

# *Practice Reflexions* Volume 4, No. 1 - December 2009

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## Editorial: *Resisting fragmentation*

In these post-modern times, we are familiar with notions of specialisation, fragmentation, individualization and decontextualisation (Dominelli 2002), and we seem to have become inured to the possibility that they produce outcomes often inconsistent with the values we regard as critical to authentic social welfare work.

Bureaucracies that fund most of our programs now operate with a dual focus, or is it a forked tongue? They emphasise whole of government approaches, integration, coordination and social inclusion. More than ever our professional task and our civic responsibility is defined as building social connectedness and facilitating social cohesion, through policies, programs and practices. Governments have rediscovered community development and early intervention.

But they continue to operate highly specialised funding programs, and in order to target another excluded group or 'new' need, they develop yet another specialised program. Because of the way they are funded, agencies can't afford to spread funds too thinly so they apply for new money for a new program, even if it is doing similar things to half a dozen old programs. Fragmentation of services is a response to fragmentation of funding, which in turn is an ideological choice, unrelated to the rhetoric of integration and the holistic meeting of needs. While the majority of resources go into individual and family services, in response to the growing complexity of social life, the degree of their separateness and lack of coordination can be questioned.

So it is reassuring to note that the papers in this issue of *Practice Reflexions* all challenge in some way the pressures that create and maintain fragmentation, that paradoxically reinforce social exclusion, and value self-sufficiency over social connectedness and collaboration. Deborah West, Gretchen Ennis and David Heath stress the importance of learning together. They create a learning context where all 'stakeholders' in social welfare work can engage together for the benefit of community, and thereby share the ownership of issues requiring intervention and redress. Joan Heron and Sandy Taylor recognise the destructiveness of denying the sexuality of older people in care, partialising their individuality. Their paper and Barbara Carter's raise important implications for us about the public-private divide, and the role of the state in protecting and advocating for the rights of vulnerable individuals. Philip Mendes examines the policy context to analyse whether the current Federal Government is meeting its own objectives to increase and facilitate social inclusion.

John Rule's provocative paper reverses this responsibility and asks: what are the obligations of individuals to challenge their peer group and the fundamental social disconnection that allows them to behave in violent ways towards others? His group of social activists are adopting impressive educational strategies to pursue their aims to reverse the fragmenting and inner-directed patterns of youth socialising. Chris Laming's review of the book *Holding Men* offers insights into working with Indigenous men who are 'wounded' but resilient, with the 'hope of building that resilience in others, both individually and in community'. John Rule's group can't tackle it all and we as a society and as practitioners need to work on the resilience of some young people and the structures that limit it.

Finally, both Melissa Lindeman's and Sue Beattie-Johnson's papers address methodological ways in which holism, genericism, connectedness and subjectivity are expressed in preference

to more limiting, objective and decontextualised approaches – Melissa in regard to assessment tools, Sue regarding program planning.

With such endorsement of the importance of context and social connectedness, we should feel hopeful that the profession's commitment to resisting fragmentation is real and active.

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***Dr Margaret Lynn is an adjunct senior research fellow in the School of Humanities, Communications and Social Sciences, Monash University Gippsland  
marg.lynn@arts.monash.edu.au***

## **A human service learning community: at work in the Northern Territory**

**DEBORAH WEST, GRETCHEN ENNIS & DAVID HEATH**

### **Abstract**

*The Northern Territory provides a diverse, vibrant and challenging human service practice environment. However the isolation of remote practice, entrenched social injustices, inadequate supervision and difficulty applying mainstream social work knowledge to an NT practice context are all factors which can negatively impact what should be a rewarding and fulfilling experience. This article discusses challenges to optimising the practice learning opportunities available in the NT. In addressing this topic we will reflect on taking a 'learning community' approach to human service education. This approach highlights the need to build relationships, identify and build on strengths, and work with communities to develop programs that are pedagogically sound and sustainable in the longer term within the NT. We provide examples of theoretical frameworks and processes that guide this approach in the hope of creating foundations for quality human service learning in the NT.*

**Keywords:** *Northern Territory, Learning Communities, Field Education, Workforce Issues*

### **Introduction**

Australian human services experience important challenges in being enacted in the Northern Territory. Given the focus of the various human service professions on social justice and working with disadvantaged populations to achieve positive social change, it is critical that human service agencies sustain an effective presence in the NT. The consequences of colonisation and historical forces that have shaped the NT have led to significant long-term social disadvantage for many people in the Territory, including the various Indigenous populations and residents in remote areas. It is a place where the gap between the economically wealthy and economically deprived appears to be growing ever wider. This has significant cultural and social implications.

The widespread inequalities that permeate the very fabric of Australia's Northern Territory are of obvious concern to community workers, welfare workers and social workers. Research conducted by the Australian Association of Social Workers (AASW) in conjunction with Charles Darwin University (CDU) found that many social workers and social work students come from other states and territories to the NT for work or field education purposes (West, Heath & Ennis 2008). Additionally, anecdotal evidence indicates a noticeable transience within NT populations of community workers and welfare workers. In part, one would conclude that this is because each group perceives the NT, quite rightly, as a place of opportunity for the human services and for personal professional advancement, but also

because they recognise the devastating impact of structural and social inequality on human lives and want to contribute to a process of change. Whilst not discounting the previous efforts of human service professionals in the NT, the harsh reality is that real change has proven difficult and many major barriers to effective practice remain.

This complexity provides the context for this article and there are two important goals attached to the discussion. Firstly, the authors wish to assist students and practitioners thinking of coming to work in the Northern Territory by providing local knowledge that will facilitate their preparatory critical reflection process. This will be achieved by describing contemporary practice conditions and major issues in the NT, using field placement as a reference point. In many ways the challenges to good field placement experiences are barometric of broader challenges for human services in the NT.

The authors will articulate a 'learning community' approach to NT social work practice, which is developing and which is seen as a key strategy in raising the professional identity and quality of NT human service practice and education. As a lecturer, field educator and student each of the authors have personal experience of the benefits of embedding such an approach into NT practice. Through articulating the learning community approach led by CDU it is hoped that the wider Australian human service community will recognise its inherent opportunities and consider their potential contribution to their own work.

## **Overview of the human service landscape in the NT**

### ***Demographics***

The Northern Territory of Australia is a vast land geographically – encompassing territory from our tropical northern coastline to the dry red deserts of central Australia. Yet with a population of 218,000, Territorians represent only a small portion of Australians (ABS 2007). The main centres where people live and work in the NT are: Darwin, with a population of 106,000; Alice Springs with 23,800; Katherine with 16,500; Nhulunbuy with 13,900; and Tennant Creek with 3000 people. In addition there are many smaller communities and outstations across the NT with populations varying from the 'hundreds' down to just a handful of people.

The average age in the Territory is 30.6 years compared to the national average of 38. Indigenous people make up 29 percent of the NT's population, compared with 4 percent or less in all other states and territories (ABS 2007). With respect to socio-economic indicators like health, employment, income and education, overall NT figures generally compare reasonably well to the rest of Australia. Unfortunately though, strong NT wide figures mask the deeper inequities faced by the Indigenous population.

The ABS (2007) reports that Indigenous participation rates in NT schools generally decrease as the school level increased. In addition, whilst the NT has relatively low unemployment rates, these low rates are primarily driven by exceptionally small unemployment figures in the urban areas. Darwin, for example had a 2006 unemployment rate of 2.5%.

Unemployment becomes far more problematic in remote and Indigenous populations (ABS 2007). With regard to income, Indigenous people in the NT have the lowest median

equivalised household income of Indigenous people in any Australian state or territory. Furthermore, at less than \$300 per week, this figure is less than half of the overall national median of \$618 per week. Finally, Indigenous people in the NT face significant health disadvantages with regard to both life expectancy and co-morbidity in relation to hospital episodes (AIHW 2008; ABS 2007).

The reasons for such serious inequality have been well documented in a range of major reports (NT Government 2007; Australian Government SCRGSP 2007), however policy and practice responses to these reports have, to date, failed to satisfactorily reduce the widespread social injustices felt by Indigenous people. Perhaps the most frequent criticism contained in the literature is that Indigenous people are insufficiently involved in decision making processes relating to policy and service provision. The 'learning community' approach to human service learning that will be discussed later in this paper can be seen as a direct response to such criticism, as it is founded on the human service ethics of working alongside disadvantaged people to promote social justice and enhanced capacity for self-determination.

### ***Human service workforce***

It should be noted that accurate workforce data on human service professionals in the NT, and in Australia more broadly, is difficult to obtain and interpret. This is largely due to issues such as ambiguous job titles combined with self reporting procedures (McCormack 2001; McDonald & Jones 2000). As an example, social workers in the NT are involved in a wide range of activities typically placed under the umbrella of 'social work'. Indeed, NT research conducted by West, Heath, Ennis (2008) found over 30 different job titles (in a sample of 49 workers) under which social workers were employed with only 3 specific titles having the words 'social work' in them.

Whilst, this research helped close some of the gaps in this area, it also starkly illustrated the need for more comprehensive further research focusing on community workers, welfare workers and social workers who are not AASW members. In terms of the current paper, this deficiency in research places limits on the provision of a comprehensive overview of the human service workforce in the NT.

In light of the above, the information that follows is based on the small amount of local research and then a local understanding, made possible by the relatively small population and comparatively visible nature of NT human service practitioners. There are currently approximately 100 AASW members in the NT however there is a general awareness of a significant cohort of additional social workers in the NT. The majority of human service professionals are located in the major centres listed earlier, yet there are also at different times workers located in the smaller centres and remote communities. These populations tend to be quite transient and/or utilised on a 'fly in - fly out' basis.

Major employers of human service professionals in the NT are the Australian Government, NT Government, Charles Darwin University, the not-for-profit sector and a small group of private practitioners. Whilst this organisational spread would be similar to that throughout Australia, the NT is very much a place of 'frontier' human service work. NT practice encompasses all the rewards and challenges of working with remote populations, working

alongside people from a broad range of backgrounds - including a large Indigenous population - often with very different cultural understandings and diverse world-views. Like other places, major fields of practice include health and mental health, alcohol and other drugs, child protection, employment, aged and disability services and defence.

‘Big issues’ are often experienced by human service practitioners in a personal way in the NT. For example, when something like the Federal government intervention into Indigenous communities hits the headlines as it did in 2007, human service workers in the NT found themselves ‘on the ground’ dealing with the often puzzling day-to-day realities of what such policy means and thinking through the ethics and values bound up with these policies.

Similarly, Darwin’s large East Timorese population, and the city’s close ties with East Timor over many decades, mean some workers have experienced that country’s development in a personal way. As in other parts of Australia, human service workers also work with significant refugee populations particularly from a range of African countries. As a response to these regional conditions, in 2008 CDU commenced enrolling students in Australia’s first undergraduate humanitarian studies degree – the Bachelor of Humanitarian and Community Studies – accredited by the Australian Institute of Welfare and Community Workers (AIWCW) and supported by Red Cross and Medicins Sans Frontières (MSF).

## **Major issues in NT practice**

Embedded in the above context are a number of distinct practice issues which impact directly on practitioners and students completing field placement. The practice issues listed below were mainly identified in research conducted with 49 Northern Territory social workers in late 2007 (West et al 2008).

### ***Transient workforce and population***

Each year there is a significant population turnover in the NT (ABS 2007). In part this is due to the prevalence of short term (3 years or less) contracts at all levels of government. The NT also hosts significant defence force populations across Army, Navy and Air Force, in addition to the United States facility at Pine Gap near Alice Springs. The cost of living is also a major factor influencing people’s ability to stay in the NT with house prices particularly becoming increasingly prohibitive. For the human service sector this translates into difficulty achieving continuity of services, relationship and network building confusion, loss of practitioners who have NT knowledge and experience, and a general lack of ‘shared history’ in the workforce.

### ***Servicing of remote populations***

Working with people in far-flung, under-resourced and frequently inaccessible communities is a serious challenge for service providers. Many agencies are struggling to deliver services to remote populations and have not traditionally been assisted by social policy formulated centrally by decision-makers outside the NT. Such policy frequently fails to adequately address the unique considerations attached to remote practice (Cheers 1998). For individual practitioners, not being able to provide adequate support is disappointing and disheartening when there are communities, families and individuals asking for a range of human services.

This creates obvious ethical tensions and raises questions about how the human service sector can effectively respond.

### ***Workforce shortages***

The NT has major workforce shortage issues across virtually all sectors, perhaps due to the two previous issues discussed in this section. There is a lack of skilled and qualified workers available to social and community service agencies. Policy, research and academic positions also have a similarly limited pool of practitioners. Increasing the skill levels of existing practitioners is a significant task. For instance, many positions that have a co-ordinating or supervisory role – positions that in other places would require at least a Bachelor degree in welfare studies or social work go unfilled for significant amounts of time or are filled by people without such qualifications. The prevailing ability of practitioners without these qualifications to successfully obtain such positions would seem to decrease their motivation to continue with further study. Overall, these issues add stress in terms of workload and supervision for the workers involved, correspondingly placing the quality of service at risk. While this situation exists in other places, in the NT it directly impacts on almost every agency and practitioner on a daily basis.

### ***Supervision***

In the context of field education, supervision is essential, but further than that, the values of the human service professions in general are at risk of erosion if high quality mechanisms for supervision are not entrenched in everyday practice. Using social work as an example, West et al's (2008) study identified that access to supervision in its many permutations is a major concern for NT social workers.

Formal social work supervision was recognised as being absent from many organisations. Though informal supervision can partially help alleviate this, practitioners outside of Darwin are at risk of reduced access because the majority of professional development events have traditionally been held in Darwin. Given the dense professional networks and community oriented nature of practice in the NT, human service workers tend to embrace opportunities for informal supervision and collegial discussion with other people facing similar practice challenges. Professional development activities are a key mechanism for this, so supporting workers across the NT to access them is vital.

It is also recognised that good supervision requires the informed use of theoretical frameworks and models (Cleak & Wilson 2007; Wilson 2000). Given resource constraints and social work staff shortages in many organisations, there is an identified need to ensure that adequate training and ongoing learning is offered to people who have a supervisory role – whether this be as a field educator or supervisor of practicing workers.

One final issue relating to supervision in the Northern Territory is the supervision of human service workers in management or co-ordinating roles in organisations. As discussed previously, workforce shortages in the NT mean that many workers can advance their career far more expeditiously than in other regions. As a consequence it is not uncommon for recent graduates to be filling senior roles in organisations. It is therefore imperative that practitioners in these often stressful positions have access to formal supervision and that

professional associations more broadly be conscious of the potentially detrimental impact of having inexperienced workers in senior positions.

### ***Government employment***

Over two-thirds of the social workers in West et al's (2008) study indicated that they worked directly for government. When combined with the knowledge that NT human service workers are typically identifiable by their job title rather than their qualifications, this raises serious ethical concerns. For example, at the NT Social Work Day in 2008, the focus was on the intervention into Indigenous communities and throughout the day social workers provided descriptions of how individual policies under this broader response fit and do not fit with the values and ethics of social work. With so much confusion about which practitioners with which skills are practising in which positions it is extremely difficult for the professional associations to influence government practice to 'fit' with a specific ethical position. This is because each position may at various times be filled with a practitioner whose code of ethics and practice standards are vastly different to a previous worker from a different profession.

In addition, the major problem attached to the prevalence of social workers practising in government organisations is the raft of constraints placed on them regarding disseminating information about their practice experiences. Whilst this is not a unique problem to the NT, under the current socio-political conditions it provides a significant barrier to developing a co-ordinated 'human service' voice for improved social justice outcomes. As the major university in the region, a major shortfall is recognised in the production and dissemination of human service knowledge about the Northern Territory. The only real solution is increased contribution from more practitioners and whilst they work for government in the current political milieu, means of addressing the lack of 'voice' in the media and other public forums need to be found. It is also about Northern Territory practitioners linking with their profession nationally to provide information about current policy and practice in the NT.

### **Implications for field education**

There are flow-on issues in terms of student placement. Often students are offered positions during their placements. If this happens in a third year social work placement there is an impact on the student's completion of the Bachelor of Social Work (BSW). In addition, agencies may place additional workload and responsibility on students as a result of staff shortages. Conversely agencies may not offer enough learning opportunities because they find it easier to do the work themselves or are too busy to properly identify learning goals and tasks with the student. Moreover, the number of placements available may be restricted due to agencies simply not having qualified staff available to provide supervision.

These issues are applicable to most regions in Australia, however they are magnified in the NT – due a range of 'extremities' - extreme remoteness, extreme climate, and high populations of extremely disadvantaged people. Wider shortages of skilled human service workers are unlikely to be addressed without a significant drive from the professional associations and the Australian government to attract students. Nonetheless, CDU is developing an approach to social work and welfare education that is seen as the optimal way to counter some of the problems described above. This 'learning community' approach has

clear benefits for local students, practitioners and agencies and generates the impetus for them to connect within the NT human service community.

## **The learning community approach and experiences**

### ***The learning community framework – theoretical foundations***

Since the professional community in the NT is not large enough to sustain a separate approach to practice and education, the best way to meet the multiple needs of students, agencies and practitioners was seen to be to join together to develop a learning community that conceptualises human service work in the NT as a holistic venture from training through to advanced practice and research.

This idea of a social work learning community comes from two main theoretical frameworks: lifelong learning and community work. The concept of ‘lifelong learning’, although often considered as a political buzzword, has much to offer in relation to how one approaches and understands learning and the various professional values and skills that students need to develop.

