expressed a wish to leave as much funds as possible in their disabled children's name; a majority of the New Zealand parents (including those who were financially affluent) expected the state to take full responsibility for their children's future financial needs. A detailed discussion surrounding the reasons for these differences is presented in Thakkar (2017) but is beyond the scope of this article.

With regard to the parents' suggestion around preparing the child to live without them, the literature suggests that, for that to happen, firstly the parents would need to believe in their children. Unfortunately, many parents underestimate their children's abilities and, as a result, have very low expectations of them. It has been suggested that this could often be the result of internalisation on the parents' part of the negative attitudes of the community towards their children and, in turn, could reinforce their dependence and social marginalisation (The World Bank, 2009). Therefore, it is vital that the parents approach this task with a positive attitude and invest time and effort in recognising their children's skills and abilities. At the same time, it is also important that they be realistic about their expectations and do not have false hopes around the level of independence that their children could practically achieve.

The literature also supports the study's findings around creating a circle of support around a disabled child. For example, Taggart et al. (2012) suggested that the concept of circle of support or a "circle of friends" comprising family, friends and the members of the community could be particularly helpful for the social well-being of people with an intellectual disability or high support needs. Further, the literature also suggests that, where such supports are not naturally available to parents, they might need to be facilitated through professional help (Duggan & Linehan, 2013; McCallin, Dickinson, Weston, AUT University, & Waitemata District Health Board, 2007; O'Brien, Thesing, & Capie, 2005). As Morgan (2009) warned, "loneliness is the only real disability" (p. 27) and hence it becomes vital that the parents take appropriate measures to help their children develop long-lasting social networks, friendships and relationships.

Finally, the literature also supports the study participants' message around "sticking up a hand when needed" and suggests that the parents do not need to do it all alone and the professionals and/or government must provide the parents with appropriate help in succession planning (McCallin et al., 2007; Taggart et al., 2012).

This need for supporting parents with succession planning has specific practice implications, particularly for people working in the social services sector. Professionals, including social workers, who work closely with ageing parents of disabled people in any capacity, have a joint responsibility, not only to raise awareness of timely succession planning, but to support them every step of the way to put things in place. The parents may need support in a number of areas including legal advice around guardianship; creating a circle of support; help connecting with local community; creating a long-term support plan for their children and so on. Thus, a targeted and coordinated approach between professional bodies and government to support these families becomes vital.

As reported by Taggart et al. (2012), there are a number of successful educational programmes such as "Future is Now" in the UK and "Safe and Secure" in Canada designed specifically to assist ageing parents and their supporters with succession planning. Whilst there are some non-government organisations in both India and Aotearoa New Zealand that provide support to the parents of disabled children in this area, the governments of both the countries could follow in the UK and Canada's footsteps and develop programmes relevant to their local context with a specific focus on assisting the parents of adult children with HCN with succession planning.

One of the key limitations of this study is that it focuses only on the views of the parents of adults with HCN and does not include the other close family members such as siblings who can potentially play a major role in supporting their disabled brother or sister once the parents are no longer alive. Therefore, a future study with a specific focus on the views of the siblings caring for adults with HCN would certainly complement the findings of this study and provide further insight into how these families could be better supported.

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ORIGINAL ARTICLE

QUALITATIVE RESEARCH

"There is competition": Facing the reality of field education in New Zealand

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ABSTRACT

INTRODUCTION: Anecdotal evidence of increasing competition for field education placements has raised concerns about the availability of quality learning opportunities for students and so it was considered timely to examine stakeholder perspectives.

METHOD: In late 2014, 15 tertiary educators from 11 tertiary institutions and 31 social work students from three Aotearoa New Zealand tertiary institutions engaged with the researcher in individual or focus group interviews on aspects of quality field education.

FINDINGS: Overall, the tertiary educators revealed considerable pressure on them to secure quality student placements due to competition with other tertiary providers, limited placement opportunities in some locations, high workloads and inadequate funding. Students recognised these pressures but questioned whether the educators are adequately supported by the tertiary institution. Placement availability was also affected by organisations experiencing funding pressures, placement fatigue, limited space and physical resources, and high workloads.

CONCLUSIONS: These qualitative findings raise questions for all the key stakeholders in field education: tertiary institutions, educators, social service organisations, the professional associations, the regulatory body and students. The findings from this study signal the need for a comprehensive, sector-wide examination of the social work field education context in Aotearoa New Zealand.

KEYWORDS: field education; quality; New Zealand; placements; field educators; students; competition

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Introduction

The centrality of field education to the professional development of beginning social workers has been widely acknowledged (Kadushin, 1991; Parker, 2006). Often described as the most memorable aspect of student learning, and the cornerstone or signature pedagogy of social work education (Parker, 2006; Wayne, Bogo, & Raskin, 2010), the benefits of field education across many disciplines are undisputed (Chilvers & Hay, 2011; Coll & Zegwaard, 2011; Cooper, Orrell, & Bowden, 2010). In Aotearoa New Zealand, students studying for social work qualifications that are recognised by the Social Workers Registration Board (SWRB) are required to undertake a minimum of 120 days of field education during the final two years of their programme (SWRB, 2017a). The SWRB further stipulates that students must have at least two placements. These placements must occur in two differently structured settings and fields of practice (SWRB, 2017a).

In 2015, 3,885 students were enrolled in social work programmes across the 17 tertiary providers and 1,827 students had placements in both government and non-government settings (SWRB, 2016a). This appears to have been a peak in student numbers with enrolments declining to 3,337 in 2016 and further to 3,310 in 2017 (SWRB, 2016b, 2017b). Placement numbers have seen an equivalent decline with 1,660 placements required in 2016 and 1,272 in 2017. During this period, some schools of social work were engaged in a transition process of moving from a three- to four-year degree programme and therefore these enrolment patterns may, in part, be reflective of this process. Future enrolment numbers may therefore rise again with the embedding of the four-year programmes across the tertiary sector. Despite these institutional developments and the recent decline in student enrolments, anecdotal concerns continue regarding the availability of quality placements. The sustainability of current field education models thus needs urgent, but careful, consideration.

This article draws on findings from a study on quality field education that canvassed the perspectives of key stakeholders including agency managers, tertiary educators, students, the Aotearoa New Zealand Association of Social Workers (ANZASW), and the SWRB. The focus of this article is on factors that might affect the availability of quality student placements in Aotearoa New Zealand as discussed by 15 social work tertiary educators and 31 students.

Literature review

Recent research in field education from Australasia has tended to focus on the roles of key stakeholders including the tertiary educator or liaison, field educators and agency managers (Chilvers, 2018; Cleak & Venville, 2018; Hanlen, 2013; Hay & Brown, 2015; Hay, Dale, & Yeung, 2016). The skills required for effective placement experiences have been examined (McCafferty, 2018) and there has been an increasing interest in international placement experiences (Hay et al., 2017; Zuchowski, Gopalkrishnan, King, & Francis, 2017). The negative effects of field education on students have been explored with the compulsory nature of placements being shown to be a burden, placing inordinate stress on students and potentially limiting optimal placement learning (Gair & Baglow, 2018; Hemy, Boddy, Chee, & Sauvage, 2016). Recommendations from Gair and Baglow's (2018) Australian study included increasing government financial support for tertiary students and greater flexibility in the social work curriculum, especially around field education. Elements of the practice environment such as assessment and supervision continue to receive attention (Cleak & Venville, 2018; Hodgson & Watts, 2016; Zuchowski, 2015). The consistent message throughout this literature, echoing earlier research (Kadushin, 1991; Maidment, 2003) is that placements remain the most powerful and memorable component of a student's learning during their qualifying programme. The variability of quality or effective learning opportunities and a persistent murmur about competition and availability of placements is however, evident and requires further attention.

Competition for placements

The levels of competition for placements and potential effects of these in Aotearoa New Zealand is difficult to measure. Anecdotal reports of limited placements have existed for a long time (Tertiary Education Commission, 2009) with claims such as:

> Every school of social work has difficulty in placing students, either because of placement scarcity or insufficient opportunity for matching student characteristics with availability of places. (Hanlen, 2011, p. 229)

Hanlen's (2013) doctoral research examined the perspectives of non-government organisation managers on what influences them to accept students on placements. The findings from her study suggested that, from the perspectives of the managers, the extent of competition for placements was more significant than previous literature had indicated (Hay & O'Donoghue, 2009). That said, no empirical research on the demand for social work placements had occurred in Aotearoa New Zealand until 2013.

Recognising the exponential growth of social work programmes in Aotearoa New Zealand since 2008 and the consequent increase in student enrolments, Hay, Ballantyne, and Brown (2014) endeavoured to map the demand for social work placements. Drawing on SWRB data acquired from social work programmes, they discovered that, in 2012, 1,374 placements were required across Aotearoa New Zealand (Hay et al., 2014). Their survey results signalled that a majority of tertiary education institutions (TEIs) anticipated increasing demand for placements in the following years. Their study also revealed inconsistencies in the quality and integrity of the SWRB data, which limited conclusions around the demand for placements (Hay et al., 2014). To date, no further published studies on the availability of, and competition for, social work placements in Aotearoa New Zealand have been located.

A recent study (Ayala et al., 2018) explored the perspectives of field education coordinators on the declared crisis in field education in Canada. They identified placement saturation as a critical issue and described this as "… the lack of sufficient numbers of practica to accommodate the increasing demand for placements from expanding social work education programmes" (p. 265). Their claims of significant shortages of placements has led to recommendations to considering alternative approaches to existing models of field education and enhancing collaboration between tertiary education programmes (Ayala et al., 2018).

Role of the tertiary educator

In Aotearoa New Zealand, the tertiary educators engaged in field education courses are employed as academic staff and are often referred to as placement or field education coordinators (ANZASW, 2016; SWRB, 2017a). They are responsible for understanding the field education context and building relationships with the complex network of people and organisations involved in placements (Jackson, 2018). Their role might include organising and allocating placements as well as teaching, monitoring and assessment. As Cleak and Venville (2018) describe, they may also mediate, problem-solve and act as gatekeepers. In their Australian study, these authors surveyed 53 students and 47 field educators on their levels of satisfaction with the tertiary educator (Cleak & Venville, 2018). Their findings emphasised that students and field educators desired interactions with knowledgeable and experienced tertiary staff, preferably during face-to-face encounters. They recommended increasing resourcing levels and reducing workloads to strengthen the educational and liaison role of the tertiary educator (Cleak & Venville, 2018).

Accessing sufficient placements that will enable student learning is a critical component of the tertiary educator role. In an environment of placement shortage, educators experience tension in the matching and allocation process as they seek "quality" experiences for their students (Gordon, McGeoch, & Stewart, 2009). As Zuchowski's (2015) Australian research testified, tertiary educators must understand not only individual student needs, but also the regulatory and programme requirements and the organisational context to facilitate effective placements. The unfeasibly high workloads of tertiary educators have been identified as a critical element in the Canadian field education crisis (Ayala et al., 2018); however, there is a notable absence of published literature on the workloads of field education tertiary educators and how they manage the complexities of their role in Aotearoa New Zealand.

Organisations and availability of placements

The neoliberal policy environment in Aotearoa New Zealand requires social services to perform as outcome-focused businesses (O'Brien, 2016). These policies directly influence funding streams for social service organisations and the limited resources do not reflect the challenges or complexity of their activities (Ballantyne, Beddoe, Hay, Maidment, & Walker, 2017; McCafferty, 2018). Financial constraints in social service organisations are a perennial issue frequently leading to high workloads, reduced staffing capacity and limited physical resources. The pressures arising from these constraints are longstanding (Beddoe & Worrall, 1997; Maidment, 2003). They do, however, continue to affect the ability and willingness of organisations to take student placements (Hay & Brown, 2015; McCafferty, 2018; Moorhouse, 2013). In an earlier publication, Maidment (2003) recognised the dependence of tertiary programmes on the social service sector to provide learning opportunities for students. The traditional model of field education whereby a student is placed in an organisation and generally receives support and supervision from one social worker or professional continues in Aotearoa New Zealand (Hanlen, 2013) despite occasional calls for consideration of alternative approaches (Maidment, 2003).

Hanlen (2013) thoroughly explored organisational pressures on non-government agency managers, identifying that a range of factors influence managers' decisions about accepting student placements. These factors include organisational pressures such as staffing capacity or restructuring, student characteristics, timing of the request, and macro influences including government provision of contracts. If accepted for a placement, students may be entering organisations that are pressured over time and resources and thus their learning may be jeopardised (Maidment, 2003; McCafferty, 2018). A framework of collective governance in field education whereby all key stakeholders have agency in the facilitation of the placement has been promoted by Australian researchers (Henderson & Trede, 2017). They recommend the development of sustainable, reciprocal relationships although they recognise that organisations are likely to accrue less benefits than the student and the tertiary provider. While they emphasise that organisations need to support field educators through the provision of time, recognition and legitimation of their educative and supervisory role, they do not critique limiting factors such as funding and available physical resources (Henderson & Trede, 2017).

McCafferty's (2018) findings from her Aotearoa New Zealand-based research with field educators echoed previous research (Hay & Brown, 2015) that signalled some organisations are resistant to taking student placements because they receive no payment for this service. The stagnant resourcing of social work education which is funded at the social sciences rate is inadequate to cover the real costs of field education (Ballantyne et al., 2017; Chilvers, 2018) and the disparity with other professional disciplines such as nursing and teaching is undisputed. Surprisingly little has been written about the impact of the current funding levels in Aotearoa New Zealand and how this may influence organisations' willingness and ability to take student placements (Chilvers, 2018; Hay & Brown, 2015).

Method

This study utilised a qualitative methodology and aimed to explore stakeholder perspectives on quality social work field education in Aotearoa New Zealand. The stakeholders included students, agency managers, tertiary educators, the ANZASW and the SWRB. Semi-structured interviews were conducted either individually or in focus groups, depending on preference and availability of participants. This article draws on tertiary educator and student views related to factors that may affect the availability of quality student placements in Aotearoa New Zealand.

The interview schedule was developed after familiarisation with the relevant literature including published material from previous stages of the study (Hay et al., 2014; Hay & Brown, 2015). The interviews enabled the generation of data from the lived experiences and perspectives of two groups of people closely involved with field education (Ritchie, Lewis, McNaughton Nicholls, & Ormston, 2014). Ethical approval from Massey University was sought and granted under the low-risk category. Confidentiality of the participants was given particular attention due to the limited number of educators and students engaged in social work field education in Aotearoa New Zealand. Consequently, the generated data and quotations are anonymised and any identifying information has been removed. Conflict of interest was avoided by ensuring that no educators or students from the researcher's institution were invited to participate in the research.

Programme heads of the 17 social work schools were emailed letters of invitation requesting that information sheets and interview schedules were forwarded to academic staff involved in field education courses and students who had completed at least one social work placement. Interested participants contacted the researcher directly to arrange either an individual interview or a focus group. As the student focus groups were held on the participating TEI's campus, the researcher liaised with relevant administration and academic staff to arrange a suitable location for the group interview.

Over the period June–December 2014, 15 tertiary educators from 11 TEIs participated in either individual interviews (*n* = 9) or focus groups (*n* = 2). These were conducted either by telephone or in person depending on convenience and the participants' preferences. The educators all taught in social work degree courses in either universities, polytechnics or wānanga[1]. They had all had recent, direct experience in field education activities including teaching, organising, monitoring, liaising and assessing placements. Students from three tertiary providers agreed to engage in focus groups on their campuses during November and December 2014. A total of 31 students participated in the focus groups. All of the students were enrolled in an undergraduate social work degree programme.

The interview data from the tertiary educators were analysed using qualitative analysis processes (Babbie, 2013) and, in particular, the Framework Approach (Ritchie et al., 2014). After the interviews were transcribed, the data were collated under the interview question headings. A thematic index was then developed for each question and charts that mapped the nature of the data and associations between themes were developed. The student focus group data were coded by the researcher using NVivo 11™. The generated node reports allowed the researcher to create thematic charts which allowed for further analysis of key themes relating to placement availability, the role of tertiary educators and organisational factors affecting availability of placements.

Findings

The tertiary educators and students voiced a range of opinions about the availability of social work placements and competition for quality placements. The pressure on tertiary educators engaged in field education was well-traversed with a continual refrain around limited funding and resourcing for this complex and time-intensive work, both for them and the field educators. Organisations that take student placements also face myriad pressures and the impact of this on placement availability and student learning was noted. These themes are further discussed below.

Placement availability

The pressure on finding suitable placements for students was discussed by all of the educators with the situation being described as a *saturation crisis*. They acknowledged the high number of social work programmes and consequent numbers of students seeking placement each year. They believed this had led to some organisations becoming more particular about the type of student they would accept, for example, someone without convictions or who had certain prior experiences. Further, there was a sense that organisations preferred to liaise with more established TEIs or those with whom they already held an existing relationship. This pressure to find placements may jeopardise student learning as some TEIs have to seek placements in new organisations or those seen to be *less traditional*:

> The pressure for placements means that we know we are placing students in areas where they won't necessarily get a quality experience, what we would like them to have, because we have to push the boundary of what constitutes a placement … that's always the dilemma. (Educator 6)

The consequences of this situation also seemed demoralising:

> Just having a real shortage of placements, and then having to beg for placements, and putting pressure on staff in organisations where the timing's wrong, or they don't actually want a student but they take a student because the student has nowhere else to go. Or you shoulder tap your friends who are out in the community to take a student. (Educator 7)

The students held differing views as to whether they were competing against each other for placements and if this affected their agency preference. Tension was apparent in one focus group about the suitability of some of the placement agencies. Even after raising concerns with the tertiary educator they were dismayed that students the following year were still placed in the same organisation although they agreed this was due to the limited placements in that particular location:

> I feel really sorry for those students, 'cos I don't think they're going to get very good learning. And I get that it's part of their availability of placements, all that, but it feels frustrating … People that were at that placement were beside themselves, coming to class crying, and you know, that's not ok. And so and still in the year after, they sent people to that same place. (Student FG1)

The students suggested tertiary educators needed to undertake better planning of the placements including establishing that learning opportunities will exist for the students:

> And speaking to those supervisors and finding out what the students could be working towards, who they would be shadowing, and just looking for those opportunities in order for us to achieve our goals. (Student FG2)

Similarly, the educators believed they needed to work more closely with field educators and their organisations to strengthen the links between industry and the tertiary sector. They suggested several ideas to assist this process including working alongside each other in the classroom, co-constructing case studies, having tertiary educators actively participating in agency work, and undertaking joint research. Inadequate levels of funding were cited as the primary limiting factor for the implementation of these ideas.

The students were emphatic about the need for more choices of placement. Two groups of students recognised the limited opportunities in the cities in which they lived, however, they questioned whether the tertiary educators had located all possible placement opportunities. One student seemed resigned to having to take whatever placement was available rather than one she was particularly interested in or thought would meet her learning needs:

> So there's not really the opportunity to really have a proper fit for the student and the placement. You've just got

> to make it work. If you get in [to the placement] and then get in, great. You have to make it fit. (Student FG1)

The tertiary educators also discussed the matching and placement allocation process. There was a commitment from them to engage in matching individual students with specific placements and considering "the kind of supervisor you're putting them with, what kind of learning styles the student has … what are some areas they might be challenged by…" (Educator 1). While this was noted as ideal, they acknowledged they often felt under pressure to confirm placements quickly especially due to competition with other TEIs:

> There is competition. And that's why we have to work so hard on our relationships with our community … because we want our local community, when they think about social work they think of [name of TEI] as being quality students, quality support and we want them to think that they have a close relationship with is, that they're engaged with us, so that there's trust there, so that they're more likely to say yes to us. (Educator 5)

Some students signalled a willingness to relocate for their placements if financial support was forthcoming from either the TEI or the placement organisation (Student FG1). The educators also supported this concept and agreed, "if we can't provide them a placement in the community area where they live, then we should be willing to put some money into that" (Educator 11). While this may not be suitable for all students depending on other responsibilities and commitments, this may take some pressure off some organisations and enable students to have excellent learning opportunities in other geographical locations.

