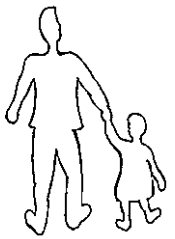
CHAPTER 13



SOCIAL WORK (ADULT)

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TASKS OF THE PROFESSION

The context of social work practice in Aotearoa, New Zealand (NZ) acknowledges Maori (Maori is a term which refers to a New Zealander who is indigenous to New Zealand) directly as Tangata Whenua ('the people of the land'). Social workers explicitly aim to work in partnership with Maori in their practice. Pakeha are considered by Maori as Manuhiri or 'visitors' to Aotearoa NZ due to their colonial origins as settlers to New Zealand from the 1830s onwards. (Pakeha is a term that refers to a New Zealander of European descent). The social worker's role is to practice in a way that aims to achieve social justice for Maori at both a structural and individual level in line with the spirit of the Treaty of Waitangi and the underlying principles of protection, partnership, participation and self-determination (ANZASW Code of Ethics, 2008; NZ Royal Commission on Social Policy, 1988). Social work in Aotearoa NZ is seen as being concerned with affirming all aspects of the person so a holistic approach is brought to social work tasks within a variety of organisational settings in public health and social care.

Evidence based research is considered useful in mental health social work in Aotearoa, NZ when it attends to holism and the individual in the context of their total environments, including the social, cultural and spiritual dimensions. Attention to family or whanau, hapu (subtribe) and iwi (tribal identity), and the relationships between people (whanaungatanga or kinship support) and whakapapa (genealogy), are key concepts underpinning well-being and mental health. The relational aspect of working with 'the other' and with 'otherness' or difference is a theme underlying social work in Aotearoa, NZ based in the Treaty of Waitangi principles of protection, partnership, participation and self-determination. 'Otherness' in this context may relate to the client's characteristics being different from the social worker's so the process of

dialogue and attunement to the 'other' is seen as being essential to the social worker's repertoire of personal resources. This creative 'use of self' in the development of rapport and relationship with the client may also relate to the social worker's interactions with the multi-disciplinary team on the client's behalf or with a range of other social agencies in an advocacy role.

Mental health social work in Aotearoa NZ draws upon multiple perspectives from the service user (tangata whaiora), caregiver, family (whanau), clinician and the multi-disciplinary team perspectives. Indigenous models of care for Maori, inform social work practice. Respect for, and acknowledgement of difference and diversity is seen as a central concern. Diversity is seen as a broad concept embracing culture, beliefs, social class, disability, age, gender, religion, spirituality, sexual orientation, ethnicity as well as underserved or marginalised populations (ANZASW Code of Ethics, 2008). Mistakenly the term 'culture' is equated often with 'race' or 'ethnicity'. However, for example, a 45 year old person may be seen as belonging to several different 'cultures' simultaneously such as being a man who is Pakeha, who plays rugby, lives in the North Island of New Zealand where he owns his own farm and works as a farmer. He attends the local church weekly with his wife and children and is a devout Christian. He is a husband and father of five children and brother and son within his own family of origin where he is the eldest child. He remains in regular contact with his siblings. His parents are retired and live in another city. He is serving on the local county council as a councillor. A social worker would take all these different aspects of this person's life into consideration when assessing his presentation and in considering his health and treatment options within the wider social systems in which he is involved.

Social work acknowledges the multidisciplinary nature of professional practice and aims to contribute to the team effort. Thus, evidence-based literature surrounding team work and social change informs social work practice. For example, ecological approaches are considered by social workers in exploring the interface between the person and their social environments (Germain, 1991). The ecological or systems approach can be related to the social worker who practises in a multi-disciplinary team where the social worker works with the 'other' (members of the team) in partnership consistent with Treaty of Waitangi principles. Biopsycho-social approaches that aim to identify and work with the various resources and strengths in people's lives and social networks resonate with social work and strengths-based theories of practice (Saleebey, 2001).

TASKS OF THE PROFESSION

The key tasks that flow from these broad concerns of social work include the establishment of a focused working relationship with the client or 'tangata whaiora' that reflects individual differences and the client's cultural and social contexts. Client autonomy in identifying the issues to be worked upon is emphasised in an effort to protect and uphold the client's rights and integrity. In engaging with clients, social workers are encouraged

to use their personal attributes appropriately, to ensure equality, power sharing, and to work in the interests of the client. Social workers also ensure access to services on behalf of clients with the aim of enhancing their clients' self determination (ANZASW Code of Ethics, 2008). Social engagement and community participation is achieved through social work interventions which include advocacy and working in solidarity with the client's identified goals and priorities. Encouraging social connection and the development of social networks in the community is considered an integral part of the social worker's role (ANZASW Code of Ethics, 2008).

