EDUCATION AND HEALTH STANDING COMMITTEE

THE ROLE AND INTERACTION OF HEALTH PROFESSIONALS IN THE WESTERN AUSTRALIAN PUBLIC HEALTH SYSTEM

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 16 OCTOBER 2002

SESSION THREE

Members

Mrs C.A. Martin (Chairman)
Mr M.F. Board (Deputy Chairman)
Mr R.A. Ainsworth
Mr P.W. Andrews
Mr S.R. Hill

DODDS, MR BRIAN J
Vice President,
Australian Association of Social Workers (WA Branch),
examined:

MOGRIDGE, MS PENELOPE ANNE
Social Work Manager, Hollywood Private Hospital,
examined:

The CHAIRMAN: Good morning. The committee hearing is a process of the Parliament and warrants the same respect that proceedings in the House itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as a contempt of Parliament. Have you read the Details of Witness form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the attached notes?

The Witnesses: Yes.

The CHAIRMAN: Have you received and read the Information for Witnesses briefing sheet regarding giving evidence before a parliamentary committee?

The Witnesses: Yes.

The CHAIRMAN: We have written to you in response to your submission and asked you to elaborate on a few points. Is there any burning issue you would like to start with?

Mr Dodds: I want to make some comments about registration, as it is the area in which I have been most involved. The association has started a process of seeking the registration of social workers as a method of supporting and reinforcing continuing professional education aimed at improving practice standards and maintaining a core of people in the profession who are committed to the obligations of practice standards. We have held preliminary discussions with the Minister for Community Development and the Attorney General. We are in the process of finalising a submission to the minister, putting together all the current issues that are happening in other jurisdictions overseas as well as in Australia.

The process involved in registration will be threefold. The first part will be to recognise the title of social worker. The second part will be to support continuing professional education as part of the registration requirement. The third part will be to give legal sanction to a registration board of some kind to deal with complaints against social workers, similar to that of the legal profession or the medical profession. At the moment there is no registration. Continuing professional education activities are voluntary. There is accredited social work status, but it affects only members who take advantage of educational opportunities. As it is a voluntary process, it is a bit hit and miss.

The connection between social workers and other professions also needs to be reinforced in the way that people do social work. We see registration as being a vehicle for improving the perception of social workers. We are still at the beginning

stages of the process and there is more work and research to be done. Jurisdictions overseas are beginning to register social workers for the same sorts of reasons. Social work registration is not new in this country. The history goes back about 30 years. The Northern Territory was the first place to have registration. It was withdrawn when the national competition policy came into being. I note that the federal Government and State Governments are now looking at a whole raft of registrations for various professions, including school teachers. We therefore felt that it was time to revisit registration for social workers and start putting forward the arguments for why social workers should be registered and perhaps how to go about doing it.

Mr M.F. BOARD: This inquiry of the Education and Health Standing Committee is primarily looking at emerging occupations and the way in which health is changing to become a little more holistic in the way it is delivered in our community, who delivers it and the interaction between the professionals. I notice from your submission that, on the one hand, you state that there is not a lack of social workers but, on the other hand, there is a lack of professionally trained social workers - in fact, virtually none - who have a background or specific training in medical areas. I would like you to elaborate on what you see developing and happening in that area. Is the career structure for social workers big enough, and would the body that you mentioned be a self-governing body and hence be able to look at issues around Australia and the developing trends of emerging occupations in social work?

Mr Dodds: I would like to make some general comments, and perhaps Penelope can be more specific about the health area. As to the trends and monitoring, I think any kind of registration board probably should be able to do that, but I do not know whether that is part of the thinking behind that. The Australian Association of Social Workers does some of that now in terms of what is developing, and does that through connections with various agencies that employ social workers, as well as schools for social workers in universities. As to connection to other professions, I think there is a general thrust for a more holistic or broader spectrum of how services are being delivered. For that reason, social workers are very well placed to be part of that, because part of our undergraduate training is very much a generalist qualification. I think you are right to say that currently no degree course offers any kind of specialisation. That is usually gained through on-the-job training, or if someone wants to do specialist training, it is usually outside social work - for example, a Master of Business Administration or some other allied profession. Perhaps Penelope can add to that.

