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Aspects of Social Work and Palliative Care

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Quay Books
MA Healthcare Limited

Quay Books Division, MA Healthcare Limited, St Jude's Church, Dulwich Road,
London SE24 0PB

British Library Cataloguing-in-Publication Data
A catalogue record is available for this book

ISBN 185642 266 6

Printed in the UK by Cromwell Press, Trowbridge, Wiltshire

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Introduction

The care of the sick, the vulnerable and the dying has been a central feature of our history. The provision of care in hospice settings goes back to Islam at the time of the Crusades. It is perhaps not surprising that the highest values of our world's religions find expression in caring for those at the end of life.

Social workers have a particular role to play in this work — a role that is possibly wider than that of other professionals involved. Although social work has a long and illustrious pedigree in hospice work, and attempts at carving out a particular theoretical base and approach have been made by emphasising its 'psychosocial' dimension, it is important not to over-emphasise this dimension or forget that social workers take into account the social needs of the individual in his or her specific life-context. Social work is not only 'holistic' in considering the individual and looking at his or her 'biopsychosocial' and spiritual needs, but it also engages clients' families, friends and other significant people.

But social work's role is wider still. It is 'socio-educative', meaning that social workers in palliative care collaborate with other professionals, volunteers and a wider audience to raise awareness about death, dying and bereavement, and to work towards the reintegration of death and dying into our vision of society.

This book addresses central questions for all social workers, whatever their area of practice and primary service user group and its supporters. Loss, bereavement, grief and mourning are all at the heart of social work's involvement with people.

However, this book delves deeper and more precisely to examine an often neglected area — namely, social work in palliative care settings. Social workers have practised with people who are dying, those who experience potentially life-shortening illnesses, their families and caregivers, for many years. Their role has suffered from lack of attention, and from an over-emphasis on either the practical details of welfare or on the psychological aspects of death, dying and bereavement. How many times have palliative care social workers received requests for assistance filling in benefit forms or for advice concerning charitable awards? How many referrals have been received for 'counselling support', whatever this may mean in practice?

Both welfare support and counselling are important elements of palliative social care work, each emphasised to a lesser or greater degree, depending on setting and team ethos. But this is not the whole story of social work in palliative care. This book addresses some of the dimensions of palliative care and social work that have not gained the attention they deserve, and moves the role of social workers to centre-stage.

It is timely to publish this book as we consolidate social work's image at the beginning of the twenty-first century. Health and social care are high on the Government's agenda for modernising services, joined-up service delivery, and increasing accountability and effective practice. We see this in the production of National Service Frameworks that address health and social care needs in an intertwined way that demands the forging of new ways of working and of the organisation of different disciplines. We must not lose sight of the fact that social workers in palliative care settings have been working in interdisciplinary and multidisciplinary ways since the development of the hospice movement and, indeed, since the inception of hospital almoners in 1895. However, the current emphasis raises new issues: it confirms the importance of working together, but begs questions of management of services; control of delivery; the agendas underpinning such work and its evaluation; and the education needed to carry it out.

The education system for social workers is changing in all four countries within the UK. The standards set for education mean there is a clear opportunity to emphasise palliative care social work and to show just how important it is. Service delivery and its organisation are responding rapidly to the demands for integrated approaches, and service users' and carers' needs are represented and their voices increasingly heard.

This book will be useful for social work students embarking on their professional learning journey. It will provide an insight into palliative care issues and into working with profound loss, grief and mourning. It will also be useful for nursing and medical students and other professions allied to medicine, providing a helpful overview to social work. The book will help other professionals to develop their interprofessional literacy skills, as it will social workers. It is also intended for qualified social workers practising, and working with others, in palliative care settings, and will be of interest to those social workers who perhaps deal only tangentially with death and dying, but come across loss, bereavement and grief in their everyday practice.

It would not be possible to cover all aspects of palliative care social work in a single text. However, this book presents a wide range of central issues in palliative care social work practice and brings together a number of authors with expertise in their particular fields. The authors are social workers from both academic and practice backgrounds, but what unites them all is their passionate commitment to best practice and the highest quality of care in palliative social work settings.