In Aotearoa New Zealand, social work has focused upon what is culturally safe and competent practice. In this way, social workers aim to address monocultural attitudes, structural or organisational issues, including the practicalities of policy, and managerial aspects of delivering services to members of diverse groups. Advocating for the client and working with the wider social systems such as the 'extended family' or whanau (however this is defined by the client), is emphasized in an effort to work towards greater social equity and to improve access to services.

Clinical and cultural safety supervision within the social work profession is seen as the main tool for ensuring safe and competent practice over time to enhance the effectiveness of the therapeutic endeavour, to establish accountability for standards of practice and to assist in the social worker's ethical decision making and professional development (ANZASW Code of Ethics, 2008). For example, social workers are faced on a day to day basis with situations involving the personal welfare of clients and their families. At times social workers are faced with life and death situations involving clients and their caregivers. These decisions are made within the social work and multi-disciplinary teams in which responsibility for safe and ethical practice is shared. Some decisions, such as whether to turn off life support units, for example, are informed by the decisions of medical and other allied health staff. Social workers in this situation are faced with social justice concerns to 'protect' and uphold the rights of the other which are seen as the domain of social work within Treaty of Waitangi principles. This 'protection' may involve providing full information about treatment alternatives, listening carefully to the client, family and caregivers' views as to what they want from their contact with the service and consulting with the multi-disciplinary team. There is a need to balance client and family/caregiver views alongside the opinions from medical and allied health practitioners when there are competing interests and when the operation of one group's claims to upholding their rights in operation is likely to compromise the rights of others.

Thus, social workers as part of the wider team effort are guided by their professional standards of practice to act to ensure the tangata whaiora's rights to participate and be heard are maintained as far as is possible. Where children or incapacitated persons are involved, however, this decision making can be problematic for social workers as Connolly and Ward (2008) (*p.351*) explain:

> *'From our perspective, individuals possess rights to the degree to which they have the capacity for agency, i.e. the degree to which an individual is capable of acting on their own conception of a good life. It is also the case that human rights are those rights necessary to protect the conditions required for us to function as agents, and as such are fundamental.'*

To illustrate the ethical dilemmas intrinsic to social work the following case example is offered. Within this example there is a balancing of family, clinician and client rights by the mental health social worker. Pseudonyms have been used to protect the identity of the client and her family members. A minimum of detail has been included to make every effort to ensure client confidentiality. The case reflects the ethical dilemmas of competing claims of different groups to make a decision (to turn off the life support unit) and the social worker's role alongside the multi-disciplinary team in dealing with the aftermath of a serious suicide attempt on family members. Elizabeth, the daughter and primary caregiver of her elderly parents and mother to her own two children is the referred client in the scenario.

SOCIAL WORK CASE STUDY

Background: A Pakeha family was referred by the local crisis psychiatric team as their father, *Bob*, had been hospitalised following a suicide attempt that had nearly ended his life. *Bob*, a seventy one year old man had a twenty year history of depressive episodes that were treated with medication and inpatient psychiatric treatment leading to discharge to his family for follow up care in the community. This was his sixth and most successful attempt at suicide. *Bob's* thirty nine year old daughter, *Elizabeth*, a sole parent with two children, had been supporting her parents throughout the long struggle her father had experienced with depression. She had resuscitated her father whilst waiting for ambulance assistance on one occasion. On this most recent occasion, the overdose of anti-depressants had left her father on life support systems. The family had asked the medical staff to turn the life support system off as the medical opinion was that there was likely damage to the brain stem caused by the overdose of medication and the extent of his recovery was unknown. The family wished for *Bob's* suffering to be over as they had witnessed his desire to end his own life since his unemployment in the late 1980s following an accident that left him in chronic pain with a back injury. Whilst on sickness benefit and worker's compensation for many years, *Bob* was assessed as fit to return to work but could not find work and became chronically depressed and suicidal from that point onwards.

The clinical specialists would not agree with the family's wishes to switch off life support, due to their focus on sustaining life and recovery. *Elizabeth* and her elderly mother, *Harriet*, (*Bob's* wife) were planning reluctantly to give up their employment to care full time for their father/husband.

