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ADMINISTRATION AND PRACTICE

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Abstract

Social workers in health care have been urged to identify the nature of their expertise and to articulate profession specific roles (Pecukonis et al., 2003). This article reports on the use of a theory of professional expertise (Fook, Ryan & Hawkins (2000)) in management and clinical practice within two Australian hospital social work settings. This theory, directly applicable to social work, was applied within these hospitals to differentiate levels in social work industrial awards, in staff selection, in supervision and continuing professional development. Specific and broader implications for application of this theory are discussed.

APPLYING A THEORY OF EXPERTISE IN HEALTH SOCIAL WORK ADMINISTRATION AND PRACTICE

INTRODUCTION

This article reports on an attempt to bridge the gulf between social work academia and health social work administration and clinical practice through the application, within two Australian hospital social work settings, of a theory of professional expertise developed by three academics (Fook, Ryan & Hawkins, 2000). This theory was applied in these hospitals to differentiate levels in social work industrial awards, in staff selection, in supervision and continuing professional development. The article concludes with an examination of some of the broader implications of these application processes.

LITERATURE REVIEW

Pecukonis, Cornelius and Parrish (2003) have suggested, "… it is imperative that we (the social work profession) define *the nature of our expertise* and clearly articulate these roles both to the public and other health professions" (p.9). Indeed, over the past three decades numerous authors have also suggested that it is important to more clearly define the critical roles of social workers in health care and the nature of associated skills, knowledge and expertise (e.g. Carrigan (1978), Kane (1982), Berkman (1996), Volland (1996), Keigher (1997), Sheppard (1998), Rosenberg et al (1999)). Similar issues were raised by Ryan, Healy and Renouf (2004, p.22) in their empirical study of expertise in mental health social work in which they sought to further test the theory of professional expertise developed by Fook, Ryan and Hawkins (2000).

The study of expertise and expert practice is a controversial undertaking as professions have often been criticised for their dominance and disempowerment of the clients they are supposed to be serving (Leonard, 1998). Professions are seen to have a vested interest in identifying and controlling the definition of expertise. In addition to this power dimension, there is also the problem of there being no agreed-upon definition of 'expert' and 'expertise' (Benbenishty, 1992).

Despite these concerns, a number of researchers have attempted to map the cognitive skills of experts, sometimes through the development of computer systems. Such studies have been criticized for their inability to map features of human reasoning that cannot be articulated easily, but which often play a key part in human decision-making in complex situations (Dreyfus and Dreyfus, 1986).

At a more general level, Dreyfus and Dreyfus (1986) developed a model of skill acquisition that provides a framework for mapping changes in thinking as professionals learn how to act in unstructured situations such as those typically encountered by social workers engaged in interactions. To develop a high level of skill in these types of situations often requires considerable experience in real situations. This model has achieved wide acknowledgment in a number of disciplines and has mostly been utilized and researched in nursing by Benner and her colleagues (Benner, 1984; Benner et al., 1996; Benner et al., 1999).

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Dreyfus and Dreyfus (1986) identified five stages—*novice*, *advanced beginner*, *competent*, *proficient*, *expert*—through which the learner advances. Throughout these five stages, the learner progresses from detached abstract and consciously analytic behaviour in a situation, to involved skilled behaviour that is based on unconscious and intuitive recognition of similarities with past experience.

The Dreyfus and Dreyfus model served as the framework for the work of Fook, Ryan and Hawkins (2000) on social work expertise, which resulted in a series of studies from 1990 onwards (Fook et al., 1994; Ryan et al., 1995; Fook et al., 1997a; Fook et al., 1997b; Hawkins et al., 2001). The entire series of studies resulted in a book (Fook et al., 2000) in which a theory about how expertise is learnt and developed was postulated. This theory was specifically developed for practice which dealt with complexities and uncertainties in making and taking value- and knowledge-based decisions and actions in changing situations.

