Social Work @ Melbourne

Promoting practice research through academic practitioner partnerships in health and mental health

Prof Lynette Joubert

Department of Social Work
Melbourne School of Health Sciences,
University of Melbourne
Australia

The aims of an academic practice research unit for social work

The academic practice research partnership seeks to promote interdisciplinary and innovative approaches in clinical and service management research, with the aim of integrating the social sciences and humanities with medical and health sciences.

- ❑Contribute to an evidence base for social work health practice
- ❑Explore innovative and rigorous research methodologies relevant to social work interventions and outcomes
- ❑Contribute to an evidence and skill base in the research areas of the psychosocial aspects of health
- ❑Contribute to an evidence base on the outcomes of health social work practice
- ❑Extend the range of research being undertaken by health social workers

Process of Academic Practitioner Partnerships

- Mentoring
- Engagement with Staff
- Patient and family focused
- Policy directives
- International collaboration

Research methodology in a health care setting

Methodologies are required that not only include traditional scientific models and inferential statistical analysis but integrate these with innovative approaches that access the broader systemic issues that impact on quality care and outcomes.

How can we demonstrate research rigour to our health colleagues?

CDM offers access to available data for pilot studies, complete projects or program evaluation

Promoting a Research Agenda within a health service

- Mentoring program for social work
- Practice research as an impetus for a policy of integration in service provision
- Social work practice research initiative as an impetus for collaboration with allied health
- Positioning of social work in the health service

Mentoring Model

aims to reduce the gap between practice and research

What constitutes “good” practice in Health Social Work?

- Integrated knowledge of theory and practice
- Good practice skills
- Insight into field of practice as it relates to health service delivery

- Good ability to observe and assess
- Good ability to record :
- Good ability to analyze and discuss :

- Ability to write clearly :

The shift from practice to practice research ….

- **Integrated knowledge of theory and practice**
- **Good practice skills**
- **Insight into field of practice as it relates to health service delivery**
- *Development of a research area, question and design*
- **Good ability to observe and assess**
- **Good ability to record :** *Data entry or collation*
- **Good ability to analyze and discuss :** *Analysis and presentation of quantitative / qualitative data*
- **Ability to write clearly :** *Formal report and presentation writing*

The Contribution of Psychosocial Factors to Secondary Risk Prevention for Myocardial Infarction in Young Adults

Prof Lynette Joubert, Ms Abigail Maturana,
Ms Jenny McNeill, Ms Christina Fitzgerald

School of Social Work, University of Melbourne
Department of Social Work, St Vincent's Health

THE UNIVERSITY OF MELBOURNE

St Vincent's Health

AIM OF THE STUDY:

- To explore and identify the contribution of complex psychosocial factors on secondary risk prevention for myocardial infarction in young adults. The information obtained will contribute to effective practice in secondary risk prevention and rehabilitation programs.

- **Hypotheses:**

  1. Complex psychosocial issues can impact on the motivation and involvement of younger patients in rehabilitation programs after myocardial infarction.

  2. Psychosocial responses to myocardial infarction including depression, social isolation and occupational changes can result in a lack of adherence to modifying life style changes that impact on secondary prevention after myocardial infarction.

RESEARCH PLAN:

- The research design involves a test, double re-test model using an integrated qualitative and quantitative methodology. A combination of open-ended and standardized questionnaires will be used.

Assessment instruments

The SF12 evaluates patients' perception of their physical and emotional well-being.

. (*Ware JE, Kosinski M, and Keller SD. A 12-Item Short-Form Health Survey: Construction of scales and preliminary tests of reliability and validity. Medical Care, 1996;34(3):220-233.)*

The Computerized Person-in-Environment assessment schedule (PIE) has good reliability and validity and assesses social functioning using a systemic model.

(*The PIE Classification System for Social Functioning Problems and the PIE Manual,* James M. Karls and Karin E. Wandrei, Editors)

The Cardiac Depression Scale (CDS) is a self-rating scale developed from the responses of cardiac patients to measure "adjustment disorder with depressed mood" (*Birks Y.[1]; Roebuck A.[1]; Thompson D.R.[2],A validation study of the Cardiac Depression Scale (CDS) in a UK population British Journal of Health Psychology 1 February 2004, vol. 9, no. 1, pp. 15-24(10))*

DISCUSSION OF THE RESULTS:

- An interim report (N=14) will be presented.
  The data reflects assessments carried out at during hospitalisation, and by telephone at 3 months and 6 months.

