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Editorial: *United We Stand?*

The national conference where Practice Reflexions was launched a year ago in Freemantle, Western Australia was, for the first time ever, jointly sponsored by the Australian Association of Social Workers (AASW), the Australian Institute of Welfare and Community Workers (AIWCW), the Australian Association for Social Work and Welfare Education (AASWWE), and the Society for Professional Social Workers (SPSW). The conference theme: UNITED WE STAND was chosen to assert the importance of a diverse and at times conflicted professional practice terrain. The intention was to focus on commonalities, rather than differences in order to maximise benefits for the membership of all four professional bodies, and more importantly, in the shared pursuit of social justice (Lonne 2006). Any call to unite presupposes a state of disunity, assumes that disparate entities will individually and collectively gain by acting supportively and aligning more closely together, and presumes that some measure of convergence and alliance is possible.

The articles contained in this edition of Practice Reflexions, some of which were presented at the conference, demonstrate that no matter how disputed the practice approach, or the professional identity, engaging with change to bring about social, political and economic justice for all sits at the core of social, welfare and community work. The authors draw variously on the themes of unity, diversity, change and social justice in offering their reflexions on their own and others' practice experiences and research findings in the professional field and policy context of human services.

Ian Murray's paper closely pursues the concerns of the conference theme by proposing the organisation of an overarching professional body as a site for change towards greater unity. He reflects on the possibility of forming an umbrella organisation for the entire community services sector as a way to address the oversight of the many blurred roles in health and community services, and the resultant neglect, by governments and existing professional organisations, of many professionals. Murray also proposes Negative Licensing as a way to avoid the problem of increasing regulation. Paul O'Neal and Winsome Roberts are also concerned with the effects of increasing regulation, and offer their reflexions on the social control effects of anti-smoking legislation. O'Neal and Roberts make the observation that anti-smoking policies and laws have acted to increase the regulation and imposition of government in the lives of socially and economically disadvantaged individuals and groups, creating challenges for social and community welfare workers who are confronted with imposing anti-smoking regulations on vulnerable client groups in institutional settings.

Philip Mendes is also concerned with the ill-considered consequences of regulatory policies for clients in regard to addictive substances. He argues that throughout the Howard government era there was an escalated influence exerted by prohibitionist lobbyists groups over Australian illicit drugs policy and funding, even though little inquiry was made into the background and political interests of these individuals and groups, or the credibility of their claims, particularly in relation to zero-tolerance.

Intended and unintended effects of social policy at the practice level are also central to Olga Bursian's article. Based on her PhD research, Bursian analyses practice approaches and policies that contributed to positive settlement experiences for

migrants to Australia during the mid–1970s to late–1990s. She found that migrant women in Melbourne not only benefited personally and socially from their contact with a range of public services as well as multicultural programs, but were also enabled to become key contributors as engaged citizens in the development of a ‘vibrant and diverse civil society’. In a similar vein, Virginia Mangazva, a Masters student at Curtin University, shares her observations and experiences as a community development worker with newly arrived refugees to Australia. Mangazva reflects that the most effective interventions often result from flexible, integrated and diverse practice approaches, such as a combination of individual psychological interventions with broader community development initiatives.

The theme of strength in unity manifests in Mark Furlong’s article as social connectedness. Furlong employs the concept of unity at the micro practice level by asserting the importance of practitioners focussing on building service users’ skills in interconnectedness and relatedness. He proposes that caseworkers have perhaps over attended to the autonomous self at the expense of the relational self, suggesting that service users who are socially connected and interdependent achieve better health and well-being outcomes. Lynda Campbell reviews a recently published text explicitly driven by this aim, ‘Good Practice in Child Protection’ co-authored by Tilbury, Osmond, Wilson and Clark, while Jan Richardson reviews Louis Nowra’s book ‘Bad Dreaming: Aboriginal men’s violence against women and children’. This is a particularly pertinent and current topic brought to the fore by the Howard Government’s response to the welfare of children in Aboriginal communities in the Northern Territory following the release of the ‘The Little Children are Sacred’ report.

In conclusion, to return to the conference title: ‘United We Stand’ – which might be described as forming the ‘umbrella’ theme for this edition of Practice Reflexions – expression of the need to unite assumes a hostile context, whether political, social, cultural, religious, or economic. And, although the articles here are diverse in approach and topic, they are all drawn together by the common theme of recognising the need to form a locus, whether conceptual or material, transient or more permanent, for uniting against and addressing the challenges, and often unintended hostilities, faced by practitioners and, particularly service users in the shared pursuit of social justice for all.

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Fighting the Drugs War: The role of prohibitionist groups in Australian illicit drugs policy

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Abstract

Prohibitionist lobby groups appear to be exerting an increasing influence on Australian illicit drugs policy. Yet remarkably little is known about their history, membership, sources of funding, political and ideological agenda, and employment of empirical evidence. This paper provides a critical introduction to their key activities and objectives. Some conclusions are drawn about their current and likely future influence on national drugs policy.

Keywords: *prohibitionist; harm minimization; illicit drugs.*

Pro-abstinence or prohibitionist groups have long been active in Australian illicit drugs policy debates. Some of the key groups appear to be Drug Free Australia, Drug Arm Australasia, the Drug Advisory Council of Australia, the Australian Christian Network, the Australian Family Association, the New South Wales Council of Churches, Make Illicit Drugs Socially Unacceptable, Coalition on Alcohol and Drug Education, the Southern Cross Bioethics Institute, and sections of the Salvation Army.

Some of their leading spokespersons have been magistrate Craig Thompson, former Judge Athol Moffitt, Salvation Army Major Brian Watters, entertainer Normie Rowe, South Australian state Members of Parliament Nick Xenophon and Ann Bressington, NSW state Member of Parliament Reverend Fred Nile, former ACT public servant Collis Parrett, Queensland naltrexone provider Dr Stuart Reece, Seventh Day Adventist Gary Christian, the Catholic Archbishop of Sydney George Pell, and Australian Family Association activists Jill Pearman, Bill Muehlenberg, Elaine Walters, Isobel Gawler, Joe Santamaria, Geraldine Mullins, and David Perrin. Most of these activists strongly adhere to a socially conservative ideology, and are closely linked to churches or other religious-based groups.

The prohibitionists espouse a zero tolerance perspective which defines illicit drug use narrowly as immoral and/or criminal behaviour, rather than as a health issue. It implies an emphasis on law enforcement and prevention of drug use, rather than reduction of harm, and is often associated with a belief in a war on drugs (Goode 1997:56-59; Lang 1998:10-11; Le Grand 2002). Prohibitionists favour abstinence as the sole goal of practice interventions. They argue that drug law liberalization will: 1) Increase the consumption of dangerously addictive drugs, and lead to large numbers of new users; 2) Fail to substantially reduce crime since a large proportion of users committed crimes prior to their dependency; 3) Is unethical since it gives drug users no incentive to end their dependency.

The key opposing perspective is called harm minimisation. This term refers to a number of strategies which exist along a philosophical continuum: supply-reduction strategies, demand-reduction strategies, and harm-reduction strategies. It is the harm

reduction strategy which overtly distinguishes harm minimisation from prohibitionist practices. Harm reduction involves strategies designed to reduce harm to individuals and the community such as needle syringe programs, pharmacotherapy prescribing programs such as methadone and buprenorphine, supervised injecting facilities, and prescribed heroin.

Harm reduction takes a dispassionate public health and morally neutral approach to illicit drug use, and is based on three core principles. Firstly, drug use is a public health issue, rather than a legal issue. Drug users are entitled to be treated as normal citizens with the same rights and obligations as other members of the community. Secondly, harm reduction is morally neutral making it possible to move away from a punitive approach toward a health oriented response. Indeed, drug use is recognised as an intractable part of society. Not only is the elimination of drug use via punitive law enforcement impossible, it may increase drug-related harm by further marginalising illicit drug users and pushing them beyond the reach of treatment agencies. Thirdly, harm reduction does not advocate the wholesale legalisation of illicit drugs. Rather, it acknowledges a responsibility to implement measures that reduce drug-related harm. If the partial legalisation of proscribed substances, such as marijuana, can be shown to reduce harm, then such a measure may fit within harm reduction strategies (Rowe & Mendes 2004:5).

The major difference between harm reduction and zero tolerance can arguably be summarized as follows: harm reductionists aim to save lives and reduce drug-related harm even if this means an overall increase in drug use, whilst zero tolerance supporters seek to reduce drug use per se even if this means an increase in the number of deaths (Wodak 2002:51; Wodak & Moore 2002:34; Macintosh 2006:20).

Prohibitionists claim to represent what they call the 'silent majority' of the community (Walters 2000). They have played a major role in opposing harm reduction measures, and attacking leading harm reduction advocates. They condemned the introduction of needle and syringe exchanges in the 1980s, the liberalisation of state marijuana laws in the 1990s, the expansion of methadone programs, the introduction of the supervised injecting facility in New South Wales, and the recently proposed trial of medicinal cannabis. They were also strenuously opposed to the proposed but never implemented heroin prescription trial in the ACT. Instead, prohibitionists urge absolute compliance with international drug control treaties, favour the compulsory rehabilitation and drug free policies adopted by Sweden, and support the prompt introduction of contentious naltrexone implant trials to assist addicts to achieve abstinence (Walters 1996; Kyte 1997; Moffitt 1998; Moffitt et al 1998; Watters 1999; Santamaria 1999a, 1999b, 1999c, 2000; Raffaele 2000; Sullivan 2000; Pike 2001; Le Grand 2002; Muehlenberg 2002; Santamaria 2002; Williams 2002; Robinson 2004; see also discussion in Marr 1999; Rowe 1999:176-183; Snow 1999; Swain 1999:64; Mendes 2001a, 2002; Walker 2003; Gunaratnam 2005).

For a number of years their views were largely marginalized within Australian drug practice and policy discourse which was dominated by harm minimization views. However, since the election of the Howard Coalition Government in 1996, prohibitionist groups have become increasingly vocal and influential. For example, a

number of prohibitionists have held leading positions in the government-appointed Australian National Council on Drugs including the successive chairpersons, Brian Watters and more recently John Herron. In addition, the government has begun to provide funding to support key prohibitionist objectives.

The groups have also held a number of significant public forums and conferences including a June 2000 summit chaired by Brian Watters in Sydney (Totaro 2000), the 2001 Citizens Drug Summit hosted by the Family Council of Western Australia, the 2005 National Harm Prevention Conference hosted by the Coalition on Alcohol & Drug Education and Drug Free Australia (Barich 2005), and the 2005 People's Drug Summit hosted by the South Australian independent MLC Nick Xenophon (Roberts 2005; Xenophon 2005).

Despite this, very little is known about the history, membership, and activities of these groups. For example, the following questions deserve consideration. Whom do the groups claim to represent? What agenda drives their views? Are they primarily motivated by religious and moral beliefs, or by broader ideological or political perspectives, or rather by personal or familial experiences of illicit drug use? What are their key sources of funding? And is there empirical-based research evidence to support their views? The remainder of this paper attempts on the basis of the limited existing literature to answer some of these questions.

The Policy Context

In Australia, harm minimisation has been the official drugs policy since 1985. As noted above, it was the addition of the harm reduction component that marked the major departure from past drug policy. The inclusion of harm reduction was directly associated with the public health threat posed by the emergence of HIV/AIDS in the early 1980s. The unprecedented nature of this threat emphasised the need to prioritise the prevention of the collateral health and social damage associated with drug use over the goal of abstinence as the sole objective of drug policy.

The priority accorded to harm reduction meant that, while abstinence remained the preferred outcome of drug treatment, it was one of a hierarchy of possible treatment outcomes. One of the most important initiatives to emerge from the adoption of harm reduction was the establishment of the Needle and Syringe Program. The efficacy of the program has been demonstrated by Australia's success in controlling the spread of HIV/AIDS amongst intravenous drug users ensuring its acceptance as a legitimate public health strategy (Commonwealth Department of Health and Ageing 2002).

Since the 1996 election of the Australian Liberal-National Coalition Government, there has been a marked shift in the balance between the three components of harm minimisation as defined above. This reflected former Prime Minister Howard's preference for prohibitionist principles that echo those of zero tolerance exponents. This became apparent when the Prime Minister personally vetoed a proposal for a heroin trial in the ACT, despite years of multidisciplinary feasibility studies and the approval of a majority of the state, territory and federal police and health ministers. Later, Howard strongly opposed the introduction of a supervised injecting facility in

Sydney (Mendes 2001b:22-26). He also wrote a supportive preface to a book by leading prohibitionist Athol Moffitt (Howard 1998).

The then Prime Minister launched his 'Tough on Drugs' national drug strategy in November 1997. This strategy openly utilized drug war rhetoric, and shifted the balance of harm minimisation policy away from harm reduction and back towards prohibitive law enforcement (Australian Government 1997). Howard committed the government to the introduction of 'zero tolerance of illicit drugs in our schools'. He argued that 'illicit drugs are highly dangerous, that there is no safe level of use, that the only sensible objective is abstinence, and that possession and use will not be tolerated in schools' (Howard 1999).

The then Prime Minister also established a new body, the Australian National Council on Drugs (ANCD), to advise on his government's drug policies. Howard appointed Major Brian Watters of the Salvation Army to chair the Council. Watters was the Salvation Army's spokesperson on addictions for NSW, Queensland and the ACT, and a member of the NSW and Queensland Boards of the prohibitionist group, Drug-Arm Australia. Watters has repeatedly described drug addiction as a 'sin. I know it's a medical and psychological problem, but the Bible tells us that sin is falling short of our potential' (cited in Bush & Neutze 2000:135). Watters believes 'there are worse things than death when it comes to heroin addiction' (cited in Bush 1998:5).

Watters' appointment as ANCD Chairman was significant given that the Salvation Army is known to be divided on attitudes to illicit drugs. For example, the Victorian Salvation Army explicitly rejects Watters' views. They support harm minimisation, accept treatment goals other than abstinence, and do not rule out the possibility of endorsing heroin trials (Marr 1999:11-12).

Yet Howard made it clear that his selection was motivated by Watters' outspoken support for prohibitionist policies: 'I deliberately hand-picked Major Watters to chair the Australian National Council on Drugs ... It is no secret that Major Watters was a critic of the heroin trial in the ACT. It is no secret that Major Watters adopts the view, as do many others, including myself, that the policy of zero tolerance of drug taking in this country is a highly credible policy that ought to be pursued more vigorously (Commonwealth Parliamentary Debates 1998:3564).

The political composition of the ANCD also changed over time. The inaugural Board contained three prohibitionists – Dennis Young, Craig Thompson and Tonie Miller – plus Major Watters as Chairman, but also included a number of leading harm reduction advocates such as Ian Webster, Margaret Hamilton, Wayne Hall, Tony Trimmingham, Wesley Noffs, Karen Hart, and Jude Byrne. But the appointment of a new Board in 2001 saw the last four persons removed, and the resignation of Hall plus the addition of pro-abstinence activist Ann Bressington. The Board shifted towards a prohibitionist majority (Mendes 2001b:27-29; Overington 2001; Totaro 2001; Fitzgerald 2004:54).

This process was repeated in 2005. Major Watters (who became a member of the prohibitionist International Narcotics Control Board based in Vienna) was replaced as Chair by John Herron, a former Howard Government Minister. Herron was co-

founder of the socially conservative parliamentary Lyons Forum (Maddox 2005:37-39) which reportedly played a significant role in undermining the ACT heroin trial (Short 1997). Herron is also Patron of the Queensland branch of the prohibitionist Australian Family Association. Whilst Herron has made few personal public statements on drugs (Herron 2002), it is reasonable to assume he shares the former Prime Minister's prohibitionist sentiments.

The ANCD continued to issue some reports which are balanced and based on empirical scientific research, but overall its role appeared to be primarily to support and promote Howard's personal prohibitionist perspective. As one leading commentator noted, the Council "is not representative of the views of the sector. It doesn't represent the non-government service providers. It is an appointed Council" (Fitzgerald 2002). It would appear in fact that the ANCD was created precisely to sidestep the views of those groups which are representative of most professional drug practitioners and researchers (Fitzgerald 2004:53-56).