Pressure on tertiary educators

The tertiary educators spoke passionately about the importance of field education in their social work programmes. They also explained at length many of the pressures associated with their role. They emphasised that all staff in the social work programmes needed to appreciate the value of field education and weave it into their teaching in the classroom so it is better integrated in the qualification. One tertiary educator explained:

> So in my view, I think practicum sits at the heart of any social work degree but generally for some reason or another, it gets shunted off to the side as the poor cousin, or the big brother that's a bit naughty and we don't really know what to do with them. (Educator 1)

There was an awareness in all the student focus groups that the tertiary educators involved in the field education courses were under considerable pressure. One group of students suggested that the tertiary educator needed other colleagues to assist with the complex and time-constrained role. A different group discussed not wanting to "bother" the tertiary educator or ask too many questions due to their busy schedule. To enhance quality placements, the students encouraged TEIs to recognise the associated workload pressures:

> Support the tutors so they have time to create a placement programme, e.g., the handbook, e.g., going out and finding the placements, so that they're paid to actually do the work, instead of …, sometimes I think there's an attitude around social work where institutes view it as not so much a degree but it comes down the strata compared to things like business, stuff like that. But actually pay tutors to go out and find the placements give them time and it shouldn't be stuff that they have to do in their own time. (Student FG1)

The tertiary educators also described the complexity of their role and emphasised the importance of planning and giving consistent messages to students, field educators and organisational management. Several educators discussed limited administrative support or systems in their TEIs and that this placed a further burden on them. Time spent on administration impeded their direct work with students and agencies and also restricted time available for other tasks such as research. One educator described this tension:

> They need to feel that time spent on supporting quality placements isn't time that's taken away from their research. It needs to be structured in a way that there's not that tension between "I must research" versus "I must provide everything that my student needs for placement" … I don't think that that's always recognised within a university. (Educator 5)

The limited resources available to the tertiary educators was considered a key constraint. Additional funding for field education courses was repeatedly mentioned so that tertiary educators could then have more time to organise placements; visit the placements more frequently; develop new resources and innovations; support students who are required to travel and also offer a suite of training opportunities for field educators. Adequate funding would also signal the value of field education:

> I'd really like placement papers to be funded realistically in accordance [with] the amount of work and the amount of hours that go into ensuring quality placements, ensuring that quality supervision is happening, to recognise the difficulties around finding quality placements. (Educator 5)

Payment of field educators and external supervisors was also highlighted as a gap in current resourcing and was deemed important to facilitate some reciprocity and recognise the critical role of these stakeholders. The lack of specific funding from the Tertiary Education Commission for social work programmes was seen as needing immediate attention. The educators believed this could significantly change the current pressured environment:

> The university would not be so worried about money. It would only be concentrating on whether these students are fit for practice, whether there's jobs out there for them, and whether there's enough quality placements to ensure they get the learning they need within their training so that the numbers weren't based on "Hey, let's get as many as we can" but were based on how many quality placements we can know that we're going to get for those students. (Educator 6)

Organisational factors

Funding cuts or uncertainty of continuing contracts in social service organisations were acknowledged by the students as limiting factors on the availability of placements. They were aware that some agencies could not commit to taking a placement student due to their own staffing and service uncertainties. Also, the tertiary educators noted that they did not feel they could put too many expectations on organisations about taking placement students, especially if they were aware of organisational stressors. There was an associated sense of having to be grateful for a placement, even if the tertiary educator was aware of the funding and staffing pressures that were occurring and that these might negatively impact on the student's learning. In contrast, one tertiary educator indicated that organisational change can create learning opportunities for students, although they still needed to be well-supported:

> …organisational change is actually part of social work. And so to try and protect your students from all of those variables that might interrupt their learning, actually that's a heap of learning … [but] it might not be a pleasant experience. (Educator 6)

Funding pressures may also lead to redundancies, further limiting numbers of available staff. This, along with a lack of registered social workers in some agencies or geographical locations, can further affect placement availability and according to one educator, was a particular challenge in Māori organisations. The educators did not disagree with the SWRB regulations but instead emphasised the need to be creative, innovative and flexible in their placement planning.

The tertiary educators suggested that some organisations have *placement fatigue* due to an almost continual cycle of students, not always just from social work but also other disciplines. Some organisations also faced challenges housing students and providing them with resources such as a desk and chair, computer, telephone and a place to store their belongings. This was seen by both tertiary educators and students to be a basic expectation of the placement:

> I think students can be really undermined if they don't have a space within the organisation … it's ideal if they can have access to a computer that is their own and a phone so that they don't feel they're interrupting other workers. (Educator 5)

The students voiced frustration at not having their own physical space:

> I found that hard at the placement I was just on, cause I didn't have anywhere to work and everyday it was a juggling match as to whose desk I could have, who wasn't going to be there and if there wasn't a desk then I had to sit at the round table in the manager's office and then if she had someone come in for a meeting I had to go and I'd just have to find somewhere to sit and I didn't have a desk. I found that really difficult. (Student FG1)

The tertiary educators recognised that field educators are generally balancing high workloads alongside their placement responsibilities and for this reason questioned whether it was fair to expect them to give up time to attend training or other professional development related to field education. Workload release time was recommended as a way "to recognise the work that it takes to have a student, or access to further education, professional development" (Educator 5) and again funding from TEIs for field educators was emphasised as necessary in order to support this approach and thereby promote excellence in field education.

Discussion and conclusions

Field education is central to the professional development of work-ready graduates (Smith, Ferns, & Russell, 2016). With a reliance on several stakeholders for its success it is a complex endeavour that requires extensive time and resourcing to ensure its effectiveness.

The participants in this study confirmed the refrain of placement saturation and competition for placements that has been heard for many years in forums of tertiary educators and more recently between New Zealand government officials and sector representatives. However, there remains no empirical evidence that the students requiring placements on an annual basis are *not* being placed in suitable learning environments. The SWRB statistics instead indicate that students *are* being placed although whether all of these are in environments conducive to learning is unknown (SWRB, 2016a, 2016b, 2017b). There appears to be an urgent need to examine the claims of competition and limited availability of quality placements. Quality benchmarks can be determined through cross-sector consultation and the utilisation of existing tools such as the national Field Education Guidelines (ANZASW, 2016). Consideration of alternative models of field education, whilst maintaining a focus on the achievement of agreed learning outcomes and assessment, could facilitate new and exciting learning opportunities and reduce pressure on all stakeholders (Maidment, 2003). Interdisciplinary, research or project-focused work are examples of models that are, to some extent, now being offered as different learning opportunities to the traditional case-focused practicum (Maidment, 2003). Further cross-sector discussion on alternative models, including practical components such as the number of required days and frequency of supervision, are required to continue strengthening field education in Aotearoa New Zealand.

Echoing previous Aotearoa New Zealand research, the findings also highlight difficulty in securing appropriate placements in some geographical locations. The students in this study expressed an openness to undertake placements outside their geographical location if this guaranteed a quality learning experience. Financial support from TEIs could assist students with relocation if appropriate placements were available. Employers in organisations that might have difficulty recruiting social workers could also work alongside TEIs to identify appropriate students who could complete a placement with the intention of future employment. The introduction of organisational incentives such as subsidised rental accommodation, petrol vouchers or other financial assistance could further support this idea. Sustainable relationships and a shared focus on student learning between TEIs and organisations are foundational for the success or otherwise of such initiatives. As Chilvers' (2018) doctoral research highlighted, field educators do not always feel their work is sufficiently valued and increased resources and opportunities such as specific training in field education or time allocated to developing communities of practice might, at least in part, address this concern. Addressing the inadequate funding levels in social work education would greatly assist with such endeavours and, importantly, increase recognition of the field educators and organisations that support student learning.

In addition, organisations may hold preferences for students with specific attributes or from particular TEIs (Hay & Brown, 2015). In recent years, national organisations including the Ministry for Children Oranga Tamariki and the Open Home Foundation have moved to regional administration of placements, effectively removing the ability for tertiary educators to directly liaise with local sites. This new development potentially alleviates some of the alleged favouritism of particular TEIs as all students are considered to be on an equal basis. Unfortunately, it also jeopardises the individual matching process between a student and a field educator as the latter are sidelined in the selection process and may not even have the opportunity to meet with a student or indicate their opinion as to their suitability prior to the commencement of the placement. This is concerning, as a transparent matching process and consideration of specific student attributes are elements that contribute to effective student placements (Hay et al., 2016). Individual, regional and national placement selection processes need to be comparatively evaluated so as to determine which method(s) are most efficacious, especially in ensuring optimal student learning and development.

In Aotearoa New Zealand, the neoliberal framework has significantly contributed to the shaping of social work education and social work practice contexts (O'Brien, 2016). The effects of contracting for services are evident in the comments from educators who directly associated funding uncertainty with a hesitation from organisations to take students on placement. Managers generally wish to offer students learning opportunities that enhance their personal and professional development (Hanlen, 2013; Hay & Brown, 2015) and might be wary of accepting students into an environment that is being restructured or has limited staffing capacity. Similarly, insufficient physical resources might inhibit the offering of placements. Overall, the findings associated with the effect of the organisational context on placement availability and suitability align with the Canadian research on field education:

> The context of the workplace is often characterised by a lack of resources,

> organisational restructuring, employee lay-offs, and productivity requirements that result in reduced capacities to accommodate social work students for practicum placements. (Ayala et al., 2018, p. 285)

There are limitations in this study including that the focus of the wider research was exploring aspects of quality field education. Therefore, some tertiary educators and students might not have felt it important to discuss their opinions on factors affecting the availability of placements. It is accepted that it cannot be argued that all educators and students would agree with the findings presented here.

Despite these caveats, it seems clear that the findings from this study signal the need for a comprehensive examination of the social work field education context in Aotearoa New Zealand. While not declared a *crisis*, at this point, the similarity of issues across the Canadian and New Zealand contexts is sobering (Ayala et al., 2018). Previous Aotearoa New Zealand research called for a "sector wide workforce strategy that endorses the importance of students for development of the profession and recruitment" (Hay et al., 2016, p. 52) and the findings presented here would validate such a process. A strategy that emphasises the learning culture of field education could also provide advantage for tertiary educators and field educators to negotiate workloads, physical resources and flexibility in the current field education model. Collaborative and transformational leadership in field education inclusive of key stakeholders could also be a significant and positive outcome (Chilvers, 2018). Most importantly, it would ensure field education remains the most memorable and important component of social work qualifying programmes rather than a burden on the next generation of social workers.

Note

[1] Tertiary institutions based on Māori philosophy.

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Strengths and Difficulties Questionnaire's strengths and limitations as a practice and evaluation tool in social work

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ABSTRACT

INTRODUCTION: The Strengths and Difficulties Questionnaire (SDQ) is an internationally recognised psychometric and behavioural screening tool. The Ministry of Social Development (MSD) have endorsed the SDQ as the primary behavioural screening and client outcome evaluation tool for the Social Workers in Schools (SWiS) service in 2018. The usefulness of the SDQ in social work practice and in evaluating client outcomes, however, remains unclear. This study explored two years of aggregated Youth Workers in Secondary Schools (YWiSS) SDQ scores to understand what client outcomes could be evidenced. This study further reflects on SDQs as a contractually mandated practice tool and their appropriateness in social work practice.

METHOD: Data were collected from the Family Works Northern (FWN) YWiSS database. Data modelling and analysis tested what aggregated client, parent and teacher SDQ scores communicated for changes in clients' behavioural difficulties at service entry, mid-point and exit.

FINDINGS: Analysis of two years of YWiSS client, parent and teacher SDQ scores aggregated at a service level provided inconsistent evidence of client need and outcomes by SDQ thematic categories. A number of factors, including the SDQ being voluntary, clients exiting service early and the challenge of asking the same teachers and parents to complete an SDQ, meant that there were very few SDQ scores completed by all parties at the service exit point, following a two-year intervention.

CONCLUSION: The findings in this research suggest that the SDQ as a standalone behavioural screening and outcome evaluation tool within social work is limited. Aggregated YWiSS SDQ results provided limited insights about the complexity of client needs or any intervention outcomes to practitioners, social service providers and funders. The use of SDQ in social work requires further scrutiny to test its ability to communicate a client's level of need and any intervention outcomes to these stakeholders.

KEYWORDS: strengths and difficulties questionnaire, social work practice, client behavioural screening, needs identification, evaluating client outcomes

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The Strengths and Difficulties Questionnaire (SDQ) is one internationally recognised psychometric and behavioural screening tool used to identify and assess mental health and behavioural disorders within young people (Vostanis, 2006). The SDQ uses scores to compare young people's self-reported[i] difficulties alongside parent/caregivers, teachers, registered nurse or doctors scores to inform decisions about what health and social services the young person could benefit from (Weller, Moholy, Bossard, & Levin, 2015).

Designed within clinical psychology, the SDQ uses nosological child mental health-screening categories from a minimum of two scorers at two points in time to monitor a young person's emotional and behavioural difficulties from first contact to treatment or service completion (Vostanis, 2006). Interest in using the SDQ as a behavioural screening, intervention planning and evaluation tool within the health and social service sectors continues to grow within a broad range of studies including language impairment in children (Toseeb, Pickles, Durkin, Botting, & Conti-Ramsden, 2017), child decision-making processes (Weller et al., 2015), and child sociality post-abuse (Lim et al., 2015).

Despite its popularity, some health professionals, social work practitioners and social science researchers see the use of standalone clinical assessment tools, like SDQ, to diagnose behavioural challenges as problematic. The problem with tools like SDQ as standalone assessment tools is that they remove the individual from their broader socio-ecological context (Black, Pulford, Christie, & Wheeler, 2010; Kersten, Czuba et al., 2016; Kersten, Dudley et al., 2016; Thomson, Seers, Frampton, Hider, & Moor, 2016; Sargisson, Stanley, & Hayward, 2016). Socio-ecological context in behavioural diagnosis is important as an individual's social and physical environments intersect and affect their overall health and wellbeing (Black et al., 2010; Kersten, Dudley et al., 2016; Sargisson et al., 2016; Thomson et al., 2016). The limits of standalone clinical assessment tools are evidenced in Thomson et al.'s (2016) work which found that SDQ scores alone provided little insight into how the Christchurch earthquakes impacted four- to six-year-old children's behaviour and emotional state one year after their initial B4 School Check SDQ was completed (Thomson et al., 2016). Thomson et al.'s (2016) work highlighted SDQs' inability to measure change between scoring points (less than 12 months) despite the advent of significant events or "shocks" (Thomson et al., 2016). Thomson et al.'s (2016) findings also aligned with Sargisson et al.'s (2016) and Kersten, Czuba et al.'s (2016) findings where parent and teachers' SDQ scores varied significantly between scoring points making cross comparison of the results difficult.

Alongside scorer variation and the exclusion of socio-ecological facets, the SDQ does not invite children younger than 11 to self-report and score their own behavioural challenges. When aged below 11, children do not complete a self-reported SDQ due to clinical assumptions that young children do not have sufficient cognitive understanding or capability to give accurate insights into how they behave (O'Neill, 2014; Tisdall, 2012). Clinical assessment tools like SDQ then rely on a young person's parent, caregiver or other professionals to report on their behavioural challenges and strengths, speaking on their behalf (Kersten et al., 2014). As SDQ is to be mandated in Aotearoa New Zealand's SWiS service in 2018, some social workers will be using an information gathering and assessment tool which downplays their clients' voice, fundamentally challenging a socially just approach to social work (Beddoe, 2014; Harrison, Van Duesen, & Way, 2016).

The Aotearoa New Zealand Association for Social Workers practice standards for social workers situates social justice, human rights and dignity at the heart of best practice (ANZASW, 2014, p. 9). These standards, which professionally guide social workers' practice, however, are often frustrated by government funder's contractual requirements and KPIs for social service provision (Hunt, 2017). The challenges faced by social work practitioners stem from the contract-outcome over a client-outcome-funding model that operates within most social service providers which rely on government agency funding (Hunt, 2017). The contract-outcome-funding model focuses social work on meeting organisational KPIs, prioritising clinical assessment outcomes (such as improved SDQ scores), service specifications, contract volumes, programme completions and evidence of client outcomes (such as self-reported satisfaction and needs meet). Social workers then operate within two, often-competing mindsets. One being their contractual KPI mindset, ticking key performance boxes to sustain their professional position and organisational funding, and the other their commitment to abate human suffering and indignity (Beddoe, 2017; Harrison et al., 2016; Hunt, 2017).

In the Aotearoa New Zealand context, SDQ previously was only a contractual requirement for one Ministry of Social Development (MSD) funded service, Youth Workers in Secondary Schools (YWiSS). YWiSS is a Prime Minister's youth mental health project where social workers (also called youth workers or mentors) provide social work support services to the base 15% of high school students who are identified as having low school attendance or poor academic performance (Wylie & Felgate, 2016). YWiSS is a two-year intervention programme where a year 9 or 10 student meets a mentor once a week to discuss their progress in school (Wylie & Felgate, 2016). YWiSS mentors are contractually required to complete an SDQ with the student, their parent and/or a teacher at service entry, a designated mid-point (usually end of year one) and at service closure (end of the two years). YWiSS SDQ results are processed by the Youth in Minds online SDQ scoring tool, which identifies a young person's total difficulties score (out of 40) alongside a series of sub-scores by SDQ theme. YWiSS have collected SDQ scores for the past three years; however, MSD have not yet assessed the strengths and weaknesses of the SDQ tool based on the YWiSS data collected. In 2017, MSD announced that the SDQ information gathering and evaluation tool would be a contractual requirement for the SWiS service. Therefore, despite SDQ remaining untested for its practice and evaluation value in social work, it is being mandated at a service provider level in 2017 to 2018.

This article analyses YWiSS SDQ data at an aggregate level and speaks to one social service provider's assessment of the strengths and limitations of the SDQ tool in the context of social work practice and service evaluation in Aotearoa New Zealand. As this article argues, aggregated SDQ scores, as a standalone social work practice and evaluation tool is limited. The findings do not seek to discredit the tool's screening and evaluation potentials. Instead, this article emphasises that SDQ represents one client screening and evaluative resource that practitioners could use alongside other practice and evaluation tools to ensure their practice is socially just and contextually responsive.

Methodology

To analyse the strengths and weaknesses of the SDQ tool, YWiSS service data collected from 286 students between 2015 and 2017 were analysed. The data collected by YWiSS staff were stored in an Excel database where the SDQ scores are entered against each client at service entry, mid-point and exit points over the two-year intervention. The data were organised by SDQ scorer with youth self-reported scores, parent scores and teacher scores presented under thematic headings ranging from high, medium and low. The analysis of all scores by scorer and theme was favoured, as the SDQ database did not distinguish between clients who had exited the service early, or between clients who had three scores entered (youth, parent and teacher) as opposed to clients with only one or two scores entered. All scores were counted based on the high, medium and low score categories for youth, parent and teacher responses by year and thematic SDQ category. In the discussion that follows, the summarised scores for YWiSS are analysed at a service level. The service level approach was favoured as, once scores were broken down to a high school or worker level, fewer than seven students (2% of all clients) had at least two SDQ scores completed at the entry and exit point. The low scores are due to the challenges YWiSS staff face in getting the same young person, parent or teacher to complete an SDQ before a client leaves the service.

This body of research was guided by Presbyterian Support Northern (PSN) internal ethics process and best social work practice guidelines. All SDQ scores were collected by YWiSS mentors—each young person whose score was analysed had been provided with and signed a client rights' form and a consent form at service entry. Each form outlined the young person's rights and how the data would be used by PSN for reporting and research purposes. The forms identify the client's rights to see and withdraw any information. The author of this article is bound by PSN's internal codes of ethics, which is advised by senior management, an independent advisory panel and Māori caucus.

Score analysis

SDQs have been a contractual requirement of Family Works Northern (FWN) YWiSS services since the services' inception; however, despite YWiSS SDQ data being collected for several years they have not yet been analysed by MSD to assess their usefulness as a client screening and outcome evaluation tool. The SDQ score ranges for client screening and evaluation purposes are provided in Table 1. Table 1 breaks down SDQ score ranges by the scorer, range (very high to very low) and thematic category. The latest SDQ scoring approach is seen on the right hand side of the table below and shows Youth in Minds categorisation of behavioural difficulty in 2017 compared to previous scores.