  DATA ANALYSIS:

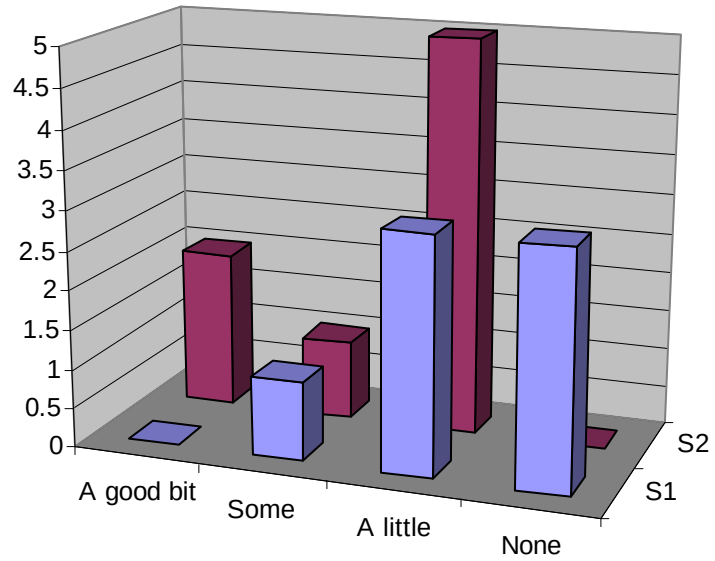
- The analysis of the data has three components:

- Descriptive Analysis to establish the frequency of age and gender

- Correlational analysis of significant relationships between variables : Pearson Correlation coefficients were calculated on the CDS, SF-12 and categorical data to establish any positive relationships between variables

- Thematic analysis of the qualitative data from the semi-structured interview schedules: the qualitative data was analysed to extract commonly recurring themes

SF12: Depressed affect (s1) and impact of health on social activities (s2) at 3 months



Thematic analysis of qualitative data

- Acute personal crisis
- Fear of death
- Increased physical and emotional vulnerability
- Emotional dependence on partner/spouse and close family
- Fear of permanent loss of competence at work and in personal relationships
- Fear of family history
- Fear of insufficient knowledge about heart disease and doing the “wrong thing” to prevent another crisis
- Fear of inadequate continuing medical care on discharge from St Vincent’s Health
- Difficulty in modifying life habits
- Fear of future health crises without appropriate support

DISCUSSION

The patients in the sample were confronted with a severe life threatening crisis which impacted on their emotional life as was shown by the significant depression scores in 41% of the sample at the initial assessment. All patients expressed an intense fear of increased mortality. These scores did not reach significance at 3 and 6 months in instances where patients reported emotional management of the crisis, as well as an ability to implement key life style changes.

Audit of social work activity

University of Melbourne, Department of Social Work

Melbourne School of Health Sciences,

- Lynette Joubert and Nicole Hill

Health Social Workers

- Alison Hocking; Anita Morris; Anna Wellington-Boyd; Glenda Kerridge; Julia Blackshaw; Lisa Brady; Carol Quayle; Catherine Ludbrook; Chris Cowan; Diane Neri; Glenda Bawden; Hebel, Lisa; Karen Rolfe; Karen Todd; Debra Leahy; Lorraine Xavier-Ambrosius; Lucio Naccarella; Marg Petrie; Penelope Vye; Sarah Firth; Sharon Sutherland; Nicole Tokatlian; Trish Kinrade; Bridget Wall; Tory Whitman; Fiona Wiseman

