
Discovering health social work in New Zealand in its published work: Implications for the profession

Liz Beddoe and Catherine Deeney

Liz Beddoe teaches in the School of Counselling, Human Services and Social Work at the University of Auckland. Liz's teaching and research interests include critical perspectives on social work education, professional supervision, the professionalisation project of social work, interprofessional learning and the development of health social work. She coordinates the Master of Social Work and Postgraduate Diploma in Professional Supervision programmes.

Catherine Deeney is a recent graduate of the BSW programme at the University of Auckland and was a University of Auckland Summer Scholar 2009-10.

Abstract

Social work in health care has been a significant field of practice within social work in New Zealand since the 1940s. This paper reports on a project inspired by a fruitless search for a current discussion on the development of health social work in New Zealand. Analysis of a bibliographic search reveals an interesting history of health social work, as it emerged as an extension of the nursing role. Five distinct periods of development are identified through analysis of the literature. The paper concludes with a brief discussion of challenges and opportunities for health social work.

Introduction

In 1953 Miss R.G Spensley wrote in the *New Zealand Nursing Journal* of the role of 'the nurse as a medical social worker':

It is difficult to enumerate a daily routine of her duties as they vary from day to day, but by uniting the medical and social needs of the individual she seeks to help the person as a whole (Spensley, 1953, p.177, emphasis added)

Social work in health care in New Zealand has from its inception added the holistic dimension to health care, as indicated in Spensley's simple description above. Auslander's (2001) review of 100 years of health social work in the international arena refers to the shift away from the 'disease' paradigm (biomedical), a social model of health (psychosocial) which takes into consideration social, psychological, spiritual, cultural and ecological factors (Auslander, 2001, p. 211). A biopsychosocial model conceptualises illness as a complex interaction between the environment and the physical, behavioural, psychological, cultural and social factors which impact on health (Bracht, 1978; Bywaters, 1986; Lindau, Laumann,

Levinson, & Waite, 2003). Bywaters argued that social work can assert 'the value of care as well as cure' (1986, p. 670-674).

Social work in health care is a significant field of practice within New Zealand social work and while not the largest sector group in social work, it makes a significant contribution to the profession (Schofield, 2001). It has assets and vulnerabilities as a field of practice where professional practice is largely practised within multi-disciplinary teams. In 2007 a report on the allied health workforce reported that 1139 (full time equivalent = 894) social workers were employed by District Health Boards (District Health Boards New Zealand, 2007, p.7). The same survey reported that health social workers made up 18.1% of the Allied Health Workforce and 1.7% of the total DHB workforce. Social work in health care has a strong history but as this passage from Avis Jones in 1963 indicates, it has often experienced difficulty defining its place:

We as medical social workers are frequently asked to explain what we do. This is not easy to define. Working with a person's strengths and limitations, that is with human beings as they are, cannot easily be explained in a few sentences. Achievement here is rather an intangible thing to measure. Can we really define it? Having listened to a patient under stress, fearful of the suggested medical programme, fearful of his future resettlement, and having helped him through the therapeutic interview, finally to work through to a satisfactory acceptance and steadfast hope for the future, is a process which really defies explanation. (Jones, 1963, p.11).

The project was inspired by the lack of a single up-to-date integrated discussion of the development of health social work in New Zealand. The aim of the bibliographic study was to trace the nature, role and strengths of health social work in New Zealand and the challenges it has faced during its development, through an examination of published articles and reports of relevance between 1939 and the present day. The texts reveal a rich understanding of the trajectory of a professional practice over seven decades.

Nash (1999; 2009) urges us to consider our history as a profession, and to ensure that we maintain the resources that document it. She notes that a number of welfare histories have been written in New Zealand but these 'relate very little about professional social workers and tend to define social service work from an agency point of view rather than from a professional social work point of view' (p.4). Nash (1999) notes also that the NZASW and ANZASW journals have provided a major location for the written record.

Method

The research method utilised a keyword search of databases and the internet for 'grey literature'. Most of the texts in the final set for analysis are from journals and professional magazines or are chapters published in edited books. Unpublished theses and dissertations were not included for reasons of time, access and resources. Constraints also prevented the authors from accessing the hundreds of issues of the NZASW/ ANZASW newsletters in all their various manifestations as this material is mostly unavailable in any electronic format.