In considering the key themes in dialogues on lifelong learning, the Organisation for Economic Co-operation and Development (OECD 1996) identified some common elements in the range of definitions that are being used worldwide. These elements include a belief in the intrinsic value of learning, the desire for universal access to learning opportunities, recognition of the importance of non-formal learning, consideration and promotion of personal qualities and characteristics that are needed for learning “including the motivation and capacity to engage in self-managed, independent learning” (OECD 1996:89). The International Academy of Education Task Force (Tuijnman 1999:6) acknowledges such commonalities and states that “(l)ifelong learning generally defines a broad set of beliefs, aims and strategies around the central tenet that learning opportunities available over the whole lifespan and accessible on a widespread basis should be key attributes of modern societies”.

Jacques Delors (1996) states that there are four pillars of lifelong learning which in turn have helped to shape the various definitions by providing a basis for commonalities. These pillars are very relevant to the development of the human service learning community. The first pillar of lifelong learning is that of *learning to live together* where knowledge and learning are seen to contribute to understanding and tolerance within society. For human services this places a focus on cultural competency, social justice and collaboration. The second pillar, *learning to know*, draws attention to the foundations of learning which contribute to the ability to build on such knowledge across the life course. Translating this pillar, the emphasis is placed on professional development and sharing. The third pillar, *learning to do*, is related to competencies for a variety of situations including work and living. For human services this relates to a variety of social work skills but with particular emphasis on generating knowledge and research about social work in the NT. *Learning to be*, the fourth pillar, relates to the individual’s personal responsibility for attaining their goals. It highlights the need to be aware of personal resources such as knowledge, experience and communication.

These four pillars are useful for considering lifelong learning in relation to the individual however they are essentially focused on the person as an individual. Little attention is paid to the structural factors which impact on each of the four pillars. Acknowledgement of the structural level that influences knowledge systems, undermines individual strengths and limits the power of the individual is vital. Systems theory (Hearn 1969), a political economy perspective (Hasenfeld 1992) and an empowerment perspective (Lee 2001) have much to offer in creating a balance between the individual and the environment. This highlights the responsibility for contributing to and nurturing the learning community as being shared by CDU, agencies, practitioners and students.

While the lifelong learning dialogue is focused on the individual, the idea of building a learning culture underpins and provides the value base for the concept of lifelong learning and illustrates the changed role of stakeholders in the process. The National Advisory Group for Continuing Education and Lifelong Learning (NAGCELL) (Fryer 1999) advocate three framework conditions for building learning cultures: 1. all institutions which provide learning need to review cultures and current ways of working; 2. employers needs to invest in employees education; and, 3. public bodies should examine how best to stimulate and support lifelong learning by redirecting and rebalancing resources.

These conditions begin to acknowledge the inequities present in the social structure and the need to address these. However, the NAGCELL still contends that individuals must take responsibility for their own learning and states that many people are locked into a culture which regards lifelong learning as unnecessary, unappealing, uninteresting or unavailable. Yet if we take a person-in environment framework, it is the interaction between the structural elements and the individual that needs to be highlighted. In working on both sides of the equation CDU hopes to generate some real change. It is by taking a community work approach that we have gone about building the learning community.

The concept of a learning community appeared to fit with the needs of the key stakeholders. Through a series of workshops, consultation sessions and focus groups particular challenges were identified including: the need for graduates who could cope with the complexity of issues faced in practice, the need for ongoing professional support and education and locally developed research as well as a keen enthusiasm for being involved with the education of future practitioners. Working with the variety of stakeholders to find solutions to local needs has been embedded in the development of the learning community model.

### ***What does it look like?***

The previously discussed reality that there are many complex social problems in the NT for which there are no clear answers indicates that students need to be prepared to commit to dialogue to explore innovative ways to tackle issues in the longer term. A problem-based approach was therefore deemed appropriate in which it is emphasised that the lecturer, or indeed the practitioner, does not necessarily have an 'answer' and problems need to be explored in a collaborative manner. Engaging with students across year levels to challenge cultural assumptions about human service work is serving a dual purpose of increasing the number of Indigenous students and ensuring our students are culturally competent

practitioners. Indigenous student numbers have increased to over 10% in both our programs compared to an average of 4% in the higher education sector of CDU.

Pedagogically, this translates into courses based around a holistic learning community in which the teaching/practice/research nexus is a central feature. Authentic learning and assessment activities are embedded into the curriculum to allow students to work on 'real world' problems relevant to the NT context in a supervised and supported environment. In this way the programs model good human service practice, provide opportunities for mentoring (practitioners/students, educators/practitioners, earlier and later year students), build professional networks, help agencies and practitioners contribute to and take an evidence-based approach, and stimulate considerable discussion in industry around research and publication and postgraduate study. By having practitioners and agencies invested in and contributing to the programs, the programs' sustainability is also increased because there is a greater likelihood of experienced practitioners undertaking postgraduate study to provide a pool of local qualified future educators.

Authentic learning and assessment activities have been embedded into the curriculum of a range of units, but are best illustrated by the following two: *Working with and Developing Communities* and *Social Work Research Methods*.

As a core component of the community work unit, students enter the competitive international program Students in Free Enterprise (SIFE) which is based on social entrepreneurialism. Using SIFE guidelines, they work in groups on a community-based project and present their work at the National SIFE forum. As such, they work for the benefit of the community which is part of social work practice. They also write a grant application for a community-based organisation in the NT which is then given to the organisation to submit.

The second example is from our research methods class. Approaches to teaching research methods across many disciplines usually entail students preparing a literature review and research proposal on a topic of either their choosing or the lecturer's interest. Students put in a lot of work and come up with great projects that are not carried out. CDU's curriculum design is different because it utilises the teaching/practice/research nexus and engages students in tackling real issues from theory through to practice. Early in the year, agencies are asked to provide research ideas from the field. A list is then compiled of approximately ten projects that allow the students plenty of scope for development. Representatives from agencies provide the students with the context of the problem. Students each choose one of the projects as their focus for the semester and all content and assessment tasks are centred on the application of research theory to the project. Agencies are invited back at the end of semester and students present their research proposals.

After assessment, some proposals are developed into student field education placements to be carried out in the agency in the following semester. Through this integrated approach, students further evaluate their proposals in light of the reality of carrying out the research as part of their placement. This means they gain valuable experience in research while also

undertaking their field education component. Agencies also make real gains with valuable research being carried out and are more likely to take a student on placement.

## **One student's experience**

Underpinned by the learning community approach one of the authors (DH) carried out a research project with the AASW as a third year placement – a fantastic experience from which significant benefits for students were observed.

Usually for the first time as a social, welfare or humanitarian worker, students are able to conduct a research project from conception to completion. Further enhancing the experience is the process of connecting theory with practice by using assessable pieces of work in real practice. One of the most frustrating aspects of being a student is producing good pieces of work which go no further than being assessed. In addition, this placement led to involvement in a number of other social work research projects. As more students take up similar opportunities and become interested in research the net effect is a burgeoning social work research group at CDU. Given previous discussion this is a critical development in addressing the need to produce and disseminate locally relevant research.

Connecting with the AASW to conduct the project offered the professional benefits of assisting in the development of significant networks of social workers, participating in branch activities and presenting the findings of the study at an AASW planning day. In this way the project provided a source of mutual learning for the AASW, the field educator and the student. Working in collaboration with a branch that largely functions via the efforts of volunteers meant that a project that otherwise would not have been possible was able to be carried out.

In line with the learning community approach, perhaps the most significant gain was involvement in a project that allowed social workers in organisations to participate in a project as social workers and not strictly in their agency role. One of the key challenges for human services in the future is to maintain the values and ethics that bond the professions, so providing practitioners with critical mechanisms for reinforcing their professional identity. In this light, the defining feature of the placement was being able to carry it out with an awareness of the theoretical framework of the learning community. Rather than just envision the research project as an isolated activity, this framework helped the student to recognise the broader contribution being made to human services in the NT.

## **Conclusion**

The development of a learning community that incorporates students, agencies, and in this case, the AASW has generated positive student, staff and agency outcomes as well as making a significant contribution to the NT community. Agencies have been enthusiastic about participating in authentic learning with many suggestions for research and projects. They welcome the opportunity to have students prepare research proposals and grant applications and then carry out projects in their agencies. This has increased the number of placements that have been offered to CDU students.

The flow on from this has been an amplified amount of research being carried out as a part of placement and in partnership with agencies. Several agencies have initiated discussions about a range of research needs including project partnerships, consultancies and post-graduate study for practitioners. As discussed previously, supervision is a major issue in the Northern Territory and this framework is informing a project that focuses on improving access to quality supervision.

From a student point of view, the feedback on the units has been very good, with comments focusing on the value of working on authentic projects within classroom-based academic units. This has been reflected in student evaluations of learning and teaching which show very positive feedback for both courses. Enrolment numbers have increased and Course Experience Questionnaire scores have gone from well below the national average to well above.

The purposeful bringing together of human service students, practitioners (both new and experienced), and academics from CDU in a framework of lifelong learning *is* community development. At a time where practice conditions, and indeed, the human service professions themselves are changing quickly, the development of such a community is vital in the NT. It is vital in terms of ongoing learning as the learning community offers a mechanism by which people involved can research, debate, challenge and shape their own professions. In terms of the wider community, Indigenous people in the Northern Territory face widespread social inequality and a number of reports implore governments, other policy makers and service providers to involve Indigenous people in decision making processes that affect them. Whilst the human service learning community is still developing, it is founded on the premise of fostering mutual education between practitioners, academics, human service agencies, community members and students.

Strong and supportive networks are the very basis of any community. The networks formed between students, practitioners and CDU academics bring potential rewards to all people in that network. Students have access to practitioners experience and support. Practitioners gain access to the enthusiasm and insight offered by students. In turn many practitioners and their organisations are establishing greater links with their local university, through which they may be inspired to access post-graduate study, research and supervision opportunities. The University is working hand in hand with social work and welfare practitioners, thus keeping abreast of practice and workforce issues.

Ultimately, however, the hope for a strong human service learning community is the best possible human services for the people that access them, the people of the Northern Territory.

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*Associate Professor Deborah West is Faculty Manager of Teaching & Learning and Theme Leader – Social Work and Community Studies in the Faculty of Education, Health, Science and Engineering, Charles Darwin University NT [deborah.west@cdu.edu.au](mailto:deborah.west@cdu.edu.au)*

*Gretchen Ennis is a PhD Student at Charles Darwin University*

*Mr David Heath is a recent BSW graduate at Charles Darwin University*

# **Nurse Manager Perceptions regarding Sexual Intimacy Rights of Aged Care Residents: An exploratory Queensland study**

**JOAN HERON AND SANDRA TAYLOR**

## **Abstract**

*Basic human rights to sexual intimacy and freedom of sexual expression for aged care residents can be denied or under-valued, due partly to stigma associated with older people and sexuality. The objectives of this study were to report Nurse Manager perceptions regarding residents' rights, policies and factors that facilitated or constrained sexual intimacy. A qualitative pilot study using semi-structured interviews was developed, Senior Nurse Managers in Central Queensland) were interviewed, and a thematic analysis undertaken. Results indicated that most facilities had unwritten policies regarding residents' rights to sexual intimacy. Residents demonstrated desire for sexual intimacy in various ways. Privacy considerations, duty of care, residents' cognitive functioning, residents' families and staff attitudes and education facilitated or constrained residents' sexual expression. Conclusions were drawn that residential facilities were complex sites for the expression and management of sexual intimacy; specific factors could facilitate or constrain residents' rights.*

**Key words:** *Aged care residents; Sexual intimacy; Nurse managers; policy.*

## **Introduction**

The right to sexual intimacy is fundamental for all adults in society including those who are elderly or of advanced age (Bauer, McAuliffe and Nay 2007; Gott 2005; Sherman 1998; Matthias, Lubben, Atchison and Schweitzer 1997; Wiley & Bortz 1996). Ageing *per se* does not necessarily diminish the desire for sexual intimacy and many older people can still yearn for the comfort of sexual or physical contact, whether it be as little as a hug or touch of the hand or as much as full sexual intercourse (Sherman 1998). For the older person however the importance of sexual contact can be readily forgotten or neglected as older people in Western society are typically undervalued and may be stigmatised in this regard (Nay, McAuliffe and Bauer 2007; Reed 2007).

For older people living in aged care facilities, such rights can become potentially more jeopardised as health professionals and service providers can be instrumental in facilitating, or constraining, expressions of sexuality within this environment (McAuliffe, Bauer and Nay 2007). Institutional aged care facilities can be highly complex sites which simultaneously embody clinical and organisational issues. These imperatives include addressing rights, needs and diverse preferences of a wide range of residents. The recognition of residents' needs regarding sexual intimacy for example may become secondary within an organisational

context which is underpinned by a biomedical framework and a strongly regulated industry based on the *Aged Care Act 1997*. For some elderly people therefore, entering an institutional aged care facility could mean that they confront the end of, or significant restrictions in, opportunities for sexual contact or intimacy with others. Few studies have been conducted within the Australian context to date regarding how management and staff in nursing homes perceive and facilitate the sexual intimacy rights of their residents (Minichiello, Plummer and Loxton 2000; Miles & Parker 1999).

This paper reports findings from a small qualitative research project that was undertaken by the first author in 2006 as a component of an Honours degree in social work and as a result of her special interest in the area of human rights and older people. The researcher's intention was to engage in collaborative and reflexive research and to raise awareness and promote discussion regarding sexuality rights and issues within residential aged care facilities. In so doing, it was hoped that older people, families, residential facility nursing staff, policy makers and professionals would benefit from the findings.

## **Sexual intimacy and the older person**

Notwithstanding the fact that ageing is a normal part of life, it is often viewed in Western society with distaste. Many older people are discriminated against on the basis of age alone, a phenomenon referred to as ageism (Bessant & Watts 2002). Discrimination can be based on misconceptions about old peoples' characteristics and capabilities (McMurray 1999). Weeks (2002) argues that the concept of ageing is often associated with negative stereotypes based on prejudice and ignorance; such a portrayal potentially affects the perceptions of older people themselves as well as health care professionals in the gerontological field (McAuliffe et al, 2007; Sherman 1998). This stereotyping is supported by multi-media portrayals of sexuality as being directly associated with being young, beautiful and healthy (Sherman 1998; Minichiello et al 2000).

Negative perceptions, stereotyping and discrimination regarding the older person are therefore also directly linked with sexuality issues (Nay et al, 2007). Over the centuries, human sexuality has been primarily conceptualised as having its basis in 'fixed' human physiology which is associated with sexual 'urges' and the need for penetrative sex. Sexual intimacy is far more than an 'urge' for penetrative sex however and can encompass a wide range of feelings and behaviours (McAuliffe et al, 2007). According to Moss and Schwebel (cited in Kuhn 2002), intimacy can take many forms including commitment, affective intimacy, cognitive intimacy and physical intimacy.

Similarly Sherman (1998) argues:

Sex and sensuality encompass a kaleidoscope of feelings and activities; from the deepest longings for mutual affection to the simple enjoyment of the company of a loved one. Sexuality also covers a gamut of behaviours – touching, kissing, caressing and cuddling, genital intercourse with mutual orgasm and feelings of closeness and of being wanted and valued as a human being. (p.3)

Finally Miles and Parker (1999) argue that sexual intimacy is integral to all human existence and is a deeply rewarding experience that encompasses concepts such as companionship, passionate love and satisfying sexual intercourse.

For aged people as for all others therefore, sexuality remains fundamental to the human condition and to human expression. Ageing alone does not diminish the yearning for sexual intimacy nor does the diagnosis of a dementing disease (Kuhn 2003). Matthias et al. (1997) argue that sexual expression can help protect people against feelings of separation, fear and coldness, particularly in times of change.

For residents of aged care facilities therefore, although sexual expression and intimacy can be potentially significant in their lives, such expressions within a primarily medical context could be overlooked (McAuliffe et al, 2007) or even interpreted as 'problem behaviours' that require medical interventions like sedation (Dersch, Harris, Kimball, Marshall and Negretti 2005). Robinson (2003) argues however that only a small percentage of nursing home residents have inappropriate sexual behaviours that are associated with dementia.

### **Sexual intimacy and residents of aged care facilities**

Little research in Australia and elsewhere has been undertaken to date involving sexual intimacy and residents of aged care facilities (Reed 2007). According to Archibald (2002), research evidence indicates a general discomfort by the public towards old age sexuality which can also be reflected amongst nursing home staff if confronted with residents' sexual behaviours. McAuliffe et al (2007) argue that the attitudes of health practitioners potentially constitute significant barriers to the sexual expression of older people in aged care facilities.

Similarly Roach (2004) claimed that the attitudes and comfort levels of nursing home staff and management regarding sexuality in general, and sexual activity of old people in particular, could be instrumental in facilitating, or opposing, sexual expression in nursing homes. Roach called this 'Guarded Behaviour' theory. Roach (2004) also found that nursing homes tended to be either 'reactive' or 'proactive' regarding how staff perceived and accommodated the expressed sexual needs of residents; depending on which stance was adopted, staff could 'guard' their discomfort about their own and residents' perceptions of sex. Generally, reactive organisations tended to be supported from top management, with staff discomfort regarding residents' sexually intimate behaviours guarded by ignoring or actively repressing such behaviours. By contrast, proactive nursing homes with associated organisational cultures offered protection, advice and support to all concerned within nursing homes regarding the sexual expressions of residents. This was achieved through staff support and education, consultation with residents' families and allowing residents to freely express their sexuality and their needs for intimacy. Roach (2004) argues however that many nursing home residents are not supported to form or maintain sexual contact or intimacy on a daily basis.

This reflects a denial of basic human rights however and reinforces social attitudes that devalue older people. McAuliffe et al (2007) argue strongly that this is an important policy

issue for aged care facilities and urge policy development, guidelines and staff training. McAuliffe et al (2007) propose a range of possible strategies for aged care facilities and the health professionals working within them that would facilitate the sexual expression of those residents for whom this issue is significant.