Although the then Howard Government reiterated a commitment to harm minimisation in both the *National Drug Strategic Framework 1998-2002* and the *National Drug Strategy 2004-2009* (Ministerial Council on Drug Strategy 2004) it appears that harm minimisation has shifted dramatically towards zero tolerance along the continuum of potential policy responses to illicit drugs. The 2003 House of Representatives Standing Committee on Family and Community Affairs Inquiry into Substance Abuse in Australian communities report arguably formalized this shift from harm reduction towards prohibitive law enforcement.

Despite noting support for harm minimisation from professional organisations such as the Public Health Association, the Alcohol and Other Drugs Council and Turning Point Alcohol and Drug Centre, the report cited concerns that 'harm minimisation may appear to encourage the maintenance of a drug habit and give rise to the idea that taking drugs is alright' (Standing Committee on Family and Community Affairs 2003:297).

This analysis accorded with views expressed in submissions (and given disproportionate weight) from prohibitionist groups such as the Drug Advisory Council of Australia and the Festival of Light, an indication of the Committee's willingness to accord greater weight to ideology as opposed to expertise (Rowe & Mendes 2004:7). Consequently, the report recommended the replacement of harm minimisation with 'a focus on harm prevention and treatment for substance dependent people' (Standing Committee on Family and Community Affairs 2003:297). The latter element was specified as 'treatment that leads to abstinence' (p.296). This new direction was also confirmed by the formal government response to the Report which emphasized a commitment to harm prevention, and abstinence-based programs (Australian Government 2006).

Nevertheless, government policies seemingly continued to reflect a cautious compromise between harm minimisation and prohibitionist perspectives. On the one hand, the government approved and even expanded harm reduction programs such as needle and syringe exchange programs and methadone maintenance treatment (Steketee 2006). Programs that divert minor drug users away from the criminal justice system to education and treatment services also continued. In addition, the former government strongly supported harm reduction programs by Asian countries to address the threat of

HIV infection among injecting drug users. One leading harm reduction advocate suggested that ‘the major difference between the drug policy pursued by the Howard Government and that of the Australian Labor Party (when in government and opposition) has been political marketing. The Howard Government has been conscious of the views of its constituency and the need for product differentiation’ (Wodak 2004).

On the other hand, the former government seemed determined to more closely align national drug policies with its zero tolerance ideals. In 2005 legislation was passed (via the Serious Drug Offences and Other Measures Bill) giving the Commonwealth the right to intervene in drug policies that have traditionally belonged to the States. In addition, the government openly encouraged a media campaign led by the conservative *Australian* newspaper to revoke the civil penalty schemes that apply to minor cannabis offences in four Australian States and Territories (Macintosh 2006). The government later called on the States and Territories to abandon the decriminalisation of personal use of cannabis, and instead agree on national uniform drug laws that will define possession of marijuana as being as dangerous as that of heroin or cocaine (Anon 2006).

The government also provided significant support to medically contentious treatment initiatives such as naltrexone therapy ‘that appear to be driven more by an abstinence-based ideology than evidence-based policy’ (Macintosh 2006:17; see also p.21). In addition, they provided a grant of \$600,000 over three years to Drug Free Australia to ‘advocate abstinence-based approaches to drug issues’ (Howard 2005).

The Prohibitionist Groups and the Inquiry into Substance Abuse

The political agenda and influence of the prohibitionist groups is best illustrated by reference to the above Inquiry into substance abuse in Australian communities. The inquiry prompted almost 300 submissions of which only about a dozen emanated from prohibitionist groups. Yet these small number of submissions were to exert disproportionate influence on the final report.

The most significant prohibitionist group appears to be Drug Free Australia (DFA) which describes itself as a national peak body of more than 100 community organisations formed in 2002 to promote a drug free Australia. DFA do not disclose the names of their members, but they do list an affiliate in every state and territory, and acknowledge close links with Christian fundamentalist groups such as the Seventh Day Adventist Church and Salt Shakers. They are headed by Michael Robinson who is a regular contributor to drugs policy debates. DFA’s submission to the inquiry called on the government to implement policies leading to the prevention of harm. Specifically, they urged the review of existing services such as long term methadone maintenance and the NSW supervised injecting facility, and called instead for increased support for abstinence-based programs (Drug Free Australia 2002, 2006).

An associated group is the Community Coalition for a Drug Free Society (CCDFS) which is listed as an affiliate of Drug Free Australia. CCDFS is headed by Peter Stokes who is also the Chair of the Salt Shakers group. The CCDFS submission urged support for prohibition and abstinence-based recovery programs. Specifically, they condemned harm minimisation programs such as needle distribution, supervised

injecting facilities and the decriminalisation of marijuana, and attacked harm reduction advocates and drug professionals (Community Coalition for a Drug Free Society 2002).

Another important group is Drug Arm Australasia or Drug Awareness, Rehabilitation and Management, which is headed by Dennis Young, a long-term member of the Australian National Council on Drugs. Drug Arm is a Christian group which was formerly known as the Temperance League or Alliance. This organisation has attained particular prominence in Queensland where it has managed to supplant the Alcohol and Drug Foundation of Queensland as the primary representative body for non-government services (Fitzgerald 2004:57). It also has operations in New South Wales, South Australia, and the Australian Capital Territory.

The DA submission urged that abstinence-oriented strategies be prioritized, and rejected any proposals for supervised injecting facilities or heroin prescription trials (DA 2002).

Another group is the Drug Advisory Council of Australia (DACA) which acknowledges links with a number of other prohibitionist organisations including the Australian Family Association, the Festival of Light, Focus on the Family, and Saltshakers. The DACA submission condemned harm minimization programs including education in schools around safe drug use, needle exchanges, supervised injecting facilities, and heroin trials as allegedly contributing to increased drug use and abuse in the community. Instead they called for abstinence-based education programs, greater law enforcement, and the availability of naltrexone detoxification and rehabilitation programs (Drug Advisory Council of Australia 2002, 2006).

Another prohibitionist group is the Festival of Light, a Christian fundamentalist church which operates a Drug-Free Ambassadors program. The Festival of Light urged the introduction of abstinence-based rehabilitation programs including naltrexone, and the rejection of harm minimization. They recommended that Australia follow the zero tolerance approach pursued in Sweden (Festival of Light 2002, 2006). Further submissions of a similar nature came from Australian Parents for Drug Free Youth, Coalition Against Drugs Western Australia, Focus on the Family Australia, Keep Our Kids Alive, Tough Love New South Wales and South Australia, and Collis Parrett.

Unfortunately, the submissions (and an associated perusal of their websites and other public statements) don't reveal a great deal of information about the relative significance and legitimacy of these groups. Most of them do not release membership lists or figures so it is difficult to tell whether they are marginal, or alternatively representative of a wide range of socially conservative opinion. Equally, most do not reveal their sources of funding although some such as Drug Arm are known to receive federal and state government resources.

Many of the groups appear to be primarily motivated by morality-based Christian beliefs (Macintosh 2006:29-32), although some individuals (e.g. Normie Rowe, Ann Bressington of Drug Beat of South Australia and Margaret McKay of Keep Our Kids Alive) are known to be influenced by personal/familial experiences of drug abuse or

drug-related death. Some of the groups present what they claim to be evidence from Australia and elsewhere to support their beliefs, but most have never undertaken empirical research that would be recognized by academic bodies or journals.

As noted by John Fitzgerald:

Historically, abstinence-based organisations with religious/moral frameworks have advocated for services, such as compulsory detoxification and long-term rehabilitation that have the lowest level of evidence of efficacy...Whilst the scientific basis for evidence relies on objectivism, moral frameworks function from a vastly different epistemological base. Evidence emerges from faith and the interpretation of the word of God rather than through experimentation and testing. (2004:57)

Nevertheless, their submissions to the inquiry were highly influential. The Road to Recovery report released in 2003 made numerous references to their representations. For example, the report positively cited the Festival of Light and Drug Beat Australia as endorsing naltrexone treatment as a path to abstinence in recommending that priority be given to naltrexone (pp.159–161). Similarly, the report noted Drug Arm's objection to heroin prescription trials in opposing any such trials (pp.164–165).

The report also cited the Community Coalition for a Drug Free Society, Joe Santamaria, and Drug Arm in opposition to supervised injecting facilities in warning against the establishment of further facilities (pp.191-192). And finally, the report cited the Drug Advisory Council of Australia, the Festival of Light, The Community Coalition for a Drug Free Society, Keep our Kids Alive, the Australian Family Association, and Drug Free Australia in recommending a shift from harm minimisation to harm prevention policies (pp.292-297 & 318). Notably, this recommendation was strongly opposed by the minority Labor Party members of the Committee who argued that harm prevention was the equivalent of zero tolerance (p.319).

In contrast, surprisingly little weight was given to the views of key professional policy and practice organisations such as the Australian Drug Foundation, the Alcohol and other Drugs Council of Australia, the National Drug & Alcohol Research Centre, the Youth Substance Abuse Service, Turning Point Alcohol & Drug Centre, and the Public Health Association of Australia. This appeared to be because their harm minimisation perspectives were at odds with the Howard government's "Tough on Drugs" agenda. The report acknowledges their views, but chooses to give precedence to the contrasting and favoured opinions emanating from the prohibitionist groups. The Chair of the inquiry, Coalition backbencher Kay Hull, subsequently re-emphasized her overwhelming opposition to harm minimisation, and her preference for abstinence (Stafford 2007).

A similar biased approach influenced the recent House of Representatives inquiry into the impact of illicit drug use on families which was headed by Coalition backbencher and hardline prohibitionist, Bronwyn Bishop (Standing Committee on Family and Community Affairs 2007).

Likely Future Policy Directions

Former Prime Minister Howard personally held prohibitionist views on illicit drug use. He regarded drug use as morally unacceptable, favoured law enforcement over public and social health interventions, and prioritized abstinence rather than harm reduction. Given these personal preferences, it was hardly surprising that he promoted prohibitionist groups and individuals, and gave them significant access and influence both in relation to policy development and funding grants. This process is of some concern given the apparent reliance of such groups on moral and theological rather than evidence-based judgements.

Nonetheless, the importance of the prohibitionist groups should not be over-stated. They retain little if any influence within the major national professional policy and practice groups such as the Australian Drug Foundation, the National Drug and Alcohol Research Centre, the Australasian Professional Society on Alcohol and other Drugs, and the Alcohol and Other Drugs Council, or within most of the key state bodies such as Turning Point Alcohol and Drug Centre and the Victorian Drug and Alcohol Association that influence state government policies.

The newly elected ALP Government does not appear to favour the agenda of the prohibitionist groups. The ALP is committed to 'harm minimisation as its underpinning philosophy' including a range of harm reduction programs such as supervised injecting facilities (ALP 2007). Only time will tell whether the ALP maintains the existing tenuous compromise between harm minimisation and zero tolerance.

In the meantime, researchers have an obligation to uncover more detailed information about the prohibitionist groups. Some detailed case studies would seriously improve our understanding of their role and likely future influence in illicit drugs policy.

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Emphasising ‘the relationship self’ as a goal in casework

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Abstract

Traditional and radical authors agree that strengthening the autonomy of service users is a primary aim in casework. The current paper seeks to balance this emphasis on individual autonomy by arguing that the relational aspects of the self also require attention. This argument proceeds in three steps. Firstly, recent theoretical work will be introduced to advance the premise that the self can be understood as ‘relational’ as well as ‘autonomous’. Secondly, a summary is offered of the research which concludes that a strong social network, or in the more recently favoured terms, that ‘social connectedness’ and ‘attachment’, is protective of health and well-being. Building on these two ideas, it is then suggested that it may be important for caseworkers to promote the quality of interdependence and connectedness of those service users with whom we work, irrespective of the presenting problem and the practitioner’s preferred method and assigned practice role.

Keywords: *Interdependence; Casework Practice; the ‘Relational self’.*

Families first?

What do groups of activists, non-residential Buddhist communities and residents in established group homes share with those living in (so-called) functional or intact families? In each case an involvement within such ensembles is likely to be a source of identity, support and social location. In so far as this proposition is true, what then can be said of individuals who experience an absence of meaningful affiliation, mindful that strong affiliations can be constructed and maintained in many ways?

The common sense of our profession would suggest that such individuals are likely to lack a sense of belonging and would therefore be likely to be, in the broadest sense of the word, less healthy than those that are well bonded. We would expect this to be true, irrespective of how well resourced, how assertive, how self-determining and how personally competent these individuals might be. That is, a flinty autonomy, without the complementary quality of connectedness, does not make for well-being. This position raises an important question about the status assigned to autonomy within and beyond our profession.

Given it is identified with the qualities of self-reliance and self-determination, there is no doubt that Western culture endows the notion of autonomy with a privileged status. It follows that developing the personal autonomy of service users is an aim many caseworkers actively pursue, a response that makes good sense especially as the majority of our service users are dis-enfranchised and dis-empowered. This is a position that both traditional and critically-oriented authors would espouse (Fook 1993; Compton and Galaway 1999; Mullaly 2007).

Yet, as well as seeking to enhance the autonomy of each service user, it is possible for practitioners to place a particular emphasis on the importance of strengthening the sense of belonging and interdependence of the people with whom they work. That is, as well as seeking to strengthen the client's capacity for independence, it can be argued that the relational needs of clients – such as feeling appreciated and knowing that they are making a contribution to their local interpersonal networks, also requires active attention. Hence, it follows that acknowledging and deepening the quality of interdependence is an important professional task. Our service users, like ourselves, do not just want to 'take, to simply be in receipt of support: all of us derive a benefit from 'giving', from seeing ourselves as contributors, as this is an elemental aspect of fully human life (Greenberg et al. 1994; Goleman 2006). This paper sets out to argue that promoting this latter dimension of human health and well-being ought to be a key motif in casework, complementing the routinely assigned promotion of the individual's autonomy in terms of their rights, resources and skills.

Finding the right words

Traditionally, the term 'family' has been used in social work to signal an interest in promoting the relationship-building potential of casework practice, as in for example, the ethos of 'family-centred' practice (Scherz 1953; Hartman and Laird 1983; Carter and McGoldrick 1999). Yet, an allegiance to the term 'family' is not necessarily relationally progressive, as a valorisation of 'family' can also be employed in ways that restrict and govern relationships that condone, or even promote, patriarchy and which act to marginalize broader, more diverse forms of affiliation. Without discounting the importance of families and family-centred practice, it is therefore important to note that many important affiliations are not well-described using terms associated with 'the family'. Therefore, if the intimate and the familial are not to be conflated, a form of words is required that is inclusive of the varied connections that can occur between people. Unfortunately, we in the (so called) developed world tend to have an impoverished vocabulary for describing the complexity of relationship types, unlike, for example, Australian aboriginal societies where there is an enormously complex vocabulary for delineating varieties of relationship.

With respect to this problem the anthropologist Louis Dumont (1986: 9) concluded that: 'Western ideology grants real existence only to individuals and not to relations, to elements and not to sets of elements.' Thus, if one wishes to respect the variety of meaningful affiliation that can occur, we may struggle with unusual, even awkward terms, if the intention is to convey the diversity in the 'sets of elements' that may be encountered in the many forms of human affiliation. Yes, it may be possible to blur the issue and say, as many people do, 'she is like a sister' or 'he's (like) my brother,' and, even more problematic, to say 'we are family' when the relationship in question concerns relations between neighbours or those of the local rave club. 'Family' might not be exactly exact, but accessible alternatives are hard to find: deliberately inclusive phrases, such as 'evolving and interdependent entities of common interest' (developed from Paterson 1996) or informal groupings at the significant end of the 'hierarchies of kinship bond' continuum (Rapport and Overing 2000), may be technically superior but such awkward phrases are unlikely to be adopted. This discussion in itself, reflects the impoverishment of our current vocabulary.