In their theory of professional expertise, Fook et al. (2000) were able to expand the five-stage Dreyfus and Dreyfus model by adding two further stages, those of *pre-student* and *experienced*. They were also able to identify 11 dimensions of expertise. These are:

1. *Knowledge* (*substantive*) – the types of facts or systems of ideas which are evident in practice (e.g. background, contextual, workplace systems, and theories);

2. *Knowledge* (*procedural*) – the translation of substantive knowledge into working knowledge about how to work effectively in a particular context;

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3. *Skills* – identifying and applying skills involved in the helping process (e.g. assessment, liaison, negotiation, referral, casework & counseling, and case planning);

4. *Values* – identifying the ideals and beliefs as to how world should be and how people should normally act (e.g. stereotyping, importance of 'family', confidentiality, non-judgementalism, self-determination, empowerment, professional distance);

5. *Contextuality* – the extent to which practitioners are context bound (domain specific) and the degree to which they are aware of contexts and how they are conceptualized;

6. *Reflexivity* – the degree to which practitioners are able to locate themselves in the context as responsible agents and the degree to which they feel empowered to act;

7. *Breadth of vision* - the degree to which practitioners identify with a vision of service which extends beyond the parameters of an employed position;

8. *Flexibility* - demonstrating the ability to generate a range of options including those which are not possible in that particular context;

9. *Use of theory* (*formal*); - the extent to which relevant formal theory is understood and applied in practice;

10. *Approach* - the initial lens through which practitioners view situations, whether through the viewpoint of the individual; or from a broader perspective;

11. *Perspective on profession* - orientation to the profession and development of the professional identity.

Fook et al. (2000) were able to outline the features of each of the 11 dimensions within each of the seven stages of professional development and have summarized these within an extensive matrix (Table 3, pp.181-184). Rather than reproduce the full table, an example using the dimension of *skills* and its features at each of the seven stages of development is given below:

Pre-student stage – listening (not advice); inability to handle conflict and the need to feel in control;

Beginner stage - can use generalized strategies;

Advanced beginner stage - more specific strategies used and generally confident;

Competent stage - broader range of strategies used;

Proficient stage- deals with conflict personally and privately (but not formally or publicly);

Experienced stage - juggling complexity and conflict; handling multi-factors; and handling uncertainty; and

Expert stage- wide variety of skills; generate range of options (can distinguish whether it is possible or impossible); responsive to change and unpredictability; can recast skills as contextual.

The work of Fook et al. (2000) has been subjected to further empirical testing and theoretical development in a series of studies on expertise in mental health social work

(e.g. Ryan, Healy and Renouf, 2004; Ryan, Merighi, Healy and Renouf, 2004; Merighi, Ryan, Renouf & Healy, 2005; Ryan, Dowden, Healy and Renouf, in press). Whilst this theory was derived from practice-based research and seen to be applicable across a number of fields practice, it remained to be seen whether it had any utility and applicability in other social work workplaces.

Two management practitioners within health care (the first and third authors) had learnt of the Fook et al. (2000) theory and had begun applying it within their places of work to differentiate levels in social work industrial awards, in staff selection, in supervision and continuing professional development. The remainder of this article reports on these applications and concludes with an examination of some of the potential broader implications.

Description of settings

Hospital 'X' is a large university-affiliated specialist pediatric teaching hospital. It draws patients mainly from the Australian states of Victoria, Tasmania, and also elsewhere in Australia and the Asia-Pacific region. It is a primary pediatric trauma centre, and has a national paediatric cardiac centre. It treats 32,000 inpatients annually and a total of 280,000 children in all. A total of approximately 50 social workers are employed by the hospital, 20 of whom work in the main social work department.

Health Network 'Y' incorporates three Melbourne metropolitan hospitals offering a comprehensive range of health services. More than 4000 people work for Health Network

'Y' (including 28 social workers) providing services for a population of 567,640 people covering a catchment area of 1,335 square kilometres. Health Service activity for July-December 2004 included 41,970 admissions, 56,159 Emergency Department presentations and over 50,506 outpatient encounters. Wide cultural diversity is a particular feature of the people who live and work in the region. Approximately 33% of people living in the catchment area are from non-English speaking backgrounds. The most commonly requested interpreting services are Vietnamese, Greek, Italian, Cantonese, Macedonian, Croatian, Serbian, Arabic and Spanish.