The Referral, Assessment and Treatment Plan: Elizabeth was referred to the outpatient community-based mental health service by her general practitioner with a diagnosis of clinical depression. Fluoxetine 20 mg mane had been prescribed prior to the referral. *Elizabeth* was assessed by the social worker and presented to the multi-disciplinary team who considered that individual counselling would be helpful to support *Elizabeth* in her role as primary caregiver for her parents. The strains of being a sole parent of two children together with another caregiving role seemed overwhelming to *Elizabeth*. Her general practitioner had requested individual counselling to work on a plan to explore her priorities and feelings if *Bob* recovered his cognitive and physical functioning and was returned home to live. At our first session *Elizabeth* accepted the option of individual counselling for six sessions initially with a review if further counseling were required. She discussed in her individual counselling what it would mean for her if *Bob* lived and also how she would cope if he died as result of his suicide attempt.

The Outcome of Contact: Beyond everyone's expectations, *Bob* survived the aftermath of his suicide attempt and though requiring intensive support and follow up in the community, was discharged to *Elizabeth's* care. At first she expressed anger at her father's recovery as she knew this would mean an additional care giving role when she felt already burdened by parenting two children under the age of ten years. At the third session, she described more of her feelings which included anger and sadness related to her relationship to *Bob*. She described how these feelings manifested in her body awareness as tightness in her throat. She expressed her plans to involve professional caregivers for her father so that she could continue with her paid employment which she told me was central to her self esteem and mental well-being.

From this point onwards, *Elizabeth* reported her sleep and appetite had improved and her mood appeared to lift. For the first time, she felt able to confront her father's clinicians about the lack of involvement she had had in the discharge planning and preparation and follow up services for *Bob's* discharge from hospital. She appeared more animated in her individual counselling sessions as she took charge of co-ordinating her father's care at home. The depression she had been experiencing lifted as she moved into a more powerful, active mode of self-expression. The multidisciplinary team witnessed and reflected to her what they had noticed about her process that, through accessing more of her feelings including anger, she appeared to be liberating herself from depression.

RESEARCH QUESTION FORMULATED FROM THE ADULT SOCIAL WORK CASE STUDY

Does multi-disciplinary team individual counselling session for adults with depression improve depression in the patients in both long and short term?

The PECOT framework formulated to assist the literature search is:

P: adults with clinical depression
E: individual counseling sessions within multi-disciplinary team
C: no treatment
O: improvement in depression
T: short and long term

SEARCH FRAMEWORK

This search took a wide search approach to capture as much literature as possible relevant to individual counseling sessions within a multidisciplinary team environment for adults with depression. Literature was sought in English language and in full text. There was no restriction on the time frame of the search.

SEARCH TERMS

Cochrane Library, OTSeeker, PEDro

adult AND depression AND treatment

Google Scholar, PubMed

adult AND depression AND (counselling session AND multidisciplinary team) AND improvement in depression

PubMed Central

counselling AND adult AND depression AND treatment AND multidisciplinary team

Scirus, TRIP Database

adult AND depression AND counselling session AND multidisciplinary team AND improvement in depression

SUMSearch

adult AND depression AND multidisciplinary team AND treatment

FINDINGS

This search found 12 potentially relevant articles, with eight being available in full text. The search findings are outlined in Table 13.1. The remainder of the search findings were only available in abstract or citation form. They thus could not be included in this review. Social workers might choose to purchase full text copies of potentially relevant papers currently only available in abstract. One way of doing this is by lodging an individual purchase order with the publisher (details are usually provided as part of the output of the internet searches). Social workers may also choose to obtain these articles through other library sources (such as hospital or Department of Health libraries, or University library sources). These papers, when read in full text, may well provide further specific guidance regarding effective counselling techniques, and more information to add to the clinical context.

Table 13.2 describes the search findings in terms of the number of relevant research designs, and how to identify the research design from information provided in the full text paper.