Ms Mogridge: Yes. Social workers in the health areas are under a huge amount of pressure at the moment, as is everybody working in the health area. There is no specialised course as such at the moment. If people wish to undertake specialised courses, they do it at their own expense, and there is no remuneration at the end of it to give them a motivation, if you like. If we could give them some sort of financial motivation or recognition, or professional progression, there would be a lot more room for that to happen. I think we need the specialised education. However, without some sort of remuneration for the effort involved and some sort of progression in the career structure, the incentive to do that is not there. At the moment, I think all the allied health professions reach a certain limit in a hospital setting, for example, beyond which they cannot progress further. A lot of project positions within hospitals etc generally tend to go to nursing or to medical staff. An issue for all allied health teams is to try to create a better progression for allied health staff, and that includes social workers.

Social workers in hospitals are under more pressure than ever before because of the complexity of the social issues. Social work has something very important to bring to that service, and it would be a shame if we lose people from the profession. There is a lot of burnout at the moment, and that relates to the fact that many teams in the public and private sector have had no increase in staffing, yet the volume and also the complexity of work have increased. Once upon a time in hospitals we had a mix of case load of surgical and general medical patients. Now, particularly because of the ageing population, we have many more general medical patients. There are many complexities in the family situation. The social worker plays a major role in discharge planning and is constantly under pressure to move the patient out of the hospital situation, while also trying to represent the needs of the patient and the family.

Mr M.F. BOARD: How does it work at Hollywood Private Hospital? Are you part of a multi-disciplinary team?

Ms Mogridge: Absolutely.

Mr M.F. BOARD: Do you see that in the public system to some degree?

Ms Mogridge: It is similar, yes. Multi-disciplinary teams exist across the parameters. There is a lot of value in that. The allied health group is working more and more cooperatively. In the old days, there were certain differences about who did what. However, there is a realisation that we need more power and more voice in the health system. Therefore, the allied health workers, as a group, have been joining forces to represent our needs in that sector. However, everybody is under a great deal of pressure, and we are losing people because of that.

We also have difficulties with training. You asked about education. A lot of the training has to happen on-site. The more and more pressured we are, the less chance we have of providing that valuable training. Therefore, employers would be more inclined to employ someone who has some experience but who may not in the end have the greatest potential, just because of the pressures that everybody is under.

Mr M.F. BOARD: Are there enough social workers in the State overall; and, if so is it then a question of working with the training institutions to develop specialities?

Mr Dodds: The answer to both questions is yes. The first time graduates who were not quickly employed occurred about a year ago. There is a need for specialised training in tertiary institutions, whether at the masters, graduate or undergraduate level. I guess it would need to be at the graduate level.

Ms Mogridge: Or even at a partnership level, but we would need the resources to do that. If we were in partnership with the universities to train graduates on-site, we would be able to do that, but we would need resources. There are probably a number of different ways in which that could be tackled. There are enough graduates. I have not heard anyone say that there is not. The problem is that graduates still need to pick up a very busy and pressured case load in the health sector. That is one of our big problems at the moment.

The CHAIRMAN: I am a social worker. When I did my degree it was a four-year course and most got through. One year of that course involved considering a specialisation. Does that occur now? I specialised in an area that suited me, which was post trauma social work. I did that deliberately. However, a number of other students looked at the medical profession and took options in that area. Those options lead a person to a career as a social worker. Is that still available? It was my

understanding that a strong code of ethics based on the B(?) principles ran throughout all social work courses. Those principles actually embed within the person. Once a person has graduated as a social worker, that person will have proven, first, through his competencies and two practicums, that he has a high ethical standard, and, secondly, that he is competent in whichever field he has chosen to pursue. Is that no longer the case? It is a question for me as well I suppose. There has been a development of new professions within the social work arena. I am a politician, but my core degree was in social work. I also understand that many professional people take social work as their first degree and then go on to other areas. I seek some clarification.

Ms Mogridge: The principles are alive and strong. We are all very passionate about our ethical background and position. I do not think there has been any compromise of that. However, some social workers from the health sector have reported to me that they feel that their ethical position is under pressure, particularly with the moving on of patients and the care awaiting placement situation, in which decisions are sometimes made and patients moved without significant or any consultation with the social worker who has been working with that family. They feel that the rug has been pulled from beneath them. That has made us feel that we need to reassert our ethical perspective. I do not think it has been compromised. We all feel passionately about that. That adds to the pressure. A lot of pressures are coming from an economic rationalist perspective about the cost of health services. This is where social work needs to reinforce its position, because we need to represent the needs of people in this system as well as work with the system.

