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THE JOURNAL OF THE ONTARIO ASSOCIATION

OF SOCIAL WORKERS



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DOUBLE ISSUE

THE IMPACT OF TODAY'S PRACTICE ON TOMORROW'S CARE: SUSTAINING SOCIAL WORK SERVICE IN HOME- AND COMMUNITY-BASED HEALTH CARE

◆ *Kate Power* ◆

*H*ealth care transformation has been a focus of discussion in Ontario for the past decade and has dominated structural reform in the home and community care sector, constituting a significant part of the provincial government's agenda. Paramount to these discussions are issues of human and financial resources that determine what services are to be available from the publicly funded envelope for health care services. Elinor Caplan's review of the home care sector (*Realizing the Potential of Home Care: Competing for Excellence by Rewarding Results, 2005*) resulted in implementation of 68 of her 70 recommendations impacting the managed competition process, human resources, structural reforms, and the basket of health services available through Community Care Access Centres (CCACs).

Social work service is included in the basket of health services available to those eligible for home care services through CCACs in Ontario. The sustainability and impact of social work on the future of home and community care invites the following questions:

- How can social workers ensure that they are providing the right service at the right time?
- In what ways can we collaborate and integrate best practices and innova-



KATE POWER

tions across the continuum of care, to benefit recipients of social work service and deliver effective outcomes?

- What is the role of social workers in a system that has sustained a high rate of change for over a decade, and one that will continue to challenge old paradigms and demand innovative methods of service delivery to home- and community-based clients?
- How can social work remain viable and affordable, providing measurable outcomes to best reflect the effectiveness of the services we provide?

see *Today's Practice... Tomorrow's Care/2*

TODAY'S PRACTICE... TOMORROW'S CARE (CONT'D FROM PAGE 1)

Broader social issues such as child welfare, substitute decision-making, elder abuse, homelessness, lack of finances and suitable housing come within the constellation of issues with which health care practitioners must cope. To address these issues, family doctors overwhelmingly identify a social worker/mental health worker as the first priority to supporting, delivering and advocating for improved care for their patients (Badger et al: 1997). From the perspective of the family physician in Ontario, access to the community-based system has improved for those who are deemed eligible for publicly funded home care or long-term care placement due to the coordinating role played by the CCACs. However, access to other supports for the continuum of patients' problems remains difficult and time-consuming (National Physicians Survey: 2004).

Much of the literature asserts that there is a significant overlap in the care and services required by users of health care services with ongoing or long-term care needs, e.g. frail or medically compromised seniors, persons with progressive/terminal illnesses or disabilities, persons with mental illness, and children with special needs who are impacted by the lack of integration of their respective care delivery systems (Hollander: 2003), (Romanow: 2003), (Kirby: 2003). In a health climate punctuated by persistent change requiring adaptations and transitions, social workers have expertise in coordinating transition points in complex health care and social service systems. Coordination and early intervention, rather than crisis intervention, provides an opportunity to foster sustainable solution-finding versus stabilizing the client through crisis management. (Kasperski, J., Power, K., VanderBent, S.: 2005).

In most areas of Ontario, home care services are contracted through a managed competition model. What skills are necessary for social workers to integrate into their service delivery "kitbag", to ensure cost-effective outcomes are achieved? A strong and measurable goal and result-driven orientation, combined

with an array of modalities, are primary tools in the community-based social worker's repertoire. Social work training provides an in-depth awareness and understanding of social systems, human growth and development, psychological principles and assessment of a capacity for change and sustainability.

Health and social supports are crucial to enable clients to age in place, sustain family configurations, reduce client transitions resulting from caregiver fatigue, and minimize transition points for clients through the health care continuum (Canadian Home Care Association: 2003). Social workers specialize in working with people, families and communities whose needs are high and whose resources to meet those needs are compromised or depleted (Antle: 2004).

Social workers in home- and community-based health care are constantly exploring ways to enhance our effectiveness and efficiency while mitigating risk and maintaining quality of care for clients, families, caregivers, and stakeholders. Hollander (2002) asserts that the costs are much lower for people who are stable in their type and level of care than those who change their type or level of care. The costs for stable clients are about one half of the cost of those in transition. Skills in providing psychotherapeutic counselling, health teaching, working effectively with families or with intergenerational caregivers, skills in mapping and working with systems that are complex and multi-level, (government, community resources, institutional, long-term care and retirement) are essential tools that social workers bring to the continuum of care.

The future of health care in Ontario is currently focused on the implementation of Local Health Integrated Networks (LHINS), signalling the regionalization of health care in Ontario. Seminal events related to this implementation include the collapsing of 42 CCACs to 14, the localizing of health funding to these regional authorities, and including populations such as those with mental

see *Today's Practice... Tomorrow's Care/6*

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PRESIDENT'S MESSAGE: OASW — A VOICE BEING HEARD

◆ Beverley J. Antle ◆

The following is the President's Report as published in OASW's "Annual Report 2005-2006" for the Provincial AGM, June 2, 2006.

It is a pleasure to report to the membership of OASW on another very successful year for our Association. In this report, I highlight where OASW has been investing its energy and resources as we strive to make a difference in the quality of life for ordinary Ontarians.

OASW: A VOICE FOR THE SOCIAL WORK PROFESSION

OASW seeks to be creative in finding ways to enhance public knowledge of the valuable services provided by members of the profession, while also being vigilant in responding to issues that affect the profession and the reputation of social workers. During National Social Work Week, for example, there were seven publications across the province highlighting the achievements of social workers, or speaking out on the theme for this year "Violence Hurts Everyone".

OASW has also been involved in a number of extensive consultations about the profession, which are highlighted in the Executive Director's Report. I would draw attention here to the consultations held with the Health Professions Regulatory Council (HPRAC) last summer about the question of regulating psychotherapy, because it required such a quick response and demonstrated the depth of expertise in our Association as we called upon members to assist us in developing a comprehensive, evidence-based brief. In mid-May, HPRAC released its report *Regulation of Health Professions in Ontario: New Directions*, that has important implications for social workers related to extending the use of the title "Doctor" and the regulation of psychotherapy, to which OASW is currently developing a response. We also have continued throughout this past year

to monitor and participate in the review of the *Social Work and Social Service Work Act*, while also encouraging key community stakeholders to be engaged in this process. We have been a strong voice for the profession and the unique needs of social work as a discipline. Social workers can view submissions on the OASW website www.oasw.org, and may also want to visit the HPRAC website www.hprac.org (typing in "psychotherapy" in the search box) to see the extensive set of responses from our colleagues with respect to psychotherapy as well as the recently released report.

OASW: A VOICE FOR THE VALUES OF SOCIAL WORK

The social justice mission of social work is always foremost in the efforts of OASW when speaking out on behalf of the profession. Through our 15-Branch structure, the Association reaches out across Ontario to influence public opinion and social policy. To achieve the goal of a higher profile, social workers, our senior staff, Executive team and Board of Directors have developed three contemporary social issues in Ontario to receive priority attention. These are: 1) upholding human rights; 2) advocating for quality health care; and 3) speaking out against violence, in particular, youth violence. By being vigilant and nimble, we now have a system whereby senior staff, the President and the Vice-President for Social and Professional Advocacy can prepare, in under four hours, a press release or letter to the editor in response to a breaking news item. In 2005, we doubled our publication rate from two years ago with, on average, almost one print publication per month. OASW's commentary on youth violence was the "Letter of the Day" in the *National Post* last summer, and garnered positive commentary from across the professional community in Ontario. Here, I would encourage you to read carefully the Social Advocacy Report (see p. 39), as the breadth of issues addressed by the Association is truly impressive. OASW



BEVERLEY J. ANTLE

members, who are not in a position right now to personally engage in social action, can take pride in knowing that simply by investing in Association membership, you are, by extension, participating in the social justice mission of social work.

OASW: A SERVICE SUPPORTING SOCIAL WORKERS

OASW is also an organization that strives to provide excellent service and benefits to its members. This year, we have invested in a completely revised website to improve both our visibility to the public as well as enhance our communication with and service to Association members. In the past two years, we have been investing in engaging social work students and new graduates to become a part of OASW. Like the broader community, membership in the Association is disproportionately represented by older social workers. If we want a vibrant future, we know we are challenged to make OASW attractive to new members of our profession.

In closing, I want to acknowledge and thank our staff in the Provincial Office, as well as members who give generously

see *President's Message*/6



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EDITORIAL: THE EVOLVING NATURE OF HEALTH CARE IN ONTARIO

◆ Joan MacKenzie Davies ◆

The theme of the September 2006 issue of *OASW Newsmagazine* focuses on the current restructuring of health care in Ontario and its implications for social work practice. Entitled “Transformation of Health Care”, this issue addresses a wide array of topics that relate to the rapidly changing nature of health care delivery within our province.

Successive provincial governments have sought to reshape health care with the intent of containing escalating costs; improving the effectiveness and efficiency of service delivery; and ensuring the sustainability of our publicly funded health care system. The previous Progressive Conservative government attempted to do so by merging, amalgamating and closing hospitals, and by creating Community Care Access Centres to deliver community-based health care services utilizing a managed competition model. Under the Harris-Eves government, decision-making in regard to the planning and funding of these services was centralized at Queen’s Park.

By way of contrast, today’s Liberal government hopes to achieve similar goals through the creation of local health systems, which have been mandated to plan, integrate and fund regionally based health care responsive to community needs. While maintaining control of the direction, strategic policy and system standards, as well as the delivery of some provincial programs and services, the Liberal government has assigned 14 local networks or LHINs (Local Health Integration Networks) the task of integrating Ontario’s patchwork of hospital and community-based services. While the current government has expressed strong support for publicly funded health care, their endorsement of three private hospitals, known as the P3s, together with official announcements confirming the government’s plans for much further hospital privatization, remain a source of serious concern.

Given the magnitude of the Liberal government’s vision to transform the delivery of health care in the province, it is vitally important that social workers are knowledgeable about what is happening; understand how changes may impact on service delivery; and are mindful of opportunities to influence the decision-making process as it relates to the planning, integrating and funding of services.

The articles you are about to read provide an informed perspective on such

“*G*iven the magnitude of the Liberal government’s vision to transform the delivery of health care in the province, it is vitally important that social workers are knowledgeable about what is happening...”

issues as the sustainability of Ontario’s health care system, looking specifically at the implications of restructuring within mental health, long-term care and rehabilitation services. Other articles address the important roles that social workers are increasingly carrying within Community Health Centres and newly formed Family Health Teams (it is noteworthy that the latter do not fall under the mandate of the LHINs).

While social work is regulated under the Ministry of Community and Social Services rather than the Ministry of Health and Long-Term Care (MOHLTC), conservative estimates suggest that more than half of the profession works in the broad field of health care. This figure increases dramatically if one uses the World Health Organization’s (WHO) definition which describes health as “a state of complete physical, mental, and



JOAN MACKENZIE DAVIES

social well-being and not merely the absence of disease and infirmity”. Given this definition, and the significant number of our members who are working in health care, OASW has played a long-standing active role in this sector.

While not an exhaustive list, over the past year, OASW has responded to health care policies related to: the establishment of the LHINs; proposed amendments to the *Regulated Health Professions Act (RHPA)*, including the potential regulation of psychotherapy; proposed changes to the *Insurance Act*; and participated in consultations related to the sustainability of Ontario’s health care system and the review of the managed competition model in home care. Furthermore, to assist social workers in hospitals facing budgetary deficits, OASW developed a two-page document entitled: “Re-Aligning Health Care Resources: Re-Affirming the Role of Social Workers in Hospitals”. Last year, OASW’s Board of Directors identified primary health care as one of the organization’s three key priorities (other priorities are human rights and issues related to children and youth, with a particular emphasis on youth violence).

see *Evolving Nature of Health Care*/6

TODAY'S PRACTICE... TOMORROW'S CARE (CONT'D FROM PAGE 2)

health needs into the home and community care health continuum of services. Our choices today will be critical to determining the quality of care for tomorrow. Social work will need to continue to strive to ensure it is a viable, sustainable service, integral to effective health service delivery, by providing effective, measurable, and affordable outcomes in the continuum of services in the home and community care sector.

Kate Power, MSW, RSW, is Regional Director at Community Rehab, a rehabilitation therapy provider contracted to CCACs across Ontario. She is also OASW Representative to APACTS (Alliance of Associations of Community-Based Therapy Services), and APACTS representative to the OACCAC & MOHLTC re: the Caplan Review of Managed Competition in Home Care and the RFP template.

Editor's Note: References to this article are available upon request from the OASW Office. 

THE EVOLVING NATURE OF HEALTH CARE IN ONTARIO (CONT'D FROM PAGE 5)


To promote the role of social workers in Family Health Teams (FHTs), OASW undertook the following activities: developed a role statement for social workers working in FHTs or primary health care (role statements already exist for hospital-based and community-based social work practice); in partnership with the College of Family Physicians and the Ontario Home Care Association, developed and distributed a position paper entitled *Social Work, Primary Health Care and Family Health Teams in Ontario: Delivering Comprehensive, Family-Centered Care*; established a virtual networking group for members working in FHTs; represented social workers on the MOHLTC's provincial FHT Action Group; and continues to explore ways to promote a greater understanding of the contribution social workers can make within primary health care.

PRESIDENT'S MESSAGE (CONT'D FROM PAGE 3)

of their time to serve OASW including Executive Officers, Provincial and Branch Board Members, Committee Members, Task Group Members and others who have provided consulting expertise; thank you all. It is through the co-ordinated efforts of many that OASW is the "voice of social workers in Ontario".

Beverley J. Antle, PhD, RSW, is President of OASW. She holds two appointments at the Hospital for Sick Children in Toronto: Academic and Clinical Specialist in Social Work, and Director of PKU in Genetics, providing leadership in clinical research and scholarship that enhances our understanding of child and family adaptation to health difficulties. Beverley is also an Adjunct

Associate Professor at the Faculty of Social Work, University of Toronto.

Letters to the President are always welcome. Please write to the President c/o OASW Office, 410 Jarvis Street, Toronto, Ontario M4Y 2G6; fax: (416) 923-5279; or e-mail: info@oasw.org. 

DID YOU KNOW?

Following the passage of Bill C-6, the *Assisted Human Reproduction Act*, it will be mandatory for anyone who goes to a fertility clinic to see a counsellor. Since 15% of Canadian couples will experience infertility, this legislation will soon create a demand for trained counsellors who are currently few in number. If this is an area of interest, contact OASW at info@oasw.org.

Additionally, OASW's Mental Health Advisory Task Group, which was established in the spring of 2005, conducted an on-line survey examining the role of social workers in the field of mental health. Data from this survey, which is currently being analyzed, will be used to develop a role statement for social workers practising within this area. For ten years, the Association has provided leadership annually by organizing and hosting the Social Work Session at the fall Ontario Hospital Association Convention in Toronto. Finally, health-related articles have been consistently featured in the *OASW Newsmagazine*. For instance, in the Summer 2004 issue, the cover article was entitled "How Social Work Brings Added Value to the Health Care Setting" and authored by Karen Nelson, based on her keynote address at the 2003 OHA Convention.

As health care in Ontario continues to evolve, it will become increasingly important for our profession to be attuned to the implications of changes on professional practice and on the nature of services available to the client groups we serve. More so than ever before, energy will need to focus on helping the public, government and colleagues in related professions better understand the role and value of social work's contribution to health care provision in the province.

Joan MacKenzie Davies, MSW, Res. Dip. S.W., RSW, is the Executive Director of OASW.

Letters to the Editor are always appreciated. 

THE SUCCESSFUL IMPLEMENTATION OF A DISCHARGE PLANNING MODEL: THE OTTAWA HOSPITAL EXPERIENCE

◆ Carol Murphy ◆ Judy Vokey-Mutch ◆

The health demands of Ontario's aging population, hospital bed pressures and an increasing volume of Alternate Level of Care (ALC) patients challenge hospitals to develop timely yet safe plans for patient discharges. Appropriate discharges reduce hospital pressures and maintain bed flow, so that acute care beds are available when patients require them. This is a priority in the Ontario Government's Transformation of Health Care plan.

Social workers at The Ottawa Hospital (TOH) address these needs within the acute care hospital system. ALC management, early identification of patients requiring discharge planning, assessment, utilization of case management skills and an emphasis on community partnerships are driving foci of the discharge planning component of the social work role.

According to Holliman et al, "the push to control and decrease health care costs has highlighted the importance of appropriate and timely discharges...discharge planning remains a critical function in health care because if monitored and executed properly, it can decrease patient length of stay and reduce the cost of continued medical care". The Ontario government's health care transformation agenda aims to improve the delivery of health care services, and appropriate hospital discharge planning is integral to this agenda.

SOCIAL WORK AND DISCHARGE PLANNING

Discharge planning is a complex process of enabling patients and their caregivers to make the transition from hospital to the community. It involves assisting patients to return home safely with the necessary supports, facilitating admission to the most appropriate level of care in the community, ensuring the safety of the client, and assisting and

supporting the patient and his or her family in the discharge process. At The Ottawa Hospital, social work has the lead role in developing and carrying out discharge plans for patients who have complicating factors and cannot be simply discharged home. The complexities of the discharge planning process often require comprehensive psychosocial assessment, counselling and crisis intervention skills, conflict resolution skills, patient/family education, advocacy and an ability to consider a continuum of options for care. As patients become more and more complex with increasing medical and psychosocial needs, these skills become even more essential. All of the social workers at The Ottawa Hospital have obtained a Master of Social Work degree and are registered with the Ontario College of Social Workers and Social Service Workers.