What ever terms are chosen, the proposition that is being put forward is that our service users, like our own selves, benefit from being a meaningful part of something that is larger and richer than themselves and that this *tribe* or *network* or *group* is broadly perceived as an entity in relation to which the person feels a positive sense of belonging. The possibility of constructing and sustaining a positive sense of life's purpose and personal well-being, seems correlated with this experience of reciprocity and embeddedness if it is taken as a given that important connections between people are not necessarily based upon institutional, legal or conventional definitions of kinship. On the contrary, meaningful interdependencies are a matter of the phenomenological experience of an important tie or bond far more than they are dependent on established, formal categories of sociality.

To promote the possibilities of relational diversity it is essential to contest the expectation that important affiliations, meaningful social bonds, are based on 'nuclear', rather than broader, 'kith' connections. In so far as this is accepted, the practice of making a primary distinction between family studies and sociology, between the private and the public, can be contested and de-constructed. This de-construction seems all the more important as the 'me-decade' has seamlessly segued into the 'I-aeon' (Bauman 2001; Beck and Beck-Gernsheim 2002; Furlong 2006). As social workers we are aware that the dominant story in this globalised period is of hyper-individualism, with its accompanying vision of constricted and privatised families (Giddens 2002).

In this context a point of departure between high status professions, such as psychiatry and psychology, whose theories and practices tend to valorise the primacy of the individual, and social work, where our theory base and values, at least potentially, tend to emphasise the collective, is that those who identify with the latter position are able to take up the contestation of the process of individualisation that is characteristic of this neo-liberal era (Beck and Beck-Gernsheim 2002). Certainly, being able to be 'in charge' of your life, being able to 'be empowered', is valuable. Yet attributes, skills and resources that are organised to service only one's own satisfaction and stimulation lack longer term legitimation. Too much self-determination and an overarching yearning for self-actualisation, tend to lead individuals towards a sense of amorality and anomie. Against this tendency, if we are given the right invitations, people seek to make a contribution, to act in ways that enjoin them into at least minimal intimacies beyond the nuclear family and at least one set of practical and symbolic interdependencies.

Against this background the current paper seeks to strengthen social work's rationale for placing 'the social' – mindful that this is to be generally defined in terms of the local and the subjective – at the centre of our practice. This goal is far from new and can be stated in terms of social workers having an important role as 'upholders of network' (Bulmer 1987). It can also be expressed more conservatively in terms of a definition of social work as the profession that aims to improve social functioning in available, as well as constructed, social contexts (Pincus and Minahan 1973). Following Paterson (1996), this motif can be articulated in terms of the importance of clients achieving a balance between the 'autonomous' and 'relational' aspects of the self.

Given that this contribution is necessarily both brief and exploratory, what follows will be significantly rhetorical and will proceed in three parts. Firstly, a summary of recent developments in theories of the self will be introduced to advance the premise that the self can be understood as both 'relational', as well as 'autonomous'. Secondly, there will be a brief summary of the research showing that a robust network, or local social capital and social connectedness, can promote and be protective of well-being. Thirdly, it will be argued that the aim of promoting the quality of interdependence can be pursued irrespective of practice method or the role undertaken.

Relevant theory: the relational and the autonomous self

Current neo-liberal orthodoxy assumes that each person is a sovereign, free-standing unit bounded by their skin (Davidson and Rees-Mogg 1997). Laws regulate and enshrine this assumption and the popular media repeats, and therefore reinforces, this claim. In the following a brief summary of alternative, albeit subjugated, understandings of personhood is introduced. For example, many people find that an examination of their own subjectivity reveals an experience of the reality, and to some extent the primacy, of the interdependence that is present between themselves and their 'significant/others' (given this relationship could be between siblings, parents and children, or any other form of close affiliation). If this reflection is undertaken intently, it is possible to raise to awareness the unofficial, and clearly non-scientific, intuitive knowledge that the 'me' and the 'you' do have, and will continue to interpenetrate in relations between reciprocally 'significant-others'. Paradoxically, phenomenologically it seems that the 'I' and the 'us' are both inseparable, as well as distinct.

In these kinds of ways it is possible to grasp the possibility that there is likely to be a quality of recursiveness between those who are participants in profound 'significant-other' relationships. Reflecting in this manner can be associated with the recognition that a person's mood or, more radically, even their appraisal of their own life and worth, is often deeply linked to that person's perception of the health and welfare of those with whom they have a close bond and to whom they have a sense of responsibility. That many people measure themselves, at least to a large extent, with respect to how well they believe they have cared for, and been loved by, those they hold dear is an important, yet opaque insight, albeit one that has probably been better articulated in oral history, fiction and auto-biography than it has been in the scientific literature. Thus, it is not surprising that those of a positivist persuasion would see such data, given it is derived from phenomenological experience and the various arts, as a non-proof of interdependence.

Mindful of this skepticism, it may be useful at this point to at least briefly introduce some key sources that contest the assumption that the self is the free standing silo that conventional political philosophy and psychological thinking would have us believe. These alternative sources include:

- (i) *Feminist scholarship*: Beginning with the work of the Harvard Project and the Stone Center, feminist scholarship has emphasized the centrality of relationships to selfhood with respect to mother/daughter connectedness and, more broadly, to the notion of women's self-in-connection (Gilligan 1982; Jordan et al. 1991).

Since the pioneering work of these earlier theorists, different feminist authors give the relational theme different accents, at times even distinct formulations. For example, Hall (1990:13) states that 'as social beings our humanity is a product of interaction, not isolation. The one and the whole are inextricably interrelated ... [and] Interdependency is a central characteristic of human nature.'

This view contends that (what might be called) the 'social self', or the 'self-in-relation', is a universal phenomena, albeit one that may be particularly performed with respect to gender, for example, Gabriel and Gardner (1999) argue that both sexes are interdependent but that women's interdependence is expressed relationally, whereas men's tends to be demonstrated collectively. Suffice to say, the feminist critique contends that the received assumption that personal autonomy is a necessary attribute of adult maturity has been presented within feminist scholarship as a particularly significant example of how Western ideology and culture privileges 'male-stream' thinking (O'Brien 1981) and inferiorises alternative modes.

- (ii) *Systems approaches*: Although not generally identified with the theorization of identity and selfhood, systems approaches also offer a rich tradition for envisaging human entities as social beings. Rather than assuming humans are bordered by their skins, which is the received Western assumption, a systems view contends that human beings inevitably have open boundaries connecting them to, and are in dynamic co-regulating dynamics with, their human and material environments, eg. Longres (1995) argues that 'the self is a system' but is never a closed system. Morin (as quoted in DiNicola 1997:200) expresses this sentiment elegantly: 'the more a system develops its complexity, the more it can develop its autonomy and multiply its dependencies. We construct our psychological, individual and personal autonomy through the dependencies we undergo.'
- (iii) *Cross-cultural studies*: Cross-cultural and anthropological scholarship offers another set of contestations to the expectation that the self should be considered as autonomous. Rather than the expectation that humans are independent beings, an ambit of depictions of selfhood can be found in the literature associated with cross-cultural and anthropological enquiry which render humans as 'relational' or, more generally, as 'social', entities. Examples of this apparently counter-intuitive practice include material on Afro-American (Williams-Gray 2001), Arab (Al-Krenawi et al. 1994; Al-Krenawi and Graham 2000), Chinese (Marsella et al. 1985; Wu 2001), Indian (Dumont 1986), Indigenous Australian (Wingard and Lester 2001; Byrnes 2002), Japanese (Tamura and Lau 1992) as well as Mediterranean (DiNicola 1997) cultures.

That there is such a consistent imaging of the self as interdependent in non-Western cultures goes some way towards de-centering, and perhaps even critiquing, 'our' assumption that the self is free-standing. In fact, it has been suggested that the current Western practice of considering personhood as synonymous with an independent, free-standing 'sovereign self' (Davidson and Rees-Mogg 1997) represents the ascendance of a particular kind of 'indigenous psychology' (Kim 1990) to the status

of absolute prescription – what the post-colonial critique might term a ‘false universal’ (Said 2001). Several observers have gone so far as to argue that the premise that the self is a silo-like, sovereign entity is not only not axiomatic, it is historically and culturally anomalous (Heelas and Lock 1981; Rapport and Overing 2000).

The three traditions that have been introduced in the above discussion do not fully represent the wide array of sources that contest the premise that the self is properly considered an autonomous unit, e.g. those with a (broadly defined) spiritual interest might be interested in Mathew’s (1991) notion of ‘the ecological self’ or of Roszak’s (1995) elaboration of ‘trans-personal psychology.’ Yet, given the purpose here of simply outlining brief examples, I believe there is sufficient evidence that our received view of the self as necessarily autonomous might be better considered a contingent, rather than an absolute, proposition.

That is, it has not been the intention to ‘prove’ that humans are not autonomous; nor has there been an attempt to warrant an alternative position. Rather, in so far as the assumption that the self is an independent entity has been called into question, the doubt that has been raised allows the space for a critical review of particular beliefs, assumptions and expectations that underpin the primary place that has been given to ‘the individual’ in the theory and practice of the human services. If the human subject is not necessarily – or even properly – inviolate, then our definitions of personal health and pathology, expectations that are based on this cultural ‘specification of the self’ as a stand-alone entity of interest and operation (Rose 1989), are also contingent. These specifications – that the individual should be independent, self-managing, self-determining, personally ambitious, and so forth – therefore may also benefit from review. This might be especially the case given these are ‘male-stream’ (O’Brien 1981) attributes that privilege particular modes and inferiorise others, such as the socially important qualities of relationality and ethics.

Relevant research: the relationship between well-being and social networks

As social workers we can work to subvert, to creatively oppose, the cult of independence and autonomy and this brings into focus the research concerned with social networks. In what follows, findings from contemporary social research will be briefly surveyed in order to support the contention that casework can be productively aimed towards the enhancement of the practical and symbolic embeddedness, the quality of interdependence, of our service users. To achieve this it is necessary to attempt a critical appropriation from several potentially related, but practically distinct, research streams that collectively might act to suggest the practicality of caseworkers aiming to enhance belonging and connectedness.

Firstly, I will present material related to interpersonal relationships and public health research; secondly, ideas concerned with how ‘wellbeing’ and ‘quality of life’ relate to the individual’s social network will be explored; thirdly, more recent work on ‘social capital’ and ‘social attachment’ will be introduced.

Interpersonal relationships and public health research

There is a developing interest in ‘social epidemiology’ as a specifically psycho-social mode of investigation (Kawachi and Berkman 2003). In this field the interest tends to be with physical health – that ‘hard-end’ of medicine concerned with mortality and disease – and how health may be correlated with the empirical measurement of local, and often directly, relational indices of the person-in-environment, e.g. Berkman et al. 1992. In a nutshell, to use Seeman’s (2001) imagery, intimates co-regulate each others’ health – they get reciprocally ‘under each others’ skin’ to such an extent as to influence the course of each others health.

Distinct from the traditional public health interest in disease, for example in examining the scale and effectiveness of immunization or sanitation, social epidemiology attends to ‘soft’ dimensions, such as the quality of relationships in people’s intimate networks (Berkman and Glass 2000). Diverging from the traditional starting point that ‘health is the absence of disease’, which is a starting point that tends to restrict investigation to surveying for disease producing processes as they are usually understood, social epidemiological research involves undertaking comparative, longitudinal and often in-depth studies, enquiries that so far suggest that health outcomes – concerned with heart disease, stroke, cancer and many other serious conditions – are conditioned to a significant degree by local social factors. This is an allied development to the study of social capital and social network (see below). It seems that a key locus for this work is the Harvard School of Public Health, specifically through two associated groups, i.e. the Centre for Society and Health and the Department of Society, Human Development, and Health (Kawachi and Berkman 2003).

In a text that is broadly complementary to the above, Goleman’s (2006) *Social Intelligence* cites (and to a degree summarizes) a very large number of studies from an array of medico-scientific journals, with attached full citations and endnotes, that detail the many ways that the interpersonally ‘intimate’ mediates a spectrum of health outcomes. Broadly, the contention is that ‘emotional support’ has a powerful and wide ranging capacity to lower risk of problems: neurological deterioration in the aged, high blood pressure, immune system responsiveness, serum cholesterol, and so forth. Two other texts that focus on this analysis are Ryff and Singer (2001) and Uchino (2004).

Such studies indicate psycho-social health and well-being are differentially distributed according to the presence of protective and risk factors, variables that are themselves systemically mal-distributed, even in ‘Anglo’ environments. Who does not do well in terms of health? It is no surprise that the excluded do poorly, especially those that are stigmatized, discriminated and/or disadvantaged (Anderson et. al. 1997; Kreiger 2000; Berkman and Lochner 2002).

‘Wellbeing’ and ‘Quality of Life’

‘Wellbeing’ and ‘Quality of Life’ can be conceptualised in many ways. More individualistic constructions tend to be embedded in narrowly Western, male-stream premises (see, for example, Leyard 2005). Such measures tend to be defined in relation to *particularly specified intra-psychic criteria*, such as ‘happiness’, ‘mastery’, ‘self-efficacy’, ‘locus of control’, ‘confidence’ and the like, and/or in relation to

materially measurable attributes, such as physical health (mobility; ‘activities of daily living’, etc) or financial status, housing or the like. Variants, such as ‘subjective wellbeing’, generally measured by the respondent’s self-report, offer some greater scope for less Western, male-stream self appraisals if the measurement instrument employed offers invitations for responses to more global, phenomenological items (Gohm et al. 1998).

Adjacent constructs to ‘well-being’ and ‘quality of life’, such as ‘adjustment’ and ‘adaptation’, have also been developed in many ways and may offer advantages for the current exercise’s emphasis on belonging and connectedness, especially if they have a ‘family focus’ – mindful that, as argued earlier, ‘family’ can be very normatively operationalised (McCubbin 1999). Work on these related constructs overlaps with other research on ‘coping’ and ‘resiliency’ (Lararus and Folkman 1984) whether or not a relational interest is assumed. There is a substantial literature around these ideas albeit one that tends to be – as far as I am aware – to be focused on those sub-populations that have encountered a specific medical / disability circumstance, such as mental illness or acquired brain injury, or a negative life event, such as unexpected unemployment.

More distinctly relevant to the current focus, there are ‘Quality of Life’ models that directly seek to acknowledge key aspects of ‘the person-in-environment.’ A Toronto University research group have constructed a specific Quality of Life model in terms of three basic dimensions with three sub-components, ie.

- ‘Being’ (physical being / psychological being / spiritual being)
 - ‘Belonging’ (physical belonging / social belonging / community belonging), and,
 - ‘Becoming’ (practical becoming / leisure becoming / growth becoming)
- (Centre for Health Promotion 2007)

This construct appears to offer both a focus on the individual’s need for material resources as well as offering a concern for more global and relational dimensions of wellbeing, that is a consideration for items such as shelter, ‘self-efficacy’ and ‘finances’ as well as an attention to dimensions related to spirituality and interdependency. In turn, such a construction can be linked to other research schemas that directly seek to theorize and measure person-in-environment matters; while researchers such as Weston (1999) have developed this concern with their specific use of invitations to respondents to offer information on more intimate and relational self appraisals.

Put very simply, Markman and Hahlweg (1993) argue that by any measure of health and well-being, being in a relatively well-functioning intimate relationship gives individuals a better quality of life. Beginning to broaden the lens, and to de-construct the distinction between the nuclear family and the broader social realm, as noted above, there are schemas that actually ask, and privilege the responses to questionnaire items such as ‘do you have a close friend’ and ‘(have you) someone to rely on?’

Health, well-being and social network/social capital

Researchers such as Cheers (1993) and Trevillion (1999; 2004) have argued that the greater the vitality and depth of a person's network, the greater the benefit to health and well-being; similarly, the converse has been argued: the poorer the network, the worse the outcome. Moreover, in so far as there is good quality in terms of family networks, friendship networks, confidant relations, helping relations and so forth, negative outcomes are attenuated and positive outcomes promoted, i.e. a poverty of networks makes persons more likely to be susceptible to, and/or to relapse from, depression or other specific mental health. And, the richer the social network the more resistance there will be to problem formation and, if a problem does occur, the more quickly health will be re-established and/or the negative effects lessened.