Table 1. SDQ Score Ranges Youth in Mind 2015-2017

	Original 3 band categories			Newer 4 band categorisations			
	Normal	Borderline	Abnormal	Close to average	Slightly raised slightly lowered	High (/low)	Very high (/very low
Parent completed SDQ							
Total difficulties score	0-13	14-16	17-40	0-13	14-16	17-19	20-40
Emotional problems score	0-3	4	5-10	0-3	4	5-6	7-10
Conduct problems score	0-2	3	4-10	0-2	3	4-5	6-10
Hyperactivity score	0-5	6	7-10	0-5	6-7	8	9-10
Peer problems score	0-2	3	4-10	0-2	3	4	5-10
Prosocial score	6-10	5	0-4	8-10	7	6	0-5
Impact score	0	1	2-10	0	1	2	3-10
Teacher completed SDQ							
Total difficulties score	0-11	12-15	16-40	0-11	12-15	16-18	19-40
Emotional problems score	0-4	5	6-10	0-3	4	5	6-10
Conduct problems score	0-2	3	4-10	0-2	3	4	5-10
Hyperactivity score	0-5	6	7-10	0-5	6-7	8	9-10
Peer problems score	0-3	4	5-10	0-2	3-4	5	6-10
Prosocial score	6-10	5	0-4	6-10	5	4	0-3
Impact score	0	1	2-6	0	1	2	3-6
Self-completed SDQ							
Total difficulties score	0-15	16-19	20-40	0-14	15-17	18-19	20-40
Emotional problems score	0-5	6	7-10	0-4	5-17	6	7-10
Conduct problems score	0-3	4	5-10	0-3	4	5	6-10
Hyperactivity score	0-5	6	7-10	0-5	6	7	8-10
Peer problems score	0-3	4-5	6-10	0-2	3	4	5-10
Prosocial score	6-10	5	0-4	7-10	6	5	0-4
Impact score	0	1	2-10	0	1	2	3-10

Table 2, Table 3 and Table 4 show the aggregated SDQ scores for the YWiSS clients at service entry, mid-point and closure points between 2015 and 2017. The data capture all students within the YWiSS database and distinguish between student, parent and teacher SDQ scores. The findings from the analysis of the scores are summarised by SDQ theme. The overarching themes are any diagnosis and emotional, behavioural and hyperactivity. These categories and scores are what YWiSS staff are sent following entering the SDQ score data in to the Youth in Mind online data tool. The raw SDQ data in the YWiSS database were broken down into ranges and thematic categories to identify (here in aggregate not individual client terms) what themes were scored high, medium or low by youth, parents and teachers at service entry, mid- and end-points. The tables compare the overall score counts for high (H), medium (M), and low (L) SDQ results at entry, mid-point and exit for the 286 youths listed as being within the YWiSS SDQ database.

Table 2. Total Entry SDQ Scores by Category, Difficulty Area and Range 2015-2017

Entry	Any Diagnosis			Emotional			Behavioural			Hyperactivity		
Counts	Student	Parent	Teacher	Student	Parent	Teacher	Student	Parent	Teacher	Student	Parent	Teacher
High	13	12	23	6	2	4	8	10	19	1	0	1
Medium	52	12	44	15	12	13	18	10	28	45	11	45
Low	77	31	40	121	41	88	116	35	58	95	45	61
No Score (0)	144	231	179	144	231	181	144	231	181	145	230	179
Total	286	286	286	286	286	286	286	286	286	286	286	286
Minus no scores	142	55	107	142	55	105	142	55	105	141	56	107
% H	9%	22%	21%	4%	4%	4%	6%	18%	18%	1%	0%	1%
% M	37%	22%	41%	11%	22%	12%	13%	18%	27%	32%	20%	42%
% L	54%	56%	37%	85%	75%	84%	82%	64%	55%	67%	80%	57%
Check	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 3. Total Mid-point SDQ Scores by Category, Difficulty Area and Range 2015-2017

Mid	Any Diagnosis			Emotional			Behavioural			Hyperactivity		
Counts	Student	Parent	Teacher	Student	Parent	Teacher	Student	Parent	Teacher	Student	Parent	Teacher
High	10	3	9	7	2	1	4	1	9	0	0	2
Medium	24	6	11	7	4	5	15	3	5	14	3	13
Low	53	21	38	73	24	52	68	26	45	73	27	44
No Score(0)	199	256	228	199	256	228	199	256	227	199	256	227
Total	286	286	286	286	286	286	286	286	286	286	286	286
Minus no scores	87	30	58	87	30	58	87	30	59	87	30	59
% H	11%	10%	16%	8%	7%	2%	5%	3%	15%	0%	0%	3%
% M	28%	20%	19%	8%	13%	9%	17%	10%	8%	16%	10%	22%
% L	61%	70%	66%	84%	80%	90%	78%	87%	76%	84%	90%	75%
Check 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 4. Total Entry SDQ Scores by Category, Difficulty Area and Range 2015-2017

Entry	Any Diagnosis			Emotional			Behavioural			Hyperactivity		
Counts	Student	Parent	Teacher	Student	Parent	Teacher	Student	Parent	Teacher	Student	Parent	Teacher
High	0	1	0	0	0	0	0	1	0	0	0	0
Medium	3	2	4	0	2	0	2	0	2	2	2	3
Low	21	9	12	24	10	16	22	11	14	22	10	13
No Score (0)	262	274	270	262	274	270	262	274	270	262	274	270
Total	286	286	286	286	286	286	286	286	286	286	286	286
Minus no score	24	12	16	24	12	16	24	12	16	24	12	16
% H	0%	8%	0%	0%	0%	0%	0%	8%	0%	0%	0%	0%
% M	13%	17%	25%	0%	17%	0%	8%	0%	13%	8%	17%	19%
% L	88%	75%	75%	100%	83%	100%	92%	92%	88%	92%	83%	81%
Check	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

It is important to note that, in Table 4, because response rates at exit were so low (highlighted by the number of zero scores in row four) the results emphasise the challenges faced by YWiSS staff in acquiring three completed SDQ forms at any time – particularly at service exit where, to date, only one youth had a SDQ completed by all three parties at entry, mid and exit points. The SDQ results from entry- and mid-points were the most consistently collected, and it was apparent that very few clients had three completed SDQ at any stage, and in most cases youth had only one or two scores entered at the entry- and mid-points.

The following subsections summarise the key findings by thematic SDQ category. Note that client, student or youth is used to refer to the young person engaged in the YWiSS service and that a high SDQ score refers to a more severe degree of difficulty, while a low score means the level of difficulty was minor. The author acknowledges the sample of clients was small and that the results will benefit from further statistical tests for data trends.

Any diagnosis

At entry, the majority of client and parent scores identified that both parties thought the young person's difficulty levels overall were low (54% and 56%). More students and teachers than parents felt the difficulties scores were in the medium range (students 37% and teachers 41%). It was parents and teachers, not the students who, at entry, stated stress scores were in the highest range (22%).

At the mid-point, the majority of youth, parent and teachers, scored overall difficulties low (over 60%), with less than 15% of all scorers stating that students' overall difficulties scores were high. It remained that youth self-identified an overall stress score of medium the most, followed by parents and teachers. Teachers' scores for overall stress at the mid-point were equal to parents at 20%.

At exit, because overall score rates were lowest, the results represented only a small sample of clients overall. At exit, 88% of all students had a low overall difficulties score, while 75% of all parents and teachers scored students overall difficulties scores in the low range. No young people had a cumulative stress score of high and no teachers scored clients as having high stress scores either. Twelve percent of youth, 17% of parents and 25% of teachers scored youth with a medium overall difficulty score at exit.

The overall diagnosis scores revealed that young people in YWiSS had predominantly low difficulty scores from entry to exit (over 50%). Few scorers placed youth in the high stress score range at any point under this theme. Taken at face value, the SDQ scores align with the overall service mandate of YWiSS which is to provide mentoring and social work services to mainly low-risk clients in terms of their level of personal difficulty.

Emotional SDQ scores

At entry, most students self-identified emotional scores in the medium range (41%); however, this was closely followed by 37% of students' self-identified scoring of emotional difficulty in the low range. Teachers and parents mostly stated that the youth's emotional difficulty level was low (74% and 84% respectively). Only 4% of teachers and parents had provided a high emotional difficulty score at service entry. This compared to 22% of students self-identifying an emotional difficulty score in the high range.

At the mid-point, 8% of youth had self-identified a high emotional difficulty score, while 7% of parents and 2% of teachers identified youth as having a high emotional difficulty score. Only 8% of youth self-identified a medium emotional difficulty score and 8% of teachers did the same. A total of 13% of parents felt their child had a medium emotional difficulties score. Overall, the emotional stress scores remained in the low bracket (sitting between 80% and 90% of respondents).

At exit, all emotional difficulties scores from youth and teachers were low, as was the overall number of scores provided. Of parents, 17% indicated that they felt their youth had a medium range emotional score; the remaining 83% scored their youth as having a low level of emotional difficulty.

Emotional difficulty scores between scorers were more varied at entry and exit compared to other SDQ themes. At the mid-point, there seemed to be more agreement between youth self-identified scores and parent and teacher scores. The scores generated at entry suggest students felt they faced more emotional difficulties than their parents or teachers were willing to disclose. This suggests that clients felt more emotionally challenged than their parents or teachers could recognise or were willing to disclose.

Behavioural SDQ scores

At entry, for the behavioural difficulties scores, 82% of youth respondents scored themselves low. At service entry, youth scored their behavioural difficulties less (compared to adult and teacher scores) in the high range (5%) and medium range (13%). Parents' and teachers' total behavioural scores were the same, scoring youth as having high levels of behavioural difficulty (18%); however, more teachers felt that students sat in the medium score range than did parents (18% parents and 27% teachers).

At the mid-point, youths' self-reported scores in the medium range were slightly higher (17%) for behavioural difficulties, but the high range remained the same as at entry. Parents' scores shifted in this category by the services mid-point, with a 13% drop in the high-level difficulties scores and an 8% drop in the medium range score. Overall, 87% of parents at the mid-point felt that their youth had transitioned to a low behavioural difficulties score. Teachers' scores in the high range dropped slightly, while medium scores dropped significantly from 27% (at entry) to 9% (at closure). Some 76% of teachers scored youths' behavioural difficulty low at the mid-point.

At exit, because overall score rates were lowest, the results predominantly sat in the low range. While a total of 92% of youth self-scored within a low behavioural difficulty range, only 8% of these sat in the medium range. Interestingly, there was a 5% increase in parents scoring youth in the high behavioural difficulties range at service exit. There were no medium range scores from parents, with the remaining 92% of parent scoring behavioural difficulties in the low range. Teachers' exit scores in the medium range increased slightly from 9% to 12% but no teachers scored youth difficulties in the high range. Some 88% of teachers felt the youths' behavioural difficulties were in the low range at service exit.

Behavioural and hyperactivity scores were the most diverse between scoring points across all themes. These scores showed that youth seemed to self-identify lower scores of behavioural difficulties than did parents and teachers. Teachers, who knew youth from a classroom setting in particular felt (more so than parents) the young people they taught had more behavioural difficulties at service entry, with noticeable changes in their scores by the service mid-point. This would suggest the intervention had a positive impact on the young people's behaviours at home and school by the intervention's mid-point; interestingly however, by exit some young people's behaviours may have relapsed as they were scored in the medium range over the low range identified at the mid-point by their parents and teachers.

Hyperactivity scores

SDQ hyperactivity scores were not well represented out of all areas of difficulty. A potential reason for this would be many people would not fit within this category because of the ambit and nature of the YWiSS service. The YWiSS service focuses on monitoring and encouraging school attendance and academic achievement, meaning any challenging behaviours identified by a social worker in the SDQ would see the student referred on to another specialist service provider.

At entry, hyperactivity difficulty scores in the high range were nonexistent in youth self-identified scores, parent or teacher scores. Medium scores were highest from teachers, representing 42% of entry scores. Hyperactivity scores in the high range were the next highest at entry where 32% of students and parents at 20% identified high levels of hyperactivity difficulty. Overall hyperactivity scores were mostly in the low range (57% of teachers, 67% of students and 80% of parents' scores).

At the mid-point, no students or parents provided a high hyperactivity score and only two teachers scored a high level of hyperactive difficulty in their students. Mid-range hyperactivity scores shrank by half for all groups at the mid-point. The low range scores were 84% for students, 90% for parents and 75% for teachers. Teachers continued to have the highest percentage of mid-range scores at the services mid-point.

At closure, all scorers had a high-range score of zero. Eight percent of youths self-identified scores, 17% of adults' scores (7% higher than at the mid-point) and 19% of teachers' scores sat in mid-range at the exit point. The low score ranges were highest, with 92% of students self-scores, 83% of teachers and 81% of parents scores sitting in this range. Overall, hyperactivity scores were not well represented within the YWiSS service particularly at service mid- and exit-points where fewer scores were available due to SDQs not being completed.

Discussion of scores

Based on the above analysis of aggregated scores, SDQ as a client screening and outcome evaluation resource showed a number of gaps in relation to what SDQ can communicate to social work practitioners, social service providers and government agency funders. Scores by theme revealed that students, parents and teachers had varied opinions about the young person's difficulties at service entry, mid-point and exit. Under the headings to follow, the implications of these differences between scores by SDQ theme are discussed in relation to reporting results to funders and for social work practitioners using the tool. The discussion focuses on the aggregated findings, as the ministry will only be using SDQ data to measure service quality and client outcomes at an aggregated, national service level at this stage.[ii]

Aggregated scores: Implications for reporting results to funders

With SDQs being compulsory for SWiS from July 2018, providers' SDQ data collection and reporting focuses on analysis of aggregated SDQ scores. Each provider will submit their SDQ scores through an online tool to MSD and provide data and narrative report summarising the scores alongside traditional client satisfaction results and success stories. In analysing YWiSS SDQ data, it was apparent that the SDQ scores provided a disjointed picture of overall service quality and client outcomes for several reasons. In particular, data entry gaps and the variability in scorer results by SDQ theme from entry to exit made it difficult to deduce consistent findings. The SDQ scores, best represented at entry and mid-points, further did not show any coherent relationships between difficulty themes at entry or how these difficulties diminished or intensified over time. Again, tracking themes was difficult due to very few clients having two SDQs completed at service exit by any of the scorers. YWiSS staff identified early exit and the challenge of asking the same teachers, and parents to complete an SDQ, as reasons for fewer closure scores.

Based on the findings from the aggregated YWiSS data at entry, mid- and exit-points, the majority of SDQ scores sat in the low range (over 50%). This suggests that, at an aggregate level, SDQ provided limited insights into the complexity of clients' service needs at entry or outcomes at closure within the FWN YWiSS service. As YWiSS is a mentoring service working with the base 15% of young adults with academic or attendance challenges these "low" difficulty scores are unsurprising. The overall lower aggregated SDQ scores align with the services' mandate to work with clients who present low levels of service need with students identified with complex behavioural difficulties being referred to specialist services. As a result, if YWiSS SDQ data were aggregated for reporting need or service outcomes to the funder at this stage, few insights could be communicated about specific cases of high need and risk or outcomes as client, parent and teacher SDQ scores were highly variable or non-existent as the service progressed towards its two-year completion point.

SWiS social service providers have been informed that SDQ from a funder perspective is being used to establish a longitudinal evidence base, substantiate need for increased funding for SWiS services, and illustrate the quality of SWiS practice through improvements in client difficulty scores by SDQ theme. Based on analysis of two years of YWiSS SDQ data, there were no coherent thematic shifts between aggregated scores taken at entry and exit-points. Aligned with the SDQ literature, there were also significant variations between scorers at all points and there were very few cases where two, let alone all three parties had completed an SDQ to rate the young person's behaviour at service entry, mid- or exit-points (Sargisson et al., 2016; Kersten, Czuba et al., 2016). For service providers, this suggests that SDQ alone cannot evidence practice quality or client outcomes to funders when aggregated at a service level. These findings do not diminish the value of the tool on case-by-case basis where social workers can use the SDQ as one of a suite of practice tools to assess client need, plan an intervention and evaluate change (Kersten, Czuba et al., 2016). Instead, these findings suggest that the aggregation of SDQ data will be fraught with challenges due to factors such as scorer variation and poor SDQ response rates. In light of these insights, social workers should continue to screen clients' service needs and evaluate their experiences in a way that uses SDQ as one of a suite of practice tools. The SDQ's creators even acknowledged that SDQ is *one* type of evaluation tool that should be used against other qualitative based formats such as surveys or interviews (Youth in Mind, 2017).

As funders continue to mandate specific screening and evaluation tools within social work it is important that all parties are transparent around the strengths and limitations of how screening and evaluation tools may work (and the likely challenges) at all levels. Agreeing with Bruns et al. (2014), more communication between social service providers around how mandated practice tools work on the ground would substantiate stronger arguments for more comprehensive testing and review before they are contractually required. This would ensure that providers have more robust, cross-agency tested, and collaboratively informed client screening and evaluation tools which can communicate client and service need (as well as quality) more comprehensively to funders.

Aggregated scores: Implications for social work practitioners

As outlined in the introduction of this article, Aotearoa New Zealand social work practitioners are guided by a commitment to social justice, humanity and human rights but work within a contract-outcome–over-client-outcome service model. This means social workers must consider the needs of their clients in the context of meeting their organisations' contractual requirements (such as service volumes) and KPIs (such as attendance and client satisfaction). This section discusses how the aggregation of SDQ scores to measure social work outcomes and practice quality may present challenges for SWiS practitioners and social work more generally in Aotearoa New Zealand. Although MSD has not mandated SDQ as a standalone assessment or evaluation tool (as it is voluntary to complete), it is important to consider that, under a contract-outcome funding model, practitioners are asked to prioritise this tool in their practice. In the 2018 SWiS service specifications Oranga Tamariki asserted:

> The SDQ is an appropriate measurement tool for SWiS as it is internationally validated, can be used in initial screening, and can be applied after an intervention to track levels of change (and hence success of an intervention). It can also be used to generate key performance indicators such as the percentage of children who have improved on before / after scores. (MSD, 2018, p. 25)

The service specification does not inhibit social workers from using existing practice tools such as Strength or Bear Cards (St Lukes Innovation Resources, 2018), Three Houses (Oranga Tamariki Practice Centre, 2017) and the Blob Tree (Wilson, 2017) for information gathering or evaluation purposes; however, it implies that the SDQ can somehow accurately express what a successful intervention looks like. The issue with this assertion is twofold. First, it empowers SDQ as a resource that can accurately measure behavioural change in social work settings without any evidence it can do so. The assertion that SDQ alone represents a comprehensive information gathering and evaluation tool is especially troubling from a social justice perspective. It is troubling as the SDQ does not invite children under age 11 to provide insights into their behavioural strengths and challenges. Instead, the SDQ privileges parent and teacher scores as an accurate representation of the young person's needs. Children's voices matter as they offer unique perspectives of social life, as their lives are multifaceted as active social agents in society (Bruce, 2014; Kirby et al., 2003; O'Neill, 2014; Tisdall, 2012). To be socially just in social work is to collaborate with people of all ages, cultures and abilities to help them take control of their environment and circumstances to alleviate human suffering at an individual and community level (ANZASW, 2014, p. 7). To take on such a task it would prudent for social workers to have the freedom to use tools which best respond to the ability, personal and contextual needs of their clients. The SDQ, as a mandated practice tool in YWiSS and SWiS, therefore requires further assessment relative to how it will implicate social worker's ability to engage with children genuinely when they are not invited to express what they want out of an intervention. A key question to test the social justness of SDQ in social work will therefore be asking whether a young child's rights, aspirations and insights are given equal consideration alongside their parent and teachers in an SDQ setting. The ministry has maintained that voluntary client satisfaction surveys will capture under-11s' voice and evidence intervention outcomes; this assertion will also need to be tested over time.

The second concern with the assertion that SDQ accurately measures client outcomes is that it overlooks the literature on the difficulties in administering the SDQ to clients of different cultures or with language or literacy challenges. Differences in ethnicity, context, age, gender, sexuality, ability and class feed in to how different people experience the world, identify their place in it and engage with others (Gibson-Graham, 2016). Kersten, Dudley et al.'s (2016) findings suggest that some individuals or families, although guided through the SDQ question by question, faced challenges about:

- Some questions being inappropriate based on their cultural background. Interviews with ethically distinct parents and families found that the exclusion of context made some questions inappropriate, for example, a Māori respondent articulated that, without reference to colonisation, their scores would be misleading.
- The social worker leading the scorer when they asked questions about a word or a question's meaning. This was a particular concern where the scorers had language or literacy barriers.
- Parents feeling nervous about the consequences (such as their children being taken away) that may flow from answering a question in a certain way.