Texts that were selected were located, scanned and material stored using bibliographic software. More than 250 items were eventually located. Key themes include: 'emerging from

the nursing role', 'professional identity', 'new and changing roles', 'interprofessional and intersectoral relationships', 'the impact of health and social policy', 'professionalisation', 'education and practice standards', 'research and evidence-based practice', 'gender and culture', 'practice approaches' and the needs of 'particular populations'. Space does not permit more than an overview of the themes by five distinct periods. The following broad questions were used to structure the review of the literature:

- What has been published about health social work in New Zealand over its 60 year history?
- What are the professional themes of concern to health social workers that emerge from these texts?
- How do these reflect the social policy and health issues of particular periods?
- What do the texts tell us about the development of health social work as a significant field within the health sector?
- What gaps and questions remain which might require further investigation?
- What are the implications for the continuing development of the profession?

Findings

In her description of New Zealand health social work at the turn of the century, Schofield identifies three broad periods of health social work: 1939-1971 'emergence', 1972-1988 'health social work and bureaucratic growth', and 1989-2001 'the impact of managerialism' (Schofield, 2001, pp.145-148). Our analysis is not dissimilar and finishes with the 2000s dominated by the impact of the Social Workers Registration Act (2003), the Health Practitioners Competency Assurance Act (2003) and the development of social work as a discipline within 'allied health'. A final brief discussion will outline contemporary and future challenges.

Table one. The development of health social work in New Zealand.

Period	Main themes	Particular features of the profession
1939- 1963	Formation and definition	Emergence from nursing as a more distinct practice
1964- 1972	Professional identity consolidation	Strong influence of the growth of the New Zealand Association of Social Workers (NZASW)
1972- 1988	Education and standards	Social Work Training Council; the Health Interest Group of NZASW
1989-2001	Managerialism and retreat Role conflict.	Restructuring; contractualism; Diminishing professional autonomy. Tangata whenua aspirations
2001-2010	The professional project: Straddling the contradictions	Regulation: SWRA (2003) and HPCA (2003) and 'allied health'.
2011	A more scholarly voice?	Practitioner research

Our thematic analysis of the texts suggests the following periods of development as shown in Table one.

1939-1963 Formation and definition: Emerging from nursing

The record of publications demonstrates clearly that social work in health settings emerged from nursing. It is noted that of the first 17 publications found on social work dated between 1939 and 1980, 14 appeared in the *New Zealand Nursing Journal* and the remaining three in the *New Zealand Medical Journal*. In 1939 Flora Cameron (1939, p. 246) reported in the *New Zealand Nursing Journal* on her special study tour to examine training for medical social work and public health nursing at Toronto University. She notes that amongst the many lectures she attended were 'social work and public welfare', 'psychological aspects of personal administration', psychology and mental hygiene and 'child hygiene' (p. 252). In the postwar period Burton (1951) and Mattinson (1951) reported on the social work role in chest medicine and obstetrics respectively.

In 1953 (p. 177) Spensley wrote a description of the role of the social worker in health care. Key tasks were:

To help the doctor in the treatment of his patient, and *under his direction* to enquire into and assist in the treatment of social conditions affecting the health of the patient and preventing him from obtaining the full benefit of medical treatment, is the first and foremost duty of the medical social worker. [Emphasis added]

Throughout the 1950s, there was not a clear delineation between social workers and nurses or midwives. It was advocated that nurses or midwives (as the case setting permitted) were to learn the tenets of social service within their practice. Nurses were initially taught social work and community resources within their training, at a separate level to nursing (Mattinson, 1951). There was also considerable public naivety concerning the role of the health social worker. Wright (1957, p.193) starts her article with this telling comment: 'one woman when told I was a medical social worker said: 'oh yes, you help take around the library books and that sort of thing, don't you'. Unfortunately this type of comment is quite frequent.'

The foundation of the client worker relationship, empathy, unconditional positive regard and attentive listening were all skills employed in the emerging practice (Wright, 1957; Spensley, 1953). For example, 'the patient should feel that the medical social worker is a person prepared to realize exactly what they are feeling' (Wright, 1957, p.193) and also 'accepting behaviour that is aggressive, uncooperative/demanding' (Wright, 1957, p. 193).