PRINCIPLES OF THE DISCHARGE PLANNING PROCESS

The Ottawa Hospital model contains a set of principles that constitute an effective approach to discharge planning, and aligns itself with the Ontario government's goals for an integrated, patient-centred and sustainable health care system. In this model, discharge planning:

- begins on admission or prior to admission for planned procedures and involves the hospital multidisciplinary team;
- is patient-centred and viewed on a continuum from home to palliative care, based on patient needs and incorporating the maximum number of patient options available;
- includes the role of a Discharge Planning Coordinator, who is a member of the Social Work department, to act as consultant to the hospital social workers to assist in resolving discharge issues and to review ALC issues;



CAROL MURPHY



JUDY VOKEY-MUTCH

- involves choices, timelines and goals;
- requires creativity and innovation; and
- contains effective links to community.

CHECKS AND BALANCES OF THE DISCHARGE PLANNING MODEL

The following checks and balances exist within the discharge planning model:

- The hospital's discharge policy

see *Discharge Planning Model/8*

DISCHARGE PLANNING MODEL (CONT'D FROM PAGE 7)

supports the necessity of patients accepting transfer to the first available long-term care (LTC) bed.

- A letter of explanation regarding the hospital discharge policy is given to patients/families applying for LTC, along with a LTC information booklet produced by The Ottawa Hospital Social Work department.
- In cases where patients/families refuse a long-term care bed, all attempts are made to achieve resolution to this conflict through involvement of the Discharge Planning Coordinator.
- Communication with the Community Care Access Centre (CCAC) is maintained where long-term care applicants are involved.
- An ALC Working Group comprised of hospital, CCAC, Ministry and long-term care representatives meets monthly to discuss ALC-related issues.
- Regular updates and education to social workers regarding discharge planning issues are provided.
- New social workers are orientated and supervised by social workers experienced in this area of practice.

QUALITY AND SUCCESS OF THE MODEL

The Ottawa Hospital's management and the Ministry of Health and Long-Term Care recognize the strengths of this model, and support social work's impetus in discharge planning at all levels. Feedback from patients and families about social work's involvement in the discharge process remains consistently positive.

This model maintains a record of success and achieves satisfactory outcomes as a result of the following features:

- flexibility providing the timeliness of discharge is maintained;
- readiness to look at all options with discharge planning viewed as a process, not a task;

- discharge plans achieved within the context of a relationship among the social worker, patient, family and multi-disciplinary team;
- use of social work skills to address psychosocial issues which may prevent timely discharge — research supports the fact that those patients remaining in hospital past their Expected Date of Discharge have complicated psychosocial needs which serve as obstacles to timely discharge (Keebler, Duder and Lechman, 2001); and
- consistency obtained through the centralization of the discharge planning activities through the office of the Discharge Planning Coordinator.


SUMMARY

In summary, this discharge planning model at the TOH has provided a struc-

ture where patient-focused, consistent and timely discharge planning services can be delivered while maintaining the unique role of social work in hospital care. Other hospitals have expressed interest in using this discharge planning model, and it is our hope that it can serve as an example of compassionate and patient-centred discharge planning.

Carol Murphy, MSW, RSW, has been the Discharge Planning Coordinator in the Social Work department at The Ottawa Hospital, Civic Campus, for the past six years.

Judy Vokey-Mutch, BSW, MSW, RSW, is the Discharge Planning Coordinator in the Social Work department at The Ottawa Hospital, General Campus.

Editor's Note: References to this article are available upon request from the OASW Office. 

OASW presents

“CREATING A DISCHARGE PLANNING MODEL THAT WORKS!”

Ontario Hospital Association (OHA) HealthAchieve 2006

Metro Toronto Convention Centre, 255 Front Street West
Caledon Room, Intercontinental

Tuesday, November 7, 2006, 2:00 – 4:00 p.m.

Panellists: Karen Nelson, MSW, RSW, Chief of Social Work, The Ottawa Hospital
Carol Murphy, MSW, RSW, Discharge Planning Coordinator, Civic Campus,
The Ottawa Hospital

Moderator: Patrick Clifford, MSW, RSW, Coordinator, Professional Practice,
Southlake Regional Health Centre, Newmarket

Increasingly, healthcare facilities are challenged to ensure that patients leave hospital promptly once their acute medical care has finished. This presentation, for social workers, other health professionals, healthcare managers and administrators, will examine how one hospital has developed an effective, multi-disciplinary model for discharge planning which is led by social work and is patient/family-centred, timely and supportive. The structures which facilitate this model, the policies and procedures that underpin it, and the quality of assurance/risk management measures used to ensure consistency will be reviewed.

Any questions regarding the OHA Convention can be directed to the OHA at tel.: (416) 205-1362; fax: (416) 205-1340; e-mail: healthachieve@oha.com; OHA web site: www.ohahealthachieve.com.

REFLECTIONS ON MENTAL HEALTH REFORM

◆ Steve Lurie ◆

As I write this article, I am on a train from Edinburgh to London, having participated in a conference sponsored by the IIMHL, the International Initiative on Mental Health Leadership, which brings service providers, funders, and consumer leaders together from the U.S., England, Scotland, Ireland, New Zealand and Australia. It is hoped that Canada will join, once the Mental Health Commission recommended by the Kirby Report, *Out of the Shadows at Last*, is established.

So what are the issues facing mental health systems in all these countries? The discourse is similar to what we hear in Ontario:

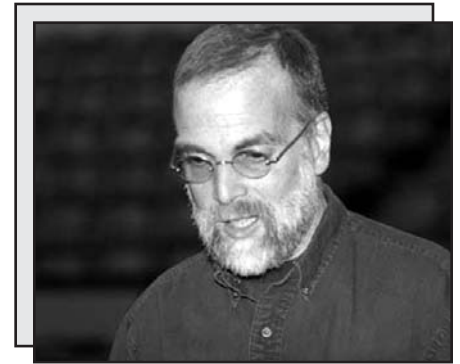
- Mental health system transformation as part of health care reform;
- Moving beyond the rhetoric and creating recovery-based services;
- Shifting resources from inpatient to community services;
- Funding more peer supports;
- Combating stigma and discrimination;
- Better integration of health and mental health services as well as improved collaboration with other systems such as housing, justice, income supports and employment;
- Reducing or ending the use of seclusion, restraints and other forms of compulsory treatment; and
- Making services more responsive to the needs of diverse clients and communities.

In the U.K. and New Zealand, there is a renewed effort to fund, plan and provide services, taking into account social deprivation and the risk profile of marginalized communities, something that we are not doing in Ontario. For example, the

prevalence of early psychosis is three times more likely if you live in the inner city and five times more likely if you are a young black male. This raises the question of whether a renewed focus on the development of social inclusion strategies (housing and employment) will have an impact on prevalence over time, and challenges the dominance of medical models of care that have tended to drive mental health systems, despite policy report protestations to the contrary.

As Ontario moves into a LHIN-led mental health future, it is timely to reflect on what has been achieved since the Graham Report was released almost 20 years ago. For those of you too young to remember, the Graham Report called for a partnership among consumers, families and providers in the planning, funding and evaluation of services; movement towards a community-focused mental health system; and strategies to improve access to housing, income and employment. How have we done?

There is more supportive housing, case management, consumer and family supports. We now have ACT (Assertive Community Treatment) teams and early psychosis programs across the province, and funding for community mental health has gone from \$45 million to close to \$600 million. Despite this progress, we are still far short of the 14,000 supportive housing units called for in an early draft of *Making it Happen* (1999). The fact that the target was not published when the final draft was released, speaks to the need to have targets to ensure that our performance matches our policy rhetoric. We have moved towards a community-focused system, but we are not there yet. Hospitals face challenges in determining which services hospitals can provide best, and what services should be devolved to the community. Community services are challenged to decide whether they wish to adhere to social care, or provide more clinical services. LHINs face a challenge of whether they



STEVE LURIE

need to restructure services or build capacity, or both.


The U.K. has had ten health system restructuring efforts in the past 20 years and, while there are more services as a result of the infusion of funding since 1997, there is limited evidence that restructuring has improved clinical outcomes. New Zealand has made progress, because their district health boards were not able to move money out of mental health services and there was a ten-year mental health plan that increased mental health funding by 85 per cent.

What are the messages we need to take forward as LHINs assume responsibility for mental health services?

- We need to continue to build capacity to provide more community-based services, including housing, employment and peer support. This will require continued investment in community mental health services over at least a ten-year period.
- We need to improve access to and continuity of care in mental health services, and continue to focus on evidence-based services that reduce the need for inpatient hospitalization.
- We need to improve coordination and linkage to front-line services, not by restructuring organizations but rather

see **Mental Health Reform/20**

QUICK FACTS ABOUT LHINs

 On March 1, 2006, the Ontario government passed legislation that gives 14 Local Health Integration Networks (LHINs) the authority to plan and co-ordinate specific health services, as well as to ensure that health care organizations work together for the benefit of Ontarians. In 2007, LHINs will also become responsible for funding local services. The following is based on a fact sheet prepared by the Ministry of Health and Long-Term Care in regard to the LHINs. For more details, please visit the LHIN website at www.lhins.on.ca.

1. What are Local Health Integration Networks (LHINs)? What will they do?

LHINs are not-for-profit corporations that will be responsible for planning, integrating and funding local health services in 14 different geographic areas of the province. LHINs will manage health services that are delivered in hospitals, long-term care facilities, community health centres, community support services and mental health agencies.

LHINs are based on a principle that community-based care is best planned, coordinated, integrated and funded at the local community because communities are best able to determine their health service needs and priorities.

Starting with community engagement*, LHINs will determine the health service priorities required in their local community, and will work with local health providers and community members to develop an integrated health service plan. They will eventually be responsible for funding and ensuring accountability of local health services providers.

2. What programs/services will LHINs be responsible for?

LHINs will have responsibility for:

- Public and private hospitals (including divested Provincial Psychiatric Hospitals)

- Community Care Access Centres
- Community Support Service Organizations
- Mental Health and Addiction Agencies
- Community Health Centres
- Long-Term Services Homes

3. What programs/services will the Ministry be responsible for?

- The government will set strategic directions and retain control for:
- Individual practitioners and Family Health Teams
- Ambulance Services
- Laboratories
- Provincial drug programs
- Provincial programs
- Independent Health Facilities
- Public Health

4. Why has the government established LHINs?

LHINs are a key component of the government's plan for transforming the health system. Through improved integration and the coordination of services, government believes that LHINs will create a more efficient and accountable health care system that will help ensure its sustainability.

5. How do LHINs plan to make health care better in communities across Ontario?

LHINs will be responsible for managing the local health system to ensure that services are integrated and coordinated. LHINs are expected to ease the flow of patients across the health care continuum and with the goal of improving their access to services in their community. They have also been given the task of planning and allocating resources to ensure better access to health care now and into the future.

LHINs are envisaged as allowing more community input into local health care decisions, thus improving health care experiences for patients in every part of the province.

6. What checks and balances are in the legislation to ensure that LHINs do not overstep the wishes of government, or take the health system in a direction counter to the government's strategic direction?

Since LHINs will be granted nearly two-thirds of the Ministry's \$33 billion budget, the legislation ensures that there is an appropriate balance between granting LHINs the authority they need to effectively and efficiently manage the local health system while retaining the ability to hold LHINs accountable for their performance. The relationship between LHINs and the Ministry will be governed by a Memorandum of Understanding between each LHIN and the Ministry, and by an accountability agreement between each LHIN and the Ministry. The accountability agreements will include performance goals and objectives for the LHINs, performance standards, targets and measures, and a plan for spending the money the LHINs receive. The legislation requires LHINs to provide the Minister with annual reports, including audited financial statements. The Auditor General will also have the authority to audit any aspect of the operations of a LHIN.

HOW SOCIAL WORKERS CAN GET INVOLVED:

- Become informed and knowledgeable about your local LHIN.
- Seek opportunities to provide input on policies, programs and services.
- Link with local agencies/organizations and network with other professional groups in continuing community consultation processes.

Editor's Note: For information about OASW's response to LHINs, please refer to page 40 as well the Association's web-

see **Quick Facts About LHINs/20**

OPPORTUNITIES FOR SOCIAL WORK AND REHABILITATION RESEARCHERS IN ONTARIO'S HEALTH SYSTEM TRANSFORMATION AGENDA

Mary Ann McColl, PhD, is Associate Director, Research, at the Centre for Health Services and Policy Research at Queen's University, and a Professor in the Department of Community Health and Epidemiology and the School of Rehabilitation Therapy. She gave a presentation at a two-day workshop held by the Ontario Rehabilitation Research Advisory Network (ORRAN) in April 2006 on ORRAN and the Transformation Agenda. ORRAN was established in 2005 by the Ministry of Health and Long-Term Care (MOHLTC) to promote and advance rehabilitation research in Ontario. McColl was interviewed by Gillian McCloskey, Associate Executive Director and Editor of the "OASW Newsmagazine", on June 21, 2006.

Q: What are the goals of ORRAN and what, in particular, stands out about ORRAN that would be of interest to our social work readership?

A: The goals of the Ontario Rehabilitation Research Advisory Network (ORRAN) can be found on our website (www.orrn.ca), and they are:

- To establish a collaborative context to support and develop rehabilitation research initiatives across Ontario.
- To maximize rehabilitation research funding for Ontario.
- To expand the number of people conducting rehabilitation research.
- To increase the exchange of rehabilitation research knowledge into practice, policy, and further research.
- To act in an advisory and networking capacity to the Ministry regarding policy, knowledge exchange and funding focus for rehabilitation research in Ontario.

One of the most significant achievements of ORRAN is the identifica-

tion of five themes that inform the content of rehabilitation research in Ontario: neurological rehabilitation; childhood disability; aging and disability; musculoskeletal rehabilitation; and rehabilitation health services and policy. Research networks have been developed around these themes, and many of the organization's activities are conducted through the five research networks.

Q: What is the most significant challenge to ORRAN achieving these goals, and give us one example of how you have addressed that challenge?

A: There are two places where rehabilitation research typically occurs in Ontario: academic health science centres based at the universities, and clinical or community health settings. Unfortunately, there are seldom bridges among the research organizations, so rehabilitation research can be a bit of a "lonely" enterprise. The rehabilitation field is very broad, with its many professional groups and varied theoretical perspectives. However, we believe that there is an opportunity in Ontario for researchers to find out more about each other. ORRAN conducts an annual conference where we hope that some connection and momentum are established among rehabilitation researchers. The conference is designed to assist participants to explore collaborative opportunities and share their research. There is something in the nature of a research relationship that requires face-to-face contact and trust, and ORRAN has been pivotal in bringing people together in the same room and helping to build relationships among rehabilitation researchers in Ontario.

Q: Do you see ORRAN as a model for other types of research that would play a vital role in the



MARY ANN MCCOLL

transformation of the health care system in Ontario?

A: ORRAN is our best attempt to promote rehabilitation research and to interact with the Ministry of Health and Long-Term Care (MOHLTC) with respect to rehabilitation research. Whether ORRAN is a model for other professional groups to collaborate with and advise the Ministry (MOHLTC) is hard to say. ORRAN has served as a critical vehicle through which to relate to the Ministry. In its absence, it would be difficult to know who to talk to. There have been a multitude of changes within the last four years at the Ministry, and rehabilitation has basically disappeared from MOHLTC's organizational chart. This makes it challenging for rehabilitation researchers to have a stable relationship with policy-makers, and to ensure that rehabilitation research answers policy-relevant questions.

Recently, ORRAN has been playing a role in assisting rehabilitation researchers to participate in the Ontario's health system Transforma-

see *Opportunities for Social Work and Rehabilitation Researchers/12*

OPPORTUNITIES FOR SOCIAL WORK AND REHABILITATION RESEARCHERS (CONT'D FROM PAGE 11)

tion Agenda, and some priority issues for rehabilitation researchers have been identified by government. Rehabilitation researchers have had some positive opportunities initiated by the Ministry such as requests for proposals on the role of rehabilitation in primary care reform, public/private payment mix, transitions across health care sectors and chronic disease management, to name a few examples.

Q: What are your thoughts about the government's vision for Ontario's health care system that would be of particular interest to social workers?

A: The Ministry has identified four priorities in its Transformation Agenda, and these are: primary care reform, access and wait times, creating an integrated system and improved information management. In my opinion, a key component of the structural and system changes that are occurring in the health care system is the establishment of 150 Family Health Teams (FHTs), where allied health professionals, including


social workers and rehabilitation professionals, can participate in a meaningful way in the province's transformed health care system. It could be immensely rewarding for both of our disciplines to take up the challenge associated with indeed being patients' first contact with the health care system. In primary care reform, the focus on chronic disease management provides social workers and rehabilitation researchers the opportunity to demonstrate their wide range of skills such as case management, community referral and coordination, and education about various conditions.

Another opportunity exists regarding the creation of a regionally integrated system. With the creation of the 14 Local Health Integration Networks (LHINs) across Ontario, there is an opportunity for both social workers and rehabilitation researchers to reconsider how they participate in the continuum of care, and to provide information to ensure that the needs of their clients will be met in the transformed health care system.

With respect to access and wait times, both social workers and rehabilitation researchers could advise the Ministry on the locations in the health care system where undue waits for their services occur, as well as on the implications for people who are waiting for service.

Finally, information management is of particular interest to researchers. The Ministry has identified over 100 databases containing health information about Ontarians. Significant strides have been made to improve quality and coverage of health data, and improve access for researchers in a way that conforms to the privacy legislation. Social workers and rehabilitation researchers can use the information contained in these datasets to help to address service needs and issues. Further, rehabilitation and social work researchers will likely be interested in participating in the identification of performance indicators and outcome measures used to track system performance.