Mr Dodds: On the point you made about graduates, I think they are competent. The gap is that when they come into a system that is so pressurised, they need a lot of support to learn about the processes of the organisation within which they are working. That is where it basically falls in a hole. It is quite difficult to provide that service. Until the graduates are able to learn the processes of their agency, they are less effective in social work than they should be. The pressure is greater these days than it was five or six years ago in terms of new graduates getting that on-the-ground support in an agency. Time has become very precious. I will respond to the member's comment about being a social worker. I have met social workers who have done other jobs as well; they are managers, politicians and other things. Some people see themselves as managers who have social work qualifications. Although that is probably valid in some ways, I do not think a person escapes his ethical responsibilities when he holds a particular professional degree. Some would argue against that, of course. That is my view. I see you as a social worker who happens to be a politician.

The CHAIRMAN: I do as well.

Mr R.A. AINSWORTH: In your submission you spoke about the lack of public health social workers in rural health services, and the heavy workload carried by those practitioners. Have these or other issues resulted in the role of social workers in rural or remote areas being substantially different from that performed in the metropolitan area? Do you think social workers are adequately trained to perform in rural and remote contexts?

Ms Mogridge: We did have some brief comments from the rural sector. However, we might need to take the question on notice. The general gist of those comments was that social workers in the rural sector feel greatly under pressure. They have

huge geographical areas to attempt to cover and service. They are very isolated and unsupported. They are perhaps in need of extra funding. Perhaps some sort of scholarship program could be established. Isolation and high pressure are particular issues for the rural social work sector. Like any social worker, those who work in the rural sector have completed their training and demonstrated that they have the skills to cope. However, there is the value of the critical mass. When you are a part of a social work department, or in your case a parliamentary group, you bounce off, support and learn from each other. People in isolated situations suffer because they do not have access to that. That adds to turnover and a lack of continuity of service in those areas. Registration might also partly be an issue. People must be attached to an agency in the rural sector - a larger hospital, health centre or something - rather than being able to function as a lone practitioner. That can be a limitation on them; the social workers may be based in a rural centre, rather than being able to cover or be based in a more remote area.

Mr R.A. AINSWORTH: I refer to the adequacy of training for that sort of setting. I know that a course in rural social work is offered by Edith Cowan University in Bunbury. It is a course with a country flavour, at least. Is there perhaps a need for a greater emphasis on the problems that country social workers face to be incorporated in a course such as the one run in Bunbury? Is what is offered in that course covered in sufficient depth in other training institutions for people who might go to the country?

Mr Dodds: The answer to that is very broad. A broader training base on rural social work needs to be available to more social workers, perhaps not as an elective but as a mandatory part of the course. The nature of country or rural social work is such that the training will be fairly generic anyway, unless a social worker happens to be attached to a fairly big hospital that has specialised teams. When social workers are isolated - there are just one or two of them in an area - they basically become the service providers for all sorts of issues. It is difficult to know whether a better qualified social worker would overcome the problems of isolation and lack of support in rural areas. It would probably make them more aware of country and rural issues and the difficulties that go with that.

Ms Mogridge: From what I have seen of the course in Bunbury, it has a dedicated focus on finding work for graduates in rural areas. That could be something I take back to the Bunbury campus. I have been quite impressed with what I have seen at that campus, and the energy that has been demonstrated. That course is very clear about its focus, which is to provide social workers for rural areas.

Mr P.W. ANDREWS: In your submission, you referred to social workers being supervised by members of their own profession. Can you explain that? How does that work in a multi-disciplinary team?

Mr Dodds: The social work profession has for many years been a leader in providing supervision to its members. The value of that is that a social worker is supervised by someone who may not be directly involved in that person's professional practice but who can understand that practice and its ethical basis, and can challenge the social worker on that basis. There are difficulties when a non-social worker provides supervision or management of a social worker or a team of social workers. The non-social worker can certainly provide administrative supervision, but in terms of professional practice, they struggle to understand our training and the concepts that

we deal with. That is the reason we support the idea of social workers being supervised by social workers.

Ms Mogridge: I am trying to think of a time when I was supervised by someone other than a social worker. I have a manager, but there is no way that she could supervise my social work skills.

Mr P.W. ANDREWS: When you put that into the team situation, how does it work?

Ms Mogridge: In the multi-disciplinary team?

The CHAIRMAN: I just want to make one comment. Supervision has three parts - administrative, logistical and professional. Are you saying that a social worker should provide supervision in all three areas for a multi-disciplinary team?

Mr Dodds: I can give a personal example of that. I have had a team leader who was not a social worker. I reported to that person in terms of administrative supervision and accountability. However, my professional supervision was by another, more senior social worker. That is probably how it would have to happen in a multi-disciplinary team in a hospital as well.

