Developing a National Health Social Work Competency Framework

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A thesis submitted to fulfil the requirements of the degree of Master of Social Welfare

University of Otago
Dunedin
New Zealand
December 2011
ABSTRACT

Health Social Workers engage with people, including the healthy and chronically ill, across the ages and stages of life from conception to death. They encounter diverse client-related issues in their day-to-day practice. The Health Social Worker’s role includes assisting clients and their families/whānau to be self-sufficient and cope with the personal, family and/or social effects of life changes due to ill health and disability.

Social Work Associations and regulatory bodies from the United Kingdom, United States, Canada, Australia and New Zealand have developed practice standards and competency frameworks within which common themes can be identified.

Competencies within social work can be described as multidimensional dynamic concepts that require social workers to have the appropriate knowledge, attitudes and observable technical skills to perform their role effectively and efficiently; that is, social workers need to have the ability to carry out the professional tasks and responsibilities that define social work scopes of practice. Thus, competencies are determined by the quality of service, training, education and practice assessment.

The overall aim of this study was to explore whether a single national competency framework could be developed that would be relevant across, and applicable to, all domains of Health Social Work practice throughout New Zealand. It was thought that such a framework would assist Health Social Workers to demonstrate their competency and accountability. In doing so, it would enable Health Social Workers to clearly articulate and demonstrate the ‘how and why’ of their practice.

The study also considered whether demographic characteristics could influence the perception of Health Social Work practice and what social workers themselves might consider relevant elements in a national framework.

A mixed method approach utilising both qualitative and quantitative research methods was used in the study. A questionnaire containing 18 competency statements comprised of 107 elements was designed and sent through the Aotearoa New Zealand Association of Social Workers (ANZASW) to all social workers who were current financial members and who stated they were employed in the health sector. Open comment sections in the questionnaire allowed participants to express their subjective views about each competency standard. The quantitative data collected was entered into SPSS (Statistical Package for the Social Sciences,
version 16) for statistical analysis. Thematic coding was used to analyse the qualitative (subjective) responses.

The results showed that on average the participants had 10.3 years of Health Social Worker experience. Just over half were employed in the Mental Health sector. The majority held a qualification that would be recognised by the New Zealand Social Work Registration Board. The results also showed that while there were significant differences between groups of social workers with different demographic characteristics in 39 of the 107 elements, differences were still within the “agreed” and “strongly agreed” points on the Likert scale.

A major and important finding of this study is that all participants agreed with the competency statements. This indicates that a single national Health Social Work Competency Framework may be developed and applied to all domains of Health Social Work practice.
PREFACE

The foundation of a social work competency framework is sufficient practice wisdom and professional judgement to effect safe ethical practice. Each social work competency embodies qualities that include personal effectiveness, validation of knowledge, and the appropriate attitudes, values and observable technical skills required to successfully perform the role.

As the Southern District Health Board (Otago) Social Work Professional Director I am responsible for ensuring that social work professional standards are maintained, and that service provision is of a high quality and is delivered effectively and efficiently. While implementing an improved social work service, I developed an interest in what underpins the professional practice standards for social work within the health system.

Simultaneously, the District Health Board (DHB) Social Work Leaders Council started working towards the development of a Health Social Work Competency Framework. A project group within the Council was established to prepare a competency standards document containing the key theories, knowledge and skills required for Health Social Work practice. As such, each competency reflects day-to-day Health Social Work practice. The overall intent was to develop a competency framework that provides clear objective statements regarding social work practice in health.

The development of the Health Social Work Competency Framework has implications for the future of Health Social Work practice. It has the potential to significantly impact on how Health Social Work is defined, how future Health Social Work education is delivered and how Health Social Workers carry out day-to-day practice.
ACKNOWLEDGEMENTS

Writing a thesis is a juxtaposition of solitary activity and collaborative work. I have had the privileged support of wonderful friends, family and colleagues along my journey of writing this thesis.

I thank the participants for their time and honesty, which allowed this research to occur. I also thank my immediate social work colleagues for helping me recognise a need for this research.

I particularly thank my thesis supervisor, Associate Professor Dr Lynne Briggs, Department of Sociology, Gender and Social Work, University of Otago, and acknowledge her advice, assistance, support, encouragement and patience during the long journey from inception to completion of this thesis.

I extend a special thanks to Linda Moir, Children’s Health Service Manager, Southern District Health Board (Otago), for her friendship, support and encouragement throughout the research. The assistance in editing my thesis and valuable feedback has been really appreciated. I would also like to thank Margaret Bowden and Sandi Jull for their editing of the final version of this thesis.

Thank you to Dick Martin for his advice regarding the use of the SPSS programme and statistical analysis of the data.

I also thank past and present members of the District Health Board Social Work Leaders Council for their inspiration, encouragement and feedback on the Competency Framework.

I especially express my gratitude to my sister Tasha who has been my rock as well as providing on-going computer support, proofing and formatting of the thesis. Finally, thanks to the rest of my family and friends who have been supportive and patient while I have completed this thesis.
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CHAPTER 1

INTRODUCTION

Social work has its origins in philanthropy and charity work. At the beginning of the Industrial Revolution, social work as a discipline first appeared in the United States and United Kingdom. This was a time of great social reform and political change. The original role of social workers was to provide assistance to distressed people and resolve social problems created by poverty. Early social workers, known as almoners, had a role related to making decisions around who deserved charitable help and who did not (Young & Ashton, 1956).

In little over a century, social work has evolved from a charity-based profession to one that requires recognised tertiary qualifications. It also has professional associations and a registration board. Although social work practice has undergone many changes over the past century, the core social work values and tasks have remained the same.

Health Social Workers work with patients from all age groups and the most vulnerable members in society. Defining competent and professional practice for Health Social Work is both crucial and essential for accountability. Increased professionalism has brought a corresponding expectation of social workers’ personal and professional accountability in their day-to-day practice. However, what constitutes competent Health Social Work practice in New Zealand has been debated long and hard. The debate has not been concluded to date.

Health Social Workers need to be able to clearly define their role and show evidence of the added value the profession brings to health. Increased visibility will allow Health Social Workers to demonstrate the appropriateness of their work with clients (Davies, Baldry, Milosevic, & Walsh, 2004). A competency framework would ensure that Health Social Work practice is quantifiable, definable and therefore accountable.

The membership of the DHB Social Work Leaders Council consists of District Health Board (DHB) social work professional leaders and social workers with operational responsibilities for social workers. During the 2005 annual DHB Social Work Leaders Council meeting, agreement was reached to develop a national competency framework for Health Social Workers. Subsequent to the meeting, the project groups had worked to develop a national Health Social Work Competency Framework. This thesis will make a major contribution to their efforts in further developing that Framework.
Structure of the thesis

This thesis contains nine chapters in total. This first chapter has introduced the concept of a national Health Social Work Competency Framework.

Chapter two discusses the challenges that define social work within the health sector. It explores the conceptual and operational definitions of social work. A conceptual definition of social work relates to the theory of social work at the interface between clients and their individual social environments. Conceptual definitions inform operational definitions. Operational definitions relate to day-to-day social work practice. One early description of Health Social Work was the identification of the relevant social factors that impact on a patient’s health, and addressing these factors by assisting people to deal with their medical needs (Gehlert, 2006). Developing a Health Social Work Competency Framework will also establish a definition of Health Social Work.

Chapter three explores why Health Social Workers need a competency framework. Although Health Social Workers are an integral part of the health system, they need to demonstrate the value they add to services in a climate of resource constraint with a constant drive for efficiency and effectiveness within shrinking budgets.

Health Social Workers often have to work with incomplete information and make decisions on the run that affect clients’ lives. Such work requires Health Social Workers to be skilled, have a sound knowledge base and be comfortable working with uncertainty. It is important that Health Social Workers demonstrate competency and accountability within their roles. Having an evidence-based competency framework will allow Health Social Workers to demonstrate accountability and the value they add to the health system.

Chapter four explores the theories that inform the development of a Health Social Work Competence Framework; how the theories and models of practice that are used influence a social worker’s worldview. This is an important aspect because understanding social work theories and their relevance to practice is necessary for a thorough understanding of a competency framework.

A competency framework cannot stand alone because it does not give the whole story of social work practice; it needs to be contextualised and related to day-to-day practice. The use of critical theory as a base for the establishment of a competency framework ensures that issues of social justice and human rights are addressed.
Chapter five explores examples of practice standards and competency frameworks currently used in the United States, United Kingdom, Canada, Australia and New Zealand, and the way the common themes contained in these frameworks and standards of practice can be identified.

The increased demands on Health Social Workers to be competent and accountable heighten their need to be clear about their roles and tasks. Currently, there is neither a competency framework nor standards of practice that provides a comprehensive framework for all Health Social Workers. This means that it is up to Health Social Workers as a specific profession in health to develop and embrace a competency framework that determines their professional standards.

Chapter six discusses the use of a mixed methods approach to research. The research design, aims of the research, research questions and hypotheses, design of the questionnaire, participant recruitment and data analysis are also discussed, recognising that each participant’s view of what they consider to be part of a competency framework for Health Social Workers will be individual and influenced by their own experiences.

Chapter seven reports on the research results. It describes the quantified and qualitative data analyses then presents the results of these. The quantitative results provide evidence that a competency framework for Health Social Workers that applies to all health specialities could be developed. Thematic coding of the qualitative data (participants’ comments) identified common themes, the top four of which included time and workload pressures, education, assessment and evaluation.

Chapter eight summarises the findings from Chapter seven and explores the development of a Health Social Work Competency Framework. It explains that the purpose of developing a competency framework is to identify a set of agreed evidence-based standards for safe and effective Health Social Work practice. Relevant information about the profile of Health Social Workers is also discussed in this chapter, which adds to the somewhat limited Health Social Worker demographic information currently available. The summary of results also demonstrates that social workers’ demographic characteristics influenced how much Health Social Workers agreed with the elements of the competency statements. The most common themes are explored further, while the qualitative comments provide richness and value to the quantitative data.
Chapter nine draws on all the information collected and analysed to develop a Health Social Work Competency Framework and suggest a definition for Health Social Work. A Health Social Work Competency Framework cannot be viewed in isolation regarding day-to-day social work practice. It must be applicable in conjunction with social work practice theories and practice wisdom. The new Health Social Work Competency Framework, which establishes the expectations of practice standards for social workers working in specialist areas of health in New Zealand, is outlined in detail. Participants’ comments related to the Competency Framework’s length are also considered along with limitations of the study.

Recommendations related to the implementation of the Health Social Work Competency Framework are discussed, including day-to-day practice, performance reviews, professional development and ‘Readiness to Practice’ programmes for beginning practitioners who will benefit from having the Framework.

Recommendations are made for further research that needs to be undertaken in response to the gaps in knowledge about Health Social Workers and their day-to-day practice this research has identified.
CHAPTER 2

WHAT IS SOCIAL WORK? CONCEPTUAL AND OPERATIONAL DEFINITIONS

The seemingly simple question of “what is social work” is very complex to answer. This chapter explores the conceptual and operational definitions of social work, as well as how the operational definition applies to Health Social Work. Conceptual definitions are based on an understanding of the nature of social work and operational definitions are based on day-to-day practice.

Formal Definition of Social Work

Both the International Federation of Social Work (IFSW) and the American based social work association, National Association of Social Work (NASW) have well-established core statements that define social work practice.

The International Federation of Social Work (2000) definition is:

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

This definition, which, is currently under review, purports that social work occurs at the interface between individuals and their social environment. Expressed in the definition is social work’s mission of empowerment and liberation, and it identifies problem solving as an essential skill (Buzducea, 2010). Implied within the human rights and social justice aspects of the IFSW definition is the concept of social development, which works in a parallel process with social justice and human rights (Nugroho, 2010).

The National Association of Social Work (1984) defines social work as follows:

Clinical social work shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and small groups. Clinical social work practice is the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders. It is based on knowledge of one or more theories of human development within a psychosocial context.

The perspective of person-in-situation is central to clinical social work practice. Clinical social work includes interventions directed to interpersonal interactions, intra-psychic dynamics, and life-support and management issues. Clinical social work services consist of assessment; diagnosis; treatment, including psychotherapy, and counselling; client-centred advocacy;
consultation; and evaluation. The process of clinical social work is undertaken within the objectives of social work and the principles and values contained in the NASW Code of Ethics.

This definition takes into account theories of human behaviour, interpersonal relations, psychosocial development, motivation and social systems. These theories are influenced by the environmental context in which they are used. The goal of social work is to work with individuals, families and communities to enhance and maintain psychosocial functioning and wellbeing (Briggs & Cromie, 2001).

**Conceptual Definition of Social Work**

The conceptual definition of social work reflects two themes: 1) that changes are expected; and 2) that changes should be based on current research. Conceptual definitions of social work are important to guide the formulation of operational definitions. Operational definitions also inform the further development of conceptual definitions. Currently, a conceptual definition of social work is always “work in progress”. Such a definition should be broad and flexible enough to accommodate future social work research findings that are not yet known, and should also be specific enough to assimilate findings from empirical research that has formed the bases of social work practice.

The conceptual definition related to the theory of social work is at the interface between clients and their individual social environments. Expressed in any conceptual definition of social work is its mission of empowerment and liberation (Buzducea, 2010). Social work is about understanding social problems as they relate to the social systems with, and within, which people interact. Social problems are described as obstacles within a society that prevent full participation in that society and lead to social dysfunction.

The conceptual definition of social work can be expressed in a number of different ways, for example by:

- Specialities of practice - Child Protection, Physical Health, Mental Health
- Practice setting - community, school, hospital or criminal justice
- Form of practice - direct practice, supervision, advisory and management
- Characteristics of its client group - children, disability, older people, mental illness or palliative care (Gibelman, 1999).

Practice methods also provide a conceptual description of social work, for example group work, case management and community work. Social work can also be described in terms of
service delivery such as discharge planning, individual and group therapy, protection and prevention work (Gibelman, 1999).

Buzducea (2010) also suggests that the definition of social work changes according to the perspective that is taken. Social work can be described as a science, an art, a profession and a system. As a science, based on empirical research, social work is defined as a set of theories and models of practice; models that are testable, repeatable and evidence-based. Therefore, social work can be defined as undertaking evidence-based social work assessments and interventions to bring about change in individuals, families and communities to reduce social dysfunction (Connolly, 2005; Payne, 2005; Seligson, 2004).

**Social Work as an Art**

As an art, social work is defined as using a combination of professional knowledge, skills, techniques, practice wisdom, life experience and intuition alongside a good understanding of one’s own values and beliefs. Such attributes are required to deliver social work interventions that bring about the changes referred to above.

An important part of the art of social work is the use of “self”. When using self in working with clients, the social worker must have a thorough understanding of their own values, belief systems and attitudes. They need to recognise their own emotions and what brings those emotions into action. They also need to be able to work with the “not knowing”, being uncomfortable and knowing when to take risks. The social worker needs to be technically proficient and at ease so they can access their own creativity (Seligson, 2004).

**Social Work as a Profession**

As a profession, social work is defined by its specialist knowledge, standards of practice, codes of ethics and professional bodies (Taylor & White, 2006). Underpinning social work practice are theories of human behaviour and social systems. Seligson (2004) notes that the art of social work requires a social worker to appropriately use empathy, a sense of humour and creativity as well as being emotionally accessible. An important aspect of the art of social work is knowing when to intervene and knowing when to let go.

Given the wide breadth of practice, social work at times struggles with its own identity as a profession. Its values and priorities focus on human rights, social justice, dignity, integrity, competence and individual worth, with emphasis on the importance of relationships (Gibelman, 1999). Theories that define social work need to be flexible and capable of
explaining the uncertainty; the constantly changing context in the actions of, and interactions between, human beings (Hugman, 2003).

**A Systems Perspective**

From a systems perspective, social work is seen to be part of an interdependent social system consisting of other support systems such as health education, welfare and government. Social work works at the interface of these support systems by developing partnerships for the benefit of the social workers’ client groups (Buzducea, 2010). The complexity increases and social work divides into subspecialities as the systems interact with each other. As more practice subspecialities develop, there is a need to define each speciality and develop an appropriate competence framework with its own set of standards.

As Simpson et al. (2007) note, enhancing the biopsychosocial functioning in individual, family and group functioning in society is a common theme in all social work definitions. In addition, social workers take a “person in situation” perspective. Historically, social work has included interactive discourses, common negotiated solutions, engagement with people and working in morally contentious arenas. Hugman (2003) notes social workers often work on the margins and boundaries of institutions and society. Central to social work are the concepts of “respect for persons” and “social justice”.

Daniels (1989) suggests that defining social work is challenging due to the conflicting ideologies regarding its nature and purpose. It could also be argued that social work is constructed by the context in which it exists, as are the clients and agencies with which social workers work. What social workers do is constructed by society and therefore, to some extent, social workers contribute to the social construction of themselves (Payne, 2005). Thus, defining social work requires examining the factors involved in its social construction.

Whilst it could be argued that some elements are similar across all social work practice, practice is different in various countries and cultural contexts (Payne, 2005). For example, social work in a country where there is subsistence living and less than adequate health care is likely to be practiced differently than social work in an Anglo-Saxon society where the dominant society is likely to be economically rich and have some form of state welfare service. In the New Zealand environment, for example, social work practice occurs within the context of a well-established state welfare system.
**Social Work Theories**

Theories can be described as consisting of shared understandings and knowledge. In turn, theories influence the perceptions of social work (Ife, 1997). The many social factors that underpin social work are based on particular theories. A good example is social construction, which examines the relationships between social workers, clients, organisations, the context in which the practice occurs and the effect they have on each other (Payne, 2005). As Connolly (2005) notes, theories are socially constructed and can look different in different contexts, thus reflecting the contextual environment within which the theories were developed.

Social workers share many theories with other professions. When social workers apply such theories in social work practice, the theories can look different from the original application. Social workers are required to make difficult and complex decisions related to risk and the implementation of interventions. These decisions need to be made with a high degree of professional knowledge and skills, all of which are based on sound research and theories (Proctor, 2002).

The main theories social workers use concern the various explanations of human behaviour. These include Freudian Psychotherapy, Skinner’s Behaviourism, Marx’s Socialism, Empiricism, Feminism, Post-modernism and Social Construction (Ife, 1997). The theories are often interwoven into the service delivery of the agencies and organisations in which social workers practice (Thyer, 2001). Working with human behaviour creates a great deal of uncertainty, making it difficult to develop scientific evidence for social work theories. Social workers are frequently assessing the moral character and worthiness of clients as well as how the person participates in society and conforms to particular roles. Consequently, the challenge is to identify which aspects of an assessment are based on particular scientifically-tested social work theories (Taylor & White, 2006).

Social work requires a competency framework with defined practice standards that considers the relationship between the client and the social worker. The distinctive factor that separates social work from other helping professions is its specialist body of knowledge. While caring is an important element of social work, it is not sufficient for professional social work practice. If caring were enough, there would be little to distinguish the social worker-client relationship from the client’s relationship with family and friends (Standt, 1997).
Daniels (1989) reinforces the challenges of formalising concepts within social work, describing how social workers often work with incomplete information, and have to be creative, improvise and make decisions instantaneously. It is challenging to define all of this without the additional verification of empirical research (Daniels, 1989).

**Operational Definition of Social Work**

As stated earlier in the conceptual definition section, social work is about understanding social problems as they relate to social systems with, and within, which people interact. Social workers endeavour to examine social problems for the individual, family, community and government to address social dysfunction and support full social participation. This implies that social workers play a role in social development.

Fundamental to social work practice is that intervention occurs with the most vulnerable and socially disadvantaged in society. Buzducea (2010) states that social work is concerned with the interaction between individuals and their social environment. Social work practice in areas of social development takes the form of poverty reduction, housing programmes and the promotion of social inclusion. Although the social environment is constantly and rapidly changing, the needs of the vulnerable and disadvantaged remain the same.

As noted earlier, social work is different in different countries and is influenced by both the government controls and culture in a society. Governments can heavily influence social work, for example in the Chinese context social work is about supporting social harmony and providing assistance to the government to control society. China recognises the altruism-orientation of the social work profession and places emphasis on the importance of social conformity and harmony. The core values of social work—empowering individuals, families, groups, organisations and communities to help themselves—remain constant. Defined this way, the social work role is more one of gatekeeper of social resources, which seeks to address social problems and reduce social dysfunction (Yong-Xiang, Li-Ya, & Mei, 2010).

Nikku (2010) argues that the social work profession in China has not been able to develop evidence-based practice because of China’s reliance on government endorsement. Furthermore, the IFSW definition is seen as a romantic view of social work that does not define clearly enough what it can or cannot deliver. Nor does it make any reference to a code of practice or ethical standards.
Application of the Operational Definition to Health Social Work

Health social workers have been working in hospitals for well over a hundred years. Early health social workers were known as medical social workers and their practice was grounded in British and American philanthropy and charitable aid traditions, which were influenced by Victorian Poor Laws. These early social workers were responsible for ensuring the ‘deserving poor’ received the right assistance based on the underlying values of self-reliance and benevolence toward the ‘deserving poor’ (Schofield, 2001). During the early years of medical social work there were various attempts to describe their role. In 1912 an early description of social work was as an expert in diagnosis and treatment of character in difficulties (Gehlert, 2006). In 1928 medical social workers were described as:

- Obtaining information in order to understand the general health issues of a patient
- Interpreting the medical jargon for patients, families and community agencies
- Obtaining relief for patients and their families (Gehlert, 2006).

Early American social work authors identified medical social work as a specialist form of social work that concerned itself with the relationship between illness and social adjustment. Social work tasks were to address the social factors that impacted on health (Gehlert, 2006).

These descriptions remain as relevant today as they were in the early 1900s. Patients were seen as part of a family and community that could be altered by ill health. As Gehlert (2006) argues, there is a need for the social work profession to be actively engaged in sound research and evidence-based practice.

Staniforth and Beddoe (2010) report that in 1943 the New Zealand Council for Education and Research defined social work as helping individuals to help themselves and to adjust to their environment in socially acceptable ways. This could be achieved through both casework and group work.

By late 1930s, as the need for almoner services decreased in New Zealand, medical social work began to emerge. In 1939, Auckland Hospital Board appointed the first medical social worker. This person worked with the District Nursing Service until the 1960s. During this time, the main tasks of medical social work included arranging patient discharges, benefit payments and domestic assistance (Schofield, 2001).

By 1971, medical social workers were also registered nurses responsible for investigating the patient’s “home condition”. Since then, social work within the health sector has diversified...
into various specialist services such as Mental Health, medical, child and family services, and healthcare of the elderly. Over time, the term “medical social worker” became “Health Social Worker” (Staniforth & Beddoe, 2010).

In 1950, the School of Social Science at the Victoria University College, Wellington, offered the first professional social work qualification in New Zealand: a Diploma in Social Science. Approximately twenty students graduated annually and in the late 1970s other universities began to offer courses for formal social work qualifications.

Nash (2001) reports that in 1975, the University of Canterbury started to offer a postgraduate professional social work qualification. The Auckland College of Education followed quickly and in 1976 Massey University offered the first Bachelor of Social Work degree. By the 1980s, it had become easier to gain a social work qualification through tertiary institutions. Nash (2001) also states social work education and qualifications have been essential components in the development of social work as a profession.

**Conclusion**

This chapter has reviewed conceptual and operational definitions of Health Social Work and found that currently Health Social Workers operate under the IFSW definition of social work. At this stage, there is no specific core conceptual or operational definition for social work practice in health. Although attempts were made at the beginning of the twentieth century to define Health Social Work as an entity in its own right, the intent of that definition was about addressing the social factors that impact on the health of individuals, families and communities. This same definition remains relevant and consistent for Health Social Work today.

Any future definition developed for Health Social Work needs to account more fully for theories and models that apply to working in the health sector as well as incorporating the core values of social work. In the following chapter, both the conceptual and operational definitions are explored further through an examination of the development of a Health Social Work Competency Framework.
CHAPTER 3

DEVELOPING A COMPETENCY FRAMEWORK FOR HEALTH SOCIAL WORKERS

This chapter explores the need for Health Social Workers to have clearly-identified practice standards and a competency framework. The current literature and research related to social work practice standards and competency frameworks are discussed. The aim is to identify possible competency elements that could be embraced to develop a national competency framework for Health Social Workers.

While the New Zealand health sector is one of the largest social work employers, its social workers are a minority among other health professions. Compared with nursing, they generally enjoy a high degree of autonomy, and until relatively recently Health Social Workers could decide how they rationed their time and work methods (McDonald, Harris, & Wintersteen, 2003). Increasingly, the health sector demands that all professionals are competent and accountable. Therefore, Health Social Workers are required to be very clear and specific about their role and tasks.

Davie, Baldry, Milosevic and Walsh (2004) argue that it is important for Health Social Workers to provide evidence of their practice and how they validate social work interventions that support clients. Health Social Workers also need to demonstrate cost-effective benefits for the health sector arising from their employment. They must identify and demonstrate what competent social work practice is within the health sector in order to evidence their added value to the sector and achieve professional accountability.

Health Social Workers are an integral part of clinical multidisciplinary teams. They work in a variety of health specialities and subspecialities with clients from varied demographics; individuals, families and consumer groups with a broad spectrum of health issues. Specialities include Physical Health, Mental Health, Alcohol and Drug services, Disability, Rehabilitation, Older People’s Health, Women’s Health, and Child and Family Health. Subspecialities include Palliative Care, Child Disability and Pregnancy Counselling (Daniels, 1989).

The constantly evolving New Zealand health system environment means the nature of hospital social work has changed. Changes and advances in health care have led to clients with chronic illnesses tending to live longer and move through the health system at a faster
pace (Berger, et al., 1996). This has resulted in fewer opportunities for Health Social Workers to spend significant time with clients or to undertake full social work assessments to facilitate planned interventions. A considerable amount of a Health Social Worker’s time is spent assisting clients and their families to make arrangements for recuperation at home or arranging placements in alternative care (Gehlert, 2006).

What is Competence in Health Social Work?
Demand for social work services has increased as the health system comes under increasing pressure from government and clients to improve efficiency (cost) and effectiveness (quality) of health service delivery (Daniels, 1989; Short & Rahim, 1995). Thus, Health Social Workers are required to clearly define their role and provide evidence of what value the profession adds to the health sector. Davies, et al. (2004) note how vital it is for Health Social Workers to increase their visibility, and to prove their worth and the appropriateness of their work with clients within the health system. The increased pressure, both internally and externally, to provide such evidence has identified an urgent need to establish a competency framework for Health Social Workers. Such a framework would ensure that practice is quantifiable and definable, and therefore accountable.

The increased requirement for accountability is driven by a number of sources, including professional associations’ Codes of Ethics, Registration Boards’ Codes of Conduct, organisational internal policies, government legislative and regulatory requirements, and client expectations (Osman & Shueman, 1988). Activities related to accountability include being able to clearly articulate Health Social Work processes. This involves describing intervention goals and plans, with evaluation methods supporting obtainable outcome measures. Health Social Workers are obligated to demonstrate logical reasoning for assessing and intervening in a client’s life, supported by critical self-reflective practice. They also need to articulate and evidence their work in clinical files and client clinical records (Osman & Shueman, 1988).

Prior to 1990, accountability was associated with effective use of time and resources. It involved throughput and productivity. In the 1990s, accountability meant outcome measures and results (Ell, 1996). In the current (2011) health setting, accountability has evolved to mean measurable, achievable outcomes with the effective and efficient use of available resources. This type of accountability does not fit easily with the Health Social Work paradigm of care. Outcomes are not necessarily an indicator of how well formulated an intervention is or whether it is supported by evidence-based practice. This is argued strongly
by Harkness and Mulinski (1988) when they suggest that measuring the quality of a social work intervention outcome is difficult because the outcome may not be an appropriate indicator of the social worker’s performance or the quality of the social work process. In social work, the intervention process is equally as important as the outcome, particularly when some social work interventions involve sensitive use of time and space. This type of intervention is difficult to define and categorise (Standt, 1997).

Thus, the challenge for the social work profession is to assess the quality of the social work process purely in objective terms. However, subjective elements, which include individual attitudes and personal style as well as dedication and initiative, are just as important as the objective elements within the social work process. Hoge, et al. (2005) suggest that reliance on an interrelated system of values, beliefs, models and theories in social work makes it a unique profession. Values and beliefs are subjective and intangible, making them challenging to define in practice, whereas models and theories are objective and definable, and therefore measurable as an outcome.

Discussions about defining social work practice standards and competency within social work are a relatively recent development (Hoge, et al., 2005). Whether social work practice standards should be defined at all is a question that has been asked. Internationally, professional associations of social workers and social work registration boards provide standards and guidelines, all of which reflect the knowledge, skills and judgements required for safe ethical practice. These standards and guidelines are in various forms such as codes of ethics, codes of conduct, standards of practice and core competencies. As such, these standards and guidelines express the essential elements of responsibilities or competencies required of social workers, and form the foundation for a social work practice framework (Verma, et al., 2009).

In general, competencies within social work can be defined as having sufficient knowledge and skill to perform the social work role effectively and efficiently. Competence can be determined by quality of service, training, education and practice assessment; it is the ability to perform the professional tasks and responsibilities that are defined within social work scopes of practice (Daniels, 1989). Competent practice is also described as a multidimensional and dynamic concept, and refers to having appropriate knowledge and attitudes as well as observable technical skills (Bogo, Power, Regehr, & Globerman, 2002; Verma, et al., 2009); that is, being able to demonstrate the knowledge, appropriate attitudes, values and observable essential technical skills that are required to successfully perform the
social work role (Hogston, 1993; O’Hagan, et al., 2001). As a concept, competent social work practice embodies qualities related to personal effectiveness.

Any social work competency framework needs to reflect the holistic nature of the profession (O'Hagan, 1996). Le Riche (1998) notes that using a competency framework to assess the quality and standards of social work practice is essential to ensure clients are protected from incompetent practice. Whilst assessing social work practice at student level is well embedded in social work education programmes and well established in evidence-based research, assessing experienced social workers’ competencies is the subject of much debate (Daniels, 1989).

A competency framework cannot include an exhaustive list of practice elements because social work practice continually evolves. Also, social workers tend to thrive on ambiguity, uncertainty and complexity, and are likely to resist a competency framework that looks like a cookbook (Silverman, 2008). Any framework needs to be a living document that reflects the connection of social work to context, time and culture. It needs to be a framework that outlines components of desired and ideal social work practice (Basma, et al., 2010). Thus, social work competencies need to reflect best practice while remaining flexible enough for application in different settings. As such, they define effective performance and state of practice fitness (Daniels, 1989).

**Why is a Competency Framework Needed for Health Social Workers?**

As mentioned in the introduction to this chapter, continual changes in the health sector environment are reflected in the challenging demands on Health Social Workers. Health system advances have, in general, resulted in today’s clients tending to be more acutely unwell while hospital stays have become shorter. This in turn has reduced the client contact time during which Health Social Workers complete assessments and implement well-planned interventions. Social work, currently a minority profession within the overall health sector, with the main focus being on the client in their context rather than the client’s illness (Verma, et al., 2009), is in a transition phase as it moves to a regulated profession.

The autonomy that social workers experience comes from their ability to define the client’s psychosocial concerns and to allocate them priority. Social workers have the ability to choose how they work with clients and how they ration their time with clients as well as undertaking other related activities (McDonald, et al., 2003). In contrast to this autonomy, without a clearly-defined competency framework, social workers are susceptible to pressure to have
their practice defined by other health professionals (Abramson, 1993). Health Social Workers often feel invisible and vulnerable, especially as other professionals at times profess to undertake the social work role. Carpenter, Schneider, Brandon and Wooff (2003) note that a blurring of roles with other health professionals can occur due to a perception of social workers’ marginal position within multidisciplinary and interdisciplinary teams. Social workers also experience challenges within health teams due to approaching a client’s situation from a different paradigm (Carpenter, et al., 2003). Thus, social workers constantly feel the need to legitimise their existence within the health sector, especially in nurse- and doctor-dominated teams (Hoge, et al., 2005). The development of a Practice Framework, Registration and Annual Practice Certificate can certainly assist the Health Social Worker in this endeavour.

A clash of values and beliefs occurs between medical approaches and the social work approach, and social workers tend to resist the dominant hierarchy models that exist in the health sector (Carpenter & Barnes, 2001). When the power and status differences between social workers and other members of multidisciplinary teams are overcome, there is great potential to enhance client quality of care (Briggs & Cromie, 2001).

Social workers’ relatively low status compared with medical professionals, in conjunction with the lack of specific health training in their first professional qualifications, has a significant impact on social workers. The key to enhancing social workers’ status within multidisciplinary teams is for them to clearly understand their role. This includes an emphasis on evidence-based practice as well as social work skills, including collaboration, coordination and ensuring the client’s perspective is heard within the team. However, many social workers lack the confidence to challenge established models and other paradigms of care within the health sector (Briggs & Cromie, 2001).

Basma, et al. (2010) report that social workers need to articulate their role and demonstrate their competence as health professionals. It is important that Health Social Workers can coherently identify their competencies to advance the profession within the health sector because doing so better positions them to advance as health professionals. A competency framework can assist with this and, as Basma, et al. (2010) note, can also inform professional development for social workers in practice. Furthermore, having a competency framework raises the social workers’ awareness of barriers to effective practice and provides a path to address those barriers (Standt, 1997).
Basma, et al. (2010) also claim that a competency framework can be used to facilitate consistent practice guidelines. It can make evaluation of practice possible and needs to be relevant across all health-related specialities, locations and populations. However, Standt (1997) reports that evaluation of social work practice is a source of debate within the profession because particular complex situations that social workers face in day-to-day practice may not be conducive to evaluation.

A clear competency framework can provide a basis for practice standard audits and other outcome measures, one of which is the intervention plan. However, circumstances beyond the social workers’ and their clients’ control can influence the intervention plan so that outcomes may not truly measure how well the plan has been formulated. Furthermore, objective measures of outcomes often cannot measure intangible social worker attributes such as personal style, dedication, initiation and attitudes, all of which Harkness (1988) notes are important in the social work process.

It is critical to have a competency framework that accounts for all social work activities. Many textbooks and journal articles about social work practice give the impression that the majority of Health Social Work involves direct contact with clients and their families to undertake assessments and counselling. Many courses place emphasis on the skills associated with direct social work with clients (Johnson, 1999). There is limited research about direct and indirect social work, which suggests an inaccurate portrayal of day-to-day practice. Johnson (1999) suggests there is a belief that once students master direct social work practices, other skills, including indirect social work, will follow.

As Basma, et al. (2010) argue, information from a competency framework would be helpful to articulate both direct and indirect Health Social Work activities. Identification of the exclusive jurisdiction of Health Social Work, and defining the domains and elements of a competency framework, would protect the profession from encroachment by other health professionals (Roach, 1992). When it is clear what is exclusive to the Health Social Workers’ jurisdiction, the challenge is to examine where blurring of boundaries with other health professions would be acceptable; where boundary merging exists, there could be an opportunity to improve holistic care.