Jonathan Parker
May 2005

Chapter 1

Social work education for palliative care — changes and challenges

Jonathan Parker

Introduction

Social work has a long and varied history. It emerged in Western cultures from the development of urbanisation, industrialism and a search for moral and religious approaches to social problems in a developing secular society, alongside deep-rooted and committed emphases on social justice and political change. In a sense, therefore, it has always focused on those who are displaced; who have experienced loss and need the support of others to (re)join and contribute to the functioning of society. At present, in the UK, dying, death and displays of loss and grief are often shunned, and social work's aim to work alongside those experiencing such phenomena emphasises the connections between palliative care and social work by enfranchising people who have been marginalised by their experiences.

This chapter will briefly chart the development of social work education, placing specific emphasis on learning for working with loss, bereavement and palliative care. As well as examining the generic ways social work programmes might address issues of loss, grief, death and dying, the chapter will focus on specialist programmes that have developed to promote palliative care social work at pre-qualifying and post-qualifying levels. Of course, social work education is concerned with learning in and for practice, as well as with practice in the classroom, and this dual or integrated approach to education will be covered. Social work education is an evolving process and recent changes to qualifying education, and the opportunities this may bring for the inclusion of hospice and palliative care, will be explored.

Jonathan Parker

The development of social work and social work education

Origins

The development of social work practice within the personal social services in the UK is interlinked with corresponding changes and developments in social policy. It is also associated with developments in education and training.

It is possible to trace the development of social welfare in the UK back into history (Horner, 2003). For instance, the Elizabethan Poor Laws of 1598 and 1601 provided relief for the needy of local parishes, laying the foundation for subsequent social security and welfare measures. Also, the eighteenth- and nineteenth-century legislation relating to the care and treatment of people with mental health problems imposed a duty of care and/or control or regulation on local authorities that is echoed in contemporary mental health legislation.

Most commentators, however, chart the development of social work practice in its modern form from one of two points. Douglas and Philpot (1997: 7) suggest that social work:

> *emerged fitfully, from the tide of nineteenth century philanthropy and largely as a voluntary activity, often undertaken by women. Social work is a product of industrialised, urban societies, dealing with the personal consequences of social dislocation.*

Adams (1996) and Sullivan (1996) consider contemporary social work from a more familiar vantage point: the creation and development of the Welfare State in 1948. At whichever point we locate the beginnings of modern social work, it is important to remember, as Pinker (1997) emphasises, that it was the last thirty years of the twentieth century that saw the radical restructuring of the organisation and functioning of statutory and non-statutory social work agencies and professional social work education.

It is important to understand some of the key themes that have underpinned the development of social work. These themes have implications for our understanding of it; the concept of loss, in particular, is central to social work and latterly, by association, to the development of qualifying education. In the nineteenth century, social work was concerned with the relief of poverty and destitution and with the 'rescue' of prostitutes. 'Loss' equated with Christian ideas of being 'lost from God', and social welfare concerned the moral salvation of people brought back into society.

The Victorian era

The roots of this type of social welfare lie in Victorian philanthropy and successive Poor Law legislation. The Poor Law Amendment Act (1834) categorised people as 'deserving' and 'undeserving' poor, which, whatever the distaste evoked by such a distinction, has characterised a recurrent theme throughout the short history of social work. With respect to palliative care and bereavement issues, this dualism reflects those losses that are legitimised and those that are not, and the ways in which people express the felt impact of those losses. For example, in contemporary society, it is likely to be commonly accepted that a person bereaved of their father has a right to grieve openly and might be classed as 'deserving', whereas the death of a distant cousin may not afford such sympathy. The educational issues here are clear: to understand how psychology and culture affect grieving and how attitudes are constructed within society. An approach that seeks to understand meanings and their impact now underpins the values of social work and education, although this has trend has developed over a long period.