The 1960s heralded an increased pace of development (Jones, 1963), and it could be ventured that the role confusion was a catalyst to some substantial role clarification. The formation of the NZASW in 1964 was significant in the development of health social work. The NZASW was the driver for professional status, recognition, and cohesion for its social work members. The Education and Training Standards committee sought to develop a code of ethics for the profession, and advocated expansion professional education (Nash, 1998). In an agenda driven by the NZASW, courses were available via the extension departments of four universities (Nash, 1998). Comprehensive eight-week courses for social workers were

then held at Tiromoana from 1963 (Mann, 1964). These courses were practical in orientation, with a focus largely on case study analysis (Mann, 1964).

1964-1972 Professional identity consolidation

There is some irony in our origins within the nursing profession, which first forged the niche for social work, recognising the need for services encompassing the patient and his or her environment (Wright, 1957; Jones, 1963) given later tensions. This overlap of community nursing and social work forged the practising of certain social work roles by nurses (Mann, 1964). Social workers remained unclear as to the role of public health nurses active in community posts, undertaking what would now be termed many psychosocial tasks (Mann, 1964). There is also some testament to the fact public health nurses themselves were not clear on either the boundaries or direction of their roles (Mann, 1964). Social work had potential as a change agent mediating between the client and his or her environment, but early social workers were also obliged to mediate between professional identities – that of a nurse and a community social worker. The seeds of ‘turf conflict’ were sown in these early years and continued to grow. Georgina Ross, then Chief Social Worker of the Wairau hospital was to write in 1990 that ‘social work’s historical inability to achieve consensus with other professions that psychosocial interventions represent its domain is making it much easier for nurses to claim this realm’ (Ross, 1990, p.24).

The professional body actively sought greater academic credibility and looked to academia to champion for this cause (Ritchie, 1967). Six years after the development of the first training opportunities, the school of social work at Victoria University in Wellington conducted generic preparation for social work. Specialist skills were to be learned on the job (King, 1969). By 1969 there were approximately 700 social workers in public service employment, including those in hospitals (Austin & Buxton, 1969) and of this number, 15% were qualified.

The practice of social casework was identified as equipping the patient to resolve her/his environmental, social and emotional problems in life, in such a way that they were strengthened through the process rather than further disabled (Jones, 1963, 1967; King, 1969). Casework was used with clients in terms of difficulty, disorganisation, disability, breakdown or maladjustment, focusing on adjusting problems between the individual and his or her environment (Jones, 1963). Practical application was to assist the patient with their fears and anxiety regarding their illness, taking an explanatory role in terms of the etiology and treatment of their illness, assisting with rehabilitation, and communicating between other medical staff and the patient (King, 1969). More formal social assessment required the analysis of personal and family resources and weaknesses, religious affiliation and educational qualification (Jones, 1963, 1967; King, 1969).

Despite the growing recognition of the body of knowledge and skills, the practice of post-ing nurses as social workers continued with an official definition of a medical social worker being ‘a registered nurse other than a staff nurse’ (Johnstone, 1969, p.37). Schofield (2001) notes that while the first medical social worker was appointed in 1939, nursing prevailed and even in the mid-1960s a third of social workers were also district nursing supervisors (Robb, 1974). The distinction between the nursing model of practice and the social model of practice also came more intently to the fore, particularly in terms of the dangers inherent

in taking a medical model into the psychosocial arena (NZASW, 1968). In addition to the contestation from nursing, overlap from other professions continued, some doctors arguably adequately addressing psychosocial elements with their patients (Carson, 1971).

Throughout this period the status of the social work profession rested dually on the understanding of the profession about its potential, and the activism necessary to develop a curriculum for education (Austin & Buxton, 1969). As a direct result of these issues through the sixties, public perception of social work remained ambivalent, the social work image even deemed invisible by one author (Clark, 1971). From its place as a mediating profession, social work then became assertive of its identity, both in visibility and in seeking to delineate a distinction. Greig and Jones (1969) reported on a meeting of medical social workers where there was a resolve to see the creation of social work advisory positions in the then Department of Health and for the provision of bursaries for formal training. Both of these aspirations were achieved.

1972-1988 Education and standards

The 1970s saw health social work develop a strong professional culture, with social workers working in a health-related field comprising 60% of NZASW membership (Beddoe, 1993) and a greater academic niche for sociologically informed practice. Whereas through the 1950s and up until the mid-1960s psychoanalytic theory was the predominant approach used by health social workers, by the 1970s systemic and sociological theories were introduced and began to gain ground (Richardson, 1973).