ST VINCENT'S HOSPITAL
MELBOURNE

the women's
the royal women's hospital
victoria

Barwon Health

Peter Mac

NorthWestern Mental Health

easternhealth
GREAT HEALTH AND WELLBEING

The Royal Melbourne Hospital

Cabrini

TheAlfred

MonashHealth

Austin Health

Western Health

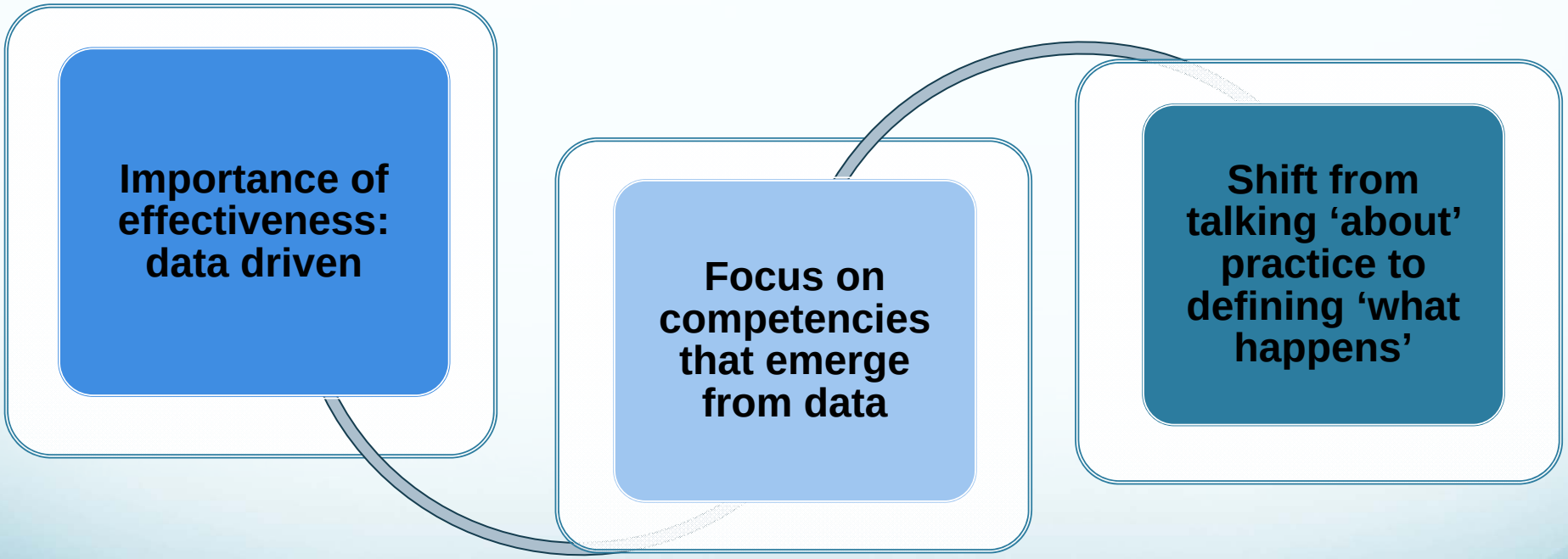
BallaratHealthServices
Putting your health first

AASW
Australian Association of Social Workers

Epworth

Audit of social work practice – why do it ?

Social Work Practice in Health and Mental Health



Background

- The shift to a practice research culture on hospital social work departments
- Shifts in health care policy to outcomes related to the patient experience
- Pilot Data (St Vincent's AH study in 2005)
  - Different practice in shared space
- Current Context
  - Interdisciplinary models
  - Extended and Advanced scope of practice

Aims of Study

- To gain an evidence-informed understanding of the current practices of social work practitioners
- To effectively contribute to broader debate about the future roles of health practitioners
- To describe amongst other key functions:
  - Patient-specific clinical intervention
  - Non patient-specific attributable activities
  - Non-clinical interventions
  - Theoretical approaches informing interventions by health and mental health social workers

Methodology

- **14** Health Services in Melbourne, Australia
- Mix of health and mental health services
- 538 Social Workers participated
- Prospective audit of usual hospital-based social work practice over a single day
- Work recorded in 5 minute intervals
- Data coding sheet