To a large extent, the growth of hospice social work is intertwined with medical social work. The development of hospital almoners, arising from the Charitable Organisation Society's (COS) secondment of Miss M Stewart to London's Royal Free Hospital in 1894, was to secure care and assistance for people in need of treatment. But it was the fact that she could detect those who were in a position to pay, but tried to avoid doing so, that captured the imagination of the hospital collecting societies and led to the employment of enquiry agents to prevent fraud. However, developments at the Royal Free led to practical casework training for almoners, under the auspices of the COS, until, in 1907, it was taken over by an independent body, the Hospital Almoners' Council. The emphasis was placed on ability to manage in a practical sense — not on the emotional impact or meaning of loss of health or ability, or loss of loved ones. This focus on practical assistance has characterised hospice social work (Small, 2001) and assessment of practical needs and securing charitable support have formed part of the education for hospice social work from its earliest days.

During the Victorian era, methods and practices developed, including the keeping of systematic records by the Charitable Organisation Society, Ellen Raynard's Bible and Female Mission and the Toynbee Hall Settlement Movement. The facts that were gathered about people were used to make plans and provide help according to perceived needs. This individual approach represented the beginnings of social casework, which, again, has permeated social work's development, reaching its zenith in psychoanalytic approaches (especially in psychiatric social work in the earlier half of the twentieth century) and remaining part of qualifying social work programmes in one guise or another. Indeed, the Department of Health (DoH) (2002) requirements for qualifying social work education stipulate learning about assessment, planning, intervention and review.

The twentieth century

Alongside the religious, moral and philanthropic foundations of social work, there grew, at the turn of the twentieth century, an emphasis on wider social and political factors affecting the welfare and well-being of people. The Settlement Movement and Dr Barnado favoured a group approach to problem-solving and providing assistance at a micro-social level. Beatrice Webb, by contrast, favoured a more radical political response to welfare. She challenged the deterrent effect and stigma of the Poor Law, demanding collective action to achieve minimum conditions in employment and social life. Webb was aided in this by the beginnings of the social survey collected by Charles Booth and Seebohm Rowntree, and a politically reformist approach of government.

The two core emphases of social work education — individual casework (assessment, case planning and intervention) and a growing sense of political and social justice — were established during the fragmented beginnings of social work in the nineteenth century. Throughout the first half of the twentieth century, however, there was no single, formal, social work education programme. Social work itself was inchoate in structure and underpinned by the conflicting discourses of 'deserving/undeserving', casework and radical political action. Some social workers became highly trained, especially psychiatric social workers, but many more remained in voluntary positions in which training and education was minimal (Younghusband, 1981). The gravity of this situation was not ignored and calls for general training mounted (Younghusband, 1951). With the establishment of the Welfare State in 1948, a tripartite system of personal social services — concerning children, physical and mental illness, older and disabled people — was established under local government administration. This system replaced the unwieldy number of independent and Government agencies that provided the range of social services (Sullivan, 1996). This system remained until the early 1970s. But still no unitary system of educating social workers existed.

The post-war years

After the Second World War, a more concerted effort to develop appropriate social work education began, with a call from medical social workers to have at least one university-level course that included a theoretical base in social science, as did existing courses in child care, youth work and family case work. The 1949 Institute of Almoners working party report argued for one-year casework courses to be developed at university level following a general social science course. This led in 1954 to the establishment of a medical social work course at Edinburgh University, followed by others at the London School of Economics (LSE) and the universities of Southampton and Birmingham

(Younghusband, 1978; Pinker, 1997). Towle (1968) called for the inclusion of knowledge and understanding of human behaviour in social work courses. This is central knowledge, alongside the practice approach to funding, finance and care, for social workers working in palliative care settings and, again, comprises a central feature of the requirements for the qualifying degree.

In 1965, the Labour Government established a committee to review local authority social services departments and family services. Whilst the origins of statutory social work had begun with the creation of the welfare state, it is at this point that Adams (1996) claims that modern social work was formally born in England and Wales.

The Seebohm Committee made three recommendations, one of which championed the development of the generic training of social workers and further research into social work practice and welfare. This consolidated the growth in general social work courses that had come to be recognised throughout the 1960s (National Council of Social Service and Women's Employment Federation, 1963), the focus of which was on social science and did not specifically include palliative care, loss, or bereavement work. However, the call for systematic curricula development in social work, and the fact that social workers were expected to work with social and personal difficulties, paved the way to focus on loss in all areas of practice. These recommendations were included in the Local Authority Social Services Act (1970) and generic social services departments were established in 1972.