Social advocacy had been seen as a longstanding role of the health or medical social worker (Richardson, 1973) and involved connecting patients, who were very often bed ridden or incapacitated, to the services necessary for their recovery (Richardson, 1973). From a skills perspective, this required social workers to have good networking and interagency communication skills (Richardson, 1973). Social workers were able to align themselves with advocacy and social reform under the banner of sociology and its application to social practice (Richardson, 1973). The growth of educational opportunities saw gains in status and visibility throughout the 1970s. There was now the acknowledgement health was about treating the whole person and the advocacy that social workers should be part of a medical ensemble to address the psychosocial elements of illness (Daniels, 1972). Connected to this awareness, public attitude favoured paramedical general practice care where a general practice in a community had both a nurse and social worker working as part of a team, although this approach never reached its full potential. This model was reinforced internationally where it had been trialed and was underway (Dixon, Dodge, Emery, Salmond, & Spears 1975). Despite some marginal gain in status however, professional contestation and overlap between social workers and other professional groups remained unresolved (Bobbett, 1994; Schofield, 2001). The role tension between public, district, Plunket and psychiatric nurses, and that of social workers, has been particularly documented (Anon, Community Health Nursing Service, 1974). Post discharge, families would be visited by both professional parties producing some expected confusion and even a sense of harassment in some families (Anon, Community Health Nursing Service, 1974, p. 21). There was also considerable discussion of the role in psychosocial aspects of primary care (Carson, 1971; Daniels, 1972). This largely encompassed arrangement of patient discharges, benefit payments, and home-based services, much of which was still visible in the early 90s (Bobbett,

1994). In that sense the technical boundary between nursing and social work had still not been made; for example the development of the Tiromoana training centre was reported in the nursing journal (De la Roche, 1971).

Community health services also underwent major development in the 1970s, and this saw the greatest increase in the number of health social workers employed in public health and community-based services. Social work in general practice was explored (Craig, 1980; Nuthall & Craig, 1980). Significant structural and bureaucratic changes took place from 1972, when mental health services transferred from the department of health to the hospital boards (Schofield, 2001). By the mid-70s ways were being looked at to curb health costs as expenditure entrenched and increased since 1972 (Schofield, 2001). Hopes for greater extension into primary care (Nuthall, 1989) were to be largely dashed, due in no small part to the managerialist plan for the public service, which was to dominate in the late 1980s and 90s.

Nash & Munford (2001, p.23) note that during this period the New Zealand Social Work Training Council was empowered to set basic minimum standards for accreditation for social work training but that 'these proved as divisive as they were useful'. The health sector at this time began to show much greater commitment to the employment of staff qualified in social work. 'Professional social work was consolidated, but this trend was contested by radical groups who felt that social work was becoming elitist and authoritarian' (Nash & Munford, 2001, p.23). Despite debates about the shaping of the profession through academic advancement, the drivers of a more scholarly approach that had become visible in the 1970s continued through the 1980s, evidenced in research on various aspects of health social work (Herman, 1985; Jaffe, Poulter, Stanton, Story, & Taylor, 1987). It was also demonstrated by radical projects informed by critical theory and discourse, one example being the Women's Resource Centre at Carrington Hospital in Auckland where the motivating force was feminism (Heighton, McLaughlin, Purolainen, & Campbell, 1987). Psycho-education continued, now formally termed as such, and undertaken in a diverse array of settings from pregnancy counselling to terminal illness (Beddoe & Weaver, 1988; Lawther, 1988).

1989-2000 Managerialism and retreat

The previous decade heralded massive change with sector restructuring that led to often passionate discussion of the impact of cost cutting and managerialism. These features remain a pervasive influence on practice. As noted by Miller in the Australian setting, change in this period was driven by a 'highly ideological economic rationalist philosophy which included a push to privatization, forced tendering by hospitals for their own existing services, hospital amalgamations' (Miller, 2006, p.185). In New Zealand, Ross (1990, p.24) noted that in the presence of severe fiscal restraints 'more overlap, role confusion and competition' would exist in the health system. She advocated greater delineation of the professions, clearly defining competence and best value.