## **The study**

This study was a small qualitative study conducted with nurse managers of five Central Queensland aged care facilities. It aimed to explore manager perceptions about relevant policy within their facilities and about factors they believed could facilitate or inhibit residents' rights to form or maintain sexually intimate relationships. The project was approved by the ethics committee of Central Queensland University (CQU) and was conducted according to standards for ethical research as determined by the National Health and Medical Council (NHMRC).

## **Method**

Five Senior Nurse Managers at selected Central Queensland facilities were invited to participate in the research. Data were collected via semi-structured interviews and audio-recorded with participants' permission: later being transcribed for analysis. Interviews lasted between 20 and 60 minutes. This approach allowed participants to report their views in their own terms and provided the researcher with flexibility to explore issues as fully as possible within the parameters and time frames of the study.

In keeping with the conventions of qualitative data analysis (Marlow 2001), interview data were collated, organised and coded for meaning as well as commonalities and differences in thematic content. Coding was cross checked through comparison with that undertaken independently by the first author's research supervisor. Thematic analysis was undertaken manually given the small number of interviews conducted. Emerging themes were then considered in light of key literature and previously gained knowledge (Marlow 2001).

## **Findings and discussion**

### ***Defining sexual intimacy***

The importance of defining sexual intimacy was a key theme that emerged from the interview data. Most participants readily identified that sexual intimacy was more than sexual penetration and included physical contact like hand holding and hugging, as well as non-physical contact such as talking and sharing emotions.

One participant reported observing particular behaviours between residents within her facility that she would regard as constituting sexual intimacy:

*... basically I notice when I'm doing my rounds, that a couple may be holding hands or just being together.*

Similarly a second interviewee reflected upon the meaning of sexual intimacy within the context of the aged care facility:

*... well I guess part of it is just...just showing some emotion together and holding hands, hugs and that sort of thing.*

A third participant presented a more holistic approach in her thinking about sexual intimacy:

*Many people when they see sexuality ... think it's got to be physical, penetrating, whatever else. Sexuality...it's spiritual, it's physical, it's emotional, all that is bound in a person's sexuality...*

The last definition, which was provided by the manager of the only facility that had a formal written policy relating to sexual intimacy, reflects Moss and Schwebel's view (cited in Kuhn 2002) that sexual intimacy encompasses a range of emotional, physical and spiritual factors. Of the four remaining participants, one talked about sexual intimacy against a background of the facility's privacy policy while the remaining two participants presented their views against backgrounds of informal, non-written policy regarding sexual issues in their facilities. The latter were less clear in their definitions of sexual intimacy.

One participant only reported having a written policy within their organisation regarding residents' sexual intimacy rights. In general terms, developing and implementing formal policies within organisations can be complex and time-consuming (Hancock 1999). When such policies relate to a potentially challenging area such as older people's rights to sexual expression within a residential care context, proactively developing and implementing policy can be made even more difficult (McAuliffe et al. 2007; Roach 2004).

### ***Facilitating or inhibiting residents' sexual intimacy***

Findings suggested that the aged care facility context was a complex one in terms of managing sexually intimate relationships. Interviewees reported a range of factors within the organisational context that could facilitate or inhibit the sexual intimacy rights of residents. These included consideration of privacy principles, duty of care, residents' cognitive functioning, residents' families and staff attitudes and education.

### ***Privacy principles***

Several participants considered privacy principles to constitute an important framework within which to consider sexual intimacy issues. One Nurse Manager for example stated:

*We make sure that everyone's privacy and dignity is maintained and as a couple that is acknowledged and recognized as well...*

while another noted:

*basically we just follow the privacy principles, providing there is no ... we can see that there is no sort of abuse...*

A third participant reported:

*...it[all] comes down to policy ... one thing we can comfortably say in aged care ...is that there is a very strong legislative basis for our operation... The current Aged Care Act under which we operate is quite prescriptive in rights of residents. ...*

Regard for upholding privacy principles therefore informed facility approaches to sexual intimacy policy, whether it was formal or informal. Roach (2004) and McAuliffe et al (2007) both strongly argue that the attitudes of organisations, health professionals and service providers are paramount in determining whether sexual intimacy rights are facilitated or not. While consideration of privacy provides a useful framework of reference for consideration of residents' rights to sexual expression in some ways, the concept of privacy is subjective however and can be open to wide variations in the interpretation of what is an acceptable level of privacy for people wishing to exercise their sexual intimacy rights (Hughes 2004). Within the broader policy context, there are currently no specific references to sexual intimacy rights within the *Aged Care Act (1997)* or the associated accreditation standards for aged care facilities in Australia (Department of Health and Ageing 2001).

### ***Duty of care factors***

Duty of care is inextricably tied to the day-to-day operation of nursing homes and often informs policy as well as practice (Gibson 1998). Several participants clearly linked the duty of care principle to their consideration of residents' rights to sexual intimacy while simultaneously acknowledging potential challenges such as protecting residents from any harm:

One participant noted for example:

*We have a duty of care to ensure that the resident who is in our care comes to no harm ...*

while another perspective reflected having to prioritise protection from harm as a primary principle:

*...if there was nobody being intimidated or harmed in anyway, or if nobody was at risk, there would be no objection.....*

While the potential for residents being harmed is important when considering duty of care, such a focus has the potential to limit residents' ability to maintain or establish sexually intimate relationships. As Gibson (1998) argues, there is a 'potential conflict between residents' rights and the duty of care'. Clinton and Scheiwe (1998) also acknowledge the complexity for clinical managers who may need to address the legal implications associated with day-to-day operations within an organisation. This was clearly expressed by one participant who indicated *We have an obligation to protect people so we exercise that.*

### ***Cognitive and family factors***

Closely linked with duty of care responsibilities were concerns about the cognitive capacity of residents and the potentially difficult issue of family reactions to a parent or spouse forming sexually intimate relationships within the aged care home. Several participants described their concerns about these two issues and gave accounts of difficult situations that they had dealt with in this regard; for example:

*We have a lady who calls everybody dad, which is what she used to call him (her husband) and still does, but any male that's around she calls dad and tends to follow them and is happy to sit and hold their hands.*

Concerns were also expressed about how children might view a parent developing an intimate relationship, with some participants believing that spouses or children should be informed and their feelings considered before residents could be 'allowed' to form or maintain a relationship. One participant expressed this in the following way:

*...if for example, there is an opportunity for people to develop a friendship ... into a level of intimacy then one of the things we would probably be doing is to have discussions with the families, especially if there is a query or concern about the level of cognition...*

While participants perceived the need to consult with family about a spouse or parent developing a sexually intimate relationship, most also reported that, after consultation, families were generally accepting of such situations. McAuliffe et al (2007) have proposed that aged care facilities involve family members in education about the normality of sexual expression in older people and its importance for general health and wellbeing.

When cognitive capacity was not an issue, all participants expressed acceptance of residents' rights to form intimate relationships; for example one interviewee noted:

*...it comes down to the capacity of that person. If they have got full capacity it's not really an issue...*

While cognitive capacity is clearly an important and complex issue within the aged care context, there can also be a danger of upholding stereotypical attitudes about older people based on implicit assumptions about the lack of capacity of old people to make decisions and control their own lives (McMurray 1999). Even where participants believed residents had such capacity however, there was still a sense of responsibility and concern regarding the potential reactions, or even over-reactions, of residents' family members. Kuhn (2002) highlights the potential for disputes to arise between staff, family members and residents about what is deemed best for residents and for concerns from nursing home administrators about possible litigation. For reasons such as this, Sherman (1998) has argued that the consideration of sexuality can depend more on the organisation's values and policy than the wishes and needs of the resident. Nevertheless, consultation with families did appear to be a relevant factor in trying to ensure that elderly residents had the right to form sexually intimate relationships.

### ***Staff and education factors***

Previous research [Kuhn 2002; Archibald 2002; Roach 2004) regarding attitudes of nursing home staff have indicated that staff can struggle with the concept of elderly people wanting and enjoying sexual intimacy. Staff attitudes have the potential to affect professional practice as well as policy development and its implementation. Within this study, several participants expressed awareness of the importance of staff attitudes about residents' rights to sexual expression and considered that education and training could alleviate stereotypical or judgemental attitudes. These participants strongly supported the value of education for staff and families about sexuality issues. Also noted by a participant:

*In the beginning before policy was brought in they [staff] were finding difficulty in accepting intimacy of any sort within residential care. Some staff were excellent but others, and I say probably 40-50% were finding difficulties in ...I'd say managing it, in just accepting it, recognizing ...that there was a need there.*

Kuhn (2002) argued 'Staff members must be aware of their own values and biases in addressing residents' expressions of intimacy and sexuality'. Similarly, Roach (2004) maintained that staff responses to residents' sexual behaviour were influenced by their own level of comfort with sexuality issues. McAuliffe et al (2007) described the importance of adequate staff education regarding sexuality and older people, including the need for staff to explore their own beliefs, values and potential biases in regard to these issues in order to understand how these can become barriers to providing holistic quality health care to residents.

Although the value of education was espoused by participants, their accounts also suggested that training and education appeared to be undertaken on a 'needs' basis rather than as part of a fully planned and proactive program (the exception to this was the organisation with formal written policy). In other words, unless an incident had occurred or had come to the nurse manager's attention, no specific training had been provided regarding sexuality issues or the rights of residents to sexual intimacy. Such practices which are largely reactive rather than proactive have the potential to deny or limit residents in their rights to lead sexually fulfilling lives.

This study was small in scale primarily due to the scope and associated time frames related to the honours degree with which it was associated. Nonetheless, the project can be described as an exploratory pilot study, the results of which merit reporting in our opinion in order to raise awareness about issues relating to sexual intimacy and older people, particularly those residing in care facilities. Generalisations from the study cannot be made. However the aim of the research was to explore the issue of sexual intimacy rights within aged care facilities from selected Nurse Managers' perspectives and to identify the factors that they regarded as facilitating or inhibiting residents' rights. Documenting the perceptions of residents of aged care facilities themselves about these issues would contribute greatly to further understanding.

## Conclusions

This study has documented the perceptions of a small number of Nurse Managers of Central Queensland aged care facilities regarding the rights of aged care residents to sexual intimacy and expression. Nurse Managers' consideration of their duty of care responsibilities, the cognitive capacity of residents, the reactions of family members and staff attitudes were all regarded as potentially instrumental factors in facilitating or constraining older people's sexual expression. Nurse Managers also believed that education for staff and families about sexual intimacy and older people was important as were accreditation standards and policy and principles relating to privacy and dignity principles. Older people's rights to sexual expression and intimacy within aged care facilities can be regarded as potentially complex and challenging as there may be inherent competing imperatives. Further research is indicated including documenting the perspectives of older people themselves about these issues as well as members of the general community. Engaging in debate and further research will raise awareness, inform and facilitate best practice and policy development and contribute to ensuring that residents of aged care facilities are valued holistically and their human rights upheld.

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**Joan Heron is a Social Worker in Rural Allied Health, Wide Bay Health Service District, Gayndah Qld 4625 [Joan\\_Heron@health queensland.gov.au](mailto:Joan_Heron@health queensland.gov.au)**

**Dr Sandra Taylor is Professor and Head of Social Work in the School of Sociology and Social Work at University of Tasmania, Launceston, Tasmania [S.D.Taylor@utas.edu.au](mailto:S.D.Taylor@utas.edu.au)**

## **Is social inclusion just a new buzzword? A half time report card on the social welfare policies of the Rudd Government**

**PHILIP MENDES**

### **Abstract**

*The ALP Government claims to be pursuing a social inclusion agenda aimed at promoting the participation of particularly disadvantaged groups. This holistic agenda recognizes that disadvantage is caused by a complex interaction of structural, local community and individual factors, and differs significantly from the former Coalition government's primary emphasis on individual responsibility. The government seems to have a genuine commitment to addressing social disadvantage and has significantly increased the level of social investment in a number of key areas. However, its application of social inclusion principles still appears to be inconsistent and unduly limited by political and budgetary considerations.*

The Australian Labor Party seeks to balance its support for free market economics with a concern for fairness and equity. They support an open, competitive global economy based on promoting economic growth and wealth creation, and keeping taxation as low as possible. But they also favour government intervention when markets fail. In the context of the global financial crisis, Labor argues that there is a critical role for government in promoting socially responsible investment, and a more equitable distribution of wealth and income. The overall aim is to more closely integrate social and economic policy, and combine prosperity with fairness (ALP 2009: 13-14; Gillard 2008; Rudd 2008).

However, this paper will argue that there are clear limits to the ALP's commitment to fairness. The government has still largely left income distribution to the vagaries of the free market. To be sure, the government has intervened at the margins to promote greater opportunities – particularly through education, training and employment – for social and economic participation by key disadvantaged groups. But the government appears unlikely to radically alter either the economic or social welfare policy models bestowed by the previous government. There is certainly no evidence of any major plan to tackle the structural causes of inequality or poverty (Robbins 2010: 451; Steketee 2009).

The ALP Government's social welfare policies appear to be influenced by two key philosophical concepts. The first is social justice which is generally defined as a fair distribution of life chances, wealth, income, rights and responsibilities. Labor argues that we should 'protect and support those who face difficulties and disadvantage whether because of disability, illness, old age, misfortune or other factors that make it hard for a person to cope. Labor holds to its tradition of reaching out, embracing, protecting and supporting those in need – as well as supporting those who help people in need' (ALP 2009: 15).

This concept suggests a continuity with the earlier Labor Governments headed by Bob Hawke and Paul Keating from 1983-1996 which also stated a commitment to social justice objectives. However, in practice, those governments arguably gave greater priority to the economic imperatives of the free market than to income redistribution, and hence contributed to producing greater inequality within Australian society (Mendes 2008: 157-163). This history of tension between support for the free market and promoting greater equity should sound a warning to the ALP that targeting support to particular disadvantaged groups whilst ignoring the root structural causes of inequality may not necessarily produce socially just outcomes.

Associated with the ALP Government's adoption of social justice is their vocal rejection of neo-liberalism, the philosophy which emphasizes the rationality of the free market, and the necessity for the size and influence of the state and government to be limited as much as possible. Prime Minister Rudd has argued that neo-liberalism – often called economic rationalism in Australia – became the 'economic orthodoxy of our time', and is responsible for the global financial crisis. Rudd argues that it should instead be replaced by a social democratic agenda which recognizes the need for government intervention to regulate markets, and provide public goods and services that address social and economic inequities (Rudd 2009).

The second key concept is social inclusion and its counterpart social exclusion. This term broadly refers to people or communities being denied the opportunity to participate in mainstream social, economic, political, and cultural systems, and assumes exclusion from informal social networks, as well as from formal institutions such as work and education. It appears to recognize that structural inequities and individual agency can both contribute to disadvantage. The term originated in France in the 1970s and became popularized through European Commission programs in the 1990s. It became the dominant policy paradigm of the British New Labour Government (Room 1999: 166).

Social inclusion/exclusion assumes that the old focus on the disposable income or expenditure of an individual or household at a given moment in time is too narrow. Instead, the terminology incorporates five key elements in the definition and study of disadvantage. They are:

1. Moving beyond financial indicators to acknowledge the multi-dimensionality of disadvantage such as links between poverty and poor housing;
2. Moving from a static to a dynamic analysis of entry to or exit from poverty;
3. Broadening discussion from the poverty of individuals or households to the poverty of local communities and the question of social cohesion;
4. Movement from distributional to relational dimensions of disadvantage so that we examine not just the individual's lack of resources, but also their lack of integration into mainstream society;
5. Shifting from a continuum of inequality to assuming that the poor are permanently separated from mainstream resources and relationships (Room 1999: 167-171; Smyth 2008: 658).

The Labor Party argues that all Australians should be able to fully participate in our economic, social and community life. This means ensuring that they can attain employment, access services, establish connections with others in the community, cope with personal crises such as ill health or the loss of a job, and have a voice in the development of services. The ALP policy acknowledges the research of Tony Vinson (2007) which identifies the relationship between specific suburbs or postcodes and chronic disadvantage. It also draws on the experience of the social exclusion model introduced by New Labour in Britain, and by some Australian states. This model suggests that interventions need to go beyond mere income-related poverty in order to address social disadvantage. There is also a need for an evidence based approach, including the setting of targets and the development of detailed plans to meet them. The ALP has elected to target support to particularly disadvantaged groups such as Indigenous Australians, the homeless, children at greatest risk of disadvantage, jobless families, older Australians experiencing social isolation and financial hardship, and marginalized neighborhoods and communities (Gillard & Wong 2007; ALP 2009: 77; Australian Government 2009a).

The ALP Government has established a new Social Inclusion Unit and Social Inclusion Board to assist the most disadvantaged geographic areas and communities to re-enter mainstream economic and social life. The Board is headed by former Victorian bureaucrat Patricia Faulkner, and includes persons from a diverse range of backgrounds including media personality Eddie McGuire, the South Australian Commissioner for Social Inclusion Monsignor David Cappel, Professor Tony Vinson, representatives of non-government welfare organisations such as John Falzon and Tony Nicholson, business people and Indigenous Australians. The government has justified this diversity by claiming that their social inclusion initiatives are not about welfare, but rather about complementary social and economic investment. Their aim is to promote 'action and hard-headed economics' which will lead to 'bottom-up' measures that empower disadvantaged communities (Gillard 2007).

These objectives appear commendable, but also raise the question as to what will happen to disadvantaged Australians who do not have the capacity to participate effectively in employment training and other social and economic activities. As we will see later, the government seems reluctant to provide these so-called undeserving disadvantaged groups with adequate levels of income support.

### **Social Inclusion Initiatives: Homelessness and Indigenous Disadvantage**

The government has provided a substantial increase in social investment measures. For example, the 2009 Budget allocated major funding to public infrastructure projects concerning public transport and upgrading of roads, green collar job creation and health provision, and also introduced a paid parental leave scheme (ACOSS 2009b).