Roach (1992) notes that a competency Health Social Workers’ framework would strengthen their professional position and therefore increase legitimacy within health systems. Casual observers may not understand the Health Social Worker role. They may interpret the Health
Social Workers’ work as being straightforward and not needing specialised training. Such observations have led to other professionals claiming to do social work. What other health professionals often miss in their casual observations are the complexities of service delivery grounded in humanitarian values (Healy, 2002). Until there is a clearly-articulated competency framework, Health Social Workers will continue to risk encroachment and competition for tasks (Roach, 1992).

Silverman (2008) suggests that the health system is not a natural ecosystem for social workers. However, as hospital stays for clients become shorter and more convalescence occurs in the community, there is an increased need for Health Social Workers to ensure that clients are discharged with appropriate supports. The role of the Health Social Worker is highlighted as services in the community struggle to provide resources in a financially-pressured and resource-constrained environment. Silverman (2008) describes the current situation for Health Social Workers as assimilating into the health system and achieving organisational goals using talent, skills and a knowledge base that are part of the social work identity.

**Possible Elements for a Health Social Work Competency Framework**

There is a need to define what Health Social Workers actually do in practice to truly understand what constitutes a Health Social Work Competency Framework. Indirect client-related social work makes up between 75 and 80 percent of social workers’ work. Johnson (1999) argues that indirect social work is where the social worker works within the client’s environment and social networks. Furthermore, as Johnson’s (1999) research into social work day-to-day practice has established, social workers spend between 20 and 25 percent of their time undertaking direct work with clients.

Johnson (1999) categorised three ways in which social workers work with the client’s environment and social networks:

- Facilitating resources and supports that exist in a client’s environment that would benefit the client
- Working with the client’s social relationships to facilitate the use of resources and support
- Collaborating with other professionals and working together to access appropriate resources and interventions.
Cavet (2000) and Powell (2002) describe the role of Health Social Work as being to reduce barriers brought about by economic and cultural systems, which can result in exploitation of the most vulnerable people in society. Health Social Workers have a responsibility to actively work to support the exploited and marginalised, and ensure health services are aware of, and responsive to their needs.

Daniels (1989) notes that social workers assist clients to reduce dependency on services and become self-sufficient. More specifically, the social work role within health is to assist with the personal and social effects of illness and disabilities. The tasks of Health Social Workers have been reported as:

- Undertaking assessment of clients’ and their families’ needs
- Assisting clients and their families to find and utilise resources and services in the community
- Providing counselling and therapeutic interventions with clients’ families and groups
- Assisting with re-admission and discharge planning
- Facilitating practical services, for example income assistance, domestic assistance and housing assistance
- Health education including parenting groups, stress management, drug and alcohol.

Daniels (1989) also reports that Health Social Workers are involved in activities that relate to clients indirectly. These activities include developing resources within the community such as self-help initiatives, support groups, and formal and informal community support networks. Simpson, Williams, and Segall (2007) note other activities social workers engage in that relate to clients indirectly, including supervision, teaching, research, evaluation of practice, policy formulation, program planning and general administration. Harly, Donnell and Rainey (2003) suggest that the central elements of social work are identifying strengths within individuals and their environments. Social work’s basic value is promoting individuals’ and communities’ capabilities to enhance independence and promote full participation in their environment.

Thompson (2010) reported that the recurring themes within social work practice definitions include the importance of understanding social work clients—individuals, families and groups —and their functioning in the wider society. An additional common theme is to enhance the clients’ psychosocial functioning. Thompson (2010) further emphasises the importance of defining social work practice in terms of social functioning at personal, cultural and structural
levels, and understanding a person in their social context. Any competency framework for Health Social Work needs to take into account these common social work practice themes.

Simpson, et al. (2007) suggest that the use of the relationship between client and social worker as a tool in its own right is what distinguishes social workers from other health professionals. This relationship is about assisting the client to understand their own subjective realities and respond to their own internal struggles in an empowering way. The end goal would be for the client to enhance their internal strengths and access external resources for improving their health and wellbeing (Simpson, et al., 2007). One of the challenges in developing a competency framework is to identify the elements of competency that express the care values of Health Social Work.

McCormack (2008) investigated the social work tasks and skills required to work with older people and reported that the most time-consuming work involved addressing client anxiety and depression. Social workers provide support for clients and their families related to grief and loss as a result of major life changes. The most frequent tasks in McCormack’s study were organising and facilitating case conferences and family meetings, psychosocial assessment, advocating and administrative services-related tasks.

McCormack (2008) reports that communication, creative problem-solving and mediation are essential social worker skills, as are social work assessments, discharge planning and coordination. Counselling is also considered an essential client-related skill. However, this work is undertaken as part of the process towards discharge rather than ongoing individual therapy.

Beresford’s (2007) research into clients’ perception of social work found that the most important aspect of social work is the supportive role. This relates to the social worker’s role in negotiating complex social systems, helping clients cope with life changes and problem solving. Beresford (2007) also notes that from a clients’ perspective, they value social input related to:

- Advocacy and advice
- Negotiation with social service providers such as for financial assistance, housing and other assistance
- Counselling and other therapeutic support
- Problem solving
- Referring to appropriate services.
Social workers are also seen as agents of social control; they can be gatekeepers to funding and are associated with enhancing client compliance with social norms Beresford (2007). This is reinforced by legislation such as Children, Young People and their Families Act 1989 and Protection of Person and Property Rights Act 1988 in the New Zealand setting. This extends to social workers having the power to influence restrictions of people’s rights and freedom, and is usually linked with social work practice in the areas of Child Protection, Mental Health, Justice and Older People’s Health. The control of rights within the Mental Health and Older People’s Health areas is associated with restricting a person’s right to safeguard against harm to themselves or others. When developing a competency framework, the control aspect of social work practice needs to be acknowledged and be part of the framework.

Conclusion
Health Social Work is ideological in nature and based as much on values and beliefs as on theoretical knowledge (Daniels, 1989). Health Social Workers need to be skilled and have a sound knowledge base because they often deal with incomplete information and have to make instantaneous decisions on the run that affect clients’ lives. The very nature of social work makes it extremely difficult to identify the content of a competency framework. The realities of social workers’ practice make it difficult to determine the concrete concepts that apply to the social work process. Therefore, the ideological and abstract nature of social work leading to accountability issues needs to be further questioned and challenged.

Whilst social work is an integral part of the health sector, it is often a misunderstood health profession. A lot of what Health Social Workers do is based on difficult-to-define abstract concepts. The lack of clarity makes it challenging to introduce any system of accountability or to determine competence. This is not to say it cannot be done. In the present health climate of constant change, there is an increased need for Health Social Workers to demonstrate competency and accountability within their roles. A sound, evidence-based, well-researched Health Social Work Competency Framework would position Health Social Workers to clearly articulate and demonstrate how and why they practice the way they do.

Since the 1990s, international social work associations and social work registration boards have developed various generic social work competency frameworks and practice standards. Since 2000, social work groups working in specialist areas of practice have developed standards of practice and competency frameworks related to these specialist areas, examples
of which include Mental Health and Palliative Care social work. Specific competency frameworks are discussed further in chapter five.

The next chapter examines the theoretical underpinnings of competency frameworks. Understanding these theories is necessary to contextualise day-to-day social work practice.
CHAPTER 4
THEORETICAL UNDERPINNINGS – DEVELOPING A SOCIAL WORK
COMPETENCY FRAMEWORK IN HEALTH

This chapter considers the social work theories that underpin competent practice. It is important to understand how each theory influences day-to-day practice in order to establish a competency framework for Health Social Workers. Each theoretical position social workers take informs their practice and influences their worldviews. In turn, social workers’ worldviews influence theories and practice. Social work practice in health and its relationships to theories, in particular the influence of critical reflective social work practice theory, are explored further. The need for a social work competency framework is explored from a critical social work practice theory perspective.

Why Social Work Theory?
It is necessary for social workers to understand social work theories, including their origins, challenges and relationship to day-to-day social work practice if they are to be competent social work practitioners. Like other areas of practice, social work in health involves working with uncertainty and unpredictability. Thus, social work itself is influenced by context and values.

As a profession, social work has its own specific skills, knowledge and theories, which makes it different from other helping professions. However, while caring for clients is one important element of social work, it does not define the professional social worker-client relationship. If caring were enough, there would be little to distinguish the social work relationship from the client’s relationship with family and friends (Standt, 1997).

Theory provides a “framework of understanding” that offers an explanation for specific phenomena. Social work theory attempts to provide an explanation of the nature of social work from multiple perspectives (Oko, 2006). It is assumed that social work theory underlies all competent social work practice and it is this aspect that sets the profession of social work apart from other forms of helping.

It is paramount to the social work profession that clinical decisions are based on theories rather than anecdotal personal experience of trial and error. A theoretical framework provides a structure that organises very complex data about a society in which inherent structural inequalities and conflicting ideologies are evident (Boisen & Syers, 2004; Oko, 2006). As
Payne (2005) argues, social work theories ideally represent shared knowledge and understanding that account for the complex nature of the work. Without a theoretical understanding of individual social work decision-making and interventions, social workers are merely technicians undertaking interventions in a mechanical way. As Gehlert (2006) also argues, competent social workers use a combination of theories and skills to deliver successful social work interventions.

Social work theories have traditionally been positioned within social sciences. This in itself is problematic due to limited consensus of what social work is, and how it is placed in political and ideological origins (Tanner, 1998). Debate continues about the relevance of social work theories at the coalface of day-to-day practice. Tanner (1998) suggests that social work practice is determined by the agency context as much as its theoretical underpinnings.

Payne (2005) argues that social work theories must be developed within social work practice contexts. Payne (2005), in light of the argument that within a scientific research framework theories do more than describe a situation because they explain provable events, also reports that debate exists about the level of testable empirical evidence needed to formalise a theory. Formal theory requires documented evidence and needs to be debated within an academic arena as well as in the practice environment. Without this debate, theories remain informal, often based purely on practical experience and anecdotal evidence. Yet there is debate about the need to base social work theory on empirical research using scientific methodology because social work theory needs to account for social movement, which includes changes in political, cultural and social constructs. Theories used by social workers need to be relevant to the practice setting, to be suitable for day-to-day practice, have the ability to be applied to specific circumstances and at the same time be able to respond to new and complex situations (Payne, 2005).

Theories are expressed in different ways for different social workers due to the complex social and political contexts within which social workers carry out their day-to-day practice (Connolly, 2005). Each practice decision a social worker makes needs to be justified in terms of theories, models and best practice guidelines (Daniels, 1989).

Payne (2005) suggests there are three groups of social work theories, each with a different focus, as below:

1. Defines the features and functions of social work. In other words, theories in this group describe what social work is about, for example:
• Marxist theories, Feminist theories, Critical Social theories and Reflective theory.

2. Describes how social work is practiced. This group includes:
• Psychodynamic theories, Task-Centred theories, Cognitive-Behavioural theories and Role theories (Payne, 2005).

3. Describes the clients’ worlds. This group includes:
• Communication theory, Narrative theory and Contemporary Hermeneutic theory (Anderson, Burney, & Levin, 1999).

The remaining part of this chapter will focus on the theories that defines the features and functions of social work listed above, as well as Kaupapa Māori theory. Kaupapa Māori theory provides a framework of practice based within New Zealand society.

**Marxist Theories**

Marxist theories describe clients’ situations and problems as structural and societal as opposed to individual. Therefore, client situations could be described as a result of a capitalist society. The inequality and injustice that exist in society are a result of oppression within a class system. As mentioned previously, social justice is one of the principles that overarch the definition of social work practice. It is only through political action that change can be implemented. Capitalist society is unable to respond; therefore, broad social and political change is needed (Payne, 2005).

Using Marxist theories, Payne (2005) identifies three distinct social work positions:

1. “Progressive”, which defines social work as a change agent. Social workers are central to facilitating change by encouraging collective social action among the working class, disenfranchised and marginalised people in society.

2. “Reproductive”, which defines social work as an agent of class control. Social workers contribute to the oppression of the working class, disenfranchised and marginalised. The social worker’s role involves reproducing the ideals of capitalist societies and controlling access to resources.

3. “Contradictory”, where social workers work with both capitalist control and with the disenfranchised and marginalised members of the capitalist society, also known as the working class.

The social workers’ role is to increase the capacity of the disenfranchised and marginalised people to participate in capitalist society. It is anticipated that people eventually cause the
breakdown of the capitalist society by increasing the capacity of the disenfranchised and marginalised (Payne, 2005).

Yull (2005) reports that Marx argued that in order for capitalist society to exist it would have to have disenfranchised and marginalised members. Marx suggests that these are the people who should overthrow those in power. Marxist theories were popular with social work training in the 1970s and early 1980s, but during the 1990s popular theories such as Post-modernism and Post-structuralism strongly rejected the concept of totality, which is central to Marxism. Today, there is a place for Marxist ideas within the current health structures (with a focus on budgets and risk management) (Ferguson, 2003).

Marxism provides a clear explanation of power relationships. In health organisations, the increased focus on budget constraints and increase in service demands can marginalise patients’ needs. Health professionals, including Health Social Workers, have less professional discretion and are subject to increased bureaucratic control. Budget constraints and increased service demands increase the barriers for both Health Social Workers and their clients (Ferguson, 2003).

According to Ferguson (2003), social workers need to organise themselves and their clients into groups within their organisation or community to collectively problem solve and achieve the best utilisation of scarce resources. Social workers, by organising groups for social action, can return social work to its foundations. Social action plays an important role in improving people’s circumstances. However challenging social action is to achieve in the current society, it is important for social workers to lead the promotion and protection of social justice, and continue to critique the current social structures and articulate alternatives (Ferguson, 2003; Ife, 1997).

**Feminist Theory**

Social work continues to be a voice for the oppressed, disenfranchised and marginalised to be heard by the dominant and powerful members of society. This can be challenging when social work, like other helping professions, is devalued. According to Feminist theory, the helping professions, along with other “caring activities”, will remain marginalised as long as the dominant rhetoric is entrenched in sexist values and attitudes (Goldenberg & Goldenberg, 1999).

According to Parton, et al. (2000), feminists see caring as central to human existence; it is not just the concern of women. Every human gives and receives care at different stages of their
life. When receiving care, one becomes very aware of how vulnerable one is as a human being. This is particularly so within the health care setting.

Feminist theory has implications for Health Social Workers and their clients’ experiences of social work services. Social workers have a responsibility to bring caring back into an impersonal-, masculine-, gendered-bureaucracy dominated health system. Parton, et al. (2000) argue that as long as there is an expectation that correct professional behaviour involves being detached and treating the illness or injury rather than being concerned with clients’ private issues, the dominant health professions will be seen as uncaring. Bureaucratic organisations, such as hospitals, have a distinct way of carrying out their purposes consistently and without favouritism. However, in doing so the bureaucracy fails to recognise the holistic helping and caring professions (Parton & O'Byrne, 2000).

The Feminist approach consistently challenges bureaucratic models’ underlying values of formal objectivity and impersonal detachment, and their focus on outcomes and key performance indicators. It suggests that social workers working with clients of such organisations cannot ignore the gender issues. In most social services and health care organisations, the majority of employees are women, as reflected in the client groups of the social work services (Jones & May, 1992).

The feminist approach places emphasis on personal and interpersonal relationships between social workers and their clients. Although these approaches are not managerial models, there are commonalities with organisational models, for example the Neo Marxist view. Feminist approaches emphasise the importance of relationships and making them mutually beneficial through collective decision-making. At the same time they reject the market forces perspective that stresses self-interest transactions (Jones & May, 1992).

Feminist approaches attempt to link theory with practice by personalising actions and connecting them to organisational issues. They also emphasise the power relationships between genders. In health organisational terms, this is between male-dominated management and female employees. Many of the themes that exist in Marxist and Feminist models and perspectives also exist in indigenous models (Jones & May, 1992).

**Kaupapa Māori Theory**

Kaupapa Māori theory provides a framework based within New Zealand society and contexts that explains the ever-developing knowledge and interpretation of the negative effects of colonisation. The theory explains where Māori are placed and how they function within a
Pakeha-dominated society. Such explanations relate to social work discourses not only of why situations exist but also how to address them (Hollis, 2005).

There are three components to Kaupapa Māori theory:

1. Consciousness raising.
2. Resistance.
3. Practice.

Consciousness raising involves the deconstruction of colonisation. It seeks explanations of the effects of Pakeha social, economic and political dominance, and includes all aspects of culture, such as how gender roles and traditions are viewed (Hollis, 2005).

As Durie (1985) suggests, Pakeha (non-Māori) and Māori worldviews are different; they affect the way both cultures think about theories. Analytical testing of ideas and theory originated from Western or Pakeha scientific methods. It is the analytical Western thinking of breaking down concepts into components that is the major difference between Western health concepts and the Māori concept of holistic health. Māori Kaupapa theory is less concerned with breaking concepts into smaller and smaller components, and more concerned about the wider systems and placing context around concepts. In doing so, it looks at the inter-related phenomena of ideas along spiritual and physical dimensions of an individual, whānau and Iwi.

Over the past few decades these concepts within Māori social structures have influenced how social work is defined within the New Zealand context. Māori traditions of social care are embedded in the social structures of iwi, hapu and whānau. One of the central concepts within these social structures is the Te Whare Tapā Wha model, which has four dimension, te taha wairua (spiritual), te taha tinana (physical), te taha hinengaro (emotional) and te taha whānau (family) (Durie, 1985).

Hollis (2005) suggests that Kaupapa Māori theory can apply to many aspects of Māori society, including social services and the health sector. It helps explain the poor outcomes for Māori and suggests ways of improving these. Durie (1985) argues that greater awareness of Māori values and understanding of a Māori worldview could improve outcomes for Māori in general.

When examining any theory associated with social work in the New Zealand context, it is paramount that Māori values and traditions are acknowledged. Hollis (2005) argues that
Kaupapa Māori theory and critical theory are in line with each other, with both theories focusing on power relationships and legitimate knowledge (Fook, 2002; Hollis, 2005).

**Social Learning Theory**

Social Learning Theory is about learning from experiences and perceptions, or insights and through observation (Leh, Waldspurger Robb, & Albin, 2004; Payne, 2005). Learning takes place when learners make an observation and change their behaviour or attitude as a result of that observation. The concept of competence is linked to social learning theory; that is, how successfully an individual performs tasks is dependent on what they have learnt through practice (Holden, Cuzzi, Spitzer, & Rutter, 1997).

Social work practice requires the ability to continue to integrate new knowledge and seek continuous improvement. Social learning theory is valuable as a practice theory as well as explaining how practice is developed. It is an important theory when analysing how social workers learn to problem-solve and learn from their practice experiences; how social workers develop practice wisdom (Petrovich, 2004). Incidental learning (informal learning), the dominant means of adult learning, enables social workers to role model skills and techniques in problem solving and empowerment. Petrovich (2004) identifies four ways in which informal learning occurs:

1. Vicarious experiences, through observing others.
2. Enactive mastery through successful practice.
3. Verbal persuasion through receiving encouragement and support from others.
4. Trial and error.

Day-to-day social work practice requires the ability to integrate theories with practice wisdom and evidence-based practice. If improvements in practice happen despite challenging situations, the social worker’s sense of competency improves (Petrovich, 2004). This is because internal feelings of competency come from an individuals’ subjective interpretation of their everyday experiences.

The concept of competence is central to theories of learning. Competence is related to self-efficacy and constructs how confident a person is to successfully perform required tasks (Holden, et al., 1997). The way individuals gain competency over time influences the perception of their mastery of skills. If individuals continue to make ongoing improvements despite occasional setbacks, they are likely to be confident about their level of competency (Petrovich, 2004). When competency levels decline over a period of time, it is most likely
due to individuals not having an adequate learning environment or not making an ongoing effort to maintain competency.

As Bandura and Schunk (1981) report, people need to be self-motivated in most adult learning environments. They need to have goal setting skills and the ability to self-evaluate their reactions to situations. Self-motivation also requires personal standards in order to evaluate one’s ongoing performance.

When social workers master a high level of social work skills they have a strong sense of satisfaction. However, as Bandura (1997) claims, social workers have less self-satisfaction when the required skills are perceived as being too lofty and unattainable. Bandura (1997) proposes that learning occurs through observation, imitation and modelling, which are all ways in which new staff learn the social norms of the profession and organisation through socialisation (Weiss, 1978).

Weiss (1978) suggests that socialisation into a profession involves an orientation to the profession’s values. Observational learning during early workplace experiences influences the development of professional values and behaviour. The beginning practitioner is more likely to imitate more experienced professionals who are perceived to be successful and competent. If effective role modelling occurs within the profession, values developed across the profession will have similar characteristics of success and competence.

Weiss (1978) also argues that self-esteem influences the acquisition of professions-related values through role modelling; that is, individuals who are less confident and have low self-esteem are likely to have less trust in their own abilities. They are more likely to imitate others, especially those of a similar status.

Zimmerman (1989) states that self-observation is an important part of social learning theory. Self-judgement, self-reaction and self-evaluation are related to the concept of self-observation. Observing oneself provides individuals with information about their progress towards goals. In order to perform these internal processes, individuals need to have knowledge of social norms and the required performance standards.

When individuals learn to be self-observant, they are able to set realistic goals to obtain realistic performance standards (Zimmerman, 1989). They are then also more able to self-evaluate and make necessary changes to meet performance standards. Cooper and Maidment (2002) report that self-awareness, along with critical reflective skills, is essential for social
workers. It is also necessary that social workers are aware of their own values, beliefs and background, and understand the impact of their interactions with clients.

Weiss (1978) notes that it is during work-based training that role modelling occurs for social work students in regard to self-observation, self-awareness and critical reflection in real life situations. Parker (2004) suggests that work-based learning is central to maintaining competence and an essential component of the continual professional development required to maintain the status quo for a professional. Work-based learning is centred on the concept that learning comes from real life situations and is a shared activity.

Cooper (2000) reports that role modelling within the social work profession is a very important component of social work education. She perceives that students and beginning practitioners alike learn by observing expert practitioners successfully use particular social work skills in complex real life situations. Teaching through role modelling and observation is seen as straightforward whereas teaching students and practitioners to reflect on ‘feelings’ generated by their work experience is challenging (Briggs & Cooper, 2000). However, developing self-awareness and self-observation skills, and being able to critically reflect on the “feeling” and observation is essential to competent practice (Cooper & Maidment, 2002).

**Reflective Practice Theory**

Although competent practice requires social workers to work with evidence-based empirical theories, in reality social workers practice in uncertainty and unpredictability. The bridge between empirical theories and “real world” practice is the Reflective model. This model requires the social worker to use knowledge, trusted practice models and practice wisdom. Although the Reflective model considers the uncertainty and unpredictability of social work practice, it is an imprecise activity (Pray, 1991). The Reflective model needs to be grounded in careful observation in partnership with critically-focused individual internal dialogue and attendance to subsequent feelings.

Reflective practice seeks to account for social workers’ real world practice. It is particularly concerned with how the social workers’ theoretical knowledge, practice wisdom and practice modes interact to inform future practice (Payne, 2005). The process of reflective practice involves a careful analysis of an event. Payne (2005) suggests there is a structure to reflective practice. It starts with describing the event or interaction, then analysing the situation, followed by identifying the implications of the analysis. In reflective practice, the social
worker draws on all available evidence, including theoretical knowledge from a wide range of professions. The social worker’s experience is a legitimate source of evidence (Payne, 2005).

Social workers’ knowledge is an important resource and is worthy of close examination. Reflexivity, which is about identifying influences on practice knowledge acquisition and the assumptions that underpin that knowledge, is an important process for social workers (D’Cruz, Gillingham, & Melendez, 2007). The concepts of reflexivity and reflective practice are closely related, making it difficult to differentiate between the two. Reference to reflective practice may also imply reflexive practice. D’Cruz, et al. (2007) note that in general, the literature interchanges between the concepts of reflexivity and reflective practice, and suggests reflexivity is the ability to act, reflect on the action and then reconstruct how the action can be shaped. This requires an examination of the influences of practice knowledge.

Reflective practice can be used to combine formal theories and practice knowledge. It could be argued that there is a gap between formal theory and day-to-day practice knowledge. Formal theory can be perceived as inflexible, with an inability to allow for the unpredictability and uncertainty that exists in real world social work practice. Reflective practice can bridge this gap by exposing the inconsistencies between formal theories and practice knowledge (D’Cruz, et al., 2007). Reflective practice, utilising formal theories, will mitigate to some degree the unpredictability and uncertainty inherent in social work.

D’Cruz, et al. (2007) suggest that the Reflective model may generate an objective view of practice. This allows social workers to locate themselves within an event to identify their own influences on their actions. Using the Reflective model allows the social worker to view clients not only through theories but also through their own beliefs and life experiences. It requires social workers to be aware of their own self. This phenomenon is constantly developing and hence requires constant acquisition of knowledge (Pray, 1991). Therefore, social workers need to be involved in continual education and to challenge their body of knowledge and perceptions.

There is a constant challenge in social work practice to work with the uniqueness of each interaction. Reflective practice responds to the uniqueness between individual social workers and individual clients. Current practice is strongly influenced by the bureaucratic nature of the organisations within which social workers practice. This is particularly true within the health sector, which, during the past twenty years, has been required to work more efficiently and
effectively, and become more risk adverse due to the changing social, economic and political environment (Ruch, 2007).

Health Social Work practice is a risk-laden profession due to the complex and unpredictable nature of working with vulnerable clients. Health Social Workers respond to the risk-laden nature of their practice by identifying the risks associated with vulnerable clients, for example safety concerns related to abuse, poor housing or lack of income. Health Social Workers, in using reflective practice, draw on their knowledge of the health system and the issues related to working with vulnerable clients within it to reduce risk and develop outcomes that benefit those clients (Ruch, 2007).

Timing of interventions is an important aspect of social work practice but is often not mentioned in the literature. As Tsang (2007) argues, the sense of appropriateness and timeliness contributes to ethical and wise practice. The ability to combine various skills, knowledge and theories, and to use them in an appropriate way in different situations underlies competent social work practice, while the integration of theories with ethically-appropriate practice and reflectivity underpins practice wisdom.

Mishna and Bogo (2007) suggest that artistry, along with practice wisdom, is an important component of competent social work practice. Artistry, in which learning experiences emerge to add to the practice wisdom, is achieved through the deliberate reviewing of one’s practice by internal dialogue and analysing factors that influence the outcome (Mishna & Bogo, 2007).

Internal dialogue within the reflective model assists social workers to evaluate their own performance, feelings and response to the immediacy of actual situations. The internal dialogue is based on subjective experiences. Adding Health Social Work knowledge to the internal dialogue enhances social workers’ self-awareness of their performance.

Practice wisdom and competence come from insight gained through the reflective process; through taking notice and addressing the thoughts and feelings generated from an event, then re-assessing the experience by reflecting on what was done well and what could be improved. The process of internal dialogue to form new insights and self-evaluation (self-assessment against set criteria and standards [Yip, 2006]) is a critical part of the reflective process.

**Critical Reflective Practice Theory**

The use of the term “critical” in this theory is concerned with taking an open and reflective approach to different social constructions. Each individual has different perspectives,
experiences and assumptions about any given event (Glaister, 2008). Critical social work practice is about practicing without oppression or exploitation; it is about challenging dominant structures and powers in society, which includes an understanding of how social constructions influence individuals’ realities. The process of self-reflection is essential to critical social work practice. It allows the dominant structure and power relationship to be challenged in everyday practice (Fook, 2002).

The critical approach to social work is a relatively recent concept. Payne (2005) reports that critical social theory has its origins in the structural social work influences from Marxist structural perspectives and Feminist schools of thought. Fook (2002), a major author of Critical Social theory, summarises some of the theory’s main ideas:

- Domination, which comes from a Feminist perspective, can be both structural and personal. Powerful groups, through a combination of external exploitation and internal self-discipline, achieve structural domination. Individuals can contribute their own oppression by perpetuating self-defeating beliefs and traditions
- False consciousness comes from a Marxist perspective. Members of capitalist society do not recognise the social construction of society and therefore fail to recognise that it can be transformed
- Consciousness raising also comes from a Marxist perspective. When oppressed members of society are aware they have the power to make changes, then collectively they can transform society
- Personal and social change is an everyday experience and is inherent in critical social theory
- Knowledge is a combination of reflection on ‘empirical reality’ and activity analysing the construction of how knowledge is formed. The forms of knowledge in critical social theory can be distinguished as coming from causal analysis, self-reflection and interaction (Fook, 2002, p.17)

Glaister (2008) suggests that critical social work practice could be divided into the three domains demonstrated in Figure 1. These are critical analysis, critical action and critical reflectivity. In conjunction with combining the three domains in an interactive process, a critical practitioner needs to be aware of their own level of engagement as well as the clients’ engagement in the overall process. The critical practitioner needs to be actively involved in creating working relationships with clients in which both social workers and clients have shared meanings and understandings. Social workers are required to be skilled practitioners,
have a sound social work knowledge base, and be open to new ideas and alternative perspectives.

Figure 1: Domains of critical practice (Glaister, 2008, p. 13)

A social worker increases their ability to work with uncertainty and unpredictability by recognising the different client and social worker realities, and utilisation of a critical social work approach. Glaister (2008, p. 8) accurately describes the day-to-day experience of Health Social Workers as:

... fire-fighting; managing time constraints; dealing with conflicting demands; setting difficult priorities; managing tricky relationship; finding short cuts; dealing with stress and frustration (both internal and external); and struggling to hang on to simply doing the job.

As mentioned previously, it is difficult to find a theoretical explanation that fully describes the challenges in health settings. Oko (2006) suggests that theories need to take account of the conflicts that are inherent in social work practice, while Ferguson (2003) reports that critical social work practice has the ability to integrate social work practice and knowledge at different levels. The first level is the use of sound reflective practice and skills bases. The second is working with a variety of value bases and respecting different approaches to a
situation. The third is understanding individuals and the social construction within which they exist, including political, economic, social and ideological contexts.

Critical theory accepts practice wisdom as a valid part of social work discourse. It also accepts the clients’ wisdom and expertise of their situation as a valid discourse. The clients’ wisdom comes from living in their experience in a way the worker has not. Both the social workers’ and clients’ wisdom and expertise are brought together to formulate an assessment of the issues and to develop interventions (Ife, 1997).

In establishing a working relationship with a client, the social worker engages in dialogue within which they must be aware of the power relationship. When there is awareness of a power imbalance, this can be addressed. There is mutual empowerment when power imbalances are acknowledged and opportunities exist to share in the ownership of outcomes (Ife, 1997).

Fook (2002) suggests that critical social work practice is working towards a society free of domination, exploitation and oppression. This is achieved in the individual client and social worker interaction by engaging in mutual dialogue and shared ownership of outcomes. In the wider society, this means establishing dialogue and at the same time being aware of the power implications across all levels of the community. As Ife (1997, p. 139) states, “the integrated approach of critical theory maintains that it is by practicing that we will develop our theory, just as it is by developing theory that we practice”.

An area of debate within the critical paradigm is the position of professionalism. A traditional view of professionalism is one of an expert in their field adhering to a specific code of ethics and set of standards. Power imbalances, resulting from the unequal use of power as a result of specialist knowledge held by particular professionals, exist within the traditional view of professionalism. This traditional view does not sit comfortably within the critical paradigm. Besides professionalism being extremely important, there are advantages for social work to be recognised as a profession, particularly in terms of adherence to practice standards and codes of ethics. Professionalism also gives social workers additional credibility and a degree of influence that they would not have without professional status.

Ife (1997) reports that senior social workers, their associations and sometimes employers usually define competency standards. Accordingly, the dominant group would define what constitutes good practice. A Critical theory approach challenges this way of setting competency standards, which, it argues, should be determined from the perspective of
frontline line social workers and their clients. Whilst involving social workers in the development of competency standards is relatively straightforward, asking clients to define competency standards would be a more radical approach (Ife, 1997).

Critical theory requires competency standards to be contextualised and related to day-to-day practice. It could be argued that competency standards could be used to control behaviour. Conversely, standards are powerful social workers’ tools. Critical theory can be used to legitimise a stance related to contentious issues within society (Ife, 1997); it can provide the basis for competent social work practice that has the potential to improve social justice and human rights as well as the lives of individuals, families and communities.

**Conclusion**

The intent of competency standards is to provide clear objective statements about what constitutes social work practice. Objectivity is difficult to achieve because uncertainty and unpredictability rule the nature of social work practice. There is a risk of overemphasising performance criteria when setting competency standards. This can result in inhibiting creative problem solving, leading to shallow and unimaginative practice (Burt & Worsley, 2008).

As Lawler and Bilson (2010) suggest, a competency framework does not give the whole story of social work practice. It cannot stand alone; it must be used in conjunction with a range of theories and practice wisdom. This issue is explored in the following chapter, which explores examples of standards of practice and competency frameworks.
CHAPTER 5
EXAMPLES OF STANDARDS OF PRACTICE AND COMPETENCY FRAMEWORKS

This chapter explores the various examples of practice standards and competency frameworks of social work associations and regulatory bodies from the United Kingdom, United States, Canada, Australia and New Zealand. Although most of the practice standards and competency frameworks have been developed independently of each other, common themes have emerged. This chapter focuses on these common themes.

In the Western world, social work professional and regulatory bodies have developed codes of ethics, standards of practice and competency frameworks; documents that set out expectations, principles, values, obligations and guidelines for social work practice. In general, codes of ethics set out the values and principles of good professional conduct. The titles “standards of practice” and “competency frameworks” are used interchangeably by some professional and regulatory bodies, but, for the purposes of this study, “standards of practice” are defined as specific guidelines for best social work practice while a “competency framework” is defined as a set of values, knowledge and skills that social workers are required to have to meet the “standards of practice”.

The following organisations, professional and regulatory bodies have developed the standards of practice discussed in this chapter:

- Alberta College of Social Workers (ACSW), Canada
- Aotearoa New Zealand Association of Social Workers (ANZASW), New Zealand
- Australian Association of Social Workers (AASW), Australia
- British Columbia College of Social Workers (BCCSW), Canada
- Care Council for Wales (CCW), Wales
- General Social Care Council (GSCC), England
- National Association of Social Workers (NASW), United States of America
- Northern Ireland Social Care Council (NISCC), Northern Ireland
- Ontario College of Social Workers and Social Service Workers (OCSWSSW), Canada
- Scottish Social Services Council (SSSC), Scotland.
The competency frameworks discussed in this chapter have come from:

- Auckland Regional District Health Boards (ADBH), New Zealand
- Canterbury District Health Board (CDHB), New Zealand
- Central Council for Education and Training in Social Work (CCETSW), United Kingdom
- National Association for Children of Alcoholics (NACoA), United States of America
- Social Work Registration Board (SWRB), New Zealand
- Southern (Otago) District Health Board (SDHB), New Zealand
- Taranaki District Health Board (TDHB), New Zealand.