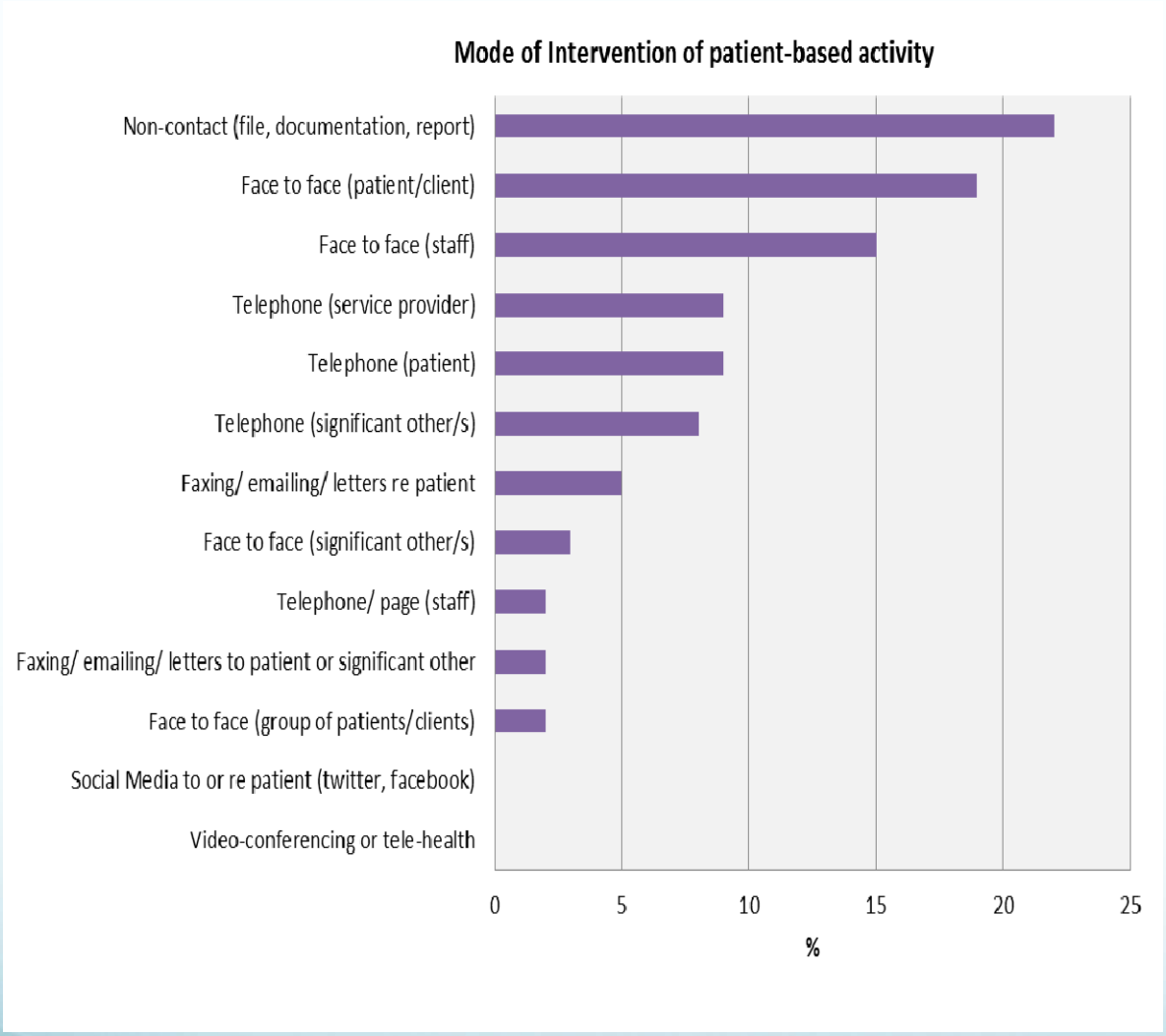
Methodology

The audit sheet and coding key is evidence informed and developed in previous audits of allied health and social work practice

(Joubert, Brock, Black, Posenelli 2004)