These ideas are not new to social workers and, broadly stated, this line of reasoning seems to reflect what feels like professional common sense: we social workers often see the sense in seeking to strengthen intimate networks. That is, more or less intuitively, we often attempt to improve the quality of connections (Nilsson 2001), to attempt to enhance what the eco-systems theorists term 'micro-level' interactions (Gilgun 2005; Healy 2005) – even if the latter perspective, however paradoxical it might be, literally centres its analysis and formulating practices upon individuals far more than the ensembles within which persons interact. In demonstrating what might be termed a familiar *sensibility*, the recent research on networks seems remarkably consistent with what these social workers have encountered in their initial training, mindful that there have been variations in the curricula of different generations of students, i.e. the approach, even the conceptual vocabulary, of early network contributors, such as Botts (1968) and Collins and Pancoast (1976), has a marked continuity with the approach taken in, and the findings of, current research (Sousa 2005; Pinto 2006). As such, the current research seems, somehow, both familiar and satisfying.

In this apparent continuity, the sociological work of Brown and Harris (1984) has played a key role. These pioneering researchers investigated depression from a social perspective and concluded that an understanding of the origins of depression was deepened if a schema of specific 'provoking agents', as well as a set of 'vulnerability' and 'protective' factors, were hypothesized. This vocabulary still seems timely as it – more or less – mirrors the constructs of 'protective' and 'risk' factors now commonly found in the more recent research on 'social attachment' and 'social capital.' The latter work is most identified with the research of Robert Putnam (2000) who explicitly argues that individuals are distinctly more vulnerable to a range of problems in direct proportion to the extent and quality of their community bonds: the poorer the bonds, the more risk of symptoms; the richer the bonds, the less risk of symptoms. (Whilst the limits of the current enquiry preclude a proper engagement with this construct, Healy and Hampshire 2002, offer a clear review focused upon the construct's potential relevance to social work, while Hariss 2002, provides a determinedly critical perspective).

Adjacent to the research on social capital, an interest has developed around the frame of 'social attachment' (Maris 1998). The focus of this investigation has been on the effects of globalisation and it has been put forward that structural changes, for example with respect to the rupturing of continuities to employment and social

location, have resulted in dramatic discontinuities to the individuals' sense of identity and to the broader quality of social connection. This latter work is associated with Tony Blair's 'Third Way' politics and some key ideas from this approach can be seen in the Victorian government-funded *Neighbourhood Renewal* program. Like Maris, Putnam's intention was also large scale, that is to speak of 'community' in the broader sense and to suggest that citizens in the United States of America are individually less socially active than previously, which, such authors argue, has had the effect of lessening the aggregate level of social participation.

This paper seeks to be informed by the above broad-stroke analysis of theory and research, and then to appropriate this thinking into the more local, casework-related actions that can be practicable for 'this person in this potential ensemble.' In this way, the caseworker can move between the foreground of attention, which focuses upon the immediate problems and experience of the individuals we work with, and the background context, which is made up of the larger tides that condition each individual social life, such as globalisation and the prevailing ideology. In terms of smaller scale activities within the purview of casework, enhancing Putnam's 'community bonds', that is the 'interpersonal connections' and 'social connectedness' end of the social capital continuum, is therefore both theoretically apt and practically sensible.

The motif of belonging and connectedness in casework practice

Casework is, of course, difficult to define as it is not just about who a social worker sees, or is in indirect contact with, but is also about how one goes about one's business: by the particular politics – the values and principles – that animate the work; by the aesthetics of how the work is done, as much or more as how one formally conceptualizes the task. For example, what distinguishes casework from bourgeois counseling is arguably that the former seeks to be ideologically and practically contesting whilst the latter espouses an allegiance to technical and political neutrality (Furlong 2000). An example of how a practitioner might be practically animated by the value s/he might give to connectedness and belonging may help.

Case vignette

A 13 year old girl, someone we might call Beth, was an in-patient in a children's hospital where she was expected to remain for the course of her illness, expected to be fatal. Some months after her admission a social worker telephoned Beth's mother Freda to ask for her view on the ward staff's plan for Beth to be given a haircut. The staff, who were doing everything they could to care for Beth, had (benevolently; comprehensively) taken over day-to-day decisions about Beth's care and had – prior to the social worker intervening – simply arranged for Beth to be taken to the hospital's hairdresser. In response to the telephone call, Beth's mother apparently said 'yes, that's fine.'

Some months later, after Beth had died, the social worker was surprised to have the parents make a point of saying to her that her call had prompted the parents to consider, and later to re-claim subjectively, their sense of their role as parents. The simple act of telephoning had been crucial as it had reminded them they had not – as one shift does to the next – 'handed over' their daughter to the hospital. Over some time, their re-appraisal led to the parents being emboldened to regard themselves as central, rather than peripheral, to their daughter.

What values and principles had animated the social worker's call to the mother? On the one hand, the worker (presumably) sought to be an advocate for her immediate client; yet, utilizing the possibilities that are inherent in an allegiance to multi-partial alliances, the social worker looked towards the relational gestalt within which her client resided symbolically as well as physically. Consistent with this latter impulse, a simple, yet powerful act was envisaged, one that had the power to prompt the potentially, yet opaque, possibilities of connectedness. The call to Beth's mother was created by a social worker's prescience and creativity and, in one important sense, actuated the space within which parents and daughter might relate more directly and with more immediacy than was set-up by the hospital's inadvertent and benevolent 'take over.' Promoting connectedness is about having a vision, a sensibility that looks forward as much as it looks at what is before us now.

So, how might one put this vision, this motif, into action? One beginning point is to ask 'interventive questions' (Tomm 1988) that act to frame positive relational futures: 'who would you like to get on better with?'; 'what might you do to feel like you are valued by (your neighbour?; your workmates; your sister; etc)?' The list of possible ways of acknowledging relationally enriching actions is vast *if* one is not constrained by conventional expectations of affiliation. Questions can be asked of the service user that elicit unconventional ties both in the present and also into a hypothetical future.

A particular constraint is that the service user's construction of 'the way it is' often limits the caseworker's imagination of the options for change: 'My dad is a bastard, he never listens.' A worker hearing a young person say this should not rush to a premature moving on; the feelings need to be acknowledged and held and, perhaps, at a later point it will be useful to say: 'would you like it to be different?; how might you like it to be?' White's (1992) notion of 'recruiting an audience' can be useful in some situations: 'Who would you like to notice that you are achieving and contributing?' One can use one's imagination broadly if the intention is to enact that which acts to further relational richness. A further constraint to our imaginative potential is the 'Western' notion of confidentiality. Clearly, a balance needs to be struck between the often competing imperatives to privacy and connection (Furlong and Leggatt 1996) but some recent material has put forward progressive, culturally sensitive options (Owusu-Bempah 1999). The Family Group Conferencing movement offers another relationally-oriented set of options (Griffiths 2001), as does the 'audiencing' approach taken with narrative-style group work with violent men (White 1992).

Decisions about providing creative responses rest on the capacity of the social worker to have an advanced degree of discretion. We are required to be reflective, advanced conceptually and practically, and flexible in being able to move between foreground (the clients' experience) and background (the different levels of social context). To do this with an eye to promoting belonging and connectedness, as the vignette above suggests, can be as powerful as it is needs to be imaginative.

Conclusion

A colleague undertook a small-scale review of the work of social workers in a large children's hospital and was not surprised to find that a large proportion of his colleagues' work was concerned with the patients' 'significant-others', and their

relationships, rather than was primarily focused on the designated patient. He thought: 'This makes sense as this is a children's hospital and we should expect that families are central to the work of paediatric social workers'. What did surprise him was that a parallel review of the work undertaken in a similar sized general hospital for adults reached similar conclusions about the profile of the work undertaken by that hospital's social work staff (Nilsson 2001). We social workers *tend* to be interested in relationship and network, but our practice always has multiple imperatives.

We have to identify, and then make choices, in relation to many possible potential goals. Depending on the opportunities and constraints of our particular agency roles, and in relation to our preferred ideology and practice model, we may seek to further the interests of our client, or client group, by:

- seeking to resolve (more or less narrow definitions of) the presenting problem,
- working at the policy / practice interface,
- promoting rights and social justice,
- generating new and enabling narratives, and
- working to appreciate and deepen client strengths.

Yet, however one proceeds it may also be possible to do so in such ways as to promote the prospects for the quality and range of relationships within which a client, or client group, participates.

An interest in promoting belonging and positive connectedness provides something of a motif, an ethic, a rationale, that might be seen to unite the apparently centrifugal aspirations of the 'identities' community work, group work and casework, aspirations that feel so antagonistic as to vex the prospects for the project of social work. For example, concurrent with the overt goals of the practitioner – for example for the caseworker to resolve the client's, and/or the agency's, definition of the client's problem – the goal of enhancing belonging and positive participation provides one overarching aspiration that *both* distinguishes social work from other disciplines *and* unites the different methods of the profession. Although the emphasis varies between authors and traditions, a central theme to all is the premise that casework theory is based on a psycho-social understanding of the relationship between private troubles and public issues, of the necessary linkages between the subjective and the structural. Given this allegiance, is it not sensible to oppose – at every level – the atomization that is one of the key effects of our current techno-consumer culture, a milieu that is increasingly characterized by an accelerating process of individualization? (Bauman 2001; Beck and Beck-Gernsheim 2002).

Finally, to contest the assumption of the sovereign self is not to deify its antithesis, that is to fall into some kind of romantic infatuation with the 'relational self' or some brand of rampant other-orientedness. A hegemonic idealizing of the relational self tends to result in high degrees of individual non-freedom as is clear from the repressive possibilities found in closed, overly regulated groups (Manne, 1998; Rose 1998). Nonetheless, actively working towards a balance between self and other seems both more ethical, as well as more ecologically sustainable, than promoting aggressive, albeit often disavowed, battling between rival robber barons as is the market place model of human relations. This purpose can provide a meaningful

chance to practice from a stance that is politically informed by feminist, ecological and cross-culturally sensitive values. And, if this position goes against the current tide, it is with good reason.

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Public services as indispensable stepping stones to migrant women's self determination

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Abstract

This paper argues that publicly funded infrastructure, or the welfare state, were indispensable in enabling a group of migrant women to exercise energetic self determination during resettlement in Melbourne between the mid 1970s to late 1990s. Even though the group of participants in my doctoral study were extraordinarily resilient, and mostly educated women, they needed the service system developed within the bi-partisan supported policy of multiculturalism which granted access to newcomers on the basis of citizenship rights. The paper unpacks the sufferings of migrants who come from communally based societies, lose their former worlds and meaningful place in society and encounter negative representations fuelled by ignorance in the Australian context. I then present the women's detailed evidence about how the network of publicly funded services, as they existed up to the end of the 1990s in Victoria, enabled them to not only recapture their former energies, but also had life affirming reverberations for their families and the community. In contradiction to recent divisive, neo-liberal public discourses (Edgar 2001; Mendes 2003), the welfare state and the policies of multiculturalism and related programs enabled engaged citizenship and the building of vibrant and diverse civil society. Rather than being a drain on the public purse, modest government investments into programs enabled the nation to benefit from the women's enormous industriousness. After some brief contextual information, I will present vignettes from their narratives about connecting with a variety of services. The tragically amusing dialogue with an isolated woman's experience of poor medical practice will provide a counter balance to the discussion.

Keywords: *Welfare state; Public and community services; Multicultural services; Self determination; Women's agency; Migrant women; Diversity*

Introduction

This paper argues that publicly funded infrastructure, or the welfare state, were indispensable in enabling a group of migrant women to exercise energetic self determination during resettlement in Melbourne. The policy of multiculturalism became devalued in the legitimisation of overt expressions of racism dating from the election of the Howard Government and its tacit support for Pauline Hanson's analysis of the ills of our society (MacCallum 2002). Within the umbrella of multiculturalism, migrants could access a complex variety of supports on the basis of citizenship rights, hence on a non-stigmatised basis. I will present evidence from my PhD study in the form of vignettes from the women's narratives, where they revealed details about the role of such services. The welfare state was legitimised after 150 years of human rights abuses in laissez-faire capitalist economies and through calamities such as the Great Depression and the two World Wars (Beveridge 1944;

Chiefly 1944; Castles 1985; Mc Mahon et al 2000). The Australian model of embracing cultural diversity by dedicating resources to programs supporting migrant resettlement was seen as investing in the nation's multi-dimensional wealth, and was backed by voluminous research (Castles et al 1990; Cope 1992). This legacy has been subject to repeated strokes of national amnesia in Australia and today, public discourses are largely couched within the mantra of 'welfare dependency', with a corresponding re-framing of multiculturalism as detracting from a pure Australian identity (MacCallum 2002). My PhD study corroborates that the combination of federal, state and local government policies and funded programs built systematically on the evidence of need, provided a web of supports which women could access for a period, deriving unexpected benefits with long term, life affirming impacts for all involved. Note that from the end of World War II until today, Australian infrastructure has been funded in terms which are niggardly in comparison with investments by comparable nation states (Esping-Andersen 2002; Castles 2004). The majority of the women were from the upper levels of their societies, with their level of privilege corresponding to similar echelons in Australia. I found that even such women needed the welfare state's stepping stones. The lack of services, or adverse contacts, lead frightened newcomers to retreat to the privacy of their homes, locking them for years in pointless treadmills, an experience illustrated by the last vignette of the paper.

Over my personal and professional life, I had witnessed at close range the ingenuity and creative energies with which migrant women re-created life for themselves and their families. Through networks, I gained access to a group of women from five world regions, namely: Vietnam, the Philippines, the former Soviet Union, the Horn of Africa and Lebanon. I ensured that a variety of ages, education and class backgrounds were represented amongst the six women from each region. Clearly, my sample is not representative, not least because I spoke to women who were known to a welfare worker from their community and with whom they had maintained a positive relationship. The women arrived in Australia after the policy of multiculturalism had been adopted and a sound welfare service infrastructure was in place. The earliest arrivals were some of the Lebanese who came either to find a more prosperous life, or were brought back as spouses to Australian Lebanese men. Most of the Vietnamese women escaped the new Communist regime and were the first boat people, who were promptly processed and released into the community. Filipinas were mostly tertiary educated and came for a range of reasons, including escaping jailing as political dissidents during the dictatorship of Marcos, and coming as married couples to build a life free from the spectre of absolute poverty, two of the women had married Australian men. All the Russians arrived as families after the collapse of the Soviet Union and were highly qualified. The African women, three Eritreans, one Ethiopian and one South Sudanese came from the elite ranks of their societies, except for a South Sudanese grandmother who had no formal education. Almost all of this group came from family and community backgrounds of great symbolic, cultural and social capital, even if some had little formal education, and more than half the group had enjoyed material wealth. They showed strong resilience as defined by overcoming extreme adversity (Deveson 2003; Nguyen 2005).

The theoretical underpinning of my exploration of migrant women's capacity to act, or agency, came from feminist, cross cultural and social theory (Schutz 1972;

Bourdieu 1977; Giddens 1984, 1991; Spivak 1987; Kandiyoti 1999; hooks 2000). Broadly understood, theory on agency refers to people's socialisation into personhood through the daily affirmations of members of one's lifeworld, on the basis of knowledge and wisdom emanating from living on a parcel of land throughout history. Hence there are diverse, continually contested and shifting meanings attached to gender, what is worth pursuing in life and how time ought to be spent. Hartley (1995) documents the variety of meanings imbued into the words, 'neighbour', 'husband', 'love', 'family' and 'relationships' prevalent in diverse, non-English speaking cultures of Australia.

The challenges of migration

In order to understand how services might be useful or not, I present an overview of the women's stories about the constitution of their suffering during resettlement. They all came from communally based societies and for them normal life signifies daily contact with many people, usually on a continual basis. This section outlines the chief seven problematics of migration.