The above is not an exhaustive list but these standards of practice and competency frameworks provide a cross section of the Western tradition of social work practice.

**New Zealand Examples of Social Work Standards of Practice and Competency Frameworks**

In New Zealand, the professional body, Aotearoa New Zealand Association of Social Workers (ANZASW), set out ten standards of practice for its members. These standards were developed to address the need for increased practice accountability in the profession. The standards of practice were adopted during the 1980s at a time when the membership of ANZASW was struggling with both its identity as the professional body for social workers and concerns related to low membership numbers (Nash, 2001).

The social work profession was unregulated and largely unqualified when the ‘ANZASW Standards of Practice’ were developed. There was minimal consumer or general public protection against incompetent practice. In the New Zealand context, practice standards are a relatively recent initiative, with the ANZASW ratifying its ‘Standards of Practice’ in the 1990s (Beddoe & Randal, 1994).

The common themes in the ‘ANZASW Standards of Practice’ are adherence to a professional code of ethics and commitment to bicultural practice. The requirement to commit to bicultural practice is unique to New Zealand and is underpinned by the *Treaty of Waitangi*. There are specific practice standards for working with, and for, clients, communities and organisations, and ANZASW members are required to use their membership to reinforce competent practice (Aotearoa New Zealand Association of Social Workers, 1997).
These practice standards, which laid the foundations for many social work courses (Nash, 2001), were developed as generic social work competencies to be applied to all social workers in all settings to:

- Improve accountability to consumers, employers and public
- Develop New Zealand standards of practice
- Improve the quality and efficiency of social work services
- Assist with performance indications and appraisals
- Enhance social work credibility and strengthen the profession
- Improve complaints and disciplinary procedures (Briggs, 1988, p. 23).

The common themes covered by the Social Work Registration Board’s (SWRB) ten core competency standards are similar to the ‘ANZASW Standards of Practice’. They include adherence to professional ethics, commitment to bicultural practice, cultural competence and understanding how to work with people and organisations (Social Work Registration Board, 2010). The SWRB competencies also include human rights and social action.

Within the New Zealand health system there are twenty District Health Boards (DHBs) responsible for the delivery of primary, secondary and tertiary health and disability services. The DHB Social Work Leaders Groups are responsible for setting standards of practice for Health Social Workers. The Social Work Leaders Groups within six of the DHBs led the development of in-house social work competency documents. Generally, the purpose of these documents is to:

- Set minimum standards and expectations for Health Social Workers
- Provide best practice guidelines for Health Social Workers
- Provide guidelines for professional development.

All DHB competency frameworks were developed around the same time using documents shared among the DHBs. The ‘Auckland Regional DHB Competency Framework’ was developed for social workers employed in the Mental Health Service from Auckland DHB, Counties Manukau DHB and Waitemata DHB.

The ‘Canterbury DHB Competency Framework’ was developed for social workers employed in the Mental Health Service within that DHB. The ‘Otago DHB Social Worker Performance and Progression’ document applied to all social workers employed by the Otago DHB. The ‘Taranaki DHB Competency Framework’, which is an adaptation of the ‘Australian
Association of Social Workers Practice Standards for Mental Health Social Workers’, applied to all social workers employed in that DHB.

The following documents influenced the development of the DHBs’ competency frameworks:

- IFSW declaration of Ethical Principles (2004)
- Recovery Competencies for New Zealand Mental Health Workers (2001)
- Te Tiriti O Waitangi.

Three additional documents influenced the development of a competency framework for Health Social Workers in New Zealand:

- Let’s Get Real: Real skills for people working in Mental Health and Addiction (2008). This document sets out seven skills for working with people experiencing mental illness
- The Whānau Ora Health Impact Assessment Tool (2007), which is a guide to developing and delivering services to Māori. This tool applies across all government-funded health services
- Health and Disability Commissioner Act 2009 and Code.

These documents are to be used alongside professional competency frameworks.

Although there is some local uniqueness of the four DHB competency frameworks, the common themes that can be identified are:

- Bicultural Practice and Cultural Responsiveness. This theme involves social workers being able to demonstrate a commitment to the principles of the Treaty of Waitangi (partnership, participation and protection). It also includes social workers practicing in a way that is culturally safe for clients/patients
- Advocacy and Social Justice. This theme involves advocating for improvements in clients’/patients’ environments and wider systems. It also involves empowering clients/patients to advocate for themselves to improve services and support systems
- Clinical and Professional Practice. This theme involves direct client/patient social work practice including undertaking social work and intra/multidisciplinary team
assessments, interventions and discharge planning. Social workers also engage in therapeutic and group work with clients/patients

- Case Management. This theme involves coordination of client/patient care in consultation with intra/multidisciplinary teams and service providers
- Risk Management. This theme is common in the Mental Health competency documents, however it belongs equally in physical health documents. The theme includes identifying when clients/patients are at risk and the following of employer and organisational polices and guidelines. It also includes undertaking assessment of clinical risk and taking appropriate action when the client/patient or others are at risk of harm through abuse, neglect and/or violence
- Organisation Requirements. This theme relates to the social workers’ obligations to their employer and includes following organisation policies related to documentation, time management and workload management
- Supervision. This theme involves participating in critical reflection of one’s clinical work with peers, senior social workers and/or supervisors
- Professional Development. This theme includes participating in ongoing education and training; attending courses, conferences and workshops. It also covers advancing social work knowledge by undertaking research, presenting at conferences and writing papers for peer-reviewed journals (Canterbury District Health Board Mental Health Social Workers, 2004; McNabb, Nes, & Sharpe, 2006; Otago District Health Board Social Workers, 2002; Taranaki District Health Board, nd).

The ‘Canterbury DHB Social Work Competency Framework’ has two additional competencies related to Health and Safety and Disaster Planning that are not covered in the other DHBs’ social work competency frameworks. Health and Safety covers obligations to the employer to ensure maintenance of a safe work environment, and obligations to a social worker’s personal safety and work-life balance.

Social work competency related to Disaster Planning does not appear in any other standards of practice or competency frameworks reviewed in this chapter. The competency involves knowing how to respond to emergencies and disasters, and includes taking an active role in developing safe practices and procedures. Given the man-made and natural disasters that have occurred throughout the world, a competency related to disaster planning and response is relevant to any Health Social Work competency framework.
Although there are common themes within the four DHB competency framework documents, they have not been used outside the DHBs within which they were developed. Discussions between the DHBs’ Social Work Leaders related to developing a single national document have taken place over several years. A project team was established to work on a national Health Social Work Competency Framework. After much discussion, it was decided to assess the ‘Taranaki DHB Competency Framework’ as a national model (DHB Social Work Leaders Council, 2008).

**Australian Examples of Social Work Standards of Practice**

The Australian Association of Social Workers (AASW) first published their practice standards in 1993 and relaunched them in 2003. The aim of the practice standards was to provide a guide for social work accountability. As a result of consultation with their membership and stakeholders, six domains of social work practice were developed: Direct Practice; Service Management; Organisation Development and System Change; Policy; Research; and Education and Professional Development (Australian Association of Social Workers, 2003).

Each of the six domains is divided into standards with the following themes:

1. Direct Practice domain themes are meeting clients’ needs and empowering clients to develop individual potential.
2. Service Management domain themes associated with the standards are for client, organisation and community expectations to be addressed in an appropriate way.
3. Organisation Development and System Change domain themes involve being able to identify and, where possible, address inequalities using organisational and societal systems knowledge.
4. Policy domain themes involve working to promote and implement policies and practices that ensure fair and equitable allocation of resources. Social workers identify and address inappropriate polices.
5. Research domain themes involve research undertaken by social workers being ethical, appropriate and based on best practice evidence.
6. Education and Professional Development domain themes involve social workers engaging in professional development activities, including supervision (Australian Association of Social Workers, 2003).
United Kingdom Examples of Social Work Standards of Practice and Competence Frameworks

Over the past two decades there have been changes in the regulation and oversight of social work education, training and professional practice in the United Kingdom. The Central Council for Education and Training in Social Work (CCETSW) was responsible for competence-based education and training core competencies. These core competencies were aimed at the social service employers rather than the profession itself (O'Hagan, 1996).

O'Hagan (1996) notes that competent practice is values-based practice delivered in a skilled manner and founded on sound evidence-based knowledge. These concepts underpin the CCETSW ‘Competence Based Education and Training Core Competencies’. The six core competencies are shown in Figure 2.

Figure 2: Six Core Competencies (O'Hagan, 1996, p. 9)
The CCETSW was the regulatory body responsible for United Kingdom education and training from 1971 to 2001 (O'Hagan, 1996). In 2002, this responsibility was superseded by the General Social Care Council (GSCC), Scottish Social Services Council (SSSC), Northern Ireland Social Care Council (NISCC) and Care Council Wales (CCW). These organisations have worked together to develop the ‘Code of Practice for Social Service Workers and Employers’ (Care Council for Wales, 2002; General Social Care Council, 2011; Northern Ireland Social Care Council, 2002; Scottish Social Service Council, 2011). Each has their own edition of the ‘Codes of Practice’, however, they are essentially the same document.

‘The Code of Practice for Social Service Workers and Employers’ lists standards of professional conduct and practice that apply to employers of social service workers as well as to social workers. It sets out the responsibility for employers to employ suitable people who are fit and proper for social work, and requires employers to provide work environments that support good practice and professional development opportunities to strengthen good practice (Care Council for Wales, 2002; General Social Care Council, 2011; Northern Ireland Social Care Council, 2002; Scottish Social Service Council, 2011).

The themes of the standards for conduct for social workers are good practice when working with clients, including protection of client rights, and promoting empowerment. The Code reinforces social service workers’ responsibility to protect clients and others from harm, and sets out social service workers’ accountability for the quality of their work (Care Council for Wales, 2002; General Social Care Council, 2011; Northern Ireland Social Care Council, 2002; Scottish Social Service Council, 2011).

The British Association of Social Workers (BASW) is a professional body that independently represents social workers in the United Kingdom. Currently, the BASW is moving to establish a College of Social Workers to provide a strong voice for social work professionalism. The BASW has a code of ethics to which members are required to adhere. However, the BASW does not have standards of practice or competency framework documents (British Association of Social Workers, 2011).

**Canadian Examples of Social Work Standards of Practice**

British Columbia College of Social Workers (CCSW), Alberta College of Social Workers (ACSW), and Ontario College of Social Workers and Social Service Workers (OCSWSSW) are regulatory bodies responsible for social work practice in their respective Canadian provinces. These three colleges have developed ‘Codes of Ethics’ and ‘Standards of Practice’
documents that are localised editions of the same codes of ethics and standards of practice (Alberta College of Social Workers, 2007; British Columbia College of Social Workers, 2009; Ontario College of Social Workers and Social Service Workers, 2009).

The purpose of the three Canadian college standards of practice was to have written expectations of appropriate practice standards. Eight principles are identified as essential components of these standards. The first four principles overarch social work relationships and responsibilities related to clients. These principles, as well as competence, integrity, record-keeping and confidentiality are congruent with the New Zealand, Australian and United Kingdom standards. Two different principles that are not in the New Zealand, Australian and United Kingdom Standards of Practice relate to ‘Fees’ and ‘Advertising’ (Alberta College of Social Workers, 2007; British Columbia College of Social Workers, 2009; Ontario College of Social Workers and Social Service Workers, 2009).

Nova Scotia Association of Social Workers (NSASW), Saskatchewan Association of Social Workers (SASW), Newfoundland and Labrador Association of Social Workers (NLASW), and New Brunswick Association of Social Workers (NBASW) are social work professional bodies that also have regulatory responsibilities in their respective Canadian provinces. NSASW, SASW and NBASW do not appear to have generic standards of practice documents but use their codes of ethics to provide guidance for social work practice (New Brunswick Association of Social Workers, 2011; Nova Scotia Association of Social Workers, 2008).

The NLASW uses the ‘Canadian Association of Social Workers’ Code of Ethics’ for guidance for practice standards (Newfoundland and Labrador Association of Social Workers, 2011). SASW has twelve practice standards for social workers. The first four standards set out the values, principles and knowledge required to practice. The second four standards relate to practice skills, including working with clients and record-keeping. The last four standards relate to the work environment, conflict of interest and professional responsibilities (Saskatchewan Association of Social Workers, 2001).

**United States Examples of Social Work Standards of Practice**

The National Association of Social Workers (NASW) is the United States’ professional body for social workers. The NASW has a code of ethics that applies to all social workers and standards of practice in specialised areas of practice. The standards of practice for social workers in health care set out social work knowledge, skills, values and methods of service delivery to effectively engage with individuals, families and communities. Health Social
Workers in the United States are challenged to work with clients where access to healthcare is inequitable. In 2003, 15 percent of the population were without any health insurance and a significant proportion of the rest of the population had inadequate health insurance (National Association of Social Work, 2005).

The NASW standards were developed by consensus of Health Social Work experts (National Association of Social Workers, 2005). The twenty standards cover ethics, values and knowledge required for social work practice, as well as working with clients, which includes confidentiality, assessments, interventions, case management, empowerment, advocacy and education. They were designed to guide social workers and their employers around social work practice within health. The NASW standards also set out social workers’ responsibilities to their employers, including workload management and documentation, and place joint responsibility on social workers and employers for social work professional development, access to information technology and having appropriate social worker qualifications. The NASW practice standards have one standard related to understanding health disparities, which requires recognising and addressing health inequalities for clients who access health services.

**Cultural Competency**

Este (2007) reports that cultural competency is the ability to work with clients from diverse cultural backgrounds in ways the clients find appropriate. The themes of cultural competency include:

- Understanding cultural diversity and oppression
- Possessing knowledge of different cultural and ethnic groups
- Having the ability to communicate with clients from different backgrounds, cultures and ethnic groups
- A commitment to practice in an ethical and effective way within the clients’ systems.

Este (2007) also suggests that strong assessment and effective intervention skills are two essential components of cultural competency. These skills include the ability to identify multiple and diverse worldviews. There is a need to recognise the impact of ethnic, cultural and spiritual worldviews on the nature and types of social work interventions that can be implemented.

To ignore the diversity within ethnic, cultural and spiritual communities is to ignore one of social work practice’s central values; to acknowledge and respect the worth and dignity of
individual clients. Understanding clients’ ethnic, cultural and spiritual systems is a key factor for the success or failure of any intervention. Conversely, it is vital that social workers acknowledge their own limitations around knowledge and understanding of the diversity that exists in society (Este, 2007).

Gaining cultural competency is a life-long process. It involves learning from the client’s systems and understanding the impact of social locations on clients from diverse backgrounds. This is achieved through understanding how to communicate respect for beliefs and being open to working within the parameters of the clients’ understanding of their own realities and word views (Este, 2007; Hodge & Limb, 2010). Therefore, it is somewhat surprising that not all standards of practice directly address the issue of cultural competency.

The NASW specialist standards of practice, while not directly addressing cultural competency, have a separate document for it. The Australian, United Kingdom and Canadian Standards of Practice documents do not directly address the area of cultural competency within their standards of practice documents. The unique New Zealand social work context, however, requires the inclusion of elements that relate to bicultural practice under the Treaty of Waitangi in all competency frameworks, as discussed previously. Competency within bicultural practice means understanding one’s cultural identity and where it is located in relation to the treaty partners, that is, in relation to Māori as Tangata Whenua and the British Crown (Perry & Tate-Manning, 2006).

Social workers are required to have general cultural competency as well as being competent in bicultural practice, Perry and Tate-Manning (2006) suggest that to achieve cultural competency social workers need an awareness of their own values, beliefs and assumptions, and how individual cultural values influence their own worldviews.

**Speciality Social Work Competency Frameworks**

Competency frameworks have become established as part of the social work practice in New Zealand and internationally. Now that core competency frameworks are well established, specialist competency frameworks are emerging. Basma, et al. (2010) report there is a long-standing debate about generalist versus specialist social work within the health system. Common competencies are required for all social workers, such as counselling knowledge of family systems, community resources and psychosocial assessments. Some competencies may only be related to specialist areas within Health Social Work practice, for example undertaking mental state examinations, pregnancy counselling and palliative care.
Consequently, it is timely to examine the value of specialty competency frameworks for social workers within the health sector.

Basma, et al. (2010) undertook research into Canadian hospice palliative care competencies. Alongside the generic competencies congruent with other standards of practice previously discussed, the competency standards unique to Basma’s competency framework are:

- Understanding the multi-dimensional nature of health and wellness
- Understanding the social determinants of health
- Spirituality of self, team and other.

These provide additional dimensions to a health-related competency framework, which are not necessarily relevant to generalist social work practice.

The AASW has specialist standards of practice that include ‘Mental Health Standards of Practice’, but there are no standards related to Physical Health. These Mental Health Standards, developed through an expert social work committee with stakeholder consultation, are linked to the six domains of the ‘AASW Standards of Practice’ (Australian Association of Social Workers, 2008). As discussed in the previous section, the standards relate to working with clients and their families, multidisciplinary teams, communities, service providers and other organisations, and undertaking case management as well as professional development and supervision. The standards that are unique to the ‘Mental Health Standards of Practice’ are ‘working with Mental Health policies’ and ‘Mental Health promotion’ (Australian Association of Social Workers, 2008).

The National Association for Children of Alcoholics (NACoA) has developed core social worker competencies to be applied in the United States for all social workers who engage with children of parents who abuse substances (National Association for Children of Alcoholics, 2006). These competencies involve understanding substance abuse and its impact on child development, family systems, values, importance of intervention, and ability to assess, engage and intervene. The core competencies also set out the required abilities to network, advocate and understand relevant policies. The NACoA competencies are additional to the generic competencies found in other standards of practice or competency documents.
Common Themes

Most social work associations and regulatory bodies in the United Kingdom, United States, Canada, Australia and New Zealand have some form of practice standards or competency frameworks that have been developed using expert panels in consultation with selected senior practitioners. Although all practice standards and competency frameworks appear to be different superficially, closer examination reveals common themes, which are listed as follows:

- Cultural Responsiveness and Competencies: involves statements of bicultural practice in the New Zealand context; cultural diversity in a sensitive manner
- Clinical and Professional Practice: involves the description of various aspects of direct practice. This includes the client/social worker relationship, assessment, intervention, discharge planning, case management, teamwork, group work, and violence and abuse intervention
- Organisational Requirements: involves statements about the social workers’ responsibilities to their employing organisation. This includes managing their own workload, documenting contact with clients and contribution to organisational policies, quality improvement and risk mitigation
- Professional Development: involves statements related to social work responsibilities, maintenance of professional development activities and keeping up-to-date with evidence-based practice
- Advocacy, Networking and Social Action: involves statements related to advocating for improvement for client access to services, developing networks, and demonstrating knowledge of community resources and services
- Leadership and Professionalism: details the responsibility of social workers to participate in supervision, and to adhere to professional ethics and standards of practice. It also explains the social worker’s responsibility to demonstrate leadership skills in teams and groups across different health settings
- Understanding Health: involves statements about social workers’ obligation and responsibility to address scope of practice inequalities in health as well as demonstrating knowledge of health promotion and wellbeing.

Table 1 enables visualisation of the commonalities and differences of these themes across the professional associations discussed in this chapter.
Table 1: Common Themes for Standards of Practice and Competency Frameworks

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Conclusion

Competency frameworks and practice standards from professional and regulatory bodies in New Zealand, Australia, the United Kingdom, the United States and Canada all have common themes even though they were developed independently. None of the competency frameworks discussed provides comprehensive statements for social workers working across all health settings.

In New Zealand (2011), there is currently no nationally accepted competency framework for Health Social Workers. Although there are six hospitals that use in-house competency frameworks, or have used these in the past, the majority of social workers working in health do not have a Health Social Work Competency Framework. In response to the increased demand for Health Social Workers to be competent, accountable, clear and specific about their roles and tasks, it is critical for a competency framework to be developed that applies to all Health Social Workers. It is the Health Social Workers’ responsibility and obligation to the profession to develop and embrace a competency framework to establish professional standards. The need for such a competency framework precipitated this study. The next chapter describes the study’s methodology, including the research design, aims, hypotheses, and data collection and analysis.
CHAPTER 6

METHODOLOGY

This chapter initially discusses qualitative and quantitative approaches to research methods. The use of mixed methods, a common approach in social science research, is also considered. The research design for this study, including construction of a questionnaire and participant recruitment, and data analysis is then discussed. The final part of the chapter covers the study’s research method.

Brief Overview of a Quantitative Approach to Research

Quantitative research comes from the natural science research tradition. Theoretical approaches to quantitative research are underpinned by a positivist paradigm that uses scientific methods. The positivist paradigm underpins acquired knowledge from objective observation and experimentation.

Quantitative research begins with a research topic concept and empirical tests. The process of having a general concept that is empirically tested and from which a specific conclusion can be drawn is known as “deduction”. Quantitative research relies on the objective nature of statistics, which are used to describe social realities and predict cause and effect of the hypotheses being tested (Grinnell & Unram, 2008). Quantitative research is about producing precise data that can be generalised across the study population.

The quantitative research methodology generally has a strict experimental design. Randomised control trials are a classic quantitative experimental design that involves randomly assigning subjects to an experimental or control group. Independent variables can then be systematically manipulated to determine the effect of a particular intervention on the experimental group (Alston & Bowles, 2003).

The presence of researchers in quantitative research approaches has little or no effect on a study’s outcome. It assumes that if another researcher using the same research instrument repeats the study, the same results will be produced (Alston & Bowles, 2003). Grinnell and Unram (2008) note that quantitative research describes social reality from an objective perspective, while Gibbs (2001) and Alston (2003) argue that quantitative research is based on the notion that reality can be objectively observed and then broken down into concrete measurable components.
As Alston (2003) points out, as well as randomised control studies, quantitative techniques used in social science research include surveys, questionnaires and structured observations. Such techniques can answer “how many”, “how frequent” or how much” questions in numerical forms such as numerical scales. The numerical data collected from the scales can be used to measure the levels or percentages of agreement or disagreement between groups (Carroll & Rothe, 2010).

Quantitative data can be categorised and mathematical modelling applied to identify whether differences occur between groups and whether this is by chance (Carroll & Rothe, 2010). Thus, it is possible to identify causal relationships between variables. Reid (1994) reports that quantitative research can produce results which demonstrate the degree of association between existing variables, and can provide alternative accounts for associations between variables.

Validity is an essential part of quantitative research. It refers to the best approximation to the truth of the research hypotheses and predictions. The four criteria for assessing the quality and validity of quantitative research are:

1. **Internal validity** – relates to the accuracy of claims made about the relationship between the variables. Did the manipulation of the independent variables cause the actual research findings?
2. **External validity** – relates to how much the results can be generalised to the real world study population. If results can be generalised, the validated hypotheses can be translated into operational definitions.
3. **Reliability** – can the research be repeated and produce similar results? Reliability also relates to what extent the research findings remain consistent over time (Cohen & Crabtree, 2008; Golafshani, 2003).

**Brief Overview of Qualitative Approaches to Research**

Qualitative research is used to examine real life experience and answer research questions as to how an event is perceived and why such events happen the way they do (Carroll & Rothe, 2010). It aims to interpret and find meaning about social phenomena. New ideas and concepts are explored, allowing the development of new theories (Alston & Bowles, 2003).

Qualitative research methodology can examine social systems using holistic approaches. Qualitative research methods can take account of contextual elements within the research subject and generate detailed explanations of social phenomena (Reid, 1994). These methods
are inductive; they move from observation of a specific situation to general ideas and theories, and provide information about participants’ perceptions of particular phenomena (Britten, 2005).

Qualitative researchers argue that research does not take place in isolation and it is impossible to remain separate from the research topic. The research is also influenced by theories, models of practice and current research subject ideology. Researchers add their own values and biases to their research (Alston & Bowles, 2003). The data collection process can be as important to the meanings as the results. This relationship between the researcher and the research subject has a significant influence on the research (Denzin & Lincoln, 1998).

Qualitative research can be described as subjective because of the inseparable interconnectedness between the researcher’s perceptions and the analysis of the research material. Qualitative researchers are able to acknowledge their own position related to the research by arguing that research can never be free of researchers’ values and judgements. From a qualitative research perspective, all research components, including topic, methodology and findings, are socially constructed. This means theories, models of practice and current political and social ideologies influenced the research (Alston & Bowles, 2003; Padgett, 2009; Rubin & Babbie, 2001).

Rubin and Babbie (2001) suggest that qualitative research attempts to tap into the underlying meaning of observation; meaning that cannot be easily accessed by pure numbers. Qualitative research can, and does, make use of statistical processes because qualitative data can be transformed into qualitative variables and entered into a database for analysis. However, the main use of numbers within qualitative research is for describing frequencies and means to summarise a particular occurrence.

The theoretical underpinnings of qualitative research are based on concepts that have socially-constructed and hermeneutic worldviews; that is, all knowledge needs to be viewed from the context within which it was developed and used. Theories commonly associated with qualitative research are Ethnography, Symbolic Interactionism and Grounded Theory (Alston & Bowles, 2003).

When analysing qualitative data, similarities and differences can be examined by creating variables such as gender, age and socio-economic groups. Qualitative analysis is used to discover patterns in language that emerge from close examination of observations and documentation such as transcripts and participants’ written comments (Grinnell & Unram,
Another advantage of undertaking qualitative research is that minority opinions can be examined and compared with the overall data. Quotations generated from comments on questionnaires need to be put into context to illustrate themes, ideas and insights (Kitzinger, 1995).

Qualitative analysis involves careful examination of emerging patterns and coding these patterns into themes (Rubin & Babbie, 2001). There is a risk of “cherry picking” data when selecting codes and themes because qualitative analysis is intertwined with the researcher’s subjective experiences (Scott, 2002).

There are four criteria for evaluating the quality of qualitative research:

1. Credibility: are the results believable?
2. Transferability: can outcome of the research be generalised to other context.
3. Dependability: if the research were repeated, would it generate the same or similar findings?
4. Confirmability: has other similar research found similar results?

**Mixed Method Paradigm**

Mixed method integrates both quantitative and qualitative research methods. These two inherently different approaches are interwoven to enable exploration of different aspects of the same research question (Alston & Bowles, 2003; Sherman, 1994). Mixing qualitative and quantitative research methods could be viewed as two phases of the research process, which involves development of new knowledge by transference from logic and theorising onto information gathering and testing. Qualitative and quantitative methods are underpinned by two different paradigms; qualitative from a heuristic paradigm and quantitative from a positivist paradigm (Gibbs, 2001).

The heuristic paradigm emphasises a reflective method of research. It is about natural discovery and participants’ contribution to the learning (Gibbs, 2001). As explained in the previous section, the basic assumption of the heuristic paradigm is that socially-constructed knowledge needs to be viewed from the context within which it is developed and used. The researcher is not neutral and cannot be objective within the research context. The data collected during research is also socially constructed. Environmental, social and political contexts influence the researcher and data collection.
As mentioned earlier, the basic assumption of the positivist paradigm is that it is an objective representation of reality and it is possible to know reality (Cohen & Crabtree, 2008). Empirical quantitative research relates to establishing reliable and accurate evidence. It is meant to remove personal bias and judgement from results (Gibbs, 2001). However, Carroll (2010) argues that quantitative research is socially constructed and, as such, is based on the researchers’ and participants’ realities. Despite the social construction, it is argued that quantitative methods produce precise information from which inferences can be drawn and generalised to the study population (Rubin & Babbie, 2001).

Cohan and Crabtree (2008) note another paradigm—the realist paradigm—is gaining acceptance within health sector research. The rationale for acceptance of this paradigm is that it softens the positivist paradigm by assimilating the positivist rigorous research values, beliefs and criteria, and recognises that knowledge is imperfect. Subsequently, researchers cannot separate themselves from their perceptions of reality and therefore they have limited objectivity.

Both qualitative and quantitative research methods originated from the modernist theoretical perspective, which proposes that knowledge about the world is discoverable through practical experimentation and rational processes. The integration of the qualitative and quantitative research methodologies into mixed methods research is based on a Post-modernist perspective. That is, truth is different for different people; a single, knowable world does not exist (Alston & Bowles, 2003). Therefore, using both the heuristic and positivist paradigms is valid. It can provide new research knowledge because using both enables representation of the whole context of the data (Payne, 2005).

Post-modernism within the social work research context is about deconstruction of all aspects of social work knowledge, ideologies and values. Data collected from quantitative research demands critical analysis to allow for the collection context. The language used when reviewing qualitative data should be closely examined because language can reflect different social constructions and is context dependent; words used in one context can mean something completely different in another context (Payne, 2005).

**Triangulation**

Integrating both qualitative and quantitative research methods will produce much richer information than using a single methodology (Alston & Bowles, 2003). A major advantage of mixed methods research is the ability to use triangulation to evaluate research findings.
This increases the credibility and validity of the results. When two or more research strategies are used to examine a particular subject, they are likely to generate higher quality results. Integrating different methodologies enables the researcher to capitalise on the strengths of both methods and offset the weaknesses of the different approaches (Golafshani, 2003).

**Guiding Research Principles**

Research in itself is not necessarily good. Researchers have a responsibility to consider the entire research process, including ethical principles. They need to ensure the welfare, privacy and integrity of participants along with how the findings are to be used. Research ethics is complemented by research theories such as Emancipatory research and Critical reflective practice theory. These theories propose that researchers have a responsibility to make a positive difference and not merely undertake research. Marxist, Feminist, Critical reflective and Educative consciousness-raising theories have influenced Critical reflective practice and Emancipatory research theories.

Emancipatory research is political action; it is about examining the nature of oppression and social construction of marginalisation of the powerless (Alston & Bowles, 2003). In this sense, Emancipatory research is intricately connected with the work of social workers because social work is a process of emancipation; it works towards bringing equality to society by working with the oppressed and marginalised.

Fook (2002) argues that Emancipatory and participatory approaches are guiding principles of the critical self-reflective researcher. Such a researcher will acknowledge both their influence on the research and the power differentials between them and the research participants; that is, the researcher is the expert and participants are variables to be examined.

The critical reflective researcher needs to view the participants as collaborators in the research process to achieve optimal outcomes, and to account for analysis of the influences of political, economic and social environments. These influences are socially constructed. They also have a significant impact on the research participants and how the research will be analysed and interpreted (Fook, 2002).
Consideration must be given to research ethics. Social science researchers have an ethical responsibility to:

- Protect participants’ autonomy
- Do no harm
- Undertake worthwhile research.

Protecting participants’ autonomy involves protecting their right to decide if they will participate in the research, to be fully informed, to understand what the research involves, to withdraw from the research process or to ask questions without prejudice (Alston & Bowles, 2003).

Confidentiality is another aspect of autonomy. Participants have the right to have their identity protected in reported findings of the research, and information about individual participants should not be divulged except with the participant’s informed consent.

Researchers have a responsibility to ensure they do not leave the research environment worse off than when they started. The principle of doing good sits alongside the principle of doing no harm. The research should benefit the participants (Alston & Bowles, 2003).

The last principle is that research should be worthwhile. It should not be undertaken for the sake of just doing research but should make a positive contribution to knowledge. Research findings are to be reported accurately. Errors and other factors that may distort the findings need to be reported (Alston & Bowles, 2003).

**Questionnaires as a Research Method**

Questionnaires are an effective method of studying a geographically diverse population such as Health Social Workers across New Zealand. Questionnaires are a very useful method of quantitative and qualitative research. Buckingham (2004) suggests that questionnaires are an effective method of studying current attitudes and behaviours. However, questionnaires are context sensitive; that is, how participants answer a question in one setting may not correspond with how they would answer the same question in another setting.

As a quantitative research method, a questionnaire has the advantage of being able to convert answers into empirical data that is appropriate for empirical analysis. As a qualitative research method, questionnaires have the advantage of eliciting opinions, thoughts and feelings (Rubin & Babbie, 2001).
Careful consideration needs to be given to the construction of research questionnaires. Depending on the methodological research employed, questions can either be open or closed. Closed questions tend to be used in quantitative research. They are only one-dimensional and participants are required to answer on rating scales or by tick boxes. These types of questions lend themselves easily to empirical analysis to produce statistical data such as frequencies, means, standard deviations and significant differences (Alston & Bowles, 2003).

The order of closed-ended questions needs to be carefully considered when structuring a questionnaire because preceding questions may influence the answer to the next question. The actual wording of the question can also influence the answer. Questions need to be unambiguous; they must only have one meaning.

Open-ended questions tend to be used in qualitative research. These types of questions require participants to write sentences and comments to be analysed using common thematic coding. Open-ended questions provide participants with the option to express opinions, thoughts and feelings. A well-structured open-ended question makes no assumptions about how participants will answer it.

Questionnaires are a cost effective method for large-scale research. Mail-out questionnaires allow for geographic flexibility. They also allow participants to answer the questions in their own time and at their convenience. This reduces bias created by phone or face-to-face interview methods (Larson & Poist, 2004). Questions need to be clear and concise to avoid misinterpretation.

In any research with populations, it is important that participants who receive mail-out questionnaires are representative of the general population being studied. Mail-out questionnaire research relies heavily on response rates. The lack of participant response to a mail-out questionnaire is known as a “non-response bias”, which can affect reliability and validity (Fincham, 2008). The response bias can be problematic because some groups of participants may be more likely to respond to a questionnaire than others, which could skew results (Schirmer, 2009).

Ideally, to obtain the best results, the response rate of participants completing and returning questionnaires should be between 60 and 70 percent. However, as Schirmer (2009) suggests, response rates between 10 and 15 percent are more common. Validity increases with higher response rate data, therefore, as Smith (2003) emphasises, it is important to maximise response rates. One way to improve reliability and validity is to increase response rates by
sending out reminders via letters, emails, reminder cards and/or additional questionnaires. Some research ethics committees are concerned that multiple reminders may be perceived as harassment or coercion, which threaten the basic ethical requirement of voluntary participation (Schirmer, 2009).

The validity of the questionnaire as a measuring tool needs to be considered. The overall validity of the questionnaire is dependent upon how accurately the data measures what it is supposed to measure. There are four aspects of validity to be considered:

- Face validity: does the questionnaire seem believable and reasonable?
- Context validity: does the questionnaire cover all the fields the researcher intends to measure?
- Internal validity: are the answers to related questions consistent logically?
- External validity: is the data collected from the questionnaire consistent with existing evidence external to the research project (Buckingham, 2004)?

Smith (2003) identifies six factors that have an impact on whether participants will complete the questionnaires or not. These are:

- How much work the participants perceive is required to complete the questionnaire
- How much interest participants have in the topic
- How credible the researcher and their organisation is
- The characteristics of the participants in the study
- The level of inducements.

Beebe, et al. (2008) argue that non-response bias is less of a concern than has long been assumed. Fincham (2008) notes that it is more important for participants to be representative of the population, while Larson (2004) suggests sending questionnaires to a greater proportion of the population to overcome low response rates. This strategy could provide sufficient responses for statistical analysis. However, non-response bias would still need to be accounted for.