Mr P.W. ANDREWS: Can you elaborate on that for me? I do not quite understand what you mean.

Mr Dodds: That is one advantage of a big hospital that has a social work department. The social work department can provide social workers with peer support, practice supervision and ethical challenges within that professional practice. It will not necessarily come from someone qualified in another profession. The team structure might lend itself to its particular specialisation in the hospital, which might be allied to a particular medical specialist. That is like a manager of a team meeting the requirements of the hospital and the specialised service. The social worker provides a service to that team. Social workers need their own supervision, as well as in terms of their practice and ethics. That is basically the difference.

Ms Mogridge: There is a directorate model, which is what you might be thinking of, which looks at social workers and other allied health workers being attached to a particular directorate, so they do not actually have social work departments. Some administrative matters might be able to be managed in that capacity. However, we do not feel that could happen with the supervision of a social worker's skill base or ethical practice. In my hospital there is a lone social worker in a psychiatric area. She comes to me because she feels extremely isolated in terms of her skill base and practice. She comes to me for supervision at that level, but she has accountability within her own area of psychiatry.

Mr M.F. BOARD: Perhaps you could give us an idea about what is happening at the interface between the patient and the social worker in these teams. What are the emerging trends? Does it mainly involve aged people? Do a lot of the issues concern care awaiting placement and issues of that nature? What are the developing trends and pressure points for social workers? What are they mostly dealing with in this State in that sense?

Ms Mogridge: I certainly work in an area where aged care is the big issue. We are admitting patients who are old. People are living longer and longer; they are getting older and older, and we are performing surgery on people at older ages. This means that the hospitals are becoming, to some extent, revolving doors. I almost think sometimes that there is a case management role for hospital social workers, because

our patients are returning to us. They are very elderly and the frequency of admission is increasing, and we have that repeating turnover. The pressure comes at the point where somebody is deemed no longer capable of caring for himself, so we have issues relating to this person going into care, and perhaps not wanting to. Whether we can override that decision-making capability, involves issues of guardianship and administration, which are very complex. There are also issues of loss and the problem of finding a suitable place for a person who can no longer return home.

Mr M.F. BOARD: Do you get involved in the community care packages?

Ms Mogridge: Community care packages are certainly utilised, but there comes a point at which they are limited. Community care packages involve about seven to eight hours a week of home nursing care. There are only two providers of nursing home level packages, which involve about 20 hours of home care. If you are looking after someone who is extremely frail, who needs nursing home level care, they will not manage at home with that level of care. There is a range of packages, but they are not the answer. It is not true to say that we can prevent people from going into care with the packages. We can defer it. We have a role to play, and we want to give people their independence for as long as possible. The ageing issue is one of the crisis points in hospitals, and, added to that, is the nursing shortage. At the moment we are looking at being quite creative in our hospital. We probably have half a ward of people who are waiting for placement, which is quite a significant number of people. That brings a lot of pressure, because there is pressure from the acute consultants, who want to bring in their patients, and they want those patients out. It is a social issue. What will we do with this ageing population if the hospitals become more and more gatekeepers and refuse to admit these people?

Mr M.F. BOARD: Earlier a witness from the Council on the Ageing made the suggestion that the multipurpose service system that operated in the country was a very good model. The council did not see why that model could not operate in the metropolitan area, and that our secondary hospitals and other institutions could be utilised on the MPS model, with federal and state funding. In other words, there might be a transitional base for people waiting for longer term care outside of the hospital situation. The tertiary hospitals would not be utilised in that sense. Would you favour a model like that, or do you have an opinion?

Ms Mogridge: I do not know. We will have to solve this problem somehow. The concern that we have is that the care and placement units are like holding pens, if you like. If we do not put enough resources into them they will be very dehumanising. Going into residential care is dehumanising in many ways too. The old C-class hospital is something we tried to move away from. Is there a risk of going back to that? That is the concern. We must look very carefully at how we do that. We are talking about human beings who are frail and elderly, coming into a system, and then going somewhere else. There are big social issues and the big challenge is for us as a society as a whole.

Mr M.F. BOARD: This is my last question. Is there a role for a new occupation in social work, other than specialisation? Does everybody have to be fully trained at the specialist level? Is there any trend for assistance in that area, or further progression of career structure?

Mr Dodds: Do you mean postgraduate level?

Mr M.F. BOARD: Postgraduate or before.