Being in foreign spaces

Even for the 'most' European group, the Russians, daily routines occur in group activities in highly structured spaces. Individualism was not a central value and traditional hierarchical relationships of respect prevailed. They all came from spaces teeming with people, whether the cities of the Former Soviet Union, of Asia and Africa. A primary orientation to family life was distinct from the Australian or modernist notion of the family of origin as a launching pad into the wider world of careers and public life (Goodnow & Cashmore 1985:235). Emerging literature on social geography (Hillier and Rooksby 2002; Mels 2004), provide useful theoretical explorations of diasporic existence and agency, such as questions of belonging, home, strangeness and strategies for self expression and survival. For the women, the empty spaces of urban Australia intensify the *stranger* experience (Schutz 1972), as much tacit knowledge about personhood and life meets with jarringly dissonant responses. Nevertheless, the new spaces were blissfully *safe* for the refugees and the material affluence was enjoyable, at least during the honeymoon period.

Loss of home

Some women continued to grieve at losing their homelands (Bao and Cahill 2001:737; Nguyen 2005):

[long silence as Anastasia fight back tears, then with a singsong tone]

We had a good life, you could go to the museum, to children's plays, there were lots of interesting things going on all the time you could go to with your children and here everything is so expensive. The schooling system was better because it was from 8.00 to 1.00 and it gave kids the time to play, do their homework and then go to hobbies, like music and dancing, available very cheap in walking distance.

Loss of familiar ways of being

Migrants do not know of the articles of faith, the myths, the histories and a-priori assumptions that define a lifestyle as self-evident truths and that hold: 'the

rationalisations and institutionalisations of the world together, other gods reveal codes of morality, of the good life, of the sacred, other propositions of the right and of nature' (Schutz 1970:85). A culture's schemata of interpreting the world coincides with prescriptions of how people connect with each other (Sloan 1996). For all of the countries in the study neighbours were included in daily life rituals of affection and care extended to kin.

Struggles in the public sphere: blocks to resumption of former occupations

Eritrean Zeinab cried for three months, angry that eminent Eritreans have to do 'rubbish jobs'. A Vietnamese dentist who provided the resources for all the members of her extended family to escape by boat over a fifteen year period, while occupying a senior post in a hospital, operating a private practice at home, treating the poor gratis and using her international networks to procure medical supplies:

I see my family, but what about my job, what about my life? also English [...] here very terrible, nobody can understand my English.

The men's experiences

Parents feel ashamed as they experience role reversal when having to resort to the assistance of their children who adapt more quickly (Deen 1995: 23). A particular dilemma for migrant men who are also deprived of the community life which operated as a mediating layer for the resolution of life and relationship issues. Now located in individualised spaces, their frustrations are usually expressed at home.

Immobilisation

The compounding effect of language, lack of money and transport create an immobilisation which, in itself, was named as the most debilitating aspect of the women's sense of dignity as competent agents. All the women in the study reported a period of up to two years of depression, which became prolonged clinical illness for a minority.

Loss of identity and negative representations

The frequency with which interpersonal encounters now include negative representations of their identity and culture is a chief problematic of settlement for many. Australian multiculturalism research documented the shallowness of tolerance' as indicated by the absence of immigrants in decision making positions and the mono-cultural basis of the Australian Constitution, political and legal institutions (Kalantzis 1989; Castles et al 1990; Vasta 1993; Castles 1995). Groups of migrants take turns at being targets in what Povinelli (2002) conceptualises as abhorrent alterity. The research interviews reported here occurred prior to the 'war on terror', a time when the 2005 Cronulla race riots were inconceivable in Australia (HREOC 2003; Poynting 2004). Teresa, who came from a famous upper class family of political dissidents during the Marcos regime says that she was treated in a much nicer way in the Philippines, where she would be often greeted in the street by former students including Senators, professors and company directors. Suddenly in Australia she was confronted by the thought that she might not be the person she – and others – thought she was. She illustrated her resistance to attempts at reconstituting her identity by describing her struggle with hospital nurses who tried to prevent her taking her new born baby to bed:

So I told them that I always had my 4 other children in bed, one until he was 10, and all of them are quite alive...

Challenges of migration

Mouffe theorises the incommensurability of cultural diversity by pointing out that social processes and institutions governing societies are constituted not only by specific forms of identity and values, but are also the expression of sedimentations of judgements about the forms of life a society has accepted over time (Mouffe 2002: 94). Quoting Wittgenstein, who first showed that there is no objective truth outside of language: 'So you are saying that human agreement decides what is true and what is false. It is what human beings say that is true or false; and they agree in the language they use. That is not agreement in opinions but in forms of life' (Wittgenstein 1958: 242 in Mouffe 2002: 96).

Most of the women went through a year or two of depression after arrival but five became clinically ill through a combination of being deprived of their previous sources of sustenance, experiencing personal tragedies and being forced into situations which were inherently debilitating, such as abusive marriages. For all of them, isolation was the common breeding ground for despair and psychiatric illness. Mouffe's (2002: 97) analysis of nihilism could apply to clinical depression:

It indicates a failure of meaning that draws into question the very possibility of a goal-directed, meaningful action. Individuals become nihilistic when they are unable to constitute their social relations and identity in order to form a will to act

The interpretive practices Mouffe (2002) refers to as important in the will to act depended on the African, Filipino, Russian, Lebanese and, to a lesser extent, Vietnamese women's groundings in a dense web of daily and affirming intimacies in a community context.

Facilitating processes: Australian publicly funded infrastructure

In the light of the difficulties of migration, the move to Australia could have been felt by the women and their families to have been an unmitigated error. The women's stories do provide evidence of the indispensability of public infrastructure in enabling them to recapture the life energies which had been eroded or buried by a variety of global, national and personal disasters. These stepping stones were characterised by their availability on a non-stigmatised basis, as part of Australian social citizenship rights granted to all newcomers as part of the overarching paradigm of the policy of multiculturalism (Turner 1993: 1–18; Salvaris 1995).

The provision of income benefits to migrants prior to the introduction of the two-year waiting time for those who are not refugees or humanitarian entrants, was named by the women as the primary facilitator of a civilised life, preventing breakdown (Australian Parliament 1998). Instead of encouraging dependency, government income benefits enabled them to work at a furious pace, as expressed by Karina:

K: Without income support we wouldn't have survived. Well, it was very hard because there was not one free minute. I learnt English till 2.00 in the morning; Sergei was 10 and went to school. My daughter spoke English already.

O: It must have been lonely.

K: Did not have time to feel lonely. We immediately started working.

The benefits of the free 510 hours of English Australian Migrant Education Program (AMEP) included having feelings of vulnerability validated and normalised by committed teachers and fellow students. This initial free service gave women an experience of the alien life-world as a benevolent one, countering fearful or distorted assumptions and interpretations, encouraging more forays into the wider community. Students were usually surprised at the generosity of the teachers and allied staff and volunteers who at times crossed professional boundaries and became family friends. The classes were sites for entry into Melbourne civil society, as friendships ensued not only within, but also across ethnicities.

The public health system was critical also in preventing personality and family disintegration. An Eritrean woman who had lived all of her life in precarious locations in African nations, gave birth to a sixteen week premature baby, weighing four hundred grams. The baby's amazing growth into a four kilogram baby six months after the interview was seen and felt by Naima as an affirmation by Allah of the transcendent value of her life of suffering, integrity, faith and love for humanity. Were such universal hospital services only available on a user-pays basis, the birth and death of a pre-mature child would have cast a negative pall over the entire extended family, with disastrous impact on her aplomb and self-determination. Instead, this crisis led to joy and a strengthening of this young woman's lifelong dedication to community service. Similarly, Teresa's previously privileged family was enabled to survive psychologically and emotionally due to Victoria's free educational services for her hearing impaired son, the universal public health and Transport Accident Commission resources when another son acquired permanent brain injury in a car accident and during her husband's two strokes. She marvels at the civility underpinning such government and taxpayer-funded infrastructure, which she names as the foundation for her sense of belonging and loyalty to Australia.

Accessible tertiary educational institutions, such as TAFE and, less frequently, university, were powerful sources of affirmation. Study opened doors to economic independence and meaningful participation in society. Most of the latest waves of arrivals, namely the Africans and Russians, were able to enrol in tertiary education. Only Larissa, as the spouse of an eminent scientist, did not qualify for access to any citizenship based resources. According to conditions for entry to Australia through a visa for eminent professionals, (assumed to be affluent), services were only available on a full fee basis and hence she was unable to reach first base by learning English. A fiercely intelligent musician, she remained alienated from the broader society, in contrast to the other women in the study. The low cost, geographical availability and broad range of vocational offerings at Victoria's system of technical colleges (TAFE) enabled career changes for those who were blocked by the discriminatory practices of professional bodies. This signalled the resumption of dignity in line with familial

cultural capital and also enabled families' active citizenship, in various spheres enriching Melbourne's social fabric. Affordability, again did not encourage complacency as the women worked at a furious pace, atypical of many Australian born students in my personal experience

Government policies

Federal government immigration policies prior to the significant retreat during 1996–1997 from bi-partisan support of multiculturalism directly impacted on the life chances of families. A Vietnamese grandmother:

When I came here, I had no way to make a living and when I came here, the Australian government and people were very good to me and even supported me with my necessities, so I felt I was in heaven... the government here respects human rights and is very caring.

Australia's vibrant Vietnamese business and cultural precincts were built centrally on policies of the eighties and nineties of accepting boat people and offering them a modicum of initial support, in contrast to the disaster of forcible detention awaiting today's boat people. This point illustrates that personal resilience needs to be complemented by structural and collective supports, lest the former be overwhelmed by life's contingencies (Deveson 2003). The African, Lebanese, and Vietnamese women's basic sense of wellbeing correlated strongly with past Federal liberal family reunion policy, unlike the Russians who, unable to sponsor other family members, live with a sense of hollowness and expressed the least sense of belonging and identification with Australia.

Intersecting supports

The existence of a diversity of services at multiple sites at grass roots neighbourhood, local government and regional levels operated as a web of synchronous stepping stones, which women could use according to need and at times for benefits which were not part of formal organisational goals. An ethno-specific Lebanese community development worker ran women's groups at the local neighbourhood house, facilitating the reversal of many oppressive domestic situations, with mothers' increased resilience resonating in their children's development. I heard similar narratives about the effectiveness of Maternal and Child Health nurses, local government employees, social workers, and other community services staff whose efforts are not often publicly endorsed. Their skill level was crucial and represented for Linda the beginning of a sense of belonging as an Australian Filipina:

[E]specially that I probably had and subconsciously have this feeling that you know, I'm not an Asian, I'm a Filipino, this person is a professional Australian, fair-headed person, and they really treat me ... they treat me like a person, and I like it. I like it. They don't care whether ... they don't care what my race is, and they were so genuinely interested about my life and genuinely enjoyed helping me.

All the African and Vietnamese women relied for some time on public housing. The much maligned high-rise estates are the fulcrum of lively, supportive communities for these refugees, in spite of the dysfunctional effects of some other tenants' substance abuse and criminality and, indeed, the often poor amenities available in those estates.

It is worth noting also that almost all the women in the study relied upon ethno-specific services of various kinds, including the wealthiest English speakers. Only Larissa, whose ineligibility for services as the spouse of the eminent academic, is absent from this list. It was noted above that her state of mind remained very alienated. My argument is illustrated particularly saliently through the story of another participant, Esther's. The life-giving reverberations of South Sudanese Esther's growth are of inestimable social, cultural and economic value with likely positive implications for the next few generations. South Sudanese refugee children and young people who have never been to a school at all exhibit unruly behaviours viewed with alarm by teachers and professionals eager to apply clinical labels of dysfunction (Centre for Multicultural Youth Issues 2003). The liaison and community education roles of ethno-specific professionals like Esther are a most effective method for enabling the integration of communities and avoiding such stark problems as the predominance of some groups of youth of culturally and linguistically diverse (CALD) backgrounds in the correctional system. Government investment into the one place Esther occupied in the Australian Migrant English Program (AMEP) free 510 hours of tuition to almost all categories of migrants, has translated into a positive cost-benefit ratio far beyond the norms of accounting.

Australian citizens

In contrast to the deference developed by most migrant women through prolonged experiences of marginalisation, the politically active and educated Horn of Africa women were able to resume their normal means of self expression as intellectual and moral leaders. All of the women who, at the time of interviews, enacted their citizenship by transforming negative Australian cultural spaces by befriending their detractors and in the process decreasing racist assumptions, educating had participated in the affordable university or TAFE systems. In contrast, the geographically isolated, equally educated and politically committed Teresa, spent many years in depression prior to finding fellow Filipina activists. She named her involvement in this advocacy group as her chief source of fulfilment, despite ongoing family tragedies. She now plays a key role in the local public school and other neighbourhood activities.

Women used a number of ingenious strategies for dealing with workplace discrimination and in the process contribute to building trust and civility at the community level. Linda, an ebullient and loving extrovert in the Philippines, suffered a precipitous decline into clinical depression due to profound emotional deprivation in the isolation of her husband's home in Melbourne's suburban expanses. Having benefited from years of free local government health and family counselling support (prior to the tendering out of such services on a commercial basis by the Kennett government), Linda initiated her re-entry into the labour market by finding now defunct employment training programs: 'they held my hand as long as I needed it'. In her first job in a large corporation she was subject to racist taunts and bullying, with remarks about table-top dancing. Linda rationalised that people are victims of media distortions and as the only Asian person in a large workforce, she needed to take responsibility for the process of breaking down stereotypes. She implemented a range of strategies including not keeping grudges and projecting a persona of integrity, even in the face of unjust treatment. When her co-workers accidentally read her Curriculum Vitae, which identified her journalism university studies and roles, they realised their error and she ended up having 'a really good time there'.

Linda recuperated her former competence as an agent, but with greatly enriched skills in dealing with people and a deepened generosity which was already outstanding according to Filipino standards. She exemplifies, as do most of the other women in the study, the creation of life from the Third Spaces according to trans-national feminists (Narayan and Harding 2004) and the transcending of Western binaries such as us-them, black-white, East-West, (Minh-ha 1989; Plumwood 2002). Linda expresses awareness of the self-reinforcing dynamism of racism and of relationship-building by saying that she has a more positive identity than most Filipinas who expect to be treated badly. She urges other Filipinas to open up to Australians. Many of the women who felt positively settled were drawing on their cultural backgrounds to build community capacity, a new goal for Australian governments, but a way of being for people from the world regions represented in the study.

Impact of poor or non-existent professionals services

The absence of useful or quality supports left some women in pointless treadmills or actually blocked the attainment of what they needed; a lack of skills amongst professionals to address the barriers faced by migrants was the key factor. Mifsud came from a nominal Muslim family leading a modern European lifestyle. When her husband and parents died suddenly, she needed to join her only sibling in Melbourne and then to marry precipitously to remain. Isolated and not knowing English, her strict, older, religious husband restricted every aspect of her life, contributing to psychiatric illness. She described her hospitalisation during an acute episode:

O: Did they understand that the way he was treating you was making you sick?

M: 100%.

O: But they didn't talk to him?

M: I did not explain much because it is my personal life. You look bad if something is not going well in your life, it makes you look bad.

O: Did they connect you to the Lebanese community or anything?

M: The interpreter told me about services but I didn't go because I could not go, I was too sick.

O: So what did you do during the day? Did you listen to Lebanese radio?

M: 24 hours.

O: Is it important to you?

M: I feel like I'm in Lebanon.

O: How would it be without radio?

M: I feel happy when I listen.

O: Did you have any contact with the Australian world, anybody, shops?

M: No, only Arabic people because I could not speak English.

O: Did you see anybody else apart from your husband?

M: My sister came for half an hour, that's it. My girlfriend came too. Later I saw a psychiatrist.

O: Did the specialist help you?

M: My husband went with me and he told him everything. I don't know what he said.

O: Was there any interpreter?

M: My husband was interpreting.

O & Interpreter: Shocking, shocking! [We all laughed]

M: The specialist told my husband that I was physically OK, it's just my mind.

O & Interpreter: Shocking, shocking! [More laughter]

She started going to an Arabic doctor by herself and said that she would go and cry, cry, cry. The doctor would check her and say 'There is nothing wrong with you'; but she would go again and cry, so he asked her, 'Why are you upset?'

O: Didn't you tell him why you were upset?

M: I told him, but he knows my husband, so he told me I need a holiday.

[we all broke up laughing here] I went back home and told my husband, I need a holiday. So my husband said, don't go back to this doctor if he tells you that. [we kept on laughing. She offered us coffee.]