Social exchange theory is the most influential theory that explains people’s willingness to participate in survey-related research. The underlying principles relate to what motivates people to return questionnaires (Ladik, Carrillat, & Solomon, 2007). Social exchange theory suggests that people will participate in surveys if they:
• Perceive some social gain
• Perceive low cost
• Trust the researcher (Schirmer, 2009).

Schirmer (2009) reports that the overall ‘pleasantness’ of completing questionnaires will influence individual motivation to return them completed. Beebe, et al. (2008), however, report that leverage-saliency theory suggests survey participation is a reasoned action. Participants consider either consciously or subconsciously the burdens of completing the questions, including time, cost, topic, interest, confidentiality, credentials of the researcher and number of previous requests to complete the survey.

There are some limitations to using questionnaires as a research method. Questionnaires can be an unreliable method for discovering information about past attitudes and behaviours. They are also a poor technique for exploring what influences behaviour because often people are largely unaware of these influences (Buckingham, 2004).

Research participants are aware of being researched and this can influence their answers. Participants may answer questions the way they perceive the researchers want them to be answered. Whilst questionnaires are useful for collecting data on individuals, they can be a clumsy method for collecting data on groups or organisations (Buckingham, 2004).

Questionnaires are a good way for collecting generalised information on a large number of subjects. The data can be used to draw conclusions about a specific population. However, caution needs to be exercised in relation to how much the participants represent the study population because those who respond to a questionnaire may differ fundamentally from those who do not respond (Buckingham, 2004; Smith, et al., 2003).

**Method for this Study**

**Research Design for this Study**

This study utilised mixed methods. A questionnaire was designed to allow for both empirical and qualitative data collection, which would enable the three research questions to be addressed (see section ‘Research Questions’ further down).

Questions about demographic characteristics were used to examine the different perceptions of what Health Social Workers consider should be part of a competency framework. Asking participants for comments was designed to enhance the data and provide additional
information about individual Health Social Workers’ perceptions of the competency statements.

**Aims of the Research**

The aims of the present study were:

- To determine what Health Social Workers consider is competent practice in accordance with national standard competencies
- To develop a comprehensive and evidence-based practice framework.

**Research Questions**

The three research questions for this study were:

1. Can a single national competency framework for Health Social Workers be developed that is relevant to all domains of Health Social Work practice?
2. Would different demographic characteristics influence the perception of what Health Social Workers consider to be relevant competency elements?
3. What do Health Social Workers consider are relevant elements for a national competency framework?

**Research Hypotheses**

The present study was conducted using a questionnaire as the research instrument. The data was collected using a mixed method approach utilising both qualitative and quantitative methods. Statistical analysis was used to test two hypotheses:

1. A single national competency framework can be developed that is relevant to all domains of Health Social Work practice.
2. Health Social Workers’ demographic characteristics influence the perception of what Health Social Workers consider to be relevant elements of a competency framework.

The present study also considered what Health Social Workers perceive to be relevant elements of a national competency framework.

**Questionnaire Structure**

The survey questionnaire comprised two parts. The first related to demographics and the eight variables (gender, age, ethnicity, social work qualification, institution where social work qualification was gained, years of experience as Health Social Workers, place of practice and practice speciality). The second part of the questionnaire was divided into eighteen sections
related to the eighteen competency statements. Each competency statement was further subdivided into a number of elements. This part of the questionnaire combined a 1 to 7 Likert-type scale (where 1 = strongly disagree and 7 = strongly agree) for each element with a comments box for each section. There was also an opportunity for participants to make general comments about the questionnaire.

Development of Present Study Questionnaire

The six competency documents used to develop the questionnaire in this study were:

- ‘Canterbury District Health Board Mental Health Service Competency Framework’ (2004)
- ‘Competency Framework for Social Workers in Mental Health Services for Auckland District Health Board, Counties Manukau District Health Board, Waitemata District Health Board’ (2006)
- ‘Otago District Health Board Social Workers Performance and Progression’ (no date)
- ‘Practice Standards for Mental Health Social Workers for the Australian Association of Social Workers’ (2000)

The ‘Taranaki District Health Board Competency Framework’, which is based on the ‘Australian Association of Social Workers’ Practice Standards for Mental Health Social Workers’, was selected as the basis for the questionnaire. The rationale for selection was that the DHBoard Social Work Leaders Council (representing Health Social Work Leadership from the District Health Boards within New Zealand) agreed to consider this framework as a basis for a national competency framework for DHB Health Social Workers. However, there was also agreement that the competency framework needed further refinement and consultation (DHBoard Social Work Leaders Council, 2008).

The other four DHBs’ and the Recovery Competence for New Zealand Mental Health Workers’ competency frameworks were used to compare various competency statements. Only competency statements relating to beginning social work practice were used. Once the questionnaire was developed, it was peer reviewed by a group of social workers who were leaders within the DHBoard Social Work Leaders Council.
The Sample
Participants were financial members of the Aotearoa New Zealand Association of Social Workers (ANZASW) who identified themselves as Health Social Workers. Current or past employees of the Southern District Health Board (Otago) were excluded from participating in the study due to the researcher’s designated professional leadership within the Board (Otago), which could have been perceived as a conflict of interest.

Information Given to Participants
Social Workers who were ANZASW members, with the exception of the exclusion group, were sent a packet, as found in the appendix B, that included a cover letter, information sheet a consent form and survey instrument with a free post return envelope. The cover letter explained the nature of the research and assured participants of anonymity. The participants were asked to return the completed questionnaire and consent form using the provided free post pre-addressed envelope.

Procedure
On receipt of the completed questionnaire, the consent form was removed and stored separately. The returned questionnaire was assigned a study number to enable responses to be entered into Statistical Package for the Social Sciences (SPSS) version 16 for Apple software for later analysis. No individual identifying information was entered into the database.

Analysis of Quantitative Data
The quantitative data was analysed utilising SPSS. Frequencies, cross tabulation, percentages, means and standard deviations were calculated to analyse demographic variables and perceptions related to elements of the competencies.

The mean Likert-type scale scores for each competency element were statistically analysed using a One-way Analysis of Variance (ANOVA) with Tukey and Tamhane T2 post hoc tests. F-ratio and p-value were also used to further analyse the data.

Analysis of Qualitative Data
The participants’ comments were transcribed and coded thematically to identify themes. The themes were transferred into quantitative variables and entered into SPSS for further analysis. This allowed the frequencies and percentages to be calculated for each theme.
Conclusion
This study used a mixed method approach to test the research hypotheses. The quantitative elements of the questionnaire used a Likert-type scale, which allowed objective statistical analysis of the participant responses. The qualitative data collected provided contextual information about the quantitative data.

A Post-modernist and social constructionist perspective was taken, meaning that each participant’s view of what they considered should be part of a competency framework for Health Social Workers was individual and influenced by their own experiences. Using mixed methods provided the opportunity to research these perspectives.

The essential principles of Emancipatory and Critical reflective research were followed because the results have the potential to affect participants’ future practice environments. Participants also needed to use critical reflection when completing the research questionnaire.

The next chapter presents the results gathered from questionnaires returned as part of the mail-out survey.
CHAPTER SEVEN

RESULTS

This chapter presents the findings from the mail-out survey in which ANZASW administrative staff sent the questionnaire to 1082 financial members who self-identified as Health Social Workers. The 10 members who were current or past employees of the Southern District Health Board (Otago) were excluded due to a possible conflict of interest. The sample and response rate comprised the 167 (16%) members who returned completed questionnaires, which was above the expected return rate for mail-out surveys of between 12 and 14 percent noted by Synodinos (2003).

Participants’ Demographic Profile

Of the 167 participants, 81 percent were female and 19 percent male. Four percent were under 29 years old, 7 percent between 30 and 34 years old, 13 percent between 35 and 39 years old, 11 percent between 40 and 44 years old, 18 percent between 45 and 49 years old, 17 percent between 50 and 54 years old, 14 percent between 55 and 59 years old, 12 percent between 60 and 64 years old, and 4 percent over 65 years old. Using the midpoint values, it was established that the mean age was 47 years.

Table 2 represents a breakdown of the number and percentage of female and male participants in each age group. It shows that the majority of participants were female (60%) and aged between 35 and 59 years. This is consistent with the ‘Future Workforce Survey’, which reported the mean age of social workers working in DHBs as 46.6 years (Allied Health Workforce Strategy Group, 2007). The mean age of those identifying themselves as social workers was not reported in the last census in 2006. The 2001 census reported the mean age of those who identified themselves as social workers as being 43.2 years (Harrington & Crothers, 2005).
Table 2: Cross tabulation of Health Social Workers’ gender and age group (N=167)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Gender</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>&lt;29 years</td>
<td>7(4%)</td>
<td>0(0%)</td>
<td>7 (4%)</td>
<td></td>
</tr>
<tr>
<td>30-34 years</td>
<td>8(5%)</td>
<td>4(2%)</td>
<td>12 (7%)</td>
<td></td>
</tr>
<tr>
<td>35-39 years</td>
<td>18(11%)</td>
<td>4(2%)</td>
<td>22 (13%)</td>
<td></td>
</tr>
<tr>
<td>40-44 years</td>
<td>15(9%)</td>
<td>3(2%)</td>
<td>18 (11%)</td>
<td></td>
</tr>
<tr>
<td>45-49 years</td>
<td>27(16%)</td>
<td>3(2%)</td>
<td>30 (18%)</td>
<td></td>
</tr>
<tr>
<td>50-54 years</td>
<td>22(13%)</td>
<td>7(4%)</td>
<td>29 (17%)</td>
<td></td>
</tr>
<tr>
<td>55-59 years</td>
<td>18(11%)</td>
<td>5(3%)</td>
<td>23 (14%)</td>
<td></td>
</tr>
<tr>
<td>60-64 years</td>
<td>17(10%)</td>
<td>4(2%)</td>
<td>21 (12%)</td>
<td></td>
</tr>
<tr>
<td>&gt;65 years</td>
<td>4(2%)</td>
<td>2(1%)</td>
<td>6 (3%)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>136(81%)</td>
<td>31(19%)</td>
<td>167 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

In terms of ethnicity, 64 percent of participants identified as NZ Pakeha/European, 16 percent as Māori, 10 percent as European, 4 percent as Pacific Islander and 9 percent Other. The European, Pacific Islander and Other categories comprised various ethnic groups. The numbers of participants in these three groups were too small to ensure anonymity.

Table 3 shows the number and percentage of females and males within each ethnic group. As evidenced in the table, over half of the participants (55%) were NZ Pakeha/European female.
Table 3: Cross tabulation of participants’ ethnicity and gender (N=167)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>European</td>
<td>12 (7%)</td>
<td>5 (3%)</td>
<td>17 (10%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Māori</td>
<td>22 (13%)</td>
<td>4 (2%)</td>
<td>26 (15%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ Pakeha</td>
<td>91 (55%)</td>
<td>16 (10%)</td>
<td>107 (64%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>3 (2%)</td>
<td>3 (2%)</td>
<td>6 (4%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>8 (5%)</td>
<td>3 (2%)</td>
<td>11 (7%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>136 (81%)</td>
<td>31 (19%)</td>
<td>167 (100%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4 shows the number and percentage of participants grouped by years of experience as Health Social Workers and their ethnicity. The majority of participants have between 5 to 20 years Health Social Work experience and are NZ Pakeha/European.

Table 4: Cross tabulation of participants’ years of experience as a Health Social Worker and their ethnicity (N=167)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>&lt;05</th>
<th>05-10</th>
<th>11-15</th>
<th>16-20</th>
<th>21-25</th>
<th>&gt;26</th>
<th>Not Stated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>European</td>
<td>3(2%)</td>
<td>3(2%)</td>
<td>5(3%)</td>
<td>3(2%)</td>
<td>3(2%)</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>17(11%)</td>
</tr>
<tr>
<td>Māori</td>
<td>5(3%)</td>
<td>10(6%)</td>
<td>8(5%)</td>
<td>1(1%)</td>
<td>1(1%)</td>
<td>1(0%)</td>
<td>0(0%)</td>
<td>26(16%)</td>
</tr>
<tr>
<td>NZ Pakeha</td>
<td>24(14%)</td>
<td>42(25%)</td>
<td>13(8%)</td>
<td>18(11%)</td>
<td>5(3%)</td>
<td>4(2%)</td>
<td>1(1%)</td>
<td>107(64%)</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>0(0%)</td>
<td>5(3%)</td>
<td>1(1%)</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>6(4%)</td>
</tr>
<tr>
<td>Other</td>
<td>5(3%)</td>
<td>2(1%)</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>1(1%)</td>
<td>1(1%)</td>
<td>9(6%)</td>
</tr>
<tr>
<td>Total</td>
<td>37(22%)</td>
<td>63(38%)</td>
<td>27(16%)</td>
<td>22(13%)</td>
<td>10(6%)</td>
<td>6(4%)</td>
<td>2(1%)</td>
<td>167(100%)</td>
</tr>
</tbody>
</table>

In total, 82 percent of the participants had a social work qualification, 11 percent reported they did not have a social work qualification recognised by the Social Work Registration Board (SWRB) and 8 percent reported gaining their qualifications from overseas.

Generally, qualifications were attained from various New Zealand tertiary institutions. There were 30 percent from Massey University (Palmerston North), 10 percent from Victoria
University, 8 percent from University of Canterbury, 5 percent each from Auckland College of Education, University of Otago and WINTEC, 4 percent from Auckland University, 3 percent from Massey University (Albany), 2 percent each from Te Wanaga O Aotearoa and UNITEC, and 8 percent each from overseas Universities and the Polytechnics. The small numbers for each Polytechnic were combined to preserve participants’ anonymity.

The number and percentage of female and male participants and their social work qualifications is shown in Table 5, which identifies that the majority of participants with a SWRB-recognised qualification are female.

Table 5: Cross tabulation of participants’ social work qualifications and gender (N=167)

<table>
<thead>
<tr>
<th>Social Work Qualification</th>
<th>Gender</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Total</td>
</tr>
<tr>
<td>No recognised qualification</td>
<td>15 (9%)</td>
<td>3 (2%)</td>
<td>18 (11%)</td>
</tr>
<tr>
<td>SWRB recognised qualification</td>
<td>111 (67%)</td>
<td>25 (15%)</td>
<td>136 (82%)</td>
</tr>
<tr>
<td>Qualification gained overseas</td>
<td>9 (5%)</td>
<td>3 (2%)</td>
<td>11 (7%)</td>
</tr>
<tr>
<td>Total</td>
<td>136 (81%)</td>
<td>31 (19%)</td>
<td>167 (100%)</td>
</tr>
</tbody>
</table>

Table 6 presents the number and percentage of participants’ years of experience as Health Social Workers and their qualifications. The majority of participants with between 5 to 10 years of experience as Heath Social Workers have a SWRB-recognised qualification.

The table shows that 21 percent of the Health Social Workers had less than five years experience, 30 percent had between 5 and 10 years experience, 16 percent between 11 and 15 years experience, 13 percent between 16 and 20 years experience, 6 percent between 21 and 25 years experience and 4 percent more than 26 years experience. Two participants did not report their years of experience. The mean for years of experience was 14.2 years (SD = 8.5).
Table 6: Cross tabulation of participants’ social work qualifications and years of experience as a Health Social Worker (N=167)

<table>
<thead>
<tr>
<th>Social Work Qualification</th>
<th>Years of experience as Health Social Worker</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;05</td>
<td>05-10</td>
</tr>
<tr>
<td>No recognised social work qualification</td>
<td>4(2%)</td>
<td>5(3%)</td>
</tr>
<tr>
<td>SWRB-recognised social work qualification</td>
<td>32(19%)</td>
<td>52(31%)</td>
</tr>
<tr>
<td>Social work qualification gained overseas</td>
<td>1(1%)</td>
<td>5(3%)</td>
</tr>
<tr>
<td>Total</td>
<td>37(22%)</td>
<td>62(37%)</td>
</tr>
</tbody>
</table>

As shown in Table 7, the majority of participants were female with between 1 and 15 years of Health Social Worker experience.

Table 7: Cross tabulation of years of experience as a Health Social Worker and Gender (N=167)

<table>
<thead>
<tr>
<th>Years of experience as Health Social Worker</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>&lt;5 years</td>
<td>30 (18%)</td>
</tr>
<tr>
<td>05-10 years</td>
<td>52 (31%)</td>
</tr>
<tr>
<td>11-15 years</td>
<td>21 (13%)</td>
</tr>
<tr>
<td>16-20 years</td>
<td>20 (12%)</td>
</tr>
<tr>
<td>21-25 years</td>
<td>9 (6%)</td>
</tr>
<tr>
<td>&gt;26 years</td>
<td>4 (2%)</td>
</tr>
<tr>
<td>Not Stated</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Total</td>
<td>136 (81%)</td>
</tr>
</tbody>
</table>

In relation to practice specialities, 3 percent of participants reported working in Disability, 53 percent in Mental Health, 33 percent in Physical Health and 4 percent in Rehabilitation. Five percent were grouped in a generic practice specialty as “Other”.

As shown in Table 8, the majority of participants were female and worked in Mental Health.
Table 8: Cross tabulation of participants’ practice specialty and gender (N=167)

<table>
<thead>
<tr>
<th>Practice Specialty</th>
<th>Gender</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female N=136</td>
<td>Male N=31</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>3 (2%)</td>
<td>2 (1%)</td>
<td>5 (3%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>66 (39%)</td>
<td>22 (13%)</td>
<td>88 (52%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Health</td>
<td>53 (32%)</td>
<td>6 (4%)</td>
<td>59 (36%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>9 (5%)</td>
<td>0 (0%)</td>
<td>9 (5%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>136 (81%)</td>
<td>31 (19%)</td>
<td>167 (100%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 9 shows the length of experience worked in a speciality. It shows that the majority of participants worked in Mental Health and had between 5 and 10 years of experience as Health Social Workers.

Table 9: Cross tabulation of participants’ practice specialty and their years of experience as a Health Social Worker (N=167)

<table>
<thead>
<tr>
<th>Practice Specialty</th>
<th>&lt;05</th>
<th>05-10</th>
<th>11-15</th>
<th>16-20</th>
<th>21-25</th>
<th>&gt;26</th>
<th>Not Stated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability</td>
<td>2(1%)</td>
<td>2(1%)</td>
<td>1(1%)</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>5 (3%)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>16(10%)</td>
<td>38(23%)</td>
<td>15(9%)</td>
<td>12(5%)</td>
<td>4(2%)</td>
<td>2(1%)</td>
<td>1(1%)</td>
<td>88 (53%)</td>
</tr>
<tr>
<td>Physical Health</td>
<td>16(10%)</td>
<td>18(11%)</td>
<td>9(5%)</td>
<td>8(5%)</td>
<td>3(2%)</td>
<td>4(2%)</td>
<td>1(1%)</td>
<td>59 (35%)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>2(1%)</td>
<td>3(2%)</td>
<td>0(0%)</td>
<td>1(1%)</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>6 (4%)</td>
</tr>
<tr>
<td>Other</td>
<td>1(1%)</td>
<td>2(1%)</td>
<td>2(1%)</td>
<td>1(1%)</td>
<td>3(2%)</td>
<td>0(0%)</td>
<td>0(0%)</td>
<td>9 (6%)</td>
</tr>
<tr>
<td>Total</td>
<td>37(22%)</td>
<td>63(38%)</td>
<td>27(16%)</td>
<td>22(13%)</td>
<td>10(6%)</td>
<td>6(4%)</td>
<td>2(1%)</td>
<td>167(100%)</td>
</tr>
</tbody>
</table>

According to the Allied Health Workforce Strategy Group (2007), social workers practice in a wide range of health services. As demonstrated in Figure 3, almost 19 percent of the 167 participants in this study practiced in Non-Government Organisations (NGO). Participants grouped in the generic “Other” category (just over 4 percent) included those working in private practice and academic institutions. The remainder of the participants (almost 77%) were employed in social work positions in DHBs.
The percentage of participants working in particular DHBs was Waikato (30%), Auckland (10%), Canterbury (8%), Capital Coast (7%), Mid Central and Hawkes Bay (6% each), Hutt Valley, Northland and Southland (4% each), and Taranaki and Bay of Plenty (3% each). A further 16 percent were employed by other DHBs not listed, however the numbers of participants in these DHBs were too small to list separately and were combined to ensure anonymity. In the 2007 health workforce census there were 1139 social workers filling 893.9 full-time equivalent (FTE) positions within DHBs (Allied Health Workforce Strategy Group, 2007).

**Quantified and Qualitative Data Analysis Overview**

The mean scores from the Likert-type scale (1=strongly disagree to 7=strongly agree) for each competency element were statistically examined using One-way Analysis of Variance (ANOVA) with Tukey and Tamhane T2 post hoc tests.

ANOVAs were calculated for each competency standard element to test the differences in mean scores between independent groups. The post hoc tests were used to determine which means were different. Both Tukey and Tamhane T2 post hoc tests gave similar statistical outcomes for the data. The F-ratio was used to determine whether or not the two samples’ variances were equal. The p-value was calculated to determine any significant differences in the means. The data produced from the present research found a normal probability distribution.
Seventy percent of participants added comments at the end of each competency question. In total, 1093 comments were coded thematically and transformed into quantitative data for analysis. The most common of the 61 different themes identified are discussed in depth throughout this chapter.

**Data Analysis of Competency Statements**

*Competency Statement 1: Establishes a respectful and empathic working relationship between the social worker and client*

There are six elements within this competency, each of which was analysed in turn. As shown in Table 10, the mean scores indicate that overall the participants strongly agreed with all the elements contained in the competency statements.

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ((\bar{x}))</th>
<th>Standard deviation ((\sigma))</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Communication</td>
<td>6.51</td>
<td>0.95</td>
</tr>
<tr>
<td>1.2 Providing information</td>
<td>6.47</td>
<td>0.93</td>
</tr>
<tr>
<td>1.3 Allocating time</td>
<td>5.77</td>
<td>1.27</td>
</tr>
<tr>
<td>1.4 Client participation</td>
<td>6.37</td>
<td>1.04</td>
</tr>
<tr>
<td>1.5 Being respectful of background</td>
<td>6.59</td>
<td>0.86</td>
</tr>
<tr>
<td>1.6 Recognising different perspectives</td>
<td>6.71</td>
<td>1.13</td>
</tr>
</tbody>
</table>

Significant differences were found between the participant groups for competency elements 1.1, 1.2, 1.3 and 1.6. Each competency element is explained in depth below, including the thematically-coded comments related to the competency statements in elements 1.3, 1.4 and 1.6, and comments related to the overall competency.

**Competency statement 1.1: communicating mutuality in relationship by using appropriate language.** The above statistical tests established that male participants were less likely to strongly agree (\(\bar{x}=6.03\)) with this competency element than female participants (\(\bar{x}=6.63, F=10.39, p<0.01\)).

**Competency statement 1.2: respecting clients’ experience, beliefs and feelings when gathering and providing information.** A significant difference was found in mean scores between participants in the different age groups. Compared with the overall participants’ mean scores (\(\bar{x}=6.47\)), participants under 29 years of age (\(\bar{x}=5.71\)) were less likely to strongly agree with the competency statements (\(F=1.99, p<0.05\)).
**Competency statement 1.3: being unhurried when working with clients.** On average, compared with the overall participants’ mean scores (\(\bar{x} = 5.77\)), participants under 29 years of age (\(\bar{x} = 4.14\)) were less likely to strongly agree (\(F = 2.04, p < 0.05\)). There was also a statistically significant difference in mean scores between participants belonging to different ethnic groups. On average, compared with the overall participants’ mean scores, participants belonging to the ethnic group listed as “Other” (\(\bar{x} = 4.44\)) were less likely to strongly agree with the statement (\(F = 2.46, p < 0.05\)). However, the “Other” cannot be relied on because this category is not a composite homogeneous group.

Twenty-seven (16%) participants reported that time and workload pressures could compromise establishing a respectful and empathic working relationship with the client. The phrase “allocate sufficient time to client activities to allow unhurried resolution of tasks” generated a number of comments related to the word “unhurried”. As one participant commented:

> In an acute hospital setting a social worker needs to prioritise their time. S/he may give the appearance to a patient that they are ‘unhurried’ but in reality the patient knows there is another patient waiting for social workers’ attention and service.

Another participant commented:

> Balancing workload requirements may mean that there are pressures on time. It is desirable to have sufficient time but in practice time is a valuable resource.

Others commented that factors contributing to time and workload pressures included crisis work, complex cases, safe discharge planning and demand for beds coupled with increased work volumes. For example:

> Working on acute wards with high volume of work does not always allow sufficient time for ‘unhurried’ resolution of tasks, although this is the ideal.

**Competency statement 1.4: client participation.** A total of 12 (7%) participants made comments about client participation. Most comments were about clients’ functioning and their ability to participate in decision-making. Two of the participants questioned whether some clients were able to participate in decision-making, for example small children and clients with acute mental illness, dementia and intellectual disability. One participant stated:

> Consideration needs to be given to the client’s mental competency, which may affect their ability to fully participate.
Another participant stated:

*When there is risk of harm to client, this can override client participation and decision-making and gathering of information, for example in regard to the care and protection of children.*

**Competency statement 1.6:** *working with families and groups, social workers take into account the different experiences and worldviews of the various members of the family or group.* There were significant differences in mean scores between participants belonging to different ethnic groups. On average, compared with the overall participants’ mean scores ($\bar{x} = 6.19$), participants who belonged to the ethnic group listed as “Other” ($\bar{x} = 4.78$) were less likely to strongly agree with the competency standard ($F = 3.64$, $p < 0.01$).

Eleven (6%) participants’ comments related to working with family. Generally, their comments related to difficulties accommodating family needs and wishes with clients. This was particularly challenging in situations where family conflict or unrealistic expectations existed. One stated:

*There are tensions in determining who is the client.*

Another stated:

*Advocating for families and groups gives a voice in the medical setting which allows their experiences and perspectives to be heard.*

**Comments Related to Overall Competency Statement 1**

Additionally, nine (5%) participants noted that overall competency is an essential aspect of social work practice, however it could be difficult for some social workers to attain. Reasons given for social workers having difficulty attaining the ideal were organisational policies and procedures, and constraints created by the lack of time and resources.

**Competency Statement 2: Developing a social work assessment**

The six elements within this competency were analysed and, as presented in Table 11, the mean scores showed that on average participants strongly agreed with all the competency statements except 2.6, where the participants indicated they agreed.
Table 11: Mean and standard deviation of elements contained in competency statement 2

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ((\bar{x}))</th>
<th>Standard deviation ((\sigma))</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Gathers information to develop a social work assessment</td>
<td>6.25</td>
<td>1.02</td>
</tr>
<tr>
<td>2.2 Identifies risk</td>
<td>6.47</td>
<td>0.94</td>
</tr>
<tr>
<td>2.3 Applies assessment tools</td>
<td>5.76</td>
<td>1.44</td>
</tr>
<tr>
<td>2.4 Reviews assessment</td>
<td>5.93</td>
<td>1.26</td>
</tr>
<tr>
<td>2.5 Documentation</td>
<td>6.43</td>
<td>0.98</td>
</tr>
<tr>
<td>2.6 Undertakes Mental State Examination</td>
<td>4.94</td>
<td>2.08</td>
</tr>
</tbody>
</table>

Significant differences between the groups of participants were established for competency statement elements 2.4, 2.5 and 2.6. Each of these is explained in depth below, along with the thematically-coded comments related to competency elements 2.3 and 2.6, and comments related to the overall competency.

**Competency statement 2.3: using assessment tools.** Thirty-eight (23%) participants commented about the use of assessments. Five participants suggested changing “assessment schedule” to “assessment tools”. One participant suggested that there was no consistency between the assessments social workers carry out. Six (4%) participants wrote that time constraints meant they could not do regular reviews of assessments. One participant statement captured the overall general comments:

*Health Social Work is often based upon a one-off session with the client and family. There is a need for a flexible approach based upon a standard assessment. Often Health Social Workers have to think outside of the box to be creative in identifying issues and resolutions.*

**Competency statement 2.4: reviewing assessments with clients.** A significant difference in mean scores was found between participants from the various age groups and those with different years of experience as Health Social Workers. On average, compared with the overall participants’ mean scores (\(\bar{x}=5.93\)), participants under 29 years of age (\(\bar{x}=4.86\)) were less likely to strongly agree with this competency statement (F=2.30, p<0.05). On average, compared with the overall participants’ mean scores, participants who had not stated their years of experience as Health Social Workers (\(\bar{x}=6.50\)) were more likely to strongly agree with the competency statement (F=2.30, p<0.01). This result cannot be relied on due to the small number in this category.
Competency statement 2.5: *documenting social work activities as required by the employer.* A significant difference in mean scores was found between participants from the various places of practice. On average, compared with the participants’ overall mean scores ($\bar{x}=6.43$), participants who worked in Hutt Valley DHB ($\bar{x}=5.67$) were less likely to strongly agree with this competency standard ($F=1.80, p<0.05$).

Competency statement 2.6: *carrying out assessments of clinical functioning and mental state examination as part of a comprehensive assessment.* There was a significant difference in mean scores between participants from different practice specialties. On average, compared with the participants’ overall mean score ($\bar{x}=4.94$), participants working in Rehabilitation ($\bar{x}=1.67$) were more likely to disagree with the competency statement ($F=16.74, p<0.01$). The participants grouped into the practice specialty “Other” ($\bar{x}=3.33$) also did not agree with the competency statement. On average, compared with the participants’ overall mean score for the competency statement, participants who practiced in Northland DHB ($\bar{x}=1.83$) were more likely to disagree ($1.83, F=2.00, p<0.01$) while participants who practiced in Taranaki DHB ($\bar{x}=6.60$) were more likely to strongly agree.

Forty-two (25%) participants made comments about mental state examinations (MSE). Ten (6%) reported that other professionals undertook the examinations. Five (3%) reported that occupational therapists undertook MSE in their services. Other participants reported that the professionals who performed MSE were nurses, clinical psychologists, psychiatrists and general practitioners.

Four (2%) participants commented that only social workers with appropriate qualifications and experience should undertake MSE, and four (2%) participants also reported MSE was not relevant to their job. One participant commented:

*Within my role we are expected to complete mental state examinations – however at times I question this; as social workers we are not really clinically trained like this.*

Another participant commented:

*I have had to learn in the field how to do mental state examinations. It would have been beneficial if this were part of social work training. Mental state examinations are a predominant part of my role.*
Another comment was:

I agree with the last question (2.6 mental state examination) where appropriate but have concern about the misinterpretation and misuse with cultural/ethical behaviour.

Comments Related to Overall Competency Statement 2

The general Competency 2 comments related to time and workload pressures, documentation and consent. Six (4%) participants commented on time and workload pressures and how these impacted on their ability to complete assessments.

Two (1%) participants wrote about documentation as beneficial for clients. However, more time was spent on paperwork than with clients.

**Competency Statement 3: Develops and implements educational interventions with clients**

There are three elements within this competency, which were each analysed in turn. As shown in Table 12, the mean scores indicate that on average participants agreed with all Competency 3 elements.

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ($\bar{x}$)</th>
<th>Standard deviation ($\sigma$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Establishes the client’s need for education</td>
<td>5.59</td>
<td>1.58</td>
</tr>
<tr>
<td>3.2 Links the client to appropriate resources and learning opportunities</td>
<td>5.99</td>
<td>1.36</td>
</tr>
<tr>
<td>3.3 Uses appropriate language and technology when presenting information</td>
<td>5.98</td>
<td>1.35</td>
</tr>
</tbody>
</table>

A significant difference between groups of participants was found for competency statement element 3.3. This will be explained in depth below, along with the thematically-coded comments relating to the competency elements 3.1, 3.2 and 3.3, and comments relating to the overall competency.

**Competency element 3.1: establishes the client’s needs for education.** Nineteen (11%) participants commented about this competency element. Eleven (6%) highlighted confusion around the education role within social work. Eight (5%) reported that they did not receive
psycho-educational therapy training within their social work courses. They also commented that they did not have time to provide education. One participant commented:

*I think in some sectors this area has not been given the emphasis it requires. While social workers may provide information, etc., to clients, they may not specifically set out to educate.*

Another participant commented

*... social work education is about how systems work/function/interact.*

**Competency element 3.2: link the client to appropriate resources and learning opportunities.** Fifteen participants (9%) commented about this competency element. Two (1%) reported that they agreed with the competency, however at times it could be challenging to provide appropriate interventions when the client chose not to engage. Thirteen (8%) participants made comments about resources. Eight (5%) reported that they referred clients to external agencies where appropriate. One participant wrote:

*Accessing external (to the agency) resources ensures opportunities are sustainable.*

Another participant suggested that the lack of up-to-date resources and technology made it difficult to present educational information to clients. One participant questioned the wording of this element by asking what a learning environment was.

**Competency statement 3.3: Using appropriate language and technology when presenting information.** A significant difference was found between participants’ means scores for this competency. Compared with the participants’ overall mean scores ($\bar{x}=5.98$), on average participants who were grouped in the ethnic category “Other” ($\bar{x}=4.22$) were less likely to strongly agree with the competency statement (F=4.65, p<0.01). This result needs to be treated with caution, as this group was not homogeneous. Nine (5%) participants wrote about terminology, reporting that it is very important to use language clients can understand. One participant noted that medical jargon needed to be translated into lay terms.

**Comments Related to Overall Competency Statement 3**

Seven (4%) participants made general comments about Competency 3. Four made comments about “time”, reporting in general that time constraints made it difficult to provide
educational interventions. Three participants reported that education was not part of their role as a social worker.

**Competency Statement 4: Advocates with and for clients in relation to rights and resources**

There are six elements within this competency. Each was analysed in turn. As shown in Table 13, mean scores indicate that on average participants strongly agreed with all the competencies.

Table 13: Mean and standard deviation of elements contained in competency statement 4

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score (( \bar{x} ))</th>
<th>Standard deviation (( \sigma ))</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Social worker advocating for clients</td>
<td>6.17</td>
<td>1.17</td>
</tr>
<tr>
<td>4.2 Alternative actions to address needs and supports the actions chosen</td>
<td>6.28</td>
<td>1.12</td>
</tr>
<tr>
<td>4.3 Ensures the treatment team is respectful and inclusive</td>
<td>5.68</td>
<td>1.55</td>
</tr>
<tr>
<td>4.4 Supporting client’s self-advocacy</td>
<td>6.02</td>
<td>1.37</td>
</tr>
<tr>
<td>4.5 Uses principles of mediation, negotiation, assertion and conflict resolution</td>
<td>6.11</td>
<td>1.18</td>
</tr>
<tr>
<td>4.6 Evaluates with the client the outcome of advocacy</td>
<td>5.74</td>
<td>1.53</td>
</tr>
</tbody>
</table>

Significant differences between groups of participants were found for competency statement elements 4.1, 4.2, 4.5 and 4.6. This will be explained in depth below, along with the thematically-coded comments related to each competency element and to the overall competency.