The above issues illustrate how the SDQ (as it is currently designed and administered) can be challenging to administer in social work settings due to barriers around culture, literacy and language and its exclusion of contextual difference. Kersten, Dudley et al.'s (2016, p. 5) study also found that it took a significant amount of time for some questions to be broken down so that the question's meaning would be understood. There were particular challenges in translating terms to non- or limited-English-speaking parties or where a question had two parts, for example nervous and clingy, were understood as two different things by some scorers despite being in the same question (Kersten, Dudley et al., 2016). Kersten, Dudley et al. (2016) also found that most parents felt that the SDQ's value and purpose were unclear, and the questions themselves were seen as challenging to decipher without assistance. Māori parents in particular felt that SDQ would only be suitable if a sit-down, face-to-face conversation was held around the questions with their social worker because, without explanation, there was concern about how the tool would reflect on them as parents, wondering what consequences lay behind the boxes they ticked (Kersten, Dudley et al., 2016, pp. 4–5). As no interviews were conducted in this body of research, a direct correlation to Kersten, Dudley et al.'s (2016) findings is not possible but is analysed to provide an example of why SDQ scores may have been so variable between scorers or no response was given. SDQ, although seen as easy to use in psychology circles (Vostanis, 2006), thus remains largely untested in social work practice for its potential strengths and weaknesses as an information gathering and evaluation tool.

Conclusions

Based on analysis of the YWiSS SDQ scores collected over a two-year period, it is unclear how SDQ, as an aggregate social work quality and client outcome evaluation tool adds value to social work practice, or provides more robust evidence to inform funders of service quality or need. Irrespective of evidence, the MSD will roll out the SDQ within the SWiS service, alongside the existing YWiSS service in July 2018. As of January 2018, all that is known at social service provider level is that SDQ will be a voluntary screening tool at service entry and as a client evaluation tool at closure. Based on initial analysis of the YWiSS SDQs, what the tool can actually tell social work practitioners and social service providers in terms of overall service quality or client outcomes requires further investigation and comprehensive debate due to:

- Inconsistency in score collection, particularly at mid- and exit-SDQ points. Score collection was particularly inconsistent for parents and teachers at mid- and exit-points.
- YWiSS data having predominantly mid-to-low difficulties scores. Scores in this range meant there was limited change between service entry and exit difficulty scores by SDQ theme. This was the case for hyperactivity, emotional and behavioural scores.
- The purpose and implications of the SDQ and the SDQ questions not always being clear to scorers as young people, parents, whānau and teachers.

Based on the issues outlined earlier, SDQ needs to be reviewed comprehensively as it is rolled out in Aotearoa New Zealand social work settings. It may be that SDQ needs to be re-designed so that the questions are made more contextually responsive to the social work practice values and scorers in Aotearoa New Zealand (Kersten, Dudley et al., 2016). This should include SDQ translations for Māori and Pacific groups and robust discussion about the purpose of the SDQ's questions to scorers to avoid confusion and anxiety (Kersten, Dudley et al., 2016). Practitioners should therefore use SDQ as one of a range of information gathering and outcome evaluation tools to meet their contractual obligations, while also speaking to the unique components of their client's wellbeing, which is specific to their socio-ecological context.

To ensure better practitioner buy-in, funders also need to be much clearer about why SDQ is being rolled out and, over time, provide evidence of the value SDQ adds to social work practice generally and SWiS specifically; and why it is being mandated into social work practice over other practice and outcome evaluation tools. In turn, it is important to consider that no self-report SDQ exists for children younger than 11 years of age, meaning the tool does not fit well within Aotearoa New Zealand social work's framework of social justice, inclusiveness and human rights. The exclusion of children under 11 years is a key consideration for SWiS practitioners because, for providers like FWN, SWiS work mostly with children under 11 years, with SDQ actively devaluing children's firsthand accounts of what they need and how they measure personal development over time. This does not align well with Aotearoa New Zealand social workers' commitment to help all people to take control of their own behaviours and their environment as SDQ privileges parents' and teachers' insights over children under 11 years. Whether client satisfaction surveys can capture under 11s' feedback adequately will need to be considered as SDQ is rolled out in SWiS to ensure children's voices are heard relative to how they respond to the interventions they receive.

This article provides a preliminary lens into some of the practical and analytical implications of aggregating SDQ results for client screening and outcome evaluation purposes in social work practice. Over time, as SDQ results are collected, the ministry, social workers and social service providers need to do more to test the strengths and limitations of the SDQ tool comprehensively. To test the SDQ, it will be crucial to consider the implications of its use in funding allocation and on SWiS social workers and social work more generally.

Declaration

I declare that I, Emma O'Neill, have no conflict of interest with *Aotearoa New Zealand Association of Social Workers* (ANZASW). All work was completed by Emma O'Neill, Evaluation Analyst at Presbyterian Support Northern as part of her normal duties as the organisation's evaluation analyst, with no conflict of interest as per organisational standards. Work was also completed in line with Presbyterian Support Northern Code of Ethics and no information which would identify clients is disclosed.

Notes

i SDQ questionnaires cannot be self-completed by people younger than 11 years of age. Youth in Mind (2016) state that, for children under 11 years, a parent/caregiver, teacher or other professional is best to judge the young person's level of difficulty.

ii The extent of what aggregate refers to (e.g., practitioner, school, regionally or nationally), is yet to be determined contractually.

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The Auckland MA Sociology (Option II – Social Welfare and Development):

A social work qualification gone but not forgotten

Barbara Staniforth

ABSTRACT

INTRODUCTION: The University of Auckland MA in Sociology (Option II–Social Welfare and Development) ("the Programme") was a qualifying social work programme that admitted students from 1975 to 1979. This article describes this programme and some of the issues that led to its short-lived tenure.

METHODS: Semi-structured interviews were conducted with 12 staff and students who had been involved with this programme. One person, involved in the accreditation of the Programme was also interviewed, and one person provided feedback in an email. Information was also obtained through archived University of Auckland documents, reports, and various forms of personal correspondence provided by June Kendrick.

FINDINGS: The Programme was championed by the Head of the Department of Sociology (David Pitt). There were resource limitations and philosophical tensions within the Department about the qualification. There was little support for its continuation at the end of a three-year grant and after the departure of David Pitt. The New Zealand Social Work Training Council accredited it after its discontinuation.

CONCLUSION: The Programme made a valuable contribution to the profession of social work and social work education and forms an important part of the history of social work in Aotearoa New Zealand.

KEYWORDS: social work qualification; education; New Zealand; history

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Introduction

There has been, over time, some attention paid to documenting the history of various aspects of social work education in Aotearoa New Zealand. John McCreary described the first postgraduate qualifying social work programme at Victoria University in his two-part series, Martians and Minions (1971a, 1971b) and John Crockett completed his thesis (in the MA Sociology described in this article) on "Social Work Education in New Zealand" in 1977. John Cranna documented his accounts of the social work programme at the Auckland College of Education (1989). Mary Nash completed her PhD thesis on the topic (1998) and has written many other chapters (see, for example, Nash, 2001) and articles on social work history. McDonald (2004) wrote about the relationship of social work education and the professional association, while the author of this article has recently written about the social work training programmes provided through the State Services Commission at Tiromoana and Taranaki House (Staniforth, 2015). Most recently, van Heugten and Gibbs (2015) have provided a historical account of the relationships of social work and sociology within an international context, and Harington (2016) has written about the sometimes uneasy relationship of sociology and social work in Aotearoa, outlining some aspects which are familiar to this programme and that are discussed in this article.

In the description of the evolution of social work education in Aoteroa New Zealand, there are often accounts that social work education programmes had begun at Victoria University in 1949–1950, with programmes following at Massey University and Canterbury University in 1976. Mention, but little detail, is given to the brief-lived social work masters qualification provided through the University of Auckland (1975–1980). While authors such as Nash (1998) have explored this qualification, there does not appear to be any comprehensive presentation about this programme in the literature.

This article uses a social constructivist lens to piece together different facts, opinions and accounts about the MA Sociology (Option–II Social Welfare and Development). The process of conducting the research is described, with a description of the content and structure of the Programme following. Possible reasons for the discontinuation of the Programme are explored, with impressions from interview participants provided to add colour to the historical documents.

Methodology

The approach to the research was interpretivist and socially constructionist (Bryman, 2016). The "data" were produced through individuals' experiences of the Programme, and the author's interpretations of their accounts and the historical documents that she was privy to.

There were three main sources used to write this article. These included previous interviews with June Kendrick, a tutor in the Programme, historical documents, and more recent interviews with staff, students and others who had interactions with the Programme.

Initial accounts of the MA Sociology Option II were provided through recorded interviews with June Kendrick, in 2006, for the author's doctoral thesis (Staniforth, 2010) and in 2011 for an historical article written about Kendrick (Staniforth & Nash, 2012). Kendrick later gave written permission, in 2015, for information from these two interviews to be used for this article.

Written information was obtained through the University of Auckland Library. A librarian provided access to locatable documents in relation to the Programme. A detailed account of the search process was not made available. The bulk of the information came in the form of documents, reports, minutes, and personal correspondence provided to the author by Kendrick, from her time in the Programme.

Consent for this research was obtained from the University of Auckland Human Participants Ethics Committee in 2014. An email invitation was sent out to members of the Aotearoa New Zealand Association of Social Workers (ANZASW) requesting that they make contact with the researcher if they were interested in learning more about the research. Three participants made contact, with two subsequently engaging in interviews. All other interviewees were approached directly, either because they were known to have been involved with the Programme, or had been suggested by other interviewees. Three staff involved in the Programme were interviewed, as were seven previous students (three via Skype, four in person). One person from the New Zealand Social Work Training Council (NZSWTC) accreditation board was interviewed and one previous fieldwork supervisor provided information via email.

Semi-structured interviews were audio recorded, with notes taken by the author throughout the interviews. Relevant quotations were transcribed from the interviews and participants were given the opportunity to either be identified or to remain anonymous. All quotations were approved by participants prior to publication.

The Programme

The MA Sociology (Option II–Social Welfare and Development) began at The University of Auckland within the Department of Sociology in 1975 and took in its final intake of students in 1979. This was only the second social work qualification in the country to emerge since the establishment of the Victoria University Post Graduate Diploma in Social Sciences in 1949–1950.

Brian Manchester, who was a member of the Social Work Training Council in the 1970s, described the beginnings of the Programme:

> At that time there were very few trained social workers in the field and Victoria University of Wellington was the only educational institution offering qualifying courses at tertiary level and the number graduating each year was small…The catchment area of greatest unmet need was the greater Auckland area but the University of Auckland did not seem ready to respond.
> Representations to the Professor of Sociology at The University of Auckland [David Pitt], who for a time was a member of our Council, resulted ultimately in a short lived course at Masters level, called if my memory serves me correctly an "MA in Social Welfare and Development".
> (B. Manchester, personal communication, January 29, 2011)

Professor David Pitt, who sat for a time on the Social Work Training Council (Department of Sociology, 1976) was described by several interviewees as "entrepreneurial" and was acknowledged as having championed the Programme into the Department of Sociology. From its beginnings, there was contention as to the nature of the Programme. Existing sociology staff within the Department believed that they were approving a traditional Master's degree in social welfare and development. In a memorandum to the Vice-Chancellor on 8 October, 1979 Vodanovich (acting Head of Department) explained:

> The M.A in Sociology Option II (Social Welfare and Development) as it was proposed and accepted by the Faculty on 4/4/1974 (App. I) had as its primary objective the training of supervisors, administrators and policy makers. (p. 1)

The degree however, would soon be presented as a professional qualifying social work degree. In a set of guidelines written for students in 1975, the purpose of the degree was described, "The degree is intended to be a two year professional training for social workers and others working in social welfare institutions in New Zealand and the Pacific" (Pitt, 1979, p. 1).

Later, in a memorandum (November 13, 1979) from Kendrick to then Acting Head of Department, Vodanovich, Kendrick described the degree as having been designed to:

> (a) recognise an academic performance at MA level with provision for graded pass and the award of appropriate honours;
> (b) provide a first qualification for social work practice.
> (p. 1)

Just as the Victoria University programme did not have the term *social work* in its qualification, the same applied in this instance. Manchester described one of the reasons for this: "On one occasion I had asked Professor Pitt why, what I understood was to be a social work practitioner course had been given such a vague title as 'Master of Social Welfare and Development.'

His response was ‘because social work is regarded as somewhat disreputable amongst my academic colleagues’” (B. Manchester, personal communication, February 6, 2006).

The Calendar Prescription (see Table 1) describes a two-year postgraduate programme comprised of course work, field practicum and a thesis requirement.

A student from the first intake described that “there were about 10 people. At least one person straight from sociology” (anonymous, personal communication, June 18, 2015). The Programme began in the Rexcourt Building on Symonds Street. “We got started without much preparation. There was no room for grad students, and there were hardly any books” (anonymous, personal communication, June 18, 2015).

Initially there were no additional lecturing staff employed in the Department of Sociology to undertake the coordination or delivery of this Programme. In 1976, Pamela Ringwood, who was also employed with the Faculty of Law, was brought onto the Programme in a half-time capacity to teach law and social work into the Programme. In 1977, June Kendrick was welcomed to the Department. Kendrick came to the Department “though the generosity of a grant of $15,000 from Mobil Oil New Zealand Limited to support graduate teaching and research in social welfare and development” (Department of Sociology, 1977, p. 1). This grant provided for a three-year tenure.

It would appear that there were somewhere between 10 and 15 students admitted to the Programme each year of its five intakes (1975: 10; 1976: unknown; 1977: 10; 1978: 15; 1979: 11). The majority of students came with a background of a Bachelor of Arts in Sociology, followed by Psychology, and then a range of subjects such as Anthropology, History, Education and English. While the Programme was intended to take two years full time, records revealed that many students completed the Programme on a part-time basis, often taking up to four years.

Pitt, guest lecturers, tutors and other Department of Sociology staff, took classes prior to the arrival of Ringwood and Kendrick. Several of the interviewees

Table 1. Calendar Prescription 1977

Option II: Sociology (Social Welfare and Development)
Four papers and a thesis which counts as two papers and a practical placement which counts as one paper, or in exceptional cases, where a placement cannot be arrange[d] to the satisfaction of the Head of the Department, four papers and a thesis which counts as three papers.
Candidates for Sociology (Social Welfare and Development) will normally be graduates (with social welfare papers) or have a degree in social work. With approval from Senate, graduates from subjects other than sociology, e.g. Anthropology and Political Studies, may be admitted.
All students must take 82.500 and 82.501, and [at] least one paper from 82.502 to 82.506. In consultation with the Head of Department [an] additional paper may be taken from the 82.300 or 82.400 series or with the approval of the relevant Head of Department [from] other prescribed courses. The papers may be spread over two years. The thesis shall not exceed 20,000 words in length. A report not exceeding 10,000 words shall be submitted on the practical placement. The placement will be arranged by the Department in an approved agency or institution and will normally be undertaken concurrently with the theoretical studies. At the discretion of the Head of Department a candidate may be examined orally on either or both the subject of his thesis or placement report.
Students intending to enrol in 1977 are asked to consult the Head of Department about their course before enrolment.

82.500 The Principles of Social Work and Social Administration
82.501 Social and Community Work Methods
82.502 Social Development and Social Services in New Zealand
82.503 Social Development and Social Services in Asia and the Pacific
82.504 Human Growth and Development
82.505 Special Topic to be prescribed by the Head of the Department
82.506 Special Topic to be prescribed by the Head of the Department

Source: The University of Auckland (1977, p. 202).

recalled a seminar orientation to classes in the early years of the Programme.

Colin Jones, one of the later-year students, provided his impression of the classes:

> He [Pitt] oversaw a fairly brief period on social policy. My recollection was that he didn't deliver a single lecture. He presented us on the first day with a series of topics, told us to choose one and go away and prepare to give a seminar on that topic. I felt sorry for those who were up first who didn't have a lot of time to prepare. (Personal communication, June 15, 2015)

John Crockett, an earlier student, had a different perspective:

> David was committed to a tutorial model where the seminar was important. "This is a theme, let's talk about it". He was encouraging intellectual freedom, but at the same time holding quite a high standard in assessment and intellectual rigour in that regard. (J. Crockett, personal communication, November 27, 2015)

Some of these seminar themes from 1979 are presented in Table 2.

Staffing the Programme

With a lack of staff dedicated to teaching social work initially, Pitt appeared to be working hard to hold the new programme together.

He [Pitt] did the course on shoe string. He gathered people from here, there, and everywhere. It looked like it [the Programme] was always under threat. His vision held it together. It was an exciting vision. He was an exciting lecturer. (J. Crockett, personal communication, November 27, 2015)

Table 2. Seminar Themes, 1979

The history of child welfare often follows a cyclical pattern between institutional and family care. Discuss this with special reference to adoption, fostering, residential and day care.
Penal services may aggravate rather than correct deviance. Discuss.
"The casework approach to poverty and income maintenance is nothing but a waste of time. It is society and not the individual that must be changed." Evaluate this statement.
Social welfare and social work have traditionally acted as agents against social change. Explore the alternatives and draw conclusions about the application of social work principles to general sociological theory.

Source: Course outline 82.500 The Principles of Social Work and Social Administration (Department of Sociology, 1979b).

Dr Ivanica Vodanovich, who was lecturing within the Sociology Department and eventually became interim Head of School when Pitt left the University in 1979, recalled that there were many guest lecturers that Pitt was able to bring in, particularly from Victoria University (I. Vodanovich, personal communication, April 7, 2016). Ringwood and Kendrick would provide the substantive social work content to the Programme.

Kendrick came to the University with a background of education and social work with her most recent position having been supervising social worker at Auckland Hospital (Staniforth & Nash, 2012). Kendrick recalled that "the position was held out to me that my job would be to be lecturer in social work, but also to take responsibility for the placement and any follow up" (personal communication, July 28, 2006). Vodanovich recalled that "… [w]ith June, it became more social work focused and that's what students wanted. Students saw themselves, and June saw herself, as teaching social work" (personal communication, April 7, 2016).

The hosting of Professor Ben Schlesinger, a Visiting Professor from the University of Toronto from July 1978 to 1979, was a highlight for staff and students. (Department of Sociology, 1979a). This undoubtedly provided quite a useful input of social work academic experience and knowledge into the Programme. Cluny Macpherson, a lecturer in sociology in the Department at the time, described how Schlesinger was able to bridge some of the social work–sociology divide while he was there (personal communication, January 27, 2016), while Stewart, a student at the time, acknowledged the status which Schlesinger brought to social work, "he was a professor of social work and they had never seen someone like that before" (personal communication, January 13, 2016).

Content and structure

As demonstrated within the Course Calendar earlier, there were few courses to choose from, with a fairly proscribed programme: O'Flaherty, a student in the Programme remembered, "There was not much variety in terms of courses. Most of us did what was on offer. We all did all the core things. Couldn't be lots on offer with those [low] numbers" (personal communication, May 26, 2016). Table 3 presents course descriptions for 1975. By 1979, with Kendrick on board, the 82.500 course had evolved slightly. Table 4 covers material from lectures in 1979.

Table 3. Course descriptions 1975

82.500 Principles of Social Work and Social Administration
Modules will include theories of social work, history of social work, fields of social work, marriage and family, child welfare and youth care, geriatric problems, housing and environment, medical social work and health services, disabilities and handicaps, mental health services, correctional services, poverty and income programmes, contemporary trends and future directions.
82.501 Methods of Social and Community Work
Individual casework, counselling methods, group work, community work, social work amongst special groups, Polynesian, elderly, deviants, social work as a vocation, ethical problems.

Source: Pitt (1975, p. 2).

Situated within a sociology department, the courses appeared to have a strong sociological perspective, especially in the earlier years. "I am pleased that I did the course. It opened my eyes to sociological, feminist, Marxist theory, reality theory" (Anonymous, personal communication, June 18, 2015).

Table 4. Course Content 82.500 Principles of Social Work and Social Administration 1979

1. Social Work Function
a) Defining the Task-Consideration of the Report Prepared by the British Association of Social Workers b) Social Workers and their Role in Society-Social change and social control operating within the "Social Welfare System". c) Philosophy Of Social Work
2. History of Social Work
a) Changing Perspectives In Relation To Social Work Theory b) Current Philosophy of Social Work Practice c) Some Theories of Social Work Casework. The "Helping Process".
3. Role of the Social Worker in Relation to Other Professions and Agencies
4. Working in a Bureaucracy.

Source: Department of Sociology (1979b).

Crockett explained his hopes for the course:

> I was wanting skills, professional skills. My main intention was to be better at my job. [Pitt had a] sociological approach. He was keen to see social work in its wider context and of its effects on society. I think he was ahead of me in that regard. It took me a while to get that perspective. I was looking at things more narrowly… psychological-skills based… I now regard him as quite a visionary. (Personal communication, November 27, 2015)

Jill Goldson had begun the social work programme at Victoria University and then transferred to study at Auckland. She recalled: "There was a political push in the curriculum that I respected. Looking at it now I think that it was pretty good, it was quite grunty, compared to Wellington that was much more 'touchy feely'. Overall it was quite intense" (J. Goldson, personal communication, August 22, 2015).