Table 13.1 ***Relevant literature from database search***

Database Searched	Hits Returned	Relevant Hits in full text	Relevant literature
The Cochrane Library	36	1	1. Abbass, A.A., Hancock, J.T., & Kisely, S. (2006). Short-term psychodynamic psychotherapies for common mental disorders. *Cochrane Database of Systematic Reviews*, 4.
Google Scholar	50	1 (2 with promising title/abstract but unavailable)	1. Primary Care Quality and Information Team. (2006). Specialised Care of Patients with Depression for adults over the age of 18. Quality Improvement Toolkit. National Public Health Service for Wales: UK.
OT Seeker	9	2	1. Clarke, G.N., Hornbrook, M., Lynch, F., Polen, M., Gale, J., Beardslee, W., O'Connor, E., & Seeley, J. (2001). A randomized trial of a group cognitive intervention for preventing depression in adolescent offspring of depressed parents. *Archives of General Psychiatry, 58*(12), 1127-34. 2. Hodgkinson, B., Evans, D., O'Donnell, A., & Walsh, K. (1999). Comparing the effectiveness of individual therapy and group therapy in the treatment of depression – systematic review. *The Joanna Briggs Institute for Evidence Based Nursing and Midwifery*, The Joanna Briggs Institute.
PEDro	43	0	-
PubMed	13	1	1. Malt, U.F., Robak, O.H., Madsbu, H-P., Bakke, O., & Loeb, M. (1999). The Norwefian naturalistic treatment study of depression in general practice (NORDEP) – I: randomised double blind study. *British Medical Journal, 318*, 1180-1184.
PubMed Central	84	2	1. Druss, B.G., Rask, K., & Katon, W.J. (2008). Major Depression, Depression Treatment, and Quality of Primary Medical Care. *General Hospital Psychiatry, 30*(1), 20-25. 2. Symons, L., Tylee, A., Mann, A., Jones, R., Plummer, S., Walker, M., Duff, C., & Holt, R. (2004). Improving access to depression care: descriptive report of a multidisciplinary primary care pilot service. *British Journal of General Practice, 54*, 679-683.
Scirus	34	None (2 with promising title/abstract but unavailable)	-
SUMSearch	79	1	1. Solberg, L.I., Fischer, L.R., Wei, F., Rush, W.A., Conboy, K.S., Davis, T.F., & Heinrich, R.L. (2001). A CQI Intervention To Change the Care of Depression: A Controlled Study. *Effective Clinical Practice, 4*(6), 239-49.
TRIP Database	9	0	-

Table 13.2 ***Summarised findings of the search***

Literature type	Number	Author, Year	
Systematic Review	2	Abbass et al (2006)	Cochrane review using standard methodology and reporting
		Hodgkinson et al (1999)	Joanna Briggs review using standard methodology and reporting
Guideline	1	Primary Care Quality and Information Team Toolkit (2006)	Summary of two established guidelines (NICE, ICSI)
Experimental	3	Clarke et al (2001)	Abstract *pp 1127* Methods *pp 1129*
		Malt et al (1999)	Abstract *pp 1180,* Methods *pp 1180*
		Solberg et al (2001)	Title & Abstract *pp 239,* Methods *pp 240*
Observational/ Descriptive study	2	Symonds et al (2004)	Abstract *pp 679,* Methods *pp 670*
		Druss et al (2008)	Abstract *pp 20,* Methods *pp 23*

SUMMARISING THE FINDINGS:
What does this literature search provide to a busy clinician?

This search found considerable recent, high level and potentially relevant literature with which to answer *Elizabeth's* case. We propose several steps related to the clinical case, to assist the clinician to work through and distill the findings in this literature base.

Step 1. *Consider the evidence summaries.* Systematic reviews of the literature are considered to be the highest form for evidence summary because of their structured and transparent approach to literature identification and evaluation. Social workers should look at the evidence on which the systematic reviews are built, and their conclusions, before doing anything else.

This search found two *systematic reviews* based on sound and well established methodologies (Abbass et al (2006) [Cochrane], Hodgkinson et al (2001) [Joanna Briggs Institute]) and a Toolkit/ Best Practice recommendation based on well established clinical guidelines (National Public Health Services, Wales 2006). This evidence summary was based on a National Institute of Clinical Studies (NICE) guideline: *Depression: The management of depression in primary and secondary care.* (www.nice.org.uk/page.aspx?o=235626) and the National Guideline Clearing House. *Major Depression in Adults in Primary Care.* Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2004 May. (www.guideline.gov/summary.aspx?doc-id=5300&nbr=3623&string=Major+AND+depression.).

All three reviews were published within the past seven years by reputable organisations. They should be the first starting point for social workers to establish an overview of the current literature. We considered the findings of the reviews in chronological order.