Seebohm acknowledged that personal problems were often a reflection of wider structural problems in society. As the attitudinal shift took place across departments and agencies providing services, so education shifted its emphasis from personal and family dynamics — casework — to social workers who were capable of carrying out a range of generic tasks; seeing people in their ecological context; and working with the impact of social factors on people's lives. Whether or not the creation of generic social services departments represented Seebohm's intentions accurately (Sullivan, 1996), the social work profession began to train generic as opposed to specialist workers, and this has remained a feature of qualifying social work education since.

Certificate of Qualification in Social Work (CQSW)

Following the implementation of Seebohm, the professional regulatory body for social work at the time, the Central Council for the Education and Training of Social Workers (CCETSW), introduced the Certificate of Qualification in Social Work (CQSW), which set out the content and methods of a course based on generic principles. The CQSW was recognised as the qualifying award for social workers and was regulated and awarded by the professional body, although taught by a range of higher- and further-education institutions. The CQSW included a multidisciplinary knowledge base, using understanding of

human growth and behaviour taken from psychology and medicine, as well as social science (Casson, 1982). Social work developed its particular focus on the interplay of interacting systems and how the actions of one may ripple outwards and back inwards to have many evolving implications for all involved (Goldstein, 1973; Pincus and Minahan, 1973; Specht and Vickery, 1977).

The move to generic education and training meant programmes were not specifically focused on one setting or service user group. But the changing emphasis from the individual to the social helped the understanding of the impact of loss and was beneficial, therefore, to palliative care social work. The locus for action grows from the individual, the patient or service user to include consideration of the wider family, friends and 'significant others' in that individual's life. It also allowed social workers to involve wider professional systems and develop practice that is holistic and collaborative. This is something that remains fundamental to contemporary qualifying education for social workers.

Social work practice was reviewed again in the Barclay Report (1982). The Conservative Government of the day was intent on 'rolling back the frontiers of the Welfare State' — that is, reducing dependency on State provision and encouraging family, community and voluntary effort. Social work was seen to be about 'enabling' rather than 'providing'. With the development of contemporary community care policy, social workers became enablers and coordinators rather than providers — care managers who were responsible for the design and purchase of packages of care. These proposals gained all-party backing for a wide variety of disparate reasons and the National Health Service and Community Care Act (1990) was fully implemented in 1993. Whilst the report had little direct impact on social work education, the development of enabling and managing skills permeated skills development.

From DipSW to Social Care Councils

The radical political changes in organisational structure that occurred and the change to a market-dominated purchaser-provider split happened at the same time CCETSW decided to review its training and education. Perhaps this was timely. The Diploma in Social Work (DipSW) was built around a set of rules and competency requirements for the qualification (CCETSW, 1989). Paper 30, as it came to be known, was later revised (CCETSW, 1996). In essence, partnerships between colleges and employing agencies were created to plan course proposals that met the competences and requirements specified for social work education.

Competence in social work education is represented by the integration of knowledge, skills and values. These were reflected in the practice requirements and evidence indicators underpinning the six core competences. Paper 30 continued the generic approach to social work education started with the implementation of Seebohm, but allowed for the development of more

specialist teaching, such as palliative care and loss. The knowledge-base for the core competence 'assess and plan' specifically included studying the:

> *social and emotional impact of physical, sensory and learning disabilities, ill health and mental illness in children, adults, families and carers… emotional impact of traumatic events and the range of emotional and psychological reactions to loss, transition and change.*
>
> (CCETSW, 1996: 21)

It was at this time that specialist modules of study, at a qualifying level, were introduced in greater numbers into social work education. The development of competence in communicating with service users, carers and other professionals; coordination of care and support; provision of information and advice; identification of risks; and promotion of a reflective, self-questioning approach — all were open to a wide range of curricula developments.