Differentiating levels in social work industrial awards and selecting staff

One of the key tasks facing all managers is the appropriate selection of staff including ensuring that they are appointed at a professional classification level commensurate with their skills and abilities. However, the industrial award (which determines an occupation's level of pay and work conditions) for health social workers in Victoria, Australia provides little guidance in differentiating between the expectations of Grade 1 (entry level) and more senior levels, Grades 2 and 3 and 4. Social work managers are forced to create their own interpretations and role delineations within their individual organisational position descriptions. While experienced managers will often independently form congruent assessments of an applicant's skill during joint interviewing, it is often difficult to articulate the subtlety of what constitutes these differential judgements for staff anxious to progress to the next grade level and who demand concrete reasons for decisions made. There is also a need to develop standardised documentation that clearly describes these differences for all parties.

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After studying the Fook et al. (2000) model, the first and third authors concluded that it appeared to provide a natural delineation between grading levels for social work practitioners. This led to the first practical application; in the rewriting of position descriptions to more accurately reflect this progressive professional pathway using language from the model.

As is usual with position descriptions, the two key areas are the *duties/responsibilities* and the *key selection criteria/necessary attributes.* Industrial award definitions are, of necessity, broad. Position descriptions however need to be more detailed in order to provide clear parameters and expectations for staff while falling within the broad scope of the award definitions.

The award under which Victorian hospital social workers are employed is the Health Services Union of Australia - Victoria # 3 Branch (usually referred to as HSUA3). The award covers 28 diverse occupational categories ranging from Occupational Therapy to Health Information Management and Medical Laboratory Technician. Social Workers in the state Mental Health Services are also included in this award.

There are now four grade levels for clinical social workers (with separate levels detailed for departmental managers). Grade 1 is entry level and has six automatic annual pay increments. The award requirement for this is merely that a person is formally employed as a Social Worker and meets Australian Association of Social Work (AASW) eligibility

standards.   Grade 2 is the next level (with three further increments in this level). Grade 3 (with three incremental pay rises) is described in the award as Senior Clinician level. In 2004, a Grade 4 level was added. (This semi-managerial/teaching Grade 4 level is not discussed in this article, as the precise interpretation for this grade within Hospital 'X' and Health Network 'Y' had not been finalized at the time of writing).

The award attempts to make a distinction between the complexity of the responsibilities of the social worker at Grade 2 and 3 levels. In fact, most of the responsibilities described would be undertaken to some extent by all hospital social workers. What distinguishes these grade levels is the quantum of additional responsibilities (e.g. while the majority of work for a Grade 1 Social Worker would be supervised individual casework, they may also supervise a student or undertake running of groups, which are specifically identified as functions within the Grade 2 level).

The HSUA3 Award does not make rigid and mutually exclusive separations between the levels of social worker. Rather it relies, via use of various subtly changed wordings, on the judgment of the employer about the level of skill required. At each level, the decision as to whether a social worker meets the requirements is ultimately left to the judgment of the employers (e.g. "in the opinion of the Chief Social Worker" (Grade 2), or "as recognised by the employer" (Grade 3), and "as designated by the employer" (Grade 4)).

In the interests of having a fair and transparent process for staff promotion, the first and third authors used the work of Fook et al. (2000) to describe and differentiate the skill

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levels of Grades 1, 2 and 3 within their departmental position descriptions. This has

proved to be very helpful for internal promotion procedures and also for general

recruitment. While remaining consistent with the award, the revisions utilizing the Fook

et al. (2000) concepts have extended and clarified the differences required at the various

levels of remuneration (i.e. they informed the 'employer's opinion' with research-based

descriptions of stages of professional development). [See Table One]

Social workers applying for promotion at Hospital 'X' now often study the Fook et al.