Q: Is there anything else that you would like to communicate to social workers?

A: To date, the main membership of ORRAN has been researchers from occupational therapy (OT), physical therapy (PT), speech-language pathology and psychiatry (physical medicine and rehabilitation specialty), and there has not been much of a relationship with social work researchers. At present, one member of our Executive is a social worker, and we are becoming increasingly aware of the role of social work in rehabilitation. If there were an opportunity to involve social work researchers to a greater extent with the activities of ORRAN, we would welcome them. 

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SOCIAL WORK AND THE NEW VISION FAMILY HEALTH TEAM: A COLLABORATION

◆ Tracey Clark ◆ Angela Hovey ◆

How fitting the theme of “Transformation of Health Care” is for this issue of the *OASW News-magazine*, when a number of changes are unfolding in our health care system. In 2005, the Ministry of Health and Long-Term Care announced the creation of 150 Family Health Teams (FHTs) across Ontario. These FHTs will bring together family physicians and other health care professionals, including social workers, to work collaboratively to provide patient care. OASW has been involved in several initiatives around primary care (*OASW Newsmagazine*, July 2005). The Health Service Organization (HSO)¹ program in Hamilton has been integrating social workers into physician offices since 1994 and its successes are well documented (e.g. Kates et al.: 1998; Kates et al.: 1997; Kates et al.: 2002). Social workers are an ideal fit for this model of integrated care and bring the experience and range of skills that can be an asset in primary care (Power & VanderBent: 2005). This article will highlight the development of the New Vision Family Health Team and our experiences in bringing social workers into the family physician practice.

The New Vision Family Health Team, spearheaded by lead physician, Dr. Mel Cescon, is a group practice in Kitchener-Waterloo with eight physicians on two sites and a roster of over 12,000 patients. The physicians were already organized as a group practice, but formed a working relationship with Pace Consulting Group in 2005 to bring mental health and nutrition services to the newly formed New Vision Family Health Team. Pace Consulting Group is a local EAP and home care service provider. Through this arrangement, Pace manages and provides the social work and dietitian services. Ongoing meetings among all team members facilitate communication, collaboration, and monitoring of the mental health and nutrition programs.

Currently, there is funding for two FTE social workers and a .2 FTE team lead to oversee the implementation, development and evaluation of the social work aspect of the program. Rather than hire two full-time generalist social workers, Pace and New Vision elected to contract five social workers to ensure a variety of skills and expertise. The current team brings experience with mental health, corrections, addictions, grief and loss, children’s mental health, abuse issues, family relationships and clinical experience with all age groups.

At New Vision Family Health Team, physicians are the primary point of contact and play a pivotal role in the promotion of health and treatment of illness. A patient most often goes to his or her physician first because of a trusted relationship, or prompted by symptoms related to physical or emotional difficulties. Social workers are uniquely poised to complement physician care because they “specialize in working with people, families and communities whose needs are high and whose resources to meet those needs are compromised or depleted” (Antle: 2004, p.3). Within the FHT model, social workers are available for consultation to all members of the multidisciplinary team, or they can provide direct service through assessment, counselling, linkage to community resources and supports, case management and advocacy (OASW: 2005). The physician can essentially send the patient down the hall, providing an accessible and seamless service. At New Vision, our patients have been comforted by the “familiar surroundings and also by the knowledge of the close working relationship between his/her family physician and the social worker” (Smith & Williams: 2004, p.14).

In order to ensure that the mental health



TRACEY CLARK



ANGELA HOVEY

program does not become a separate clinic with social workers working in isolation, team members need to be aware of the knowledge and experience each discipline brings to the team in order to collaborate effectively. In addition, adequate office space for social workers or additional team members is essential. Group practice and psychoeducation programs can also enhance patient care; however, social workers require appropriate space to be able to see an individual, couple,

¹ HSOs (Health Service Organizations) are rostered family medicine practices, funded by capitation, with the per capita payment being weighted according to projected service utilization (Kates et al.: 1997).

see *New Vision Family Health Team/18*

COMMUNITY HEALTH CENTRES: A MODEL FOR HEALTHY COMMUNITIES

◆ Sue MacLatchie ◆

In 2005, the Ministry of Health and Long-Term Care (MOHLTC) announced an increase in the number of Community Health Centres (CHCs) across Ontario. Since the 1970s, CHCs have been major players in delivering health and social services to neighbourhoods. Many features of the CHC model contribute significantly to health care reform in an exciting and dynamic way.

I became involved with a Community Health Centre (CHC) movement in 1974 as a member of the community committee which established a multi-service centre to coordinate social services in Ottawa West. The Centre was small, with two staff and a Children's Aid office. A "moms and tots" program, a loan fund and an employment program were developed. Community leaders fully supported the request to MOHLTC to add primary health care to the centre in the early 1980s; when this component was added, the Centre became a CHC. Most important was the involvement of community members in this process as volunteers, board members, and spokespersons. Elected boards ensured local accountability.

CHCs were funded from the program budget of the Ministry of Health (MOH) as experimental pilot projects. In 1982, the MOH announced that CHCs would be part of mainstream health care services, and the Ontario Association of Health Centres (AOHC) was formed. Currently, 54 CHCs, 10 CHC satellites and 10 Aboriginal Health Access Centres serve Ontario. In November 2005, the Ministry announced that 22 new CHCs and 17 satellite CHCs would open before 2009.

In 2005, the Ontario Health Quality Council was formed by the provincial government to monitor publicly funded health systems in Ontario. This spring, the first report was released. On April 26, 2006, Adrianna Tetley, Executive

Director of AOHC, stated, "Praise from the Ontario Health Quality Council for Community Health Centres confirms that the government has made a far-sighted decision expanding the network of CHCs through the province... The Health Quality Council's report confirms Community Health Centres are Medicare's best kept secret... With an even more expanded network, CHCs and Aboriginal Health Access Centres can transform our health care system and strengthen Medicare. The CHCs provide accessible primary health care services, giving clients coordinated access to a number of primary health care services from a variety of team members. Our interdisciplinary team provides appropriate care for many clients with complex health needs. With a focus on social determinants of health, our centres focus also on community health, offering innovative health promotion, outreach and other programs tailored specifically to local community needs."

Primary Health Care Reform embraces multi-disciplinary teams, with social workers as strong players on the teams. In CHCs, an interdisciplinary team of health care professionals works with individuals, families and organizations. Social workers can provide front-line practical assistance while functioning as managers and therapeutic staff. For example, at a walk-in clinic, the mental health counsellor works closely with the nurse practitioner. Anxiety and depression are among the most common complaints at the walk-in clinic, necessitating a close working relationship between the nurse practitioner and the social worker.

Reforming primary health care is not just about faster individual medical care. At the Somerset West CHC, the Asthma Project has shown that a two-pronged approach, enhancing the skills of doctors and nurses and teaching people how to manage their asthma, has cut hospital visits and associated costs. Executive Director Jack McCarthy stated, "I'd like more asthma educators working in local

schools and seniors residences to teach health care plans so people do not have to go to hospital." Enhancing an Asthma Care Management Program demonstrates an effective approach to reforming primary health care in Ontario.

As a community developer and a social worker, I engaged community residents in our democratic process by encouraging them to participate in community groups working on issues such as recreation, housing and poverty. One client was very depressed and was referred to me by a medical professional. By participating in community organizations, he used his considerable public relations skills to address city-wide issues such as food security, barriers to poverty and the lack of affordable housing. He is the recipient of three much deserved awards from municipal and provincial bodies for his contributions.

Primary health care is being reformed to address the social determinants of health, mirroring the mandate of CHCs. Health is affected by social factors such as income, education and housing. CHC services emphasize building vibrant communities where people can find the services they need, including medical services, employment and education. The Board committee at Somerset West was concerned about childhood obesity when it advocated for affordable recreational opportunities through articles in the local newspapers, public meetings and requests to politicians. When a local school was in danger of being closed, our board supported the residents' desire to keep the school open by sending a letter of support with the President and Executive Director to the community meeting. With the announcement of a new housing development in our area, the Centre approached municipal and federal governments to request that 25 per cent of the new units be deemed affordable, as this would directly benefit the many clients of our Centre who are homeless or "couch surfing".

see Community Health Centres/20

WHAT'S HAPPENING TO LONG-TERM CARE?

◆ Ethel Meade ◆

Not long after the McGuinty government was elected in October 2003, a series of sensational articles in The *Toronto Star* revealed shocking conditions in several of Ontario's long-term care facilities. They were so appalling that The Honourable George Smitherman, the newly appointed Minister of Health and Long-Term Care, committed his Ministry to investigate conditions and to take whatever steps necessary to end these horrors. By December 2003, he had appointed his Parliamentary Assistant, Monique Smith, MPP for Nipissing, to undertake a review of long-time care facilities across the province. Her report was released in the Spring of 2004 and was followed by an extended period of consultations, including face-to-face meetings with seniors' and other community organizations and a web-based consultation paper to which both individuals and organizations were encouraged to respond.

Has anything changed as a result of all this activity? The answer has to be a positive one, and changes include:

- Compliance **inspections** are now **unannounced**, rather than scheduled in advance so that facilities could put on a good, but temporary show;
- **Family** and residents' **councils** are being established where they do not yet exist, with support to Concerned Friends of Ontario Citizens in Care Facilities and the Advocacy Centre for the Elderly to make this happen;
- A Registered Nurse must now be available 24/7 in every care facility;
- A toll-free Action Line for complaints has been set up (1-866-434-0144), calls to which will trigger an immediate inspection;
- A new operations manual states clearly the standards of care expected; and

- A website is up and running which lists all long-term care homes, with reports of any non-compliance that has been registered by a Compliance Inspector.

According to the buzz, a new "Long-Term Care Act" has already been drafted and will be introduced during the Fall sitting of the Legislature. We do not expect many surprises. Like the legislation establishing the Local Health Integration Networks (LHINs), many improvements have already been put into effect.

Some measures that will become effective only when the Act has been passed and proclaimed are **mandatory reporting** by anyone who suspects or has witnessed abuse within a long-term care home and **whistle-blower protection** for those who do report. Both of these measures will be difficult to enforce. Failure to report can only come to light when the abuse has been revealed in some other way. As for whistle-blower protection, its overt forms may be effectively eliminated, but there are many invisible ways that a superior can make a front-line worker's life miserable.

Three potentially significant changes that, unfortunately, are not expected to be in the Bill presented to the Legislature are: a return to **required staffing ratios**; a return to a **50/50 split** between preferred accommodation and basic accommodation; and **equal pay for equal qualifications** for all health care workers, whether employed in community care, long-term care homes or hospitals

1. **Required staffing ratios** are the only way that the improved levels of care can actually be affected. Under-staffing has become a serious problem, in non-profit as well as for-profit facilities, not so much because of staff reductions as because not enough new front-line workers have been added to meet the needs of the older and frailer residents¹ whom they are now serving.



ETHEL MEADE

Until the Harris government was elected, such ratios were in effect. At that time, each facility was required to have enough staff to provide an average of 2.25 hours of care per person per day. Since that time, the rise in the age and the acuity level of residents has led workers in the field to estimate that an average of 3.5 hours would now be a bare minimum.

2. The current **40/60 split** between beds for basic accommodation and those for preferred accommodation should be returned to the **50/50 split** that prevailed before the election of the Harris government. This has become all the more urgent because supportive in-home care has virtually disappeared, while the CCACs are fully occupied with caring for the sicker patients now being discharged earlier from our hospitals.

Low-income seniors (and there are a multitude of them) have very little choice if public in-home care is less than adequate. They cannot afford to purchase additional care from private operators. Unless they have available family members to fill the gap², they must either find a black-market retirement home³ that they can afford or go, perhaps prematurely, into a long-term care home.

see *What's Happening/16*

WHAT'S HAPPENING? (CONT'D FROM PAGE 15)

3. Our current system for remunerating front-line health care providers remains grossly unfair and threatens human resource crises in community care and long-term care. **With equal qualifications**, both professional and paraprofessional health care workers receive the lowest pay for work in the community; a somewhat higher pay scale is in effect in long-term care homes, while hospitals pay the highest rates of all.

If the government cannot be persuaded to correct this grossly unfair disparity, they may soon be forced to correct it because of human resource problems. Some nurses may remain in community service because they are extremely dedicated to caring for their clients or prefer to escape the stress of institutional employment. Many, on the other hand, may require and therefore look for better remuneration in a long-term care home, while those in long-term care may accept

the first opportunity to achieve a hospital position.

OASW has been active in consultations with Ministry of Health and Long-Term Care (MOHLTC) officials, and the activity of various seniors' and other community organizations has played and continues to play a significant role in the planning stages of the province's transformation agenda. The Elder Health/Elder Care (EHEC) Coalition, which consists of provider and consumer organizations in partnership with the Ministry, has, for the last three years, been lobbying for a framework for integrated care for seniors and for senior advisory panels for each LHIN. It has now established four working groups, each with members from both the EHEC Steering Committee and the Ministry. The four groups are focused on: supportive housing, elder abuse, transportation and chronic care.

Public consultations or hearings will

follow second reading of the new "Long-Term Care Act" which, Monique Smith has advised, will be tabled in the Fall. EHEC and all its constituent organizations will certainly participate in the hearings, and OASW will undoubtedly make its own submissions as well.

Meanwhile, we may all find that advocating on specific issues may be most effective at the level of the Local Health Integration Networks.

Ethel Meade, PhD (Eng. Lit.), has been a long-standing community activist on health care issues and has held numerous leadership positions including currently: Board member and Steering Committee Co-Chair at OCSCO (Ontario Coalition of Senior Citizens' Organizations); Vice-Chair of Care Watch Toronto; immediate Past Chair of Ontario Health Coalition; Member of Senior Secretariat Seniors' Liaison Committee; and Member of OASW's Committee on Issues of Aging.



TAKING LIVES BACK FROM THE EFFECTS OF VIOLENCE AND ABUSE: A NARRATIVE APPROACH

Jill Freedman MSW

Co-author of
*Narrative Therapy: The Social
Construction of Preferred Realities*

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- 1 The Health Services Restructuring Commission mandated the closing of 5000 chronic care beds in Ontario. This had already been anticipated and in the mid-90s, chronic care hospitals stopped admitting patients who were not dependent on a machine to keep them alive.
- 2 In our society where two-earner families are commonplace and adult children may reside wherever their careers take them, seniors who need more help than they are getting may not be able to count on their children's help.
- 3 Retirement homes in Ontario are unregulated and require no license to operate. Fire and Sanitation inspectors may enter, if they know a retirement home exists; however, without licensing, a vile boarding house may operate, providing minimal care, less than adequate supervision, unappealing or less than nutritious meals and no programming aside from one television set and absolutely no publicity. Residents have only the protection of the *Landlord/Tenant Act*, which provides some protection from hasty eviction. A few cities (e.g. Hamilton, Windsor) require licensing to operate a retirement home, and obtaining a license depends on prescribed standards. They hire inspectors who may enter to make sure the standards continue to be met.



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THE VAST AND COMPLEX HEALTH NEEDS OF ABORIGINAL COMMUNITIES

In June 2006, OASW called upon federal and provincial political leaders and MPs/MPPs to take action related to the Kashechewan community and the continued evacuation of its residents, due to unsafe water conditions and flooding. The message was repeated in letters to the editor of 37 major provincial and national newspapers. The Association's Vice-President, Dr. Julie Woit, who travels regularly to First Nations communities in the North, had been instrumental in communicating with several Band Chiefs as well as with the Grand Chief and been receiving full approval by them of OASW playing an advocacy role. She co-wrote with Erica Penno, Health Director of Pic River First Nation Health Centre, the following introduction to the text of OASW's letters to Prime Minister Harper and Premier McGuinty for the *OASW News-magazine*, in which the theme of "Transformation of Health Care" is featured:

The health needs of Aboriginal communities are vast and complex. Historical variables such as colonialization, residential schools, stripping of culture and language, and sexual, physical and emotional abuse all play significant roles in presenting problems. They manifest in physical, emotional and mental concerns for community members. The physical concerns include Type-2 diabetes, hypertension, kidney disease, liver disease, arthritis and lupus. Children and youth are also exhibiting such symptoms. Many children in elementary grades are considered morbidly obese, and some have elevated blood pressures. Mental health concerns include depression, post-traumatic stress disorder, anxiety, panic and concurrent disorders. Self-medicating occurs through alcohol, over-the-counter or illegal drugs and prescription medicines. Gambling and over-eating disorders are also prevalent.

Accessing health care is a challenge facing many communities. Non-Insured Health



ONTARIO ASSOCIATION OF SOCIAL WORKERS
L'ASSOCIATION DES TRAVAILLEUSES ET TRAVAILLEURS SOCIAUX DE L'ONTARIO

June 9, 2006

Hon. Dalton McGuinty
Premier of Ontario
Legislative Bldg Rm 281
Queen's Park
Toronto, ON M7A 1A1


Dear Premier McGuinty:

The Ontario Association of Social Workers (OASW) is writing to voice grave concerns about the ongoing environmental disasters and associated health risks confronting members of the Kashechewan community. On three different occasions within the past year alone, unsafe water conditions and now flooding have forced members of the community to relocate to Sudbury and other northern communities for indefinite periods of time. Evacuation from one's home would have a destabilizing effect on anyone; however, members of the Kashechewan community have additionally had to cope with the stress, health and safety concerns associated with returning to unsanitary water treatment conditions, damaged electrical equipment, mould and an array of other problems emanating from the flooding. Aside from the practicalities of re-establishing their daily activities, the short and long-term health implications of the recent environmental disasters on these individuals and families, are profound.