The professional body, CCETSW, was replaced in 2002 by the creation of Social Care Councils in each of the four UK countries. At the same time, the education and training of social workers was again reviewed. Training and education for qualified social work practice remains within higher education, but the content and methods of training and education are more determined by the demands of practice and the exigencies of social work employers, and those undertaking the qualification.

Contemporary education

Dissatisfaction with the DipSW, expressed by employers of social workers — and as the profession responded to policy shifts and developments; inquiries into cases that had gone tragically wrong; and the need for some level of consistency across qualifications — led to a fundamental review of the training and education of social workers. The result was to develop a new honours degree in social work as the professional qualification for practice. In England, this was implemented in September 2003. Increased emphasis has been placed on practice learning within the new qualifying degree, and the involvement of service users and carers is central.

Until the foundation of the honours degree course, qualifying education for social workers comprised the two-year diploma awarded by the professional body (now the General Social Care Council), which could be delivered and gained in a range of ways, including undergraduate diploma, undergraduate degree plus diploma, postgraduate diploma, or masters degree level. The diploma represented the qualification and was awarded not by the universities and colleges, but by the professional body.

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From September 2003 in England, the qualifying award for social work focused on an undergraduate degree delivered and awarded by accredited universities and colleges and approved by the GSCC after university validation of the programme. Wales, Scotland and Northern Ireland introduced their new qualifying programmes in 2004. The core principles for these changes concern the commitment to raising standards, harmonising qualifications and emphasising the centrality of practice learning.

Degree in social work

The degree itself is developed individually within universities, with each institution able to promote its own core areas. However, degrees are built around a complex of regulations, benchmarks and standards, underpinned by values and skills development in extended practice learning settings. They still emphasise the development of competence, exemplified by the integration of values, skills and knowledge.

Subject benchmarks, or specific standards, for honours degrees in social work were developed and published in 2000 (QAA, 2000). These remain the benchmarks for the new qualifying degree, but the new qualification in England also demands integration with National Occupational Standards for social workers (Topss, 2002), DoH Requirements (DoH, 2002), and the Code of Practice for Employees produced by the GSCC (2002). There are also further practical matters to be fulfilled by adherence to GSCC requirements for admission, selection, reporting, delivery and management of the degree. *Figure 1.1* shows the degree's core aspects.

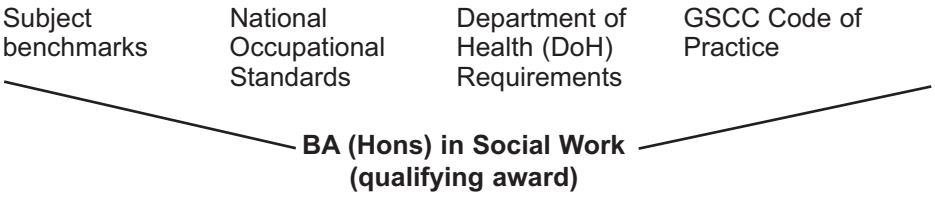

Figure 1.1: Core aspects of the BA (Hons) degree in social work

The structure of the degree has implications for learning and teaching related to palliative care. Although, of course, social work students are not being educated to undertake medical or nursing interventions, some question what it is that social workers are being educated to do. Anecdotal evidence suggests that social workers are seen either as offering counselling support or practical assistance related in particular to the completion of welfare-benefit claims.

Certainly, these activities may comprise a part of the role. There are, however, educative, group and family work, care coordination and management roles taken on by social workers. Often, within the hospice movement, this has been encompassed under the umbrella term of 'psychosocial work' (Sheldon, 1997; Oliviere *et al*, 1998). But although the term may have offered a degree of professional acceptability, it may also have over-emphasised the psychological and intrapersonal (ie. internal-emotional) aspects of the work to the detriment of social and interpersonal (ie. relational) practice. The wider impact that derives from the way society is organised and the ways in which care is delivered, plus the tendency to create particular ways of judging needs, are ignored in this model. Palliative care social work, however, is supported by building on a clear social-science foundation that acknowledges the impact of societal factors on the ways in which loss is perceived and care needs apportioned. Social workers bring a critical perspective that helps balance an over-medicalised approach.