**Competency statement 4.1: social worker advocates for clients.** A significant difference was found between participants’ means scores for this competency element compared with the overall participants’ mean scores (\( \bar{x} = 6.17 \)). Participants who practiced in Rehabilitation (\( \bar{x} = 5.33 \)) were less likely to strongly agree with the competency statement (\( F=3.49, p<0.01 \)). Participants grouped into the ethnic group “Other” (\( \bar{x} = 5.33 \)) were also less likely to strongly agree with the statement (\( F=2.33, p<0.05 \)).

Twenty-three (14%) participants’ comments were coded thematically into advocacy. There were very mixed views on the advocacy role among social workers. Ten participants supported the advocacy role for social workers. As one participant noted:
Advocacy is an integral part of Health Social Work. Advocacy takes extra time—letter writing, refocusing, and a social worker can access resources that might not be available to a client otherwise.

Another participant stated:

This is especially important in health where clients can feel intimidated by medical jargon/power.

Seven (4%) participants suggested that other professional organisations, or clients themselves, were responsible for advocacy. One participant stated:

This may sometimes be the role of Health and Disability advocates. When social workers are involved in this role it can create ethical dilemmas for them. While standards of practice dictate advocacy and social justice—this is not well understood within the health environment.

Four (2%) participants suggested making sure clients are involved in the process. One participant noted that advocacy is the role of all health professionals.

**Competency statement 4.2: alternative actions to address needs and supports the actions chosen.** A significant difference in mean scores between participants was found for this competency element. Compared with the participants’ overall mean scores ($\bar{x}=6.28$), participants from the ethnic group listed as “Other” ($\bar{x}=5.56$) were less likely to strongly agree with the competency statement ($F=2.63, p<0.05$), as were participants who worked in Hutt Valley DHB ($\bar{x}=5.83$) ($F=3.46, p<0.01$).

Eight (5%) participants argued that interventions needed to be client-focused; it is important to identify whether the client is a family, couple or an individual. One participant noted that social workers often worked with the client’s carers, not the client. Another participant suggested that “collaborative model of working” needs to be added to this competency.

**Competency statement 4.3: ensuring the treatment team is respectful and inclusive.** Nine (5%) participants commented that a Multi Disciplinary Team (MDT) was very helpful when they were advocating for clients. Two participants commented that when the MDT was dysfunctional it might have a negative effect on a social worker’s ability to advocate for their clients.

**Competency statement 4.4: supporting client self-advocacy.** Three (2%) participants discussing resources reported that this competency element was difficult to achieve due to the lack of resources.
**Competency statement 4.5:** uses principles of mediation, negotiation, assertion and conflict resolution. A significant difference was found in mean scores between participants. Compared with the participants’ overall mean score ($\bar{x}=6.11$), males ($\bar{x}=5.61$) were more likely to strongly agree with the competency statement ($F=2.63$, $p<0.05$).

Three (2%) participants commented on mediation and conflict resolution. One stated:

*Social workers should do as stated, but many are not adequately trained to deal with mediation and conflict resolution.*

Another participant commented:

*Only when culturally appropriate.*

**Competency statement 4.6:** evaluates with the client the outcome of advocacy. A significant difference was found between participants’ mean scores. Compared with the participants’ overall mean scores ($\bar{x}=5.74$), participants with more 26 years of experience as Health Social Workers ($\bar{x}=4.86$) were less likely to strongly agree with the competency statement ($F=2.55$, $p<0.05$). Participants who had not stated their years of experience ($\bar{x}=7.00$) were more likely to strongly agree. This result needs to be treated with extreme caution because there were only two participants in this category.

Ten (6%) participants commented on evaluation. They reported that the lack of feedback regarding referrals to other agencies made evaluation difficult. Two reported that social workers might only see a client a couple of times and so had little time to evaluate the intervention. One participant reported:

*There are no systems for evaluating outcomes of interventions. Time constraints are a huge factor in why social workers are unable, a lot of the time, to evaluate practice methods/interventions and analyse outcome/results.*

**Comments Related to Overall Competency Statement 4**

Six (4%) participants suggested that although competency 4 is an ideal, it is difficult to obtain due to time constraints.

**Competency Statement 5: Case management**

There are four elements within this competency, each of which was analysed in turn. As shown in Table 14, the mean scores indicate that on average participants strongly agreed with all the competencies.
Table 14: Mean and standard deviation of elements contained in competency statement 5

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ((\bar{x}))</th>
<th>Standard deviation ((\sigma))</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Undertakes social work assessment</td>
<td>6.31</td>
<td>1.28</td>
</tr>
<tr>
<td>5.2 Develops a plan of intervention with a client</td>
<td>6.06</td>
<td>1.30</td>
</tr>
<tr>
<td>5.3 Develops a service plan in consultation with client, significant others and MDT</td>
<td>6.13</td>
<td>1.41</td>
</tr>
<tr>
<td>5.4 Evaluates the service plan with clients</td>
<td>5.67</td>
<td>1.70</td>
</tr>
</tbody>
</table>

Significant differences between groups of participants were found for all the elements in this competency. This will be explained in depth below, along with the thematically-coded comments related to each of the competency elements and comments related to the overall competency.

**Competency statement 5.1: undertakes a social work assessment.** A significant difference in mean scores was found between participants in the different Health Social Workers’ years of experience groups. On average, compared with the overall participants’ mean scores (\(\bar{x}=6.31\)), participants who had more than 26 years experience (\(\bar{x}=5.33\)) were less likely to strongly agree with the competency statement (F=2.24, p< 0.05).

In regard to assessments, seven (4%) participants had mixed views as to whether assessments should be social work-specific or multi-disciplinary. Three (2%) thought that in Mental Health they did not do social work-specific assessments but comprehensive initial assessments. One participant stated:

_A lot of social workers are fine at assessments but not at interventions. I think this section is very important._

**Competency statement 5.2: develops a plan of intervention with a client.** A significant difference was found in the mean scores for male (\(\bar{x}=5.35\)) and female (\(\bar{x}=6.31\)) participants. On average, males were less likely to strongly agree with this competency statement (F=11.90, p< 0.01).

In general, nine participants (5%) commented that while intervention plans were an important part of social work, often they were done poorly. One stated:
Interventions with clients are not ongoing. So during the assessment, supports and counselling are offered, and if required referrals are made from the assessment appointment.

**Competency statement 5.3:** develops a service plan in consultation with family, significant others, service provided and MDT. On average, males (\(\bar{x}=5.68\)) were less likely than females (\(\bar{x}=6.31\)) to strongly agree with this competency statement (F=4.01, p< 0.05).

Two (1%) of the participants reported that social workers had a significant role in the MDT. In regard to involving families, seven (4%) participants believed this was important. One participant thought this should only happen where appropriate. Another stated:

> In some cultures/ethnic groups the inclusion of significant others, particularly family/aiga/whānau, is important and is required from the beginning.

Two (1%) participants did not like the words “service plan” in this element.

**Competency statement 5.4:** evaluates the service plan with clients. Compared with the overall mean score (\(\bar{x}=5.67\)), a significant difference was found between male and female participants for this element. Male participants (\(\bar{x}=4.97\)) were less likely than females (\(\bar{x}=5.83\)) to strongly agree with the competency statement (F=6.78, p<0.01). Participants who did not state their years of experience as Health Social Workers (\(\bar{x}=3.50\)) were less likely to agree with this statement. Participants with less than 5 years experience as Health Social Workers (\(\bar{x}=4.95\)) and participants with more than 26 years experience (\(\bar{x}=4.83\)) were less likely to strongly agree with the competency statement (F= 3.00 p<0.01) compared with the other participants.

**Comments Related to Overall Competency Statement 5**

Twenty-three (14%) participants made comments related to competency 5 as a whole. Thirteen (8%) thought gaining the client’s consent was very important. Four (2%) participants made the point that at times it was difficult to gain a client’s consent, however they still needed to work with the client. Six (4%) of the 13 (8%) participants who commented about evaluation and review reported that due to their interactions with clients for very short periods they did not have the opportunity to review plans. Three (2%) participants discussed case management, two of whom thought that although their role did not include case management, they believed it was about process management as a concept that is fundamental to the social work approach.
The eight (5%) participants who made comments about time or workload pressure agreed with Competency 5 as being ‘best practice’, but time constraints limited their ability as social workers to carry out many of its aspects. One participant commented that in their service:

*On average hospital stays are 2.9 days. Short stays tend to result in a more task-focused intervention than therapeutic process.*

Another commented:

*Although I strongly agree, constraints around resources mean that review and evaluation are often not given the attention it deserves. This is a shame as so much effort and time is spent doing thorough assessment that care monitoring sometimes is not given the same attention, time and resources.*

**Competency Statement 6: Intensive casework**

There are four elements within this competency, each of which was analysed in turn. As shown in Table 15, the mean scores indicate that on average participants agreed with the entire competency.

There were no significant differences between groups of participants for any of the competency elements. Thematically-coded comments related to competency elements 6.1, 6.3 and 6.4, and comments related to the overall competency are explored below.

**Table 15: Mean and standard deviation of elements contained in competency statement 6**

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ((\bar{x}))</th>
<th>Standard deviation ((\sigma))</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Supports client to select a course of action</td>
<td>5.47</td>
<td>1.56</td>
</tr>
<tr>
<td>6.2 Supports client to implement a course of action</td>
<td>5.84</td>
<td>1.36</td>
</tr>
<tr>
<td>6.3 Evaluates problem-solving activities with the client</td>
<td>6.00</td>
<td>1.27</td>
</tr>
<tr>
<td>6.4 Consults with family, significant others, MDT and other service providers in order to solve problems</td>
<td>6.01</td>
<td>1.40</td>
</tr>
</tbody>
</table>

**Competency statement 6.1:** *supports the client’s selection of a course of action.* Sixteen (10%) of 48 (29%) participants who commented on clients’ choice and consent reported that they needed to consider risk, or the possibility of harm to self or others. Ten (6%) participants stated that they would not support a client’s choices if they were unrealistic or not in their best interest. One participant wrote:
Depending on the risk identified, I cannot always support a client’s course of action. If they have the capacity to consent then I would support them while highlighting risks and seeking ways to manage them.

**Competency statement 6.3:** evaluates problem-solving activities with the client. Six (4%) participants commented on review and evaluation. They agreed that monitoring of activities was an important part of case management. One wrote:

*I agree there should be some support and monitoring but be careful the social worker does not become a co-dependent.*

**Competency statement 6.4:** consults with family, significant others, MDT and other service providers in order to solve problems. Seven of the 14 (8%) participants who commented on family involvement said they would only involve the family with the client’s consent. Others qualified this by suggesting they would involve family if a client “lacks cognitive abilities or insight” or “when risk is involved” without client consent. Two also reported that they worked mainly with the client’s family, one of whom stated:

*Because I work mostly with chronic illness and those over 65 years, it is sometimes the significant other who I work on the social work plan with. Also people with dementia lack insight into safety and risk which can challenge the social work/client agreement.*

**Comments Related to Overall Competency Statement 6**

Five (3%) participants who commented on time and workload pressures in general noted that the input required for undertaking intensive casework made it difficult for social workers. One stated:

*Requires good time management to be effective and efficient.*

**Competency Statement 7: Intensive family casework**

There are eight elements within this competency. Each was analysed in turn. As shown in Table 16, the mean scores indicate that on average participants strongly agreed with the overall competency.

Significant differences between groups of participants were found for competency statements 7.7 and 7.8. This will be explained in depth below, along with the thematically-coded comments related to competency elements 7.3, 7.4, 7.5, 7.6, 7.7 and 7.8, and comments related to the overall competency.
Table 16: Mean and standard deviation of elements contained in competency statement 7

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ((\bar{x}))</th>
<th>Standard deviation ((\sigma))</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 Develops a respectful working relationship with family members</td>
<td>6.09</td>
<td>1.47</td>
</tr>
<tr>
<td>7.2 Undertakes a family social work assessment</td>
<td>5.90</td>
<td>1.42</td>
</tr>
<tr>
<td>7.3 Supports family’s action</td>
<td>5.12</td>
<td>1.65</td>
</tr>
<tr>
<td>7.4 Supports the family implementing the course of action</td>
<td>5.37</td>
<td>1.70</td>
</tr>
<tr>
<td>7.5 Evaluates and problem solves with the family</td>
<td>5.50</td>
<td>1.59</td>
</tr>
<tr>
<td>7.6 Consults with the consumer, significant others, MDT and other providers to assist in problem solving</td>
<td>5.93</td>
<td>1.61</td>
</tr>
<tr>
<td>7.7 Advocates with and for families</td>
<td>5.93</td>
<td>1.53</td>
</tr>
<tr>
<td>7.8 Negotiates with families the limits of confidentiality</td>
<td>5.94</td>
<td>1.63</td>
</tr>
</tbody>
</table>

**Competency statement 7.3:** supports family’s action. All six (4%) of the participants who discussed supporting families in casework agreed that it was an important part of the work. However, three participants qualified their comments with “only when appropriate”. Eleven (7%) participants believed that it was important to give careful consideration to interventions when working with families, with one participant summing it up by stating:

*Families of people with severe mental illnesses are often burnt out and relieved to have their family member ‘in care’. Slow and careful interventions are needed to repair relationships. A non-judgemental perspective must be maintained.*

**Competency statement 7.4:** supports the family implementing the course of action. Eighteen (11%) of the 39 (23%) participants commenting on family choice reported that they would only support the client’s choices if it were in the best interest of all the family members. Two participants suggested that consensus between family needed to be reached.

**Competency statement 7.5:** evaluates and problem solves with the family. Five (3%) participants reported that they monitored and evaluated where appropriate.
**Competency statement 7.6:** consults with the consumer, significant others, MDT and other providers to assist in problem solving. One (1%) participant suggested that this element could be a problem in private practice, for example:

*I totally agree but a client is paying for my time and this can compromise full involvement as it becomes too expensive.*

**Competency statement 7.7:** advocating with and for families. Compared with the females’ ($\bar{x}=6.07$) mean score, males ($\bar{x}=5.45$) were less likely to strongly agree with this competency statement ($F=4.23$, $p<0.05$). Two participants suggested that advocacy is a necessary skill for social workers.

**Competency statement 7.8:** negotiates with families the limits of confidentiality. Compared with the participants’ overall mean score ($\bar{x}=5.94$), participants who gained their social work qualification at University of Canterbury ($\bar{x}=4.31$) were less likely to strongly agree with this competency statement ($F=2.39$, $p<0.01$).

Four (2%) participants commented in general that no information could be gathered without clients’ expressed permission.

**Comments Related to Overall Competency Statement 7**

Thirty-seven (22%) participants made comments relating to the overall Competency 7. Six (4%) of the participants commented that when working with families, relationships have an impact on what interventions can be put in place. Two participants (1%) reported that family work is difficult for Health Social Workers sometimes when there is conflict between family members. Two other participants (1%) noted that working with families is not always practical and may not always be desirable. Another participant argued that good social work involves family work. In regard to family work, three participants (2%) reported they did family work only if time allowed. One participant said:

*There is not usually time for comprehensive family/carer assessments.*

Another five (3%) participants reported that while they agreed with the competencies, they did not do family work.

Eleven (6%) of the twenty (12%) participants commenting on client choice and consent said they only supported the client’s choice if it was in their best interest. One participant stated:
I don’t have to support a family’s action, only what the client needs and identifies. Families do not always know best.

Another stated:

Consent is a negotiation process about limits of confidentiality.

Yet another stated:

It’s important to support and advocate for clients and families where appropriate but social workers need to empower and encourage clients to take responsibility and ensure decisions and plans are safe and achievable.

**Competency Statement 8: Develops and implements educational interventions with groups**

There are ten elements within this competency, each of which was analysed in turn. Mean scores indicate that on average participants strongly agreed with the overall competency, as shown in Table 17.

**Table 17: Mean and standard deviation of elements contained in competency statement 8**

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ((\bar{x}))</th>
<th>Standard deviation ((\sigma))</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1 Establishes a working relationship with group members</td>
<td>5.86</td>
<td>1.83</td>
</tr>
<tr>
<td>8.2 Assesses the group’s need for education</td>
<td>5.51</td>
<td>1.96</td>
</tr>
<tr>
<td>8.3 Establishes group goals, norms and expectations</td>
<td>5.63</td>
<td>2.05</td>
</tr>
<tr>
<td>8.4 Implements learning experiences for the group</td>
<td>5.20</td>
<td>2.14</td>
</tr>
<tr>
<td>8.5 Encourages individual members to achieve learning goals</td>
<td>5.51</td>
<td>2.04</td>
</tr>
<tr>
<td>8.6 Encourages group members to support each other</td>
<td>5.13</td>
<td>2.20</td>
</tr>
<tr>
<td>8.7 Facilitates problem solving and conflict resolution within a group</td>
<td>5.51</td>
<td>2.00</td>
</tr>
<tr>
<td>8.8 Maximises opportunities for self-learning</td>
<td>5.50</td>
<td>2.09</td>
</tr>
<tr>
<td>8.9 Evaluates learning outcomes of group activity</td>
<td>5.32</td>
<td>2.16</td>
</tr>
<tr>
<td>8.10 Terminates group involvement</td>
<td>5.26</td>
<td>2.16</td>
</tr>
</tbody>
</table>
Significant differences between groups of participants were found for element 8.1. This will be explained in more depth below, along with the thematically-coded comments related to competency elements 8.1, 8.2 and 8.4,

**Competency statement 8.1: establishes a working relationship with group members.** On average, compared with the female overall mean score ($\bar{x}=5.99$), male participants ($\bar{x}=5.26$) were less likely to strongly agree with the competency statement ($F=4.14$ $p<0.05$).

Three (2%) participants made comments about relationships within group work. They suggested that group work was beneficial to their client groups by providing support for each other.

**Competency statement 8.2: assesses the group’s need for education.** Fourteen (8%) participants commented on group work. Two of the participants (1%) reported that their experience of group work was confined to social work peer groups. Some of the participants mentioned areas where group work was undertaken, for example, MDT support groups, living with cancer groups, Parenting courses, Brief Therapy groups and Social Skills. One participant stated:

> This is an important part of social workers’ learning which is not very strong.
> A lot of social workers find it difficult to participate in group work and learning groups.

**Competency statement 8.4: implements learning experiences for the group.** Ten (6%) participants reported that education was not always appropriate within group work. One participant suggested that education skills were needed when working in the MDT, especially education around the role and scope of social work practice. Four participants argued that adult education training and group facilitation needed to be part of social work training. Five participants commented they had done group work in the past but were no longer able to do it because of contractual constraints.

**Competency Statement 9: Develops and implements therapeutic groups for consumers and family carers**

This competency statement consists of eleven elements, which are analysed in turn. The mean scores indicate that on average participants agreed with all the competencies, as shown in Table 18.
Table 18: Mean and standard deviation of elements contained in competency statement 9

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ((\bar{x}))</th>
<th>Standard deviation ((\sigma))</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1 Develops purpose, membership, and planned activity of the group</td>
<td>5.11</td>
<td>2.51</td>
</tr>
<tr>
<td>9.2 Assesses the needs of group members, as they relate to the groups purpose</td>
<td>4.95</td>
<td>2.45</td>
</tr>
<tr>
<td>9.3 Establishes group goals and norms to maintain a supportive group culture</td>
<td>5.05</td>
<td>2.49</td>
</tr>
<tr>
<td>9.4 Develops and implements group activities to meet group goals</td>
<td>4.80</td>
<td>2.53</td>
</tr>
<tr>
<td>9.5 Encourages feedback to individuals</td>
<td>4.99</td>
<td>2.51</td>
</tr>
<tr>
<td>9.6 Engages group members to support each other’s goals</td>
<td>4.80</td>
<td>2.46</td>
</tr>
<tr>
<td>9.7 Monitors group activity</td>
<td>4.74</td>
<td>2.57</td>
</tr>
<tr>
<td>9.8 Applies group process skills to meet group goals</td>
<td>4.99</td>
<td>2.48</td>
</tr>
<tr>
<td>9.9 Modifies group activity as needed</td>
<td>4.84</td>
<td>2.50</td>
</tr>
<tr>
<td>9.10 Facilitates problem solving within the group</td>
<td>5.01</td>
<td>2.49</td>
</tr>
<tr>
<td>9.11 Engages group members in terminating the group</td>
<td>4.87</td>
<td>2.49</td>
</tr>
</tbody>
</table>

No significant differences were found between groups of participants. The thematically-coded comments related to competency elements 9.3 and 9.11, and comments related to the overall competency.

**Competency statement 9.3:** establishes group goals, norms and expectations to sustain a supportive group culture. Three (2%) participants commented on boundaries and suggested that setting group ground rules needed to be done in collaboration with group members.

**Competency statement 9.11:** engages group members in terminating the group. Four (2%) participants made comments about termination and evaluation. These participants agreed that evaluating group processes was important at termination of the group.
Comments Related to Overall Competency Statement 9

Fifty-six (34%) participants made general comments about the competency. Twelve (7%) participants looking at the group work supported therapeutic group work. Four (2%) participants commented that social work training needed to include how to lead therapeutic groups.

Twenty-five (15%) participants reported that group work was not part of their role. Approximately half of these participants would like to develop skills around running therapeutic groups.

**Competency Statement 10: Develops an assessment of community needs and resources**

There are six elements within this competency, which were each analysed in turn. As Table 19 shows, the mean scores indicate that on average participants strongly agreed with all the competencies.

Significant differences between groups of participants were found for elements 10.4, 10.5 and 10.6. This will be explained in depth below, along with the thematically-coded comments related to competency elements 10.1, 10.3, 10.4, 10.5 and 10.6, and comments related to the overall competency.

**Table 19: Mean and standard deviation of elements contained in competency statement 10**

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ($\bar{x}$)</th>
<th>Standard deviation ($\sigma$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1 Interprets demographic data</td>
<td>4.74</td>
<td>2.10</td>
</tr>
<tr>
<td>10.2 Assesses a range of information from agencies for assessment purposes</td>
<td>4.57</td>
<td>2.10</td>
</tr>
<tr>
<td>10.3 Accesses information from a variety of sources</td>
<td>4.60</td>
<td>1.94</td>
</tr>
<tr>
<td>10.4 Engages key professionals to identify resources and gaps</td>
<td>5.11</td>
<td>2.00</td>
</tr>
<tr>
<td>10.5 Gathers detailed information about agencies</td>
<td>5.44</td>
<td>1.83</td>
</tr>
<tr>
<td>10.6 Integrates data gathered to form an assessment of the community</td>
<td>4.92</td>
<td>2.89</td>
</tr>
</tbody>
</table>

**Competency statement 10.1: Interprets demographic data.** Three (2%) participants made comments about this competency element. One participant said they collected demographic
information as part of statistical monthly reports. Two (1%) other participants reported that they did not see collecting demographic information as a major part of a social worker’s role.

**Competency statement 10.3: Accesses information from a variety of sources.** There were mixed opinions among 15 (9%) participants about the gathering of information. Four suggested that newspapers, television and the Internet are not appropriate sources of information. Another participant qualified their comment about gathering information with the statement:

... as long as it is up-to-date, factual and legal.

Four participants suggested that information gathering should only be done if necessary, in line with the Privacy Act 1993 and organisational policies. One participant added that interpreting budgets should be added to the information gathering.

**Competency statement 10.4: Engages key professionals to identify resources and gaps.** Compared with the participants’ overall mean score ($\bar{x}=5.11$), participants who did not have a social work qualification recognised by the SWRB ($\bar{x}=6.29$) were more likely to strongly agree with the competency statement ($F= 2.96$, $p< 0.05$). Participants who identified as Pacific Islander ($\bar{x}=6.50$) were more likely to strongly agree with the competency statement ($F=2.40$, $p<0.05$).

Thirteen (8%) participants made comments about this element. Eleven (7%) of these commented on community resources and argued in general that assessing availability and accessing community resources were important parts of their role. Two (1%) participants reported that they attended network meetings in the community and two (1%) suggested that social workers needed to act when gaps were identified.

**Competency statement 10.5: gathers detailed information about agencies.** Participants who did not have a social work qualification ($\bar{x}=6.64$) were more likely to strongly agree with the competency statement ($F=2.82$ $p<0.05$) when compared with the participants’ overall mean score ($\bar{x}=5.44$)

Eleven (7%) participants made comments that were coded as networking, which is related to this element. They all agreed that networking was an important part of social work. One participant stated:

... networking skills are essential to social work.
**Competency statement 10.6:** integrates data gathered to form an assessment of the community. Compared with the participants’ overall mean score (\(\bar{x}=4.92\)), participants who did not have a social work qualification and did not have a tertiary qualification (\(\bar{x}=6.64\)) were more likely to strongly agree with this competency statement (\(F=2.11, p<0.01\)). Participants grouped into the ethnic category “Other” (\(\bar{x}=3.33\)) were less likely to agree with the competency statement (\(F=2.30, p<0.05\)).

**Comments Related to Overall Competency Statement 10**

Seventeen (10%) participants made comments relating to the overall competency. Nine (5%) of these participants suggested that time constraints meant that it was not always possible to be involved in community activities. Eight (5%) participants made general comments about developing an assessment of the community needs and resources as not being part of their role. One participant commented:

> Probably do some of this in the course of work, social worker meetings, discussion with other professionals without being consciously aware of it.

**Competency Statement 11: Networking**

There are five elements within this competency, each of which was analysed in turn. As shown in Table 20, the mean scores indicate that on average participants strongly agreed with all the competency elements.

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ((\bar{x}))</th>
<th>Standard deviation ((\sigma))</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1 Contact with stakeholders</td>
<td>5.92</td>
<td>1.34</td>
</tr>
<tr>
<td>11.2 Maintains knowledge of current services and relevant contacts</td>
<td>6.26</td>
<td>1.07</td>
</tr>
<tr>
<td>11.3 Facilitates liaison between agencies and community services</td>
<td>6.14</td>
<td>1.34</td>
</tr>
<tr>
<td>11.4 Co-operation and communication among stakeholders</td>
<td>6.04</td>
<td>1.46</td>
</tr>
<tr>
<td>11.5 Brings people together to share ideas</td>
<td>5.76</td>
<td>1.58</td>
</tr>
</tbody>
</table>

Significant differences between groups of participants were found for element 11.5. This will be explained in more depth below, along with the thematically-coded comments related to competency elements 11.2, 11.4 and 11.5, and comments related to the overall competency.
**Competency statement 11.2:** maintains knowledge of current services and relevant contacts.

Five (3%) participants commented about knowledge of services. One suggested that developing a working knowledge should be within an area of work and expertise. Another stated:

*You need to know who you are working with.*

**Competency statement 11.4:** co-operation and communication among stakeholders. Four (2%) participants commented that collaboration is an important part of social work:

*We can’t function properly for our client group without planned collaboration between agencies in social services.*

**Competency statement 11.5:** bringing people together to share ideas. Compared with the participants’ overall mean score ($\bar{x}=5.76$), participants aged between 30 and 34 years ($\bar{x}=4.55$) were less likely to strongly agree with the competency statement ($F=3.00$, $p<0.01$).

Four (2%) participants suggested networking needed to be relevant to the client groups social workers were working with. They argued that there are limits to networking and it is important to be conscience of professional boundaries.

**Comments Related to Overall Competency Statement 11**

Forty-five (27%) participants commented about the competency as a whole. Nine (5%) participants argued that meeting these competencies was dependent on available time. Fifteen (9%) participants suggested that networking was an essential part of social work. Four (2%) noted that this competency might not be relevant to all Health Social Workers. Another two (1%) participants suggested that this competency was an ideal, however in reality it was not always possible. Two (1%) participants stated that this was an essential part of social work:

*Networking is extremely important in ensuring appropriate linkage between clients and services.*

*Social work cannot survive where there is a lack of connection to the local community. Networking is an important skill requirement in this profession.*

Ten (6%) of the 17 (10%) participants who commented about networking suggested that it is an important skill for being successful as a social worker. One participant stated that contact with all sectors of the health field might not be practical:

*Whilst I think all the statements reflect an ideal world, again, I don’t think practically it is always possible–depends on nature of position, community and other resources in that community.*
**Competency Statement 12: Contributes to health policy development**

There are five elements within this competency, each of which was analysed in turn. The mean scores indicate that on average participants strongly agreed with all the competencies, as shown in Table 21.

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score (x̄)</th>
<th>Standard deviation (σ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1 Gathers feedback from consumers and carers about the agency</td>
<td>5.53</td>
<td>1.67</td>
</tr>
<tr>
<td>12.2 Gives feedback to decision-makers about policy implementation</td>
<td>5.56</td>
<td>1.72</td>
</tr>
<tr>
<td>12.3 Makes submissions about health policy</td>
<td>5.12</td>
<td>1.67</td>
</tr>
</tbody>
</table>

Significant differences between variable groups of participants were found for 12.1, 12.2 and 12.3. This will be explained in more depth below, along with the thematically-coded comments related to competency elements 12.1 and 12.3, and comments related to the overall competency.

**Competency statement 12.1: gathers feedback from consumers and carers about the agency.**

Compared with the participants’ overall mean score (x̄=5.53), participants who identified as Pacific Islander (x̄=6.83) were more likely to strongly agree with the competency statement (F=2.21, p<0.05). Participants who did not state their years of experience as Health Social Workers (x̄=7.00) were also more likely to strongly agree with this competency statement (F=2.26, p<0.05).

Seven (4%) participants commented about client input, four of whom reported that they sought client feedback by using “client feedback pamphlets”, “tell us what you think forms” and other client satisfaction surveys. Two (1%) participants reported that client input was not sought on policies. One suggested that care is needed in consultation to avoid burdening stressed consumers/whānau.

**Competency statement 12.2: gives feedback to decision-makers about policy implementation.**

Compared with the participants’ overall mean score (x̄=5.56), participants who identified as Pacific Islander (x̄=6.83) were more likely to strongly agree with the competency statement (F=2.73, p<0.05). Participants who did not state their years of
experience as Health Social Workers ($\bar{x}=7.00$) were also more likely to strongly agree with the competency statement ($F= 2.23, p<0.05$).

**Competency statement 12.3: makes submissions about health policy.** Compared with the participants’ overall mean score ($\bar{x}=5.12$), participants who identified as Pacific Islander ($\bar{x}=6.67$) were more likely to strongly agree with the competency statement ($F= 2.78, p<0.05$). Participants who did not state their years of experience as Health Social Workers ($\bar{x}=7.00$) were also more likely to strongly agree with the competency statement ($F= 2.24, p<0.05$). Conversely, participants who gained their social work qualification from the University of Otago ($\bar{x}=3.85$) were more likely to disagree with the competency statement ($F=2.05, p<0.05$).

Eighteen (11%) participants commented about policy development, ten of whom suggested social workers needed to be proactive in this area to ensure that policy is responsive to clients’ needs. One participant stated:

*There are some great opportunities to participate in policy development.*

Another stated:

*The word ‘suggests’ is not strong enough. Social workers need to assess appropriateness of policy in the same way as we assess client need and advocate strongly for change when needed.*

**Comments Related to Overall Competency Statement 12**

Forty (24%) participants made comments about the competency as a whole. Twelve (7%) participants’ comments were coded as related to social work tasks. They argued that social workers have opportunities to contribute to policy development through representation on steering committees, change processes and other forms of consultations. One (1%) participant suggested that social workers’ ability to meet these competencies was dependent on a social worker’s level of education. Six (4%) participants reported that contributing to health policy development was not part of their role as social workers, while five (3%) noted that it was not the role of the individual front line social worker but of professional leaders and managers.

Sixteen (10%) participants reported that there was not often any opportunity to contribute to policy. Two participants (1%) noted that they often did not hear about opportunities to contribute to policies and change processes. One participant stated:

*This is ideal, but seldom allowed or listened to.*
Five participants added they were concerned that often there was poor communication between employees and management.

Three (2%) of the participants reported that it was difficult to find enough time to work on policy development. One participant noted that they undertook much of the work around policy development in their own time.

**Competency Statements 13: Practices within the ethical guidelines of the NZ SWRB (Code of Conduct) & ANZASW (Code of Ethics)**

There was only one element within this competency and the mean scores indicate that on average participants strongly agreed with this competency statement, as shown in Table 22.

**Table 22: Mean and standard deviation of the element contained in competency statement 13**

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ($\bar{x}$)</th>
<th>Standard deviation (σ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.1 Practices within the guidelines for professional ethical practice as detailed in the ‘NZ SWRB Code of Conduct’ &amp; ‘ANZASW Code of Ethics’</td>
<td>6.67</td>
<td>0.82</td>
</tr>
</tbody>
</table>

No statistically significant differences were found in the participants’ responses, which was an expected result because participants were drawn from the ANZASW membership list. Comments related to this competency were thematically-coded and are explained below.

Sixteen (10%) participants argued that this competency is very important to social work and a foundation of the profession. Five participants (3%) suggested that it should be mandatory. One participant wrote that the Code of Ethics and Code of Conduct should be reviewed regularly.

**Competency Statement 14: Manages personal workload**

The eight elements within this competency are analysed in turn. Mean scores indicate that on average participants strongly agreed with the whole competency, as shown in Table 23.

Significant differences between groups of participants were found for elements 14.1, 14.2 and 14.7. This will be explained in more depth below, along with the thematically-coded comments related to competency elements 14.1, 14.2, 14.3, 14.4, 14.7 and 14.8, and comments related to the overall competency.
Table 23: Mean and standard deviation of elements contained in competency statement 14

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ($\bar{x}$)</th>
<th>Standard deviation ($\sigma$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.1 Social worker has an understanding of their position</td>
<td>6.47</td>
<td>0.94</td>
</tr>
<tr>
<td>14.2 Social worker should be able to articulate their role</td>
<td>6.25</td>
<td>1.26</td>
</tr>
<tr>
<td>14.3 Recognises management structures and understands professional responsibility and accountability</td>
<td>6.23</td>
<td>1.23</td>
</tr>
<tr>
<td>14.4 Prioritises work activities</td>
<td>6.23</td>
<td>1.04</td>
</tr>
<tr>
<td>14.5 Meets agency deadlines</td>
<td>6.05</td>
<td>1.16</td>
</tr>
<tr>
<td>14.6 Efficient completion of administrative and professional tasks</td>
<td>6.04</td>
<td>1.23</td>
</tr>
<tr>
<td>14.7 Record-keeping and accountability</td>
<td>6.20</td>
<td>1.14</td>
</tr>
<tr>
<td>14.8 Complies with occupational health and safety policy</td>
<td>6.15</td>
<td>1.16</td>
</tr>
</tbody>
</table>

**Competency statement 14.1: social worker has an understanding of their position.** A significant difference was found in mean scores between participants of different ethnic groups. Comparing the participants’ overall mean score ($\bar{x}$=6.47) with participants who belonged to the ethnic group listed as “Other” ($\bar{x}$=5.56), it was found that this group was less likely to strongly agree with the competency statement ($F= 2.67, p<0.05$). This result needs to be treated with caution because, as mentioned previously, the “Other” category is not a homogeneous group.