Lynda Court (nee Jaffe) felt that the curriculum "was a mainstream approach to supporting people … it covered everything that it should in terms of a social work course then. It had all the basics. I became a good social worker" (personal communication, December 2, 2015).

The practical experience was what differentiated option I versus option II of the MA. As is still often the case, the practicum presented the Programme with some of its greatest challenges and the students with some of their greatest opportunities.

Practicum

Students were required to complete a "practical placement and a 10,000 word report which counted as one paper" (NZSWTC, July 1981, p. 1). Students completed more than 1,000 hours and often completed their placement in more than one setting.

In a 1979 (November 13) memorandum to then Acting Head of School, Dr Ivanica Vodanovich, Kendrick described her initiation into the practicum component: "When I joined the staff in 1977, with special responsibility for the oversight and arranging of placements, I found a confused and generally unsatisfactory situation" (p. 1).

The yearly Department Annual Reports also demonstrated some of the shifting sands under which the placements occurred:

> From the 1976 *Annual Report*:
> 1976 also saw the opening of the two student units at Greenlane/National Women's and Kingseat Hospitals. Miss M. Somerville, and Mrs. M. Lawrence were appointed as respective supervisors. (p. 1)

> From the 1977 *Annual Report*:
> During the year there was continuation of the two student units for the MA (Option ii) through [sic] we were sorry to say goodbye to Miss M. Somerville and Mrs. M. Lawrence who had acted as supervisors. (p. 1)

> From the 1978 *Annual Report*:
> The student units for the MA (Option ii) were plagued with staffing shortages during the year but a new unit was established with the Department of Social Welfare. (p. 1)

> From the 1979 *Annual Report*:
> In April, three field work teachers, funded by the Departments of Health and Social Welfare—Diane Naftel, Peter Pascoe and Griff Richards—were appointed to supervise the practical placements of the students enrolled in the M.A. Option II. (1979a, p. 1)

Peter Pascoe was one of the people appointed to work as a student supervisor through the Department of Social Welfare. He reiterated some of the difficulties with supporting the placements described previously by Kendrick:

> I enjoyed my two years as a Student Unit Supervisor/Fieldwork Teacher despite being totally without organisational support, either from the Department or the University. However we 3 student unit supervisors—[myself and] Griff Richards, Diane Naftel—all worked together very well. (Personal communication, June 1, 2016)

As demonstrated by the Department Annual Reports, the student units were short-lived. Kendrick wrote to Vodanovich, in the November 1979 memo, that:

> The present situation—where we have no intake of Government bursars (and possible non-intake of other students in 1980), our teaching staff reduced to one temporary lecturer whose appointment terminates in June of 1980, and no person in charge of the course, mean[s] that we are very vulnerable to criticism (if not worse) from the public agencies that have funded field-work units in good faith that we will use them. (p. 3)

Placements

Students undertook their placements in a variety of settings and spoke positively of their experiences.

> I did one placement at Kingseat Hospital in the alcoholic unit. There were some good and bad experiences which also fitted in with some of the theory we did … around stigmatising and labelling effects. I was seeing that straight out. (J. Crockett, personal communication, November 27, 2015)

> I did two placements: Greenlane Hospital in the cancer ward and a community work placement at Pakuranga Community Centre, with the City Council where I did a survey of the needs of the area. Two very good placements. Greenlane was excellent: I worked with a lot of patients who were dying of cancer using Kubler Ross' work. (R. Stewart, personal communication, January 13, 2016)

> My first placement was at National Women's Hospital. There's nothing like getting thrown in to a department with all its madness. I was given clients, went up to wards, spoke to women … My second placement was at probation. I absolutely loved that, working with first offenders. I had 13 clients. It was fantastic. My second placement was particularly memorable, especially in terms of learning about how to connect with involuntary clients. (L. Court, personal communication, December 2, 2015)

While students enjoyed their placements, there was some concern from them, as well as from Kendrick, around the structure surrounding assessment of placements.

One of the anomalies of the placement was that there were no marked assessments of the students' practice abilities, with completion of the required hours, and production of a 10,000 word report being the only requirements. While supervisors provided some feedback, there was no formal assessment procedure for students' time in the field.

Pascoe (Student Unit Supervisor) offered some insight into this lack of formal assessment:

> Griff, Diane and I spent a great deal of time developing written protocols for student placement assessment. After doing all this work we were very upset when the sociology lecturers said that the degree was an academic one and they would not accept that student placements were to be assessed… Griff, Diane and I had some very heated meetings with the sociology lecturers at staff meetings. (P. Pascoe, personal communication, June 1, 2016)

While there were some difficulties with finding and supervising placements, a strength of the Programme was the research component expected of all students.

Theses

A 20,000-word supervised thesis was a required component of the course. Supervision was sometimes difficult to obtain, as there were few lecturers in the Department of Sociology and even fewer who felt willing or able to supervise practical social work research.

> We had a Social Work Professor: Schlesinger, whose forte was on one-parent families and he was my supervisor for my thesis on prisoner's wives and their families. Half way through Professor Schlesinger had to leave. They wanted me to change the thesis to be based on sociological theory. (R. Stewart, personal communication, January 13, 2016)

Students often completed the thesis after they had left the University campus and finished other coursework. This sometimes made it difficult to maintain momentum: "I was discussing the thesis with a sociology lecturer who had no knowledge of social work. I was looking at role of CYF social worker…. Once I got back to work it was almost impossible to focus (Anonymous, personal communication, June 18, 2015).

Table 5 provides a list of the theses undertaken during the Programme's duration. These represent a significant contribution to early social work research in Aotearoa New Zealand.

Discontinuation

One of the *mysterious* elements surrounding this qualification was its very short existence. The first intake of students occurred in 1975 and the last in 1979. There were many views surrounding potential reasons for this, which came out in the interviews and, when put together, they created a picture of faculty in the Sociology Department who were unaware of what they were signing up to deliver, a lack of resources to deliver it with, and the person with the vision to deliver it leaving soon after the Programme's establishment.

Macpherson and Vodanovich both recounted the way that the Programme had been introduced into the Department. Ivanovich remembered that the Programme had originally been touted as an MA in Social Welfare and Social Development. "We went along with it at the beginning as we thought it was social development, but it evolved quickly into a professional social work qualification" (I. Vodanovich, personal communication, April 7, 2016).

Table 5. Theses' Titles

Malaysian Students at University
Remarriage in New Zealand
Auckland Private Rest Homes
Social Adjustment of Schizophrenic Patients
A Burn-Injured Child inHospital
Community – Te Araroa
Sociodrama in Social Work
Family on Remand
Sentencing Practice and Public Opinion
Motherless Families
"TheWelfare"
The Polynesian Client Speaks
Alcohol and the Māori
Social Work Education in New Zealand. An Historic and Interpretive Study
Client Satisfaction With Social Work Services
Transnational Corporations and Their Impact on Third World Countries. A Case Study of the Rothmans
Enterprise in Western Samoa
A Baseline of SocialWork Practice
The Problemof Meaning at Adolescence
Periodic Detention, an Innovation in the Treatment of Offenders:
TheWomen's Centre – A Case Study
Social Conflicts and Changes in the Auckland Jewish Community
Social Work: The Reluctant Profession
Family Home Fostering: A Role Study
The Implications of the Family Therapy Model For the SocialWorker
A Study in Role Conflict. The Social Worker's Role in Relation to The Children And Young Persons Act, 1974
Continuity, Accommodation and Change in a Māori Community.
The Adolescent in the One-Parent Family. "…And No-One Has Bothered To Speak To Us Until Now"
Sentencing Criminal Offenders: Judicial Practice and Public Opinion
The Health Camp Movement in New Zealand
The Social Process Of Retirement in Western Societies
Planning for Community: The Mythology of Community Development and Social Planning
Probation in New Zealand
Prisoners' Wives
Adolescent Suicide
The Policy and Practice of Primary Health Care in Early Childhood
Social Work in a Medical Setting – An Application of Concepts of Role and Reference Group
Community Power and the Social Worker
Adolescent Pregnancy. Transitions to Adulthood

Source: Personal communication provided by June Kendrick (n.d.).

> David Pitt was a free agent … David assumed we would be happy with anything he did. He announced without consultation that one of the major fuel companies had agreed to sponsor a social work programme for 3 years and to provide a chair. We were all completely taken aback… (C. Macpherson, personal communication, January 16, 2016)

Pascoe, working within the student unit, also saw this: “It became clear that Pitt had developed this course without the support of the staff of the Sociology Department of which he was head. This was an obvious recipe for disaster. And so it was not surprising when the course folded very quickly” (P. Pascoe, personal communication, June 1, 2016).

There were other philosophical tensions that existed for the degree being housed in the Department of Sociology. Macpherson described these clearly:

> Most of us had a very strong socialist thread running through a lot our teaching, even if we weren’t in fact Marxists. We were committed to a socialist ideal. The idea that we were going to harbour a group of people who would disguise the flaws in the system; administer palliative care to people in the system and prevent the emergence of a class that would arise and overturn the system was anathema. That lay behind a lot of the resistance.… (Personal communication, January 16, 2016)

Some of the students were also aware of this philosophical tension:

> David [Pitt] was the entrepreneur looking for sociology to have relevance in the world like social work and community development. People like Roger Oppenheim and David Bedggood were theorists and purists, and that it was contaminating and denigrating sociology to be associated with social work. When David [Pitt] left it didn’t take long for that stream to wash over. (J. Crockett, personal communication, November 27, 2015)

Jones recalled that:

> From the first day we were made to understand in no uncertain terms that we were in the sociology department under sufferance. We were not considered to be proper students and the MA [Social Welfare and Development Option II] was not considered to be of any academic respectability. (C. Jones, personal communication, June 15, 2015)

Macpherson recounted that certain people within the Department attempted to work between these ideologies:

> Pat Shannon was an absolute radical. Everyone loved and respected Pat. He attempted to bridge the two. In the end even Pat found the going tough. He was a junior lecturer in sociology. He said, “Hold on. While you wait for the revolution there are people in trouble and somebody’s got to do something about it. And that’s why social work should be given a hearing.” (Personal communication, January 16, 2016)

Shannon went on to have a longstanding career at the University of Otago, teaching and researching in, social work, community development and policy.

In 1979, Pitt left the University to pursue a contract working for the United Nations in Geneva, Switzerland. He did not come back as expected. This left another vacancy in an under-resourced department. O’Flaherty described how sociology had been overtaken and swamped by social work with the number of Option II students (those undertaking placements) significantly outnumbering the Option I students—15 in B; only 2 in A (personal communication, May 26, 2016). There were few staff in the Sociology Department available to provide on-going thesis supervision to the social work students.

In 1974, the NZSWTC produced the "Interim Report on Accreditation", which established minimum standards for a basic professional qualification in social work. This report and accreditation were contentious for the Programme.

In a 1979 (October 8) memorandum for the Vice-Chancellor on the Interim Report of NZSWTC on accreditation, Acting HOD, Vodanovich, wrote that:

The present M.A Option II will not meet the requirements for accreditation. Modification of the course to ensure that it does comply with these requirements means that it will no longer be equivalent to the M. A. in Sociology Option I and not conform to the regulations and academic criteria governing the M.A. degree. (p. 2)

The University of Auckland agreed to suspend enrolments for 1980 and established a sub-committee to review the Social Welfare and Development Course (Tarling, 1980a). At that time, a proposal for a two-year diploma in social work was put forward by Ringwood and Kendrick with an accompanying memo (March 24, 1980) from Vodanovich stating, "We see no reason why a single Department, given the content of such a course, should carry the burden of this new development. An autonomous unit, responsible to all contributing departments would be the ideal solution" (p. 1). In the same memo, Vodanovich made a recommendation to withdraw the MA–Option II.

The sub-committee recommended that the current MA Sociology–Option II should be removed and that the proposed diploma should be "introduced into the Faculty of Arts, with a view to its being taught, if feasible from 1981…" (Tarling, 1980a, p. 2). The sub-committee also noted, however, that the University had limited resources and "[t]hat there must be substantial provision made for the basic training of social workers in other institutions, such as teacher colleges or technical institutes, and that the Social Work Training Council should be urged to take up this question anew" (Tarling, 1980a, p. 2). In a further report on the Department of Sociology, the sub-committee (also chaired by Professor Tarling) refuted the Department's suggestion that a social work programme should not sit within a sociology department.

Despite this recommendation, there was little enthusiasm or resource provided for any particular department to host a social work programme. Kendrick's funding from Mobil Oil finished in 1980, but she remained on staff for a short period in order to help remaining students in the completion of their degrees.

John Crockett, in his role as convenor of the Education and Training Committee of the then New Zealand Association of Social Workers, wrote to the Chancellor of the University of Auckland (November 20, 1979) with several concerns about the course not meeting the new SWTC Accreditation standards: "We as [a] professional body, view the situation as requiring urgent remedy … we feel it vital to ensure the continuation of the MA course, with suitably qualified, permanent teaching staff as laid down by the Social Work Training Council" (Crockett, 1979, p. 1).

The Vice-Chancellor of the time, C. J. Maiden responded, on November 27, 1979:

> There is no possibility at the present time of any specific assurances relating to expansion of course in social work at this University. … the matter of social work training in Auckland will be looked at in a national context by the University Grants Committee, at the request of this University. (p. 1)

Students were also vocal about the imminent closure and made their voices heard in various ways, targeting various members of the University hierarchy, "I don't think that the Vice-Chancellor appreciated being rung up at home by the students" (I. Vodanovich, personal communication, April 7, 2016).

Despite these pleas and protests, there was no further intake into the MA Sociology (Option II–Social Welfare and Development) after 1979. The status of the degree as a professional social work qualification was left in limbo, with no accreditation of the degree having occurred during its tenure.

Accreditation

The New Zealand Social Work Training Council (NZSWTC) was set up in in 1973. Nash (1998) detailed that "The Council's initial priorities were thus to increase the number of courses available; to increase the number of qualified staff and to develop basic minimum standards and a system of accreditation in order to ensure a professional work force" (Minutes of 1st meeting of the NZSWTC, August 7, 1973 cited in Nash, 1998, p. 287).

In 1974 the NZSWTC produced its first draft of basic minimum standards for social work educators (NZSWTC, 1974), and soon after began the contentious process of accrediting social work education providers.[1] Graduates of accredited programmes would receive a Certificate of Qualification in Social Work (CQSW). Members of the NZSWTC conducted a consultation visit to the University of Auckland in 1976 and a further, informal, visit in 1980. Various recommendations were made regarding the Programme through these visits. In 1981 the NZSWTC was asked by the Department to consider application for accreditation after the Programme had ceased.

The NZSWTC Accreditation Panel consisted of Ian Culpitt, Angela Gilbert, Margaret MacKenzie, Murray Short and Judith MacKenzie. Judith MacKenzie recalled arriving at Auckland where it was clear that there were divisions between those involved in the course and the lecturers in the Sociology Department: "We weren't made to feel particularly welcome. The students were very anxious. They were older, bright and very verbal. Their questions were to the point … we were aware of the tension" (J. MacKenzie, personal communication, June 12, 2015).

The Panel report took 1979 as its base year for assessment and had concerns regarding the Programme not specifically being housed in a social work department, the lack of social work dedicated staff and some ambiguity regarding formality of placement contracts and assessment. In particular, the Panel noted that:

> …there had been no change in title of the course since the previous panel's recommendation. In 1976, "identification of the course with social work education and training" was recommended. It was further recommended that the title of the course, M.A. Sociology (Social Welfare and Development) should not be continued longer than absolutely necessary. The Panel agrees with this original comment, and believes that the title of the degree still does not identify it as a course in social work. The Panel strongly recommends that any future course should contain the term "social work" in its title. (NZSWTC, 1981, pp. 2–3)

This concern was reiterated by one of the students, "It's a shame that my certificate from the University does not say 'Social Work.' It just says 'Sociology Option II'. What the heck is that?" (R. Stewart, personal communication, January 13, 2016).

In the end, the panel found that the course, based on its review of the 1979 year, met the standards required for accreditation (NZSWTC, 1981). This was a very significant development for all of the students in terms of formal recognition of their qualifications. Even with accreditation however, some students experienced difficulties having their qualifications recognised overseas. When attempting to obtain a CQSW in England, students such Goldson (personal communication, August 22, 2015) described difficulties due to perceived lack of fieldwork days, while Jones was told unofficially that he did not qualify due to insufficient social policy content (personal communication, June 15, 2015).

The course currently sits on Schedule Two, Part 1 of the list of "Historical Recognised New Zealand Social Work Qualifications" on the Social Work Registration Board website. It is referred to as the MA in Sociology (SWRB, 2016).

Contributions of the Programme

There were many from the Programme who went on to excellent careers in social work, social work education, community work, counselling, research and politics. The Department of Sociology's *Annual Report* from 1977 states:

> One must mention with pride the successes our students, especially those from MA (Option ii) are having in obtaining University or Tertiary Lectureships. These have included recently Ian Shirley (Massey), Pat Shannon (Otago), Dr John Lindsey (James Cook University, Townsville), Peter Harwood (Melbourne), Milton Kayes (Townsville). (1977, p. 1)

In an interesting twist of fate, Susan Kemp, also a graduate from the Programme, has recently returned from the USA to act as Professor in the current University of Auckland social work programmes.

Overall, most students who were interviewed viewed the Programme positively and felt that the combination of a strong sociological orientation and the practicum provided good preparation for a career in social work, "I thought it was an excellent programme overall. It integrated community, social work and counselling as strands of social work. I think today these are seen as something different to social work" (R. Stewart, personal communication, January 13, 2016).

Discussion and conclusion

Soon after the discontinuation of the MA–Option II, a basic qualifying two-year diploma began at the Auckland Teachers' College. This eventually turned into a three-year degree programme, and then a four-year degree programme. The Auckland College of Education merged with the University of Auckland in 2004. Thirty years after the MA Sociology (Option II–Social Welfare and Development) closed its intake, the University of Auckland approved a two-year, professional Master's degree in social work which began in 2010.

Many of the issues described in this article remain current in social work education. Practicum experiences remain difficult to locate and manage; there are often challenges in having enough supervisors to supervise research and social work programmes continue to experience difficulties due to their Tertiary Education Commission funding levels being funded at the same level as other non-professional social science programmes (Beddoe, 2014).

One remarkable issue, however, is the difference between then and now in terms of recognition and acknowledgement of Māori as Tangata Whenua, Te Tiriti o Waitangi and of social work's bicultural commitments. The Programme was winding down as the Māori Renaissance began (Eketone & Walker, 2016). The revised 1976 version of the NZSWTC's Minimum Standards for an Accredited Course in Social Work, makes mention only of inclusion of study "of plural societies with particular reference to New Zealand" (NZSWTC, 1976, p. 5) and makes no mention of Te Tiriti o Waitangi. The winds of change were coming, however, and social work education would change dramatically in the 1980s and further thereafter.

While this article has in no way presented an exhaustive account of the Programme, and there are many staff and students' voices that have not been represented, it has attempted to synthesise some descriptions, documents and recollections regarding the brief-lived Auckland MA Sociology (Option II–Social Welfare and Development). It is hoped that it has provided a rich description of the Programme and some analysis of why it survived for such a short time.

Note

[i] The NZSWTC did not accredit a community work programme being provided by the YMCA which further contributed to a growing divide of academic and community orientations of the profession. For a full account, see Nash's 1998 thesis.

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"Going the extra mile": A descriptive exploratory study of Primary Health Services based on the experiences of Pacific Primary Health Organisation Service managers and providers

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ABSTRACT

INTRODUCTION: This exploratory study is part of a larger evaluation of the primary health care strategy (PHCS) in Aotearoa New Zealand, using a mixed methods research approach. The aims of this qualitative arm of the research were to explore the extent of use and satisfaction with the PHCS through the operation of Pacific-led Primary Health Organisations (PHOs) in relation to service provision and delivery from the service providers' and managers' perspectives.

METHOD: The exploratory study was conducted using a case study design and in-depth interviews with service managers and health providers at six Pacific-led PHOs. A review of the literature on primary healthcare was conducted prior to undertaking the research. In this literature review, several themes were noted from the review of policy documents providing background to the development of primary healthcare in New Zealand.