Social work or social security?

People still confuse social services departments and social work with social security. The emphasis on practical assistance in hospice social work (Small, 2001) may have contributed to this confusion. According to Adams (1996), this view reflects the low standing of social work in the minds of the general public. The topic is a difficult one to tackle because of the many conceptions of social work and the lack of consensus on roles, tasks and meaning in social work. Adams (1996: 6) captures this uncertainty well:

> *Social work has a rather weak professional identity partly because social workers deal with a large proportion of the less powerful, less influential and low-status members of society; social workers practise in diverse agencies, roles and settings and, unlike lawyers, doctors and engineers, for example, do not draw upon a body of knowledge and expertise agreed and held in common to all in the profession. There are often uncertainties about what course of action would be most productive and there may be no agreement about this among social workers themselves, let alone among other professionals and… the mass media.'*

The confusion is deepened by the professional and educational distinctions between England, Wales, Scotland and Northern Ireland: these countries have different social work systems and, with the development of the social work degree, each UK administration has developed a separate (albeit transferable) education programme.

It is worth returning to the definition of social work agreed by the IASSW/IFSW in 2001, which articulates the conjoint activities of intrapersonal and interpersonal work and a commitment to community development and social justice as key to social work in all settings, but which can be developed in palliative care social work in particular.

The themes of social work

> *The social work profession promotes social change, problem solving in human relationships, and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.*
>
> IASSW/IFSW (2001)

Social workers are educated to understand and practise in situations of loss. This is the case when children are separated from their families, and for families that have 'lost' children as a result of social intervention. Social workers work with people experiencing loss as a result of relationship breakdown, redundancy, loss of housing, loss of health, loss of abilities, and so on.

In relation to palliative care and hospice social work, this network of loss still occurs, although it is the loss associated with declining health, limited life expectancy and bereavement that figure most highly in people's minds. These experiences are not singular in effect, and a range of associated losses may figure highly for each individual or family.

Social work education must address loss, theories of loss, grief and bereavement and ways of working with people experiencing loss. This was highlighted by Keating (2002) with respect to social workers practising with bereaved families in Ireland.

Small (2001) acknowledges the significant contribution that UK social work has made to the development of palliative care services, while bemoaning the paucity of literature. There are over two hundred social workers employed in specialist palliative care settings and many more in hospitals, residential and other community settings that work with people at the end stages of life and quite a number in senior positions. Palliative care is recognised as a specialty, having developed from the work of Cicely Saunders and her promotion of hospice as a movement for person-centred care. However, there are still relatively few qualifying programmes that include an overt and significant emphasis on loss and bereavement. These issues are dealt with in the context in which the losses are experienced. This is helpful, but there is room for the

development of a more particular focus.

Social work literature dealing with issues of loss, death and dying was sporadically published during the 1940s, 1950s and 1960s (see Clark, 1998). Since 1977, according to Small (2001), a number of themes emerge:

- social work has always been concerned with responding to loss
- social work brings a whole system view, placing the individual in his or her wider ecological context
- social work in palliative care is concerned to deal with the practical as well as emotional, although Lloyd (1997) does suggest that emphasis on the practical must not detract from listening and providing emotional support.

The role of social workers as coordinators and educators, together with their experience of working with volunteers and their knowledge of loss and bereavement, represent important strengths to bring to the palliative care team. The literature also indicates an important role in providing support to the wider multidisciplinary team. Smith (1982) examines the special role social workers have in assisting service users to 'make meaning' from bereavement experiences. Oliviere *et al* (1998) emphasise the focus on the whole person and psychosocial issues. Small (2001: 969) states:

> *There has been a continuing wish to firmly identify the social work role within palliative care and to argue that it is a role consistent with the overall functions and philosophy of social work… Social work, as undertaken within the palliative care team, has looked to the emerging practice and the established principles of hospice and palliative care. It has less often reflected the strains and achievements of the broader social work community. The values of social work and palliative care are linked.*

In working in palliative care settings, there is a further need to develop a wide professional and interprofessional literacy. Social workers do not work in a vacuum, and if they are to play a full part in palliative care settings, they need an understanding of hospice, health and social care service delivery; social and health care policies with people who are dying or have a life-threatening illness; and an understanding, at theoretical and practical levels, of the roles and tasks associated with other professions working within that context. Continuing professional development and education is warranted here.