Eight (5%) participants’ comments related to administration tasks and record-keeping competency. In general, they suggested that it is essential for social workers to complete administrative and related tasks to a high standard. They also noted that a lot of their time was spent on administrative tasks and record-keeping rather than on working directly with patients.

**Competency statement 14.2: social worker should be able to articulate their role.** A significant difference was found in mean scores between participants from different practice specialties. Comparing the participants’ overall mean score ($\bar{x}$=6.25) with participants who
worked in Rehabilitation ($\bar{x}=5.00$), it was found that this group was less likely to strongly agree with the competency statement ($F=2.65$, $p<0.05$).

Seven (4%) participants suggested that it is very important to be able to articulate the role of the social worker. Two of these participants thought that articulating the role of the social worker could be difficult for beginning practitioners.

**Competency statement 14.3:** recognises the management structures and understands professional responsibility and accountability. Five (3%) participants’ comments were related to the management’s role in workload management. Two of these participants suggested that management has a responsibility to assist social workers to manage workload. One participant who worked in a management role suggested that this competency is very important in their role. Another participant reported that this competency is not fair for beginning practitioners.

**Competency statement 14.4:** prioritises work activities. Eight (5%) participants’ comments were coded as prioritising workload. Four participants (2.5%) who commented on prioritising workload reported that casework was prioritised over administration tasks. One participant wrote that when prioritisation was not possible, this situation needed to be communicated to management.

**Competency statement 14.7:** complies with record-keeping and accountability. A significant difference was found in mean scores for participants’ gender. Comparing the participants’ overall mean score ($\bar{x}=6.20$) with male participants ($\bar{x}=5.00$), it was found that this group were less likely to strongly agree with the competency statement ($F=4.61$, $p<0.05$). Ten (6%) participants reported that accountability is a very important part of social work practice.

**Competency statement 14.8:** complies with occupational health and safety policies. Five (3%) participants noted that it is important to be aware of safety in the work environment. Three participants (2%) reported that they were health and safety representatives.

**Comments Related to Overall Competency Statement 14**

Nine participants made comments relating to the competency as a whole. Their comments were coded thematically as related to workload. In general, they suggested that there was an increasing volume of work and case complexity, which made it difficult to manage workload.
**Competency Statement 15: Practices as a member of a Multidisciplinary Team (MDT)**

There are six elements within this competency, each of which was analysed in turn. As shown in Table 24, the mean scores indicate that on average participants strongly agreed with the competency as a whole.

**Table 24: Mean and standard deviation of elements contained in competency statement 15**

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ($\bar{x}$)</th>
<th>Standard deviation (σ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.1 Respect for social work and other health disciplines</td>
<td>6.50</td>
<td>1.15</td>
</tr>
<tr>
<td>15.2 Articulates skills, knowledge and values social work</td>
<td>6.34</td>
<td>1.13</td>
</tr>
<tr>
<td>15.3 Articulates specific statements about the social work purpose</td>
<td>6.19</td>
<td>1.35</td>
</tr>
<tr>
<td>15.4 Articulates knowledge and values that underline Health Social Work practice</td>
<td>6.29</td>
<td>1.21</td>
</tr>
<tr>
<td>15.5 Contributes a social work perspective in MDT clinical activity</td>
<td>6.33</td>
<td>1.23</td>
</tr>
<tr>
<td>15.6 Applies a range of social work management skills and activity within the multidisciplinary team</td>
<td>6.33</td>
<td>1.21</td>
</tr>
</tbody>
</table>

Significant differences between groups of participants were found for 15.3 and 15.5. This will be explained in more depth below, along with the thematically-coded comments related to competency elements 15.2, 15.3, 15.4 and 15.6.

**Competency statement 15.2: Articulates skills, knowledge and values social work.** Six (4%) participants suggested it was important to articulate the scope of social work knowledge, skills and values. It was also noted that it was important to explain what social workers do and why they are doing it. At times, social workers needed to justify their assessments and interventions to patients, colleagues and the organisation. One participant commented that there was no clear scope of practice for social workers working in speciality areas and that this was an issue that needed to be addressed.

**Competency statement 15.3: Articulates specific statements about the social work purpose.** A significant difference was found in mean scores between participants from different ethnic groups. Comparing the participants’ overall mean score ($\bar{x}$=6.19) with participants grouped
into the ethnic category “Other” \((\bar{x}=4.67)\), this group was less likely to strongly agree with the competence statement \((F=3.38, p<0.05)\). A significant difference was also found between participants with variable years of experience as a Health Social Worker. Participants who had worked less than 5 years as Health Social Workers \((\bar{x}=5.59)\) were less likely to strongly agree with the competence statement \((F=2.57, p<0.05)\).

Six (4\%) participants emphasised the importance of articulating the role of social workers. Four participants commented that social workers needed to actively educate other members of the team about their role. Three participants (2\%) mentioned the different ways they educate others about social work roles, including the use of presentations to MDT and visual resources. One participant commented that it is important for social workers have a common view and understanding of their role in a health setting. Another participant suggested that it is important to articulate what is not a social work task while clearly articulating what a social worker does.

**Competency statement 15.4:** articulates knowledge and values that underline Health Social Work practice. Two (1\%) participants suggested their organisation placed a high value on social work. Two other participants commented that the structure of the health system meant they felt that their voice was not heard and so they did not feel valued as social workers. They argued that some social workers might be intimidated by medically-focused work and a hierarchical system.

**Competency statement 15.5:** contributes a social work perspective in MDT clinical activity. A significant difference was found in mean scores of participants from different ethnic groups. Comparing the participants’ overall mean score \((\bar{x}=6.33)\) with participants grouped as “Other” \((\bar{x}=5.11)\), it was found that this group was less likely to strongly agree with the competency statement \((F=3.38, p<0.05)\).

**Competency statement 15.6:** applies a range of social work management skills and activity within the multidisciplinary team (MDT). Thirteen (8\%) participants commented that most of them were MDT members. Four of these participants (approximately 2.5\%) reported that at times there was a struggle with power imbalances between members of the MDT. One participant suggested that how well an MDT works depends on the team mix, experience level and maturity.
**Competency Statement 16: Uses social work supervision to enhance practice**

There are nine elements within this competency, each of which was analysed in turn. The mean scores indicate that on average participants strongly agreed with all the competency elements, as shown in Table 25.

**Table 25: Mean and standard deviation of elements contained in competency statement 16**

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ((\bar{x}))</th>
<th>Standard deviation ((\sigma))</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.1 Contracts a supervisory relationship</td>
<td>6.41</td>
<td>1.16</td>
</tr>
<tr>
<td>16.2 Determines goals and processes of supervision as it applies to social work</td>
<td>6.31</td>
<td>1.14</td>
</tr>
<tr>
<td>16.3 Prepares for the supervision session</td>
<td>6.03</td>
<td>1.34</td>
</tr>
<tr>
<td>16.4 Uses critical reflection in supervision session</td>
<td>6.45</td>
<td>0.97</td>
</tr>
<tr>
<td>16.5 Identifies practice issues with supervisor</td>
<td>6.28</td>
<td>1.09</td>
</tr>
<tr>
<td>16.6 Identifies practice competence issues in supervision session</td>
<td>6.25</td>
<td>1.22</td>
</tr>
<tr>
<td>16.7 Negotiates learning goals for supervision</td>
<td>6.07</td>
<td>1.22</td>
</tr>
<tr>
<td>16.8 Applies problem-solving skills and develops plans of action within supervision</td>
<td>5.96</td>
<td>1.40</td>
</tr>
<tr>
<td>16.9 Reviews progress goals and modifies as needed in the supervision session</td>
<td>6.04</td>
<td>1.29</td>
</tr>
</tbody>
</table>

Significant differences were found between groups of participants for elements 16.2, 16.4 and 16.5. This will be explained in depth below, along with the thematically-coded comments related to competency elements 16.1 and 16.5, and comments related to the overall competency.

**Competency statement 16.1: contracts a supervisory relationship.** Eleven (7%) participants believed a supervisory relationship is very important. Five of the participants (3%) suggested that it is the quality of supervision that is important, not the supervisor’s profession. Some of the participants reported that professionals who were not social workers supervised them. One participant commented that:

*If you don’t have an honest and trustworthy relationship with your supervisor then you do not have the opportunity to utilise supervision as it should be.*
Competency statement 16.2: determines goals and processes of supervision as it applies to social work. A significant difference was found in mean scores between participants from different ethnic groups. Comparing the participants’ overall mean score (\(\bar{x}=6.31\)) with participants grouped as “Other” (\(\bar{x}=5.00\)), it was found that this group was less likely to strongly agree with the competency statement (\(F=3.19, p<0.01\)).

Competency statement 16.4: uses critical reflection in supervision session. A significant difference in mean scores was found between participants from different ethnic groups. Comparing the participants’ overall mean score (\(\bar{x}=6.45\)) with participants grouped as “Other” (\(\bar{x}=5.44\)), it was found that this group was less likely to strongly agree with the competency statement (\(F=2.65, p<0.05\)).

Competency statement 16.5: identifies practice issues with supervisor. As with elements 16.2 and 16.4, significant difference was found in the mean scores between participants from different ethnic groups for this competency statement. Comparing the participants’ overall mean score (\(\bar{x}=6.28\)) with participants grouped as “Other” (\(\bar{x}=5.22\)), it was found that this group was less likely to strongly agree with the statement (\(F=2.50, p<0.05\)).

Eleven (7%) participants made comments about identifying issues as well as the content within supervision. It was suggested that it could be challenging for supervisors to identify the practice issues because agenda are dependent on what the supervisee brings to supervision. Supervision needs to include critical reflection as well as emotional and psychological aspects of the work.

Comments Related to Overall Competency Statement 16

Twenty-two (13%) participants made comments relating to the overall competency. Fourteen of these participants (8%) made comments about supervision being best practice. Thirteen participants (8%) argued that supervision is essential to social work practice. Comments included:

Critical to safe/best practice of professional development.

And:

...[supervision needs to involve] critical, open, reflective, challenging supervision grounded by ANZASW code of ethics.
One (1%) participant suggested that the competency was best practice, however this would differ in real practice.

Five (3%) participants made comments relating to organisational commitments to supervision. It was reported that there were various levels of support for both internal and external supervision, as well as peer support. Individual organisations also strongly influenced the frequency of supervision. Three participants emphasised the importance of training for supervisors, while another suggested that the competency statements appeared inadequate to cover the breadth of supervision activity.

**Competency Statement 17: Maintains professional development**

There are seven elements within this competency, each of which was analysed in turn.

Table 26 shows the mean scores, which indicate that on average participants agreed with the whole competency.

Participants’ mean scores showed that on average participants agreed with all the competency statements. Significant differences between groups of participants were found for 17.1, 17.2, 17.3, 17.4 and 17.7. This will be explained in more depth below, along with the thematically-coded comments related to competency element 17.7 as well as comments related to the overall competency.

**Table 26: Mean and standard deviation of elements contained in competency statement 17**

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score (x)</th>
<th>Standard deviation (σ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.1 Identify professional development needs for effectiveness</td>
<td>6.41</td>
<td>1.10</td>
</tr>
<tr>
<td>17.2 Identify professional development needs to work across other specialties</td>
<td>5.90</td>
<td>1.60</td>
</tr>
<tr>
<td>17.3 Take personal responsibility for their own professional development</td>
<td>6.09</td>
<td>1.31</td>
</tr>
<tr>
<td>17.4 Contribution to social work knowledge</td>
<td>4.06</td>
<td>1.86</td>
</tr>
<tr>
<td>17.5 Participate in professional development activities</td>
<td>5.24</td>
<td>1.74</td>
</tr>
<tr>
<td>17.6 Participate in a range of advanced level professional development activities</td>
<td>4.72</td>
<td>1.82</td>
</tr>
<tr>
<td>17.7 Contribute to social work student placements</td>
<td>4.88</td>
<td>2.16</td>
</tr>
</tbody>
</table>
Competency statement 17.1: *identify professional development needs for effectiveness*. A significant difference was found in mean scores by participants’ gender. Comparing the participants’ overall mean score ($\bar{x}=6.17$), it was found that males ($\bar{x}=5.45$) were less likely to strongly agree with the competence statement (F= 10.91, p<0.01). It was also found that participants with over 26 years of experience as Health Social Workers ($\bar{x}=4.17$) were less likely to strongly agree with the competency statement (F= 2.78, p<0.05).

Competency statement 17.2: *identify professional development needs to work across other specialties*. A significant difference in mean scores was found between participants with different numbers of years of experience as Health Social Workers. Comparing the participants’ overall mean score ($\bar{x}=5.90$), participants who had over 26 years of experience as Health Social Workers ($\bar{x}=3.83$) were more likely to disagree with the competency statement (F= 2.38, p<0.05).

Competency statement 17.3: *take personal responsibility for their own professional development*. A significant difference was found in mean scores for participants from different ethnic groups. Comparing the participants’ overall mean score ($\bar{x}=6.09$) with participants grouped in the ethnic category “Other” ($\bar{x}=4.78$), this group was less likely to strongly agree with the competency statement (F= 2.53, p<0.05).

Competency statement 17.4: *contribution to social work knowledge*. Again, a significant difference was found in mean scores between participants from different ethnic groups. Comparing the participants’ overall mean score ($\bar{x}=4.06$) with participants grouped as Pacific Islander ($\bar{x}=5.67$), it was found that this group was more likely to strongly agree with the competence statement (F= 2.58, p<0.05). It was also found that participants who did not state their years of experience as Health Social Workers ($\bar{x}=7.00$) were more likely to strongly agree with the competency statement (F= 2.21, p<0.05).

Competency statement 17.7: *contribute to social work student placements*. Comparing the participants’ overall mean score ($\bar{x}=4.88$) with participants grouped as Pacific Islander ($\bar{x}=6.83$), it was found that this group were more likely to strongly agree with the competency statement (F= 3.71, p<0.05). It was also found that participants who did not state their years of experience as Health Social Workers ($\bar{x}=7.00$) were more likely to strongly agree with the statement (F= 2.39, p<0.05). When applying the stated statistical tests with participants of different practice specialties who were grouped as “Other”, it was found that this group was more likely to disagree ($\bar{x}=3.33$) with the competency statement (F=5.28, p<0.05).
Twenty-three (15%) participants made comments about students. Half of these participants questioned why this element only mentioned fieldwork education for social work on placement in Mental Health. The words “Mental Health area” were left in this competency element in error. Many of the participants commented that social work students should be in all areas of health. One participant stated:

"Not all contexts are conducive to good learning for students, especially where environment may be hostile to social worker."

Comments Related to Overall Competency Statement 17

This competency generated the most comments compared with the other competencies. Seventy-eight (47%) participants made comments about the overall competency, which were coded thematically into eight different themes.

Fifteen (9%) participants made comments related to particular professional development interests. One of the participants reported that competency elements 17.1, 17.2, 17.3, 17.5 and 17.7 are “musts” to maintain safe professional practice. However, 17.4 and 17.6 should be driven by individual desire. These two competency elements may also require support from line managers. Two (1%) other participants commented that 17.4 and 17.6 would depend on relevance to the job and interest of the social worker. Four participants (2%) suggested that 17.4 and 17.6 were not required. They reported that they did not think it was necessary to write papers, attend conferences or complete postgraduate papers to maintain competencies. One (1%) participant suggested that skill-based training is more relevant for maintaining competency. Five (3%) participants suggested that not all of these competencies related to their role as social workers.

Fifteen (9%) participants suggested that there were time limitations when trying to meet professional development competencies. Two of these participants (1%) reported that working part-time made taking advantage of professional development opportunities very difficult. Another participant commented that full-time work could be demanding, leaving little time for professional development.

Two of the three (2%) participants who commented about best practice suggested that the professional development competencies were ideal, however heavy workloads and lack of agency support sometimes meant professional develop did not happen. One participant reported that professional development was fundamental to good practice.
Most of the 23 (14%) participants who made comments about organisations’ support for professional development suggested that there was a lack of commitment from employers. Participants commented that there was not often the required funding. Sometimes there were no allocated study days for social workers. Lack of cover also added challenges. Two participants reported that their employer provided in-house professional development but did not support external professional development, for example conferences and workshops.

Eight (5%) participants commented about work-life balance. Three of these participants (2%) suggested that it was difficult to maintain this balance. Two participants (1%) commented that most of their professional development was undertaken in their own time because of lack of cover, high workloads or lack of support from employers for study days. Three (2%) of the eight participants wrote that professional development competencies were very challenging to achieve. Two participants (1%) commented that it was difficult to continually upgrade qualifications. Not all social workers would aspire to do more than their basic qualification. One participant questioned whether those who did not aspire to anything other than the basic qualifications should or should not be seen as less competent than those who did further study. All three (2%) participants who commented about performance reviews suggested that professional development goals should be identified, discussed and reviewed annually.

Fifteen (9%) participants made comments about the professional development they were undertaking, which included being active members of the ANZASW, writing articles for journals, attending and presenting at conferences, and undertaking postgraduate study including Masters and PhDs.

**Competency Statement 18: Bicultural practice**

There are four elements within this competency. Each was analysed in turn. As shown in Table 27, the mean scores indicate that on average participants strongly agreed with all elements of the competency.

No significant differences were found between groups of participants. Comments were coded thematically as they related to the competency elements, which are summarised below as a whole.
### Table 27: Mean and standard deviation of elements contained in competency statement 18

<table>
<thead>
<tr>
<th>Competency element summary</th>
<th>Mean score ($\bar{x}$)</th>
<th>Standard deviation ($\sigma$)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>18.1</strong> Applies the principles of the Treaty of Waitangi</td>
<td>6.17</td>
<td>1.56</td>
</tr>
<tr>
<td><strong>18.2</strong> Understanding the Treaty of Waitangi as it relates to health</td>
<td>6.23</td>
<td>1.55</td>
</tr>
<tr>
<td><strong>18.3</strong> Understanding of the different health outcomes for Māori and non-Māori</td>
<td>6.18</td>
<td>1.56</td>
</tr>
<tr>
<td><strong>18.4</strong> Applies the Treaty of Waitangi to social work practice</td>
<td>6.08</td>
<td>1.74</td>
</tr>
</tbody>
</table>

### Comments Related to Overall Competency Statement 18

Thirty-eight (23%) participants made comments about this competency as a whole. Six participants (4%) commented about gaps in cultural practice. Three of these participants noted that bicultural practice was stronger in some areas of New Zealand than others. One participant stated:

*There is still a lack of application to bicultural practice and understanding of the Treaty of Waitangi amongst a lot of social workers. Hearing and talking about it does not mean people practice it at all.*

Another participant suggested that multi-cultural practice should be included in the competencies:

*Aside from the Tiriti O Waitangi people need to be educated about multi-cultural needs.*

Seven (4%) participants thought that this competency would be difficult to achieve. They reported that having a bicultural practice is not easy in many areas of New Zealand or when working in some agencies. Two of these participants reported having difficulty applying the principles of the Treaty of Waitangi to practice.

Nine (5%) participants suggested that bicultural practice is essential to best practice. One participant stated that bicultural practice competency:

*Related to achieving good outcomes for Tangata Whenua.*
Another participant reported:

*The Treaty provides a strong basis for cultural competency in working with Māori and non-Māori in New Zealand society, which is becoming more culturally diverse.*

Eight (5%) participants suggested that only Māori workers should see Māori patients. Half of these participants reported that they worked for agencies that had policies and services where Māori patients were seen by Māori workers. The other four participants (2.5%) commented that while they saw the value in Māori clients working with Māori workers, they did not work in agencies and organisations that provided this opportunity for Māori clients. Two participants (1%) suggested there were a limited number of Māori social workers. Thus, more needs to be done to attract Māori into the Health Social Work profession.

Four (2%) participants made comments about support for ongoing bicultural practice training. One participant argued that bicultural training should be compulsory. Another participant commented that these competencies:

*Should be well-entrenched in social work schools of learning and able to be transferred into the work environment.*

Two (1%) participants commenting about multi-cultural practice reported that New Zealand society is changing and so some areas of the country have greater multi-ethnic, multi-cultural diversity than others. One participant reported that in their area of the country they were great at multi-cultural practice but not so good at bicultural practice. One participant stated:

*There is a lack of questions around cultural awareness. It is debatable that bicultural practice covers this. It is especially important given that Auckland is the largest Pacific Island city and the number of Asian people is likely to increase in New Zealand.*

**Summary of Major Findings from Quantified Data**

All elements contained in the competency statements had an overall mean score of greater than 4 (agree). This suggests that generally there is overall agreement for all elements of the statements. While there were some significant differences between some mean scores, this difference tended to be between 4 (agree) and 7 (strongly agree).

Female participants had significantly different mean scores than males in nine of the elements. Pacific Island participants had significantly different mean scores in six elements compared to other ethnic groups. Participants who stated they had over 26 years experience as Health Social Workers had significantly different mean scores in four elements when
compared with less experienced Health Social Workers. Participants who were under 29 years old had significantly different mean scores in three elements than other age groups.

Participants who did not state their years of experience as Health Social Workers had significantly different mean scores in seven elements compared with participants who did state their years of experience. Participants who were grouped as “Other” had significantly different mean scores in 12 elements compared with other ethnic groups. The last two results need to be treated with caution because neither of these participant groups were homogeneous.

**Summary of Major Themes**

One hundred and seventeen (70%) participants took the opportunity to add comments at the end of each of the 18 competencies. There were 1093 comments coded thematically into 60 themes. The participants on average made nine comments each throughout the questionnaire.

The most common themes identified were time and workload pressures (9%), education (9%), assessment (5%), competency not part of the social work role (5%), evaluation (4%), mental state examination (4%), family choice (4%), ideal and best practice (3%), family involvement (3%), client participation (3%), client choice (3%) and competency essential to the social work role (3%). These themes occurred across more than one competency with the exception of ‘mental state examination’ and ‘family choice’. Sixteen of the themes were common across more than one competency, as shown in Table 28.
Table 28: Frequency of themes related to competency statements

<table>
<thead>
<tr>
<th>Theme</th>
<th>Competency Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Time/workload pressure</td>
<td>27</td>
</tr>
<tr>
<td>Education</td>
<td>19</td>
</tr>
<tr>
<td>Assessments</td>
<td>38</td>
</tr>
<tr>
<td>Not part of role</td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td>10</td>
</tr>
<tr>
<td>Ideal/best practice</td>
<td>9</td>
</tr>
<tr>
<td>Client choice</td>
<td>2</td>
</tr>
<tr>
<td>Social work role</td>
<td></td>
</tr>
<tr>
<td>Family involvement</td>
<td>11</td>
</tr>
<tr>
<td>Client participation</td>
<td>12</td>
</tr>
<tr>
<td>Networking</td>
<td></td>
</tr>
<tr>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>Advocacy</td>
<td>23</td>
</tr>
<tr>
<td>MDT</td>
<td>9</td>
</tr>
<tr>
<td>Intervention plan</td>
<td>9</td>
</tr>
<tr>
<td>Resources</td>
<td>13</td>
</tr>
</tbody>
</table>
There were a total of 101 comments on time and workload pressures across competencies 1, 2, 4, 5, 6, 10, 11, 12, 14 and 17. In general, these comments related to the difficulty in meeting the competencies due to lack of time. Ninety-seven comments were about the role of education within social work across competencies 3, 5, 6 and 8. These comments were mixed between being supportive of education as part of the social work role and not being supportive. Fifty-two comments across competencies 2, 5 and 7 were made about assessments. The comments related mainly to the nature of social work and multidisciplinary assessments. In general, participants reported that there was no consistency in the expectation of what a social work assessment is.

Thirty-eight comments were made about evaluations across competencies 4, 5, 6, 7 and 9. In general, participants reported that evaluation was very important. However, there were a number of barriers that made evaluation of interventions challenging, including very short stays in hospital, time and lack of feedback from referrals.

Forty-nine comments were made about parts or all of competencies 7, 10, 11, 13 and 17, which they did not see as part of their role as social workers. Twenty-five of these comments were related to Competency 10, which was about therapeutic groups not being part of their social work roles.

There were 32 comments related to ideal or best practice in competencies 1, 16, 17 and 18. Participants who made these comments supported the competencies as best practice. Another eleven participants wrote that all the competencies in the questionnaire were ideal but could be difficult to achieve in reality.

**Conclusion**

Overall, the results indicate support for all of the competencies. Some participants suggested some changes in wording and there were concerns about difficulties in achieving some or all of the competencies in day-to-day work due to time and workload pressures. Time constraints and workload pressures included crisis work, complex cases, safe discharge planning, bed demands, increases in the volume of work and shorter hospital stays. It appears from the comments that there are some differences in interpretation about social work assessments, the role of education, group work and advocacy.

The next chapter continues the data analysis in light of the inference from this chapter that the results support the first hypothesis of this thesis: that a single national competency framework can be developed that is relevant to all Health Social Work practice domains.
CHAPTER EIGHT

DISCUSSION

The purpose of developing a competency framework for Health Social Workers is to set the benchmark for safe and effective practice within a New Zealand context. The framework will describe the skills, knowledge and values required for social workers to work in specialist health fields. The two aims of this study were to investigate whether a national competency framework could be developed that applied to all Health Social Workers and to identify what elements of the framework would be relevant.

The analysis of the data in the previous chapter demonstrates general agreement with a competency framework. Given the findings, it seems that a national Health Social Work Competency Framework can be developed that is applicable to all Health Social Work. This supports the hypothesis that:

• A single national competency framework can be developed that is relevant to all Health Social Work practice domains.

Analysis of the data also shows that demographic characteristics influence what participants consider to be relevant competency framework elements. This is evidenced by the fact that there were significant differences between demographic groups in 39 of the 107 elements of the 18 competency statements used in the study. This finding supports the second hypothesis that:

• Health Social Workers’ demographic characteristics influence the perception of what Health Social Workers consider to be relevant elements of a competency framework.

This chapter will further explore these differences. The lack of robust information related to a social work workforce profile within health is also discussed. The common themes relating to the questionnaire add a further dimension to the results and are discussed in depth in this chapter.

Demographic Variable

There is very little information on the profile of the social work workforce. The 2001 New Zealand Census reported that 10,404 workers identified themselves as being employed as social workers (Harrington & Crothers, 2005). The subsequent 2006 census combined social work with other helping professions, making it impossible to determine the actual number of
social workers employed in New Zealand. In 2011 the ANZASW had a membership of 3934 and there were 2677 registered social workers. However, neither the ANZASW nor the Social Work Registration Board (SWRB) have accurate data on how many social workers are employed in New Zealand. This will be the case until the title of “social worker” is protected in law because currently anyone can call her/himself a social worker.

In 2007, the Allied Health Workforce Strategy Group conducted a survey of the allied health workforce that included social workers employed within the DHBs. They reported there were 1139 people employed as social workers within DHBs (Allied Health Workforce Strategy Group, 2007). If this data is accurate, the current questionnaire was completed by 11.2 percent of the DHB-employed social workers.

The lack of information available about the social worker workforce employed in New Zealand, particularly in health, makes it difficult to identify whether the demographic characteristics are representative of the whole social work population. The available sparse information appears to support the current study as a true representation of Health Social Workers. On average, the social workers participating in the study had about 14.2 years of experience and a little over half of them were employed in the Mental Health sector. The majority had a social work qualification but a small proportion remained unqualified.

Although there were significant differences between some demographic groups, these differences were only between the “agreed” and “strongly agreed” range on the Likert-type scale used to collect demographic data. As shown in the previous chapter, female participants had significantly different mean scores from males in nine of the elements, seven of which related to the working relationship with the client. Another two elements related to record-keeping and professional development.

Peer review journal database searches failed to locate published studies on practice differences between genders in social work practice. Conversely, there are extensive studies of this in other health professions, suggesting that some gender differences influence how particular situations are approached (Wentzel, et al., 1999). Gender differences could impact on the therapeutic relationship within the social work context, which is an important aspect of service delivery. The end goal of the social work therapeutic relationship is to enhance the client’s internal strengths and their ability to access external resources. How individuals within each gender group approach the therapeutic relationship will be different; it will be influenced by individual beliefs, values and experiences.
Participants who identified as Pacific Islanders had significantly different mean scores in six elements when compared to other ethnic groups. Four of the six elements related to gathering feedback from clients and the community to help identify gaps and inform policies. The other two elements related to contributing to the social work profession. Currently there is no research data on ethnic difference in social work service delivery within the New Zealand context, and yet social work practice is context dependent, as mentioned in Chapter 2. Cultural influence on Pacific Island social workers may account for the difference in how strongly they agreed with the six afore-mentioned competency elements.

Participants with over 26 years experience as Health Social Workers had significantly different mean scores in five elements compared with those with less than 26 years experienced. Whilst these results need to be treated with caution due to the small numbers of participants, in general the longer-serving Health Social Workers were less likely to “strongly agree” with the five competency elements, two of which related to professional development and two to evaluating outcomes with clients. The fifth element related to social work assessments.

It is difficult to ascertain why these differences exist without further research. The social workers’ practice environment has changed significantly in the last 26 years and the expectations for social work professional development have also changed. Therefore, in relation to professional development, participants with over 26 years of experience may perceive less need to be involved in such activities, particularly as they have extensive practice wisdom. When they were novice practitioners, social work qualifications were only just becoming easily available. The majority of social workers who entered the profession at this time were employed without formal social work qualifications. The ANZASW began the competency assessments debate twenty-three years ago. Continual professional development is a relatively recent requirement for social workers.

The participants’ comments about the competency elements produced a rich source of information. Time and workload pressures generated 101 comments. Many participants suggested that meeting the competency standards was difficult due to time and workload pressures, yet there are limited studies on time or workload pressures within Health Social Work practice. Most studies about social work workloads relate to child welfare or child protection services.
Yamatani, et al. (2009) investigated the workload of Child Welfare social workers in New York. They found high workloads contributed to poor outcomes for children. They also reported service standards were not being met and consequently mistakes were made that led to children being harmed. High workloads are also known to contribute to high staff turnover, burnout, feelings of dissatisfaction and demoralisation (Abamowitz, 2005; Yamatani, et al., 2009).

Murdach (2007) notes that despite significant changes in the way social work services have been delivered over the last fifty years, the workload complaints from social workers have not changed. Boston (2009) suggests that social workers do not get a reprieve from interacting with people at their most vulnerable in their day-to-day routine. The stress of working with vulnerable people can lead to demoralisation and burnout. She suggests that constant stress comes from experiences of lack of control and feelings of ineffectiveness. Such feelings can keep social workers from perceiving positive outcomes of their work.

It could be argued that heavy workloads and limited time to complete tasks could affect a social worker’s ability to meet practice standards. However, complaints about workload could also be symptomatic of social workers feeling dissatisfied, demoralised or ineffective. Due to the lack of research into social work in the health sector, especially within New Zealand, it is difficult to determine how workloads and time pressures affect practice standards. Participants’ comments suggest they felt compromised by heavy workloads and time pressures. It could also be argued that some of the participants may lack job satisfaction and therefore any additional competency standards add to the feeling of being under pressure.

Participants agreed with the competency elements relating to client education. Some participants’ comments suggest a mixed understanding about how education relates to social work. A small proportion of comments relate to not having enough time or available resources to provide education. Resources used in educational interventions included pamphlets, factsheets and Internet information. Some resources may be scarce but a skilled social worker with creative problem-solving skills can overcome this.

One of the primary values of social workers is to empower clients and help them break down social barriers. Payne (2005) suggests five elements to empowerment practice: personal; social; education; economic; and political. When a social worker works with each one of these elements they build the capacity for an individual to participate more successfully within existing social structures.
Participants reported that some social work courses did not provide training in the education component of social work. “Facilitate educational programmes” was part of the compulsory standard for social work courses (Te Kaiawhina Ahumahi: The Industry Training Organisation for the Social Service, 1997) but individual social work programmes govern how this standard is taught. Although education is only mentioned once in the compulsory standards, it is an implied requirement in other compulsory standards including those that discuss facilitating client empowerment, and providing information and counselling skills.

Fournier (1999) argues that education is an integral part of the many social work models of practice such as motivational interviewing and psycho-educational therapy. However, a small number of participants reported that education was not part of their social work role. This result needs to be explored further because it is incongruent with what should be taught in social work courses. It may be that the education role within social work is not well defined and, therefore, is open to interpretation.

**Assessment-related Elements**

The participants who commented on assessments wrote about time constraints, which meant social workers were often not able to undertake full social work assessment. Social workers often can only see patients one or two times within acute physical health settings. This means it is difficult to undertake full social work assessments and generally there is little opportunity to review them.

Patients are more likely to be involved in longer-term health service areas such as Older People’s Health, Mental Health, Physical Health, Rehabilitation, Palliative Care and Child Development Services. Therefore, social workers in these areas are more likely to have time to complete and review social work assessments.

Assessment is an essential element of any social work practice for accurate identification of a client’s issues and what resources they may need to access. The ways in which social workers undertake assessments, combined with the theories and models used, influence interventions. The information gained from social work assessment and its report in clients’ clinical notes will influence other members of a multidisciplinary team in their decision-making about the client’s treatment.

The type of social work assessment used and how it is carried out is context dependent. It depends not only on the theoretical practice background but also the work environment. Other influences include models of practice, speciality, and organisational polices and
guidelines. Participants in the current study reported that generally there is no consistency in the expectation of what a social work assessment is. The different approaches to social work assessments is problematic within a health setting because it affects decisions around care and protection, family violence, discharge planning and allocation of supports.

Some participants reported that they undertook multidisciplinary assessment. However, there are about as many multidisciplinary assessments as there are multidisciplinary teams. Some assessments contain a social work-specific section and some are a generic assessment that any member of the multidisciplinary team may complete.

Undergraduate social work courses are also generic. They do not offer specific health models; thus, there is no standard way to teach social work students about the complexity of working in a health sector context. One of the consequences of this is that there is little or no education related to conducting social work assessments in the health sector. Therefore, while students are taught how to undertake assessments for many, it is not until they are on fieldwork placement that consolidation of classroom learning occurs. Thus, the quality of fieldwork placement has a large influence on a student’s ability to undertake assessments effectively. While standardising the social work assessment within the health sector seems like a viable solution to this issue, it can be problematic due to the many different social work approaches used by individual practitioners.

**Evaluation**

Evaluation is the final aspect of a systemic approach to working with clients. It is not only important to assess outcomes but should be considered a central component of critical reflective practice (Fook, 2002). Many participants commented on evaluation and reported that the fast pace of the hospital environment made it difficult, if not impossible, to evaluate the effectiveness of interventions. It is important to note that there is a general agreement that evaluation is an essential part of competent Health Social Workers’ practice.