The social inclusion agenda has particularly underpinned a number of important government policies and initiatives. One is the plan to reduce homelessness which is now estimated at 105,000 people on any given night. The *Road Home* report released in December 2008 aims to prevent homelessness, tackle the long-term causes of homelessness, and provide access to adequate, secure and affordable housing. The long-term goal by 2020 is to halve overall

homelessness, and offer supported accommodation to all rough sleepers who need it. The report argues that the causes of homelessness are complex, and recognizes contributing social and economic inequities such as unemployment, limited availability of affordable housing, poor life transitions from prison or state out of home care, and neighborhood disadvantage. The report also identifies individual triggers such as family breakdown, substance abuse, family violence and mental illness. For example, it notes that ‘people without support networks, skills or personal resilience, or who have limited capacity due to their age or disability’ are more likely to become homeless (Australian Government 2008a: 24).

The government has provided \$6.1 billion over five years via the National Affordable Housing Agreement to fund social housing, assistance to private renters, and support and accommodation for people who are homeless or at risk of becoming homeless. They have also provided additional funding of \$1.2 billion over five years to prevent and reduce homelessness and increase the supply of affordable and supported housing for people who would otherwise be homeless (Australian Government 2008a).

The funding initiatives have generally been welcomed by the housing sector (Australian Council of Social Service 2008a). One commentator called this ‘the largest single investment in affordable housing in Australia in the last 50 years’, and argued that it could lead to a serious improvement in the availability of priority public housing (Nash 2009). However, another commentator has noted with concern that the report may reinforce popular beliefs that homelessness is caused primarily by individual dysfunction, rather than by structural inequities (Fopp 2009).

Social inclusion has also influenced the government’s approach to indigenous disadvantage. The government has identified Indigenous Australians as experiencing an unacceptably high level of social exclusion, citing high mortality rates for infants; high numbers of deaths due to accidents, suicide and assault; low school retention rates; and poor labour participation rates (Gillard & Wong 2007).

The government has established a National Policy Commission in order to reduce the gap in indigenous and non-indigenous life opportunities pertaining to health, education and employment outcomes. They have promised particularly to improve the availability of indigenous remote housing, reduce the incidence of chronic disease and enhance Indigenous peoples’ access to mainstream health care, support Indigenous Australians to find and maintain employment, and improve access to early childhood education for Indigenous children. The government has committed to engaging and working with Indigenous individuals, families and leaders to develop and implement strategies to promote better indigenous life outcomes. This includes the formation of a new National Indigenous Representative Body to provide a voice for Indigenous Australians in national policy debates (ALP 2009: 79-81). In addition, the government produced a national apology to the Stolen Generations in February 2008, and also endorsed for the first time the United Nations Declaration on the Rights of Indigenous Peoples. Previously, the Coalition Government had joined only three other countries in opposing the Declaration which was supported by 143 countries (Macklin 2009a).

The challenge facing the government is immense as reflected in the recent Productivity Commission report on indigenous disadvantage. This report shows that whilst in some areas

(e.g. employment, incomes and home ownership) the gaps in outcomes between Indigenous and non-Indigenous Australians are narrowing, in other areas (e.g. substantiated child abuse and neglect and involvement with the criminal justice system) they are either not improving or growing wider. Nevertheless, the report emphasizes that four factors tend to contribute to successful indigenous programs: co-operation between indigenous people and government; bottom up community involvement; ongoing government support; and good governance, within indigenous communities and within government (Banks 2009). The government has promised to include the Indigenous community as active partners in a community development plan to close the gap (Rudd 2008; Macklin 2009a). Evidence from successful indigenous programs in health, education and other areas suggests that the active participation of Indigenous Australians in the development of policies and the implementation of service delivery will be crucial if government plans are to prove successful (Cox 2009a).

### **Other social policy initiatives**

The government has cut the so-called middle-class welfare payments favored by the former Coalition Government by means-testing the Family Tax Benefit Part B and the baby bonus, and reducing private health insurance rebates. At the same time, they have targeted additional resources and support to disadvantaged groups. For example, low to middle income working families eligible for Family Tax Benefit A, pensioners and carers received a one-off payment of up to \$1400 as part of the government's economic stimulus package (Karvelas 2008a). The government also increased the weekly pension rate for single recipients of the aged pension, carer payment, and the disability support pension from \$300 a week to \$333 a week including supplements.

But conversely, the unemployed received no assistance from the economic stimulus package, and neither the unemployed nor sole parent pensioners received any increase in their weekly payment. The unemployed remain on \$227 a week which is \$106 a week below the newly increased single pension (Gordon 2009). The government justified the different levels of payments on the grounds that parenting payment and Newstart were designed as temporary payments for those who will return to the workforce, whilst the other payments are intended to provide permanent support (Swan cited in Schubert 2009).

However, this argument has a number of limitations. Firstly, many sole parents and the unemployed do rely on income support payments for a long period of time, and are even more likely to do so during a time of global economic recession. For example, half of all recipients on Newstart Allowance now rely on this payment for over one year, and 29 per cent have received payments for five years or more (Australian Government 2008b:4; ACOSS 2009a). Secondly, the distinction between different groups of income support recipients seems to be based mainly on subjective readings of public opinion, rather than any objective measures of merit. Groups such as age pensioners and carers seem to be regarded as deserving, whilst other groups such as sole parents and the unemployed seem to lack public legitimacy (Cox 2009b). Thirdly, there is a strong economic as well as compassionate argument for providing additional assistance to the unemployed and sole parents who are seeking work so that they can actually access the resources (clothes, grooming, transport etc.)

necessary to attain employment. Fourthly, a significant number of the long-term unemployed seem to be moving by stealth onto the higher paid Disability Support Pension (Macklin 2009b). Finally, the entrenchment of many individuals and families in long-term poverty is likely to have adverse implications for social cohesion, and lead to greater costs in other areas such as health care and criminal justice (Edwards 2009).

### **A softer form of mutual obligation**

The ALP has appeared to soften the mutual obligation policies introduced by the former Coalition Government. These policies placed compulsory obligations on jobseekers under the assumption that they had an obligation to give something back to society in return for their income support payments. The Coalition had introduced Work for the Dole for job seekers aged 18-49 years, and imposed harsh breaching penalties on income security recipients who failed to meet their job seeking requirements (Mendes 2008: 139-142).

The ALP shares the Coalition's belief that social rights should be accompanied by responsibilities, and support the principle of mutual obligation. But they argue that it should be a 'two-way street', and include positive incentives such as the government taking responsibility for providing training and employment opportunities. They also argue that mutual obligation requirements should be fair, and not unreasonably penalize income security recipients and their dependants (ALP 2007: 89-90; Gillard 2007; ALP 2009: 16).

The ALP established a Participation Taskforce in June 2008, chaired by Social Inclusion Board head Patricia Faulkner, to examine concerns that sole parents and mature-age job seekers found existing participation rules overly rigid and demanding, and counter-productive in regards to accessing stable employment. The Taskforce argued that participation requirements should reflect the particular individual circumstances of recipients rather than a 'one size fits all' approach. They recommended that single parents involved in caring roles be given a wider range of activity options including voluntary work and part-time study rather than having to accept any job offered, that victims of domestic violence be excused from looking for work for 12 months, that exemptions should be granted during school holidays, and that single parents caring for disabled children be paid a higher rate (Australian Government 2008c). The government announced in May 2009 that they had accepted the key recommendations of the Taskforce, and would introduce a range of new exemptions and flexible arrangements that recognized the family and community responsibilities of these two groups of recipients (O'Connor 2009).

The government also undertook a review of the existing employment services model. This review suggested that the existing compliance system for job seekers was punitive and counter-productive, and had directly contributed to ill-health and homelessness. They recommended an end to automatic eight week suspensions for jobseekers who receive three participation failures within 12 months. Job seekers who fail to comply will now be reviewed instead via what is called a comprehensive compliance assessment that will identify when a job seeker is unable to meet their obligations due to circumstances beyond their control. A list of vulnerability indicators will be placed on the computer records of job seekers for this

purpose. And the jobless will now have twelve, rather than six months before they have to work for the dole (Australian Government 2008b; Karvelas 2008b).

In addition, the government's rhetoric has been far more compassionate than that of the previous Coalition Government. The Coalition had regularly used blame the victim language, labelling the unemployed as dole bludgers, job snobs, and work shy (Mendes 2008: 136-137). In contrast, the ALP Government has generally used neutral language which recognizes the complex causes of disadvantage, and favours incentives and opportunities rather than punitive sanctions. However, both Prime Minister Rudd and two leading Ministers implied on one occasion that job seekers were too choosy (AAP 2009; Packham & McMahon 2009), and the government has not revised the title of the work for the dole program despite acknowledging that the term stigmatizes job seekers (Karvelas 2007).

The neo-liberal Centre for Independent Studies has predictably condemned the amendments to the compliance system, and accused the government of acting at the behest of the welfare lobby to undermine the principle of mutual obligation (Saunders 2008). Similarly, the *Australian* newspaper accused the government of aiding job seekers who 'would rather laze than work' (Editorial 2008), and the Coalition opposed any softening of mutual obligation principles (Andrew Southcott cited in Karvelas 2008c).

However, the compliance system remains tough, and the significance of this softer line should not be over-stated. Advocacy groups such as the National Welfare Rights Network (2008) have in fact argued without success that vulnerable groups such as the homeless, the mentally ill, substance abusers, the illiterate, and those who have been subject to domestic violence should automatically be exempted from all aspects of the penalty regime. They have also expressed concern that there remain few protections for those who will be subject to loss of daily payments under the new 'No Show No Pay' provisions, and may be left without sufficient income to pay their rent, purchase medicine, buy food for their children, or meet other essential expenses. And they criticized the government for retaining the eight week no-payment option although the government says it will rarely be used.

### **A compact with non-government welfare agencies**

The ALP Government's approach to non-government welfare agencies (NGOs) – also called the non-profit sector - suggests another major difference with the former Coalition Government. The Coalition had actively attempted to suppress the advocacy activities of groups such as the Australian Council of Social Service which receive government funding (Mendes 2008: 130-132; Staples 2008: 279-280).

In contrast, the ALP has recognized the legitimacy of advocacy activities including criticism of government policy, and sought to establish a cooperative partnership with the non-government welfare sector. One of their first actions was to remove the controversial 'gag' clauses included in government contracts with NGOs which limited this advocacy role (Franklin 2008; Horin 2008, Murphy 2008). The government also commissioned ACOSS to undertake a consultation process with NGOs with a view to developing a National Compact between the government and the sector. A compact is a non-binding agreement which would

seek to outline how the relationship between the government and NGOs might be strengthened. Key issues to be considered include sector independence, consultation processes, funding arrangements, sector accountability and transparency, and practice principles (Edgar 2008). The report by ACOSS suggested strong support by NGOs for a more collaborative relationship with government based on a recognition of the important contribution made by the non-government sector (Australian Government 2008d).

But there appears to be limits to the nature of the partnership proposed. To date, the government has not considered introducing a community development model of service provision that would grant genuine independence to NGOs so that they can both develop policies and deliver services based on the stated needs of consumers (Fowkes 2009). For the Job Network, for example, this might mean an employment and training scheme run by a local cooperative (potentially involving trade unions and progressive local governments and business people) to meet the aspirations of participants, rather than those of government or providers.

## **Enforcing responsible behaviour**

In two key areas, the ALP has essentially mirrored the Coalition's argument that welfare payments should be conditional on meeting obligations of good behaviour.

The first is the government's decision to continue the key initiatives of the Northern Territory Emergency Response (NTER). In June 2007, the Coalition Government announced a national emergency plan for remote indigenous communities to counter an epidemic of child sexual abuse. The plan included a range of measures to tackle alcohol abuse, improve school attendance, reform public housing arrangements, and quarantine 50 per cent of all income support and family assistance payments so that the money could be spent only on food, school, rent and other essential items. Critics expressed concern that the intervention was highly paternalistic and not based on any consultation with Indigenous people; that the 'tough love' measures were being applied to all Indigenous parents whether negligent or otherwise; that negative sanctions alone were unlikely to resolve deep-seated problems such as child abuse and neglect, unemployment and substance abuse; and that applying restrictions to welfare payments on the basis of race may breach the Racial Discrimination Act (Altman & Hinkson 2007; ACOSS 2008b).

The ALP Government organized an independent review of the NTER chaired by West Australian indigenous leader Peter Yu. The report of the review, which was released in October 2008, agreed that the intervention had made some positive changes in the Northern Territory in relation to improving housing, health and education. But it also argued that the intervention was too top-down, and had failed to engage the communities involved. The report called for an end to the compulsory income management system under which welfare payments are heavily controlled except where child protection or school attendance matters were involved, and urged a reinstatement of the Racial Discrimination Act. Overall the report recommended that the intervention be continued in order to address the unacceptably high levels of deprivation, but urged that it be reframed as a partnership with indigenous communities (Australian Government 2008f).

The government has committed to implementing more active community development and engagement processes with the local indigenous communities. However, it rejected the recommendations of the review report pertaining to compulsory income management, arguing that it had provided benefits for women and children such as increased household expenditure on food and other essential items, less gambling and drinking, and reduced alcohol-fuelled violence. They stated, however, that they would re-draft compulsory income management measures via parliamentary legislation to be introduced in October 2009 to make them comply with the Racial Discrimination Act (Australian Government 2008e; 2009b).

The second area of authoritarian welfare has involved the government introducing trials of welfare quarantining for parents who abuse or neglect their children or fail to ensure their school attendance. The Child Protection Pilot was introduced in selected WA communities from July 2008. The Western Australian Department for Child Protection is able to request that Centrelink manage up to seventy per cent of parents' income support and family payments to ensure that the essential needs of children at risk are met. Parents will receive income payments through Income Management debit cards which cannot be used to purchase alcohol, tobacco, pornography or gambling (Centrelink 2008).

A separate school attendance and enrolment pilot was introduced in six NT communities and two metropolitan locations in January 2009. State education authorities will be able to notify Centrelink in cases where parents fail to take reasonable steps to ensure children attend school. Non-compliant parents will have their payments suspended. The government has justified these trials on the grounds that linking personal responsibility to financial reward is an effective way of changing behaviour and ensuring that parental responsibilities are met (Macklin 2008: 84-85). But critics have questioned whether sanctions alone in the absence of improved support services including particularly extensive case management will address the complex factors such as poor skills, substance abuse, mental illness and family violence that contribute to child abuse and neglect and poor parenting (ACOSS 2008b: 14-15).

## Discussion

The social inclusion philosophy underpinning the government's social welfare policies seems to be driving a more holistic approach to social disadvantage. The government has demonstrated that it views poverty and inequality as unacceptable outcomes that need to be addressed by government intervention, and it has prioritized groups such as the homeless and Indigenous Australians whose needs cannot be resolved by the free market. The government recognizes that disadvantaged Australians are not all the same, and that a complex range of factors including structural inequities, local community resources, and individual capacity influence outcomes. It seems to accept that social participation may need to be defined more broadly than just involving attachment with the labour market.

However, the government has been inconsistent in its application of social inclusion principles. Whilst it has rightly recognized that elderly pensioners and carers need additional resources to participate in society, it has failed to apply the same assumptions to sole parents and the unemployed. Similarly, it has acknowledged that many income support recipients

have different individual capacities and circumstances which need to be reflected in their job seeking requirements. However, at the same time, the government has applied compulsory income management to all remote NT communities, irrespective of how well individuals can manage their money and care for their children and families. And blanket sanctions have also been applied in the child protection and the school attendance pilots irrespective of the capacity of individual parents. These contradictions appear to reflect political and budgetary considerations, rather than objective evidence. They also reflect a reluctance to challenge free market orthodoxy (Edwards 2009; Robbins 2010: 470) despite the Prime Minister's rhetorical critique of neo-liberalism (Rudd 2009).

The government has also struggled to translate its rhetoric about creating more bottom-up partnerships with local communities into practice. All income security programs would arguably benefit from more formal consultation with groups representing service users as well as service providers. And equally policies to address indigenous disadvantage including particularly the Northern Territory Emergency Response should involve much greater consultation with and devolution of control to local indigenous communities.

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**Dr Philip Mendes is a Senior Lecturer in the Department of Social Work at Monash University, Caulfield [Philip.Mendes@med.monash.edu.au](mailto:Philip.Mendes@med.monash.edu.au)**

## Emerging tensions in the use of assessment tools in home and community care

MELISSA LINDEMAN

### Abstract

*Access to community care services for older people and younger people with disabilities is based on the assessed needs of individuals seeking assistance to remain at home in the community. This paper reviews literature related to use of assessment tools in community care in the context of findings from a Victorian study that focussed upon initial needs assessment processes in home and community care. The trend toward more formalised (and potentially standardised) assessment tools in community care assessment may give rise to unintended tensions that potentially undermine the critical thinking and flexibility required to assess need across diverse populations. Training and professional development for community care assessment, where the focus is on critical thinking, rather than on the use of assessment tools alone is suggested.*

**Keywords:** assessment tools, community care, training

### Introduction

Home and Community Care (HACC) services, for frail older people and people with disabilities, include home care (such as cleaning or shopping), home maintenance, personal care, social support, day activities/day care, other forms of respite, delivered meals and community transport. HACC is a funding program of the Commonwealth and State governments. Access to HACC services is based on the assessed needs of individuals seeking to remain at home within their community. HACC assessors are required to meet certain standards of practice in areas such as developing cooperative relationships with other providers, collecting basic client data on a common referral form, assessing certain domains, involving the client and carers in the process, and developing care plans. The assessment process in HACC is usually clients' first point of contact with services and a critical stage in clients' engagement with the broader service system.