(2000) theory in preparation for promotion interviews. With the permission of the

authors, many photocopied versions of Table 3 from the book (pp.181-184) abound in

that department as the importance of this theory is well understood by staff.

The applicability of this theory to the management task of delineating roles has also

proved useful to the first author in reviewing the program-related role of one of his staff

members following a departmental restructure. In deciding how that role was to be

graded, the position responsibilities were formally reviewed. Apart from the usual

processes of benchmarking with 'like' services, the theory provided a tool that could be

utilised to provide academic rigor to this review process. Of particular importance was

the *Skills* dimension. The review demonstrated that this particular role was structurally

well supported by a Senior Clinician (Grade 3) which negated the need for that position

to be regraded from Grade 1 to the Grade 2 level which may require the ability to manage

a higher level of complexity in order to *handle multi-factors & uncertainty* or *juggle*

complexity & conflict (as inferred from the Fook et al. (2000) theory).

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Table 1: Elaboration of Description of Grade Levels of Victorian Hospital Social Workers using Fook et al.'s (2000) stages of the development of expertise

DIFFERENTIATING POSITION DESCRIPTIONS WITHIN INDUSTRIAL AWARD	KEY THEMES FOR STAGE OF EXPERTISE FROM FOOK et al (2000)	KEY ELUCIDATING WORDS ADDED TO POSITION DESCRIPTIONS
Grade 1 (Salary Range: $39,478 -$54,392)	**EXPERTISE LEVEL:** Beginner – Competent	
• No competency description, only description of qualification (AASW eligibility)	'Limited formal theories; Uses situational rules; Developing knowledge of self; Beginning understanding of nature of social work; Domain specific; Hides personal values; Tension between personal and professional dichotomies; Vision limited to job'	Demonstrate basic professional competencies; basic conflict resolution and negotiation skills; willingness to seek clarification or support; respond appropriately to feedback; develop own learning plan; efficient & effective use of resources.
Grade 2 (Salary Range: $52,910 - $62,551)	**EXPERTISE LEVEL:** Proficient – Experienced	
• With Additional Responsibilities Specified • Employed on work which *in the opinion* of the Chief Social Worker requires special knowledge and depth of experience in any one or more of the following: individual/family/, group, program development, research/evaluation • On the recommendation of the Chief Social Worker is in charge of a section…recognised by the employer.	'Increased use of contextual and organisational knowledge; Awareness of worker's role in organisational context; prioritising factors and processes; Juggling complexity, conflict; Handling uncertainty; Professional handling of ethics; Separating personal and professional; Commitment to profession; Concern for client not job; Process oriented; Justify and fight for profession'.	Demonstrable proficiency; contextual/organizational awareness and knowledge of situational rules; ability to deal with conflict, skills in mediation; independence of thought; internalize responsibility; flexibility & responsiveness; understanding & sensitivity to ethical issues; commitment to client centered practice; commitment to student supervision; actively seek learning opportunities
Grade 3 (Salary range: $65,036 - $72,940)	**EXPERTISE LEVEL:** Experienced - Expert	
• Possessing specific knowledge in a branch of the profession and working in an area that requires high levels of specialist and knowledge as *recognised by the employer…e.g. consultation/teaching*	'Recognize multiple viewpoints/multi-faceted aspects; Uses amalgam of knowledge; Prioritise according to broad values; Transferability of knowledge; Responsive to change and unpredictability; Change framed as challenge or opportunity; Recognises own ability to act; Sense of personal power; Risk-taking and creative; Contextual theory development; Creates own theory; Critical and self-reflective; Profession as 'calling'.'	Demonstrated expertise; advanced knowledge base; strong conceptual skills; undertake risk management; comprehensive understanding of theory; critical reflection & capability in creating practice theory; flexibility; proficient negotiation & communication skills; work skillfully & creatively; proactive approach; identify systemic issues.