The acute hospital setting offers a unique environment for social workers to practice in. Hospital stays have become much shorter over time. In 1989, the average length of a patient stay was 6.13 days. In 2006, the average length of stay decreased by 50 percent to 2.81 days (Malcolm, 2007). Today, patients are expected to do more convalescence at home with community agency supports. This means social workers are often challenged to complete a social work assessment and make appropriate referrals in less than three days. However, practice evaluation does not always receive the priority it should due to the fast pace of the
health environment. Adams (1998) argues that focusing on evaluating social work practice can greatly enhance service delivery.

There are many different methods of evaluating practice. These include seeking feedback directly from patients and referral agencies, or through questionnaires and surveys. Scrugg (2008) suggests that supervision is another way of evaluating social work practice. Reflecting on and evaluating interaction with patients, assessments and the resulting interventions during supervision sessions provides the opportunity to identify what is working well and what is not.

**Networking**

What constitutes networking may be open to interpretation, which could explain why some participants reported that it was not part of their social work role. Trevithick (2000) reports that mastering networking skills is increasingly important for social workers due to the increased decentralisation of services to community agencies. Networking for social workers involves assessing and strengthening natural links between the client and their formal and informal support systems.

Networks are a vital source of information, co-operation and collaboration. Therefore, involving client networks in care plans will complement formal services and supports. Skills that are essential for networking are mediation, advocacy, relationship-building and organisational skills. Networking involves cultivating links with individual groups and organisations; for social workers, they are a source of developing political footing in organisations and communities. Increasing political status improves access to resources for clients. Opportunities to develop networks exist in many arenas, such as professional meetings, conferences, workshops and collaborative activities (Jones & May, 1992).

**Policy Development**

Although participants agreed with the policy development competency, a small number did not consider this to be part of their role. Whilst what constitutes policy development is open to interpretation, it could be argued that policy development is an integral part of social work. Social workers are constantly required to rationalise access to services and resources for their clients; they must exercise discretion when accessing supports and advocating for their clients (Jones & May, 1992).

Social workers, as part of practice, negotiate their way through a myriad of policies as well as the requirement to understand the political and social context within which these policies are
developed. Social work is one of the few professions that can claim policy development at an organisational, professional and political level as part of its practice. It is necessary for social workers to understand how government and local organisational policies work in order to practice effectively. They need to be able to analyse, and work in accordance with, policy guidelines. At the same time, social workers need to understand how to influence and shape these guidelines (Jones & May, 1992).

Policy development is embedded in social work practice and is taught in undergraduate social work courses. One of the curriculum standards for social work training is to provide interpretations of social policies and structures (Te Kaiawhina Ahumahi: The Industry Training Organisation for the Social Service, 1997). It could be argued that social workers need to have a thorough understanding of social policies to achieve good client outcomes. Fraser and Matthews (2008) argue that social workers need to be willing to engage in the policy process. They also have a responsibility to take an active role in policy development to ensure the best possible outcome for clients.

**Professional Development**

Social work has moved toward recognition as a health profession, therefore professional development has become increasingly important. The challenge for the social work profession is to decide what level of professional development is the minimum standard to meet competency requirements. This study has shown that in general, the participants did not strongly agree with the professional development competency associated with undertaking postgraduate courses, research and writing papers for peer-reviewed journals. Although these are important aspects of professional development, not all social workers acknowledge the importance and therefore do not engage in these activities.

Social workers are required to have current knowledge and skills to practice social work. They cannot work with clients in a purposeful way without this knowledge and skills. Maintaining knowledge and skills, and therefore competence, is not a static process. If social workers are to claim to be a profession, ongoing professional development needs to be a lifelong mandate. The introduction of the *Social Workers Registration Act 2003* has brought with it a requirement to provide evidence of continual professional development (Calvert, et al., 2007). Furthermore, Fowler-Davis, Lynam, and Candelin (2006) suggest that professional development is intrinsically motivating and a powerful agent for change.
Social work schools cannot equip social workers with all the knowledge and skills they need for the duration of their career (O'Sullivan, 2006). Hence the need for professional development, which not only assists social workers to keep abreast of the latest developments, but it also helps increase critical reflective practice skills, self-awareness and understanding of clients (Calvert, et al., 2007). Competence is not only about social workers having the knowledge and skills required to carry out their work. It is also about the quality of practice as much as skills and knowledge because it is related to safe and effective practice. Continual professional development is an essential component for promoting high quality and competent practice (Calvert, et al., 2007; O'Sullivan, 2006).

In order for the social work profession to progress, it needs some social workers in clinical practice to be actively involved in postgraduate study, research activities and writing for peer-reviewed journals. However, individual social workers do not necessarily need to be involved in these activities to ensure their own practice is of high quality. All participants in the study agreed that professional development should be part of a competency framework.

**Group work**

Competency elements relating to client group work generated a lot of comments. As reported in the previous chapter, although participants agreed overall with the competency elements relating to group work, many reported that either they did not have the opportunity or it was not part of their role. Constraints on social workers’ time resulted in a limited ability to do group work with patients. In general, the participants’ comments indicate a general desire to do group work and that this should be covered in the social work curriculum.

In a health setting, social workers engage in many different forms of group work, however this may not always be recognised as such by the social workers and other health professionals. The type of groups the study participants described included family meetings, discharge planning meetings, Multidisciplinary Team meetings, group supervision and peer review meetings, and strengthening families and support groups. In many of these groups, facilitation is the social workers’ responsibility; therefore, it is important for social workers to understand group processes.

Although participants generally agreed with the group work-related competency elements, their responses indicate that these elements need to be reworded to reflect the type of group work social workers are more likely to be involved in. Currently, the competency statements are too narrow to relate to most social workers in a variety of settings.
Limitations

Many participants suggested that the competencies and their elements were ideal; they would find it difficult to disagree with them. It was also argued that because the competency statements could be considered best practice, to disagree with them would suggest the participants were not competent to practice.

The competency statements used in the study have come from other competency frameworks. They are what expert social work panels have considered best practice in their countries of origin. Outside the present study, these competency statements have not been widely debated in the New Zealand context. Internationally, there has been much debate about the content of competency frameworks but competency frameworks within Health Social Work are a relatively recent development. Debate is needed to ensure they reflect the knowledge, skills and values required to practice social work in a safe and ethical way.

It has been argued that social work is context-dependent and, if this is the case, just because a competency framework has been identified as best practice in one context does not mean it will translate as best practice in another social work context. All but one of the competency statements used in this study were developed by the Australia Association of Social Work (AASW) as part of their ‘Practice Standards for Mental Health Social Workers’ (Australian Association of Social Workers, 2008). Whilst Australian expert panels developed these Standards, they have not been tested in the New Zealand social work practice environment. The bicultural-related competency statement was developed from the ‘Recovery Competency for New Zealand Mental Health Workers’ (O'Hagan, et al., 2001).

These competency statements need to be tested and debated within the New Zealand social work practice environment. It would be hoped that open debate could be undertaken to ensure development of the best competency framework for the New Zealand context. The present study is one forum that starts this debate. Its mixed method survey, undertaken with standard research precautions to ensure participants’ anonymity, provides an example of protecting debate participants’ identities so that they provide honest comments. However, there is some limitation to the study’s generalisability because participants were selected from the membership of the ANZASW; membership that is completely voluntary in New Zealand. This means that social workers who are members of the ANZASW are likely to be cognisant of professional ethics and concepts related to a competency framework. Therefore, due to the limited sample pool, it is impossible to draw any comparisons between social workers who are members of the ANZASW and those who are not.
The response rate for the returned surveys was 16 percent, which represents 16 percent of the whole population of members of ANZASW who identified themselves as working in health. This response rate was lower than desirable. The surveys were sent out to all members of the ANZASW who identified as working in health, with the exception of social workers who were currently or in the past had been employed by the Southern District Health Board (Otago Region).

Participants commented on the length of time it took to complete the questionnaire. The quantitative section of the questionnaire could be completed within half hour but when participants’ added value by writing comments, it would have extended the time quite considerably. The length of time needed to complete the questionnaire and add comments may have deterred potential participants from completing it, thus impacting on the response rate.

**Conclusion**
Overall, the participants agreed with the competency statements. Therefore, the results supported the hypotheses. Given the high level of consistency in mean scores on the Likert-type scale for each element of the competency statements, it may be possible to generalise the results to the population of Health Social Workers. This means a single national competency framework can be developed that is relevant to all domains of Health Social Work practice.

Although demographic characteristics influenced the perception of what Health Social Workers consider to be relevant elements in a competency framework, overall these differences were small.

According to the mean score for each element of the competency framework, the participants considered all elements relevant for a competency framework for Health Social Workers. However, some participants’ comments suggest the need for refinement in the areas of group work, assessments, evaluation, education, advocacy and networking. Wording related to family and client choice also needs changing to reflect work done with involuntary clients and family violence issues.

It was suggested that there were too many elements to the competency framework, and that competency statements were ideal practice and not necessarily achievable in day-to-day practice. In order for a competency framework to add value to the profession, it needs to reflect best practice in the “real world”. The length of the competency framework needs to be reduced and the elements made more concise. These considerations and evaluations of the
study results are discussed in the next chapter to make recommendations for competencies to comprise the national Health Social Work Competency Framework in New Zealand.
CHAPTER NINE

CONCLUSION AND RECOMMENDATIONS

Health Social Work specialises in addressing the social factors that impact on the health and wellbeing of individuals, families and their communities. Health Social Workers need to be skilled and possess a sound social work knowledge base. They often deal with incomplete information and make decisions on the run that may affect clients’ lives.

Today, social work as a recognised profession is an integral part of the health sector. In any economic and political environment where constant changes exist there is an increased requirement for Health Social Workers to demonstrate competency and accountability. The nature of Health Social Work in today’s environment makes it extremely difficult to identify the content of a competency framework.

There is an increased demand on health professionals to be competent, accountable, clear and specific about their roles and tasks. It is now critical for a competency framework to be developed for Health Social Workers that can be applied across all health sectors. It is Health Social Workers’ responsibility and obligation as members of the social work profession to embrace an evolving competency framework and establish professional standards.

An evidence-based Health Social Work Competency Framework, founded on sound research, will ensure Health Social Workers are well positioned to clearly articulate and demonstrate how and why they practice the way they do. A competency framework does not give the whole picture of social work practice; it cannot stand alone but must be implemented in conjunction with social work practice theories and practice wisdom.

A competent Health Social Work workforce needs the necessary knowledge, skills and abilities to deliver social work service effectively and efficiently. The Health Social Work workforce also needs to have the ability to translate policy, theory and research into current social work practice. The identification of the elements needed for a relevant competency framework is a conduit for the development of shared and agreed understandings of what constitutes Health Social Work.

A Health Social Work Competency Framework should be used to underpin Health Social Work training, academic study and continued professional development. In the employment context, a Health Social Work Competency Framework is what informs quality improvement,
performance reviews, clinical career pathways and job descriptions. Thus, it is critical for the future development of Health Social Work to have its own competency framework. Such a framework will confirm Health Social Work as a specialised field within social work practice.

**Developing the Health Social Work Competency Framework**

The results of the study described in this thesis were presented at the 2011 DHB Social Work Leaders Council annual meeting. The presentation outlined the outcomes of the research along with the competency statements from the research questionnaire and international standards of practice and competency frameworks (Derrett, 2011). The DHB Social Work Leaders were asked to consider which of the competency statements they believed reflect Health Social Work practice in New Zealand.

Defining Health Social Work is an essential component of the development of a competency framework. The primary focus of Health Social Work is to provide and enhance individuals’ and families’/whānau natural support resources because social wellbeing and function is an essential element of an individual’s overall of health. Therefore, the main goal of Health Social Workers is to enhance the social wellbeing and functioning of individuals and families/whānau in their own social environment. Health Social Workers work toward establishing support systems and communities at a local and national level to improve responsiveness to the social needs of individuals and families/whānau.

The core aspects of Health Social Work practice were considered to be part of a competency framework and informed development of this Health Social Work Competency Framework, which is intended to complement the generic ‘ANZASW Standards of Practice’ and the ‘SWRB Code of Conduct’. It is also intended to complement existing employers’ policies and guidelines.

The Health Social Work Competency Framework discussed in this chapter is the first national competency framework that can be implemented across the nation. It has been developed specifically to meet the needs of Health Social Workers in all health settings in New Zealand. The list of competency statements developed for the framework, which are outlined in the next section, describes the social work standards required for professional practice in the New Zealand health system. It is envisioned that the framework will reflect existing day-to-day best practice.
The Health Social Work Competency Framework

**Competency 1: Understand the Health Context**

Health Social Workers require knowledge and skills to address the effects of illness and/or disability faced by clients/patients, including inequalities in the social determinants of health. Health Social Workers work towards improving access to health services for their clients/patients.

**Indicators**

- Knowledge of the biopsychosocial context of Physical and Mental Health including trauma and disease
- Knowledge of the sociology and social history of disease, disability and illness
- Understanding of clients’/patients’ and carer issues, including the sociology of disability, history of mutual support, empowerment process, cultural experience of illness, hospitalisation and treatment interventions
- Understanding and interpreting Aotearoa/New Zealand Health policies and statutory processes.

**Competency 2: Bicultural Practice**

Health Social Workers demonstrate an ability to apply the principles (partnership, participation, protection) of the Treaty of Waitangi to practice. Health Social Workers use the principles of the Treaty of Waitangi/Te Tiriti o Waitangi to address the effects of inequalities in the health sector for their clients/patients and their whānau/family.

**Indicators**

- Understanding the Treaty of Waitangi/Te Tiriti o Waitangi and its relevance to the health of Māori in Aotearoa/New Zealand
- Incorporates the principles of the Treaty of Waitangi/Te Tiriti o Waitangi (partnership, participation, protection) and Tikanga/Tikaha best practice into social work practice
- Committed to bicultural development in social work practice Aotearoa/New Zealand at individual, whānau, hapu, Iwi and institutional levels.

**Competency 3: Cultural Responsiveness**

Health Social Workers demonstrate an understanding of cultural diversity, in particular how it relates to clients’/patients’ interactions with health services. Health Social Workers practice
in a culturally-sensitive manner that reflects their awareness of cultural diversity among clients/patients.

**Indicators**

- Demonstrates respect for clients’ cultural background and sensitive to the individual and family/whānau belief systems that might influence the working relationship with the client/patient
- Evaluates own cultural value base and understands how their beliefs influence the working relationship with clients whilst respecting differing cultural and belief systems
- Demonstrates awareness of the diversity within culture, ethnicity, class, age and gender, and integrates this knowledge into social work practice.

**Competency 4: Clinical and Professional Practice**

Health Social Workers establish respectful, purposeful and collaborative relationships with clients/patients, families/whānau, Multi/Interdisciplinary teams and service providers to address the biopsychosocial needs of clients/patients. Health Social Workers undertake a range of assessments, interventions and discharge planning to improve the health outcomes of clients/patients.

**Indicators**

- Able to establish an appropriate and purposeful working relationship with clients
- Understands and keeps clients/patients informed of the practical limitations of confidentiality of information
- Works with client/patients to gather information to develop a comprehensive assessment of clients’ concerns, strengths and support within their social context
- Identifies risk indicators and implements risk mitigation plans appropriately
- Able to effectively use specific assessment tools that are relevant and appropriate for clients/patients and the services within which the social worker practices
- Completes comprehensive discharge plans with input from the client/patient, family/whānau, significant others and the inter/multidisciplinary teams to ensure effective discharge from the social work service
- Facilitates collaboration between inter/multidisciplinary teams, service providers, and clients and their families to provide efficient and appropriate services to address clients’ biopsychosocial needs
• Able to articulate the scope of social work practice, including skills, values and knowledge within the health system.

**Competency 5: Organisational Requirements**
Health Social Workers have responsibilities to the organisation in which they work. They contribute to, and comply with, organisational policies, procedures and guidelines. Health Social Workers work towards making organisations and systems responsive to clients/patients.

**Indicators**
• Maintains social work documentation that reflects social work interaction with clients, including assessments, intervention plans, goals and discharge plans in accordance with organisation policies and guidelines
• Maintains a workload that allows effective, efficient and quality social work service delivery
• Demonstrates knowledge of legislation and polices that impact on Health Social Work practice
• Demonstrates working knowledge of current social work methods of practice, social policies and community resources, and integrates such information into practice.

**Competency 6: Professional Development**
Health Social Workers have adequate qualifications to undertake their role in health care. Health Social Workers actively participate in professional development and contribute to the advancement of social work knowledge and evidence-based practice.

**Indictors**
• Recognises own learning needs, and participate in career development strategies, continuing education and profession activities
• Contributes to the advancement of the social work profession through participating and delivering in-service education of social work students, writing papers for peer-reviewed publications, participating in research and presenting at conferences
• Maintains and enhances the current social work knowledge base through reading professional journals and web articles, and attending workshops, seminars and conferences
• Maintains and enhances a critical reflective approach to individual social work practice through supervision, peer review and self-evaluation.
**Competency 7: Advocacy, Networking and Social Action**

Health Social Workers are involved in advocacy and networking activities to improve service delivery to clients/patients. Health Social Workers work collaboratively with other health professionals, and community and government agencies and service providers to improve outcomes for clients/patients.

**Indicators**

- Applies advocacy skills to improve service delivery and health outcomes for clients/patients and promotes client/patient self-advocacy to access services within the available resources
- Maintains a working knowledge of available resources, service providers and community agencies that provide benefits to clients/patients and their family/whānau
- Applies networking and collaborative skills to ensure robust intervention plans for clients/patients and their families/whānau are implemented in co-ordination with other professionals, community agencies and service providers
- Identifies gaps in service provision and resources, and works to address these gaps through social action, advocacy and networking.

**Competency 8: Leadership and Professionalism**

Health Social Workers adhere to professional ethics, Standards of Practice and Codes of Conduct as set out by their professional bodies and registration board. Health Social Workers have a responsibility to demonstrate leadership skills to improve access to health care services.

**Indicators**

- Demonstrates knowledge of, and practices within, the guidelines established by social work professional and regulatory bodies’ Codes of Ethics, Standards of Practice and Codes of Conduct
- Engages in social work critical reflective practice within supervision processes to ensure a high quality of service delivery to include the identification of practice that needs improvement, and the development and achievement of identified and agreed supervision goals
- Applies critical reflective skills as part of ongoing formal and informal evaluation of social work practice to assess quality and appropriateness of social work practice to ensure ongoing competency.
These eight competency statements that form the Health Social Work Competency Framework are designed to enhance the knowledge, values and skills that Health Social Workers require to deliver effective social work services to individuals, families, whānau and the community. However, the competency framework alone cannot enhance the quality of Health Social Work practice; it needs to be disseminated, embraced and implemented at the practice level in partnership with educational institutions, the Social Work Registration Board and the ANZASW.

The Health Social Work Competency Framework is a powerful tool to guide Health Social Workers’ employers and educators. It can assist in building workforce capacity. The support for, and of, key people within the Health Social Work workforce will strengthen Health Social Work as a speciality, and contribute to its advancement and ultimate improvement to the quality of practice, education, training and research.

**What is Incompetent Practice?**

Defining incompetence in social work practice is fraught as a subjective issue. It can be difficult to identify isolated and specific indicators of incompetent practice. Incompetent social work could be defined as anything that is not set out in the competency framework. However, no competency framework can cover all social work tasks without placing restrictions on social work practice.

Competent practice can be described as part of a continuum on which the Health Social Work Competency Framework sets out the minimum standards. Experienced and competent practitioners would expect to be positioned at the top leadership end of the continuum while novice practitioners would be at the beginning. Incompetent practice sits below the competency framework on the continuum. The nature of good social work practice is inherent in the Health Social Work Competency Framework.

**Readiness to Practice for Beginning Practitioners**

A Health Social Work Competency Framework can assist in planning undergraduate social work education. Educators will be better informed about the requirements in health because the framework sets out the basic requirements for practicing as a Health Social Worker.

The Health Social Work Competency Framework can be used to establish basic training for new entry Health Social Workers. This training could take the form of Health Social Work internships or new social work graduate training, and a return-to-practice programme. The current generic social work qualifications meet the basic needs of the social work profession.
and social work employers. However, Health Social Work is a specialised practice, consequently there is a need for additional education, training and study. This would allow social workers to practice competently in the health sector in the future.

Currently, most Health Social Workers gain competency to practice in health through in-house mentoring and professional development programmes. This leads to an inconsistent level of competency and relies on the quality of the in-house programmes. Having a National Health Social Work Competency Framework will inform post qualification programmes such as internships as well as in-house programmes.

**Areas for Further Research**

There is little research in general about Health Social Work practice in New Zealand. Researching Health Social Work practice in New Zealand would provide opportunities to advance the knowledge about this particular specialist field of social work in the New Zealand context.

There needs to be more research into the demographic characteristics of Health Social Workers because little is known about their profile in the New Zealand setting. This study has provided a snapshot of 167 Health Social Workers, which has given an overview of Health Social Work demographics, even though this was not the primary reason for the research. It is difficult to draw conclusions about the profile of all Health Social Workers due to the small sample size. Although the Allied Health Workforce Strategy Group collected some limited data on the Health Social Work workforce, it is difficult to measure the data’s accuracy because there is no benchmark. There is even less information about the demographic profile of Health Social Workers working in private practice and for community providers.

Reliable and accurate demographic information about Health Social Workers would better position researchers to evaluate whether the research undertaken is representative of the whole population of Health Social Workers; it would allow for research results to be generalised to all Health Social Workers.

Participants in the current study commented that time and workload pressures have an impact on competent practice. There is very little research and no published journal articles in New Zealand about the impact of time and workload pressures on Health Social Workers. Identifying whether these pressures exist due to lack of social work resources in the health sector or the nature of Health Social Work is an area that needs further research.
research question is: does time and workload pressure have an impact on the competency of Health Social Workers?

The nature of social work assessments also needs further research. Some of the participants’ comments implied different interpretations of what type of assessments Health Social Workers should undertake.

Evaluation of social work practice is another area that needs further research. Many participants commented that they did not have the time or opportunity to evaluate the effectiveness of their interventions, yet evaluation is an important component of social work practice.

**Where to from here for the Competency Framework**

The District Health Social Work Leaders Council has endorsed the Health Social Work Competency Framework. Each social work leader will be asked to take the Framework to their DHB and assess how to implement the document. Some initial work towards implementing the Framework has been undertaken within the Southern DHB. Some of this work involves ensuring the job description and performance review documents align with the Framework.

Following the implementation of the Health Social Work Competency Framework across all DHBs, further research will be needed to evaluate how it was implemented, subsequent improvement and newly identified gaps. Once the Health Social Work Competency Framework is established in the DHBs and community providers, consideration needs to be given to presenting it to the Social Work Registration Board.

A Health Social Work Competency Framework can provide the foundation to define the scope of Health Social Work. When this happens, Health Social Workers will be in an excellent position to request that Health Social Work be recognised as a Health Profession under the *Health Practitioners Competence Assurance Act 2003*. This would give Health Social Workers the same status, responsibilities and obligations as other professions within health.

**Conclusion**

This is the first time a national Health Social Work Competency Framework has been developed in New Zealand. Although the Competency Framework does not give the whole picture about social work practice, it sets out the expectation of practice standards for social
workers working in the specialist area of health. The intent of the Competency Framework is to provide clear objective statements about what social work practice is. The competency statements can be used to set practice standards and performance criteria for job descriptions and performance reviews. However, it is necessary to be mindful that any framework is a work in progress and should be subject to constant review.
REFERENCES


## APPENDIX A

### RESEARCH APPROVAL

<table>
<thead>
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<th>Approval Type</th>
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<tr>
<td>University of Otago Ethics Committee Approval</td>
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<td>Ngai Tahu Research Consultant Committee Approval</td>
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<td>Correspondence with ANZASW</td>
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</tbody>
</table>
Dr L Briggs  
Department of Social Work and Community Development  
Division of Humanities  
520 Castle Street

23 November 2007

Dear Dr Briggs

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled "Developing a standardised national practice framework for health social workers".

As a result of that consideration, the current status of your proposal is: Approved

The comments and views expressed by the Ethics Committee concerning your proposal are as follows:-

While approving the application, the Committee would be grateful if you would respond to the following:

Please clarify Dr Lynne Briggs' relationship with Refugee and Migrant Mental Health Service, and why her contact details are not within the University of Otago.

Approval is for up to three years. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

Mr G K (Gary) Witte
Gary Witte  
Ethics Committee  
Academic Committees  
University of Otago  
PO Box 56  
Dunedin  

3rd December 2007  

Dear Gary,  

Re: “Developing a standardised national practice framework.”  

Thank you for advising me of Ethic Committee Approval for the study “Developing a standardised national practice framework.”  

In regard to the Ethics Committee’s question as to why my contact details are the Refugee and Migrant Mental Health Service, CDHD, rather than within the University of Otago I offer the following:  

1 I am employed as a full time academic with the University of Otago with teaching responsibilities on the MSW Distance programme and I live and work from Christchurch.  

2 Four tenths of my time is contracted to the CDHB Mental Health Division where I am responsible for the Refugee and Migrant Mental Health Service.  

3 I don’t have a separate University office in Christchurch thus my work address is the CDHB Mental Health Division. If my mail goes directly to the Social Work Department in Dunedin there is often a considerable delay in my receiving it (as in this case your letter was dated 23rd November 2007 and I received on 1st December 2007).  

4 I consider using my CDHB Private Bag address as being more secure than using my home address.  

I trust this answers the question about my contact details  

Yours sincerely  

Dr Lynne Briggs  
Senior Lecturer  
Copy: Professor Amanda Barusch- Department of Social Work
NGĀI TAHU RESEARCH CONSULTATION COMMITTEE
TE KOMITI RAKAHU KI KAI TAHU

18/12/2007 - 07
Thursday, 20 December 2007

Dr Briggs
Social Work and Community Development
Dunedin

Tēnā koe Dr Briggs

Title: Developing Standards of Practice Framework for Health Social Workers.

The Ngāi Tahu Research Consultation Committee (The Committee) met on Tuesday, 18 December 2007 to discuss your research proposition.

The Committee considers the research to be of importance to Māori health.

The Committee notes that the researchers intend to collect ethnicity information and the Committee recommends the use of the Census question as the framework to collect ethnicity from participants.

The Committee notes that the researchers intend to do comparisons based on ethnicity, they therefore suggest including in the research team a researcher with expertise in analysing data by ethnicity.

The Committee suggests dissemination of the research findings to relevant Māori health organisations.

The Committee would also value a copy of the research findings.

The recommendations and suggestions above are provided on your proposal submitted through the consultation website process. These recommendations and suggestions do not necessarily relate to ethical issues with the research, including methodology. Other committees may also provide feedback in these areas.

Nāhaku noa, nā

Mark Brunton
Kaitakawaenga Rangahau Māori
Facilitator Research Māori
Research Division
Te Whare Wānanga o Otago
Ph: +64 3 479 8738
email: mark.brunton@otago.ac.nz
Web: www.otago.ac.nz

The Ngāi Tahu Research Consultation Committee has membership from:
Te Rūnanga o Otakou Incorporated
Kāti Huirapa Rūnaka ki Puketeraki
Te Rūnanga o Moeraki
Michelle Derrett
Mosgiel

25th June 2007

Dominic Chilvers
Executive Office
Aotearoa New Zealand Association of Social Workers
PO Box 14 230
CHRISTCHURCH

Dear Dominic

I am undertaking research for my Master in Social Welfare thesis under supervision of Dr Lynne Briggs through Social Work and Community Work Department, University of Otago. It is my intention to investigate the framework of practice that Health Social Workers use. I intend to do this by surveying social workers working in the health sector. Would it be possible to have access to the Association membership list in particular the contact details of the social workers that identify themselves as working in the health field? When have completed my survey questions and identified the source of participants for my research I will submit my research proposal to the University of Otago’s ethics committee. Once I have ethics committee approval I intend to send out the survey hopefully sometime in November or early December.

Thank you for your assistance.

Yours sincerely

Michelle Derrett
Friday September 28th 2007

Michelle Derrett

Mosgiel 9024

Dear Michelle,

Re: Research Proposal

I must apologise because I have just found a letter I received from you in June about some research you are proposing to undertake and I don't believe you ever received a response.

You are certainly able as a member of ANZASW to utilise the membership database to recruit subjects for your research. I can provide you with an excel file with members details that you can then use to create a random sample. However, I do need to receive from you a copy of the ethical approval that you have obtained from Otago's ethics committee. Once this is received then we can make the necessary arrangements for this information you need.

Yours sincerely,

Dominic Chivers
Executive Officer
Michelle Derrett

MOSGIEL

7th January 2008

Dominic Chilvers
Executive Office
Aotearoa New Zealand Association of Social Workers
PO Box 14 230
CHRISTCHURCH

Dear Dominic

Re: Access to the Membership List for Research

Further to my letter sent to you dated 25th June 2007, and as requested in your letter dated 28th September 2007, please find enclosed the letter of approval from the University of Otago Ethics Committee.

Thank you for agreeing to give me access to the ANZASW membership list for research purposes. I would be grateful if you could supply me a membership list in an Excel File so that I can generate a sample. My daytime contact details are (03) 4740999 ext 8608 and evening (03) 4898600 if you need to contact me to make arrangements to give me the file.

Thank you again for your assistance.

Yours sincerely

Michelle Derrett

MSW Student
APPENDIX B

DOCUMENTS SENT OUT TO PARTICIPANTS

Covering Letter 157
Information Sheet for Participants 158
Consent form 161
Survey Instruction 163
Questionnaire 165
Dear Social Worker

Re Research Project

I am currently undertaking a research project in order to meet the requirements for the Master of Social Welfare through the University of Otago. The aims of the project are:

1. To determine what Health Social Workers consider to be competent practice in accordance to national standard competences
2. To develop a comprehensive practice framework, that is based on research.

ANZASW executive has agreed to mail the enclosed questionnaire and associated documents to you on my behalf in order to carry out the research project.

I invite you to participate in the research. Please read the enclosed information sheet for more information. If you decide to participate please complete the enclosed consent form, personal information sheet and questionnaire.

The results of the questionnaires and personal information sheet will be collated for statistical purposes to draw comparisons and conclusions between groups. No individual identifiable information will be included in the study.

The completion of these forms should take no longer than 30 minutes. Please return them in the freepost self-address envelope provided by the 30th April 2008.

If you decide to participate I thank you. If you decide not to take part there will be no disadvantage to you of any kind and I thank you for considering my request.

Yours sincerely

Michelle Derrett
MSW student
Social Work and Community Development
University of Otago
INFORMATION SHEET FOR PARTICIPANTS

Developing Standards of Practice Framework for Health Social Workers

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you of any kind and we thank you for considering our request.

What is the Aim of the Project?

The information collected by the questionnaire will be collated and analysed as part of a Masters of Social Welfare (MSW) thesis. The results from the questionnaire will be analysed in order to:

1. To determine what Health Social Workers consider to be competent practice in accordance to national standard competences

2. To develop a practice framework, which is comprehensive and based on research.

What Type of Participants are being sought?

Members of Aotearoa New Zealand Association of Social Workers employed by Health sector throughout New Zealand will be invited to participate in this research project.

What will Participants be Asked to Do?

Should you agree to take part in this project, you asked to complete the attached consent form, personal information sheet and questionnaire and return in self-addressed envelope supplied.
The questionnaire should take about 30 minutes to complete

Should you decide not to take part in the project this will not disadvantage you in any way.

**Can Participants Change their Mind and Withdraw from the Project?**

You may withdraw from participation in the project at any time and without any disadvantage to yourself.

**What Data or Information will be Collected and What Use will be Made of it**

The results of the questionaries and personal information will be collated for statistical purposes to draw comparisons or conclusions between groups. No individual will be able to be identified.

**Purpose of the questionnaire**

The purpose of the questionnaire is to collect information that will address the aims of the research, which are:

1. To determine what Health Social Workers consider to be competent practice in accordance to national standard competences

2. To develop a practice framework, which is comprehensive and based on research.

Information will be analysed by Michelle Derrett, MSW student under the supervision of Dr Lynne Briggs, Senior Lecture, Department of Social Work and Community Development

The results of the project may be published and will be available in the library, but every attempt will be made to preserve your anonymity.

You are most welcome to request a copy of the results of the project should you wish.

The data collected will be securely stored in such a way that only those mentioned above will be able to gain access to it. At the end of the project any personal information will be destroyed immediately except that, as required by the University's research policy, any raw data on which the results of the project depend will be retained in secure storage for five years, after which it will be destroyed.
Reasonable precautions will be taken to protect and destroy data gathered by email. However, the security of electronically transmitted information cannot be guaranteed. Caution is advised in the electronic transmission of sensitive material.

**What if Participants have any Questions?**

If you have any questions about our project, either now or in the future, please feel free to contact either:

Michelle Derrett

Student in Master of Social Welfare

Social Work and Community Development

University of Otago, PO Box 56, Dunedin, 9054

Email: dermi740@student.otago.ac.nz

Or

Dr Lynne Briggs

Senior Lecture

Social Work and Community Development

University of Otago, PO Box 56, Dunedin, 9054

Email: lynne.briggs@otago.ac.nz

This project has been reviewed and approved by the University of Otago Human Ethics Committee, November 2007
CONSENT FORM FOR PARTICIPANTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary.

2. I am free to withdraw from the project at any time without any disadvantage;

3. Personal identifying information will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for five years, after which they will be destroyed;

4. The results of the project may be published and will be available in the library but my anonymity will be preserved.

5. I understand that reasonable precautions have been taken to protect data transmitted by email but that the security of the information cannot be guaranteed.

I agree to take part in this project.
Name of participant: ___________________________

Signature of participant: ______________________  Date: ___________________

Please return the completed consent form, personal information sheet and questionnaire in the self-addressed envelope supplied.

This project has been reviewed and approved by the University of Otago Human Ethics Committee, November 2007
**Personal Information Sheet**

Please return the completed consent form, personal information sheet and the questionnaire in the self-addressed envelope supplied.

Academic qualifications: ____________________________________________________________

Social work related qualifications: __________________________________________________

Year completed social work qualification: ____________________________________________

Institution you gain social work qualification from: _________________________________

Years of experience as a social worker: _____________________________________________

Years of experience as health social worker: _________________________________________

Age group (*please circle*)
>24  25-29  30-34  35-39  40-44  45-49  50-54  55-59  60-64  <65

Gender (*please circle*)
Female
Male

Ethnicity: _________________________________

Place of practice (*please circle*)
District Health Board (*please specify*) _________________________________
Non-Government Organization
Private Practice
Other (*please specify*) _________________________________

Practice specialty (*please circle*)
Mental Health
Physical Health
Disability
Rehabilitation
Other (*please specify*)
References


This questionnaire has been adapted from a number of competences documents. The references can be found at the end of this questionnaire.

On the following scales please mark the appropriate number that indicates how much you agree or disagree with the following statements as related to the task of a social worker working in the health system within New Zealand.