CONCLUSION: The themes from interviews suggest a core tension between the business model, Ministry reporting requirements, and more altruistic values of both managers and service providers in their delivery of services. Overall, there was a positive response to the lowered cost of healthcare from the providers and managers interviewed in the Pacific-led primary health services, mirroring the findings of the larger evaluation report of PHOs (Cumming et al., 2005). The availability of wrap-around, holistically based, accessible services delivered by culturally responsive health providers who were considered to "go the extra mile" for their clients was the predominant theme accounting for an increased uptake and use of the services. The implications for health social work are discussed.

KEYWORDS: primary health, mental health, social work and Pacific health

Introduction

This article begins by providing the demographic and historical context in which the Pacific-led PHOs were developed in Aotearoa New Zealand from the mid-2000s. Definitions of the terms *Pacific*; and *Pasifika* are given and some of the key barriers in the provision and uptake of services are then outlined. The literature review underpinning the research is reported, along with the aims and objectives of the project and its research design and methods. Finally, the results of the data analysis are summarised and the

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article concludes with key implications and recommendations for health social work in Aotearoa New Zealand.

Definitions and demographic trends

Pacific peoples within the context of the present study is an umbrella term used to describe those residents and citizens living in Aotearoa New Zealand who self-identify culturally with one or more of the predominant Pacific cultures living there. The predominant Pacific cultures represented in the present Aotearoa New Zealand population include: Samoan, Tokelau Islander, Cook Island Māori, Niuean, Tongan and Fijian. The term *Pasifika* relates to those born in Aotearoa New Zealand with a Pacific heritage which has been used to distinguish those residents from those born in the Pacific Islands who later migrated to live in Aotearoa New Zealand. The current research on the Pacific-led PHOs encompasses both groups, whom together comprise the term Pacific peoples, or those who identify culturally with one or more of the Pacific cultures represented in Aotearoa New Zealand, regardless of place of birth.

In 2013, the Pacific ethnicity with the highest proportion of Aotearoa New Zealand-born people included those self-identifying as Niuean, with 78.9% born in Aotearoa New Zealand.Those self-identifying as Cook Island Māori were 77.4% of the Aotearoa New Zealand population; Tokelauan 73.9%; Samoan, 62.7%; and Tongan 59.8% (Statistics New Zealand, 2013). In 2013, 7.4% of the population (295,941 people) identified with one or more Pacific ethnic groups, compared with 6.9% (265,974 people) in 2006. However, the rate of growth for the Pacific peoples ethnic group slowed across recent censuses, growing 14.7% between 2001 and 2006 but only 11.3% between 2006 and 2013. The Pacific peoples ethnic groups whose growth slowed between 2006 and 2013 included Tongan, Samoan, Cook Island Māori, Niuean and Tokelauan. In contrast, the Fijian ethnic group grew by a bigger percentage between 2006 and 2013 (46.5%) than between 2001 and 2006 (40.1%) (Statistics New Zealand, 2013).

Literature review: Barriers to Pacific healthcare

The following section summarises the predominant themes found in the literature review which framed the research. These themes include the barriers faced by Pacific peoples to accessing and using healthcare in Aotearoa New Zealand; the prevalence of long-term health conditions and low uptake of health services amongst this population; and the evolution of the PHO service network aiming to ameliorate the barriers to accessing and using healthcare by Pacific peoples. Removing the business imperative from healthcare that enables innovation including a culturally appropriate healthcare model is the predominant theme of the literature review.

There are many barriers that have been identified involving Pacific peoples' access and use of health care in Aotearoa New Zealand. Pacific peoples are disproportionately represented in the most deprived areas of the country and have poorer health status than other New Zealanders (Pack, Minister, Churchward, & Fa'asalele Tanuvasa, 2013). Thus, Pacific citizens and residents in New Zealand are a key priority group for the primary health services, given the focus on reducing inequalities in health. The PHCS was implemented by the Labour Government in Aotearoa New Zealand in the mid-2000s. The services established were evaluated to determine what the impact was on the delivery of primary health care services nationally and the resulting changes in the health of local geographic populations of enrolled residents. The PHCS had a focus on services for Pacific peoples provided by Pacific peoples, active involvement of Pacific communities in service delivery, further building of Pacific provider capacity, the formation of Pacific-led services, and leadership at a national level. All providers of PHOs were to identify, reach out to and address Pacific health needs (King, 2001).

The key intention of the PHCS is the removal of the business emphasis in primary health thus opening the way to the development of culturally relevant models of healthcare provision and delivery. Re-structuring care teams to include allied health beyond simply nursing and medical staff; delivering education to patients on how to manage healthcare and using Pacific languages in healthcare delivery are some of the ways suggested to overcome barriers to addressing Pacific health needs (Beddoe & Deeney, 2012; Döbl, Beddoe, & Huggard, 2017; Keating & Jaine, 2016; Southwick, Kenealy, & Ryan, 2012).

Accessibility of services and long-term health conditions

Concerns about the accessibility of health care, influenced by increases in the prevalence of chronic conditions and an ageing provider workforce have dominated the literature on primary health service evaluations worldwide (Hogg, Rowan, Russell, Geneau, & Muldoon, 2008). Recent frameworks for primary healthcare internationally have emphasised the service delivery aspects guided by principles of "comprehensiveness, integration and accessibility" (Hogg et al., 2008, p. 308). In the Canadian and Aotearoa New Zealand contexts, indigenous populations have been consulted and new models of healthcare provision have thus developed. These models are designed to tackle the social determinants of health which inevitably impact, relative to poorer health outcomes and lower life expectancy than for European service users (Barnett & Barnett, 2004). The context of historical colonisation has been cited as influencing equity and as a social determinant of health among Pacific nations (Anderson et al., 2006). Under the Treaty of Waitangi, the founding charter between Māori and Pākehā in Aotearoa New Zealand, partnership, participation and protection are guiding principles, which necessitate a focus on identifying and addressing inequities in health as in other areas of life (Anderson et al., 2006). Social work in Aotearoa New Zealand has enshrined in its professional standards of practice, standards aimed at working for greater equity under the Treaty, encompassing all areas of service provision including health (Beddoe & Deeney, 2012; Döbl et al., 2017; Pockett & Beddoe, 2017). Barriers to accessing primary health care in Aotearoa New Zealand continue to revolve around the financial cost of seeing a general practitioner, with the survival strategies of service users including delaying seeking care, lack of uptake of medication and putting others in the family first, such as children and the elderly (Barnett & Barnett, 2004; Hawley & McGarvey, 2015; Pulotu-Endemann & Faleafa, 2017).

Alongside these principles underpinning health models, the broader focus in primary healthcare has been on community empowerment, education and the demographic and cultural aspects of health (Hogg et al., 2008). Western models of health care involving diagnosis and treatment often do not conform to the cultural norms of Pacific service users and their *aiga* (family) and the wider *nu'u* (village, community). Pacific models of healthcare to address these differences need to integrate principles of choice, self-determination, and culturally relevant models of health care delivery. This goal has been achieved in the field of mental health care by translating health information into Pacific languages, providing choices of provider, a range of support services and integrating hospitality as part of the care (Agnew et al., 2004; Pulotu-Endemann & Faleafa , 2017; Southwick, Kenealy, & Ryan, 2012; Suaalii-Sauni et al., 2009; Tamasese, Peteru, Waldegrave, & Bush, 2005).

Primary health care in Aotearoa New Zealand

In relation to the Primary Health Care Services history, in February 2001, the New Zealand government released the Primary Health Care Strategy (PHCS) with the aim of improving the health of New Zealanders and reducing health inequalities. The five to 10-year vision of the strategy was to shift primary health care

(PHC) services to focus more on the health of the population by providing services which are easy to access; improving and maintaining their health; and coordinating their on-going care (King, 2001). Underlying this vision was a greater emphasis on the role of community participation in health improvement. PHC was seen to encompass a wide variety of services, including health promotion and preventive care, which necessitated the involvement of a wide range of health professionals (multidisciplinary teams) in the service delivery model.

To achieve the vision, the strategy emphasised six key directions for the future development of PHC in Aotearoa New Zealand: 1) work with local communities and geographic populations of enrolled residents; 2) identify and remove health inequalities; 3) offer access to comprehensive services to improve, maintain and restore people's health; 4) co-ordinate care across service areas; 5) develop the primary health workforce; 6) and continuously improve quality using good information (King, 2001).

A large number of PHOs were established between 2002 and 2005 whose brief was to address these aims. By mid-2008 there were 80 PHOs in operation, with additional funding to the value of $2.2 billion having been provided for further PHC service developments since 2001 (Cumming & Mays, 2011). Early evaluations have noted the unique way in which each PHO has been adapted to the communities in which they have developed. The dilemma is the struggle for smaller and remote PHOs to stay local when there have been pressures to amalgamate with larger PHOs to effect economies of scale (Gauld & Mays, 2006). These amalgamations lead to a dilemma over control of services trying to remain relevant to local resident populations whilst maintaining altruism over a concern to show a profit (Gauld & Mays, 2006).

The contribution of social workers to establishing PHO services based on social justice principles within these evaluations have indicated a synergy between social work and primary health care aims. Both aims are ideally structured and delivered by adhering to culturally relevant principles that acknowledge the holistic nature of health which includes the role of spirituality, community and family participation in healthcare (Pack, 2008). Jantrana and Crampton (2009) found that ethnicity and gender were significantly associated with higher odds of deferring buying a prescription. The low uptake of dental care due to high cost was identified as a compounding factor in the escalation of physical health problems including exacerbations of chronic conditions. Social workers, through advocating for a holistic vision of health, are ideally placed to highlight where barriers in health exist (Beddoe & Deeney, 2012; Döbl et al., 2017; Pockett & Beddoe 2017). Social work is well placed to suggest alternative models of health care.

This comprehensive, holistic, model acknowledges the importance of four facets of primary care service delivery that is prefaced on the importance of the patient and treatment provider relationship, awareness of the whole person, and gender, culture and family (Hogg et al., 2008). To evaluate the model, provider satisfaction is considered pivotal as treatment providers, when satisfied with the services they are working within, are found to be more open to alternative processes and a holistic and individually tailored approach when working in primary healthcare (Hogg et al., 2008).

Method

Research aims

The two main aims of the exploratory study were: 1) to identify the environmental and organisational context that impacted treatment providers and service managers of the PHOs; and 2) to identify the structural aspects of the policy and governance of the practice agency and its impact on the delivery of services by the provider, and, therefore, its impact on health outcomes.

In undertaking this exploratory study, our research team comprising four Pacific health researchers, had earlier completed the interviews and transcribed the audio recordings. The author was then invited to analyse the data, report the major themes from the interviews, and to develop recommendations that were to sit alongside the larger mixed methods study on Pacific patients and their families' perspectives of the same PHOs. As I had been involved earlier in the establishment, development and service management of a culturally led PHO that was not part of the research, the team requested my involvement as they valued my background to provide rich and in-depth knowledge of the field of PHO development. The overarching study received Research Ethics Approval from Victoria University of Wellington's Research Ethics Committee.

Research design and methodology

An exploratory, descriptive, qualitative research design and methodology were used to explore the service managers and provider's perspectives of the structure and the day-to-day operation of their PHOs. The researchers adopted a case study approach based on Yin's description of case study (Yin, 2009). Each PHO was considered to be an example or a *case*, in the sense that each PHO had developed uniquely relative to its management structure/governance, service establishment and delivery due to a range of factors such as geography, size of resident population, funding or budget and local health demographics. Yin (2009) discusses the importance of triangulation in case study research for its potential to assemble different narrations on a theme. Thus we were able, in the current study, to incorporate service managers' views to explore how the service setup and structure impacted on the service delivery from a health provider's perspective within each PHO. A case study research approach enabled the context and structure of each PHO to be described alongside the accounts of health providers/managers and brought together with the service user accounts in the broader research project.

Findings

The following section presents the themes from the interviews conducted with managers and service providers. These themes were related to: 1) lowered costs of healthcare; 2) publicising the availability of services offered; 3) access to a range of services; 4) an ethic of care and "going the extra mile" for clients; 5) holistically based/integrated models of care; 6) incorporating culturally appropriate models of well-being; 7) relationship with community: PHO partnerships with NGOs, residents and local communities: 8) building workforce capability, and 9) providing services in a shared language. Due to the differing perspectives of the groups of participants, some themes were more figural for one group, for example the managers, than for service providers. In some themes both groups were in agreement about the issues. Therefore, in some themes, managers' perspectives predominated while in others, service providers' views did.

Lowered costs of healthcare

There was an enthusiastic response to the lowered cost of healthcare from the stakeholders interviewed. Reducing the costs of medical consultations was a primary motivation for practices to initially become involved in the PHOs. As one manager of a Pacific-led PHO explained during the first round of interviews in 2005:

> …You know the first benefit to us is no or low cost and they [patients] don't pay. (Manager)

The CEO from another Pacific PHO stated in 2009 that the fee-paying structure still offered a means of providing a targeted approach to those patients most in need of low or no-cost consultations.

> PHO I think it's a success with 90 plus percent enrolment throughout the

> country plus Pacific people, people are saying that they [lowered costs] are the advantage of PHOs. Low cost consultation fees I think is the main product … So a lot of people have enrolled and are making use of the services. (Manager/CEO)

Publicising the availability of low-cost services

The availability of low-cost health care was not, however, widely known in the local community initially, which necessitated promotion of the PHO service. There was also a need to publicise the specific services that were offered. Information dissemination about how patients could enrol themselves and their family members in order to obtain access to low- or no-cost consultations, lower prescription fees and other services, was part of the implementation strategy of each of the PHO managers interviewed. For example, the use of promotional campaigns on Pacific Radio spoken in a range of Pacific languages was one way of publicising the availability to an audience of Pacific clients that was discussed at interview with one urban Pacific-led PHO. Community meetings with local groups were another way in which this PHO publicised the range of services their organisation offered. Fono organised by this PHO provided an opportunity to distribute more general information about health promotion to a range of audiences in face-to-face mode. It was considered important to follow up any presentations to answer queries and to hold meetings with the professional groups working at the PHO:

> We have a very strong Samoan Residents' Association and we tell them about health stuff and the PHO as well and then we also have a meeting of other nurses of different communities and we tell them about the PHO. (Manager)

Access to a range of services

Access to a range of other services such as free transport to treatment and lower prescription costs were important incentives to establishing a PHO. This widespread appeal was seen by participants as a means of improving access to comprehensive health care services for residents. Another PHO organised *health days* to introduce a range of health services to local residents including their promoting their own services:

> … we just have a health day, we go to a hall and stakeholders are invited to come and display their information and tell people about the services that they provide. (Manager)

An ethic of care and "going the extra mile" for clients

The attitudes of Pacific PHO staff towards their work were reported by participants to differ from the business orientation of many medical practices which worked from a business-centred model. This difference in philosophy was thought to partly stem from the values underpinning PHOs being supported by charitable trusts. A workplace based in a shared enthusiasm for helping under-resourced communities was the major motivation described by one general practitioner working in a PHO where 97% of the local enrolled population is described as "low income and Pacific Island":

> The philosophy of this practice is improved access with lower fees … affordability has always been an important part of the organisation really for us and for other members of the PHO… We provide a free taxi service for people who can't get to their appointments as well. We have access to free PHO funded prescriptions. (General practitioner)

Altruism, and the *not-for-profit* motivation to remain working within the PHO was seen by PHO health workers as important for putting funds back into community, as the same general practitioner interviewed suggested:

> I'm a salaried GP so I don't get the financial incentives, it's not my business

> that I'm safeguarding, that's a different model from the sort of third sector where there's a long history of community ownership and not-for-profit being part of the way that we operate. (General practitioner)

Holistically based /integrated models of care

A community model of care facilitated by the PHOs was described as a positive development across the providers interviewed. This model consisted of several elements – remaining small enough to know the local community which enabled treatment providers to remain aware and responsive to locally defined needs. Co-ordination of services and communication across practices meant that duplication of services in a geographic area could be avoided as the following excerpt from an interview with a general practitioner in a Pacific-led PHO illustrates:

> You know it's good to have that sort of relationship because of referral – we're basically seeing people from the same community. It helps avoid duplication of services and knowing what people are doing, having input with different families without knowing that each other is involved in, which I think happened a lot more under pre-PHOs. (General practitioner)

Incorporating culturally appropriate models of well-being

Pacific PHOs looked at health more holistically deriving from social inequalities and so they actively advocated on behalf of patients. A nurse described advocating with income support agencies on behalf of sickness and invalid beneficiaries who could not afford to see a general practitioner for review of their medical condition to avoid a cessation of weekly income benefit payments. She encouraged those patients with long-term or complex presentations who had debts to pay to continue coming to the practice for treatment despite lacking the means to pay for their health care. This kind of advocacy was common and seen as part of the responsibility of providers in the Pacific models of health earlier reviewed (Agnew et al., 2004). The Treaty of Waitangi principles aim to guide the health care delivery in Aotearoa New Zealand to ensure equity of uptake of services and satisfaction of the service user's healthcare experience as far as possible (Barnett & Barnett, 2004; Barnett, Smith, & Cumming, 2009).

Relationship with community

The establishment of PHOs was seen as a positive move by their managers as it provides an opportunity to collaborate to provide culturally appropriate services designed and delivered by Pacific clinicians. As one manager of a Pacific health organisation stated, it was envisaged that PHO funding would build capability in the workforce for care of Pacific by Pacific.

> As services move into the community, we are organising the Pacific community to work as a team. Pacific people need to work together as a team that is how it works best. (Manager)

Providing services in a shared language

Another Pacific-led PHO used the services of a medical specialist to run a clinic to see patients who had been screened by a self-administered patient questionnaire to identify health issues. This consultant was unique in being able to speak a number of Pacific languages which enabled him to engage more easily with the majority of patients at that service. The shared language was an important means of building relationship with Pacific clients.

This is in contrast to comments made by a non-Pacific PHO about the difficulty of engaging with Pacific communities when the process was not relational (for example, one PHO mailed out about 5,000 letters to

Pacific families and received less than 100 responses). This illustrates the importance of understanding how to engage Pacific and the value that Pacific practices bring in their capability to do this. Establishing processes and protocols for making decisions and acknowledging shared values, including the spiritual dimensions of care, aided success, as a CEO of a Pacific PHO explains:

> We're bound by a common philosophy… I think fundamentally in essence we are a Christian organisation bound by a set of Christian values that hold us together in quite hard times and they are around all of those things, you know like…, integrity, respect… we do have hard times and we have our difficulties and battle but we try to work through them and there is a lot of passion. It's still trying to work through that respect and just wanting the best for our community. (CEO/Manager)

Collaboration, co-ordination and team work across services

Since their joining of a Pacific PHO, a common experience amongst participants was improved communication between diverse social and statutory agencies to avoid the silo-effect of services acting independently of one another. These social connections and networks enabled more comprehensive wrap-around services to be offered to Pacific patients.

> The difference between [name of another PHO] and [name of participant's Pacific PHO] is the community focused, community driven, focus on, you know, the health needs of the people. Whereas [name of other PHO] is very much doctor driven now….(General practitioner)

Having a manager who shared a vision and philosophy of working with under-resourced communities was seen to be advantageous by colleagues working at the same PHO as a shared vision of the local community was facilitated. A common purpose for continuing to work within the PHO was a *passion* for work with what were considered to be under-resourced communities. As one participant commented:

> Our manager [name] who is Māori understands where the lower socio-economic people are coming from. She has a passion for this population here. And that's why we are getting that support because we know that she's there because of that passion. (Nurse)

Another participant who worked as a general practitioner in a not-for-profit PHO described this collaboration as "a collective approach to providing a service." This was seen by those interviewed as being part of this shared vision for work in the PHO:

> We are not alone as [Pacific Islanders] within this PHO. We are here working alongside others and do collectively have a very strong communication strategy, making sure the population focus on their needs. (General practitioner)

Barriers

Initially there was enthusiasm about the funding available for services to improve access. There were many initiatives that participants considered were working effectively for people accessing the health care they required. However, high and complex patient needs inevitably increased the length of consultations which impacted on the workload of the PHOs' treatment providers such as general practitioners and nurses, as the following comment from a general practitioner working in a Pacific PHO illustrates:

> The heavy workload is helping them [patients] with social issues, so, sickness benefit, housing, all immigration issues. There is a lot of expectation that we will help them with that. We do quite a lot of it which prolongs our consultation time with the doctor or nurse. There are social workers in public health that we pass things on to ... very nice to have social

> workers except that their contracts are all around youth ... But the strategy needs to cater for elderly and social issues a bit better. (General practitioner)

General practitioners working in Pacific-led PHOs found that they needed to take longer to explain medical screening procedures prior to undertaking them with Pacific patients. This work needed to be done in face-to-face mode as contact by telephone and letter did not work as effectively with Pacific patients. The unavailability of funded transport to treatment was seen as an obstacle by a clinical manager/general practitioner of one Pacific PHO:

> We had a lot of DNAs [did not attends] and she [nurse] said to me yesterday that she thinks transport has got something to do with it and that if we could provide transport, that would really help. (General practitioner)

Social problems were tackled by the nurses interviewed. For example, one nurse who had an established relationship with local social services organised food parcels from a local food bank for a patient who had not been eating an adequate diet due to lack of money to spend on grocery items. The lack of food had meant that he had become dizzy and fallen from scaffolding at work resulting in a trip to the local hospital's accident and emergency department. Through the PHO's nurse liaising with the accident and emergency department at the hospital, the reason for the accident was clarified with the patient and advocacy arranged with the social services.