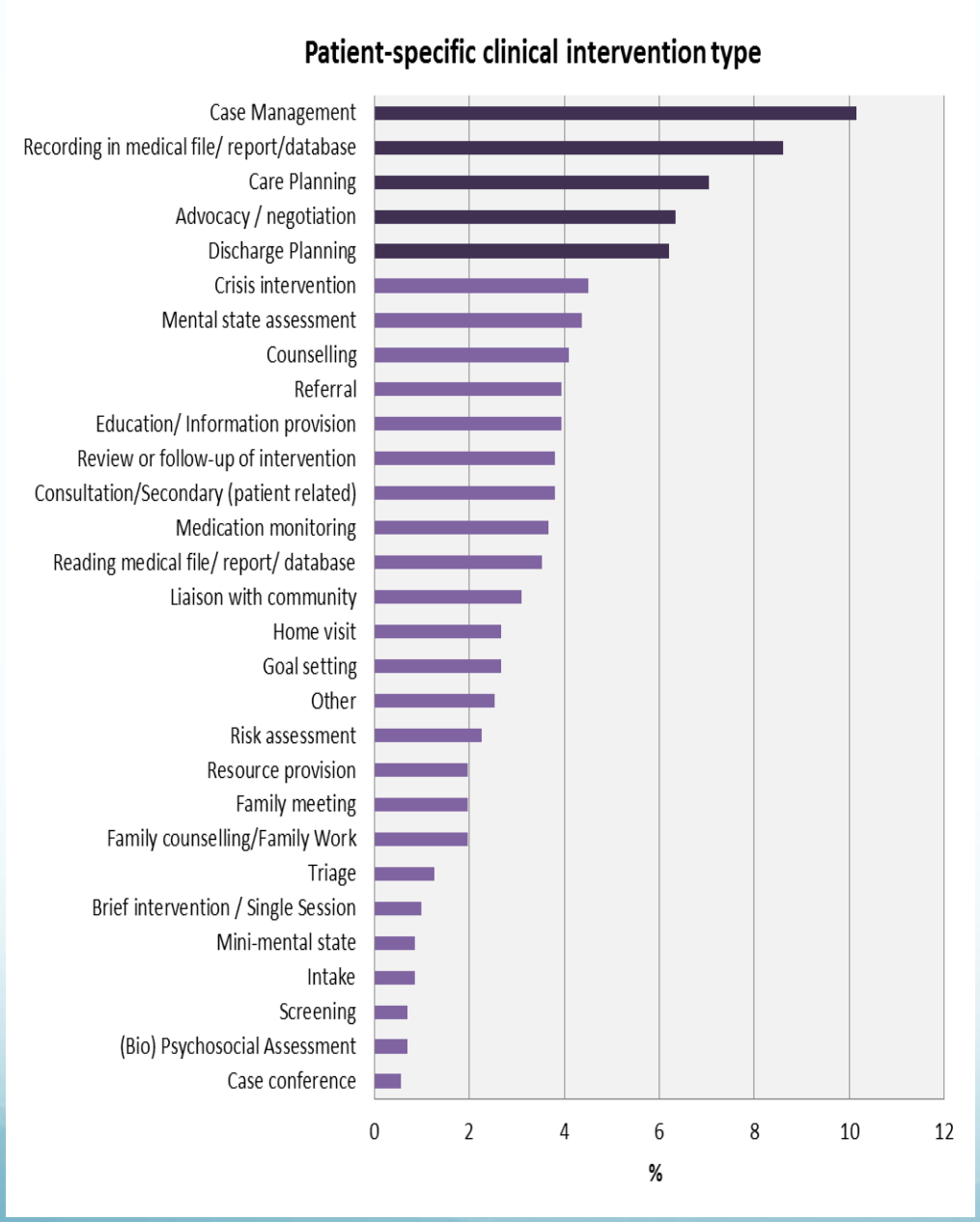
Results

- Average numbers of clients per social worker for the day was 6
- Total number of activities: 995
- Average amount of time spent on each activity was 38 mins
- 48% of contact for the day was directly client +/- family related
- Further 25% was client related work with other staff or service providers


Mode of Intervention of patient-based activity
Non-contact (file, documentation, report)
Face to face (patient/client)
Face to face (staff)
Telephone (service provider)
Telephone (patient)
Telephone (significant other/s)
Faxing/ emailing/ letters re patient
Face to face (significant other/s)
Telephone/ page (staff)
Faxing/ emailing/ letters to patient or significant other
Face to face (group of patients/clients)
Social Media to or re patient (twitter, facebook)
Video-conferencing or tele-health
0
5
10
15
20
25
%

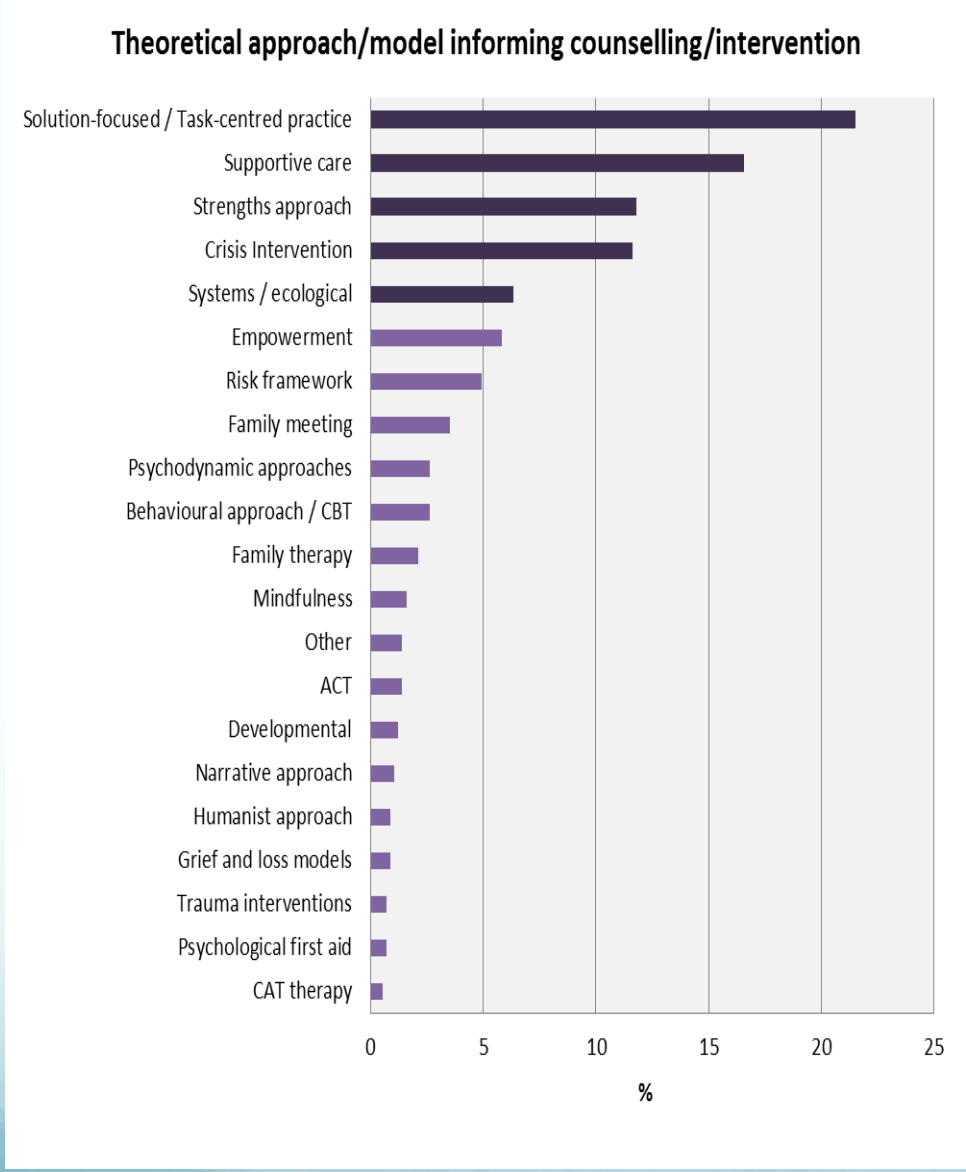
Patient-specific clinical intervention type