OASW strongly recommends that funding be made available to support families who have been displaced, drawing upon the expertise within the Aboriginal communities to design and implement such support, contingent upon agreement from the Band Chiefs. Similarly, we urge the provincial government to work in partnership with the Band Chiefs and federal government to improve living conditions on the reserve, with particular emphasis on strengthening infrastructure related to water treatment systems.


Furthermore, OASW calls upon the Ontario Ministry of Health and Long-Term Care to act upon the findings of the Ontario Health Quality Council, which has identified as a "disturbing reality" the inequitable access to health care experienced by aboriginals, immigrants and low-income families as compared to most other residents in Ontario. While the newly established agency which monitors medicare in the province has not yet had time to determine reasons for the findings, the health council has proposed that Ontario and Canada move quickly to establish electronic records for every patient, which it believes are fundamental to measuring the performance of the health care system. Additionally, OASW proposes that government pursue further research and through a consultation process seek to better understand the root causes of inaccessibility and use this information to create mechanisms to address service inequities.

Sincerely,



Beverley J. Antle, PhD, RSW
President

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www.oasw.org oasw@web.net
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ONTARIO ASSOCIATION OF SOCIAL WORKERS
L'ASSOCIATION DES TRAVAILLEUSES ET TRAVAILLEURS SOCIAUX DE L'ONTARIO

June 9, 2006

The Rt. Hon. Stephen Harper, Prime Minister
House of Commons
Prime Minister's Office
Wellington Street
Ottawa, Ontario K1A 0A6


Dear Prime Minister:

The Ontario Association of Social Workers (OASW) is writing to voice grave concerns about the ongoing environmental disasters and associated health risks confronting members of the Kashechewan community. On three different occasions within the past year alone, unsafe water conditions and now flooding have forced members of the community to relocate to Sudbury and other northern communities for indefinite periods of time. Evacuation from one's home would have a destabilizing effect on anyone; however, members of the Kashechewan community have additionally had to cope with the stress, health and safety concerns associated with returning to unsanitary water treatment conditions, damaged electrical equipment, mould and an array of other problems emanating from the flooding. Aside from the practicalities of re-establishing their daily activities, the short and long-term health implications of the recent environmental disasters on these individuals and families, are profound.

OASW strongly recommends that funding be made available to support families who have been displaced, drawing upon the expertise within the Aboriginal communities to design and implement such support, contingent upon agreement from the Band Chiefs. Similarly, we urge the provincial government to work in partnership with the Band Chiefs and federal government to improve living conditions on the reserve, with particular emphasis on strengthening infrastructure related to water treatment systems.

Furthermore, OASW calls upon the Ontario Ministry of Health and Long-Term Care to act upon the findings of the Ontario Health Quality Council, which has identified as a "disturbing reality" the inequitable access to health care experienced by aboriginals, immigrants and low-income families as compared to most other residents in Ontario. While the newly established agency which monitors medicare in the province has not yet had time to determine reasons for the findings, the health council has proposed that Ontario and Canada move quickly to establish electronic records for every patient, which it believes are fundamental to measuring the performance of the health care system. Additionally, OASW proposes that government pursue further research and through a consultation process seek to better understand the root causes of inaccessibility and use this information to create mechanisms to address service inequities.

Sincerely,



Beverley J. Antle, PhD, RSW
President

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L'ATTSO est affiliée à l'Association canadienne des travailleuses et travailleurs sociaux.

T ransformation of Health Care

ABORIGINAL COMMUNITIES (CONT'D FROM PAGE 17)

Programs (First Nations and Inuit Health Branch, Health Canada) fund mental health counselling, but restrict the frequency of participation in treatment programs and also deny funding for transportation costs to access counselling services. Many communities lack qualified staff to respond to the complex treatment needs.

The above variables, in addition to lower education levels, increased rates of poverty, lower employment rates, and increased rates of teen pregnancies, all need to be considered in addressing social determinants of health. Assisting individuals in assuming responsibility and ownership of

their health helps to promote a community-based proactive approach to wellness. Current initiatives, including wellness conferences, health programs, as well as traditional efforts such as elder teachings, sweat lodges, ceremonies and healing lodges, need to be supported. A call remains to honour a holistic approach to care, and to view the individual within a physical, mental, emotional, and spiritual context, with mitigating factors of finances, housing and education considered. Only then can the principles of wholeness and interconnectedness, as taught within the Medicine Wheel, be fully realized.

Editor's Note: OASW requested an opportunity to make a presentation to the Federal Expert Panel on Safe Drinking Water during the public hearings being conducted in the summer. From the perspective of the social work profession, the issues facing Aboriginal communities, such as Kashechewan, are of a systemic and complex nature and therefore require a multi-pronged, broad-based approach. With limited spaces to hear from groups/organizations, the Association was, unfortunately, not able to make a presentation.



NEW VISION FAMILY HEALTH TEAM (CONT'D FROM PAGE 13)

family or groups when needed.

At New Vision, the physicians, nurses and support staff were involved in the planning process and as a result, were supportive and welcoming to the expanded team of social workers and dietitians. An orientation and social events were held to help team members get to know each other. Physicians, nurses and support staff were provided with information about the social work role in assessment, treatment and management of mental health issues, and the particular areas of expertise of each social worker. Team members have demonstrated a willingness to work together and have an open-door policy.

The use of current technology and the common electronic medical chart have been a tremendous asset to our ability to collaborate with the size of our team. The social worker has access to the medical chart for pertinent information that may assist in the assessment or treatment planning. Additionally, after every patient contact, the social worker completes his or her documentation within the electronic medical chart and messages the physician. This confidential messaging process enhances communication and ensures a shared plan of care. Opportunity for informal case discussion or consul-

tation is readily available because of team members' proximity to each other.

While the common medical chart and sharing of information is important to provide coordinated care, this can create a challenge to ensuring patient confidentiality. Confidentiality practices are reviewed with each patient and appropriate procedures have been implemented to address patient confidentiality, particularly regarding mental health documentation and requests for information from third parties. This issue poses challenges to ensuring the patient's right to confidentiality and privacy, while balancing the need to collaborate and share information. These are issues that we continue to work through.

Social workers are well suited for work in primary care because of their experience in working with interdisciplinary teams in a variety of practice settings. Some patients require brief intervention, while others with more complex needs may require longer-term psychotherapy or case management. Although a session limit at New Vision has not been established, the goal is to provide brief, evidence-based treatment. As the demand increases for social work input, we need to evaluate and monitor to ensure that our services are accessible and meeting the needs of the patients and the practice.

With Family Health Teams expanding, patients have access to enhanced primary care services. Social workers can offer a range of skills and interventions that complement physician care and make them valuable members of the shared health care team. Our first nine months at New Vision Family Health Team have fostered an environment of collaboration and shared intervention. As we move forward and the government's transformation agenda gains momentum, we will continue to review, monitor and evaluate our efforts to ensure exemplary patient care.

Tracey Clark, MSW, RSW, is the Mental Health Team Lead at New Vision Family Mental Health Team. Prior to her position at New Vision, Tracey worked for a number of years in the Hamilton HSO's Mental Health and Nutrition Program, and had the opportunity to experience the benefits and challenges of working in a shared care model.

Angela Hovey, MSW, RSW, is a part-time social worker with New Vision Family Health Team and currently a PhD candidate at Wilfrid Laurier University.

Editor's Note: References to this article are available upon request from the OASW Office.



SUSTAINABILITY OF ONTARIO'S HEALTH CARE SYSTEM

◆ Gillian McCloskey ◆

In the spring of 2006, OASW was invited by the Ministry of Health and Long-Term Care (MOHLTC) to participate in consultation sessions on the long-term sustainability (20 years or more) of our health care system, as part of a new long-range scenario planning (LRSP) initiative. With factors such as a growing aging population, technological changes, and the availability of health human resources that are putting the sustainability of the system at risk, the Ministry is interested in exploring the long-range impact of these and other potential driving forces on system sustainability for the purpose of developing future strategies. Keith Adamson, OASW Vice-President, Social and Professional Advocacy, and Fay Lim-Lambie, Practice & Educational Leader – Social Work, at St. Michael's Hospital in Toronto, have been the representatives for the Association.

As MOHLTC explained, long-range scenario planning has been increasingly recognized over the last decade, in highly complex sectors like health care, as a useful tool for informing decisions with long-range implications. It has been proven, in other jurisdictions, to be a successful method for generating information required by government and health care leaders faced with critical decisions with long-range consequences. In recent years, the Ministry has used a scenario planning methodology in allocating physician training resources and in expanding the number of family medicine residency positions.

The goal of this new and more extensive LRSP initiative is to develop, during this year, three to six distinct scenarios describing the possible future state of Ontario's health care system. This will provide the evidence needed to inform the development of future strategies.

There are five major steps to this initiative and they are as follows: 1) identification of key issues around the sustain-

ability of the health care system; 2) consultation with thought leaders and stakeholders from the health sector, community organizations, government and academia to document the key questions, assumptions and driving forces impacting health care sustainability; 3) development of multiple scenarios of plausible alternative futures of a sustainable health care system; 4) transforming scenarios of a sustainable health care system into quantitative models and applying data; and 5) analysis of modelled scenarios of a sustainable health care system and uptake of results.

Global examples of topics for round table discussions included the following:


- China is poised to become a global economic powerhouse in the near future. What aspects of Ontario's economy may be affected by this trend, and how may this in turn impact the province's ability to pay for services for its citizens?
- In the European Union and other western nations, there has been a political shift to neo-liberal policies, leading to less state intervention in the economy, changing social policies, etc. How might this political trend impact policy-making in Canada and, specifically, Ontario?
- Scientists have determined that the ice in Greenland and the Arctic is melting so rapidly that much of it could be gone by the end of this century. In what way might environmental issues, such as this one, impact Ontario's natural environment and, thus, the health of Ontarians?

Questions specific to Ontario's health care system were formulated by consultation participants, and consisted of four themes: a) the health "market" (health seen through a "business" frame, market controlled health system, supply and demand as drivers, funding and allocation); b) setting limits to reflect values (values and ethics of citizens, government, professionals, making choices,

understanding the boundaries); c) generating knowledge-based decisions (basing decisions on evidence from a broad base of inputs, valuing innovation and research, technology advancements); and healthy people (determinants of health, promotion and prevention versus acute care, demographics, access). These questions revealed paradoxes about our current system, and a sampling are as follows:

- How can we have American-style taxes and European-style services?
- How do we set benchmarks for service supply when there are no limits on demand?
- How do we know that spending 45% of the current provincial budget is too much?
- How can we move to a health-focused system when it was designed to treat acute illnesses?
- How do we balance short-term political thinking with the need for a long-term vision?
- How do we change the system so the right service provider provides the right service when the government will not challenge the OMA?
- Why do we acknowledge the importance of public health, but devote such a small percentage of our health care budget to it?
- How do we promote innovation/better practices when we struggle to maintain current health standards?

The above thought-provoking questions frame some of the context in which the scenarios are played out twenty years into the future. OASW shall keep you posted on the developments of this major MOHLTC initiative.

Gillian McCloskey, MSW, RSW, is Associate Executive Director of OASW and Editor of the "OASW Newsmagazine". 

MENTAL HEALTH REFORM (CONT'D FROM PAGE 9)

by removing barriers to service that includes improving our ability to provide services which are responsive to the needs of diverse communities.

- We need to acknowledge interdependence and work together rather than engage in turf wars, be they organizational or professional.

Finally, we need to recognize that since mental illness affects one in five of us, it really affects all of us, as the other four are friends, relatives or partners of people living with mental illness. As such, improving mental health services needs to be a priority in the transformation of our health care system.

Steve Lurie, MSW, RSW, MM (Management), is Executive Director of the Toronto Branch of the Canadian Mental Health Association, and has written and lectured extensively on mental health policy issues. Steve is Chair of OASW's Mental Health Advisory Task Group.



QUICK FACTS ABOUT LHINS (CONT'D FROM PAGE 10)

site (log on to the Member Site, click on the Advocacy tab, and then on Health Issues) for our written submission regarding "Bill 36, Local Health System Integration Act, 2005".

*The Community Engagement Strategy describes a process of continuing discussion and consultation – one that seeks balanced and objective information to resolve health service gaps, and to uncover new opportunities for service integration and better coordination between caregivers. Its goal is to build sustainable relationships that benefit the quality, availability and accessibility of local health services for all stakeholders.

To achieve this goal, the Strategy relies on principles of inclusiveness, timeliness, appropriateness, accessibility, responsiveness, transparency, balance and accountability. It recognizes that lasting, positive change occurs over time, through measured steps that must balance the needs of small and large interests alike.



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COMMUNITY HEALTH CENTRES (CONT'D FROM PAGE 14)

Through working and volunteering with CHCs, I am convinced that they provide a strong and effective way to working with individuals and communities to improve their quality of life. CHCs are set up in areas where there are people who face barriers to good health such as poverty, isolation, and lack of education. CHC doctors are on salary, and this allows the time to deal with complex care issues. CHCs are cost-effective, as hospital visits are lower through managed care and walk-in clinics. As more communities are served by CHCs, primary health care will be easier to access, health education and promotion will increase people's ability to prevent and manage disease, health care dollars will be saved and communities will be stronger.

Sue MacLatchie, BSW, MSW, retired in 2005 but, previously, worked for 15 years in social housing and 14 years at the Somerset Community Health Centre (CHC). In the 1980s, she was a Board member of Dalhousie Community and Health Services, and is currently serving on the Board at Country Roads CHC in Portland, Ontario.

Editor's Note: The author wishes to acknowledge the editing assistance of Lori Truemner, SSW, RSSW, in regard to this article.



OPTIMIZING THE ROLE OF COMPLEX CONTINUING CARE AND REHABILITATION IN THE TRANSFORMATION OF THE HEALTH CARE DELIVERY SYSTEM

The following is the Executive Summary, an excerpt from Recommendations and Priorities, and some information charts from the Ontario Hospital Association's (OHA) Discussion Paper "Optimizing the Role of Complex Continuing Care (CCC) and Rehabilitation in the Transformation of the Health Care Delivery System", which was released in May 2006.

The OHA report uses the World Health Organization's definition of "Rehabilitation" — "a progressive, dynamic, goal-oriented and often time-limited process, which enables an individual with an impairment to identify and reach his/her optimal mental, physical, cognitive and/or social functional level." "Complex continuing care" is defined as "a specialized program of care providing programs for medically complex patients whose condition requires a hospital stay, regular onsite physician care and assessment, and active care management by specialized staff."

Comments received from social workers about this report include: "...impressed and pleased with the scope of its analysis of the current situation, not just in CCC but across the continuum of health care, and the implications...this is an important paper for social workers to read, as it accurately highlights the systemic problems that affect everyday clinical practice."

EXECUTIVE SUMMARY

The Ontario government's health care transformation agenda aims to improve the delivery of health care services through better integrated services and a more systemic approach to service delivery. The province's complex continuing care (CCC) and rehabilitation sectors, which have undergone dramatic change over the past decade, provide an excellent, but all too often overlooked, resource to achieve the transformation agenda.

Along with the acute care sector, the long-term care sector and community programs, the CCC and rehabilitation sectors have a valuable role to play in enabling a transformed health care system. However, the roles that CCC and rehabilitation can play in an optimized system can only be achieved if their current role and capacity become better understood and integrated in health policy and in decision-making at all levels of the health system.

This paper summarizes some of the dramatic changes which have taken place in both rehabilitation and complex continuing care over the past decade, explores their differentiation as distinct sectors, illustrates their capacity to relieve system pressures (e.g., in relieving the alternative level of care [ALC] challenges in acute care hospitals), and recommends better integration of these sectors in health policy planning.

The paper argues that a more optimal integration of the CCC and rehabilitation sectors in how we think about the delivery of health care services could dramatically enhance system effectiveness.

RECOMMENDATIONS AND PRIORITIES

A renewed focus on filling the policy void in the post-acute sector must be a priority if the role of CCC and rehabilitation in improving integration and ensuring appropriate care for patients along the care continuum is to be realized. The current restructuring agenda unfolding within the Ministry of Health and Long-Term Care and the emergence of the Local Health Integration Networks (LHINs) provide a real opportunity to strengthen policy leadership to support post-acute care services and, in doing so, to better position CCC and rehabilitation as critical resources along the care continuum. In some regions, this will require that CCC and rehabilitation services be realigned to realize the benefits of critical mass. In other areas, new programs may need to be

FIGURE 1: CHANGING DISEASE PATTERNS/BURDEN OF CHRONIC DISEASE OVER THE PAST DECADE

- Growing number of individuals living with chronic disease and disabilities.
- Growing health problems arising from increase in certain conditions (e.g., genetic disorders, obesity, respiratory problems, cardiovascular disease, end-stage renal disease, diabetes, and Alzheimer's disease).
- Survival of children born with disabilities (e.g., muscular dystrophy, cerebral palsy, spina bifida) or acquired injuries in childhood surviving into adulthood.
- Shift from acute to chronic illness (e.g., asthma, diabetes, arthritis), more of which can be managed at home with intermittent medical and therapeutic interventions to stabilize conditions if suitable housing and support is available.
- Increase in demand of some rehabilitation services arising from the overall burden of chronic disease and disability.
- Changing patterns of practice (e.g., rehabilitation for total joint replacement, increased use of life-maintaining techniques — ventilation, G-tube feeding in children and young adults).