Reforms to community care systems in Australia have often focused on the use of assessment documents and processes. Ostensibly this has been to minimise duplicate assessment of clients shared by more than one agency (so that some questions only need to be asked once), and to improve systems of client data collection (Brian Elton and Associates & Department of Human Services and Health 1995; Caban 1993; Helling 2002). The Client Information and Referral Record (CIARR), a simple, common information and services record completed at the time of assessment, has been replaced (in Victoria) by the Service Coordination Tool Templates (SCTT), and all HACC providers, have been required to use these documents since 2002. Some non-HACC providers are also mandated by DHS to use SCTT such as

Psychiatric Disability Rehabilitation & Support Services (PDRSS). The SCTT has the same aims as the CIARR: to help improve service coordination and client referral, and reduce duplication and multiple assessments of the same person by different agencies, but is much more detailed in scope and depth of assessment domains. This essentially signifies a move towards more systematised assessment processes and documentation across a range of service providers, a trend that is set to continue as a requirement for HACC services (Howe & Warren 2005).

Staff employed in assessment roles have diverse backgrounds such as social and welfare work, nursing, health, and disability studies (Howe 2000: 100; Prideaux, Clark, Goonan and McCormack 2004). The need for flexibility in assessment that complements rather than competes with more formalised or standardised assessment tools is implicated in the various perspectives each staff member may contribute.

## **Method**

A research study was conducted in Victoria with the aim of developing a greater understanding of the assessment workforce in HACC in order to develop better approaches to their professional preparation and support (Lindeman 2006). The study used qualitative methods: in-depth interviews were conducted with twelve key informants (including funding body representatives, trainers, consultants, and peak body representatives) and with twelve individuals employed in assessment roles in HACC. The current paper integrates findings from this study relating to implementation of assessment documentation with a discussion of literature focused on this area. De-identified direct quotes from research participants are included for this discussion.

## **Assessment tools in community care**

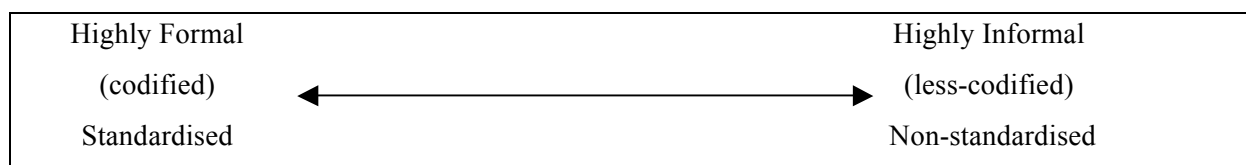
Assessment documents can be represented along a continuum of ‘highly formal’ to ‘highly informal’, as represented in diagram 1. At the highly formal end of the continuum are the standardised tools that are norm referenced and which have been subjected to extensive field testing and statistical analysis. These standardised tools are said to rate highly in terms of reliability (they produce the same results regardless of who is administering the tool) and validity (they measure what they are supposed to measure). Examples of standardised tools include those that test for dementia, such as the Mini Mental State Examination (Folstein, cited in Hodges 2007), or for functional capacity for activities of daily living, such as the InterRAI suite of assessment tools (Lincoln Centre for Ageing and Community Care Research, 2004) ([www.interrai-au.org/suite.htm](http://www.interrai-au.org/suite.htm)) (InterRAI website accessed 31<sup>st</sup> March 2009). Standardised assessment tools are commonly used in health (The Royal College of Physicians of London & The British Geriatrics Society 1992) and allied health professions such as occupational therapy (Cramer & Bartholomew 2000; Eakin & Baird 1995; Vertesi, Darzins, Lowe, McEvoy, and Edwards 2000) and less frequently in social work (Ivry 1992). It is assumed that professionals are competent to administer standardised tools due to their professional training. In general, medical/health professions tend to favour standardised assessment tools, and social welfare professionals tend to favour non-standardised assessment tools (intuition and judgement-based approaches). The use of standardised assessment tools

is relatively uncommon in HACC (Howe & Warren 2005) but very common in Aged Care Assessment Teams in Australia (Lincoln Centre for Ageing and Community Care Research, 2004) which are staffed by medical and allied health (discipline-based) professionals.

Further along the continuum, are highly codified documents that assist workers to formulate judgements but which are not necessarily standardised. In community care, some falls risk assessment tools (Hill, Schwarz, Smith, Gilsenan and Bull 2001) are in this category, and the tool to assist workers judge need for personal alarms/personal alert systems (Mayhew-Rankcom, Lindeman, Hill and Smith 2001) also fits here. Further along still are more simple tools designed to assist assessors judge whether or not an issue requires monitoring, a special service response, or referral to a specialist assessor. The HACC nutrition risk assessment tool (Wood 1998) is an example of this which is designed for application by any HACC assessor.

At the opposite end of the continuum are assessment processes that are highly *informal or unstructured*. These may simply be lists of domains (or headings, such as “mobility”) with free text space allowing for the assessor to record any information they feel is relevant.

#### Diagram 1: Continuum of levels of formality of assessment tools



Arguments that support the use of formal, or structured, instruments include that they reduce the risk of inconsistency between assessors and enhance the program’s ability to collect reliable data. On the other hand, there are arguments that assessment tools are only as good as their users (Kane & Kane 2000). Seed & Kaye (1994) suggest that the assessor’s attitude is more likely to influence the assessment process and outcome than the instrument itself. Woods and Baldwin (1998) note that while needs assessment processes that include predetermined lists are helpful to ensure that an adequate range of activities is considered for assessment, it cannot substitute for more open-ended techniques that are based upon the assessor using good professional judgement. They also note that while all clients share universal needs, most clients will also have specific needs, often relating to religious, ethnic and other cultural factors including specific aspects of their disabilities (Woods & Baldwin 1998). The implication is that formal/structured (standardised tools) are less likely to capture client diversity than less structured, open-ended, and fluid processes. Highly formalised documents (including standardised tools) are more likely to be ‘score based’ compared to less formal documents. Score based approaches give a numeric score to clients based on data collected from them which assists assessors to make comparative judgements and to assess relative need objectively (Seed & Kaye 1994).

An assessment in community care may include application of a number of ‘tools’ depending on the nature of the referral. There will also usually be a document (or it will be all inclusive) that records other client data important for the provision of services. Informal tools are more

often associated with application by non-professional staff, although these are the tools that rely most heavily on professional judgement of the assessor. A lack of integration of 'health' and 'social' domain groups in community care assessment tools has been reported (Stewart, Challis, Carpenter and Dickinson 1999), possibly reflecting an assumption that no one assessment worker can cover both (all) areas sufficiently.

### **Professional backgrounds of staff**

Evidence from the United Kingdom suggests that differences in professional backgrounds of staff involved in client assessment presented difficulties when a common assessment form was introduced (Lewis, Bernstock and Bovell 1995; Vernon, Ross and Gould 2000). Essentially this was because the information required by the different professions was different, and because it was unclear whether one profession should accept another's assessment. Similar issues were experienced in Australia in relation to implementation of the CIARR for the HACC program (Brian Elton and Associates & Department of Human Services and Health 1995). The difficulty of designing a comprehensive tool to suit the diversity of the aged and community care workforce, despite the range of services having common clients and common objectives, is marked. The influence of the professional background of the assessor in community care is well recognised (Butler, Dickens, Humphries, Otis and Russell 1998; Kane & Kane 2000). A person with greater expertise in a particular domain is likely to explore that domain in greater detail than someone whose expertise lies elsewhere. The implication here is that the worker's professional background and training will shape the assessment process and the information that is collected and, in turn, the client outcome.

Worth (1998) refers to research studies that conclude that assessment is seen to be rooted in the professional identity of the assessor; the assessment style and language is profession-specific and is therefore limited in scope. The differences between the value frameworks of nursing and social work professions and the resulting differences in practice are cited. In contrast, Hughes (1995) reports not only differences in the scope and content of assessments performed by different professional categories (social workers, occupational therapists, and home care co-ordinators), but often wide variation between people within the *same* professional category. Similarly, Dill (1993) points out that precisely because of the uniqueness of each assessor (in relation to personal characteristics and approach) as well as each individual who is assessed, needs assessment will vary from case to case regardless of the degree of standardisation of the assessment instruments used (Dill, 1993). Assessments have been shown to be a selective and interpretive process, either a structured exploration of key needs of service users according to key topic areas with the assessment framework, or they can be more conversational with services users and informed by the assessment framework (Foster, Harris, Jackson, Morgan and Glendinning 2006). Whilst the sector tends to be preoccupied with the influence of individual professions in community care assessment, this suggests that the professional background of the assessor only tells part of the story and that a range of other factors may come into play to influence an individual's approach to assessment. A greater understanding of these other factors would enable initiatives, such as joint training/learning programs which focus on common 'frameworks for thinking', to be developed more strategically. Even within respective disciplines, there is considerable

diversity in the professional training/disciplinary approach of the worker as well as personal characteristics of the workers themselves (Lindeman 2009).

## **Current Practice and Emerging Tensions in Application of Assessment**

### **Tools**

Some of the critical tensions that are pervasive in community care become clear on consideration of assessment documentation in needs assessment. According to Dill (1993)

“the technical superiority of the bureaucratic form derived largely from its ability to rationalise decision-making, replacing personalistic, affective criteria with universalistic, objective means and measures” (Dill 1993: 456).

As such, assessment documents that are designed to enable predictability, fairness of decision-making and efficiency fit within a positivist frame. Practitioners are required to uncover essentialised patterns and determine whether they contribute to or hinder functioning (Iversen, Gergen and Fairbanks 2005). Professionals often tend to make extensive use of formal documentation to both assist in their judgements and to justify their decisions. Yet, while professional (discipline-based) practitioners are encouraged to use formal assessment tools, they are also encouraged to evaluate them from the perspective of the tools' ability to take into account “each person's unique needs and abilities, as well as the environmental and social factors that may be affecting the clients' performance” (Pollock 1993: 298). This seems to be at the heart of a tension between the need for service providers to manage the volume of clients presenting for services and to be responsive to the diversity of clients and contexts. The place of clients' stories, the narrative that should provide the context for assessment judgements, can become secondary through over prescriptive use of some assessment tools with predetermined frameworks (Dill 1993; Tanner 2001). Tanner (2003) states that a focus on health and medical concerns may even obscure the significance of clients' social situations as the medical model serves to objectify or depersonalise clients' stories.

In the Victorian study, that included interviews with assessors, participant ‘Jennifer’, who worked with Indigenous clients, made a similar observation. She described existing assessment documentation as being too skewed towards health and medical information perhaps at the exclusion of other potentially useful information. She felt such questions were often unnecessary as her clients (Indigenous people) found them to be intrusive and served to obstruct the assessment process. The professional relationship between the client and the assessor was the most crucial aspect, rather than the tool itself:

“...I don't think assessment is one form, one visit. It needs to be an ongoing process where you are learning more about the person and developing a relationship as you go along” (Jennifer).

Higher value tends to be placed on clinical expertise over other areas of expertise in the sector. Mykyta and English (2002) criticise the trend of “de-medicalisation” of assessment on

the basis that assessment, particularly basic assessment for home and community care, has been “de-professionalised by the introduction of protocols and screening instruments that can be administered by clerical rather than clinical workers” (Mykyta & English 2002: 84). The evidence from the Victorian study negates this conceptualisation; such a polarisation is not evident from the professional identities of assessment workers. They are, in fact, a highly diverse group with health and social care backgrounds represented, and no participant in the study was without some sort of formal qualification (Lindeman 2009). Further, evidence suggests that basic (initial) assessments in community care are undertaken holistically in HACC services:

“... how is the family relating to each other? Who’s letting who have a word? What’s the physical environment like? Have these people struggled all their lives and are real battlers? Are these people that perhaps in the past have had very comfortable existences and now are struggling and don’t know how to deal with that circumstance? Is this a household that is absolutely falling down around their ears, that’s perhaps a health risk, dangerous? Are there things like electrical cords everywhere? Are we in a real mess here, are we at the point where we need an industrial clean? You know, all of those things give you alarm bells as to how this person is coping or where they’re at in their life now. Whether it is through health issues, whether it be mental issues, whether it be through just having absolutely no repertoire of the experience to understand, ‘I’m old now and this is what’s happening to me’. You know, all of that, so just listening and observing everything. There are cues everywhere and you’ve got to be on red alert for taking in and looking for information everywhere and then I guess drawing on your experience ... whether it be professional or personal or whatever and putting it into some sort of context” (Heather).

However, HACC assessors *are* faced with the program requirements for more formalised documentation and standardised approaches to assessment that can present challenges to holistic practice. Some participants held the view that the funding body placed too many demands on the sector for assessment “paperwork”, reporting, accountability, and minimum service standards without providing adequate funding and other support to assist services with these tasks nor to meet the growing demand for their services in the community. This is a view commonly encountered when a practice innovation involves the use of assessment tools (Guberman, Keefe, Fancey and Barylak 2007).

Client-centred assessment necessarily requires the assessor to obtain ‘biographical information’ in order to arrive at an understanding of the client’s world view (Worth 1998). Without allowing the client to tell their own story, their account could become objectified and depersonalised through the assessment process so that their goals and values are hidden (Richards, 2000). Attention to narrative is therefore crucial. As well as eliciting information about the client that will help needs identification and care planning, allowing clients to tell their stories helps to reduce the power imbalance between clients and practitioners as the assessor engages with the client instead of “expecting them to fit into bureaucratic and professional agendas and ways of thinking” (Richards 2000: 47). Some commentators view

the language of ‘assessment’ itself as unhelpful as it is a “social construction that privileges the professional and disempowers the client” (Iversen et al. 2005: 695). Participant Jennifer made a similar observation, pointing out that terms such as ‘assessment’ and ‘need’ may have unintended connotations, or even be meaningless, for many Indigenous people with whom she works.

According to Dill (1993), clients’ stories are not amenable to interpretation within the framework of many formal assessment instruments used by highly trained professionals. In some instances it is not possible to easily ‘fit’ the client’s story into a standardised assessment instrument, thereby leaving the client’s perspective open to misinterpretation and for assumptions to be made based on normative data (Dill 1993). Similarly, Chevannes (2002) reports that diverse voices of older people are little considered in defining needs, and professionals exercise control over how clients are categorised. The findings of the Victorian study indicate less constraint felt by assessment workers in implementation of assessment tools in current use. Participants were very aware that clients’ stories were critical to establishing the nature of client need and, although the SCTT is not a standardised assessment instrument, assessors were aware of the potentially negative consequences of using the assessment document too prescriptively. As the following quote indicates, the assessment tool is not the primary focus of the assessment process:

“Apart from the full assessment [SCTT], in your own head you’re listening to just how they talk about their family, like when you’re asking them ‘who is your next of kin, do you have family locally’, generally just the way they talk about them, you can tell whether they actually help or not and then whether you can then speak to the family to rely on getting a bit of help from them. Also, looking around the house, just to see the conditions - is it safe, what sort of condition is it in? Things like that. Safety aspects like steps, rails and things like that - they may say their walking is fine but they may take a couple of minutes to answer the door and you can hear the frame shuffle up the hallway, but they’ll say ‘oh no I walk really well, I walk to the shop every day’. But then you get in the house and there might be steps into every room, and yeah they may walk fine, but it is an issue because they’ve got to lift the frame up or lower it down. So you look at all that, and it’s just being open to anything, like you just don’t know what to expect when you get into some houses” (Ivan).

Assessors were very aware of the primacy of client stories and dialogues and described instances of negotiation and collaboration with clients. For example:

“Working with the carers you do the ‘gate assessment’. That is where as they are walking you to the gate they tell you that the client is telling lies, or it is really like this. We used to joke about this being the ‘gate assessment’. You sit with the client in the assessment, and the carer is sitting there shaking their head or rolling their eyes. So you talk to them as you walk to the gate. But then as an assessor how do you use that information? It might mean another phone call or a second assessment if necessary” (Anna).

According to a key informant employed in a policy role, the assessment documents are not designed to encourage a ‘form-driven’ process, but rather, to enable individual assessors and organisations some flexibility while meeting certain minimum standards:

“Obviously there are certain standards and the need for flexibility. That’s why the ... tools have been developed as templates rather than ‘mandatory forms’ that have to be used in a certain way... It creates a mindset and a framework rather than dictating that this is the one and only way that it can be done” (State government employee).

However, the trends towards more formalised documentation may have unintended consequences for practice. In a study of implementation of a standardised assessment tool in community care in Canada (Bay Consulting Group & Workflow Integrity Network 2004), assessment/case management staff were found to be experiencing “pathology of drift”, meaning that increasing administrative functions (a by-product of the current environment of community care and associated trend towards more formalised, standard documentation) were reducing the ‘flow’ of their work. This was found to create a less than ideal environment for the “critical thinking” required in dealing with complex clients and “messy situations” which tend to be common in community care (personal email communication with K., Parent, 29 March 2005). Similar findings from Victoria, where some assessors felt that assessment “paperwork” had become “burdensome”, indicate that greater attention needs to be focused on the realities of practice resulting from changing (increasing) documentation requirements. Any move towards the introduction of more formalised or standardised tools in initial needs assessment in home and community care should be considered in the light of research evidence.

## **Implications for Practice and Professional Development**

Standardisation is often equated with equity and therefore ‘fairness’ in regard to allocation of services and resources. However, practitioners need to be able to reflect upon and consider the unique and diverse needs of clients in order to provide safe and equitable care.

Standardisation can, without adequate flexibility and encouragement of critical thinking, lead to a ‘one size fits all’ mentality that inherently discriminates against sectors of the community. Training in the use of assessment tools to avoid over-prescriptive application is recommended (Guberman et al. 2007; Kane & Kane 2000). The emerging tensions for assessors in managing both the increasing demands on services through practices such as prioritisation, as well as responding to the diversity of client’s individual stories in assessment, should be acknowledged in professional development programs.