1. Case management
2. Documenting, recording in files, reports
3. Care planning
4. Advocacy and negotiation
5. Discharge planning


Patient-specific clinical intervention type
Case Management
Recording in medical file/ report/database
Care Planning
Advocacy / negotiation
Discharge Planning
Crisis intervention
Mental state assessment
Counselling
Referral
Education/ Information provision
Review or follow-up of intervention
Consultation/Secondary (patient related)
Medication monitoring
Reading medical file/ report/ database
Liaison with community
Home visit
Goal setting
Other
Risk assessment
Resource provision
Family meeting
Family counselling/Family Work
Triage
Brief intervention / Single Session
Mini-mental state
Intake
Screening
(Bio) Psychosocial Assessment
Case conference
0
2
4
6
8
10
12
%

Theoretical Approaches

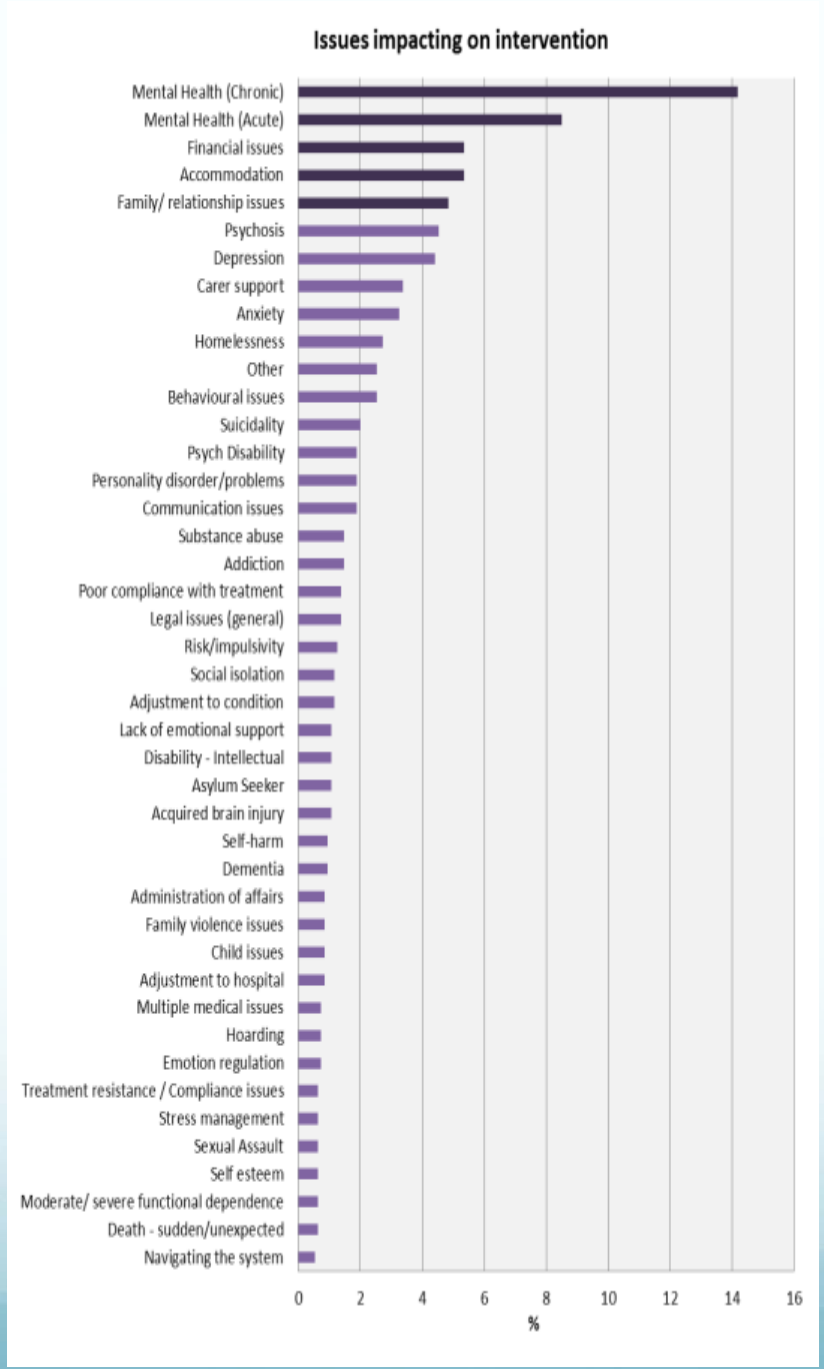
1. Solution focused /task centred – 21%
2. Supportive Care – 17%
3. Strengths based – 12%
4. Crisis Intervention – 12%
5. Systems/ecological – 6%