FIGURE 2: REHAB CLIENT GROUPS (RCGs) CIHI (CAN. INSTITUTE FOR HEALTH INFORM.), NATIONAL REHABILITATION REPORTING SYSTEM

- Orthopaedic conditions
 - Hip Fracture
 - Hip Replacement
 - Knee Replacement
- Stroke
- Brain Dysfunction
- Amputation of Limb
- Spinal Cord Dysfunction
- Medically Complex
- Debility
- Cardiac Disorders
- Neurological Conditions
- Pulmonary Disorders
- Arthritis
- Major Multiple Trauma
- Pain Syndromes
- Burn
- Other RCGs (including congenital deformities, developmental disabilities, other disabling impairments)

see Complex Continuing Care/22

COMPLEX CONTINUING CARE (CONT'D FROM PAGE 21)

established (or enhanced) to better meet the needs of specific population groups.

The report sets out a number of recommendations on how to make better use of the services within these sectors, including:

- Working with the post-acute sector to develop a systemic approach to managing/planning CCC and rehabilitation services at the local, regional and provincial levels.
- Further articulating the understanding of differences in care among programs (i.e., CCC, rehabilitation, long-term care, convalescent, interim ALC beds, etc.)
- Strengthening policy leadership to support post-acute care services, and positioning CCC and rehabilitation as critical resources along the care continuum.

- Developing a systemic approach to discharge planning.
- Establishing and/or enhancing new programs to better meet the needs of specific population groups.
- Assessing capacity and funding issues to correlate with system needs and intensity of care provided in CCC and rehabilitation beds/facilities.
- Developing consistent clinical practice patterns that reflect best practice protocols (by patient population) in the use of services.
- Ensuring ALC patients requiring CCC and rehabilitation are so designated.



To see the full report, visit: www.oha.com and click on Reports and Studies. 

FIGURE 3: CHANGES IN THE CCC SECTOR OVER THE PAST 15 YEARS

- A 67% decrease in length of stay.
- A 44% decrease in beds.
- A 59% increase in separations.
- An increase in the proportions of new residents classified under RUGS (Resource Utilization Groups) in the special rehabilitation group (38.9% to 45.4%), followed by the extensive care group (9.9% to 13.8%).
- A move in CCC towards more active rehabilitation of more complex patients.
- Greater specialization and lesser program mix within CCC facilities.

FIGURE 4: MOST COMMON DISEASE/CONDITIONS MANAGED IN CCC FACILITIES

- Heart/Circulation
- Hypertension
- Neurological
- Musculoskeletal
- Psychiatric/Mood
- Diabetes Mellitus
- Dementias (Alzheimer's and Non-Alzheimer's)
- Cerebrovascular Accident
- Endocrine/Metabolic/Nutritional
- Cancer
- Depression
- Arthritis
- Pulmonary
- Emphysema





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OASW POLICY STATEMENT ON HEALTH CARE PRIVATIZATION

In keeping with OASW's focus on three social advocacy areas, policy statements have been developed to state our position with the media, government and external groups/organizations.

The Board of Directors of the Ontario Association of Social Workers (OASW) establishes annual priorities regarding social issues affecting the lives of Ontarians. While OASW will continue to monitor social policies and contemporary problems, in 2006, our priority areas are:

- human rights,
- violence involving children and youth, and
- primary health care reform.

A social justice perspective underpins all of social work practice. Social workers focus on vital issues affecting health and well-being such as the crucial need for sufficient income, safe and affordable housing, and social inclusion.

Primary health care reform is inclusive of all populations. Failure to receive adequate health care has not only physical but also social, emotional and economic implications. Moreover, evidence points to poverty as a key determinant of health.

The increasing privatization of health care undermines the *Canada Health Act* and puts access to publicly funded health services at risk. Sharing the costs for the funding of health care among all Canadians and newcomers enables everyone to have access and choice, based on need rather than wealth. This is particularly important to people who are seriously ill, have limited financial resources or live in rural/remote areas where access to services and specialists would otherwise be very costly.

The Romanow Commission on the Future of Health Care in Canada found

no compelling evidence to demonstrate that privatized health care provides a better solution to the current funding ills in the public health care system. Indeed, for-profit care costs more, is not necessarily of superior quality and results in higher caseloads involving lower or unqualified practitioners (Canadian Centre for Policy Alternatives, December 2005).

In fact, the Romanow Report underscored that the public health system is highly valued. Private health care does not enable centralized planning for the development and delivery of services. Rather, it results in duplication and/or gaps in service; and siphons off physicians and other health care providers, reducing access to publicly funded care.

Social workers offer constructive solutions to contemporary problems by mobilizing the strengths of persons and communities. Issues such as violence and social exclusion are addressed on multiple levels, especially among vulnerable populations, by highlighting the relationship between private problems and social inequities.

Approved by the OASW Board of Directors, June 2006.

WHAT NEEDS TO HAPPEN:

- Provincial and federal governments must preserve the principles of the *Canada Health Act*.
- Reforms must address the entire system and include centralized planning and innovation.
- Solutions to funding problems in the public health care system must be based on evidence of effectiveness.
- Stakeholder consultations must be held, to involve the public in determining what they want for their health care.



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ADDRESSING STRUCTURAL OPPRESSION IN SOCIAL WORK PRACTICE

◆ *Jana Vinsky* ◆

*I*n 1999, I was a fourth-year social work student at Ryerson University and part of a student/faculty group called the Social Work Anti-Oppression Coalition (SWAOC). This group provided an opportunity for students to dialogue across differences and to learn from one another about various forms of oppression, as well as about strategies for emancipation and change. As a group, we were invited to be part of a committee at York University that was looking at developing anti-racism material for Canadian Schools of Social Work. This is where I met Dianne Prevatt-Hyles, the Director of Liberation Practice International (LPI). Dianne was a member of this committee through her position as Contract Faculty at York's School of Social Work and her many years as a leader in the African Canadian community, as well as an educator in the social work profession-at-large. Upon our meeting, we quickly engaged in a powerful conversation about issues commonly found when teaching about race, homophobia, anti-Semitism, and the various other social issues relevant to practice.

In the summer of 2000, I attended the International Schools of Social Work Conference in Montreal, also as a member of SWAOC. Our group attended Dianne's presentation on a new practice approach that she and her sisters conceptualized. During Dianne's presentation, I fell silent. I was struck by the wholeness of this new approach. Although it was rooted academically, it was clear that it was born of lived experience. It felt very real and alive. The approach was practical and something I could utilize not only with service users, but also with myself! It included spirituality and emotional well-being, and discussed the many ways of navigating in the face of social inequity. Similar to SWAOC, it was about connection, emancipation and change. Most importantly, it was about hope.

Dianne and I met back in Toronto, and I listened to Dianne tell her story as she recounted her 23 years of experience as a black school social worker working with issues of diversity, empowerment and change. Dianne was committed to integrating an analysis of power relations within all practice, rather than setting apart the issues of diversity and oppression as a "special topic". She also believed it was essential to be strength-focused and to champion resiliency. She was especially interested in supporting individuals and communities to find their "personal power" to become change agents in the face of social injustice. What was particularly interesting to me was her holistic understanding of individual and community healing as essential to political transformation. Since then, Dianne and I have worked together with the support of many people to create LPI Training, and we have a growing team of instructors. This

"The approach was practical and something I could utilize not only with service users, but also with myself! It included spirituality and emotional well-being, and discussed the many ways of navigating in the face of social inequity."

training includes various frameworks for transformative practice and reflection processes to generate insight that liberates and action that transforms. LPI Training centralizes issues of self-care and well-being for the worker, while exploring diversity and equity in social work practice.



JANA VINSKY

Although LPI Training does not offer any definitive answers, it does facilitate a process of inquiry and provides a skill-set that specifically addresses the scripts, social discourses and material barriers that frequently block people in their self-care and well-being initiatives. In LPI Training, workers learn how to work with themselves as they learn how to address the impact of marginalization, oppression, stressed living and working conditions on service users.

LPI Training has been described as something unique and concretely helpful in everyday practice and living. The success of LPI Training begins with the practice of externalization where thoughts, feelings, and bodily sensations are externalized, thereby moving them "away" from who the person who is dealing with them. Once externalization is applied, the issue being viewed as something outside of oneself, becomes easier to deal with. For example, feeling anxious, helpless, powerless, overwhelmed or defeated is externalized as the influence of "Doom and Gloom". The insidious companion of "Doom and Gloom" is identified as "Systemic Chatter"; "Systemic Chatter" consists of the

see *Addressing Structural Oppression/28*

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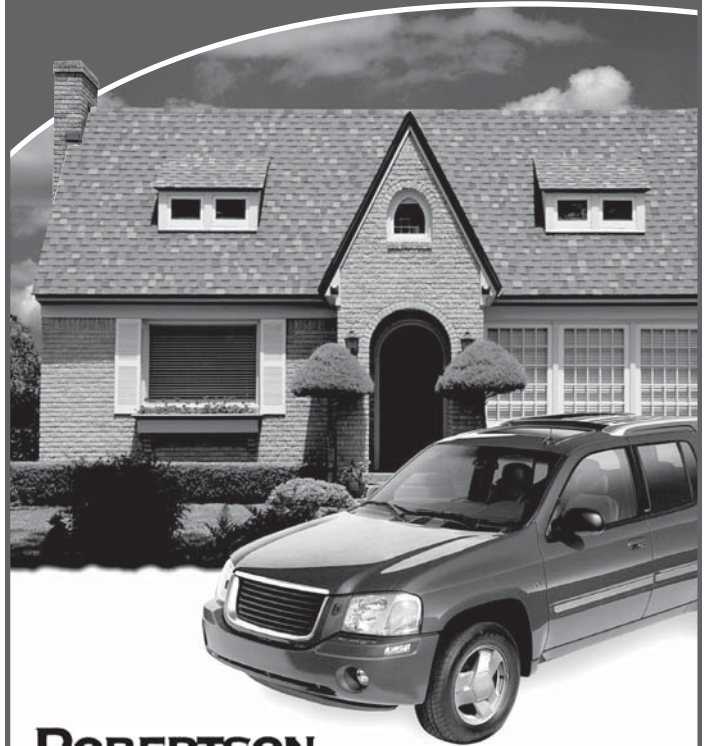
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CANADA AT THE CROSSROADS

◆ *Dan Andraea* ◆

The following is a synopsis of Dan Andraea's presentation to the OASW Board of Directors in February 2006, in his capacity as Chair of the Government Relations Advisory Committee.

On January 23, 2006, a new political era commenced in Canada, the longer-term impacts of which are yet to be determined. The Federal Liberals, who had been in power for 13 consecutive years over three mandates, were defeated by Stephen Harper's Conservative Party. However, the Canadian electorate collectively ensured that the new Prime Minister would be denied a majority government which he so coveted. Voters had decided that they wanted to change the government and, in the process, punish the Liberals, a party that was believed to have become tired, unfocused, arrogant, and even "corrupt" in the public perception. The governing Liberals were expected to suffer a humiliating defeat according to many pundits prior to the election. However, they emerged with 102 seats, considerably better than former Prime Minister John Turner had secured in the Mulroney landslide of 1984. This result indicated that Canadians were cautious and somewhat reticent about change, despite serious misgivings about the ruling Liberal Party. Mr. Harper managed to do as well as he did by running a masterful campaign, in which he successfully stifled his more neo-conservative candidates, avoided discussion of many contentious social issues, instead focusing on the key message of the need for change and portraying himself as a moderate leader.

Canadians might have known what they were voting against, but were they aware of what it was that they were endorsing? Mr. Harper, wishing to appear decisive in contrast to Paul Martin who was perceived by many as "dithering", has moved swiftly to enact

some of his key platform promises including a reduction in the GST, crime legislation, abolishing the Gun Registry, an *Accountability Act* for government, and a subsidy to parents for children six years of age and under; however, he has lagged far behind in reducing wait times for certain medical procedures. Presently, polls indicate that Canadians appear to support some of his initiatives such as his resolve to clean up government practices, but are decidedly mixed or against others such as dismantling the Federal-Provincial Child Care Agreements, withdrawing from the Kyoto Accord, and extending military action in Afghanistan. Additionally, Harper's decision to reopen the same sex-marriage debate has met with strong opposition.

Currently, Canadians appear to be giving Mr. Harper the benefit of the doubt, but this could change in an instant in the highly volatile world of federal politics where a day is proverbially considered an eternity in political life. Public opinion polls consistently indicate that Canadians still support such core values as tolerance, compassion, fairness, and equity. If Mr. Harper's agenda is perceived to threaten or undermine these cherished goals, then he may well suffer the electoral consequences. The question remains what is his agenda beyond his five well-publicized priorities, and where does he intend to take the country? Signs indicate that his plans will result in further decentralization and fragmentation of the federation, rendering it increasingly impossible to enact national programs such as pharmacare, day care, or aboriginal initiatives. This, in turn, will lead to the further dismantling of social programs either by downloading them to the provinces or eliminating them covertly or by stealth; closer alliances with the United States on economic and military policies; a fundamental reorganization of the electoral process including an elected senate; further reduction of strict environmental standards; and increased privatization of the health care system



DAN ANDRAEA

under the guise of offering Canadians a choice.

In order to reach his longer-term objective of restructuring the Canadian state and the delivery of services, Harper requires a majority government and, to this end, he has assiduously courted various groups across the country appearing at a variety of ethnic functions and has been meeting frequently with Quebec Premier Jean Charest in a bid to woo Quebecers, a key element in his strategic march towards his hope for majority. Mr. Harper at present is aided and abetted by a disorganized and lacklustre opposition sphere headed by the Liberal Party that is preoccupied with a leadership campaign, in search of its *raison d'être* and in debt. The NDP is poised to challenge the Liberals for leadership of the progressive agenda, but it is not yet in a position to capitalize on Liberal malaise.

Canada stands at the crossroads, and the next period of time may well determine the future directions of the nation for many years to come. Will it be recognizable from what we are familiar with today, or will it be radically different? Canadians can choose to reaffirm their commitment to essential Canadian

see *Canada at the Crossroads/28*

ADDRESSING STRUCTURAL OPPRESSION (CONT'D FROM PAGE 25)



DIANNE PREVATT-HYLES

dominant cultural messages that permeate us — messages we may inadvertently enact against oneself and others.

For more information about practices of externalization, an article by Dianne Prevatt-Hyles and myself is available upon request from the OASW Office.

Jana Vinsky, MSW, RSW, is the Curriculum Coordinator for Liberation Practice International (LPI). She is also a Narrative Therapist in private practice, specializing in videotherapy, and has produced numerous social work videos including "On the Road to Becoming Anti-Oppressive Peers Teaching Peers".



CANADA AT THE CROSSROADS (CONT'D FROM PAGE 27)

values that have historically defined the social fabric of this country, or witness the erosion of these guiding principles. It is incumbent upon social workers to inform colleagues, family, friends and neighbours of the implications of key federal government decisions now being developed and implemented. For the stakes are enormous for the profession and clients served across the country. Signs indicate that failure to act will jeopardize the funding and even existence of social and health care programs that are dismantled, downloaded or severely curtailed. Canadians and their communities will suffer, as Canada embarks on an unknown and precarious path.

It is one thing to defeat a government that needs to be held accountable, and quite another to elect an alternative party with an agenda that polls demonstrate is out of sync with the majority of Canadians.

Dan Andrae, MSW, RSW, Ed.D., is a former president of OASW (1993-2000), and is currently Chair of the Association's Government Relations Advisory Committee. In June 2006, he was bestowed the CASW Award for Outstanding Service (see p. 47).



OASW LAUNCHES NEW VIRTUAL NETWORKING GROUPS

In 2006, OASW has launched four new Virtual Networking Groups for:

- Social Work Students
- Social Workers in Private Practice (Group A) (with 5 years or less experience in private practice)
- Social Workers in Private Practice (Group B) (with more than 5 years of experience in private practice)
- Social Workers in Family Health Teams.

These join two groups set up earlier for: Social Workers in Home Care, and Social Workers in Automobile Insurance-MVA Sector.

The aim of OASW virtual networking groups is to provide members with an opportunity to network, share information and problem-solve. These groups communicate via e-mail and members can participate at their convenience — any time, anywhere. E-mail is sent to one address, and it gets distributed to the whole group. Group members, who must be OASW members, can choose to participate more actively by sending messages, while others may choose to simply read the messages that get sent. The time commitment relates only to the time taken to read and/or send messages, at the member's convenience.

For more information about virtual networking groups, visit www.oasw.org and enter the Member site, and click on Benefits and Services, Networking Groups.

OASW members who would like to participate in any OASW virtual group should contact the OASW Provincial Office at info@oasw.org.



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2ND ANNUAL NHPN TOMMY DOUGLAS AWARDS

◆ Jennifer Ajandi ◆

From June 8 to 9, 2006, the New Health Professionals Network (NHPN) held their Second Annual Tommy Douglas Celebration of Medicare Awards in Ottawa. OASW affiliated with the NHPN when it was founded in 2004, and now represents over 20,000 future health care professionals training in social work, nursing, pharmacy, medicine, physiotherapy, occupational therapy and chiropractic. OASW is represented in the capacity of Co-Chair by its Provincial Student Director, Melissa Kimber, and Interim NHPN Co-Chair, Jennifer Ajandi.