> Primary Care Quality and Information Team (2006). Relevant to this clinical question are three of the recommendations in this Tool Kit, namely: *'**Apply a multi disciplinary approach** to the treatment of depression involving community psychiatric nurses, psychologists and psychiatrists where appropriate, **Use screening procedures** such as screening questionnaires or computer-administered interviews to improve recognition of depression. This is important since recognition improves outcome even when the patient does not comply with treatment., **Use cognitive behavioural therapy** and other non-drug treatments where appropriate' pp 5.*

> Abbass et al (2006) reports that *'short-term psychodynamic psychotherapies (STPP) shows promise, with modest to moderate, often sustained gains for a variety of patients. Common features of these therapies include the use of selection criteria, therapeutic focus, active therapist involvement, use of the transference (therapeutic) relationship and time restriction. However, given the limited data and heterogeneity between studies, these findings should be interpreted with caution. Furthermore, variability in treatment delivery and treatment quality may limit the reliability of estimates of effect for STPP' pp 1.*

> Hogkinson et al (1999) in the Joanna Briggs systematic review indicates that: *'Either group or individual cognitive behavioural therapy can be used to treat moderate to severely depressed patients with the choice of therapy dependent upon the clinicians' perceived receptiveness of the individual patient within group versus individual treatment. The use of the computer-assisted therapy can be useful as an aid to CGT in moderate to severely depressed patients. Individual cognitive therapy can be effective in place of pharmacotherapy in moderate to severely depressed patients if the patient is opposed to being treated with drug therapy. Group cognitive behavioral therapy has not been compared to pharmacotherapy so no direct recommendation can be given as to its effectiveness as a replacement therapy'. pp15*

Step 2 *Consider the findings of the experimental studies published since the last systematic review.* Two of the three experimental studies were relevant to this search (Clarke et al 2001, Malt et al 1999). The Solberg study was not relevant, being a test of Quality Improvement in Processes for Identification and Referral of Depressed Patients. Neither of the experimental studies postdated the systematic reviews and thus their findings should be used to add context only, to the reviews. The conclusions are summarized below.

> Clarke et al (2001): A brief, group cognitive therapy prevention program can reduce the risk for depression in the adolescent offspring of parents with a history of depression. *pp 1127*

> Malt et al (1999): The combination of active drug and simple psychological treatment (counselling, emotional support, and close follow up over a 24 week period) was more effective than simple psychological treatment alone, in particular for those with recurrent depression. Overall, women may benefit more than men. If confirmed in future studies, the findings should lead to more differentiated treatment guidelines for depression in primary care. *pp 1180*

Step 3. *Consider the consistency of the findings of the relevant studies.* All studies indicated the value of individual and group therapy presented within the context of a multidisciplinary team. A range of treatment approaches could be applied with generally similar evidence of effectiveness. Of note were the findings of the Clarke et al (2001) study of an effective group cognitive therapy prevention program to assist the children of depressed parents.

Step 4. *Consider the internal and external validity* of the most recent and high level studies (in this instance the systematic reviews, and the toolkit recommendations).

Internal validity

The Cochrane and Joanna Briggs systematic reviews take a consistent rigorous approach to evaluating the literature. This provides assurances of transparent and reproduceable

methodologies and findings. Similarly, the clinical guidelines which underpin the Welsh Public Health Toolkit (2006) have sound and well established methodologies, and thus provide believable findings from transparent processes. The findings of these studies can be accepted as being of high quality.

External validity

The descriptions of adults with depression are consistent, and would appear to reflect *Elizabeth's* case. The individual and group behavioural management approaches are also well described and appear to be able to be provided by an 'average' social worker with appropriate training and professional credentials, in an 'average' treatment setting.

Step 5. *Frame the review findings as an answer to the clinical question.*

Does multi-disciplinary team individual counseling session for adults with depression improve depression in the patients in both long and short term?

There is consistent, high-level evidence to support the effectiveness of multidisciplinary team individual counselling sessions in improving depression in adults in the short and long term. There was evidence from one experimental study that counselling for adolescent children of parents with depression could assist the young person in understanding and dealing with their parent's health. This study may provide additional context for *Elizabeth's* treatment.

SUMMARY OVERVIEW: Critical Considerations and Recommendations

This search found a useful number of recent good quality secondary evidence to support the effectiveness of individual counseling sessions for *Elizabeth* to assist her depression, and to also move forward to manage her father's health. Social Workers may wish to include evidence from the studies which are not currently available in full text, although it is unlikely that these additional studies will change the findings of the recent reviews. *Elizabeth* and her Social Worker, working within a multidisciplinary team, can be assured that individual or group counselling sessions will be effective in assisting her to manage her health and circumstances.

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