O: So eventually you got better?

M: This doctor is mad, [more jokes about holidays] ... I kept going to him. I had my holidays two and a half years ago. Syria, Lebanon, I came back feeling much better. [Laughter]

O: But until then, after being in hospital, how long before you felt OK?

M: My husband stayed with me away from his work for 5 months. For about 2 years, on and off I felt better and worse.

O: Doctor gave you medicine?

M: Yes. They made me feel better but I could not feed my son... The doctor told me double the dose, and it didn't make me feel better, just sleepy. The child came in 1994, he is 5 now. My life was different because I had to look after the baby.

O: Did you know what to do?

M: I knew how to look after a baby. He is all I have, so I was happy to look after him. I was very unwell physically and mentally after the baby. After he was 2 yrs and 7 months and I went to Lebanon, only then did I feel better.

O: Do you think you had Post Natal Depression?

M: I told the specialist and he agreed I was depressed. He said he could not treat me for depression, I would have to look after myself he was an Australian specialist.

O: With an interpreter?

M: My husband was the interpreter [we laughed with dismay]

O: So what kept you going during those two years?

M: I felt I was defeated, that I was not strong any more after the birth.

O: So how did you cope?

M: I just stayed at home, would go up Sydney Road for a walk, Kmart and Coles. I had one girlfriend only. Now I have a lot, my life is different and I am happy. I went to Lebanon, still on my tablets. Every time I didn't take a tablet, I thought something terrible might happen to me. I was happy in Lebanon, I bought a car, I had my baby, stayed with my brother and then my sister in Syria.

O: So all of the sudden you felt well, did you, without your husband you felt great?' [We laughed]

Mifsud's account suggests the consequences of not using professional interpreters and the paucity of professional skills in treating her in isolation from her living conditions. Mary was a Filipino nurse, with full English fluency. The privatised JobNetwork system had pleasant staff but kept referring her to factory positions because 'she had no local experience'. The evidence suggests a very minimalist level of service, with no information about the available bridging courses for overseas nurses, no effort in investigating options for a nurse with full English fluency, no advice about other study options nor about interview techniques with Australian employers who expect assertive self promotion, compared to the self-effacing norm of civilised Asian people. She saw an advertisement for a course in Aged Care Support at the local TAFE by accident and was then able to change careers.

Conclusion

The women's narratives provide insights about the human condition, that is, the centrality of connectedness and a meaningful sense of one's place in the world beyond the home. Even this group of unusually resilient women from privileged backgrounds would not have been able to surmount adversity and begin to participate as citizens without the public services of Australia's welfare state, however rudimentary some of them were. Sponsorship arrangements, more often than not break down because of sponsors' own material and social fragility. Few established families would be able to endure another family co-habiting with them for two years, nor could they afford to fully support them financially. In the present study, the women who were most vulnerable to domestic violence were primarily isolated due to their total dependence on their sponsors, the perpetrators. When they did connect with basic information about supports, they were able to escape their abusive conditions. Sponsorship arrangements are the most prevalent conditions for immigration now.

Welfare states operate to artificially recreate certain functions provided by natural social embeddedness that have been disrupted by the requirements of industrialisation and, more recently, of a consumerist society where needs are manufactured by capital. I noted in the women's accounts the exponentially beneficial relationship between the very modest investments of public funds into services, such as neighbourhood houses, English classes, a community worker, a playgroup and local employment program, and the quantum leap the women were able to make in rebuilding their lives. Such enormous strides usually depended on the medium of a positive connection with another human being, whether a professional or a friend or neighbour. A lack of skills or negligence on the part of professionals had, some times, disastrous impacts on women's lives and their families, over protracted periods of time. Rather than being divisive, the policies and programs valorising multiculturalism facilitated the release of great human capital and the building of a vibrant civil society based on trust and appreciation of diversity in daily life (Parekh 2000). One can reasonably question whether the serendipitous role played by the welfare state may not also be equally applicable and necessary to facilitate the self determination of Australian born people.

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Raising an umbrella organization?: Countering government and industry neglect of professionals

IAN MURRAY

An earlier version of this paper was presented at the “United We Stand” Conference, sponsored jointly by the Australian Association of Social Workers (AASW), the Australian Institute of Welfare and Community Workers (AIWCW), the Australian Association for Social Work and Welfare Education (AASWWE), and the Society for Professional Social Workers (SPSW), held at Fremantle, WA 19–21 Nov. 2006.

Abstract

As professional bodies representing workers and educators in the field of social and community services, we need to stand united against a tendency to ignore or dismiss us by some representatives of government and industry. The Productivity Commission report on the research into Australia's Health Workforce emphasised the increasing blurring of roles, but ignored the great overlap between health and community services work in its proposal for over-arching health accreditation and regulation boards. In this paper Negative Licensing is suggested as an alternative to additional regulation of professions. A broad concept of ‘professional’ is used as a basis for a proposed umbrella network involving the whole community services sector. This could counter neglect by government bodies and provide a focus for resources, identity and organisation within the sector.

Introduction

By way of introduction, I want to start with a mention of ‘professional identity’. There may be some who question the label “professionals” as applying to the range of workers represented at this conference. Without going into the long-lasting confusion about what is a professional, nor the now surely exhausted debate about the formal professional status of social work, I am referring for convenience to an early analysis of the “human services profession” in the USA, which is roughly equivalent to “professional welfare work” in Australia. According to a well respected human services textbook written by Woodside & McClam (1990: 179), professionals have:

1. A high degree of generalised systematic training in the knowledge, skills and values of the profession;
2. a primary orientation to a focus upon clients and their needs;
3. self-control and regulation by a personal and professional code of ethics; and
4. recognition by the community and bureaucracies; which reward work achievement and foster feelings of professional accomplishment.

There is now acknowledgement that great overlaps in the duties performed by the various professions occur in practice. What seems to be retained is an emphasis on a

body of generalised knowledge which is not necessarily exclusive to one profession, together with a client-centred and ethically guided focus. This has been applied to workers with relatively minimal formal qualifications such as a two year diploma. Human services workers in the USA with these qualifications recognise themselves as at least “beginning professionals”, and the term “para-professionals” has generally been discarded within this profession, although it still has common usage outside it (Schmolling, Youkeles & Burger 1997; Mehr 1998; Roth & Fonargy 2005).

There is external support for applying the term “professional” to two year programs in Australia. The Victorian Office of Youth Affairs (1995) determined that:

While in the past the term "professional" in particular contexts has been reserved for people having at least a three-year tertiary-level qualification (with two year course characterised as "para-professional"), we believe that a well designed high-quality two-year program can equip its graduates to perform competently and to professional standards. (Office of Youth Affairs 1995:28).

This kind of generic professional experience can be transferable to some extent, whatever the separate theory, skills and techniques which might attach to an identified (and perhaps even regulated) profession. If a worker takes the wishes and needs of the clientele seriously, and practices with reference to ethical standards, with honesty and integrity, then this can count as valid and relevant ‘professional’ experience, even if the work has used techniques identified with quite separate disciplines such as physiotherapy, teaching, nursing or journalism.

The fourth characteristic listed above by Woodside & McClam (1990) characterises ‘professional identity’, and, as it seems to be under increasing threat, provides a focus for this paper. It is apparent that government policy and its bureaucracies, including sponsored enquiries and the proposed overarching regulatory structures resulting from them, all deny proper recognition, and withhold a sense of professional accomplishment from the professional worker, more especially those within the community services field.

Semi-government bodies, such as the Community Services and Health Industry Skills Council (CSHISC), seem well aware of the neglect of community services among wider enquiries, and it presented trenchant criticism of this in its submission to the Productivity Commission project on the health workforce. But these, like the similar protests within submissions from the AASW, were ignored by the Productivity Commission Report on Australia’s Health Workforce, which was produced in December 2005.

Productivity Commission Report on Australia’s Health Workforce and the COAG Response

On 14th July 2006, the Council of Australian Governments (COAG) responded to this report by accepting the major findings and most of the recommendations (COAG 2006). Agreement was reached:

- To establish a single national accreditation board (and)

- To establish a single national registration board for all health professional education and training.
- Each board to represent the “general public interest”, rather than the interests of particular stakeholders (such as professional associations).
- The new accreditation board to assume statutory responsibility for the range of accreditation functions currently carried out by existing entities.
- Recognition of overseas trained health professionals.
- Eventual inclusion of those trained within the VET system, such as at TAFE colleges.

Further, the new registration board should be given authority:

- To determine which professions to register and which specialities to recognise, (but)
- It will initially cover only those professions which are currently registered.

It is apparent that these over-arching provisions ignore the overlap into non-health areas by many of the health workforce professions, which share their scope with the community services.

A Taskforce set up by COAG (2006) is to work on refinements, undertake projects, and provide advice to the Australian Health Ministers' Conference. But prolonged attempts to alert this task force to the biases and omissions in the Productivity Commission Report, and the subsequent COAG Response, have also led to little result. The problems were outlined in more detail in a recent AIWCW summary paper (Murray 2006c), which was sent to the COAG secretariat, to the National Health Workforce Secretariat, and to the secretariat of the Australian Health Ministers' Advisory Council, and although a response was promised by some officials, none has been forthcoming. These problems are summarised below.

Problems of omission and overlap

It is not expected that in a report which received over 370 submissions that any one submission or profession would receive individual attention, but what is striking about the Productivity Commission Report (2005) is the almost complete omission of the whole community services sector, including social work, and welfare and community services work. In addition, there is minimal mention of counselling, psychology and psychiatry. This is in contrast to the claim in the Report that: '[T]he term 'health workforce professional' [is] defined to cover 'the entire health professional workforce', from a number of education and training backgrounds, including vocational, tertiary, post-tertiary and clinical' (2005:2).

The “community services sectors”, and case managers and counselling are mentioned only under “disabilities” in the special needs section of the Report (2005:278). There

seems to be only three passing mentions of social work in the whole report. The Australian Association of Social Workers protested about this neglect in its submission to the Productivity Commission (AASW 2005) but it seems to no effect, since the protests were ignored in the final report by the Commission.

Social workers, welfare and community workers, counsellors, and psychologists are all employed throughout the health and medical sector, and in considerable numbers, so the lack of analysis, or even much mention in either the original report or the COAG response, is therefore difficult to understand. Several organisations, including the AASW, mentioned in their submissions that their members overlapped both health and non-health employment, but there was no mention in the Productivity Commission Report (2005) of the problems this posed for uniform regulation and accreditation.

A detailed study of the health and community services workforce was undertaken by the Monash Centre of Policy Studies in 2005. For the purposes of this discussion, a partial reproduction of the analysis is outlined below:

Table 1. Health & Community Services Workers, 2003-04

Occupations	Hospitals, Medical, nursing homes etc	Total community services & health	Other industries	Total all industries	Estimated percentage change 2004 to 2001
Social Welfare Professionals	16,400	36,900	25,800	62,700	20.7%
Misc Health Professionals*	52,900	54,700	5,900	60,600	15.7%
Medical Practitioner	53,800	54,100	2,100	56,200	6.9%
Nursing Professionals	170,200	176,300	9,700	186,000	10.9%
Health & Child Care Managers	4,900	10,000	2,700	12,700	38.1%
Welfare Assoc. Professionals	1,000	11,400	7,500	18,900	33.9%
Enrolled Nurses	21,300	22,600	1,000	23,600	-13.6%
Aboriginal Health Workers	1,000	1,200	500	1,700	29.4%

* This category includes a great range of practitioners, such as dentists, OTs, physiotherapists, chiropractors, podiatrists, dietitians, natural therapy and other health professionals.

Source: Monash Centre of Policy Studies, *Industry Skills Report*, CSHISC, ANTA, Brisbane 2005: 20, 17.

These data (in the second column) clearly show a substantial number of “Social Welfare Professionals” (i.e. social workers, welfare and community workers, counsellors, and psychologists) engaged directly in health related settings. If the vast numerical domination by professional nurses is omitted, these workers constitute about 13% of the remainder. Also, the number of these social welfare professionals is close to that of enrolled nurses and Aboriginal Health Workers (AHWs). And yet these latter workers are given considerable attention in the original Report, and significant analysis and policy directions are applied to them in the COAG response. So one can only wonder why the Social Welfare Professionals were ignored.

It is worth noting (in the far right column) the projected increase in this category to the year 2011, compared to the other major health professions. Only managers and Aboriginal Health Workers are likely to increase at a greater rate, but their overall numbers are much smaller. The expected marked decrease in the numbers of enrolled nurses is at odds with their proposed enhanced role in the Report as generalist health workers. This study reinforces the contention that a truly generalist role might also be suitable for social welfare workers, since their overlap into community services and other industries is likely to be just as significant as any overlap in roles by enrolled nurses.

There is acknowledgement in the Productivity Commission Report (2005) that the areas of ‘special need’ such as mental illness, disabilities, and aged care, are relatively neglected (2005:280), but social welfare workers are not confined to these specialties. Many of them work in general medical settings such as hospitals, clinics, and in private practice as counsellors, as illustrated in Table 1 above.

As a comparison, and in order to provide more detail regarding some professions which remain unregulated, the following numbers are derived from the 2001 Census, but for NSW only:

Table 2. Unregulated Health Professionals, NSW, 2001

Counsellors	4397	Natural Therapy Professionals	1248	Speech Pathologists	896
Dieticians	781	Occupational Therapists	1726	Welfare and Community Workers	8758
Massage Therapists	1705	Social Welfare Professionals	323	Other Health Professionals	2399
Minister of Religion	4892	Social Workers	2460	Total	29,585

Source: *NSW Parliament* (2006: 34), using census data, 2001.

The above data are distorted by the categorization of Social Welfare Professionals as only those holding a university degree. Some of those who identified as “Counsellors” for the census, might have welfare work or social work qualifications, but presumably not psychology, which is a regulated profession. Social welfare and community workers are by far the most numerous; comprising 31% of the total, with counsellors

14% and social workers 8%. Table 2 also shows the number of categories which overlap outside the health sector.

Perhaps the omission from the Productivity Commission Report (2005) of this Social Welfare professional category reflects the problem these professions pose for the proposed regulatory and accreditation bodies. These practitioners also work in non-health occupations, as Table 1 illustrates. Of the total of 36,900 workers in community services and health, some 19,000 work in community care services. There are also significant numbers employed in other industries, such as corrections, housing, education, employment, and social security.

Alternative Regulatory Structures

If these professions are to be regulated or formally accredited via legislation, there could be at least three different regulatory structures. One possibility is that only those members of the profession practising in the health sector will be covered. But this ignores the difficulty in defining the boundaries of the health sector', as well as the problems in the practice setting of many of these workers, where roles and duties are very flexible. Some social welfare workers will be greatly involved in family, legal, housing, and career issues with clients whose point of contact may be a health facility. On the other hand, a social welfare agency which specialises in housing problems may employ social welfare workers who must deal with physical or mental health issues in at least a significant minor proportion of their work.

Another possibility would be to simply regulate each of these professions right across their total scope, in whatever field they are practised. If the legislation and regulatory board is located in the health sector however, this is likely to be fiercely resisted by non-health workers, some of whom may have nothing to do with health, such as employment or corrections. Again, there would be significant problems with definitions, the drafting of legislation, and with administration.

A third alternative is provided by the NSW Parliament (2006) which early in 2006 conducted an enquiry into unregistered health professions. The committee conducting the enquiry agreed that the Health Legislation Amendment (Unregistered Health Practitioners) Bill 2006, introduced into the NSW Parliament in September 2006, "will effectively allow the Commission to deal with dishonest or incompetent providers in the absence of a registration system." (2006: par.10.49). This "Negative Licensing" scheme involves "the preclusion of persons deemed incompetent or irresponsible from operating in a particular industry, upon establishment of this incompetence" (2006: par.10.25). The NSW report goes on to note "In light of National Competition Policy requirements, negative licensing has been identified as a suitable first step in regulating unregistered professions, as it imposes few restrictions on the health market whilst enabling practitioners who do pose a risk to consumers to be prevented from practicing" (2006: par. 10.26). Thus it would seem that the original threat of a draconian, rigid form of registration may be averted, and negative licensing may be all that is needed.