Theoretical approach/model informing counselling/intervention
Solution-focused / Task-centred practice
Supportive care
Strengths approach
Crisis Intervention
Systems / ecological
Empowerment
Risk framework
Family meeting
Psychodynamic approaches
Behavioural approach / CBT
Family therapy
Mindfulness
Other
ACT
Developmental
Narrative approach
Humanist approach
Grief and loss models
Trauma interventions
Psychological first aid
CAT therapy
0
5
10
15
20
25
%

Issues impacting on intervention

1. Long term/Chronic illness
2. Acute illness
3. Financial
4. Accommodation
5. Family

1. However there were 42 different psychosocial issues identified as impacting on clients and their family/carers


Issues impacting on intervention
Mental Health (Chronic)
Mental Health (Acute)
Financial issues
Accommodation
Family/ relationship issues
Psychosis
Depression
Carer support
Anxiety
Homelessness
Other
Behavioural issues
Suicidality
Psych Disability
Personality disorder/problems
Communication issues
Substance abuse
Addiction
Poor compliance with treatment
Legal issues (general)
Risk/impulsivity
Social isolation
Adjustment to condition
Lack of emotional support
Disability - Intellectual
Asylum Seeker
Acquired brain injury
Self-harm
Dementia
Administration of affairs
Family violence issues
Child issues
Adjustment to hospital
Multiple medical issues
Hoarding
Emotion regulation
Treatment resistance / Compliance issues
Stress management
Sexual Assault
Self esteem
Moderate/ severe functional dependence
Death - sudden/unexpected
Navigating the system
0
2
4
6
8
10
12
14
16
%

% Frequencies across specialist and generic fields of practice :
Patient specific intervention type

	Total sample %	Mental Health %	Oncology %
Discharge planning	16.4	6.2	12
Care planning	8	18	15
Recording in medical file	7	8.5	14
Advocacy or negotiation	6.1	6.3	51
Referral	4.2	3	12
Bio/psycho/social Assessment	4.2	0.8	3
Education/information processing	4.2	3.9	17

Frequencies :
Issues impacting on intervention

	Total sample %	Mental Health %	Oncology %
Adjustment to condition	9.5	14	7.2
Accommodation	7	5	9.5
Carer support	6	3.5	5.2
Family/ relationship issues	4.8	2	5
Financial issues	4.7	5	7
Anxiety	4	2.8	5
Depression	2.1	4.2	2

Frequencies :
Theoretical approach informing practice

	Total sample %	Mental Health %	Oncology %
Task centred practice /solution focused	26	23	31
Supportive care/counselling	11	4.2	12
Strengths approach	11	6.1	7
Crisis intervention	6	4.2	8
Systems (ecological)	16	7	18
Behavioural	1	3	1
Grief and loss models	4		13

Conclusions – questions raised

- Focus and distribution of patient needs and referrals
- Role of financial stress – *"fiancial toxicity"*
- Importance of brief practical evidence based interventions
- Time taken for administration
- Interesting split between patient focused and patient aligned practice which supports the significance of coordination and negotiation skills for social work practice

Data reflects the interaction between hospital need AND social work professional perception and training (ie skills and competencies)

BUT raises further questions

- ***Specific competencies***
- ***Social risk factors***
- ***Liaison skills***
- ***Complexity of interacting issues***

Generic or specific path forward ?