The NHPN is committed to caring for future patients within a single-tier, publicly funded and delivered health care system which recognizes the critical role of interdisciplinary health care in our public system. Over the past two years, the NHPN has achieved significant media attention at both the Premiers' Meeting at Niagara-on-the-Lake and at the First Ministers' Meeting in Ottawa. The Annual Tommy Douglas Awards are in honour of health professionals who exemplify attributes related to the delivery of quality health care within interdisciplinary settings. I had the honour of presenting this year's winner for excellence in the category of "Home Care" to Carolyn Tayler. Carolyn is the Director of Hospice Palliative and End of Life Care for Fraser Health, a program located in Lower Mainland, British Columbia. The NurseLine Palliative Care Telenursing Program has made significant strides in providing access to Hospice Palliative Care services 24 hours a day, seven days a week, for patients and families living with life-limiting illnesses.

For the Second Annual Tommy Douglas Celebration of Medicare Awards and Summit, I had the opportunity to hold the position of Interim Social Work Co-Chair for the NHPN. The Co-Chairs from the various disciplines helped plan

and facilitate the Awards Ceremony and Summit. We invited six students from each discipline to participate. The event was held at the University of Ottawa.

We started off the Summit on a very celebratory note. Our guest speaker was Ms. Shirley Douglas, renowned actress, mother, Medicare activist, Officer of the Order of Canada, and daughter of the founder of Medicare. She presented the awards that were named after her father, Tommy Douglas, to the recipients and offered passionate words of encouragement and inspiration. Shirley Douglas's presence on this special occasion was also very fitting because the federal *Medical Care Act* received Royal Assent on December 21, 1966. We celebrated Medicare's 40th birthday with a large cake in the shape of Canada.

The Co-Chairs of the NHPN and Ms. Douglas went to Parliament where we introduced ourselves and the NHPN's mission to The Honourable Tony Clement, Minister of Health and also Minister for the Federal Economic Development Initiative for Northern Ontario, as well as to federal NDP Leader, Jack Layton. We presented them with a birthday card celebrating 40 years of Medicare and emphasized the importance of preserving and strengthening our Medicare system within a single-tier, publicly funded and delivered health care system so that we can offer high-quality care to all Canadians based on need, not on ability to pay.

Students who attended participated in workshops that introduced the history and evolution of Medicare. In discussion groups, we examined the importance and value of interdisciplinary teams, and we had some reflection involved in the strategic planning for 2006/2007 for the NHPN.

We closed the event with a presentation from Dr. Christine Dehlendorf, Executive Vice-President, Committee of Interns and Residents (CIR), from the



JENNIFER AJANDI

U.S.A., entitled "Lessons from the American Health Care System". Dr. Dehlendorf's presentation was both passionate and informative. Some of her stories were shocking as we heard about dire situations in which patients are put, due to their inability to pay. However, this also gave us a moment to reflect on why we are involved with the NHPN in the first place. She truly gave us a wonderful gift in being appreciative of what we do have, while reminding us not to let go of what we still need to accomplish. She gave us insight into why it is so important for us to continue our commitment to universal, publicly funded health care.

For more information, please visit www.futurefaceofmedicare.ca.

Jennifer Ajandi has recently graduated from Ryerson University, receiving her BSW and Ryerson's Gold Medal Award. She will be pursuing her MSW at the University of Toronto this fall. Jennifer represents OASW Central Ontario Branch on the Provincial Board of Directors.



THE CASW NATIONAL CONFERENCE: OASW STUDENT DIRECTOR'S PERSPECTIVE

◆ *Melissa Kimber* ◆

When I began my term as Student Director for OASW, I was uncertain of the events that were ahead of me. While I have had exciting and challenging experiences thus far, my journey to Halifax for the 2006 CASW National Conference (June 17-20) has been one of my greatest learning experiences as both a student and as the Student Director for OASW.

After being graciously greeted by the Nova Scotia Association of Social Workers' Executive Director, and being amazed by the keynote address of Judy Rebeck, Past President of the National Action Committee on the Status of Women, who spoke on issues of social equity and justice, it was hard to believe that this Conference could be any more inspiring. The concurrent sessions were equally intriguing, the agency tours were fascinating, and the social events served as a wonderful opportunity to meet colleagues and network within the profession. Yet my most memorable experience at the CASW Conference occurred through my attendance at Session 65: "Helping Undergraduate Students Chart Their Course into Social Work". Arriving at the session slightly early, I had the opportunity to meet with our esteemed presenter Barry Moore who is, in my opinion, an ambassador of the social work profession. Barry is a delightful individual, who is quite open about his feelings surrounding the importance of students in making an informed decision when entering the field of social work. Moreover, Barry is passionate about the value of students in the social work profession and our professional associations. In our short discussion before the beginning of his presentation, I had the opportunity to share with Barry information about the web-based communication project that I am attempting to create for students belonging to OASW (a provincial forum) and the CASW (a national

forum). Pleased to hear about my initiative, Mr. Moore kindly set aside some time at the conclusion of his presentation so that I could announce my project to the rest of the session's attendees.

Consequently, at the end of Mr. Moore's presentation, I announced my initiative to the group. In an effort to facilitate some sort of dialogue and exchange of e-mail addresses, I highlighted not only the importance of the student voice in the professional association, but also how a national web-based communication forum could lead to increased awareness about each one of the delegates' provincial agencies/organizations and educational institutions. Finally, SUCCESS! Not only was everyone in the room astonished that I was attempting to undertake such an "enormous task", but each and every person offered both their support and their business cards to assist me in the networking and connection process. I am pleased to say that because of Mr. Moore, I now have some sort of connection in every province/territory of Canada; and am looking forward to increasing these contacts over the last year of my term as Student Director.

Such genuine interest in student endeavours highlighted for me the importance that social workers place in maintaining the strong presence of our professional associations and in continuing to raise awareness about the important role that the profession of social work continues to play in our ever-evolving society. It became clear to me that there is a need and a want for a collective social work voice across Canada for both its students, and for our registered professionals. Having a collective voice and asserting our strengths, as a united profession with common values and ethics, can



MELISSA KIMBER

only benefit the social work profession and the clients whom we serve. In demonstrating our strength, faith and support for one another, social workers and social work students have a foundation from which to advocate for both the accessibility of our services, but also for services that meet the needs of our client populations.

I would like to thank the OASW Executive Committee for sponsoring me to attend the National Conference. Such sponsorship again highlights the commitment of the Association to support its future social workers in the interest of our profession and client populations. The value of this experience cannot be overestimated, and I would like to invite anyone who is reading this article and is interested in being involved with creating the provincial and national networking forum to please contact me at: kimberms@mcmaster.ca.

Melissa Kimber, OASW's Student Director, is in her final year of the BA/BSW program at McMaster University, and would like to continue post-graduate studies in the area of Refugee Women and Health Policy.



OASW MENTORING PROGRAM

OASW will be offering its Mentoring Program again this year.

The main goal of the program is for mentors to demystify the professional job search process by providing information and advice about the profession or a particular field of practice. We are seeking mentors who enjoy their work and have some time to share their enthusiasm with a mentee. We are looking for mentees who are committed to following up with mentors and making good use of their time.

If you wish to participate in this program, visit the OASW website at www.oasw.org, enter the Member Site, and then click on Students or on Benefits & Services, and then Mentoring. For further information on the Mentoring Relationship, Expectations and Responsibilities, please check our website. Or contact the Provincial Office at (416) 923-4848, fax: (416) 923-5279, or e-mail: info@oasw.org.



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AFFORDABLE HOUSING: A REQUIREMENT, A RIGHT, AND A RESPONSIBILITY

◆ Michael Shapcott ◆

The following is a synopsis of the keynote address by Michael Shapcott at the OASW Provincial Annual General Meeting on June 2nd. Mr. Shapcott, LLB, is recognized as one of Canada's leading housing policy experts. He has written extensively on the social determinants of health, housing, poverty and urban issues, and has also worked at the local, provincial, national and international levels on both governmental and non-governmental initiatives.

I do not need to tell social workers how important housing is. Over the years as a housing policy advocate, I've developed my "gods" from the social work profession. One is Humphrey Carver of the University of Toronto School of Social Work, who wrote *Houses for Canadians* in 1948, the first important academic text looking at housing issues from a social perspective. Dr. Carver said: "The ultimate objective of the national housing programme should be the provision of a decent dwelling for every Canadian family. From this it follows that the crucial ultimate test of the effectiveness of the housing policy is the condition of the worst-housed families in our communities". So, in other words, you don't judge the success of a housing policy by going to Rosedale to find lots of really good houses for a price, but you go into the poor neighbourhoods and look at the worst housing to judge the relative success of Canada's housing programs.

Dr. Carver's work is not simply of interest as historical trivia. Just this week, I was invited to give evidence to the Standing Committee on Finance for the current Federal Budget. In a conversation with a Conservative member of the Committee about the role of the private market in terms of providing housing, I was quoting Dr. Carver, who, in 1948, was telling us that markets can do a very good job of delivering housing

for people who have money, but do not do a good job of delivering housing to people who do not have money.

My second social work "god" is Dr. Albert Rose who in 1952, in an important essay called "Tenant Participation and Responsibility", wrote about the emerging public housing programs. Dr. Rose was almost prophetic in his advice. He wrote in the late 1940s when the first shovels were going into the ground in the Regent Park housing development in downtown Toronto, the first major post-war housing project in Canada and what would become the model for many projects. He said that it is a fine project, but the tenant has been excluded from the administration/management/design/development of the project and that is going to be a problem. And it certainly did become a problem with which we continue to wrestle today.

What I want to say today is: Housing is a requirement, a critical social determinant of health. Housing is a right — a right recognized in international law. Housing is a responsibility on personal, professional and government levels.

Housing is a requirement, because the lack of good-quality, affordable housing affects personal health. Homelessness and insecure housing lead directly to higher morbidity and higher mortality. Endless studies have been done. Leading epidemiologist at St. Michael's Hospital (Toronto), Dr. Steven Wang, has correlated housing insecurity and homelessness to illness and death. He reports that, for instance, homeless women are dying at a rate of eight to ten times higher than housed women in their same-age cohorts. We know from studies in Canada and other parts of the world that there is a direct relationship between homelessness, insecure housing and various illnesses, infectious diseases, tuberculosis and also premature death.

We also know that subsidized housing



MICHAEL SHAPCOTT

is a key factor in helping the homeless become housed. Academics in New York City, Mary Beth Shinn and Beth Weitzman, have done detailed longitudinal studies on homelessness and the pathways that lead people from homelessness to being housed. They have reported that when you look for all the various correlations, you might think factors that may prevent people from moving from homelessness to housing are issues of systemic discrimination, poverty, mental illness; however, they found one factor that explains housing stability and that is, in fact, providing subsidized housing. Obviously, some people also require supports and additional services to help them maintain their housing, but housing itself is an important first issue.

Housing is not simply a personal requirement, but housing is also important for the health of communities. Housing insecurity causes social and economic problems for communities. Poor housing leads to, for instance, higher taxes and diminished competitiveness; therefore, in recent years, it has not just been housing advocates and social workers calling for housing programs, but it has also been banks,

see *Affordable Housing*/34

AFFORDABLE HOUSING (CONT'D FROM PAGE 33)

boards of trade, and business associations. Businesses are saying they need to have a good housing base in order to maintain a good work force. And emanating from that, subsidized housing is a good investment for people in the community. Subsidized housing leads to new homes, good jobs, and economic stimulation. As I pointed out to the federal government this week, on average, every new home — that's every new affordable house that is built in Canada — contributes about \$27,000-\$37,000 in taxes to the federal government in various direct and indirect taxes.

It is also important that housing be understood as a right. The first articulation of housing as a fundamental human right came in 1948 with the *Universal Declaration of Human Rights*. There are three major treaties: the *Universal Declaration of Human Rights*, the *International Covenant on Economic, Social, and Cultural Rights (1966)*, and the *International Covenant on Civil and Political Rights (1966)*, which together are called the *International Bill of Rights*. These define human rights and fundamental freedoms along with 50 additional United Nations' human rights conventions, declarations, rules and principles.

It is important to understand that these covenants that Canada and other countries have signed are international legal instruments. The governments that ratify these covenants and treaties voluntarily agree to bring the national legislation, policy and practice into line with international obligations. They accept that there is an international right to housing. By ratifying these and other binding texts, the states become accountable to their citizens, to other states and to the international community-at-large.

The right to housing has been extensively defined. The introduction section alone on the United Nations housing rights website is 95 pages long. It does not say that you have the right to housing, period, but it also defines issues such as security of tenure, affordability,

habitability, and cultural appropriateness.

There is also a mechanism to make sure that the right to housing is realized. The Committee on Economic, Social and Cultural Rights, established by the UN's Economic and Social Council (ECOSOC), meets every five years to review countries around the world. In May, the UN Committee released its concluding observations on how Canada has met its international human rights obligations to its residents.

Even with the normally restrained language of international diplomacy, the latest review for Canada was very powerful and direct. The UN Committee found, in very stark terms, that Canada has failed in its obligations to women, Aboriginal people, children, low-income people, and others, and refers to housing and homelessness as a national emergency. It urges the federal government to reinstate or increase social housing programs for those in need, improve and properly enforce anti-discrimination legislation in the field of housing, increase shelter allowances and social assistance rates to realistic levels, provide adequate support for people with disabilities, and implement a national strategy for the reduction of homelessness. While, normally, countries are reviewed every five years, the UN has requested a report in one year.

Finally, housing is a responsibility. On a personal basis, people have a responsibility to be informed, to speak out, and to take action. There is a responsibility for professionals, including the OASW, and the fact that your Association monitors reform and advocacy is very important. There is also the responsibility on the part of the government to meet its obligations, especially through funding and programs.

The housing pendulum in Canada swings from relative security to security. The issues are very dramatic in Toronto because it is a big city but, in remote rural northern communities or smaller communities, the issues are equally

stark. I was invited to Bracebridge, Ontario recently to speak to housing providers; it is a different context, not as many people, but very similar problems exist.

The high-water mark came in 1973 when the federal government declared when introducing the *National Housing Act* that good housing at a reasonable cost is a social right of every citizen. From 1973 to 1993, the federal and provincial governments provided more than half a million co-op and non-profit homes across Canada which continued to provide good-quality, affordable housing for almost 1.4 million people.

Starting in the 1980s, the pendulum began to swing back. The federal government cut \$2 billion from housing and stopped spending new money on housing and, by 1996, was downloading its housing responsibilities to the provinces and territories. In 1995, the Ontario government cut all new funding for housing and cancelled 17,000 units that had been approved for development and downloaded housing to the municipalities — that brought us to the housing disaster and homelessness disaster in the 1990s. Professor Wolfe, a housing expert from McGill, says: "It was never imagined that a system that had taken 50 years to build up could be dismantled so quickly."

In the last few years, there has been an emerging patchwork of federal programs. The most recent federal budget includes \$1.6 billion in spending on new housing, approved in the previous minority government. However, the federal government thinks that private markets can meet the housing needs of Canadians. Since 1998, as a result of advocacy on the part of many, the federal government has made significant promises to put money into housing. Unfortunately, some of those promises have not turned into reality. In the first three years of the federal-provincial affordable housing program in Ontario, the Ontario government promised 9,800 new homes and it delivered 22. The

see *Affordable Housing/36*

SOCIAL WORK WEEK SHORT ARTICLE CONTEST WINNER: SOCIAL WORK — MAKING A VITAL CONTRIBUTION

◆ Elizabeth Lacey ◆

The following is the winning article of OASW's 2006 Social Work Week Short Article Contest. Numerous submissions were received. Contributors were asked to feature and illustrate, with a case example, the positive impact that social workers have on people's lives. In addition, the aim of the contest was to assemble stories that will resonate with the public, and foster an improved understanding of why social work services are essential.

I am a social worker, as is the man who helped me find peace with my father in his last days of life. Mike promptly returned the voice message I left for him only moments before, and spoke in a way that was compassionate but left little question about my father's condition. He was aware that I had not seen my father for ten years, but showed no negative judgment toward me.

He told me that the doctors recommended removal of life support, and offered to meet with me to prepare for a visit with my father. He encouraged me to do what was right for me and was available to answer any questions I had.

Later that day, I met Mike in his office. Quickly, he created an environment of safety — a great comfort — since I had never seen anyone on life support. Mike told me of the heart attacks, surgery, infection and an additional surgery that necessitated removal of my father's sternum.

Before escorting me to the ICU — where a man who looked nothing like my father lay — Mike prepared me by describing in detail what I would see. He told me that my father had been unresponsive, with multiple major organ failure for fifty days and that it was unlikely he would know I was there.

His work day ended at four o'clock but, by the time I made a tentative decision to

see my father, it was five. He seemed not even to notice the time as he led me toward my father's room. I stopped numerous times, unsure if I was doing the right thing. Mike patiently waited at my side. He didn't speak, but somehow I knew he would answer any questions I had.

When we arrived at the ICU, he told me to wait as he went in to speak with the nurse. I thought he was checking to see if I could visit, given the time; however, when he returned, he told me that he wanted to ensure that my father was not having any medical procedures. The empathy Mike displayed made it possible for me to put one foot in front of the other.

I entered the room and stood quite a distance from my father's bed. When he moved his feet, fear gripped me and I had to leave. Mike said nothing but led me back to his office. He told me that my reaction was normal and that any time I wanted to come back, he would happily escort me.

Eventually, I was able to visit my father without Mike. However, I knew that he was available any time I might need him. As a social worker, Mike was a vital link in the bridge that allowed me to safely cross over and find peace with my father before he died. Social work is a profession that helps people to heal lifetimes of pain and find ways to hold onto the good in bad situations.

Elizabeth Lacey, MSW, RSW, owns Oakridge Counselling in London where she provides individual, couple, family and group therapy.