Discussion: The implications for Health Social Work

Participants in the Pacific-led PHOs have suggested in this study the need to consider co-ordinated approaches to health care which are comprehensive, culturally appropriate and flexible to respond to local needs. These approaches derive from traditional Pacific beliefs which include "going the extra mile" to meet the consumer where they live in a diversity of local and cultural contexts. The importance of incorporating Pacific values and ways of being in primary health cannot be underestimated in the uptake of services (Agnew et al., 2004; Beddoe & Deeney, 2012; Döbl et al., 2017; Pockett & Beddoe, 2017). Previous studies provide evidence that community-based models of intervention contribute to positive health outcomes (Barwick, 2000; Beddoe & Deeney, 2012; Döbl et al., 2017; Pockett & Beddoe, 2017).

The service providers mentioned a number of Pacific models they drew from in their work that were used alongside clinical models of assessment and treatment. Many of these frameworks adopt a focus on wellness in the community and are underpinned by an ethos of altruism, interpersonal relationship and social inclusion. These same principles need also to guide the provision of secondary health services including social work in hospitals where the tasks involve returning clients to extended family in the community to support ongoing care.

Building trust and support at the first point of contact requires what has been termed "a roundabout Pacific rapport building approach" which is learned by healthcare providers in practice rather than in theory (Agnew et al., 2004, p. ix). This approach involves ensuring that patients feel comfortable in their surroundings as an integrated part of the health service delivery. Rapport building to engage patients and their families is considered an important requirement when working with Pacific peoples (Agnew et al., 2004). Pacific models and modes of service delivery are distinct from western models of care and remain implicit in the practices of the health care providers who use them. These styles of service delivery follow the principles underpinning the government's strategic direction for Pacific health care. These principles are: respecting Pacific culture; valuing family; quality health care, and working together (Minister of Health & Minister of Pacific

Island Affairs, 2010, p. 5). Social workers require a detailed understanding of Pacific principles and models in their tertiary training including both theory in the lecture room and practice in the field placement. Clinical supervision attending to cultural safety needs to be factored into the wider learning of social workers both before and after their courses of study, as a programme of ongoing professional development. The Aotearoa New Zealand Association of Social Workers would be well placed to attend to such professional development nationally with the support of the workforce (Beddoe & Deeney, 2012; Döbl et al., 2017; Pockett & Beddoe, 2017).

Conclusion

The results from this exploratory study reveal that the implementation of Pacific PHOs has provided a capability for better communication between various parties from board level down to those working at the community level. It has increased the cultural relevance of healthcare approaches offered by removing the economic imperative to manage health as a business. For example, providers in the Pacific-led PHOs offered a broader range of services including efforts in health promotion, advocacy and education in programmes. This development has meant expanded roles and responsibilities beyond the medical model. The expectation of work in these PHOs can sometimes test the reality for some of the providers interviewed and is clearly impacting on the recruitment and retention of staff as the role is less bounded and consultation times are longer due to the complexity of assessing social issues that inevitably impact health and wellbeing. The use of Pacific language was considered an important component of engaging successfully and working well with Pacific patients. Further research is needed to more clearly delineate what is uniquely Pacific in the approach of the Pacific PHOs.

Engagement in community is a core competency when practising social work within Pacific models of healthcare. These competencies need to be reflected in the learning outcomes for social work programmes of education at undergraduate and graduate levels in Aotearoa New Zealand. Spirituality and a holistic approach are key aspects of Pacific models of healthcare involving collaboration and relationship at their core, which differ from more linear, *expert-knows-best* approaches. Ongoing professional development in Pacific models of healthcare and culturally based models of clinical supervision are areas for further research and development for social work and other healthcare providers in Aotearoa.

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Exploring the role of cultural support workers in the New Zealand healthcare setting

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ABSTRACT

INTRODUCTION: The introduction of the community health worker (CHW), or cultural support worker (CSW) as they are more commonly known in Aotearoa New Zealand, is being increasingly seen as an effective strategy to engage with migrant communities and improve health outcomes. With specific cultural knowledge and understanding, CSWs act as a bridge between their ethnic community and healthcare services to improve cross-cultural interactions in the healthcare setting. As Aotearoa New Zealand becomes increasingly ethnically and linguistically diverse, the use of CSWs will become an integral part of the delivery of healthcare services. However, very little is currently known about the needs of these workers – the challenges of the role; their needs for appropriate training, support and supervision; and, how these can be met.

METHOD: Semi-structured interviews were conducted with five CSWs employed in healthcare settings across the Auckland region. Interviews explored the experiences of CSWs, current training opportunities, availability of support and supervision, and future directions. Data were collected and a process of thematic analysis used to identify key themes.

CONCLUSION: This study identified significant challenges for the CSW role but also describes a workforce committed to developing the role and optimistic about their ability to make a positive difference within the healthcare setting.

KEYWORDS: cultural support; healthcare; communication

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The effects of globalisation have had a significant impact on the delivery of healthcare services both here in New Zealand and overseas, with service providers now required to deliver services to increasingly ethnically and linguistically diverse communities (Crawley, Marshall, Lo, & Koenig, 2002). As healthcare providers also become more ethnically diverse, healthcare interactions require a greater level of skill and cultural understanding (Crawley et al., 2002; Kagawa-Singer & Blackhall, 2001).

Healthcare providers have met this challenge with a range of innovations including the use of cultural support workers (CSWs), to access underserved patients (Dohan & Schrag, 2005). While the use of CSWs, or CHWs as they are also known, is seen as an effective strategy to engage with ethnic minority communities and to improve access to services and health outcomes, very little is known about the challenges of, and potential for, the role, resulting in poor understanding and underutilisation of the role (Dohan & Schrag, 2005).

While the use of CSWs is a relatively recent innovation in Aotearoa New Zealand, such roles have been a part of the healthcare environment in North America for many decades (Nemcek & Sabatier, 2003). Established in North America in the 1960s as a strategy to reduce health inequalities and improve access to cancer treatment services for minority communities, the CSW role has proved to be an effective development and is seen as an integral part of the delivery of healthcare services to ethnic minority populations (Alvillar, Quinlan, Rush, & Dudley, 2011; Dohan & Schrag, 2005; Love, Gardner, & Legion, 1997; Nguyen & Kagawa-Singer, 2008; Rosenthal, Wiggins, Ingram, Mayfield-Johnson, & De Zapien, 2011; Sherwen, Schwolsky-Fitch, Rodriquez, Horta, & Lopez, 2007; Wells et al., 2008; Witmer, Seifer, Finocchio, Leslie, & O'Neil, 1995).

In the USA, CSWs are now being employed in a diverse range of healthcare settings, from homes to community clinics, schools and hospitals, and are undertaking a range of different tasks (Perez, Findley, Mejia, & Martinez, 2006). The proliferation of community health worker and health navigator programmes has now focused attention on a need to gain a better understanding of their role in reducing health disparities, their training and professional development opportunities, and the way in which these workers can gain greater acceptance in the healthcare workforce (Nemcek & Sabatier, 2003; O'Brien, Squires, Bixby, & Larson, 2009; Rosenthal et al., 2011).

Context

Changes to Aotearoa New Zealand's immigration laws over the past two decades have seen dramatic demographic changes, with our largest city, Auckland, now being described as "superdiverse" (Chen, 2015). In the 2013 census, almost 50% of Auckland's population identified as Māori, Asian or Pacific peoples, with over one third (40% of the population), not born in Aotearoa New Zealand. Auckland is now home to over 200 ethnicities and with more than 160 languages being spoken, superdiversity is the new reality (Walker, 2014).

In Auckland, the growth of *CALD* communities has presented significant challenges for healthcare providers. CALD is the term used to describe culturally and linguistically diverse populations from Asian, Middle Eastern, Latin American and African backgrounds (Lim & Mortensen, 2013).

As workforce diversity also increases, so does the frequency of cross-cultural interactions (Lawrence & Kearns, 2005; Mortensen, Latimer, & Yusuf, 2014). The introduction of CSWs into the healthcare setting is seen as an effective strategy to engage with CALD communities, to identify barriers and to improve access to, and the delivery of, healthcare services (Mortensen et al., 2014).

The databases searched for this study included the Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus with Full Text, Scopus, Medline, Web of Science and Google Scholar. Initial keywords used in various combinations were: community health worker; cultural case worker (in) healthcare; support (for) cultural support workers; patient navigation; personal support; job satisfaction and challenges; training needs; and education programmes.

While much of the international literature reviewed focuses on describing the CHW role and its impact on improving access to health care, there was evidence of a growing interest in evaluating training programmes and gaining a better understanding of the factors that contributed to the effectiveness of the role. However, limited literature was found, either internationally or locally, that explored the personal experiences of CHWs, the challenges of their role, and their needs for ongoing training, professional development, support and supervision.

Method

The aim of this study was to explore the role of CSWs in the Aotearoa New Zealand healthcare setting, to focus on gaining a better understanding of the needs for ongoing training, support and professional development. A qualitative, explorative approach was thus selected as being the most appropriate for this study, as it is able to place an emphasis on the meaning of participant experiences, providing insight into the depth of understanding and knowledge required.

This article is based on a research study completed and submitted as part of a portfolio as a requirement for a Masters in Health Science degree at the University of Auckland. Ethical approval for the study was sought from the University of Auckland Human Participants' Ethics Committee, and approval given for the study to proceed.

The study was based in the Auckland central area, recognised as the most ethnically and linguistically diverse city in Aotearoa New Zealand. Participation in the study was restricted to participants employed in a CSW role in a healthcare setting within the region. Participants were selected using a purposive sampling technique with a total of five participants recruited for the study.

The five participants recruited were all employed in a CSW role by healthcare services within the Auckland region, including two District Health Boards, a Primary Health Organisation (PHOs), and a non-governmental organisation (NGO). All five participants (three female and two male) were themselves migrants, coming from areas in the Asia region, including China, India and Hong Kong.

Although, both the Chinese and Indian communities represent the largest Asian communities within Auckland (Walker, 2014), employers were not interviewed for the study, so the recruitment rationale for these workers was not specified.

The qualifications and experience of participants varied, with all of them holding a professional healthcare qualification or having experience in a healthcare or disability setting. The contribution of prior training and/or work experience to the understanding of their current CSW role was acknowledged by all participants.

Data were collected using semi-structured in-depth interviews. The interviews were conducted in English, even though it was acknowledged that, for some participants, English was not their first language. The interviews were digitally recorded and then transcribed. The data were then coded and a thematic analysis using a general inductive approach was adopted to analyse the data. Advice was sought from a Chinese cultural advisor regarding any potential cultural issues that may arise, and care was taken throughout the process to ensure any cultural norms and practices were adhered to.

Findings

Describing the role

Although participants were employed in a variety of healthcare settings, several common functions and tasks of the role were identified. The provision of cultural support and cultural guidance was identified as a main component of the role.

The term *bridge* was used by participants to describe the dual focus of the CSW role, to support patients and families and to provide cultural support and advice to their colleagues and to the greater organisation. One participant, using the bridge metaphor to describe the role, states: "The basic role is about emotional support, cultural support for patients and families, and also we give cultural advice for healthcare staff . . . co-ordination. To build a bridge between patient and the staff" (Participant 4).

Another major theme identified was the personal motivation of the participants and their commitment to their own communities.

This commitment was demonstrated in many ways, including: working additional unpaid hours; the seeking-out of training and development opportunities to increase their skills and knowledge; and their endeavours to build strengths and resources within their communities. An example of this potential for community development was when a participant described noticing that many clients were facing the same issues, and this led to the establishment of a support group for service users.

The relationship between the CSW role and social work emerged throughout the data, with participants recognising the similarity between their work and that of social workers when describing the tasks associated with the role. This included providing support, information, advocacy and also their role in community development as a way to better support patients and their families.

Developing the CSW role to become more like social work was also identified by participants as a way of receiving more recognition for the role and work they do. One participant, using the social work role as an example of the importance of having a clearer role title and description, states: "They do need that role, kind of set up a proper role, a title of the name, and then maybe we can say like social worker, they have their title, and we can have our own title so making clearly what our role is and then people more understand what we need" (Participant 4).

Cultural support

All the participants acknowledged the importance of cultural understanding and demonstrated a strong commitment to the delivery of culturally appropriate healthcare. Being able to offer an understanding of, and insight into, cultural beliefs and behaviours was seen as an important way to improve outcomes for patients, as well as the cultural understanding and knowledge of health professionals.

Participants gave examples of their role providing cultural support in palliative and end-of-life care, where differing cultural values can emerge and have the potential to cause distress. They described liaising with hospital staff to ensure the cultural beliefs of patients and families are recognised and considered in the process, and ensuring that bad news is delivered in a culturally sensitive and appropriate way. Recognising how attention given to addressing these relatively small issues makes the patient feel respected and cared for, enabling the building of rapport and trust which are essential components of a positive, therapeutic relationship between the patient and the healthcare service.

The importance of good communication was identified by participants as an important factor in reducing the risk of misunderstandings, and providing positive and satisfying interactions between patients and health professionals. They described the importance of the connection established through language and how this creates an effective way to establish rapport with clients and families. However, participants were very clear that their role was not that of an interpreter.

When participants described creating their connection with clients, they highlighted the importance of, not only a common cultural background, but also the shared experience of migration. The experience of leaving family, and knowledge of the difficulties and challenges faced by migrants in a new country create a bond based on this shared experience and understanding. While some participants shared in detail their story of migration to Aotearoa New Zealand—the issues and challenges faced when building a life in a new country—others also referred to the huge impact of migration and resettlement.

Supporting the emotional and psychological needs of clients was seen as a key function of the role, by being able to act as a confidante and offer a sympathetic ear for service users.

Participants acknowledged with clients the need to express their frustrations and feelings in a safe relationship with someone who shared their cultural background and experiences.

Education and training

Although no specific training for the CSW role is currently available, all participants demonstrated a commitment to ongoing training and professional development, were engaged in a variety of learning activities, and were proactive in seeking out opportunities to build skills and knowledge to enhance their effectiveness in the role.

Participants identified a range of training opportunities available to them in their current roles, acknowledging the need for ongoing training and development. Ongoing professional development was recognised by participants as a way to advance their knowledge and skills, but also as a way to gain credibility within the wider multidisciplinary team. One participant identified the importance of training, saying, "that's why we learning. We still need to improve, continue to improve making our [role] more professional" (Participant 3).

Support systems

While all the study participants described feeling well supported in their CSW role, the nature and level of support varied across settings. For some participants, strong support was provided by their service managers and through formal structures such as team meetings and supervision, while for others the support was gained less formally, for example, through discussion and interaction with colleagues.

The opportunity to access formal clinical supervision varied across the participants' experiences, with those employed by District Health Boards in the region reporting being offered regular formal clinical supervision. Despite the lack of formal support systems for some workers, the informal support provided by clients and families, colleagues and the wider organisation in which they were employed, and the sense of being valued and appreciated for the work they do, was a common theme expressed by all the participants.

Discussion

As healthcare providers meet the challenge of delivering healthcare services to increasingly ethnically and linguistically diverse communities, cross-cultural understanding and communication have become increasingly critical features of effective healthcare delivery. While there is an emphasis on delivering equity in healthcare services, the importance of acknowledging and embracing cultural differences needs to be recognised (Henderson & Kendall, 2011).

The value of cultural understanding and support, as well as the impact of the connection that is created with someone who shares the same cultural background, language and experience of migration, is a key factor in the establishment of trust and rapport, the foundation for an effective therapeutic relationship in the healthcare setting. However, a significant challenge for the exploration and understanding of the contribution of the CSW role in the healthcare setting is the lack of clarity around the description and functions of the role. This challenge, identified in the literature, hinders the ability to generate meaningful data about the role and its acceptance within the healthcare setting (Love et al., 1997).

This lack of clarity combined with the current lack of specific training and development opportunities for CSWs here in Aotearoa New Zealand is reflected in the findings from overseas studies. Rosenthal et al.'s (2011) most recent study into CHW training programmes in the USA echoed the results of their previous study in 1998, in finding that the most common training provided was stated as "on the job" (2011, p. 256).

Despite this, participants demonstrated a strong commitment to training and ongoing professional development, and to career advancement in the CSW role.

For CSWs to become accepted and integrated into healthcare delivery, there needs to be an investment by healthcare providers in their training, ongoing professional development and support. CSWs are themselves members of our migrant and refugee communities and, like others, are seeking meaningful employment that offers opportunities for career advancement and appropriate recognition and remuneration.

Study limitations

This small study, limited to the scope available within a research portfolio, offers an insight into the challenges faced by CSWs in healthcare settings within the Auckland area. While the five participants interviewed for the study provide rich data on the lived experience of CSWs, the data cannot be generalised to all CSWs. A future study that includes the perspectives of those who are impacted by the CSW role—including other stakeholders, service users and colleagues of CSWs—would provide a richer and more detailed narrative.

Conclusion

Although only a small study, findings describe a highly motivated workforce, with these CSWs committed to their role as a bridge between ethnic communities and healthcare providers. It highlights the importance of the connection made through a shared cultural background, and reinforces the value of this connection in establishing the rapport and trust essential for an effective interaction between health provider and health service user.

Despite the challenges that exist for CSWs, opportunities for the role to be developed and strengthened also exist. The introduction of specific training and mentoring programmes will allow the role to be better understood, more integrated into the healthcare setting, and will allow the valuable contribution made by these workers within the healthcare setting to be appropriately recognised and rewarded.

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Jacques Donzelot's *The Policing of Families*: Then and now

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In the early 1980s I was in the final year of my social work degree and on placement in a children's mental health service where family therapy was the primary mode of intervention. It was a challenging placement, I had a wonderfully engaged supervisor who saw her job as teaching clinical skills and helping me to integrate my university learning with the challenges of working with families.

My placement was a great introduction to a model of intense clinical work, with feedback provided instantly and the opportunity to watch skilled clinicians who were very dedicated to practice. And yet, I was experiencing some cognitive dissonance stemming from the contrast between the family focus of my placement setting and the focus on structural analysis in the early part of my Master of Arts (Social Work) programme. We had been challenged to think about the deep inequalities in Aotearoa New Zealand society; we had talked constantly and passionately about racism and sexism. Over the summer with some student colleagues I had helped to run a two-day conference on racism in social work. John Rangihau spoke, signalling the work that would emerge, in a few years, in *Pūao-te-Āta-tū* (Department of Social Welfare, 1986). John McCreary, in his final year as head of social work at Victoria University of Wellington, was in his element, encouraging rich and honest dialogue. In class, Trish Hall and Jenny Harré Hindmarsh encouraged many discussions about patriarchy and the glaring impact of violence and sexual harassment against women.

And yet here I was, in the midst of this very rich and demanding clinical setting which appeared to me somewhat disembodied from the politics of everyday life – unemployment, housing problems, family violence, health disparities, racism, sexism, ableism and homophobia. It seemed to me that our work was depoliticised, that we *treated* private troubles and ignored public issues.

In my reading for a major assignment I explored a range of critical texts that helped me to better understand my concerns through exploring a radical and feminist framing of social work's problematic positioning in relation to a conservative state, brilliantly epitomised by Bourdieu's much-quoted depiction of social workers as "agents of the state" who are "shot through with the contradictions of the state" (Bourdieu, 1999, p. 184). One book in particular, Jacques Donzelot's (1979) influential text, *The Policing of Families*, stood out for me then and, in re-reading it now, it seems to have enormous relevance to our present era. It taught me that the state's focus on families was deeply political. In the foreword, Gilles Deleuze situates Donzelot's contribution as a commentary and critique of "the rise of the social" (p. ix), with "the social" being "... a particular sector in which quite diverse problems and special cases can be grouped together, a sector comprising specific institutions and an entire body of qualified personnel ('social' assistants, 'social' workers)" (p. ix).