Ms Mogridge: Because of the complexity of the social issues, we need social workers to be well trained. The strength of social work has been our systems perspective. That is seeing things not just at an individual level, but seeing the implications beyond that level. We need social workers to be very well trained, and maybe even to be in a more coordinating or overseeing position, by understanding and helping others to understand the implications of what we are doing for human beings in the health system, and representing their needs. We must also understand that there are financial and resource constraints. Bringing all those components together requires very well trained people, rather than lesser trained people. In the nursing situation, for example, patients who are in an acute setting who are not deemed to be acutely ill, could be nursed by an under-nursing level of carer. That will be an emerging model, because there will not be enough nurses. That is feasible, because those people are no longer acutely ill, but are still sitting in an acute setting. That could work, with adequate training, but from the social work profession point of view, we need to be very well trained and maintain our knowledge of the complexities of these systems, and represent that much more assertively than we have done in the past.

The CHAIRMAN: You discussed in your submission the need to develop strong links between social work departments, universities, major health agencies and other departments. Can you share some of your views on how this can be achieved?

Mr Dodds: The process has partly started, with schools of social work and the Association of Social Workers, for example, and some hospitals looking at particular practice or policy issues, and developing specialised in-service training. They are also looking at postgraduate training - what it offers, and what needs to change in it - and creating and maintaining a dialogue between all those groups and agencies. It is no quick process, really. It could be reinforced even more. I am not sure that we have got to the level we need to be at in exchanging information and debating issues.

The CHAIRMAN: In the social work courses, the first two years are generic and the second two years provide more options to specialise in different areas. About 10 years ago, when I did my degree, it was more community development. There has been a change in trends. There were two streams, as I understood it. One was community development and the other was counselling in pure terms, with a bit of administration and that sort of thing. Now, however, we are seeing a trend in which social work is actually needed more in the medical arena. I just needed to clarify that.

Mr Dodds: Yes.

Ms Mogridge: The association has become more proactive as a group. The health administrators group has had meetings with the universities. We want to have them a bit more accountable to us for the graduates that we are receiving, in terms of the content of the course. We are having meetings, and a number of forums are already in process to do that. We are happy to assist with that by offering some training and assisting with the arrangements.

The CHAIRMAN: You would be happy for, say, Curtin University to have the schools of medicine and social work under the same amenities area, so that there is an opportunity to get the students together.

Ms Mogridge: Yes.

The CHAIRMAN: In your submission, you also mentioned the need for development of teamwork skills within the medical professions. Would you like to elaborate on that?

Ms Mogridge: I am not responsible for that comment, but it would be fair to say that the medical model, as we understand it, is still alive and very healthy in the hospitals. By that I mean that it is driven by consultants. Sometimes, if a consultant leads a team, he may not necessarily have the same managerial or leadership training as somebody else who may lead that team. Encouraging leadership training for anybody in the health professions who is leading a team is very important, so that it will bring out the best in all the members of that team. Having said that, I mean no disrespect to any consultant, but sometimes the consultative process, and perhaps the maximum utilisation of a multi-disciplinary team, does not happen. It could perhaps be assisted through leadership training.

The CHAIRMAN: How would that impact on patient care and outcomes for your clients?

Ms Mogridge: I can speak for myself. I feel that we have fairly consultative teams where I am, but I know that is not the case across the board. Where there is good consultation, generally we have a team meeting and discuss every patient, all the members of the multi-disciplinary team are present and all are invited to contribute. That is the ideal model.

Mr Dodds: That is the key to it.

Ms Mogridge: It does not always happen, and, notoriously, the surgical area is where there is least consultation. I know that is not the case across the board. It comes from what people report to me.

Mr Dodds: We tend to think that we can throw a bunch of people together and call them a team, and there is no process involved. The process becomes important - how to negotiate and discuss issues and come to an agreed position. They tend to work well when operating under that premise.

The CHAIRMAN: Thank you very much. You will receive a copy of the Hansard transcript in the mail soon. If you could go through it and make any necessary changes and return it within 10 working days, it would be appreciated.

Ms Mogridge: There is one more point I would like to make. One of the other complexities of being in the hospital sector, for example, is the multitude of community service providers. That is hugely complex, and is often quite a cost factor, because we might do an assessment in a hospital, and refer the patient to the community service, which does another assessment. We are probably losing a lot of resources in the duplication of assessment. Perhaps there is a lack of trust in that process, and I often feel that we could have more resources at the coalface if this did not occur. It also adds to the stress of the work within hospitals - that there are so many providers, you are often a broker, knocking on doors trying to get services and there are not enough.