In preparing workers for needs assessments that are based on standardised or highly formalised tools, the role of critical thinking and critical reflection should be prominent. The adoption of frameworks for service delivery to diverse populations such as cultural safety and cultural competence has prompted a shift in thinking around what it means to provide equitable care. In regards to cultural safety specifically, there has been a major philosophical

shift from the provision of care *regardless* of cultural background, to care that is *regardful* of the unique needs of individuals and groups (Ramsden 2002). This philosophy in particular has reflection on the practitioner's own cultural influences and power, as well as the need to engage in dialogue with the client as key tenets. The value of this conceptualization of culture is that it has broadened the definition from ethnicity only to include culture as relevant to age, gender, socioeconomic status, religion, sexual orientation and so on.

Further, the use of common 'frameworks for thinking' in professional development programs and practice such as the International Classification of Functioning, Disability and Health (ICF), developed by the World Health Organisation, also holds the promise of encouraging critical reflection and consideration of the uniqueness of individual clients when applied along with standardised assessment tools. Used as a conceptual framework, the ICF provides a model for assessing the interaction between different components of a person's life, provides a common language and framework for multidisciplinary and lay workers and carers, and provides an integrative framework for training (Allan, Campbell, Guptill, Stephenson and Campbell 2006; Lindeman & Newman 2006).

## Conclusion

Standardised assessment tools, based on normative assumptions and used inflexibly, can have difficulty capturing diversity. At this stage in HACC, assessors report flexible approaches in their use of common documentation, and clients' stories are at the heart of the assessment interaction. However, current practice may be challenged as assessment documentation becomes even more formalised (and potentially standardised), along with the associated trend towards professionalisation of the workforce, and the need to manage ever increasing demand for services. Deeper understanding of the practice and professionalism of these workers is therefore required, and a greater focus on developing appropriate training and professional development opportunities is suggested. Rather than focusing on the physical design and content of assessment documents such training should be focused on developing critical thinking and reflection skills to assist assessors use such tools in their holistic practice with diverse clients and in diverse settings. Frameworks for practice and professional development such as 'cultural safety' and the 'ICF' can assist multidisciplinary practitioners to develop the necessary critical thinking and reflective skills to ensure that their practice remains responsive to the unique needs of individuals.

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***Dr Melissa Lindeman is the Director of the PHCRED Program, Centre for Remote Health, A joint Centre of Flinders University and Charles Darwin University <http://crh.org.au/>***

## Keeping it simple: manageable program planning and evaluation in human service organisations

SUZANNE BEATTIE-JOHNSON

### Abstract

The following review of program *planning and evaluative models* seeks to determine relevance within 21<sup>st</sup> century Victorian welfare in the context of increasing regulation of service quality and standards of practice. This paper examines three distinct models from the literature: incrementalism, the ethical model, and the effectiveness model as they demonstrate a shift from a simplistic means-focussed approach, to values-based, measurable and outcomes-focussed planning and evaluation methods. These models are critiqued, recognising that complex frameworks can be resource-intensive and ambiguous in their practical application. Thus, common elements are identified to inform a more generic program planning framework. This article asserts that discrete program planning models cannot be universally applied, and that specific models or hybrids should be considered by planners and evaluators within the organisational and broader environmental contexts. The key is to ensure the resultant framework – whether generic or tailored, is meaningful, manageable and of value.

**Keywords:** *program planning models, evaluation, human services management, quality improvement*

### Introduction

As a human services consultant, I have been engaged by diverse organisations across health and welfare sectors to undertake a broad range of activities including strategic and business planning, service and program development and review, policy development, submission writing and quality improvement, to name a few. There are key areas of commonality between each of these organisational activities, in that they all involve planning, development and review of organisational processes and systems or sub-systems as a means of creating change to improve outcomes for consumers\*. Improving the lives of people and communities is the fundamental purpose of human service programs (Lewis, Packard and Lewis 2007), and therefore underpins all levels of planning and evaluation.

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\* The term 'consumer' herein refers to past, current and potential clients

Program planning models proposed by social science theorists provide practitioners with a suite of approaches from which to draw and adapt to specific contexts (service specific, organisational, integrated (cross-sectoral partnerships), community and/or governmental). Determining the most appropriate planning model is largely informed by the nature of the program and the anticipated impact of the program on consumers, the organisation, other key stakeholders and the community. Furthermore, program planning and change management are inextricably linked, in that implementation of new programs always creates change within an organisation.

Consideration must be given to a range of factors such as staff animosity, fear, enthusiasm, innovation; budgetary allocation across cost centres placing greater pressure on bottom line funding; profile, management responsibility, and so on. In addition to identifying and developing strategies to address or thwart potential internal politics and conflict, it is equally important to consider external environmental influences. Cohen and Cohen (2000) state that it is crucial to understand the broader contexts of change in which a program operates. Planning activities should therefore take into account the local and broader environmental factors (political, cultural, social, economic, ecological and technological) that may impact on, influence or be affected by implementation of programs.

In line with welfare sector best practice that promotes tailoring services to individual client needs, program planners should be tailoring planning techniques to each individual program context to maximise effectiveness of processes and achievement of desired outcomes. This may involve taking the ‘best bits’ of two or more models and creating a hybrid model or simply adding other criteria or frameworks to an existing program planning model.

This paper considers three distinct models: incrementalism, the ethical model, and the effectiveness model, in order to explore how approaches can be adapted to ensure relevance to organisational and broader environmental contexts. I also draw on other frameworks I have found useful in my work.

## **Model critique**

### ***Charles Lindblom’s incrementalism***

As its name suggests, incrementalism is a program planning model that is focussed on the implementation of a series of small, generally unplanned, organisational changes (Lindblom 1959). Planning activities within this framework are focussed on the means for change rather than the ends, which are pre-determined and imposed.

The five key elements of incrementalism are: separation of political and planning centres; lack of value consensus; absence of general ends; specific ends are remedial, opportunistic or unclear; and functional rationality (Mayer 1985).

This process does not generally seek community or organisational input or agreement regarding issues and their resolution, but is driven by political influence and a preoccupation with facts. Planning objectives may be corrective in nature – involving a negative focus. It is often

underpinned by a concern with economic development, and may be intentionally ambiguous to avoid ‘accountability for an undisclosed decision making rationale

Incrementalism is focused on process, and specific outcomes rather than broader end results; thus it might be described as aligned with Wadsworth’s *Open or Inquiry Evaluation* (Wadsworth 1997). The open evaluation model provides for an ongoing planning and assessment of processes – a continuous cycle of plan, act, assess, review. There are variations of continuous quality improvement (CQI) models, but essentially they involve a process of system/program reflection, planning and trialling of change, analysis and either further reflection/planning or implementation. The wider relevance of Wadsworth’s open and review evaluations will be revisited in greater depth.

My view is that incrementalism as a planning approach appears to be most prevalent in government departments and large bureaucratic organisations, but may also be seen in smaller organisations where change is imposed and inflexible, and those charged with responsibility must plan an evolutionary process of change within restrictive boundaries.

Whilst Lindblom (1959) and Mayer (1985) have indicated that incrementalism is the most commonly adopted planning model, the lack of recent reference to this model in human service management literature, could suggest that this view is outdated. The once ‘ad hoc’ and ‘gently, gently’ approach to welfare management and practice (Liddell 2003) has in my experience, given way to a decidedly more strategic and evidence-based approach. And whilst one may argue that this shift has been imposed to a large degree by government policy, it appears to have inspired innovation and a competitive desire for service providers to be perceived as leaders in excellence. Whether this has actually improved outcomes for clients however, is a question still to be answered.

Lewis, Packard and Lewis (2007) identify incrementalism as a useful budgeting model if based on a strategic plan and evaluation evidence of existing programs, however traditional approaches have negated any consideration of effectiveness or necessity of programs, and the “method does not help decide what programs or services should be cut, in what order, and to what extent” (Lewis et al 2007:177). One could argue that a greater emphasis on compliance with privacy and other rights-based legislation, enshrining principles of inclusion, consumer engagement; difference and diversity; greater accountability and transparency to government and the community at-large, have influenced a shift from the ‘simplicity’ of incrementalism to more comprehensive program planning models that indeed do examine broader policy implications, social or organisational systems, values and effectiveness, on which decisions are more likely to be justifiable and validated when scrutinised by key stakeholders, especially consumers.

### ***An ethical planning model***

Ethical planning models, according to Liddell (2003), are preferred by welfare sector professionals, as they are focussed on decision making that is informed by ethics and social equity. The ethical model as described by Mayer (1985) is a consultative and participatory approach underpinned by social values. It aligns with professional Codes of Ethics which inform

social workers' (and affiliated professions) and psychologists' methods of practice, behaviour and decision making.

According to Mayer (1985), who draws from Titmuss (1975), MacRae (1971), Rawls (1971), and Rein (1971), the three key elements of this model are: Clarity, consistency and generality. When debating competing value systems, this enhances rational decision making; objectives are determined through parity with values; and competing ends and means are resolved through determining consistency with a given value.

Essentially, these elements combine to create a program planning model that is focussed on establishing goals, measurable objectives and strategies based on a value system agreed to by those assigned planning responsibility.

The value system is utilised to determine the most appropriate people, processes and tools to achieve the program goals, and to inform key performance indicators which establish a basis for program evaluation at the outset.

Titmuss (in Mayer 1985) purports that decisions made during the program planning process should be ethically-based against a predetermined value system. For example, there is evidence of the ethical planning model within the disability field, whereby the Quality Framework for Disability Services in Victoria – Industry Standards and the newly developed Outcomes Standards *make explicit* the rights-based value system which underpin the management and direct care practices, organisational systems and policy development, program monitoring and review activities. Accordingly, all disability service providers are required to demonstrate compliance with these Standards in order to continue to be eligible for funding.

Similarly, other systems of quality self assessment, external accreditation and registration are being rolled out across human services sectors establishing universal standards of practice and outcomes through provisions of Funding and Service Agreements. Further examples of 'value systems' being disseminated across sectors include CSO Registration Standards derived from *Every Child Every Chance*, (Department of Human Service 2007) and the Victorian Children, Youth and Families Act 2005; Homelessness Assistance Service Standards (DHS Dec 2006) across the Victorian housing sector; and Victims of Crime Standards (Department of Justice September 2007) to inform victims assistance programs across the state, to name a few examples.

There is a clear parallel between the ethical model of program planning, and the emergence of rights-based service standards' frameworks, in that both are underpinned by social values and ethics. Service standards are in essence value systems which establish ethical and evidence-based benchmarks with specific criteria upon which organisations may assess their performance, achieve compliance and identify areas for quality improvement. The service standards highlighted thus far, make value statements based on ethical principles of practice, such as ensuring consumer participation in decision making and program planning; upholding and promoting consumer rights; access and equity; safe and culturally appropriate environments. Thus, it can be argued service standards are evidence of the practical application of an Ethical model of program planning and evaluation.

Lindblom (in Mayer 1985) suggests that program planning theories should be generic and therefore cannot address individual circumstances. There is validity in his argument that the cost of such intricate analysis may outweigh the benefits derived from such an exercise and cause planners to lose focus on their primary task. However, this approach, in my view is at the very core of ethical planning. When applying this model in practice, the program model, implementation and evaluation plans will by necessity reflect the values identified with the relevant services – whether they be values related to the cultural/social identity of the consumer base or values assigned by government policy based on measures of best practice, or a combination of both. If the plans do not achieve this, engagement of the consumer group/s might be fraught with resistance.

Wadsworth's (1997) *Open or Inquiry Evaluation* presupposes an ethical model of program planning, which assesses organisational processes on an ongoing basis, and therefore allows greater flexibility in (incrementally) modifying practices in line with consumer input. This model is more likely to yield achievement of outcomes that are in the best interests of those the program is designed to assist.

### ***The effectiveness model***

The effectiveness planning model is focussed primarily on achievement of client and program outcomes through recording of data, ongoing monitoring of program and client progress, continuous review and measurement of outcomes (Kettner, Moroney and Lawrence 1999).

The key elements of an effectiveness model may be described as: understanding of the problem (needs identification such as mapping, research, consultations); measuring client functioning, needs, barriers (pre-intervention assessment); identification and delivery of the best possible interventions (sector best practice, evidence-based research); ongoing monitoring of client progress (measurement against baseline upon entry into program, and assessment of gap between current status and achievement of end goal); measuring client functioning, needs, barriers; and follow up assessment of achievement of sustainable longer term outcomes (Kettner et al. 1999).

The ongoing assessment of effectiveness and recording of client progress is designed to provide quantitative and qualitative data to managers and planners for informing current practice and systems improvements, and future program planning activities. However, this approach is resource-intensive. The development, trialling and assessing of performance outcome measures, assessment tools, longitudinal client studies, and evaluation of service delivery effectiveness (benchmarking), are tasks that require a considerable commitment of time, funding, technology and personnel.

In order to critically analyse the viability of applying an effectiveness model, one must consider the complexity and magnitude of the program planning process in question. In other words, does the cost and broader organisational impact equate with the expected benefits of applying such a model? Is it sound management practice to commit significant resources to planning a new program with a service delivery focus in a single organisation when this allocation could have resource implications more broadly across the organisation? Can the effectiveness model be more readily justified when applied to a larger integrated program comprising external stakeholders on

the basis of strategic and political relationship building, raising organisational profile and sustaining status of 'stakeholder' issues with governments and the social services sector? Perhaps the effectiveness model might be enhanced with value-based components of the ethical model to demonstrate leadership in, and commitment to, excellence through practice based research that contributes towards a shared 'body of evidence' to inform development and uptake of best practice models.

It is not within the scope of this paper to address these questions, but suffice to say, decisions regarding application of the most appropriate planning model need to balance the viability of 'means' with the worth to the organisation of the 'ends', and retain as the primary focus the 'best interests of consumers'.

Critical analysis, development and implementation of the program planning models discussed must occur with consideration of broader welfare sector trends and policy directions. Effectiveness-based program planning and evaluation designs, seem to be favoured by funding bodies as a means of ensuring accountable, effective and efficient use of resources, by specifying inputs, throughputs, outputs, and outcomes in funding and service agreements – incorporating the program 'ends' which Kettner et al (1999) argue should be included in program designs. Such models are evident across the sector, albeit in various forms depending upon the capacity and sophistication of the organisation, through: stringent client data recording and reporting systems; greater specification of unit costs and rationalisation of funding models; public and social policy reforms requiring integrated service models, formalised partnerships, multiple entry points, centralised intake and universally adopted service delivery models; and quality self assessment and external accreditation/registration processes that determine compliance with established values and standards of performance.

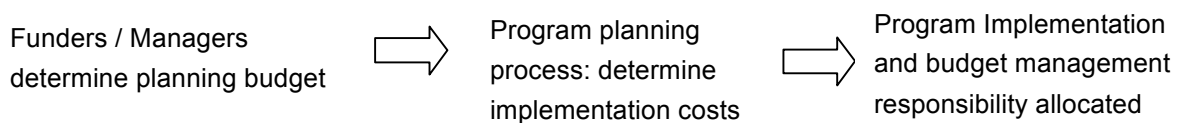
In my experience, the application of an effectiveness approach to program planning involving research, is often jointly driven by peak bodies and university departments such as psychology, social science and social work departments in conjunction with community service organisations (CSO's). This makes for a productive inter-relationship whereby the CSO supplies the 'raw data', subjects of study and a 'real life' research context; the peak body provides contacts, expertise, resources and documentation; and the university applies a theoretical framework, academic analysis, and a research ethics policy / committee to protect the interests of research subjects.

The managerialist focus of the effectiveness model appears inattentive to broader social, economic, environmental, technological and political factors that may influence, contribute to or be the primary cause of the 'consumer's problem'. The elements of this model are restricted to focussing on the individual (Kettner et al. 1999) – an approach that can be construed as inherently insular in regard to addressing broader societal factors, ultimately construing the client's 'problems' as purely subjective. One would hope that professionals charged with the responsibility for designing program planning based on the effectiveness model – whether at an individual service level or broader partnership level with a research focus, would incorporate a broader systems analysis into the design.

### *A Generic approach to program planning*

The program planning models discussed thus far are distinctive in terms of their priority of focus and approaches, but there are also common elements. Whilst financial considerations do not feature prominently in the ethical and effectiveness models, on the ground decisions regarding program planning, development and implementation costs are influential in defining, monitoring and reviewing the planning process. Lewis et al. (2007:12) indicate the importance of managers being aware of how the planning process is translated into financial terms. As figure 1 illustrates, there are financial considerations at either end of the program planning spectrum, regardless of the model.