ELIZABETH LACEY

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2006 OASW ELECTION RESULTS

At the 2006 Annual General Meeting on June 2nd, the results of the Executive elections were announced:

- Beverley Antle of Toronto (Central Ontario Branch) was re-elected as President. Beverley is also the Chair of the Executive Committee and the Salaries and Working Conditions Advisory Committee.
- Anne Sawarna of London (Western Branch) was re-elected as Treasurer. Anne serves as the Chair of the

Budget, Finance and Audit Committee and the Nominating Committee.

- Karen Nelson of Ottawa (Eastern Branch) was elected as Vice-President of Membership Services. Karen is Chief of Social Work at The Ottawa Hospital.

The other Executive Officers are: Keith Adamson (Central Ontario Branch), Vice-President, Social and Professional Advocacy; Julie Woit (Northwestern Branch), Vice-President, Branch Affairs; and Marie Turcotte (Sudbury Branch), Secretary. All have one year remaining in their term. 




KAREN NELSON

AFFORDABLE HOUSING (CONT'D FROM PAGE 34)

trend continued in 2003 and 2004 and, by 2005, they stopped releasing the numbers. We have one of the worst records in terms of housing in this province.

One of the important new partners emerging in terms of housing advocacy is the private sector. TD Economics in June of 2003 issued a major report saying that housing is "one of Canada's most pressing public policy issues".

They made an important observation, stating that "the ultimate solution to the affordable housing problem is to raise market incomes and develop a more effective and equitable income transfer regime". When "translated in English", this means that if you want to deal with the housing problem most effectively, you have to deal with poverty, raise the minimum wage, and address social assistance rates which are criminally low.

Canada has a rich history of successful and cost-effective housing solutions. The nation-wide affordable housing crisis and homelessness disaster have created strong public support for action. Effective political advocacy has created an emerging patchwork of funding and programs which has allowed some new development in some parts of Canada, but the challenge is to move from that patchwork to a comprehensive and fully funded program. 

The Toronto Art Therapy Institute announces:

**A one-year advanced
Certificate in Art Therapy,
beginning September 2006, for individuals
with a Master's degree in counselling,
psychology, education, social work or
a related field with clinical experience.**

Please call 416-924-6221.

WHAT'S NEW FROM THE BOARD OF DIRECTORS

◆ Rita Mascherin ◆

The OASW Board of Directors is composed of the Executive Committee, 17 Branch Representatives, a Francophone Director, a Student Director and the Ontario Director to the CASW Board. The OASW Board meets three times per year. The following is a brief report of selected decisions and information presented at the February and June 2006 Board meetings:

IN FEBRUARY:

- A presentation on post-federal election analysis was provided by Dan Andraea, Chair of the Government Relations Advisory Committee. The intent of the presentation was to enable the Board to consider how the Association should position itself in the new political environment. Please see article on p. 27.
- A report on the activities of the New Health Professionals Network and the creation of a Virtual Networking Group for Student Members was provided by Melissa Kimber, Student Director. As well, she indicated that she is developing a web-based initiative to facilitate student social activism through the internet. For more information on recent Student Director activities, see p. 31 for Melissa's article on the 2006 National Conference.
- Preliminary results on the Quality of Work Life Survey were presented related to gender, geographic regions, language, visible minorities, disability, employment status, annual salary, workload issues, overtime, career conditions, advancement opportunities, caregiver responsibilities, and health and safety. A presentation of the results was made at the 2006 National Conference in Halifax and further presentations are planned in many Ontario Branches. More details on p. 38.

IN JUNE:

- A revised Strategic Plan was approved by the Board. The Strategic Plan is reviewed annually. The goals outlined in the plan can be viewed on OASW's website (enter the Member Site, click on About OASW).
- OASW Policy Statements on human rights, youth violence and health care privatization were approved in principle by the Board.
- A number of recent online surveys were reported on: Survey on Social Work Practice in Mental Health; Survey of FindASocialWorker.ca Participants; Virtual Networking Groups Evaluation Survey; and Pre-Launch Questionnaire of the Virtual Networking Group on Private Practice. OASW has found online surveys a very useful tool in gathering information and evaluating services.
- Toronto was approved as the location of the 2008 National Social Work Conference by the Board in February, following extensive fact-gathering by staff. In June, the Board heard that the Marriott Toronto Downtown Eaton Centre had been determined as the best site for this important event on May 22-25, 2008, when more than 400 social workers will be expected from across Canada. The theme of the conference will be "Human Rights in a Global Community", and prominent keynote speakers are being sought. Any OASW member interested in being involved in the planning and activities leading up to the national conference should contact OASW at info@oasw.org.

In addition, every Board meeting includes a networking session of the Branch Representatives to exchange information and ideas about activities across the province.

For further information about the OASW Board of Directors or to find



Janet L. Graham

RITA MASCHERIN

out how to contact someone in your Branch to learn about activities at the local level, please contact Rita Mascherin at the Provincial Office at (416) 923-4848; fax: (416) 923-5279; or e-mail: rita@oasw.org; or visit the OASW website at www.oasw.org.

ANNUAL GENERAL MEETING, JUNE 2, 2006:

OASW's AGM was held on June 2, 2006. Approximately 70 members were in attendance to hear the reports of Executive Officers on the Association's activities during the past year and to approve the audited financial statements. OASW's *Annual Report 2005-2006* is available from the OASW website at www.oasw.org for download (Member Site, click on Resources in left-hand menu) or in print format from Shop OASW. For the results of this year's Executive elections, please see p. 36.

The keynote speaker was Michael Shapcott who spoke on "Affordable Housing: A Requirement, a Right, and a Responsibility". See p. 33 for a synopsis of his very stimulating speech.

Rita Mascherin, BA, is Executive Assistant at the OASW Provincial Office.



OASW's QUALITY OF WORK LIFE SURVEY

The Ontario Association of Social Workers (OASW) presented preliminary findings from its online Quality of Work Life Survey at the 2006 Canadian Association of Social Workers (CASW) Conference in Halifax in June 2006. The survey was conducted over a period of four months during the fall of 2005. It gathered employment-related data regarding: salaries; benefits; hours worked; opportunities for training and advancement; caregiver responsibilities; and health and safety. The survey is believed to be unique in that it specifically targets social workers related to the issue of harassment and their experience in balancing personal caregiving and work responsibilities.


The survey included multiple choice, as well as open-ended questions (254 people provided comments). It was completed by 1,114 individuals with BSWs, MSWs and doctorates in social work from across Ontario. Respondents were recruited from OASW's membership, alumni from the schools of social work, major unions and registrants of the Ontario College of Social Workers and Social Service Workers. Financial support was provided by McMaster University, Labour Studies Department, and CUPE to assist with the data analysis.

A diverse cross-section of the profession responded to the survey. This was reflected by the fact that: approximately 13% of respondents identified themselves as French-speaking (Statistics Canada figures indicate that 4.5% of Ontarians are Francophones); and our sample of respondents who reported having disabilities (9%) was proportionally representative of the number of working Canadians with disabilities (Disabilities Research Bulletin, Social Development Canada, 2003). Not sur-

prisingly, respondents reported being busier than a year ago and being asked to do more at work, with over 71% donating anywhere from one to six or more hours of unpaid work per week. It is noteworthy that the Ipsos Reid: The 2006 Expedia Vacation Deprivation Survey placed social work second in the list of careers perceived to be vacation-deprived (46%). Additionally, 63% of respondents reported experiencing workplace stress — a significant number citing feelings of depression, irritability with colleagues and clients, frequent illness and mistakes. Also concerning was the fact that approximately one-third of respondents indicated that they were the recipient of unwanted, unsolicited or intimidating attention, comments or behaviours in the workplace. Greater detail and fur-

ther analysis of the data will be published in academic papers and future issues of *OASW Newsmagazine*; posted on OASW's website; and presented at conferences and workshops.

The survey was designed with the potential for it to be replicated within Ontario in five years, and replicated by CASW member organizations in order to collect data across Canada.

Findings and conclusions from the provincial/territorial surveys and a national data set will be used to advocate for improved salaries, benefits and working conditions for members of the profession. 



findasocialworker.ca

www.findasocialworker.ca continues to grow! The first year of the online directory of social workers in Ontario was a success. Check out the website to explore the services that your colleagues are offering. Use it as a tool for referring clients across the province. Search by location, specialty, language, gender or name.

We are also offering a new marketing tool for private practitioners. For a fraction of the cost of designing your own website, members listed on **www.findasocialworker.ca** may purchase a 3-page web template — and we'll pick up the monthly hosting fee! For further information about creating your listing on **www.findasocialworker.ca**, or setting up your website, contact us at **info@findasocialworker.ca**.

SOCIAL ADVOCACY HIGHLIGHTS 2005-2006

◆ Keith Adamson ◆ Gillian McCloskey ◆

The following are highlights of OASW's social advocacy initiatives from June 2005 to May 2006, which were published in our Annual Report for the Provincial AGM on June 2nd. Any documents referred to in this report are available upon request.

I. HUMAN RIGHTS ISSUES

A) FAITH-BASED ARBITRATION IN ONTARIO

In January 2006, OASW wrote a letter to the Canadian Council of Muslim Women (CCMW) related to the Association's activities on the issue of faith-based arbitration in family law disputes in Ontario, fully endorsing CCMW's position as well as other major women's rights organizations, with respect to their grave concerns about the Marion Boyd report (December 2004). This report, commissioned by the McGuinty government, recommended the continuation of faith-based arbitration as an alternative dispute resolution option in family law cases. The Association undertook extensive consultation in the development of a position on this issue. In addition, last summer and fall, OASW wrote letters to the editors of major newspapers concerning this issue, and voiced grave concerns regarding the potential to erode women's equality rights and to have group rights supersede individual rights, thereby undermining the intent of the *Canadian Charter of Rights and Freedoms*. While OASW vigorously upholds the rights of Ontarians with respect to religious expression and recognizes that minority groups require protection from discrimination, we underscored government's unequivocal duty to protect the civil rights and liberties of all Canadians.

Following new legislation passed in February ensuring all family law arbitrations are conducted only under Canadian law, the Association is com-

mitted to monitoring developments in the legislative process in regard to the drafting of regulations.

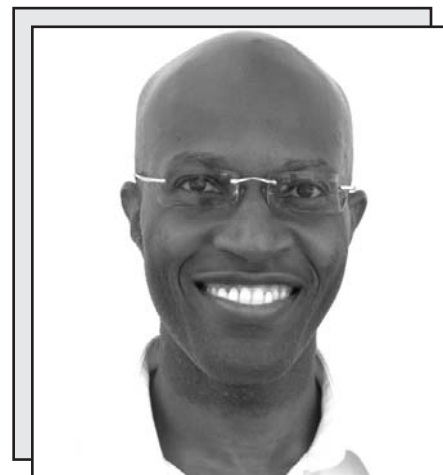
B) OASW RESPONSE ON HUMAN RIGHTS AND FAMILY STATUS

In September 2005, OASW submitted a response to the Ontario Human Rights Commission's (OHRC) Discussion Paper on Human Rights and Family Status. We commended the government for having the vision to identify and conceptualize significant systemic issues affecting individuals because of their family status – issues that may be having a pervasive impact regarding access to employment, housing and services. Examples of groups marginalized by family status include non-traditional families, employees with caregiving responsibilities and social assistance recipients. OASW pointed out that a critical component of the Discussion Paper is its connectedness with the “social determinants of health”, thereby providing a framework as well as a rationale for reviewing and proactively addressing the issues related to human rights and family status.

II. CHILDREN & YOUTH ISSUES

A) YOUTH VIOLENCE

Since the summer of 2005, the escalation of violence involving youth, especially in large urban centres, has been a focus of concern for OASW. The Association's letter to the editor, published as the “Letter of the Day” by the *National Post* last August, stated that the criminal justice system does not hold long-term solutions to this troubling social phenomenon and that the roots of youth violence are in family poverty and social exclusion. The answers lie in strengthening social policies related to: income supports, adequate housing and access to services that foster a healthy environment in which to raise children. Priority must also be given to more expansive youth training and employment opportunities and changing the “zero tolerance” policy in schools.



KEITH ADAMSON



GILLIAN MCCLOSKEY

As a result of OASW's letter, a number of activities took place last September. President Beverley Antle was invited by TVO to participate in a panel discussion on the topic “Gun Violence: What Should We Do?” Keith Adamson, Vice-President, Social and Professional Advocacy, and Joan MacKenzie Davies, OASW Executive Director, participated in a CityTV Special on the same subject. In addition, OASW representatives attended a “Federal GTA Forum on Urban Violence” held at the University of Toronto and organized by the Government of Canada, and had two meetings with the

see *Advocacy Highlights/40*

ADVOCACY HIGHLIGHTS (CONT'D FROM PAGE 39)

City of Toronto's Community Safety Secretariat (CSS). The latter involved Central Ontario Branch in a research project led by the University of Toronto's Faculty of Social Work, which aims to develop a community crisis response.

As well, the February 2006 issue of the *OASW Newsmagazine* focused on social work in response to youth violence as it is manifested across Ontario. Finally, discussions and meetings have taken place this spring with key government officials including Opposition Party Leaders.

B) FEDERAL-PROVINCIAL CHILD CARE AGREEMENTS

In March 2006, as a Provincial Partner of Campaign 2000, OASW signed an Open Letter to Prime Minister Harper, Provincial Premiers and Federal Opposition Leaders calling for the honouring of Federal-Provincial Child Care Agreements. The Open Letter stated that cancelling agreements would cut almost \$4 billion from child care funding. While income support for families is a valid policy goal, a taxable family allowance and a tax credit for employers will not create early learning and child care services that are of a high quality, and are available and affordable. Subsequently, through the OASW's *E-Bulletin* to members and to Branches, individuals and organizations were encouraged to make their voices heard and to sign the petition. Furthermore, as part of Pre-Budget Consultations, the Association wrote to Federal Finance Minister Jim Flaherty urging that the Federal Budget 2006: i) honour the existing commitments to families across Canada by confirming that provinces and territories will receive multi-year funding of at least \$1.2 billion annually, specifically tied to building a high-quality, accessible, affordable, community-based child care system; and ii) ensure fair and effective income support programs for Canadian families.

C) OPEN LETTER TO PRIME MINISTER TO REPEAL SECTION 43 OF THE CRIMINAL CODE

In November 2005, OASW again lent

its support, in conjunction with many other like-minded organizations, to the Open Letter to the Prime Minister on the need to repeal Section 43 of the *Criminal Code* which currently sanctions the use of physical punishment for children. The Open Letter was published in *The Globe and Mail*, the *Toronto Star* and the *Hill Times* prior to National Child Day on November 20th.

D) BILL 210, THE CHILD AND FAMILY SERVICES STATUTE LAW AMENDMENT ACT

In December 2005, OASW had been approached to speak on the issue of the Ombudsman's powers being curtailed related to Children's Aid Societies, which was reflected in Bill 210. This proposed legislation had the strong potential to decrease the Ombudsman's independent oversight powers related to adoption through amendments to the *Child and Family Services Act*. Although the Association had sent a response to the Review of the *Child and Family Services Act* in February 2005, this particular issue had not been addressed. Unfortunately, because of tight timelines, there was not an opportunity to study the issue and give it due diligence. A recommendation stemming from this process was the establishment of a Children's Issues Advisory Group, and a preliminary teleconference has been held to identify issues and potential representation.

E) PROVINCIAL PAEDIATRIC PANDEMIC INFLUENZA PLANNING

Beverley Antle, in her capacity as President of OASW, was approached by The Hospital for Sick Children (HSC) to participate in developing a provincial influenza pandemic strategy for the paediatric sector. HSC had been asked by the Ministry of Health and Long-Term Health Care (MOHLTC) to take the lead in this Ministry initiative. Beverley Antle serves on the Provincial Steering Committee and chairs the Psychosocial Support and Ethics Sub-Committee.

III. OTHER SOCIAL ADVOCACY INITIATIVES

A) OASW RESPONSE TO 2006 ONTARIO BUDGET

OASW responded to the 2006 Ontario Budget in the form of a letter to the editors of major newspapers, which was published in March by the *Thunder Bay Chronicle Journal* and Sudbury's *Le Voyageur*. The Association commended the provincial government for reinvestments in health care, education and public transit, but pointed out that it missed the mark by failing to address poverty, a key social determinant of health. The grossly inadequate increases in welfare benefits have failed to compensate for the massive 40 per cent loss in real income that has taken place since 1995. When the government does not recognize the adverse effects of family poverty, we all suffer the consequences.

B) OASW RESPONSE TO LHINS (LOCAL HEALTH INTEGRATION NETWORKS)

In February 2006, in a written submission, OASW stated that while we support the intent of *Bill 36: Local Health Integration Act, 2005* to provide an integrated system of health care in Ontario, we have concerns related to: funding and accountability; protections to support publicly funded health care; the enshrinement of the principles within the *Canada Health Act*; and the composition of the Health Professional Advisory Committee (HPAC) established by the LHINS. In regard to the latter, OASW pointed out that since social workers provide important services within the health care system and are regulated, our profession should be included in the composition of HPAC.

In addition, the Association has been active in disseminating information about LHINS to its Branches to enhance members' understanding of the dramatic changes that are occurring within the health care system. OASW has also been meeting with a number of other professional associations, to explore ways in which we can together engage with the LHINS and better understand their role.

As part of this process, a letter of introduction has been sent to the 14 LHINs across the province, and strategies are being developed to encourage our members to seek opportunities to have input into the planning and funding of services within government's transformation of health care.