Clinical data mining of 200 elderly people referred to mental health service Research Questions

- In this first phase of the project
  - The demographics and social situation of clients –
    - who are they
    - what supports do they have and
    - What supports do they need

Results: Demographics

- 58% female age 75.59 – given 65+ a little younger than expected
- 21% lived alone
- 31% with spouse
- 39% independent house/unit
- 35% widowed
- 10% reported negative relationship with their partner
- 15% had no kids
- Of those with kids 10% reported negative relationship with their kids

Results: Demographics

- 44% did not complete yr 10
- 55% born in a non-English speaking country – 27% needed interpreters

Results: Health

- 35% referred from primary health sector
- 25% had a diagnosis of dementia (more males than females)
- 45% had mood disorder (more females than males)
- 14% had schizophrenia or other psychosis
- 20% reported a disability
- 11% treated under the mental health act
- 22% current alcohol use
- 1% current drug use
- 10% current and a further 10% past smoking

Results: Needs and interventions

- The top five psychological needs identified were:
  - Current mental health issues (n = 191);
  - Adjustment to diagnosis (n = 85),
  - Care planning (n = 71);
  - Aged care supports (n =71) and
  - Carer or family support (n = 80).

Results: Needs and interventions

- The top five interventions provided to the elderly consumers were:
  - Mental state examination (n=150);
  - Psychosocial assessment (n = 179);
  - Care planning (n = 134);
  - Risk assessment (n = 143) and
  - Mini-mental state examination (n = 118).

Consumers with dementia

- more likely to receive:
  - care planning (c^2=5.471, df=1, p=0.019) and
  - liaision with a community agency (c^2=5.330, df=1, p=0.021).
- more likely to have identified as a psychosocial need
  - adjustment (c^2=6.819, df=1, p=0.009), and
  - suicidality (c^2=4.570, df=1, p=0.033)
- Less likely to
  - be in residential care than expected and living alone more than expected

Consumers with depression

- more likely to receive
  - care planning (c^2=5.138, df=1, p=0.023).
- more likely to have identified as a psychosocial need
  - treatment compliance (c^2=10.675, df=1, p=0.001), and
  - suicidality (c^2=15.231, df=1, p<0.001)

Consumers who were widowed

- less likely in comparison to all other marital statuses to receive
  - review of intervention (c^2=5.693, df=1, p=.017) but they were
- more likely to have identified as a psychosocial need
  - accommodation (c^2=4.672, df=1, p=.031)

Consumers who were divorced

- were more likely to have identified as a psychosocial need
  - aged care (c^2=4.359, df=1, p=.037)

Consumers with a spouse

- were less likely to receive
  - liaison with a community agency (c^2=3.858, df=1, p=0.050).

Consumers with a support from children

- were less likely to receive
  - intake (c^2=9.655, df=1, p=0.002),
  - medication monitoring (c^2=8.266, df=1, p=0.004),
  - neuropsychiatric assessment (c^2=4.920, df=1, p=0.027) and
  - capacity assessment (c^2=4.920, df=1, p=0.027).

Consumers who were not fluent in English

- were significantly more likely to receive
  - care planning (c^2=4.493, df=1, p=0.034)
- They were more likely to have identified as a psychosocial need
  - accommodation (c^2=4.367, df=1, p=0.037).
- However, they were less likely to have
  - treatment compliance (c^2=8.020, df=1, p=0.005).

Consumers who had social supports from friends

- were less likely to receive
  - brief intervention (c^2=4.476, df=1, p=0.034) but they
- were more likely to receive
  - education and information (c^2=6.867, df=1, p=0.009)

Social networks

- 12% did not receive support from their family
- 7 people had a negative relationship with all identified family members
- 23% support from friends
- 20% support from no one
- Religion and neighbours being greatest source of support

Qualitative results:

- 10 main issues identified
  - History of trauma
  - Suicidality – self and family
  - Loss/grief and bereavement
  - Social isolation
  - Language barriers
  - Physical health/disability
  - Family conflict/Carer stress
  - Migration
  - Compliance issues
  - Capacity issues

Where to from here

- Look at physical health of the elderly from the general practitioner
- look at networks and community linkages
- Stage 2 study evaluating social work intervention