**Figure 1: Budgetary influence across Program Planning**

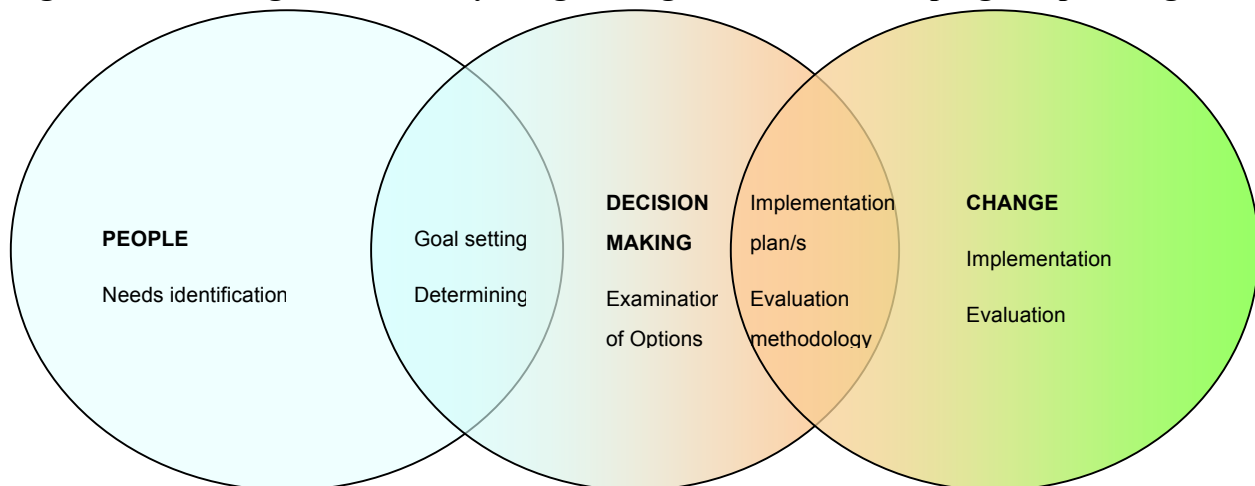


Program planning always comes at a cost, whether through external contracting of expertise to facilitate the process, or through designation of tasks to internal personnel which invariably results in reallocation of normal duties.

Regardless of the approach adopted, each program planning model broadly comprises: People → Decision Making → Change. Donovan and Jackson (1991) categorise the planning components as ‘analysis, implementation and measurement’, and Austin (2002) refers to the term ‘program technology’ which comprises ‘rationale, strategy and intervention’, all of which ultimately involve the same processes.

Lewis, Lewis and Soufflée’s (1991) *Generic Program Planning Model* is a framework that can be readily adapted to organisational planning processes such as strategic planning, problem solving and program development. The summarised components of the Generic Model may be assigned to the three broad categories outlined above, as follows.

**Figure 2: Venn diagram of broadly categorised generic elements of program planning**



This diagram demonstrates the three broad categories and areas of overlap of Lewis et al's (1991) generic model. Need or problem identification is recognised as a 'people' process involving all or a combination of managers, policymakers, service providers and consumers. The identification of goals, objectives and seeking of feedback from consumers and other stakeholders is a process that directly informs decision making. Lewis et al. (1991:19) suggest that "these decisions actually precede the real decision making challenge" – hence the overlap of the 'people' and 'decision making' categories.

'Decision making' as depicted in Figure 2, also overlaps with 'change', as it is critical for informing development of the implementation plan and evaluation methodology. As is commonly accepted in human service literature (for example, Coulshed and Mullender 2001; Lewis et al. 2007), decision making should be a consultative, participatory and collaborative approach in order to ensure selection of the most appropriate and effective responses.

The formulation of the implementation plan may involve conducting a literature review of international models of best practice; visiting organisations that deliver best practice programs and learning through observation; and/or utilising the outcomes of consultations with the proposed target group as a basis for modifying approaches. The resultant program model may involve a complex cycle of research, presenting model options, examination by stakeholders, deliberation, feedback and further modification. As indicated in Figure 1, budgetary consideration is also an important aspect of the decision making process, as budgetary decisions regarding a new program will almost always have an impact on other organisational activities (see Lewis et al. 1991).

The briefing and training of organisational personnel and relevant stakeholders, infrastructure establishment, resource allocation, and service delivery tools must be developed with consideration of broader impacts of the inevitable change that will occur. Lewis et al. (1991) purport that the choices derived from the decision making process invariably effect behaviours, productivity, the current status quo and the future directions of the organisation as a whole. Once change has been implemented, Lewis et al. (1991:20) indicate that the process of evaluation "completes the administrative cycle by measuring the effects of past decisions and laying the groundwork for new choices".

## **Tailoring a model to the context**

### ***Keep it Simple!***

As argued throughout, the rationale or criteria for determining the most appropriate program planning and evaluation framework is dependent upon the type and extent of the planning to be undertaken, and the context of the organisation. A small scale program planning process involving minimal gradual change within an organisation that is means focussed, may be suited to application of the Incremental planning model. Conversely, a program that is of greater significance to the organisation in terms of investing in and trialling a large scale, innovative

evidence-based service approach may be best planned, implemented and evaluated using an effectiveness planning model.

Regardless of the program planning model selected by managers the key to success is ensuring 'best contextual fit'; establishing that the means are commensurate with the ends.

In my experience of facilitating program planning processes across the health and welfare sectors, the most effective formulas have been those that are presented to planners in a simple, easy to understand format. The key is to keep it simple, meaningful and of value. Complex program planning models involve intricate methodologies, and the analysis and synthesis of findings require a deep level of cognitive processing. Complex approaches are resource-intensive and are best suited to long term developmental interventions with communities and larger population groups.

In most of the human service organisations where I have worked, the framework utilised for decision making regarding program plans has been more in line with Jackson and Donovan's (1999) generic approach, with a focus on asking 'who, what, why, where, when and how'. This 'simple' approach is reflected in Quality Improvement and Community Services Accreditation (QICSA) (Australian Institute for Primary Care 2007) documentation, which applies this method when establishing and reviewing a program or system, as it prompts a comprehensive thinking and decision making process through self questioning. Soriano (1995) uses this approach to identify sequential steps required to define the purpose and design of the first step in the Generic Program Planning Model - a needs assessment.

Donovan and Jackson (1991), Lewis et al. (1991), Smith (1990) and Soriano (1995), discuss the necessity for identifying and assessing needs as a basis for prioritising the appropriate response as part of the generic program planning process. Thus the planning process according to Lewis et al (1991:37), "must begin with a definition of the problem being addressed (and) there must be some measurable difference between the current state of affairs and what is desired". In order to measure progress and achievement, planners must identify 'what is desired' and this is a process whereby needs are translated into immediate and ultimate program objectives (Suchman in Smith 1990:40). Defining a program goal and specific measurable objectives at the outset is essential for determining what is required (process, resources) in order to bridge the gulf between 'what is' and 'what should (or can) be'. This has in my experience been most effective in keeping those involved, focussed and on track.

In facilitating program planning processes, one of the most critical learning outcomes for me has been the recognition of the necessity for consultation with staff and worker level ownership.

Most program planning discussions, decisions and activities occur within management forums, and can preclude service delivery staff. Sometimes there can be sensitivities created by program planning activities, especially where it involves restructuring and loss of positions, and as such managers rightfully need to demonstrate discretion in the information that is shared, with whom and when. Conversely, if there is inadequate consultation with staff from the outset, they may be more likely to perceive the program plan as something that management is 'imposing' upon them. This can create a sense of apathy, but also hostility. At the end of the day, managers rely upon their staff to implement and integrate programs; if they do not share a sense of ownership,

passion and commitment, then the program is likely to be fraught with tensions and inefficiencies. Similarly, this interpretation may be applied where there is lack of consumer engagement and ownership of goals and objectives (as previously discussed). Thus decisions regarding ‘who’ is to be involved and consulted in program planning; ‘what’ information is shared; ‘why’ they need to know; ‘when’ is the best timing for consultation; and ‘how’ we do this in a way that maximises benefit for all stakeholders – are intrinsic to implementation and effectiveness.

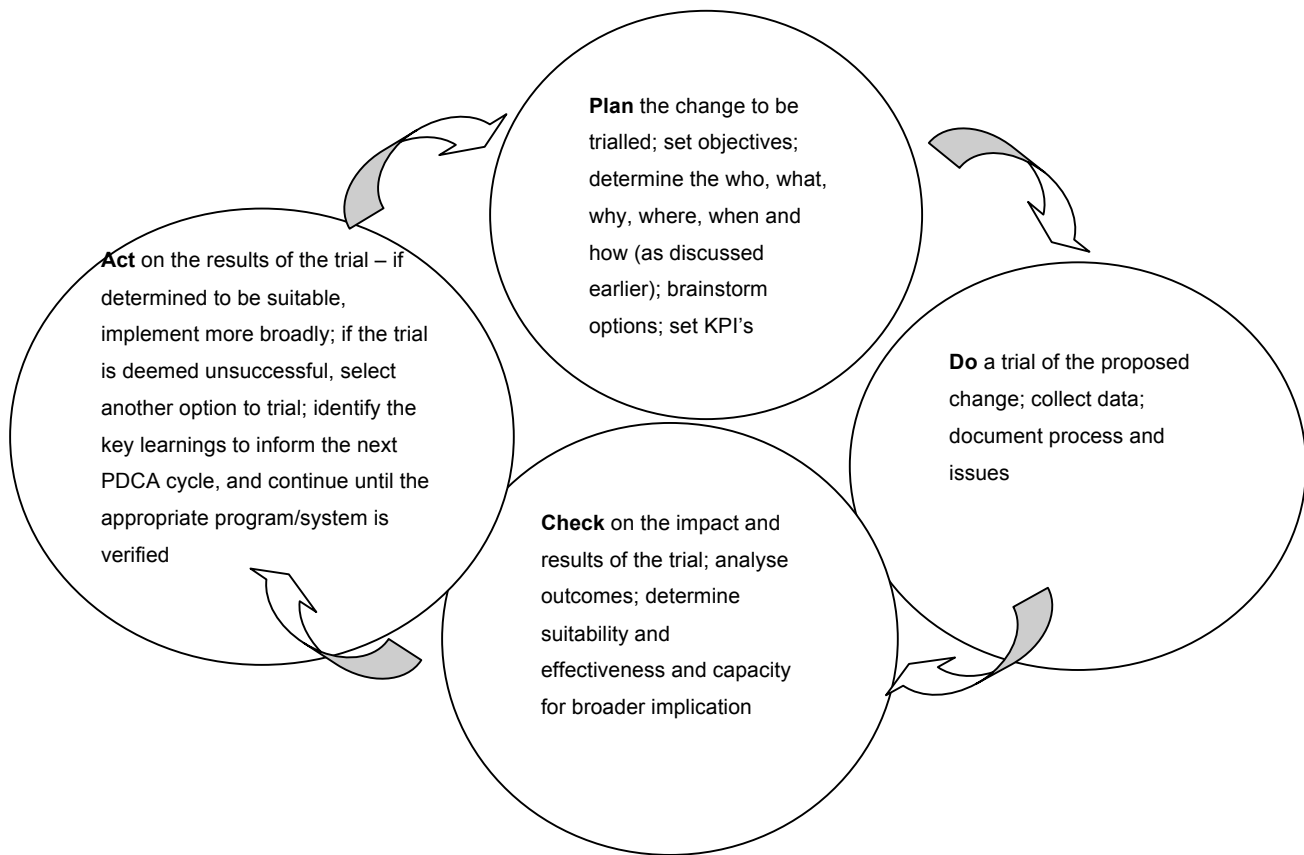
Once program planners have determined the need to be addressed and the program goal, they may choose to outsource the detailed planning and development process to a consultancy or project manager. A highly effective framework in developing a more detailed plan to keep all parties focussed and within timelines, is the Project Management Brief and/or Project Plan. This is based on the Australian Institute of Project Management (2004) *National Competency Standards for Project Management (NCSPM)*, which is widely adopted by project managers across diverse industries throughout Australia. It comprises: scope; time; cost; quality; human resources; communication; risk; contracting/procurement; and integration. This framework is readily adapted to program planning/development in the welfare sector and is highly comprehensive, useful and effective in tracking progress.

Weinbach (2003) describes a program as a system, and essentially it is, albeit to varying degrees in terms of complexity. QICSA (Australian Institute for Primary Care 2007) encourages welfare organisations to apply the DICED framework as a checklist when developing new programs / systems and reviewing their effectiveness. This is a simple yet very effective framework that can be integrated into everyday work practices as a basis for ongoing assessment of program/system performance, comprehensiveness and effectiveness. The DICED acronym is defined as:

**D**ocumented (program/system policies, procedures etc.); **I**ntegrated and implemented (program/system reflects the written description, is integrated and implemented consistent with the plan); **C**ommunicated (evidence that relevant people have contributed to and know about the program/system, understand its purpose; methods for communicating new/amended programs/systems are documented; feedback mechanism is in place to ensure the communication was received, understood and implemented); **E**valuated (feedback mechanisms exist to monitor practice compliance and evaluate effectiveness; responsibility for evaluation is allocated); and **D**esignated (responsibility for implementing the program/system is designated to relevant personnel).

A program can comprise a range of systems or sub-systems, and every system is made up of people, processes and tools. If each aspect of DICED is considered within these contexts during the program planning and evaluation phases, it is a very comprehensive tool that is simple to apply. Further to DICED, I have observed the ‘Plan, Do, Check, Act’ cycle promoted by QICSA (Australian Institute for Primary Care 2007) as a tool for planning, trialling, reviewing and implementing new programs and systems, to be a simple and readily adaptable evaluative approach.

The key elements of this evaluative cycle according to QICSA training documentation (AIPC 2007) are:



Wadsworth (1997) similarly describes the action research cycle as identifying current status, reflection, design, fieldwork, analysis and conclusions, feedback and planning for new actions. It is easy to remember, and can provoke dynamic brainstorming outcomes if the program planning group comprises the 'right' mix of people – strategic thinkers, management, financial/HR representatives, service delivery staff with relevant expertise, and (where appropriate) consumer representation.

## Conclusion

The social welfare sector has traditionally adopted an 'ad hoc' approach to program planning (Liddell 2003), with committees of management demonstrating more goodwill than good governance; limited strategic thinking and documentation of policy and procedures; and reactive planning based on a perception of need rather than a proactive and strategic approach to mapping needs and determining the best possible program model.

In line with government policy changes during the past decade, the welfare sector has demonstrated a shift towards business sector management frameworks that has resulted in a

greater emphasis on strategic and business planning; quality assurance systems; risk identification and management; integration; partnerships; centralised and comprehensive recording of data and reporting (accountability); and rationalisation. As the sector becomes increasingly competitive for funding, so too does the need increase to find an advantage over competitors. Investing in improving business and planning systems, external accreditation, and implementation of best practice utilising theoretical frameworks is becoming more prevalent.

Lindblom in Mayer (1985:41) states that “theories create a greed for facts because they generate their own hypotheses for testing that may have little or no bearing on the actual situation in question....most theories...are insufficiently precise to provide prescriptions for particular situations”. Thus no singular program planning model in isolation is going to provide a ‘one size fits all’ (universal) approach. In order to be effective managers/planners of human service programs, we need to exercise discretion in determining which models or variations are applicable to and likely to be of greatest benefit in each unique planning situation.

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***Suzanne Beattie-Johnson is Manager of Quality Improvement at Windermere Child and Family Services, Narre Warren, Victoria***

## **Ten things I learned working at the Office of the Public Advocate**

**BARBARA CARTER**

The Office of the Public Advocate (OPA) is a statutory office set up under the *Victorian Guardianship and Administration Act 1986*. It provides individual and systemic advocacy for people with disabilities and the Public Advocate may be appointed by the Victorian Civil and Administrative Tribunal (VCAT) as guardian of last resort for adults with a cognitive disability. OPA also investigates and reports on applications to VCAT for the appointment of a guardian or administrator (financial manager).

OPA employs around 28 advocate/guardians whose main responsibilities are to provide advocacy, act as a guardian and investigate applications to VCAT. There is no established profession of guardian, nor is there any specific university or professional qualification for the position. Current advocate/guardians are drawn from a range of professional backgrounds and experience including social work, nursing, law, psychology, disability studies and education. They share a commitment to promoting the dignity, rights and interests of people with disabilities.

I have worked at OPA since 1992 and some time ago, as Acting Public Advocate, I was asked to provide a welcoming talk to a group of new advocate/guardians as part of their orientation program. It was later suggested to me that some of what I said may be worth repeating to a wider audience and be relevant to people working in other areas of disability. I spoke about ten things I have learned or observed during my time at OPA.

### **1. Nobody is immune from disability**

Maybe this is just stating the obvious. Any one of us, within the next hour, year or decade could find herself with a disability of one kind or another. Equally, this could happen to someone we love, perhaps someone we love even more than we love ourselves. Alternatively, you could say that everyone has some type of disability; it is simply a matter of type and degree or that disability is instead a social construct where the response of society creates disability from a particular personal characteristic or impairment.

Whichever way you look at it, the message for me is that we are all in this together and we grow or are diminished by the way we handle this reality. In my experience, people working in the disability field will always say that they agree with this. However, deep down, some people fundamentally know it in their bones and believe it and some do not. I don't think there is a great deal that can be done about this, except to try to guard against an "us and them" approach developing either in your practice or in the organisation where you work.

### **2. All disabilities are not equal**

If you are going to have a disability, I would advise you to try to have one that is medically clear and attracts funding and good service provision. Arguments about the diagnosis of disability and associated arguments about eligibility for services can be used to exclude people from treatment and services or keep them in a state of uncertainty for years.

Assessments, second opinions and reviews of eligibility can cost as much as providing the service the person is seeking in the first place.

Some disability services are specifically funded and some are not. If you have an acquired brain injury through a workplace accident or traffic accident, your treatment and services (in Victoria at least) will be funded through Workcover or TAC. If you acquire it through alcohol and drug abuse or an hypoxic brain injury such as a seizure or swimming pool accident, it will not. Psychiatric disabilities are problematic for a number of reasons, particularly if you do not have private health insurance. In any case, even if you receive psychiatric treatment, whether in a private or public hospital, community services and accommodation following your discharge will be very hard to obtain. Above all, try not to have two or more disabilities at once. The danger here is that all the effort will go into working out why you are not eligible for services associated with one disability because of the existence of your second disability. If you are also abusing drugs and alcohol, you might as well abandon all hope.

P.S. Beware of the justification that can be offered by service providers, or OPA, for not providing adequate assistance or for ceasing involvement, based on the argument that the person is thereby being empowered to take responsibility for him or herself. They may well be ready for that degree of autonomy, but it may also be an excuse, lacking empathy, that assumes far greater agency and independence of the person than the professional expects of themselves.