This concept of 'negative licensing' could also eventually apply to the community services, where the employment of non-traditional professions and occupations has

been resisted on the grounds of inadequate protection of the public. Negative licensing could facilitate the employment of workers with less formal training who use informal networking and cross-referral and consultation among other skilled practitioners, whatever their formal qualifications and occupational identity or job title. These workers could be said to be 'professional', as presented at the beginning of this paper.

The Productivity Commission Report (2005) also advocated the use of 'credentialing' and 'delegation' as alternatives to additional registration of professions. Although not defined in detail in the Report, Credentialing might involve a pragmatic and presumably widespread focus upon employer responsibility for recruitment, taking into account the applicant's experience, generic qualifications, personal attributes, and 'fit' with the current workforce and the particular vacant position. Delegation refers to the ability to undertake tasks with minimal training, while under close supervision.

Role Boundaries and Overlaps

The Productivity Commission Report (2005) opposed a dependence on profession-specific training that placed unnecessary and unconstructive constraints on workplace innovation and job design, and led to 'professional silos' which resisted the increasing overlap of roles and duties typical in multi-disciplinary team approaches to service delivery. It proposed a national accreditation scheme to integrate the existing profession-based system, but this has been vigorously opposed by some of the established professions, according to submissions to the Report (2005).

The earlier National Health Workforce Strategic Framework asserted 'boundaries and established professional roles will need to evolve [with] a greater focus on the length ... and content of education and training' (Australian Health Ministers' Conference, 2004:11). Not mentioned in the Framework is the substantial research evidence for the relative equivalence in outcomes of minimally trained generalists compared to highly trained specialists in counselling and psychotherapy. This research has relevance in examining the length and overall costs of training (especially 'clinical' training), but it is not well known or discussed, possibly because of entrenched resistance to its implications from the traditional professions, (see Roth & Fonargy 2005; AIWCW 2006: Appendix for summaries).

The national accreditation scheme proposed by the Productivity Commission (2005) and endorsed in the COAG response (2006) might break down the worst aspects of professional silos, but it might also restrict the more radical opening up of flexible work roles, if too much emphasis is placed upon qualifications alone. The National Health Workforce Improvement Agency, also proposed by the Productivity Commission (2005) plans to review the mix of generalist and specialist roles, but there is no guarantee that the overlap with social welfare work will be addressed. On 13th April 2007, COAG:

[A]greed on the arrangements for a new national system for the registration of health professions and the accreditation of their training and education programs for implementation by July 2008 ... Each profession will develop standards for its profession for approval by Health Ministers. Individual registration and accreditation decisions will remain the responsibility of the professions.

(COAG 2007)

The new system is to cover only nine professions which already have registration requirements: medical practitioners, nurses and midwives, pharmacists, physiotherapists, psychologists, osteopaths, chiropractors, optometrists and dentists (including dental hygienists, dental prosthetists and dental therapists). Other professions will be able to apply to become part of the system, after it is functioning smoothly for these nine professions.

It seems possible that the overall support by COAG for national bodies to overview the health workforce may soon spread to other sectors, including community services. The fact that COAG ignored the overlap of these two sectors increases the need to make our collective voices heard. The inclusion of 'dental therapists' in the agreed registration scheme might indicate a future propensity to widen the scope of registration beyond the traditional professions. A mechanism to monitor and respond on behalf of the full community services workforce to the developments in national accreditation and registration proposals seems to be necessary, even if such a process is not directly represented on any formal body.

Raising an Umbrella Organisation?

The needs outlined above lead to the suggestion to establish an umbrella organisation which would link the workforce of the whole social and community services and welfare sector, and perhaps act as a monitoring and lobbying body, with a watching brief on government and other external proposals which might affect us.

The tentative proposal has a number of features, all of which could be open to discussion and modification or refinement. It could:

- Be **workforce oriented** within community services. Not competing with ACOSS (Australian Council of Social Services), which is not much interested in workforce matters;
- Have a **community services identification**, but with flexibility, incorporating those who trained and now still identify with this sector, even if employed in quite separate industries, such as transport or manufacturing;
- Have an **extensive vertical basis** including those with minimal training – and maybe volunteers and students;
- **Liaise with existing professional organisations** – not replace or compete with them;

- Be **broadly `professionally' oriented** - client-centred, ethically guided, maybe link to a generic code of practice;
- Be **oriented to general workforce issues** rather than to individual workplaces or wages and conditions.

It would:

- Not compete with trades unions
- Encourage organisation
- Promote recognition and identity
- Be network oriented, and this is perhaps the key concept.

The metaphor of an “umbrella” relates to a place of shelter, and creates an image of inclusiveness. It could offer shelter and a counteracting influence to external criticism and neglect of the sector, under which resources can be gathered and mutually advantageous responses can be discussed and implemented. It could be a loosely organised network of associations and aggregations of workers – a network of networks, with a flexible and relatively flat, hierarchical structure. It would not be a ‘peak body’ in the usual sense of that word, although it would have a charter to promote particular viewpoints and reactions to public statements and discussion. However, it would also be a forum for discussion and repository of information and resources, perhaps making extensive use of innovations in information technology. It might therefore have links with the new AIWCW electronic journal Practice Reflexions www.aiwcw.org.au/practicereflexions/index.html.

A more extensive model, involving potentially all professional organisations, is provided by the Professional Association’s Resource Network (PARN), begun in 1996 in the United Kingdom by Andy Friedman. This network now has over 125 members, and it provides research results and a forum for information exchange on such matter as governance and how to retain and recruit members. A much more limited model in terms of structure might be the Australian Association for Social Work and Welfare Education (AASWWE).

An Australian umbrella organisation might encourage or facilitate currently unrepresented groupings of workers to organize at a national level, for exchange of ideas, practices or issues. Prominent among these are community development workers and youth workers, each of which have been unable to establish a national organisation with wide recognition, and especially by government and similar bureaucracies.

Ideological resistance from community development workers to establishing anything that looks like a professional organisation has been apparent in the past, but it would seem from the above discussion that there are also disadvantages in being formally unrepresented. For example, currently, “community worker” applicants for permanent residence in Australia under the skilled migrant scheme are assessed only on the basis of a vaguely relevant degree (such as sociology), without reference to any skills training within the qualification. ‘Qualifications do not need to be specifically related to your nominated occupation’ (VETASSESS 2007). Community development

workers have been subject to disparagement by some government bureaucrats (DVC 2006).

The proposed umbrella organisation could act as a guide or even as a mentor to any category of workers (such as community workers or disability support workers) which does wish to organise. They may wish to amalgamate with existing organisations (such as AIWCW), or establish a truly national representative organisation of their own, within the overall network-of-networks umbrella.

The umbrella organisation could also promote occupational and professional recognition and identity, including a concern with career paths and articulation. It would provide a positive focus for workers in the community services, and perhaps address the very vexed question of articulation between the VET sector and universities.

Conclusion

This paper provides the beginning of a discussion of the possible benefits of a Community Services Umbrella Network and the features outlined are only suggestions as to how such a network might be set up and function. The name is only a very tentative suggestion - CSUN sounds a bit strange as an acronym (but, better than CSUA – it sounds a bit like effluent). I admit, this proposal may be no more than a “dream some of us have”, and perhaps it seems like a very high “kite to fly”.

Nonetheless, the challenges to the community services workforce raised by the COAG initiatives deserve attention, whether or not we come up with a structure of some sort to address the challenges which may emerge for our shared professions and occupations. Raising an umbrella organisation might not be the answer, but at least I hope this paper makes us aware of some of the questions.

In the meantime, this paper has raised some alternative ways of looking at the concept of a professional, which might fit under such an umbrella, and has also promoted at least a partial solution to registration problems, in the form of negative licensing.

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The continuing problem of social control *or* Thank you for smoking...!: A brief reflexion

PAUL O'NEIL and WINSOME ROBERTS

The vexed question of *social control* has occupied the musings of historians, sociologists, and welfare theorists in various ways for several decades now (eg., Mead 1925; Parsons 1951; Piven & Cloward 1972; O'Connor 1973; Janowitz 1975; Platt 1977; Cohen 1979; Donzelot 1979; Giddens 1982; Meier 1982; Offe 1984; Edwards 1988). Theorists and practitioners alike have raised important questions about the nature of the social services, *what* social welfare workers do, *why* they do it, and *whose interests* are truly being served. Central to these discussions has been the perceived 'dual' nature of the social welfare profession, a duality that straddles an ambiguous (and often contradictory) divide between competing outcomes: *care* or *control*, *freedom* or *restriction*, *empowerment* or *disempowerment*, and *rewards* or *punishments*. The concept of social control, itself, has come under fierce criticism, [see, for example Robert van Krieken's excellent critique, *Sociological Review*, 1991], and its usefulness as a theoretical paradigm has been seriously challenged. However, this brief article cannot do justice to the erudite critiques previously canvassed, so readers are encouraged to have a look at some of these for themselves to gain a balanced perspective on why the concept of social control has limitations, especially in relation to other important sociological concepts such as *class*, *power* and *culture*. [see Higgins 1980; Thompson 1981; Foucault 1982; Cohen, 1985; Gerstenberger 1985; Gordon 1986]. For the purposes of the current discussion, the idea of social control will be used as the organising tenet to stimulate further debate, despite Van Krieken's disparaging yet humorous reference to the concept as '*a Disneyland relic of our sociological childhood*'.

This short paper will briefly reflect on some aspects of social control with respect to a contemporary and controversial public health issue: namely, cigarette smoking. We should state from the outset that we, ourselves, are *not* smokers and have no vested interests in the cigarette industry.

As a general observation, the encroachment of 'the state' into the lives of its citizens waxes and wanes according to the historical epoch within which it is located including the dominant political philosophy of the times. Thus, the Whitlam era of the early 1970s brought substance to the ideals of social democracy through the introduction of a platform of sweeping social and cultural reforms, which, while increasing intervention in the workings of the economy and, thus, within citizens' lives, brought to bear positive changes to society as a whole, eg. withdrawal from the Vietnam war, the introduction of a national health system, free tertiary education, expansion of cultural and community programs, increased public housing, increased immigration, refugee intakes, and so on. Since that period, successive Australian governments, regardless of their political colour, have reduced their direct involvement within the lives of their citizens, essentially returning control (and therefore personal responsibility, liability, and 'blame') back to its citizens. If we look at trends in federal government policy during the last few decades concerning health, education, welfare, income security, labour market deregulation, public telecommunications, and

occupational superannuation, the dominant political trend is to move away from government intervention and control whilst allowing market principles to regulate wage rates (WorkChoices), utilities (power supply, electricity and gas distribution), public assets (Telstra, SEC), private investment in infrastructure (CityLink), and placing responsibility for retirement provisions back onto the citizen (compulsory occupational superannuation). The Howard federal government, whilst promoting policies that reflected free market and libertarian principles, paradoxically, was increasingly intrusive into the lives of its citizens, especially the most disadvantaged and vulnerable. A clear example of this was the increased policing of income security compliance obligations, ie. ensuring that CentreLink recipients upheld their obligations as an indicator of their “worthiness” to receive payments from the public purse. Another contemporary example was the unprecedented intrusion into the lives of indigenous Australians in the Northern Territory, on the face of it, to “manage” the social and health problems of remote Aboriginal communities. It will be interesting to observe how the newly-elected Rudd Government (November 2007) will address similar, contemporary issues.

As students of the human services, we are introduced early in our careers to the disquieting assertion that, in our professional roles, we act as *agents of social control*. One of the authors of the current paper recalls, as an undergraduate student at the former Gippsland Institute of Advanced Education (GIAE) in Churchill, Victoria, feeling affronted by the unpalatable notion that, whilst ‘we social welfare workers’ purported to protect the interests of our respective clientele, in reality, the underlying impetus was probably less altruistic and, perhaps, even mildly sinister. Were we part of a greater machinery (willing or otherwise) that imparted to our disempowered and vulnerable clients, socially constructed and sanctioned rules of behaviour *in order to elicit a particular and desired result*? It was incredulous that our (noble) efforts to instigate positive change within individuals and, more broadly, at a societal level, could be viewed as anything but *inherently good*. Whilst, perhaps, we now have a far more critical view of the human services, including the political economy that underpins it, happily, some of that freshness of spirit remains intact! All has not been eroded, despite the exigencies of professional practice and academia over a number of years!

However, the harsh reality *is* that in our professional roles, we *do* look for empirical changes in the behaviour, knowledge, attitudes, and, perhaps even the *values* of our ‘target groups’, the people who we serve whether these be individuals, families, groups, or some other constituency. With positive change comes positive reinforcement and rewards, whatever shape these take. Equally, the opposite holds true in attracting sanctions and punishments, however subtle and condescending these may be. This then, represents the insidious aspect of *social control*; the surreptitious attempts to *modify* how our clients *think*, and to then reward them for it.

The question of social control and its corollary, ‘*whose interests are being served?*’ was brought into stark relief one evening recently whilst returning home to Melbourne after a day’s work in Warragul. Tuned in to the ubiquitous ABC, one’s attention was seized by a lively discussion ensuing between radio journalists and a guest, the latter who was an apologist for smokers’ rights. The guest’s contention was that, in recent years, cigarette smokers have been increasingly ‘persecuted’ [*our words*] by political

interest groups intent on discriminating against and shaming people for a largely free choice they have made and, in many instances, continue to make. In his opinion, smokers have been harshly dealt with by a bevy of political spin-doctors and powerful lobby groups buoyed by swathes of public health funding.

The guest speaker, from the outset, *clearly acknowledged the serious harms* known to derive from cigarette smoking and, to his credit, made no attempt to minimize these accepted medical facts. He calmly asserted the following about smoking-related diseases:

- Approximately 15% of all deaths (approximately 20,000 deaths) in Australia are due to tobacco smoking each year.
- Tobacco smoking is the largest single preventable cause of death and disease in Australia.
- Smoking is a key risk factor for the three diseases that cause most deaths in Australia: ischaemic heart disease, cerebrovascular disease and lung cancer.
- Smokers are at increased risk of developing chronic obstructive pulmonary disease and reduced lung function.

Yet, this was not the point of his argument. The speaker's motivation was *not to defend smoking, nor to justify an untenable ideological position*. Indeed, he decried the plethora of risks that smoking poses to all and sundry, and quite correctly canvassed people against it. Rather, his concern centred around the accepted axiom of an adult person's civil and political right to make choices about his or her life, in full knowledge and acceptance of the consequences of their (rational) actions; a rational action being one that is made in the light of all available knowledge with a substantial understanding of the benefits and risks involved with that decision. He argued that changes in public attitudes and policy towards smoking have had unforeseen negative consequences for smokers and that these consequences have had a disproportionate impact upon those who choose to smoke.

In 2007, smokers represent a relatively small proportion of the general Australian population, around 25%. This compares with the period of high consumption during the 1950s when the rate of smoking amongst Australian adult males was in the order of 70%. Since then, public health campaigns and the anti-smoking lobby have been highly successful in getting their key message across, with impressive results. A significant decrease in smoking has been seen across most Western nations over the previous few decades. We all agree this is, indeed, a very good thing.

Yet, the speaker's argument was essentially libertarian, being based upon a loose confluence of the philosophical traditions of John Stuart Mill and Jeremy Bentham. His argument encompassed key tenets of utilitarianism, liberty, and freedom to live without state interference so long as no harm was promulgated towards others. We can reasonably accept this argument in relation to passive smoking, yet it fails when people smoke alone, away from the possibility of harming others. .

To this, the speaker added a further important dimension that added weight to his thesis. Namely, that, historically, smoking has not been adopted uniformly across all strata of society. . Certain sub-groups within society have a much higher propensity to smoke. For example, people with mental illness are amongst those who smoke the most frequently and heavily. On average, smoking is three times more prevalent among people with schizophrenia, as compared to the general population. Smoking rates among the mentally ill are not declining commensurate with the general population (QUIT Victoria 2006). An Australian study conducted at the Centre for Young People's Mental Health in Parkville, Victoria, found that 75% of the sample were smokers. Another study conducted in an outpatient setting in Melbourne reported that 76% of those surveyed were smokers.