Education has always been a significant issue for health social work, and on the cusp of the new decade significant work was done to develop competencies and standards for social work in health care, in the absence of statutory regulation. Several projects were carried out on behalf of the Area Health Boards Chief Social Workers' Association and funded by the Health Workforce Development Fund (Daniels, 1989; 1990).

The literature suggests that throughout the late 1980s and the 1990s social workers may have adopted a dual role within their organisational professional practice. These two role identities can be understood conceptually as an 'organisational face' role, and a more explicit change agent role often minimised during this era. The former sees social workers contributing to organisational frameworks, management, tight accountability and the strict budgets under which health social workers were mandated to work during this period (Curry, 1993; Daniels, 1989; 1990). High levels of practicality in case work are still evident in this period. In hospital and treatment settings this includes arranging disability or sickness benefits and accommodation of dependent children (De Souza, 2000) as well as the comprehensive consideration of where cultural, religious or spiritual supports would benefit the client (De Souza, 2000).

The last decade of the 20th century was a grim and challenging time for health social work. In Beddoe (1993, p.30) one of the authors of this current paper noted that when she had joined the profession in 1978 as a medical social worker she 'was expected to wear a white coat and carry a locator. There were symbols of both status and toadying to the medical profession whom we knew really ran the show'. There were debates within the profession about the best way to respond to the restructuring of health (for different viewpoints see, for example, Henderson (1998) and Stewart (1998)). Phillips (1989) suggests using the jargon of the day to promote social work as a 'value added service' emphasising the importance of client-centred quality improvements. Tan (1994, p.28) cautiously suggested some glimmers of optimism and urged social workers to 'speak up and learn the language of management and use it in our discussions with them'.

The notion of the change agent role was thus undertaken in the same circumstances by subtly advocating for clients in the face of resource restrictions. A case example was encouraging the visibility of a management and service feedback survey, as a way to conglomerate the negative experiences of service users, and produce pressure for change (Sullivan, 1998). In this way, the advocate role of the practitioner, who while retaining employment, operated both a client-centred practice and addressed the social justice foundations of the profession.

The other most significant development in the 1990s was in the assertion of tangata whenua aspirations for a more responsive health services (Marshall & Paul, 1999; Parkinson & Elliott, 1999; Wikaira 1999). One aspect of the resurgence was the development of tangata whenua writing on social work in health care as in other fields of social work. Marshall and Paul (1999) and Parkinson and Elliott (1999) described the development of an embedded indigenous approach to integrated practice with Maori whanau in teams in health services. Social workers sought to develop and support kaitiaki and kaiawhina embedded within health services to 'maintain and strengthen their own cultural support for each other as well as clients' and to legitimise the expression of Maori philosophies of health 'such as self-esteem, confidence, pride, a sense of identity, control and voice' (Parkinson & Elliott, 1999, p.52).

2000-2010 The professional project: Straddling the contradictions

The influence of contracting in the health and mental health sector continued through this next decade (Munford & Sanders, 2001). A business model prevailed, creating major chal-

lenges for social work (Orovwuje, 2001). Accountability and professionalism were two of the drivers in social work (Staniforth & Larkin, 2006), with a focus on cost effectiveness and competition between professionals regarding service provision (Woodward, 2001).

Social workers also took advantage of new opportunities. In the early days of reform, managers for the new environment tended to segue from the ranks of existing practitioners, in New Zealand as elsewhere. Noordegraaf (2006) notes this feature in Europe and suggests that this advantages social work and offers the notion of a hybrid, a crossover to 'the dark side' from a profession that was reeling from its new-found loss of autonomy. Gilbert and Powell (2010, p.9) argue that critics of the classical approach to understanding professions have long noted 'the extent to which professions have always tended to readily adapt to forces of change, as well as conform to externally dictated organisational policy and procedures'. Evidence of adaptation abounds; many social workers were able to reinvent themselves as managers, especially in community care services.

Developing practice in alignment with other professionals saw the status of social work improve (Hunt & King, 2000). Collaborative practice in this decade, though still a major agency and professional challenge (Pakura, 2004), was vital to social work's deemed status and perception by the public, its clients and other professional colleagues. Despite such gains, the age-old argument in terms of occupational voice and role remained intact (Adamson, 2001).