Donzelot's focus was on developing a new analysis of the family in the 20th century. The conservative view of the family is as a protector of traditional values and bourgeois accumulation. The left's view of the family traditionally is that it reproduces inequalities and, for feminists, it preserves the patriarchy and the resultant oppression of women. The family is also an institution about which competing discourses surge. In this passage Donzelot has an eerily prescient take on the contestation, although he is discussing prostitution, and in the context of the 18th century:

> What troubled families was adulterine children, rebellious adolescents, women of ill repute – everything that might be prejudicial to their honour, reputation or standing. By contrast, what worried the state was the squandering of vital forces, the unused or useless individuals. (1979, p. 25)

And there, contemporary reader, we have a forewarning of the modern neoliberal state's obsession with costs, and its anxiety about managing the 'forward liability' of 'troubled' or dysfunctional families. And how rooted it is in very old narratives about the moral character of the poor.

Donzelot argues that the family in the 20th century was a "buttress at the foot of which all criticism" of the family stops (1979, p. 5). It became a site for protection of living standards and for transformation. The idea of saving or rescuing families, birthed in the early decades of social philanthropy, was institutionalised as a state project. The conservative view has exhausted itself from any further development and simply reproduces the old order. The left critique ties the discussion of family to economic systems and thus reduces critique to one dimension. And yet, in post-war social policy, the family became the focus of so much renewed intervention in the new sphere of "the social." At the heart of Donzelot's critique, and clearly influenced by Foucault's work, is the exploration of how this project became so focused on family life at what we would call the micro level. Donzelot attributes this narrowing of gaze to the growth of the psychological professions.

It was at this point in my understanding of Donzelot's thesis that lightbulbs flashed for me. While some of my discomfort in my placement was about the invisibility of structural analysis of the families we worked with and, in our work in the clinic, their disembodiment from their communities and the social forces that impacted on their lives.

Donzelot's analysis was based on a thorough historical review of how concepts of interventions in families reflected institutional and political discourses – the incursion of the medical profession into intimate parts of family life, for example, childbirth; family planning; parenting and so forth; alongside the growing role of judicial and correctional influences on families.

His exploration of his contemporary society included detailed analysis of case records from juvenile justice and child protection services. Add to this the *psy complex* – the group of professions dealing with the human psyche: psychology, psychiatry, psychoanalysis, psychotherapy, psychiatric nursing, and social work – and Donzelot argues families are surrounded by technicians in the service of the apparatus of the state:

> Set within this double network of social guardians and technicians, the family appears as though colonised. There are no longer two authorities facing each other: the family and the apparatus, but a series of concentric circles around the child: the family circle, the circle of technicians, and the circle of social guardians. A paradoxical result of the liberalisation of the family, of the emergence of children's rights, of a rebalancing of the man-woman relationship: the more these rights are proclaimed the more the stranglehold of tutelary authority tightens around the poor family. In this system, family patriarchalism is destroyed only at the cost of a patriarchy of the state. (1979, p. 103)

This passage captures much of Donzelot's thesis about the policing of families in the service of continuing capitalist accumulation in the 20th century. A significant contribution from his historical review is found refreshed in very contemporary critical social policy and parenting studies. In her 2018 book, *Parenting the Crisis: The Cultural Politics of Parent-Blame*, Tracey Jensen acknowledges Donzelot's legacy in his reporting of the 20th century turn to *scientific motherhood* – the obsession with child-rearing practice, the constant measurement and assessment of children, and the growth of parenting education. Jensen notes that this represents a "professionalisation of child-rearing. Producing happy, compliant and convenient children required standardised and 'scientific' practice and was considered crucial to reproducing the nation and the citizens of tomorrow" (p. 30).

It is at this juncture of family and the development of a science of childrearing, relabelled as "parenting" later in the century, that social work expanded its reach. In the early 20th century obsession with the *mothercraft* of poor mothers, social workers drew on the emerging science to identify at-risk families and to intervene. At the worst end of the spectrum, and perpetuated by the medical profession, mass sterilisation was promoted as a solution to the problem of the poor (Tyler, 2013a). At the gentler end was the emergence of parenting expertise: as the power of the male parenting expert waned, mothers themselves (or at least white, middle-class mothers) were expected to become their own experts, to discipline themselves. Jensen discusses the way parenting becomes a kind of "shopping around" for the right advice, the consumerist concept of parents as autonomous individuals negotiating choices. This becomes a rather false empowerment, though, when examined from a class/race perspective: "we need a deeper theorising of the difference between mothers, some of whom live lives that are already inscribed with social and cultural value and some of whom are already pathologised as lacking or deficient" (Jensen, 2018, p. 38).

And it is because of the embedded inequalities that permeate so much of the argument that "dysfunctional families" must be corrected, that social workers must have all their critical faculties engaged when exposed to the waves of experts who will seek to impose their will based on pop-culture science. It has fascinated me for decades how simple attempts to humanise medicalised natural processes can become fetishised and oppressive. For example, the discovery of the link between maternal bonding in childbirth and skin-to-skin contact, initially challenged medical routines; yet later, in the hands of the same maternity care professionals, it becomes almost compulsory, a requirement for all *good* mothers regardless of individual circumstances.

This new wave of societal policing of parenting is clearly exemplified in the current focus on early intervention. And nowhere has the consequence of the uncritical acceptance of this as holy writ been more brilliantly challenged than in "A marriage made in hell: early intervention meets child protection" by Featherstone, White, and Morris (2014). Featherstone et al. locate the current focus on early intervention within the politics of welfare cuts and the neo-conservative anxiety about welfare and morality. Ignoring ingrained, persistent poverty, neo-cons obsess about future financial liability for dysfunctional or troubled families and, using all kinds of social engineering tactics, attempt to assert control over the unruly poor (Crossley, 2018; Tyler, 2013a, 2013b). Rather than address the structural issue of poverty, neoliberal governments want to minimise tax liability, and to do so by holding errant mothers to account. Early intervention has never been just about wanting the best for children. There is a pernicious association with surveillance, so brilliantly described by Donzelot in 1979 and captured again in the current critique. At the heart of this phenomenon is the need for patriarchal capitalism to ensure uninterrupted capital accumulation – for which a white, middle-class family form, one that reproduces itself consistently, is required. Social mobility must be kept within bounds. Intervention – whether early childhood education, widening participation schemes or charity – must not rock the boat too much. When the post-war social contract loses favour because of global economic crises, austerity rules. In their recent book Gillies, Edwards, and Horsley (2017) challenge "the politics of early intervention." Gillies et al. (2017) provide a detailed analysis of the political direction and influence of early intervention, including the wholesale acceptance of weak neuroscience as legitimising surveillance of parents (Wastell & White, 2017). Gillies et al. point out that the old axiom that prevention is better (and cheaper) than cure provides a basis in common sense. This narrative then overshadows the broader concerns of poverty, racism and gender inequality, health inequities and social exclusion:

> Rather, a prevailing liberal orthodoxy foregrounds personal agency. This convention sustains the notion that individual actions, intentions, behaviours and biological traits are at the root of all social ills .... It is such a denial of collective responsibility for human travails and wellbeing that drives futile attempts to manage risk at the level of the individual through expensive and often ineffectual intervention programmes. (Gillies et al., 2017, p. 168)

So, four decades later, we face intensified inequalities, global crises of displaced people, homelessness and social conflict. In this climate, Donzelot's book still has currency. He asks, again, with seeming prescience, "how can one go on claiming that prevention no longer has anything to do with the exercise of a repressive power when it is judicially mandated in order to penetrate into the family sanctuary, when if necessary it can mobilize a police force to accomplish this?" (1979, p. 98).

Donzelot goes on to essentially argue that we should stop arguing about whether social work is about care or control (1979, pp. 98–99). Rather, he suggests, we should study social work and try and understand the strategic forces at play in the institutions in which it is practised. Does it comprise:

> Those generous human sciences which will lead ... to the near-disappearance of man's oppression... [or] that abominable power which appropriates knowledge for its own ends and nullifies pure intentions in the interests of a blind and extensive domination[?] (1979, p. 99)

So, in 2018, social workers should be as wary of the white-coated men (and, sadly, women) of science as they were of the white-coated doctors of the middle decades of the last century. Have the rigid bibles of child rearing and mothercraft been replaced by the beguiling and narcissistic calls to *best practice* parenting where children's every moment is engineered for maximising their future performance? There's a great deal to think about and I found re-reading Donzelot very rewarding.

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Vulnerability and marginality in human services

Mark Henrickson and Christa Fouché, 2017
Routledge, Oxford, UK
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What happens to people when they are classified as *vulnerable* or *marginalised*? That is the central question posed by this book. In human services and social policy alike, it has become almost automatic to describe some people as vulnerable or marginalised based on their individual characteristics or belonging to a population group. This book draws together Henrickson and Fouché's diverse research interests to pose questions about the concepts of vulnerability and marginality that emerge as common concerns. They achieve this through focusing on the core human experiences of intimacy and relationship.

The focus for this concentrated volume is restoring the *human* to human services. The book comprises nine chapters, with the first four chapters exploring how vulnerability and marginality affect people's lives using the overarching themes of intimacy and sexuality. This first part also introduces theoretical contributions to help make sense of the phenomena to emerge from both authors' research. The thoughtful review of both authors' research fields illuminates how notions of vulnerability and marginality have come to dehumanise people who are deemed to be vulnerable or marginalised. Unlike other prominent fields where vulnerability features, this does not include children or child protection. Instead, the dual focus incorporates two adult experiences where people have "changed state" from not being considered vulnerable or marginalised to becoming perceived as such. These research focuses are older people (and specifically older people in residential care) and lesbian, gay, bisexual, trans, intersex, and queer (LGBTIQ) communities, including the specific experiences of HIV+ people.

Henrickson and Fouché draw on structural analyses, in particular that of Loïc Wacquant, to understand the shift from vulnerability and marginality being aspects of the social structure to becoming perceived as characteristics of individuals. These analyses uncover the dehumanising effects that these labels impose on people and their lives in a social environment where risks are perceived as a cost to society. Incorporated throughout is a critique of the dominance of business and efficiency models in human services and the current environment where these are perceived as inevitable or inescapable. The authors explore how these models obscure the workings of power and privilege in turning vulnerability and marginality from structural concepts into characteristics of individuals and communities which, in turn, become thought of as *risks* that require managing. These discourses of risk are likely to be familiar to anyone working in human services in recent decades.

The book includes a concise and approachable discussion of the rise of neoliberalism as a "how did we get here?" discussion in chapter 4. This provides the foundation for advocating critique of power and privilege that is exercised through structural mechanisms that are rendered invisible by individualising vulnerability, marginality and, consequently, also risk.

As becomes apparent in their final chapter, Henrickson and Fouché's challenge for human services and social work is to render that structural power visible again through critical and reflexive practice. A vital contribution, this chapter provides the theoretical and political groundwork for resisting individualisation of structural phenomena prevalent in the neoliberal approach to social policy. Structural analysis of these factors increasingly inscribed onto individuals allows them to be re-ascribed to social structures rather than being perceived as a *fault* or deficiency of the individual.

When concepts or words become tainted with unwanted meanings, there is a temptation to abandon them as irredeemable from those connotations. Henrickson and Fouché do not suggest abandoning the concepts of vulnerability or marginality entirely. Rather, they conclude the book with an exploration of how to reimagine the concepts and the role of critical reflexive social work and human services. They advocate for sustained attention to the workings of power at structural levels that lead to the detriment caused by application of these concepts to people. They argue that the appropriate response "is not merely to 'help' vulnerable and marginalised individuals and communities, but to critique those with power who create and label those individuals and communities" (p. 132). The challenge for social workers and other human services professionals is to identify how being labelled as vulnerable or marginalised may affect any person and what implications this has for their agency, autonomy, and access to the means for exercising self-determination.

One of the key contributions to the field in this book is its focus on individuals and communities not commonly at the centre of discussions about vulnerability or marginality. The core of this discussion has reach far beyond the focus on older people and LGBTIQ communities. It has implications for any individual or group identified as vulnerable or marginalised. What the focus on older people and LGBTIQ people does is allow us to see more clearly the effects of notions of vulnerability and marginality when applied to persons. This is especially significant for perceiving the effects on individuals and groups who are routinely or automatically considered vulnerable or marginalised, including children and people with cognitive impairments.

By focusing on groups of adults who have shifted state from being perceived as not vulnerable or not marginalised into a state of being perceived as such, the discussions in this book demonstrate the negative impact of these concepts on people's lives. The examples from their respective research serve to illustrate how people's personhood, autonomy, and self-determination become curtailed when they are labelled as vulnerable or marginalised. Labelled with these concepts. people's lives are rendered subject to scrutiny and restriction beyond the scope of the person's limitations. As Henrickson and Fouché argue, this effect is not simply on the individual as a reductionist and isolated unit but infringes on the person's ability and rights to intimacy and relationships subject to the conservative moral qualms of the dominant culture. The most poignant and difficult discussions to read in this regard are the denials of intimacy to older people in residential aged care because of their perceived vulnerability. As many of the cases discussed illuminate, these are the result of legal or organisational policy manifestations of the prudishness of others. Here, where caring, intimate relationships of decades are rendered void by a designation of vulnerability on one of the partners, the dehumanising effects of being labelled as vulnerable are made plain.

The dense theoretical discussion in some sections may offer some challenge for readers who are less practised at reading these types of text. However, the skill of the authors in supporting readers to develop their critical reading and reflection shines through in the key questions presented at the end of each chapter. In this respect, the book presents a useful addition to continuing professional development activities as well as a resource for educators and students.

The questions and challenges raised in this book are vital, even central, to social work. It is essential for social workers confronted with organisational focus on risk and risk management in their work to be alert to the effects of deeming an individual or community as vulnerable or marginalised. This must include thinking about people we routinely or automatically think of as vulnerable, including children, and what effect this has on our perceptions of their competence, their personhood and self-determination.

What this book achieves is to provoke readers to think carefully about what we harm we might be doing when we refer to a person or group of people as vulnerable or marginalised. Henrickson and Fouché's discussion presents a clear argument that this is not a simple or benign act. If we are serious about social work's responsibility to social justice, empowerment, and tino rangatiratanga, then this is a vital discussion to have.

Reviewed by **Justin Canty,** Lecturer, Social Work, Western Sydney University

Social work practice in health:
An introduction to context, theories and skills

Melissa Petrakis (Ed.), 2018
Allen & Unwin, Australia
ISBN 978-1-76029-451-9, pp. 288, NZD56.99

I recently started a secondment position at the University of Auckland, and am to be involved in supporting lecturers and students bringing the practice world of social work in health closer to the academic world.

When approached to review the book, I was initially hesitant, but when I saw the title, I was immediately attracted. Finally – a whole book about social work in health! Social workers in practice it find it challenging to make time to stay up to date with the latest literature. To come across an edited book, with information covering different areas of social work in health, and written from a perspective which can be applied within the health context of New Zealand, is exciting.

The first chapter provided a good foundation for the rest of the book. It gives an overview of what the role of social workers in health might entail, the challenges to social workers, and the connection to social determinants of health. The second chapter encourages social workers towards evidence-informed practice and to engage in practice research. Social workers not engaging in research as much as other allied health professions seems to be common and, due to practice demands, social workers might need more support from management levels to contribute in this area of social work.

The title gives the impression that context, theories and skills will be discussed in even amounts of detail, but I found that the context and role of social work weighed heavier. Most chapters make reference to theories relevant to the working environment and one would need to have foundational knowledge about social work theories to integrate and make the connection between practice and theory within the variety of contexts of social work in health. However, credit should be given to the chapter on forensic social work (Chapter 10) which captured aspects of theory in more detail.

Practice skills which might be relevant in the health context are also discussed, but a social worker would still need to be practising social work in the field to apply and develop basic social work skills to fit within the health environment.

I did enjoy the unexpected gems that surprised in some chapters, for example the short but dynamic explanation of crises support/psychological first aid (Chapter 4), psycho-education (Chapter 7), the importance of supervision (Chapter 8), motivational interviewing (Chapter 9), and additional aspects to consider when performing assessments for older people (Chapter 13). As a social worker in the field of cancer, Chapter 12 impressed, capturing the foundational aspects of a huge context effectively.

As a social worker who appreciates a strong, supportive counselling approach in my social work practice, I observed the careful and limited presence of the role and value of the therapeutic role of social work in health in this book. In practice, the application of these skills may be limited due to the pressure on social workers to focus on discharge planning and supporting patients in practical matters. It seems to me that this contributes to a perspective of a narrow scope of practice in the context of (especially physical) health. However, it is still an essential skill which social workers should be able to integrate with confidence within their social work practice.

In general, I appreciated the information written in language that is easy and quick to read, with the information quite succinct. The chapters are well organised, creating the feel of flowing naturally from one context to the next. The first two chapters provide a foundation, then the different contexts are addressed. It starts with children, then women, mental health and aged care. It includes complicated areas such as trauma-based social work, oncology and end-of-life care, disability and refugee health.

Cultural components are also addressed, and appreciation is expressed for considering a Māori-informed approach to health social work. However, in reading this chapter, I found it hard to connect with the information, as it seems to me that there are practice challenges in the application of the approach, e.g., the role of whānau advocates that are impacted by changes within the district health boards, shorter hospital stays, and a bi-cultural approach may not be evident in the health context of Aotearoa New Zealand. Social workers might have a stronger role to play in ensuring that bi-cultural practice approaches are applied within the context of health in Aotearoa New Zealand.

It was interesting to find a chapter on forensic social work in this book, but I struggled to make the connection within the context of health. It seemed that the link between corrections and the health context was missing, e.g., the role of social work when supporting a person linked with the correctional system who needs to go for medical treatment or to access appointments.

This book is relevant to the context of Aotearoa New Zealand taking into consideration that the health systems of Australia, UK and Aotearoa New Zealand are quite similar. For Aotearoa New Zealand, all aspects of this book might not be relevant (for example, relating to the area of disability, the National Disability Insurance Scheme). The local reader will have to familiarise themselves with the context of Aotearoa New Zealand. This also applies to matters relating to policy, legislation and demographics. I do think that this book will especially be valuable to students and social workers who are interested in pursuing their career working in the area of health. It provides a foundation for social work within the context of health and could contribute to the professional confidence of the social worker working in this field. This book will definitely form part of the reading list of every session I am involved with in the lecturing of students. Congratulations.

Reviewed by **Karin Jansen,** Social Worker in Health, Cancer Support, Counties Manukau Health and Clinical Secondment Lecturer, University of Auckland

Integrated care in action: A practical guide for health, social care and housing support

Robin Miller, Hilary Brown and Catherine Mangan (Eds.), 2016
Jessica Kingsley Publishers, UK
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Integrated Care in Action provides a practical and engaging narrative for managers already working within, or working towards, integrated service delivery, as well as for students and others eager to better understand possible designs, models and tools with which to achieve integration goals.

The authors offer the view that "integration is concerned with a fluid set of interactions between individuals accessing services … professionals who support them, and organisations and policy contexts" and set about providing tools to support those interactions and the actors at large (p. 8). This theme is woven throughout the various chapters based upon the building blocks which, the authors argue, are integral in the success of an integrated care initiative.

The style of the chapters encourages the reader to dip in and out of the chapters that appear most relevant, while also providing a powerful continuum when read in the order the chapters are displayed.

For those looking for practical tools, programmes or models there are also plenty of these on offer. Easily recognisable tools such as the PDSA (Plan Do Study Act) cycles sit comfortably alongside Kotter's 8-Step Change Model and co-production frameworks such as Experience Based Design. Working with and leading staff feature largely, with good resources to empower and manage resilience throughout the possible paths to integration.

For those seeking to undertake change processes, this text provides a framework for readers to understand the types of change in order to engage with it. This focus creates a space for the reader to reflect on the tools provided throughout the book.

So, too, do the variety of real-life case examples which demonstrate the application of concepts and tools described in each chapter. While many of the case examples provided are from the UK and NHS perspective, they are framed in a way so as to be meaningful to an international audience.

Overall, Dr Robin Miller, Hilary Brown and Catherine Mangan have produced an easily readable, engaging text which feels immediately useful and realistic for any health and social care setting. They invite the reader to think about their own current state and, through well placed questions, invite the reader to imagine an integrated future.

As the authors highlight, "this is a start, and not the finish" (p. 114). They encourage us as readers to look more deeply into the areas that capture our attention and the tools that could be useful within our own actions towards Integrated Care. They also remind us that "Integrated care is … a long term endeavour … which will always require our attention and energies" (p. 210).

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