Indigenous people also smoke at a much higher rate compared with the general population. The estimated rate of 51% represents more than double the Australian average. In addition, people in less wealthy [socioeconomic groups](#) also have significantly higher rates of smoking compared to median income persons. Finally, past surveys have demonstrated that people with [less](#) education smoke more than those who have higher levels of education (QUIT Victoria 2006).

The point being made here is that people who smoke cigarettes are likely to hail from lower socioeconomic backgrounds, which means they are probably living in poverty with substandard private rental housing and limited tenure, work in occupations that are semi-skilled or unskilled and are highly stressful, have a chronic mental illness, and come from marginalized indigenous communities.

Consequently, it is only a small conceptual step to suggest the dramatic changes we have seen in public health policy regarding smoking closely mirror dominant 'middle class' ideologies that have been imposed upon already disadvantaged groups whilst pursuing politically-driven health agendas. No reasonable person would argue against the various harms related to smoking: there are, indeed, no safe levels for smoking. These facts remain undisputed. However, what is amenable to further critical analysis is the process by which contemporary smoking policies and laws have evolved and the differential impact these policies and laws bring to bear upon disadvantaged and vulnerable groups.

As a case in point, the introduction of anti-smoking laws in 2006, banning smoking from public mental health facilities, are likely to generate unforeseen impacts upon the management of patients within inpatient treatment and rehabilitation facilities. Due to the very high rates of smoking amongst the mentally ill, this will almost certainly pose a significant operational issue that managers and clinicians will need to contend with. Social workers involved with managing the care process for patients within psychiatric units are obliged to uphold compliance of the new anti-smoking laws, irrespective of the wishes of patients or their own personal views. The fact is, since the new laws were introduced some twelve months ago, there have been some problems in implementation within psychiatric inpatient units where things can be volatile at the best of times. It is difficult to inform a floridly psychotic patient that he/she can't have a cigarette and then attempt to explain why. Sometimes, short-term compromises in policy are necessary to effect positive changes over the longer-term. Perhaps it is more prudent to allow mentally unwell people to smoke during times of

acute illness and stress, and then when they are well again, modify their smoking behaviours through education, emotional support, and positive incentives. The introduction of nicotine patches during inpatient stays will be beneficial for only a proportion of cases. These are not universal or immediate solutions to chronic smoking habits. Once a person is admitted to an inpatient unit, smoking must cease immediately, rather than being gradually reduced. It is well-known that a gradual decrease in cigarette consumption with a range of psychological, social, and emotional supports will have a better chance of long-term cessation as compared to the proverbial 'cold turkey approach'.

An often overlooked aspect of tobacco use is its social character. Often one of the few occasions where isolative patients may engage in social interaction without feeling unsafe or threatened within a mental health facility is during the informal 'smoko', which historically has occurred in a garden area outside the inpatient unit.

It is worthwhile asking the question why the excessive consumption of alcohol has not been subjected to the same, very high standard of control to which tobacco consumption has been subjected. The main rationale is probably linked to the fact that there are safe levels of alcohol consumption, whereas there is no safe level of cigarette consumption. Notwithstanding this, that alone does not proffer a convincing argument when the plethora of social ills directly related to excessive alcohol consumption are well-known, severe, and far reaching: domestic abuse, degradation of culture, violence against women and children, destruction of life through motor vehicle accidents, loss of jobs, income, social status, and self-esteem. Yet, there has been no serious attempt to control alcohol consumption to the same extent as tobacco.

As a concluding comment, government policy and its associated machinery (viz: legislation and executive departments) does indeed have a critical role to play in shaping citizens' knowledge, attitudes, values, and behaviours. Some policies are far more pervasive and influential depending upon where it sits on the public policy agenda of the day. Social and welfare workers, especially those in the direct employ of government departments are expected to uphold legislative imperatives, rules, and the spirit of government policy. If not, then they themselves risk running foul of the authorities who control their employment and their careers. Some government employees are compelled to agree to uphold a code of conduct without fail. The introduction of state policies and laws in relation to cigarette smoking (across a variety of settings) gives testament to the limited scope for personal action and choice for individuals and the key roles which social and welfare workers are expected to play in relation to regulating individual choice and human behaviour. The issue of social control, and all which that means for a contemporary society, remains a key sociological concept for understanding power and authority.

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Reflections on practice when working with families and communities newly arrived in Australia

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The aim of this paper is to explore families and communities from a refugee and Migrant background, drawing on my practice in the Perth Metropolitan Area. People around the world migrate from one country to another for a variety of reasons.

The term 'refugee' has been used to describe a particular category of migrants. Refugees differ from immigrants in that they flee from their homeland for political reasons. They leave families and friends behind knowing it is very unlikely they can ever return. By contrast, immigrants choose to leave their homeland and settle in a country of their choice knowing they can return to their country if they wish to. They often immigrate with families. (Allan, Pease and Briskman 2003).

In my practice, providing intervention to refugees and migrants, understanding the issues of language difference, cultural difference, client's knowledge and skills about effective treatments are essential aspect of practice that can contain client anxiety and assist to regain power.

Working With People from Other Cultures

Working with people from other cultures who are survivors of torture and trauma, primarily those who have come as refugees, provides professionals with a complex array of tasks and issues to focus on. It is also deeply challenging at a personal level, as one needs to existentially struggle with what it means to live and work in a world where the cruellest of human suffering is deliberately imposed.

Migrant/Refugee Families and Communities Settlement

Being a stranger in a strange environment is a stressful experience for most people, even though the degree of stress varies from person to person. In the case of refugee families and communities, this kind of stress inevitably comes in a double amount, namely, the stress of being a refugee and the culture shock of being in a new environment. In other words, the refugee is confronted with torture and trauma, grief and loss issues, as well as culture shock of being in the host society, both of which are completely new experiences for her or him. Most survivors will have experienced multiple losses and traumas.

Culture shock can be defined as a situation in which people who are normally stable, well-adjusted individuals in their home countries develop a wide variety of problems, including anxiety, restlessness, loss of appetite, loss of initiative, inability to concentrate, self-consciousness and even paranoia, as a result of being in a culturally alien environment. Assuming that a large majority of refugees would suffer from

various stresses of torture and trauma, and culture shock, the chances of translating their emotional or psychosocial problems into somatic complaints are very high. Correspondingly, the chances of their seeking the help of medical practitioners instead of counsellors are probably equally high. In that case, the real underlying problems beneath the somatic symptomatology may go undetected by both the doctor and the patient until a major breakdown occurs (Alston et al 2001).

It is important for professionals to assess all survivors for the risk of self-harm. Given the highly traumatic backgrounds of many survivors, surprisingly few people indicate that they are at risk. However, some of the newly arrived families and communities that I have worked with are showing severe signs of stress and seem to be at greater risk of self-harm, possibly for several reasons.

For many families, especially single women with children, they do not know the whereabouts of their husbands or well being of their family members and even if they do, they find it difficult to apply for their remaining family members to join them; and they do not know their future in Australia. All of these factors seem to make them more vulnerable to mental health problems.

Concepts of Mental Health

Resettlement in a different country with a totally different culture is traumatic and stressful in itself, many migrants and refugees' have different understandings and concepts of mental health. If the clients experience mental illness, it can be associated with the more severe forms of psychopathology that require institutional care. As a result this might mean that because some conditions are highly stigmatised, interventions may be avoided. Other factors that contribute to this understanding are the beliefs that mental illness is familial or inherited, with serious implications for marriageable family members. That is, information about illness in one family member may be spread throughout the particular ethnic community and is, therefore, potentially damaging to family reputation. Thus, for a family, knowing that they have to attend an interview at a mental health service may be confusing and frightening.

Cultural Competency and the use of Interpreters

The term cultural competency refers to knowledge and set of skills that the worker needs to develop in order to be effective with culturally diverse clients (Maidment 2004: 169).

From a social work point of view, understanding the client's view of their problems is important as different cultures express symptoms differently. Using interpreters for both assessment and ongoing treatment is essential when neither the worker nor the client speaks the same language with a degree of fluency. However, it is important for interpreters to have had appropriate training in interpretation for example, mental health services. Untrained interpreters or family members are not favourable to most clients, except in emergencies.

Essential as it is to engage assistance from interpreters, the process of doing so also poses problems. In the metropolitan area in which I practice, the population of

individual ethnic communities is generally small and most members know each other and interact in many different situations. Thus, the issue of family shame, confidentiality, and personal and community boundaries may be an issue to consider.

Different cultures express symptoms of illness or “help seeking” in their own ways and without a shared language it can be difficult to form a working relationship. This makes the involvement of interpreters in the assessment process, the negotiation of therapeutic goals and interventions crucial. As such, interpreters are the voice of the client and play an important role by ensuring that the client’s view of the problem is understood. However, most of the clients that I have worked with prefer to speak slowly rather than use interpreters, because of the issues of confidentiality and misunderstanding.

Families

Everyone knows a lot about families:

Yet the more one knows, the less one seems to know. The family is a wonderful institution that is the source of so much pride and yet so much shame; so strengthening and yet so draining; so nurturing, yet so demanding; so easy to understand yet so confusing. (Maidment et al 2004: 146)

The structure, membership and roles of families vary over time, within and between cultures. Therefore, there can be differences of structural membership and role within extended families of the same culture, and between families of different cultures. Furthermore, multiple diverse cultures, with varying ideas about role, membership and structure, can exist in one family system, which operates within one dominant culture.

Recognition that not all families are organized the same way, or have the same membership with the same part to play, is a crucial component of effective family and community work. Family systems theories seem to be more powerful in my practice. A system is a set or consistent arrangement of things so related or connected as to form unity or to operate as a whole. Family systems perspectives posit that individuals cannot be understood without assessing the system in which they are embedded. Families cannot be understood except within the context of the neighbourhood, community, or social system in which they function (Allan et al 2003). This is most common in working with African communities in Australia. Systems and subsystems are organized to create boundaries or limits around themselves.

Work with families and communities differs from work with individuals in that many different perspectives may confront the worker at one time. Each family member may have differing perceptions of the issue at hand and of the family strengths and resources available to deal with that issue. Family meetings, in particular, can be rich opportunities to bring all minds in one room together to produce exciting and creative outcomes. However, such meetings may also be a time when tension and family conflict is at the fore because of the meeting, and where family discussions move in many different directions. In my social work practice I come across a number of these challenges in working with families and communities.

Having discussed families, it is worth defining the word community, as most of my target groups are highly supported within the communities they belong to. Community, from an African refugee's perspective, is your 'second home', as one has not much kinship to relay on.

Identity and Belonging

According to the clients that I have worked with, the word community would incorporate some feeling of 'belonging', or being accepted and valued within the group. It is this that leads to the use of the term member of the community, this concept of membership implies belonging, acceptance by others and allegiance or loyalty to the aims of the group concerned. Thus, belonging to a community gives one a sense of identity.

Encouraging Community Participation

In my previous role as project officer, I learned, and as Ife (2002) observes:

1. People participate if they feel the issue or activity is important. The way this can most effectively be achieved is if the people themselves have been able to determine the issue or action;
2. People must feel that their action will make a difference. Thus, it is necessary to demonstrate that the community can achieve something that will make a difference, and that will result in meaningful change;
3. Different forms of participation must be acknowledged and valued. Too often community participation is seen in terms of involvement in committees, formal meetings and other procedures;
4. People must be enabled to participate, and be supported in their participation. This means that issues such as, the availability of transport, the provision of child care (or the inclusion of children in activities), safety, the timing and location of activities and the environment with which activities will occur are all critically important and need to be taken into account in planning community-based processes;
5. Structures and processes must not be alienating. Traditional meetings procedures, and techniques for decision making, are frequently alienating for many people, particularly those who are not good at talking, would not want to interrupt others, lack confidence or do not have good verbal skills. During my practice as a project worker, I learnt that people participate if they feel that their participation will make a change.

The project in which I worked was a Multicultural Women's Consortium comprising of four agencies, which adopted the 'whole community approach', and included most of Ife's (2002) characteristics of community participation. It was designed to ensure an effective, culturally acceptable and responsive strategy, collaborating with a cross-section of community members, including community leaders, youth and seniors. It

was titled: 'Preventing Family Disintegration in Culturally and Linguistically Diverse Communities: A Partnership Approach: August 2005 – August 2006'. A whole community approach, from the outset of the project generated a sense of 'ownership' for the strategy, thus ensuring acknowledgement by the communities involved that they took full responsibility for the project. This ensured the sustainability of the successful inroads made by the communities to remove stigma and barriers surrounding discussion of family and domestic violence. The successful completion of the project was due to the use of a community engagement and partnership approach to capacity building and it emphasized the importance of culturally appropriate measures and services.

The project demonstrated the positive aspects of the increased level of community participation through a strategy of informing, consulting, involving, collaborating and empowering families and communities (Jurak 2005).

Intervention

When working with people from other backgrounds it is important to remember that the client is the expert about their own culture and experience. The most crucial element is to build trust with the client and thus help the client re-establish trust in the world. This is not only a precursor to the work; it is in a very real sense the heart of the work. Sometimes it is necessary for 'me' the counsellor to prove myself before the more difficult psychological work can begin. This may involve advocacy tasks or proving oneself able to cope with sorts of material the clients knows needs to be dealt with. It can, for example, be very important to respond respectfully to any little "test run" stories or tasks, thus demonstrating my availability to hear more difficult stories.

Social work practice with the target group can be challenging in that trauma can be carried by an entire family and by groups and the communities. The loss, disappearance, or torture of a parent or sibling traumatizes all family members, and living with a person with a severe post-traumatic condition continues to be distressing. Family and domestic violence may be experienced in a family in which one member has been arrested and tortured. Some people act out aggressively in response to internal triggers from imprisonment.

In this field of my practice it is important not to pathologise people who have normal responses to abnormal experiences by using psychiatric labels, such as chronic or complicated post-traumatic stress disorder, as this may hinder the worker/client relationship. However, categorizing their symptoms can be a helpful framework for people to understand their confusing condition.

Reflecting on Practice

Although, there are many challenges in my social work practice, the most interesting point to mention, is that, most of what I have studied at Curtin University, Department of Social Work and Social Policy to some extent can be connected to my field of practice. In my practice, I am realizing that successful practice, involves learning and doing at the same time. I have learnt 'praxis' as an alternative word for this process during my undergraduate and first year postgraduate studies. The essence of praxis is

that I should be involved in a constant cycle of doing, learning and critical reflecting, so that the three effectively become one. Praxis is more than simply action: It is understanding, learning and theory building as well (Allan et al 2003).

Ethical issues

On a day-to-day basis, social workers have their own professional ethical dilemmas to contend with. Poorman (2003) argues that, because professionals have power and influence in society, it is especially important that they conform to ethically justifiable standards. For social workers, these standards are outlined in the AASW Code of Ethics which emphasizes the primacy of the client's interests.

Resource limitations, rationing and distribution, inevitably pose questions of social justice and ethics. Social workers have to prioritise their work, making choices about whose needs must come first, often doing more with less. In targeting particular groups for service, they know that some may not have their needs met adequately.

Professional Self Care

It is worth emphasizing the need for good professional self care when undertaking this sort of work. Supervision, which is always important, becomes crucial. Debriefing after a particularly difficult session might be necessary. Given the toxic nature of much of the material one is exposed to it is important to consider carefully with whom you will debrief as one wishes to avoid traumatizing others or simply feeding some people's interest in the unusual and perverse.

In summary, my field of practice is exposing me to more understanding of the issues confronting refugees through networking with other non-government and government agencies. I am learning that torture and trauma services in Australia operate on a diversity of models. Some services follow a more traditional medical model, and others combine a range of interventions within a broad community development framework. In the more traditional services, the roles of social workers tend to be more family and welfare oriented. In services combining community development approaches with psychological and other intervention, the roles of the social worker tend to be more flexible and diverse. In my practice, a combination of community development and psychological approaches and other interventions prove effective, as clients come with different problems, and this requires flexible approaches and interventions.

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