One response to secure professional identity (Beddoe, 2011a), is found in the call for social workers to publish; to articulate their expertise and practice to the best of their ability (Woodward, 2001). This decade then, was characterised by increasing interest in scholarship and research and the call for evidence based interventions (Adamson, 2001; Briggs & Cromie, 2001a). This firm direction of both practitioners and educators operated within a level of case complexity in this decade that has perhaps been unprecedented (Briggs & Cromie, 2001a) and conditions that emanated the same difficulty as the two preceding decades. Growing research in practice was a new initiative aimed at raising practitioner interest in research (Beddoe, Yates, Fouché & Harington, 2010) with several publications reporting practitioner projects (Haultain, Thompson, Loli & Herd, 2010; Zhang, Wong, Li, Yeh & Zhao, 2010).

The 2000s also significantly, saw the advent of statutory registration although it was not quite the schema wanted by some. The Health Practitioners Competence Assurance Act (HPCA) was also passed in 2003. This legislation was developed to protect the health and safety of the public by ensuring that registered health practitioners are competent to practise. The SWRA was developed with the HPCA in mind, but the non-mandatory nature of social work registration meant that all health social workers did not immediately register (Beddoe & Duke, 2009). This has led to some legitimate concerns that social workers could be perceived as 'second-tier' health professionals (Briggs & Cromie, 2001b, p.1).

2010 and beyond: Opportunities and challenges for health social work in New Zealand

In recent decades social workers have intensified their involvement in the health system. Having taken opportunities to gain supervisory and managerial qualifications on top of a broadly based preparatory education, social workers have continued to enter management

roles. Randall and Kindiak (2008, p.353), writing from a Canadian perspective, comment that in 'many instances social workers have taken on management positions in which they have supervisory roles'. Randall & Kindiak, also suggest that social workers have also expanded into numerous new roles including in acute care, home care, the community sector, and palliative care (p.352). In New Zealand a good example is provided by Jan Tan (personal communication) who noted that in 2003 there were no social workers working in hospices in the Auckland area and 'there are now at least eight' many of whom have had previous experience in health social work and have undertaken specialist study of palliative care.

Visibility and leadership

The visibility and status of the profession in health remains a concern. Fry (2010 p. 111) writes that still 'social workers often talk about their work being unseen, behind the scenes and based on relationship and rapport building with not just clients and their families but staff too'. Fry (2010) notes that two significant, linked challenges for health social work are contributing to the 'interprofessional health' discourse and negotiating the shift to inclusion of social work in the New Zealand health system into 'allied health'. Fry (2010, p.111) argues that a key issue for social work is defining its place in allied health, managing the tensions of strengthening a distinct professional identity while being an integral part of a wider group. In mental health where social work has long been a significant contributor to multi-disciplinary teams, McNabb (2002; 2010) along with Fry, identifies leadership as critical.

New Zealand social work could well look to social work in Victoria, Australia, where gains have been made through strategic thinking. Miller (2006) suggests that 'the perception of a *glass ceiling* which limits social workers but not medical and nursing staff will need to be addressed' and she sees a need for flexible career paths (p.188). Joubert (2006) advocates for joint academic/practice appointments to enhance work satisfaction. In addition to opportunities for practitioner research and teaching, middle management hospital roles such as discharge planner, case/care manager, project management and quality assurance or other roles which draw on core social work skills and experience. Miller (2006, p.188) cautions that despite the gains made by health social workers in Victoria, Australia there is no room for complacency. She perceives the following challenges which have relevance for New Zealand social work: increasing pressure for demonstration of outcomes and the demand for an evidence base for interventions; continued devolution to allied health departments where managed in interdisciplinary teams by non-social workers; and the continuing challenge from related professions such as nursing, psychology or 'counselling' to work in the traditional core areas of social work.

Research and scholarship

Miller (2006) notes the influence on health social work in Victoria of the Mount Sinai Social Work International Enhancement of Leadership Program (p.186). The University of Auckland was successful in negotiating a place for New Zealand in this programme and the first New Zealand candidate participated in 2009. Professor Irwin Epstein from Mount Sinai and Hunter College New York visited New Zealand in 2009 and provided support and inspiration for the extension of practice based research in health social work.

The candidates have reported being inspired by the programme and returned with enthusiasm to make a difference to practice-based research in the New Zealand health sector. The annual eight-week programme is coordinated and managed by the Department of Social

Work Services at the Mount Sinai Medical Center in New York City. It is currently offered to 4-6 social workers each year from Israel, Australia, New Zealand, Singapore, and China. Miller (2006, p186) cites Rehr, Rosenberg & Blumenfield (1993) in asserting that those who have participated 'feel validated, inspired and return to their workplaces with a new sense of vision and purpose'.