C) CONSULTATIONS ON THE SUSTAINABILITY OF ONTARIO'S HEALTH CARE SYSTEM

OASW was invited by MOHLTC to participate in two consultation sessions in May and June around the long-term sustainability (20 years or more) of our health care system, as part of a new long-range scenario planning initiative. With factors such as a growing aging population, technological changes, and the availability of health human resources, the Ministry is interested in exploring the long-range impact of these and other potential driving factors on system sustainability for the purpose of developing future strategies. Keith Adamson represented OASW in the first of the two round table discussions to date.

D) CONFERENCE ADVISORY COMMITTEE TO THE MUNICIPAL HEALTH AND SAFETY ASSOCIATION OF ONTARIO/PROVINCIAL PAEDIATRIC PANDEMIC INFLUENZA PLANNING

OASW has been involved in the planning of an Emergency Response Conference, to be held in October 2006 in Toronto. It will target all sectors which offer services to municipalities in Ontario including the Workplace Safety and Insurance Board, Red Cross, fire and ambulance services, police services, health care, social services, First Nations, etc. This will serve as an opportunity for the social work profession to further develop a profile in emergency response work.

As previously mentioned, since April 2006, Beverley Antle has been representing the Association in a MOHLTC initiative based at The Hospital for Sick Children, and is serving on the Provincial Paediatric Pandemic Influenza Steering Committee and chairing the Psychosocial Support and Ethics Sub-Committee.

E) NEW HEALTH PROFESSIONALS NETWORK (NHPN)

In June 2005, the New Health Professionals Network (NHPN), (of which OASW Student Director at the time, Jessica Diamond, was a Co-Chair), launched the inaugural Tommy Douglas Celebration of Medicare Awards by selecting four examples of innovative projects across Canada to receive the special honour. This event began with a video-taped introduction by Commissioner Roy Romanow and was moderated by the Minister of State for Public Health. The NHPN represents over 20,000 health professional students and trainees across different disciplines, and stands for a commitment towards preserving and strengthening Canada's single-tier, publicly funded health care system. In June 2006, there will be a second Awards Ceremony followed by a Conference in Ottawa. OASW is represented on NHPN by Jennifer Ajandi (OASW Central Ontario Branch Board Representative/Interim NHPN Co-Chair), who is temporarily assisting Melissa Kimber (OASW Student Director/NHPN Co-Chair).

IV. REPORTS ON STANDING COMMITTEES

GOVERNMENT RELATIONS ADVISORY COMMITTEE

- The Government Relations Advisory Committee has been active in advancing its priority goals which include the building of long-term relationships with MPPs as well as political and senior staff. This spring, meetings have been held with the two Opposition Party Leaders, Howard Hampton and John Tory, with a focus on youth violence and the Review of the *Social Work and Social Service Work Act*. As a non-partisan organization, it is important for OASW to have meetings with all major political parties as part of its government relations strategy to promote the profession's values and principles. The Advisory Committee supported the Social Work Doctors' Colloquium in bestowing to the Honourable Sandra

Pupatello an award presented annually to an elected official, for her advocacy regarding social justice issues. OASW was invited to attend an Open House given by Sandra Pupatello in her new portfolio as Minister of Education, and had an opportunity to speak to her about the 450 school social workers across the province in light of the extensive funding for anti-bullying programs within schools. Also at Queen's Park, OASW participated in a forum sponsored by the Interfaith Social Assistance Reform Coalition (ISARC) – an opportunity to explore like-minded, broad-based partners around the issue of income supports and adequate housing for Ontarians.

- In addition, key messages to use with government and the media are being developed, together with policy statements on human rights, youth violence and health care privatization. At the February Board meeting, the Advisory Committee Chair, Dan Andreae, provided a post-federal election analysis to enable the Board to consider how the Association should position itself in the new political environment with a federal Conservative government under Stephen Harper's leadership. He will follow up with an article for the next issue of the *OASW Newsmagazine*.

SCHOOL SOCIAL WORK COMMITTEE

- In October 2005, the School Social Work Committee held its annual Symposium, sponsored by the Toronto Catholic District School Board. It was very successful, with 460 registrants in attendance. The Symposium featured an all-day workshop entitled "The Explosive Child" led by Dr. Ross W. Greene, PhD, Associate Professor at Harvard Medical School, who has developed a practical, comprehensive approach called the Collaborative Problem-Solving Approach for helping inflexible, easily frustrated and explosive children at home and at school.

see *Advocacy Highlights/42*

ADVOCACY HIGHLIGHTS (CONT'D FROM PAGE 41)

- In November 2005, Executive members of the School Social Work Committee made a presentation to the Ministry of Education's Safe Schools Action Team and, subsequently, put forward a written submission on the *Safe Schools Act* from a school social worker's perspective. It states that how the Act is interpreted and implemented varies greatly among school boards, and has not furthered along the understanding or interventions with at-risk students. School social workers firmly believe that the root cause of students' problems needs to be addressed, including the provision of access to more support academically, socially and emotionally at the school level. A summary of the written submission was published in the February 2006 issue of the *OASW Newsmagazine*.
- The School Social Work Committee produced a comprehensive background paper on School Social Work in Ontario. The document recognizes school social work from a worldwide perspective, then moves on to school social work in Ontario, ethics and regulations, the School Social Work Committee, the uniqueness of school social workers, funding, recommendations and resources. The intent of this document is for presentations to boards of education, school staff, the Ministry of Education, professional associations and school social work groups. There have been follow-up discussions with OASW Executive members and staff on developing strategies to maximize the impact of this paper.
- Laura Shepherd, a member of the School Social Work Committee, represents OASW on the Ministry of Education's Advisory Council on Special Education (MACSE). MACSE has provided input to the Minister of Education on matters concerning special education policy and programs since 1977.
- In February 2006, the Committee held its annual Ministry Day, at which time the Branch Directors of

Special Education and Secondary Schools Policy and Programs gave presentations on current government initiatives that include "Early School Leavers" and "Student Success/Learning to 18".

- The annual School Social Work Award was given to Frank Orlando of the Toronto District School Board. He headed the crisis team which responds to child disappearances and deaths.
- In late fall of 2005, the Committee published its School Social Work Newsletter distributed to 400 school social workers throughout Ontario and, additionally, to school social work contacts in 12 different countries. The topics of articles included school refusing behaviour, self-harming, cyber-bullying and anxiety as well as a school board's critical incident response program, school social work in the North, and helpful websites for school social workers.

COMMITTEE ON ISSUES OF AGING

- A summary of the *OASW Policy Statement on Adult Protection Legislation*, which has been a continuing initiative of the Committee on Issues of Aging, was prepared for the February 2006 issue of the *OASW Newsmagazine* as part of a plan to widely distribute this document.
- Substantial progress has been made on the updating of OASW's *Elder Abuse: A Practical Handbook for Service Providers*, which is a major initiative of the Committee. Following an extensive literature search and the preparation of a first draft by OASW member, Jane White, work is currently underway on the development of a second draft. Additionally, the Committee is planning a province-wide survey of organizations and agencies that are largely geared towards multicultural and other marginalized populations, to provide up-to-date resource information for the Handbook.

- In November 2005, OASW became active, under the auspices of the Committee, in supporting the "Take Our Seniors Off Welfare" (TOSOW) Campaign, in collaboration with the Institute of Doctors in Social Work, urging the provincial government to change the social assistance legislation back to what it was before 1998 for those over age 60. This would exempt seniors between 60 and 64 from Ontario Works (OW) requirements and deem them eligible for the Ontario Disability Support Program (ODSP), thus significantly increasing their income to cover adequate housing and food costs. Subsequently, OASW wrote to the Minister of Community and Social Services, and also informed the membership and the Branches of how they could get involved in lobbying their local MPPs.

SOCIAL WORK IN HEALTH CARE COMMITTEE

- In November 2005, the Social Work in Health Care Committee hosted the Social Work Session at the Ontario Hospital Association Convention (OHA) in Toronto. The panel presentation, followed by a Q & A session, was entitled "Interprofessional Collaboration: Ensuring Better Patient Outcomes". Panellists represented a number of disciplines including social work, medicine, occupational therapy, and speech-language pathology. OASW was commended by the diverse professional audience for profiling this "hot" topic and offering a most informative and thought-provoking session.

Keith Adamson, BSW, MSW, RSW, is pursuing PhD studies at Wilfrid Laurier University this fall, and will continue working part-time at St. Joseph's Health Centre in Toronto. Keith is OASW's Vice-President of Social and Professional Advocacy.

Gillian McCloskey, MSW, RSW, is Associate Executive Director of OASW and Editor of the "OASW Newsmagazine".



NEW OASW WEBSITE: WWW.OASW.ORG

The fully bilingual, revised and enhanced OASW website is divided into three sections:

PUBLIC SITE

The Public Site provides information to the public about issues that affect social workers and their clients, how to start a career in social work, frequently asked questions about social workers, information for the media, links to **FindASocialWorker.ca**, and general information about the Association.

SOCIAL WORK COMMUNITY SITE

The Social Work Community Site provides helpful information about the benefits and services of OASW, social advocacy and professional practice initiatives in which OASW is involved, publications, profiles of our Branches, How to Join information and registration for notification of OASW events.

MEMBER SITE

The Member Site provides more detailed information about OASW advocacy initiatives, members-only publications, job-board access, committee profiles, a student section, membership renewal and professional practice resources.

The Member Site is accessed through a “login” using the member’s last name and membership number. After logging in, members are eligible to receive discounts on publications, event registration and merchandise through Shop OASW, the Association’s online store.

ADDITIONAL FEATURES

ONLINE NEWS

OASW news will be updated frequently and appear at the bottom of each site’s welcome page, making it easy to find new information quickly. Visit often to keep up-to-date with news that affects social work in Ontario.

ONLINE STORE

Through Shop OASW, publications and OASW-related merchandise can be purchased quickly, easily and securely. Please note: in order to receive the membership discounts, members need to log in to the membership area first, and then select the Shop OASW link at the bottom of the page.

Visit www.oasw.org today and tell us what you think.
We look forward to your feedback.

NEW MEMBERSHIP SECTION ON OASW WEBSITE

OASW members now have access to a “password-protected” member section on the OASW website.

On OASW’s new website, members can:

- renew and change membership information online
- read regular news updates
- download or purchase publications
- view and download *OASW Newsmagazine*
- link to resources and events
- link to FindASocialWorker.ca and SocialWorkJobs.ca
- browse the new online store
- link to membership benefits
- visit new sections for students and branches
- find updated information on OASW committees and initiatives.

To enter the Member Site, members need to enter their last name for the Username and their membership number for the Password. Members can find their membership number (up to 4 digits) on their membership card and receipt.

We look forward to your feedback.

The Canadian Association of Psychoanalytic Child Therapists
with
**The Toronto Child Psychoanalytic Program &
The Institute for the Advancement of Self Psychology**
Present

**Making Connections:
Incorporating Attachment Theory Into
Self Psychological & Intersubjective Clinical Work**

Shelley Doctors, Ph.D.

Saturday, October 21, 2006

Shelley Doctors, Ph.D. is an internationally respected author, teacher and psychoanalytic clinician. She will present key concepts emanating from attachment theory and research, and she will illustrate their application to self psychological and intersubjective clinical work with teens and adults.

This conference should be of interest to all practising psychotherapists who work with children, youth and adults, and who are interested in contemporary developments in theory and clinical approaches.

**For more information or to register online please visit
www.capct.ca or www.iasptoronto.com or call 416.690.3722**

**TORONTO NARRATIVE
THERAPY PROJECT
PRESENTS**

From Adelaide, Australia
Alan Jenkins
Toronto - November 9-10, 2006



**Day 1: November 9, 2006
Restorative Practice After Domestic Abuse:
Ethics, Justice and Accountability**

This workshop examines Invitational Practice with men who have abused, in the context of relationships, family and community. The workshop will focus on the nature of restoration in the aftermath of abuse and will critique popular ideas concerning remorse, apology, forgiveness and reconciliation, while highlighting possibilities for ethical practices of restorative action.

Practical approaches will be outlined and demonstrated with a focus upon:

- Facing shame without shaming
- Moving from ethical realization to restitution
- Determining respectful forms of connection which are accountable to those who have been affected by abuse.
- Developing integrity through ethical action

**Day 2: November 10, 2006
Making It Fair: Respectful Intervention With
Disadvantaged Young People Who Have Enacted
Violence and Abuse**

This workshop will address the politics of intervention by highlighting dilemmas and principles for just and respectful practice. Invitational Practice which fosters a foundation for fairness, accountability to the experiences of childhood and the discovery of respectful ethics, will be outlined and demonstrated.

This workshop will highlight practical ideas in the following dilemmas:

- How can we challenge abusive behavior without reproducing abuse?
- How can we address young people's own experiences of victimization and oppression without sacrificing a priority on responsibility and accountability for their own abusive actions?
- How can we work with shame without shaming young people

Information and
Registration:
Kate Lum
(416) 944-9142
56 Roxborough
St. West, Toronto,
ON M5R 1T8

EARLY RATE (UNTIL October 20th): Day 1, \$125.00 • Day 2, \$125.00. • Both DAYS, \$200.00

REGULAR RATE: Day 1, \$175.00 • Day 2, \$175.00. • Both DAYS, \$275.00

Students and under-employed: Day 1, \$100.00 • Day 2, \$100.00. • Both DAYS, \$150.00


VISA, CHEQUE AND CASH ACCEPTED AS PAYMENT

UP-TO-DATE WORKSHOP INFORMATION: www.yaletownfamilytherapy.com

EMAIL: torontonarrative@hotmail.com

**Location:
the beautiful,
historic
Enoch Turner
Schoolhouse
106 Trinity St,
Toronto ON**

KALEV HELDE HONOURED BY OASW/CASW


 OASW is pleased to announce that Kalev Helde is the Ontario recipient of the 2006 CASW Distinguished Service Award.

After obtaining an MSW at The Queen's University of Belfast in 1981, Kalev returned to Canada and began his career in child welfare. Employed by the Catholic Children's Aid Society of Toronto (CCAS) for over 20 years, Kalev has worked: as a Child Abuse Specialist investigating serious allegations of physical and sexual abuse and providing consultation to staff at day care centres and school boards; as a Group Worker organizing programs for children and their parents; and as part of an inter-agency team providing both individual and group treatment for victims of sexual abuse as well as adolescent offenders. During this time, Kalev presented papers in the U.S. on adolescent group treatment, and provided clinical consultation for group leaders working in sexual abuse treatment programs. Additionally, from 1992 to 1998, Kalev served as President of CUPE Local 2190, and was a member of several contract negotiation teams. In 1997, Kalev transferred to the CCAS Foster Care Department, where he continues to provide support and resources to the Society's foster families and the children in their homes.

Kalev has been a member of OASW for 24 years. During this period, he served a number of terms in various capacities on the OASW Central Ontario Branch's Board of Directors including Vice-President of Continuing Education, Vice-President, and two terms as President. During his years on the Branch Board, he also served as Branch Representative to the OASW Provincial Board of Directors and on the Provincial Budget and Finance and Professional Development Committees. Remarkably, he even provided leadership to the 2001 OASW

Provincial Conference Planning Committee while at home recovering from a very serious health problem. As well, Kalev served on the Appeals Committee, and was an Oral Examiner for the former Ontario College of Certified Social Workers. Additionally, he has been a field instructor for the schools of social work at both York University and the University of Toronto. In late 2005, Kalev accepted another appointment to the OASW Central Ontario Branch Board of Directors.

It is with pleasure that OASW recognizes Kalev Helde with the 2006 CASW Distinguished Service Award for Ontario for his commitment to the

social work profession and to his professional association. 

Gillian McCloskey



KALEV HELDE WITH BEVERLEY J. ANTLE, PRESIDENT, AT OASW'S AGM ON JUNE 2ND



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DAN ANDREAE RECEIVES CASW NATIONAL AWARD

On June 19, 2006, Dr. Dan Andreae was honoured as the recipient of the 2006 Award for Outstanding Service given by the Canadian Association of Social Workers (CASW). The award, bestowed to one individual across Canada every two years, was presented at a banquet at the national association's Conference in Halifax. Dan gave an inspired acceptance speech to approximately 500 delegates from across Canada on the need to fight strategically for social justice and human rights, in spite of the inevitable opposition that will occur from adversarial groups. Dr. Andreae served as President of OASW between 1993 and 2000, and played a pivotal role in obtaining social work statutory regulation in Ontario. He is currently Chair of the Government Relations Committee. Dan co-founded with Dr. Frank Turner, the Social Work Doctors' Colloquium and the Institute of Doctors in Social Work, which raise the profile of the social work doctorate and provide commentary on current issues with an

approach grounded in social work's history of advocating social justice and humanitarianism at national and international levels.


Dan has previously received several honours for his contributions to social work, public policy, the health sector, and volunteerism including the CASW Distinguished Social Work Award for Ontario (1999), the Governor General Medal in Recognition of Canada's 125th anniversary (1992), the Alumnus of the Year Award, Wilfrid Laurier University (2001), Professor of the Year from the University of Guelph-Humber (2004), and the University of Waterloo's Distinguished Teaching Award given at Convocation (2005). Recently, Dan received a citation from the House of Commons for "demonstrating the spirit of volunteerism and citizen engagement". He previously served as the first Executive Director of the Alzheimer's Society for Metropolitan Toronto, and was also head of an organization that established the National Eating Disor-



Courtesy CASW

DAN ANDREAE, AT THE NATIONAL SOCIAL WORK CONFERENCE IN HALIFAX ON JUNE 19TH.

ders Information Centre at the Toronto General Hospital.

As CASW states at the end of its media release: "The profession salutes Dan for his accomplishments and thanks him for his contribution to social work education and practice." 

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