Supervision and continuing professional development

Supervision, training and access to theory-based professional development (both internal and external to the organization) have also been a particular focus for the first and third authors within their management practice. Within their discussions about professional development needs, practitioners often specifically articulate the desire to become more 'expert'. This may be partly in order to gain recognition from others for their professional contribution. Common themes that have emerged within departmental planning meetings have included the greater need for the elucidation, articulation and promotion of professional 'identity' within the organization in order to increase the 'profile' of social work. There has been a strong desire expressed by staff to provide increased evidence of the 'complexity' of social work practice in health-care and of sub-specialist knowledge/skills required within particular clinical areas, and to identify underpinning theories or bodies of knowledge.

The professional development component of supervision also necessitates that the supervisee be able to identify their specific learning needs or goals. As was previously noted, many social workers strive to become more 'expert'. This is particularly so in the years following the initial consolidation of clinical practice (i.e. about 3-4 years post graduation). It has been the experience of the authors that many social workers in this phase struggle with identifying and articulating their particular strengths, and areas needing further growth.

The Fook et al. (2000) theory has provided a number of our staff with an understanding of the multi-dimensional nature of expertise. The summary outlined in their Table 3 (pp.181-184) has proven to be particularly helpful in providing a concise overview of many of these dimensions, and has provided a useful starting point for discussion within supervision about learning goals and what new learning opportunities may be sought. The theory has also proven useful for assisting staff to identify those areas where they are already achieving highly and to enable positive feedback on this (too often managers fail to acknowledge and praise ongoing achievement). For staff not used to identifying their own strengths, applying the theory in this way can assist with promoting professional confidence.

When presented to social workers in supervision, the Fook et al. (2000) theory has also proved useful in assisting them to self-identify their current stage of practice expertise. For many it comes as a revelation that the number of years of experience alone does not equate in a linear manner with 'expertise'. Some workers are mistakenly of the belief that they *must* be expert simply because they have practised for a certain number of years. Feedback and identification of stages of expertise both contribute to increased self-awareness, which in itself is required for the development of expertise.

This theory has had particular utility in supervising Grade 3 Senior Clinician staff (who often hold team leadership responsibilities), as their positions fundamentally require at least some demonstrable expertise. As more senior workers, these staff members are responsible for providing supervision to other team members who look to them for

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leadership and guidance. The Senior Clinicians are responsible not only for overseeing competence within clinical practice, but they are increasingly responsible for contributing to, and/or leading, program development and innovation. With the increasing complexity of health-care service provision, social work Senior Clinicians now require the kinds of expert skills outlined by Fook et al. (2000, pp.181-4) that include: "*Risk-taking and creative*, *Prioritising re broader values*, *Recognise own ability to act*, *Involvement not intervention*, *Transferability of knowledge*, *Transcendence of professional codes/rules*."

Often staff at this level are particularly interested in the concept of 'expertise' as they are generally highly motivated and set high expectations for themselves. They also often demonstrate a level of ambition wherein they actively consider their own career development and future prospects. They tend to understand the need to demonstrate a broad range of skills and that 'expertise' is not only valued, but is also required for promotion. Given that '*use of theory'* is one of the hallmarks of expertise, it is not surprising that those who are interested in becoming 'expert' will readily engage with a theory of professional expertise development if it is presented to them.

One of the important findings from a subsequent study undertaken by Ryan et al. (in press) was the demonstrated importance of the role of supervision in passing on 'expertise'. It would therefore be beneficial to the profession for information about this theoretical framework to be more widely disseminated in order to better facilitate this process of mentoring expertise development and make it a conscious and acknowledged part of professional supervision.

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As the expectations for accountability within health care increase, so too does the significance of the leadership roles within social work departments. There is an expectation that managers (and to a lesser extent, Senior Clinicians) will demonstrate and promote 'expertise' within professional practice. These expectations are increasingly enshrined within the role descriptions for social work managers (and Senior Clinicians), and are tested within annual performance appraisals.