### **3. If something is “fragmented”, does that mean that it is broken?**

Everyone working in the disability and health fields knows that the social and community service system has become very complicated. Arrangements vary across state boundaries and across regional boundaries within each State. Services are more often contracted out than provided directly by government, a legacy of the “steering, not rowing” debate. Aged care is the responsibility of the Commonwealth government and Disability services are the responsibility of the State governments, and the Commonwealth State Disability Agreement is a less than perfect co-ordinating arrangement between them. In the interests of flexibility, competition, efficiency and transparency, a person may need to deal with multiple agencies, government, non-government and private, in order to have their particular needs met. Even when arrangements are finally in place, a change in policy, an increase in age or a change in needs may necessitate new arrangements with different service providers and the whole process begins again.

This fragmentation of services has generated increased job opportunities for case managers who are needed to manage people’s care packages and navigate a way through systems. But case managers are usually attached to a particular disability-specific service and may not have the knowledge or authority to negotiate outside their own system. Sometimes guardianship is seen as an answer to this problem with a guardian being seen as some sort of super case-manager. Perhaps, however, we should admit that when we use weasel words such as “fragmented”, “devolved” or “diversified”, we may actually mean that the system is broken or

in chaos. Perhaps the answer lies in more integration and less competition as is the case in Scandinavian countries.

#### **4. Personality survives/transcends disability**

Personality characteristics are more likely to be intensified by disability than suppressed by it. People with acquired disabilities are usually recognisably the same people as before, gregarious or private, optimistic or pessimistic, selfish or altruistic, emotional or stoic, intense or relaxed in their approach to life. People who have disabilities from birth have the same range of personality characteristics as anyone else. The difference seems to be that personal characteristics are often intensified by disability, perhaps because some of the self-limiting mechanisms by which we control our personal behaviour have been affected.

Being mindful of this is an important part of person-centred practice. While it may seem obvious when you think about it, I fear that we often act as if it were not the case.

#### **5. Get to know your client and allow them to get to know you**

It may seem trite to suggest that it is important to get to know the person for whom you are guardian or advocate. Unless you can understand who a person is, how they live their life and what makes them tick, you are not in a very good position to be making decisions for them or advocating on their behalf. The quality of your guardianship or advocacy for a person is closely linked to the quality of the relationship you have with them, and this relationship should be characterised by understanding and respect.

Another part of a good guardianship or advocacy relationship is allowing your client to get to know you, not only as a professional but also as a person. I understand that this is more controversial but most people are reluctant to allow you access to important personal, intimate areas of their life unless they know and understand something about you in return, beyond the fact that you work for the Office of the Public Advocate. It is part of negotiating trust and building a working relationship based on respect. At the same time, the maintenance of appropriate professional boundaries and not becoming too personally involved remain important considerations that need to be regularly discussed with your colleagues and supervisor.

#### **6. There is no value in reminding people about hurts they have forgotten**

Frequently a guardian is appointed in circumstances of conflict that has its origins deep in family history. The conflict may be about who was overseas for twenty years and was not there to look after a parent who was sick. It may be about who regularly started the family fights at Christmas dinners or who has always been seen as the favoured family member. These historic grievances may have been forgotten by the person who is under guardianship but are rarely forgotten by other family members.

Part of the role of a guardian is to find out what the person's wishes are now and take these into account as far as possible when making decisions. If, for example, they have forgotten

the past and now want to see a particular person, it does not seem sensible to remind them about why they previously did not wish to see them, unless there is some real concern about their safety. (If you can persuade various family members not to remind them of past hurts, you are doing really well!). Be prepared, however, for this to be seen as very unfair by other family members. Because of this, I think it is important to give all involved time to tell their stories, and not rush to tell them that you are interested in the present and the future rather than the past. Moreover, while you may need to say at some stage that, as the guardian or advocate, you cannot heal all the family hurts, do be gentle about it, remember that disability places enormous pressures on everyone involved and don't just say "That is not my role".

## **7. One of the best things we can do is hold open the door for reconciliation**

This follows from my previous comment. As a person nears the end of their life, different things become significant, and "unfinished business" is probably the most important of all. This is equally true for both persons in a relationship and the opportunity for apology, forgiveness and making peace is crucial. OPA has had experience with a client, unconscious in hospital as a result of an ultimately fatal assault by a family member, where it was believed that allowing a visit may provide an opportunity for some form of reconciliation. The Public Advocate perceived that it was consistent with the person that she would choose to see the family member if able to make that choice. Nobody will ever know if some form of reconciliation took place during that visit.

## **8. Take responsibility**

If you are not prepared to make difficult decisions and take responsibility for what you do as an advocate or guardian, you are in the wrong job. The decisions you make are of enormous importance for the person you are guardian for and there is rarely certainty about what is the right decision. There is a high degree of judgment involved. We have guidelines, policies and processes to follow but in the end, you need to have faith in your judgment and be prepared to explain and justify why you made the decisions you did. In this, you will have the full support of the organisation.

There seems to be an increasing reluctance by professionals and by the organizations that employ them, to accept responsibility. Attempting to transfer risk and responsibility to the individual and avoiding organisational risk by strategies such as the appointment of a guardian appear to be emerging features of service provision. Encouraging other professionals to accept their own responsibilities may also be a part of your role from time to time.

## **9. People are complicated**

People are complicated. Nobody is defined by one particular aspect or feature of his or her life and we change our minds. I was once guardian for a man with mild dementia who was facing an operation that may have required him to have a blood transfusion. This was contrary to his faith, or perhaps more to the faith of his wife and one of his children, but he told me that if a blood transfusion was needed to save his life he wanted to have it as "he had a lot of

living left to do”. I believe he understood that this was contrary to his faith. I gave consent for the blood transfusion to be given, if needed, as a last resort and did not tell his family what he had told me. This was partly about respecting his current wishes even though he had been found by the Tribunal not to have the legal capacity to make this decision for himself. It was also about understanding that there were many things that were important to him in life, of which his faith was one and his wish to be part of the lives of his grandchildren was another. Finally, it was about being prepared to take responsibility for the decision, as I mentioned above.

### **10. Be careful about earlier views**

A person should not be locked into a view s/he may have expressed at a different time and in different circumstances. For this reason, I am always wary about taking at face value a view that a person may have expressed in anticipation of certain occurrences. When he was a teenager, my very tall, fit, basketball-playing son told me that if he became a paraplegic, he would not want to live. He is now a very tall, fit, bicycle-riding, married father of two little girls and has probably changed his mind. What if he had been able to sign an “advance directive” then and was in hospital now, unable to express an opinion?. A person may dread dementia and ask that no medical treatment be given to her if she develops Alzheimer’s Disease and is unable to look after herself. However, if she does develop Alzheimer’s Disease, she may be quite happy living at home, or later in a dementia specific hostel, enjoying activities and visits from her family. How can you know in advance when life will be so bad that it will not be worth living?.

Autonomy is highly valued in our society and making advance directives or Enduring Powers of Attorney with clear instructions to the attorney or agent has a great deal of support in our community as a means of promoting autonomy. There is no clear mechanism at present for making advance directives in Australia, except arguably in common law, but the issue is very much on the agenda.

### **Conclusion**

I would like to think that there are other things that I have learnt in my years at the Office of the Public Advocate. These are just a few that I hope you may find helpful or may strike a chord. I hope also that they generate your own thinking about what you have learnt from your work in the disability area.

*Barbara Carter has held a variety of positions at the Office of the Public Advocate since 1992, her last full-time position being manager of guardianship and advocacy. The opinions expressed in this article are her own and do not necessarily reflect the views of the Office of the Public Advocate.*

## Unity against street violence: *Step Back Think*

### JOHN RULE

James Macready Bryan (MB for short) and I went to school together, played footy together and partied together, until he was brutally bashed in the city on the night of his 20<sup>th</sup> birthday, October 2006. He didn't quite die but his brain was damaged beyond repair, and as MB's neurosurgeon, Andrew Kaye, said he's in 'a twilight zone where you're neither dead nor alive.' MB had been like a lot of us; we felt invincible, particularly in a group, but now we were shocked and powerless. Throughout the trial of MB's attackers, our feelings ranged from rage to deep sorrow, everything had changed and it didn't make it better when those responsible were sent to jail.

A group of his closest friends started *Step Back Think* with the aim of targeting Melbourne's escalating culture of street violence. The group is not against drinking or partying, just the violence that often goes with it. And there can be no denying that the level and nature of aggression, in terms of the intensity of violence, the willingness of people to attack police, to carry and use weapons, to carry out violence in gangs and to kick victims in the face and head after they've gone to the ground, has reached disturbing new levels.

We've had a lot of interest and support from the State and Federal governments, the police, business and the public which has been great, but sadly, it doesn't translate into peace on the streets. Melbourne has a culture of violence and it seems to be getting worse. Every week we're killing and seriously injuring each other for no reason. There's no easy answer and "knee-jerk" political responses are not the solution. Violence is based in culture and human nature, and change will be slow and must come from young people, who are the demographic responsible for street violence. This is obviously an ambitious objective, but through a series of new approaches, which will aim to address the core issues that surround street violence, *Step Back Think* hope to make Melbourne, and ultimately Australia, a place where fighting is no longer an acceptable part of a night out.

Recent research has shown that the target group largely responsible for street violence (15-26 year old males) does not respond well to consequential type messages. For this reason alternative approaches are necessary and violence needs to be sold as "uncool" rather than merely showing the consequences of what can happen. What's more, we believe that the problem of aggression and violence is not only a consequence of binge drinking and drug taking – although these factors obviously contribute – but is also a matter of regulating staff and physical environments in licensed venues, committing to relevant awareness campaigns, adopting a more holistic approach to education (in schools and other mediums) and coordinating these approaches with carefully planned policing strategies.

### Education Program

Recent research by the Australia 21 team has tentatively shown that the trends in violent

behaviour could be attributed to a decline in respect and empathy, possibly associated with increasing individualism, as well as perceptions of violence as the norm, and an increased pressure to work harder but also to play harder.

*Step Back Think's* peer-to-peer education program (at this stage with the working title of “No Regrets”) aims to curb the culture of violence in Australia by addressing these underlying problems. Over the past 12 months we’ve created a layered program with the help of the Victorian Education Department and the Foundation for Young Australians. The pilot program for ten eastern metropolitan region schools was launched at Balwyn High School in October. The program targets years 9 to 12, focussing on peer leadership and giving ownership of the problem to students. With the help of a number of volunteers and members of *Step Back Think*, “No Regrets” enables students to come up with ideas and methods for addressing issues of violence and problems of disrespect. It gives them the opportunity to think about ways of dealing with confrontational situations and aims to dispel myths over issues of violence, drugs and alcohol and the ability to make your own decisions.

## **Rate Your Venue**

Deregulation of licensed premises in the CBD, arising out of the Federal Government’s competition policy of the 1990s led to a massive increase in the number of licensed premises in Melbourne.

This policy called on the state governments to relax regulatory burdens and consequently has seen commercial development take precedence over public health and harm minimisation. An estimated 300, 000 patrons come into the CBD on an average Friday or Saturday night and the rapid growth has raised concerns over the management of licensed venues and the training of staff not only in relation to selling drinks but also in handling aggressive behaviour.

Over the last 12 months *Step Back Think* have worked with Grey advertising to develop an interactive “Rate Your Venue” website, which aims to hold Melbourne’s licensed venues accountable and assist patrons in making informed decisions about where they go out. Marketed as a gig guide this website would provide information about live music, good food, events and promotions, while also offering a safety rating which would incorporate both Victorian police statistics and patron input. The website would tackle, amongst other things, information about whether bouncers are “male friendly” or unnecessarily violent at a particular venue, the street lighting, how long queues tend to be and whether it’s easy to get transport (and particularly taxis) to and from the venue.

## **Future Projects**

While the education campaign and Rate Your Venue website have been our primary projects over the last two years, we’ve also had a working relationship with the AFL, including meetings with the big bosses who’ve pledged their allegiance (and more importantly their time and money) to the cause.

A joint venture with the AFL would probably focus on awareness around the issue of street violence in a bid to transform public perception – along the same lines of the *Just Think* campaign which used AFL captains to talk about violence during the footy finals. But in 2010

we also plan to incorporate an element of education, by using the influential power of football and the administrative abilities of the AFL to promote a single anti-violence round in all metropolitan leagues in Melbourne – and hopefully all country leagues in Victoria as well – to coincide with an anti-violence AFL game. It would include having an information pack with a DVD and other promotional gear (maybe rub on tattoos) sent out to the clubs, and each league record having a section devoted to addressing the key issues around street violence.

## **Conclusion**

I spent this past Sunday at a friend's barbeque, held for MB's 23<sup>rd</sup> birthday. He's shown no signs of improvement and is still unable to speak, eat or move from his wheelchair. Although it's been three years and violence still haunts Melbourne's streets, there has at least been acceptance that there is a problem which needs addressing. Governments have shown a willingness to get involved in the issue, and even if they've been imperfect in some of their proposals the intent and motivation to make a difference is there. Now we need the implementation of carefully aligned programs of initiative in the areas of education, awareness, policing and the regulation of venues. Like the campaigns that transformed public opinion about smoking and drink driving, cultural change is possible and, fingers crossed, will happen in the foreseeable future.

***John Rule is a member of Step Back Think, a growing movement who seek to represent Melbourne's youth as a voice of unity against street violence. [Stepbackthink.org](http://Stepbackthink.org)***

## Book review

**Brian M McCoy (2008) *Holding Men: Kanyirninpa and the health of Aboriginal Men* RRP \$34.95 ISBN: 978 0 85575 658 1 Publisher: Aboriginal Studies Press, AIATSIS**

### CHRIS LAMING

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[www.eurekastreet.com.au](http://www.eurekastreet.com.au)

In *Holding Men*, McCoy explores issues central to the Indigenous men of the Western Desert region. Issues of masculinity, of grief, of illness, and how these relate to Kalyirninpa (holding, nurturing, teaching, growing-up, respect). Though specifically about that region, *Holding Men* has crucial implications for the whole of Australia.

For nearly forty years Brian McCoy has lived and worked with Indigenous communities, mostly in the Western Desert, and from this depth of experience and from his PhD research about the health and well-being of Aboriginal men, comes this extraordinary book.

It is a book about an ancient culture and its people, trying in their own way, to survive in 21<sup>st</sup> century Australia. Rigorously researched yet simply written, it challenges us with human stories of heart-breaking enormity whilst reflecting a quiet hope in resilience and healing of *kalyirninpa*.

There are many profound insights in this book, which come from years of respectful relationships and deep reflection. *Kalyirninpa* points a way forward, a way out of the nightmarish day to day tragedies of disease and ill-health among Indigenous Australians, because it involves ‘a proper looking after’.

Three chapters in particular situate serious current issues for Indigenous communities, particularly men, within the embrace of *Kalyirninpa*: ‘Petrol sniffing: More than a risk’; Football: More than a game; Prison: more than a holiday’. As McCoy puts it: ‘From the perspective of *kanyirninpa* these socially significant spaces (petrol sniffing, Australian Rules and prison) can offer men both healthy outcomes and unhealthy risks’. My own meaning making around those ‘spaces’ was deeply challenged and enriched with constructive alternatives.

The key *Puntu* (Aboriginal) values, of *ngarra* (land), *walytja* (family) and *tjukurrpa* (ancestral dreaming) are represented as ‘continually dynamic and inter-relating’ and *kanyirninpa* provides the balance for creative tension between relatedness and autonomy, on

the one hand and nurturance and authority, on the other. McCoy manages to maintain a similar balance in his book.

Juxtaposed to his deeply sensitive, respectful, inculturated research - in the tradition of de Nobili or Matteo Ricci - is his empathy and compassion for those affected by the personal tragedies associated with petrol sniffing, alcohol abuse, a prison sentence or premature death.

McCoy's insights are profound and he is able to articulate them in a very clear way. His rolling narrative at times has the feel of a foreign correspondent in a battle zone. This is a silent 'battle zone', and arguably the most important moral battle ground in Australia today.

*Holding Men* is also a challenging resource for policy makers in the area of Indigenous health and well-being, precisely because it is the antithesis of armchair philosophising and moralising. It is deeply respectful and mindful (and heartfelt), of traditional values and customs (eg 'Sorry Business') and offers a key to understanding the links between life and death, mourning and celebration, health and disease, for Western Desert Indigenous people.

McCoy manages to move through this difficult terrain with the sure-footedness of an ancient Aboriginal tracker and a confidence founded on years of sitting, listening, observing and quietly healing. Reading the book is at times like sitting in on a conversation under a Boab tree. Brian McCoy is a healer who carries his wisdom quietly. The ethical dilemmas and questions are addressed with integrity, humanity, respect and truthfulness, with no attempt at glib answers.

This is an important book, written in a lucid thoughtful way that leads us step by step through what is, for most of us, foreign land on Australian soil. In particular *Holding Men* lets us feel the impact on Indigenous boys and young men, no longer being held by the land, by their elders, more and more autonomous and physical and psychological peril, adrift from their traditions, lands and culture.

*Holding Men* is about being wounded but it is also about being resilient and the possibility or hope of building that resilience in others, both individually and in community, through *kalyirninpa*.

The Indigenous artwork is riveting, confronting and evocative, with many paintings graphically illustrating the stories of young Aboriginal men and the spaces they find themselves in.

The Spirit of Christmas is fully alive and well in *Holding Men*.

***Dr Chris Laming is a Senior Lecturer in Social and Community Welfare, Monash University, Gippsland [chris.laming@arts.monash.edu.au](mailto:chris.laming@arts.monash.edu.au)***