Discussion

The challenge of writing up a project like this is what to include and what to leave out. There are numerous themes that could have been further explored and the authors are well aware that readers may have exclaimed while reading 'how could they leave out the article by X?' In choosing not to search unpublished theses we know that we will have missed out on excellent and fascinating published research. Such is the fate of unpublished theses: they languish on the shelf at the library, often to be read only by other MSW or PhD students. We urge social workers who undertake research or practice development projects to publish in order to disseminate this important work to a wider audience.

Our interpretation of themes from the literature reviewed of course is heavily influenced by our 2009-2011 perspectives and experiences on insider and outsider viewpoints, the first author as an academic and former health social worker and the second as a student and more neutral reader of the texts. Also, as Chambon, Johnstone, & Winckler (2011, p.640) point out in examining texts and other archival material crucial dimension is missing, how these works were perceived 'at the time' by their audience. Another researcher with a different lens may have perceived different themes and explicated alternative conclusions.

There is undoubtedly a need for the scholarship of health social work to continue and research demonstrates a will to do this within the profession (Beddoe 2011a; 2011b). Informed and reflective research and scholarship on substantive health social work issues, whether in relation to practice, policy, research or education. In particular the study suggests that the following are neglected: health inequalities, social work in primary health, social work and health promotion, and the promotion of content related to health and well-being in the undergraduate curriculum for social work education curriculum. These areas of neglect potentially impact on the effectiveness and continuing development of social work in health care.

Citing the Ottawa Charter for health promotion (1986), Nuthall (1989, p.9) wrote that 'one of the essential components of creating a healthy society means moving resources from secondary care to primary health care'. Twenty-two years later her question is still of great relevance: 'just ask yourself how many social workers in your area health board are in positions where people can come directly for help. I expect you will find that the vast majority of social workers are only reached through referral'. Our project revealed earlier work carried out in Christchurch (Craig, 1980; Botting & Chetwynd, 1989) which showed early promise for social work in primary care. Anecdotal evidence suggests that this may return to the agenda. We are aware of increasing roles for social workers in public health and further research is needed to explore this development.

The implications of this project suggest the need for health social work in New Zealand as elsewhere to develop a programme of research and scholarship to ensure the profession

can demonstrate an informed and reflective contribution to both clinical priorities and advocacy on substantive health and social policy issues (Giles, Gould, Hart, & Swancott, 2007). It is proposed that an action research approach is developed as a partnership between practice and academia to develop and disseminate original and high-quality research on social work in health and well-being.

Each decade in New Zealand health social work then can perhaps be conceptualised as having a particular emphasis, or identity strength. In the 1950s this was a *mediatory* role, straddling the centre line between nursing and social practice. In the 1960s a *qualitative argumentative* role emerged. This was exemplified through public endeavors to argue for the qualitative nature role and status of the professional health social worker. Through the strong professional culture of the 1970s this role became one of *narrator*, where social workers took their professional 'story' of people's health experiences and turned it into professional and client gain. During the 1980s and 1990s, social workers assumed dual roles: *face value* roles to organisational demands and *subversive roles* to real client needs. In this current decade, health social work is perhaps the *insurgent*: on a quest for research driven and led best practice, in an increasingly complex contradictory and demanding environment.

Conclusions

In this article we have offered a necessarily brief overview of more than seven decades of social work in health in New Zealand, based on a selection of published texts. As we conclude this paper, further change is taking place. We wish to encourage social workers in health care to recognise our history and note that while the challenges endure, so do we!

We hope those living authors whose work we have cited appreciate their efforts in writing for publication were not in vain and merely gathering dust. Instead their experiences and ideas live on in texts that can inform us. We are grateful to them as our forebears and colleagues and we urge others to contribute to the history of our profession. Accordingly, we give the last word to Avis Jones, who seemed to have prescient knowledge of the audit culture of the 1980s and beyond:

Yes, we can say how many interviews we have had, how many community resources we have contacted, how many miles we have travelled but the true heart of the work is not measured by numbers on a page or lines on a graph. Results are achieved through the exercise of social casework principles within the medical setting (Jones, 1963, p.11).

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