Organisational management expectations have moved beyond merely demonstrating a highly competent level of individual clinical practice and managing limited budgets, to now requiring a broader range of skills such as those outlined in the 'expert' stages of the eleven dimensions of the Fook et al. (2000) framework (eg characteristics like *Recognise multi-faceted aspects*, *Prioritise according to broad values*, *Wide variety of skills*, *Responsive to change and unpredictability*, *Contextual knowledge development*, *Change framed as challenge/opportunity*, *Longitudinal prioritising*, *Critical and self-reflective*) (pp.181-184).

CONCLUSION

The Fook et al. (2000) theory on the development of professional expertise has demonstrable practical application in clinical practice settings with both practitioners and managers potentially benefiting from broad dissemination of this knowledge. The profession must continue to find ways to reinvigorate practice and promulgate greater levels of expertise as too often social workers quickly lose touch with the theoretical

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underpinnings of their professional practice post-graduation. Another important related issue is evaluating how social workers gather the skills and expertise to move up from one level to another. Undertaking a higher degree in social work, involving oneself in the professional association or the union, attending social work conferences and training, reading the professional journals all assist with this journey. However, conceptualizing the professional journey by reference to the stages developed by Fook et al. (2000) will help social workers understand the nature of their increasing professional competence and to set goals for their future development. Broad promotion of the theory is important to achieving this. Partnerships with academia are also fundamental to ongoing practice knowledge and skills development.

The work of social workers in hospitals is complex. Part of the complexity results from the need to work within and between systems and to move from 'case to cause'; to understand the broad environment within which the client is situated in order to understand when it is possible or appropriate to attempt to influence that environment. It commonly takes social workers some time to feel confident in their new professional role as they struggle to integrate knowledge and understand the multi-layered social systems within which their clients operate.

A new graduate who does not see the complexity of the social work role can quickly become complacent working in, for example, a specialist medical unit where they may have the chance to develop in-depth counseling skills and acquire a great deal of knowledge about the effects of particular medical conditions and procedures. Such social

workers may however end up with a limited vision, working more like clinical

psychologists or general counselors and not attaining the sort of social work expertise

described by Fook et al. (2000) within their theory. This is a situation which one

colleague has dubbed the 'unit pet syndrome'. Fook et al's (2000) theory of expertise

(particularly the dimensions of contextuality and breadth of vision) may assist social

workers in this regard and can be very beneficial to them in developing their

understanding of the profession, thus helping them to grow from hesitant beginners to

self-assured expert social workers.

Retaining excellent social workers in hospitals post 15 or 20 years of experience is

another particular challenge. Indeed, the experiences of the authors have suggested that

there is not a large enough pool of social workers at the experienced and expert levels,

which creates difficulties in recruiting appropriate workers to these roles. The approaches

described within this article illustrate how it has been possible to integrate the traditional

Australian industrial approach of ensuring 'reasonable' working conditions with the

profession's own understanding of its expertise and its desire to improve standards of

practice. This has assisted with demonstrating genuine and definable expertise within the

profession and justifying overall improved levels of remuneration. The use of the theory

in these ways can strengthen the professional workforce in health care by contributing to

staff retention, developing excellence in health social workers and providing meaningful

lifetime careers in health for social workers.

The challenges of knowledge and skill development are not unique to the social work profession however. The potential practice applications of this theory as outlined within this article are just as likely to have equal relevance for other allied health professions. Health care practice relies upon effective multi-disciplinary collaboration and this should extend to the sharing of relevant theory where it may develop higher professional standards of practice.

This paper has demonstrated how a theory of expertise developed by Fook et al. (2000) which arose from a series of research studies on practitioners, was able to: 1) assist in differentiating levels in industrial awards for social workers; 2) be utilised in job selection; 3) be of use in professional development; and 4) in supervision. In these ways, a theory with its origins in research on practice was able to feed back to that very practice. In doing so, it served both as a tool and an opportunity to respond to the challenge to articulate the nature of expertise in health social work and thereby set practice standards for practitioners to aspire to and hopefully ultimately attain.

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