**Question 1: Establishes a respectful and empathic working relationship between the social worker and client.**

1.1: Communicates mutuality in relationship by using inclusive language, avoiding language that emphasizes differences in experience, power and personhood between the consumer and the worker, and avoiding blocks to communication such as the use of jargon, sexist, racist, ageist, or other language disrespectful of others.

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1.2: Gathers and provides information in a way that respects the client’s experience, beliefs, and feelings.

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1.3: Allocates sufficient time to client activities to allow unhurried resolution of tasks.

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1.4: In all aspects of client work, the worker encourages maximum levels of client participation in decision making, emphasizing choice and power over day to day activities.

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1.5: The worker is respectful of the client’s cultural background and sensitive to ethnicity, race, class, age and gender as variables which might affect the worker-client relationship.

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1.6: When working with families and groups, the worker recognizes and seeks to accommodate the different experiences and perspectives of different family and group members.

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**Do you have any comments on this section?**
**Question 2: Developing a social work assessment.**

2.1: Gathers information with the client from a range of sources to build up a comprehensive understanding of the client’s problems and strengths, and problems and strengths in the client’s social context.

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2.2: Identifies the potential risk indicators in order to minimize risk to the client or to others.

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2.3: Applies specific assessment schedules as appropriate to develop a detailed knowledge of specific aspects of the problems and strengths of the client, or problems and strengths of the client’s social context.

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2.4: Regularly reviews the assessment with the client to retain the focus on shared understanding of problems and strengths.

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2.5: Maintains records of activity as required by accountability standards within the agency.

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2.6: Undertakes Mental State Examination and other assessments of clinical functioning as part of comprehensive assessment service.

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Do you have any comments on this section?
Question 3: Develops and Implements educational interventions with clients.

3.1: Establishes the client’s needs and demand for specific information and skills as a basis for education.

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3.2: Links the client to appropriate resources and learning environments in order to maximize opportunities for self learning, or learning through mutual support and education.

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3.3: Uses appropriate terminology and technology in presenting information.

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Do you have any comments on this section?
Question 4: Advocates with and for clients in relation to rights and resources.

| 4.1: Establishes with the client some form of advocacy to address the client’s identified rights or problems and makes representations on behalf of clients and facilitates negotiation as appropriate. |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly disagree | strongly agree |

| 4.2: Explores with the client the range of alternative actions available in order to address the identified need and supports action chosen. |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly disagree | strongly agree |

| 4.3: Monitors the activity of the treatment team to ensure that all decision making at every stage is respectful and inclusive of the needs and wishes of both consumers and family members. |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly disagree | strongly agree |

| 4.4: Supports and encourages client self-advocacy through assisting with preparation, providing resources and giving feedback on performance. |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly disagree | strongly agree |

| 4.5: Uses principles of mediation, negotiation, assertion, and conflict resolution. |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly disagree | strongly agree |

| 4.6: Evaluates with the client the outcome of advocacy. |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly disagree | strongly agree |
Do you have any comments on this section?
Question 5: Case management.

5.1: Develops a social work assessment of the client’s needs and circumstances.

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5.2: Develops and implements the service plan with the client that includes short-term and long-term goals of intervention.

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5.3: Consults with family, significant others, members of the treatment team and other service providers as appropriate to the implementation of the service plan.

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5.4: Reviews, revises and monitors the service plan regularly with the client.

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Do you have any comments on this section?
**Question 6: Intensive casework.**

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<th>6.1: Supports the client’s selection of a course of action.</th>
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<th>6.2: Supports the client practically and emotionally in implementing the course of action.</th>
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<th>6.3: Monitors, evaluates, and revises problem solving activity with the client.</th>
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<th>6.4: Consults with family, significant others, members of the treatment team and other service providers as appropriate in order to solve problems.</th>
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**Do you have any comments on this section?**
**Question 7: Intensive family casework.**

| 7.1: Establishes an empathic and respectful working relationship with family members. |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly | disagree |
| | | agree | strongly |

| 7.2: Develops a social work assessment of family needs and circumstances. This provides the basis for a shared understanding of the specific problems confronting the individual family members. |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly | disagree |
| | | agree | strongly |

| 7.3: Supports the family’s selection of a course of action. |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly | disagree |
| | | agree | strongly |

| 7.4: Supports the family practically and emotionally in implementing the course of action. |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly | disagree |
| | | agree | strongly |

| 7.5: Monitors, evaluates, and revises problem solving activity with the family. |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly | disagree |
| | | agree | strongly |

| 7.6: Consults with the consumer, significant others, members of the treatment team and other service providers as appropriate in order to solve problems. |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly | disagree |
| | | agree | strongly |
7.7: Advocates with and for the family to obtain resources and achieve goals.

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7.8: Negotiates with the individual client and their family, the practical limits of confidentiality of information obtained from all sources.

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Do you have any comments on this section?
**Question 8: Develops and implements educational interventions with groups.**

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**8.1:** Establishes an empathic and respectful working relationship with group members.

- | strongly agree | strongly disagree |
- | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**8.2:** Assesses the needs of group members and demand for specific information and skills as a basis for education.

- | strongly agree | strongly disagree |
- | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**8.3:** Engages group members in establishing group goals, norms and expectations. This process of developing and sustaining a supportive group culture of learning is ongoing.

- | strongly agree | strongly disagree |
- | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**8.4:** Using educational principles, designs and implements learning experiences for the group. A range of educational activities is applied, including lecturing, group discussion, role-play and rehearsal.

- | strongly agree | strongly disagree |
- | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**8.5:** Gives encouragement and feedback to individual members to support learning goals.

- | strongly agree | strongly disagree |
- | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**8.6:** Engages a group member in the process of supporting each other’s learning.

- | strongly agree | strongly disagree |
- | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
8.7: Facilitates problem solving within the group around conflict and difficulties in meeting group goals.

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8.8: Links group members to appropriate resources and learning environments in order to maximize opportunities for self learning, or learning through mutual support and education.

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8.9: Engages group members in evaluating learning outcomes of group activity.

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8.10: Engages group members in terminating group involvement.

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Do you have any comments on this section?
### Question 9: Develops and implements therapeutic groups for consumers and family carers.

**9.1: Develops a clear statement of the purpose, membership, and planned activity of the group.**

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**9.2: Assesses the needs of group members, and their strengths and problems in so far as they relate to the purpose and activity of the group.**

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**9.3: Engages group members in establishing group goals, norms and expectations. This process of developing and sustaining a supportive group culture is ongoing.**

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**9.4: Develops and implements group based activities to meet the goals of the group. The range of activities is extensive, but includes the sharing of problems and experiences as in mutual support groups, mutual problem solving, and shared creative experiences.**

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**9.5: Gives encouragement and feedback to individual members to support therapeutic goals.**

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**9.6: Engages group members in the process of supporting each other’s therapeutic goals.**

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9.7: Monitors group activity in terms of instrumental and process goals.

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9.8: Applies process skills in leadership, challenging, supporting, and problem solving to meet group goals.

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9.9: Modifies group activity to meet the needs of specific group members, and in response to ongoing evaluation of the group by group members.

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9.10: Facilitates problem solving within the group around conflict and difficulties in meeting group goals.

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9.11: Engages group members in terminating group involvement.

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Do you have any comments on this section?
Question 10: Develops an assessment of community needs and resources.

<table>
<thead>
<tr>
<th>10.1: Accesses and interprets demographic data from appropriate sources.</th>
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<tbody>
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<td>strongly disagree</td>
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<table>
<thead>
<tr>
<th>10.2: Accesses a range of formal reports from government and non-government agencies to gather data for assessment purposes.</th>
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<td>strongly disagree</td>
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<th>10.3: Accesses information from media sources such as newspapers, journals, radio, television and Internet.</th>
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<tr>
<th>10.4: Engages key in professionals in the community to identify community resources, and gaps between resources and needs.</th>
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<tr>
<th>10.5: Gathers detailed information about agencies through site visits and discussions with staff and consumers of services.</th>
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<tr>
<th>10.6: Integrates data gathered to form a tentative assessment of community needs and resources.</th>
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Do you have any comments on this section?
**Question 11: Networking.**

11.1: Makes contact with stakeholders from all sections of the health field.

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11.2: Develops a working knowledge of relevant services in the community, and maintains formal and informal contact with service providers and management within these services.

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11.3: Provides information about the social worker’s agency and encourages appropriate liaison between this agency and the range of community services.

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11.4: Supports communication networks and co-operation among all stakeholders in the health services in the community.

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11.5: Brings individuals and groups together to share ideas on issues of common concern.

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**Do you have any comments on this section?**
**Question 12: Contributes to health policy development.**

| 12.1: Seeks feedback from consumers and carers about the strengths and deficiencies in agency services. |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly disagree | strongly agree | strongly disagree | strongly agree |

| 12.2: Provides detailed feedback to management about service effectiveness and difficulties in existing policy implementation. |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly disagree | strongly agree | strongly disagree | strongly agree |

| 12.3: Suggests policy directions for broader health policy within the policy making process. |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| strongly disagree | strongly agree | strongly disagree | strongly agree |

**Do you have any comments on this section?**
**Question 13:** Practices within the ethical guidelines of the NZ SWRB (Code of Conduct) & ANZASW.

13.1: Practices within the guidelines for professional ethical practice as detailed in the NZ SWRB Code of Conduct & ANZASW Code of Ethics

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**Do you have any comments on this section?**
**Question 14: Manages personal workload.**

14.1: Develops a clear understanding of the range of professional and administrative tasks required in the position.

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14.2: Articulates the role of social work within the agency.

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14.3: Recognizes the management structure of the agency and understands the lines of professional and administrative accountability.

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14.4: Prioritizes work activities.

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14.5: Meets agency professional and administrative deadlines.

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14.6: Maintains agency procedures for efficient completion of administrative and professional tasks.

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14.7: Maintains agency requirements for record keeping and accountability of resources.

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14.8: Complies with agency occupational health and safety policies.

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Do you have any comments on this section?
### Question 15: Practices as a member of a multidisciplinary team.

15.1: Demonstrates a respect for the profession of social work, and for other health disciplines.

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15.2: Articulates the scope of social work domain, skills, knowledge and values in the health area.

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15.3: Articulates a specific statement of social work purpose, roles and activities within the agency.

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15.4: Articulates the knowledge, values, and practice bases of social work in relation to other health disciplines.

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15.5: Contributes a social work perspective in team deliberations around clinical activity at every level – individual client work, group and family work, community work and work at the broader systems level.

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15.6: Applies a range of skills in assertion, problem solving, education, and conflict resolution to management of day to day professional social work activity within the multidisciplinary team.

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Do you have any comments on this section?
**Question 16: Uses social work supervision to enhance practice.**

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<tr>
<th>16.1: Contracts a supervisory relationship with a social work colleague.</th>
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<td>1 2 3 4 5 6 7</td>
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<td>strongly agree strongly disagree</td>
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<thead>
<tr>
<th>16.2: Determines the specific goals and processes of supervision to be applied, and the frequency and structure of the supervision meetings.</th>
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<tr>
<th>16.3: Prepares analyses of practice as the basis for discussion at supervision sessions.</th>
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<th>16.4: Engages with the supervisor in a process of critical reflection on practice during supervision sessions.</th>
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<tr>
<th>16.5: Identifies practice issues specific to social work through discussions with supervisor.</th>
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<tr>
<th>16.6: Identifies strengths and weaknesses in practice competence through discussions with supervisor.</th>
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16.7: Negotiates learning goals for supervision.

1  2  3  4  5  6  7
strongly agree strongly
disagree agree

16.8: Applies a problem-solving model to resolve problems in practice and to develop plans for practice activity, in discussions with supervisor.

1  2  3  4  5  6  7
strongly agree strongly
disagree agree

16.9: Reviews progress towards identified goals and modifies these in ongoing discussions with supervisor.

1  2  3  4  5  6  7
strongly agree strongly
disagree agree

Do you have any comments on this section?
**Question 17: Maintains professional development.**

17.1: Identifies personal needs for development of knowledge and skills in order to work more effectively in the agency.

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17.2: Identifies needs for knowledge and skills, experience and qualifications in order to work in other parts of the mental health or human services system.

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17.3: Maintains a strong knowledge base through reading professional journals, attending workshops, seminars and conferences.

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17.4: Writes papers for presentation at conferences and for publication in professional journals.

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17.5: Participates in ANZASW sponsored and agency based professional development activities.

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17.6: Undertakes a range of postgraduate course work and research courses to upgrade professional qualifications.

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17.7: Contributes to the field education of social work students on placement in the mental health area.

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**Do you have any comments on this section?**

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**Question 18: Bicultural Practice**

18.1: Demonstrates the ability to apply the principle of the Treaty of Waitangi/ Te Tiriti o Waitangi, to practice

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18.2: Understanding the Treaty of Waitangi/ Te Tiriti o Waitangi and its relevance to the health of Māori in Aotearoa/New Zealand.

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18.3: Demonstrates knowledge of differing health and socio-economic status of Māori and non Māori

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18.4: Applies the Treaty of Waitangi/ Te Tiriti o Waitangi to social work practice

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**Do you have any comments on this section?**
Do you have any additional comments related to the questionnaire?

Please return the completed consent form, personal information sheet and this questionnaire in the self-addressed envelope supplied by the 30th April 2008.
How many social workers does it take to change a light bulb?

• None. They empower it to change itself!
• None. The light bulb is not burnt out, it’s just differently lit.
• None. They set up a team to write a paper on coping with darkness.
• Only one...but it depends on whether or not the light bulb wants to be changed.
• "The light bulb doesn't need changing, it's the system that needs to change."

Competency Framework for Health Social Workers
The research

- My study was conducted using a questionnaire as the research instrument. The data was collected using a mixed method approach utilizing both qualitative and quantitative methods. Statistical analysis was used to test two hypotheses, which are:

Hypotheses

- A single national competency framework can be developed that is relevant to all domains of Health Social Work practice.
- Health Social Worker’s demographic characteristics influence the perception of what Health Social Workers consider to be relevant elements of a competency framework.
Hypotheses

- The present study also considers what Health Social Workers consider relevant elements of a national competency framework for health social worker.

Questionnaire

- The five competency documents used to develop the questionnaire were:
  - Taranaki District Health Board Competency Framework (2005)
  - Canterbury District Health Board Mental Health Service Competency Framework (2004)
  - Competency Framework for Social Workers in Mental Health Service for Auckland District Health Board, Counties Manukau District Health Board, Waitemata District Health Board (2006)
  - Otago District Health Board Social Workers Performance and Progression (no date)
  - Practice Standards for Mental Health Social Workers for the Australian Association of Social Worker (2000)
Participants

- The participants were current financial members of the Aotearoa New Zealand Association of Social Workers (ANZASW) who identified themselves as working in the health sector. Current or past employees of the Southern District Health Board (Otago) were excluded from participation in the study due to my designated professional leadership position at the Southern District Health Board (Otago) as this could have been perceived as a conflict of interest.

Method

- This study utilized mixed methods survey. The questionnaire design allowed for both empirical and qualitative data to be collected to allow the three research questions to be tested.
Method

• The survey questionnaire comprised two parts. The first related to demographics and the nine variables (gender, age, ethnicity, social work qualification, institution where social work qualification was gained, years of experience as Health Social Workers, place of practice, and practice speciality).

Method

• The second part of the questionnaire was divided into 18 sections related to the competency statements. Each competency statement was further divided into a number of elements. This part of the questionnaire combined a 1 to 7 Likert-type scale (where 1 = strongly disagree and 7 = strongly agree) for each element along with a comments box at the end of each section. There was also an opportunity for the participants to make general comments about the questionnaire.
Demographics

- On average social workers have about 10.3 years of experience working in health. A little over half of the social workers are employed in the Mental Health sector. The majority of social workers have a social work qualification, however there is still a small proportion of unqualified social workers employed in the health sector.

Gender
Age

Ethnicity
Social Work Qualification

- No Recognized Social Work Qualification: 11%
- SWRB Recognized Social Work Qualification: 81%
- Social Worker Qualification Gained Overseas: 5%

Institution Social Work Qualification Gained

- Various institutions with different percentages of students gaining Social Work qualifications.
Years of Experience as Health Social Worker

Practice Specialty
Quantitative data

- The 18 competency statements were made up of 107 elements, and 39 of these elements having significant differences between demographic groups.
- Although there were some significant differences between demographic groups this is still within the “agreed” and “strongly agreed” on the scale.
Competency Statement 1: Establishes a respectful and empathic working relationship between the social worker and client.

- 1.1: Communicates mutuality in relationship by using inclusive language, avoiding language that emphasizes differences in experience, power and personhood between the consumer and the worker, and avoiding blocks to communication such as the use of jargon, sexist, racist, ageist, or other language disrespectful of others.
- 1.2: Gathers and provides information in a way that respects the client's experience, beliefs, and feelings.
- 1.3: Allocates sufficient time to client activities to allow unhurried resolution of tasks.
- 1.4: In all aspects of client work, the worker encourages maximum levels of client participation in decision making, emphasizing choice and power over day to day activities.
- 1.5: The worker is respectful of the client's cultural background and sensitive to ethnicity, race, class, age and gender as variables which might affect the worker-client relationship.
- 1.6: When working with families and groups, the worker recognizes and seeks to accommodate the different experiences and perspectives of different family and group members.

Competency Statement 2: Developing a social work assessment.

- 2.1: Gathers information with the client from a range of sources to build up a comprehensive understanding of the client's problems and strengths, and problems and strengths in the client's social context.
- 2.2: Identifies the potential risk indicators in order to minimize risk to the client or to others.
- 2.3: Applies specific assessment schedules as appropriate to develop a detailed knowledge of specific aspects of the problems and strengths of the client, or problems and strengths of the client's social context.
- 2.4: Regularly reviews the assessment with the client to retain the focus on shared understanding of problems and strengths.
- 2.5: Maintains records of activity as required by accountability standards within the agency.
- 2.6: Undertakes Mental State Examination and other assessments of clinical functioning as part of comprehensive assessment service.
Competency Statement 3: Develops and Implements educational interventions with clients.

- 3.1: Establishes the client’s needs and demand for specific information and skills as a basis for education.
- 3.2: Links the client to appropriate resources and learning environments in order to maximize opportunities for self learning, or learning through mutual support and education.
- 3.3: Uses appropriate terminology and technology in presenting information.

Competency Statement 4: Advocates with and for clients in relation to rights and resources.

- 4.1: Establishes with the client some form of advocacy to address the client’s identified rights or problems and makes representations on behalf of clients and facilitates negotiation as appropriate
- 4.2: Explores with the client the range of alternative actions available in order to address the identified need and supports action chosen
- 4.3: Monitors the activity of the treatment team to ensure that all decision making at every stage is respectful and inclusive of the needs and wishes of both consumers and family members.
- 4.4: Supports and encourages client self-advocacy through assisting with preparation, providing resources and giving feedback on performance.
- 4.5: Uses principles of mediation, negotiation, assertion, and conflict resolution.
- 4.6: Evaluates with the client the outcome of advocacy.
Competency Statement 5: Case management.

- 5.1: Develops a social work assessment of the client’s needs and circumstances.
- 5.2: Develops and implements the service plan with the client that includes short-term and long-term goals of intervention.
- 5.3: Consults with family, significant others, members of the treatment team and other service providers as appropriate to the implementation of the service plan.
- 5.4: Reviews, revises and monitors the service plan regularly with the client.

Competency Statement 6: Intensive casework.

- 6.1: Supports the client’s selection of a course of action.
- 6.2: Supports the client practically and emotionally in implementing the course of action.
- 6.3: Monitors, evaluates, and revises problem solving activity with the client.
- 6.4: Consults with family, significant others, members of the treatment team and other service providers as appropriate in order to solve problems.
Competency Statement 7: Intensive family casework.

• 7.1: Establishes an empathic and respectful working relationship with family members.
• 7.2: Develops a social work assessment of family needs and circumstances. This provides the basis for a shared understanding of the specific problems confronting the individual family members.
• 7.3: Supports the family’s selection of a course of action.
• 7.4: Supports the family practically and emotionally in implementing the course of action.
• 7.5: Monitors, evaluates, and revises problem solving activity with the family.
• 7.6: Consults with the consumer, significant others, members of the treatment team and other service providers as appropriate in order to solve problems.
• 7.7: Advocates with and for the family to obtain resources and achieve goals.
• 7.8: Negotiates with the individual client and their family, the practical limits of confidentiality of information obtained from all sources.

Competency Statement 8: Develops and implements educational interventions with groups.

• 8.1: Establishes an empathic and respectful working relationship with group members.
• 8.2: Assesses the needs of group members and demand for specific information and skills as a basis for education.
• 8.3: Engages group members in establishing group goals, norms and expectations. This process of developing and sustaining a supportive group culture of learning is ongoing.
• 8.4: Using educational principles, designs and implements learning experiences for the group. A range of educational activities is applied, including lecturing, group discussion, role-play and rehearsal.
• 8.5: Gives encouragement and feedback to individual members to support learning goals.
• 8.6: Engages a group member in the process of supporting each other’s learning.
• 8.7: Facilitates problem solving within the group around conflict and difficulties in meeting group goals.
• 8.8: Links group members to appropriate resources and learning environments in order to maximize opportunities for self-learning, or learning through mutual support and education.
• 8.9: Engages group members in evaluating learning outcomes of group activity.
• 8.10: Engages group members in terminating group involvement.
Competency Statement 9: Develops and implements therapeutic groups for consumers and family carers.

- 9.1: Develops a clear statement of the purpose, membership, and planned activity of the group.
- 9.2: Assesses the needs of group members, and their strengths and problems in so far as they relate to the purpose and activity of the group.
- 9.3: Engages group members in establishing group goals, norms and expectations. This process of developing and sustaining a supportive group culture is ongoing.
- 9.4: Develops and implements group based activities to meet the goals of the group. The range of activities is extensive, but includes the sharing of problems and experiences as in mutual support groups, mutual problem solving, and shared creative experiences.
- 9.5: Gives encouragement and feedback to individual members to support therapeutic goals.
- 9.6: Engages group members in the process of supporting each other's therapeutic goals.
- 9.7: Monitors group activity in terms of instrumental and process goals.
- 9.8: Applies process skills in leadership, challenging, supporting, and problem solving to meet group goals.
- 9.9: Modifies group activity to meet the needs of specific group members, and in response to ongoing evaluation of the group by group members.
- 9.10: Facilitates problem solving within the group around conflict and difficulties in meeting group goals.
- 9.11: Engages group members in terminating group involvement.

Competency Statement 10: Develops an assessment of community needs and resources.

- 10.1: Accesses and interprets demographic data from appropriate sources.
- 10.2: Accesses a range of formal reports from government and non-government agencies to gather data for assessment purposes.
- 10.3: Accesses information from media sources such as newspapers, journals, radio, television and Internet.
- 10.4: Engages key in professionals in the community to identify community resources, and gaps between resources and needs.
- 10.5: Gathers detailed information about agencies through site visits and discussions with staff and consumers of services.
- 10.6: Integrates data gathered to form a tentative assessment of community needs and resources.
Competency Statement 11: Networking.

- 11.1: Makes contact with stakeholders from all sections of the health field.
- 11.2: Develops a working knowledge of relevant services in the community, and maintains formal and informal contact with service providers and management within these services.
- 11.3: Provides information about the social worker’s agency and encourages appropriate liaison between this agency and the range of community services.
- 11.4: Supports communication networks and co-operation among all stakeholders in the health services in the community.
- 11.5: Brings individuals and groups together to share ideas on issues of common concern.

Competency Statement 12: Contributes to health policy development.

- 12.1: Seeks feedback from consumers and carers about the strengths and deficiencies in agency services.
- 12.2: Provides detailed feedback to management about service effectiveness and difficulties in existing policy implementation.
- 12.3: Suggests policy directions for broader health policy within the policy making process.
Competency Statement 13: Practices within the ethical guidelines of the NZ SWRB (Code of Conduct) & ANZASW.


Competency Statement 14: Manages personal workload.

- 14.1: Develops a clear understanding of the range of professional and administrative tasks required in the position.
- 14.2: Articulates the role of social work within the agency.
- 14.3: Recognizes the management structure of the agency and understands the lines of professional and administrative accountability.
- 14.4: Prioritizes work activities.
- 14.5: Meets agency professional and administrative deadlines.
- 14.6: Maintains agency procedures for efficient completion of administrative and professional tasks.
- 14.7: Maintains agency requirements for record keeping and accountability of resources.
- 14.8: Complies with agency occupational health and safety policies.
Competency Statement 15: Practices as a member of a multidisciplinary team.

- 15.1: Demonstrates a respect for the profession of social work, and for other health disciplines.
- 15.2: Articulates the scope of social work domain, skills, knowledge and values in the health area.
- 15.3: Articulates a specific statement of social work purpose, roles and activities within the agency.
- 15.4: Articulates the knowledge, values, and practice bases of social work in relation to other health disciplines.
- 15.5: Contributes a social work perspective in team deliberations around clinical activity at every level – individual client work, group and family work, community work and work at the broader systems level.
- 15.6: Applies a range of skills in assertion, problem solving, education, and conflict resolution to management of day to day professional social work activity within the multidisciplinary team.

Competency Statement 16: Uses social work supervision to enhance practice.

- 16.1: Contracts a supervisory relationship with a social work colleague.
- 16.2: Determines the specific goals and processes of supervision to be applied, and the frequency and structure of the supervision meetings.
- 16.3: Prepares analyses of practice as the basis for discussion at supervision sessions.
- 16.4: Engages with the supervisor in a process of critical reflection on practice during supervision sessions.
- 16.5: Identifies practice issues specific to social work through discussions with supervisor.
- 16.6: Identifies strengths and weaknesses in practice competence through discussions with supervisor.
- 16.7: Negotiates learning goals for supervision.
- 16.8: Applies a problem-solving model to resolve problems in practice and to develop plans for practice activity, in discussions with supervisor.
- 16.9: Reviews progress towards identified goals and modifies these in ongoing discussions with supervisor.
Competency Statement 17: Maintains professional development.

- 17.1: Identifies personal needs for development of knowledge and skills in order to work more effectively in the agency.
- 17.2: Identifies needs for knowledge and skills, experience and qualifications in order to work in other parts of the mental health or human services system.
- 17.3: Maintains a strong knowledge base through reading professional journals, attending workshops, seminars and conferences.
- 17.4: Writes papers for presentation at conferences and for publication in professional journals.
- 17.5: Participates in ANZASW sponsored and agency based professional development activities.
- 17.6: Undertakes a range of postgraduate course work and research courses to upgrade professional qualifications.
- 17.7: Contributes to the field education of social work students on placement in health settings.

Question 18: Bicultural Practice

- 18.1: Demonstrates the ability to apply the principle of the Treaty of Waitangi/ Te Tiriti o Waitangi, to practice
- 18.2: Understanding the Treaty of Waitangi/ Te Tiriti o Waitangi and its relevance to the health of Maori in Aotearoa/New Zealand
- 18.3: Demonstrates knowledge of differing health and socio-economic status of Maori and non Maori
- 18.4: Applies the Treaty of Waitangi/ Te Tiriti o Waitangi to social work practice
Summary of major finding from quantified data

- All elements of the competence statements had an overall mean score of greater than 4 (agree). This suggests that generally there is an overall agreement for all elements of the competency statements. While there were some significant differences between some mean scores, this difference tended to be between 4 (agree) and 7 (strongly agree).

Summary of major finding from quantified data

- Female participants had significantly different mean scores compared to males in nine of the elements. Pacific Island participants had significantly different mean scores compared to other ethnic groups in six elements. Participants who were under 29 years old had significantly different mean scores compared with other age groups in three elements. Participants who stated they had over 26 years experience as health social workers had significantly different mean scores compared with less experienced health social workers in four elements.
Qualitative Data

• The comments made by participants about the competency elements produced a rich source of information.

Summary of major themes

• One hundred and seventeen (70%) participants took the opportunity to add comments at the end of each of the 18 competencies. There were 1093 comments thematically coded into 60 themes. The participants on average made nine comments each throughout the questionnaire.
Themes

- Time/workload pressure
- Education
- Assessments
- Evaluation
- Ideal/best practice
- Client choice
- Social work role

Themes

- Family involvement
- Client participation
- Networking
- Group work
- Advocacy
- MDT
- Intervention plan
- Resources
Themes

- The most common themes identified were time and workload pressures (9%), education (9%), assessment (5%), evaluation (4%), mental state examination (4%), family choice (4%), ideal and best practice (3%), family involvement (3%), client participation (3%), client choice (3%), competency not part of social work role (5%), and competency essential to social work role (3%). With the exception of mental state examination and family choice, these themes occurred across more than one competency.

Conclusion

- Overall there was support for all of the competencies. Some participants suggested some changes in wording. There were concerns expressed about difficulties in achieving some or all of the competencies in day-to-day work due to time and workload pressure. Time constraints and workload pressure include crisis work, complex cases, safe discharge planning, bed demands, increase in the volume of work and short hospital stay. It appears from the comments made there is some differences in interpretation about social work assessments, role of education, group work and advocacy.
Common Themes of Competency Frameworks

- Cultural responsiveness/ competences
- Clinical and Professional practice
- Organisational requirements
- Professional Development
- Networking and social action
- Leadership and Professionalism
- Understanding Health

Competency 1: Understand Health

Health Social Workers require knowledge and skills to address reducing the affects of inequalities faced by clients/patients including inequalities in the social determinants of health and. They work towards improving access to health services for their clients/patients.

Indicators

- Knowledge of the biopsychosocial context of physical and mental health, trauma and disease as well as the context diagnosis and treatment intervention in
- Knowledge of the sociology and social history of disease disability and illness
- Understanding of client/patient and carer issues including the sociology of disability, history of mutual support and empowerment process, cultural experience of illness, hospitalisation and treatment interventions
- Understanding and interpreting Aotearoa/New Zealand Health policies and legal statutory processes
Competency 2: Bicultural Practice

Health Social Workers demonstrates an ability to apply the principles of the Treaty of Waitangi to practice. They use the principles of the Treaty of Waitangi/Te Tiriti o Waitangi to address the effects of inequalities in the health sector for their clients/patients.

Indicators

- Incorporates the principles of the Treaty (partnership, participation, protection) into clinical practice
- Understanding the Treaty of Waitangi/Te Tiriti o Waitangi and its relevance to the health of Maori in Aotearoa/New Zealand
- Committed to bicultural development in social work practice Aotearoa/New Zealand at an Individual whānau, hapu, iwi institutional level

Competency 3: Cultural Responsiveness

Health Social Workers demonstrate an understanding of cultural diversity in particular how it relates to clients/patients interactions with health services. Health Social Workers practice in a cultural sensitive manner that reflects their awareness of cultural diversity among clients/patients.

Indicators:

- Demonstrate respect for clients' cultural background and sensitive to the individual and family/whānau belief systems that might influence the working relationship with the client/patient.
- Evaluates own cultural value base and understand how they might influence the working relationship with clients whilst respecting differing cultural and belief systems.
- Demonstrate awareness of the diversity within culture, ethnicity class, age and gender and integrate this knowledge into social work practice
Competency 4: Clinical and Professional Practice

Health Social Workers establishes respectful, purposeful and collaborative relationship with clients/patients, families, whānau, Multi/Inter-disciplinary teams and service providers to address the biopsychosocial needs of clients/patients. Health Social Workers undertake a range of assessments, interventions and discharge planning to improve the health outcomes of clients/patients.

- Indicators
- Able to establish an appropriate and purposeful working relationship with clients.
- Understand and keeps clients/patients informed of the practical limits of confidentiality of information.
- Works with client/patients to gather information to develop comprehensive assessment of clients’ concerns, strengths, and support within their social context.
- Identifies potential risk indicators and take appropriate action to minimize the risk to clients/patients and to others.
- Able to effectively use specific assessment tools that are relevant and appropriate for client/patient and service social work practices in.
- Completes comprehensive discharge plans with input from the client/patient, family/whānau significant others and the inter/multidisciplinary teams to ensure safe discharge from the social work service.
- Facilitates collaboration between inter/multidisciplinary teams, service providers and clients and their families to provide efficient and appropriate services to address clients’ biopsychosocial needs.
- Able to articulate the scope of social work practice, including skills, knowledge and values in the health system.

Competency 5: Organisational Requirements

Health Social Workers have responsibilities to the organisation they work in. They contribute to and comply with policies, procedures and guidelines of the organisation. Health Social Worker work towards making organisation and systems responsive to clients/patients.

Indicators
- Maintains social work documentation which reflects social work interaction with clients’ including assessments intervention plan, goals and discharge plans in accordance with organisation policies and guidelines.
- Maintain a workload that allows efficient and quality social work service delivery.
- Demonstrates knowledge of legislation and polices that impact on Health Social Work practice.
- Demonstrate a working knowledge of current social work methods of practice, social policies, community resources and integrate such information into practice.
Competency 6: Professional Development

Health Social Workers have sufficient qualifications to undertake their role in health care. Health Social Workers are involved in professional development and contributes to the advancement of social work knowledge and evidence based practice.

Indicators:
- Recognise own learning needs, participate in career development strategies continuing education and profession activities
- Contributes to the advancement of social work profession through education of social work student writing papers for peer review publication, participating in research delivering in-house in-service and presenting at conferences.
- Maintains a strong social work knowledge base through reading professional journal, web articles, attending workshops, seminars and conferences
- Maintains a critical reflective approach to own social work practice through supervision, peer review and self evaluation

Competency 7: Advocacy, Networking and Social Action

Health Social Workers are involved in advocacy and networking activities to improve service delivery to clients/patients. Health Social Workers work collaboratively with other health professionals, community and government agencies and service providers to improve outcomes for clients/patients.

Indicators:
- Applies advocacy skills to improve service delivery and health outcomes for clients/patients and promotes client/patient self-advocacy to access services.
- Maintains a working knowledge of resources, service providers and community agencies that would benefit client/patients and their family/whânau.
- Applies networking and collaborative skills to ensure robust intervention plans for client/patients and their families/whânau are implemented in coordination with other professionals, community agencies and service providers.
- Identify gaps in service provision and resources and works to address these gaps through social action, advocacy and networking.
Competency 8: Leadership and Professionalism

Health Social Workers adhere to professional ethics, standards of practice and code of conduct as set out by their professional bodies and registration board. Participates in regular clinical supervision. Health Social Workers have a responsibility to demonstrate leadership skills to improve access to health care.

Indicators:

- Demonstrate knowledge of and practice within the guidelines established by social work professional and regulatory bodies’ codes of ethics, standards of practice and codes of conduct.
- Engages in critical reflection on social work practice within the supervision processes to ensure high quality of service delivery including identifying practice areas needing improvement and developing and achieving supervision goals.
- Applies critical reflective skills as part of ongoing formal and informal evaluation of social work practice to assess quality and appropriateness of social work practice to ensure ongoing competency.