Education programmes

There is a great deal of emphasis on education for palliative care: often, it is non-qualifying and/or health professional-focused, such as the Scottish Partnership for Palliative Care (SPPC; www.palliativecarescotland.org.uk) and Douglas' (2002) in-house work on bereavement education for nurses or support staff (Brown, Burns and Flynn, 2003). Nurse education for palliative care is innovative and well-supported. For instance, van Boxel *et al* (2003) report a study into the effectiveness of face-to-face and video-conferenced teaching delivery to community nurses. The study found that both were equally effective in promoting learning, thereby opening up possibilities for reaching a greater number of professionals. Kenny (2003) uses thinking games to encourage critical and reflective practice in nurses in palliative care.

Palliative education is also developing within medical education, showing an increasing emphasis within the curriculum on symptom relief, attitudes to death and dying, and sometimes using the dying patient as instructor (Field and Wee, 2002). The usefulness of such programmes is not in doubt (Ferrell and Borneman, 2002), but many also recognise that improvements in palliative care education for health professionals are needed (Reb, 2003; Piller, 2001).

Post-qualifying programmes

There are an increasing number of post-qualifying programmes that are offered on a multiprofessional basis. There is also a growing emphasis on undergraduate interprofessional teaching (Wee *et al*, 2001; Weinstein, 2002), although there is a lack so far of rigorous evaluation of learning in these innovations (Barr, 2002). The value of interprofessional learning and the ability to deal with distressing situations by undergraduate students is clear, as is the importance and potential catharsis for carers contributing to these programmes (Turner *et al*, 2000; Turner, 2001; Latimer *et al*, 1999).

This is an important factor, as it is now imperative for social work students to learn about collaborative ways of practising, and interprofessional education is seen as fundamental in health and social care. The DoH (2002) consider working together across professions to be a requirement of qualifying programmes. Palliative care and hospice social work and issues provide a useful focus to develop such understanding. This is especially the case in developing practice learning opportunities for social work students.

The inclusion of palliative care as a core uniprofessional feature of qualifying programmes has been minimal. The degree offers a chance to rectify this, although programme planners may be put off from doing so because of the tight timescales set for delivery of an intensive programme and the increased demands for practice learning. Opportunities involved in

developing interprofessional approaches with health-related students offer a way forward and meet a core component of the DoH's (2002) requirements for social work education. The emphasis on statutory working in the degree must not detract from the evolution of creative approaches to joint learning in voluntary and charitable body settings, especially with respect to practice learning opportunities. Programmes can begin to seize the momentum for constructive educational development by acknowledging the centrality of issues of loss, working to the new health and social care agenda and increasing interprofessional opportunities.

The teaching of palliative care

The teaching of palliative care to social work students studying at undergraduate and postgraduate levels for a DipSW at the University of Hull began in 1993 with the appointment of a Macmillan Lecturer in Palliative Care Social Work — one of a handful appointed at the time. In early years, the focus was enhanced by teaching that was specifically related to HIV and AIDS, although latterly it is hospice, palliative care, loss and bereavement that is emphasised within the curriculum. Palliative care and social work developed as a specialist pathway on the programme, attracting students on a national basis because of the palliative care focus. The teaching developed at this time covered such topics as:

- the hospice movement and history of palliative care
- theories of bereavement, health and illness
- health and social care policy related to palliative care
- visiting local palliative care agencies and funeral directors
- dealing with death and dying
- understanding death
- working with loss in a range of areas and situations.

The teaching was modular, representing a focused area of study that relates to social work with adults, children and families, but is linked to the programme as a whole meeting the requirements for social work qualifying awards. Originally, there were five aims to the programme, including:

- Providing a theoretical framework for understanding the processes of loss and grief.
- Examining ways in which this framework can help social workers understand personal and social changes and losses, and their effects on individuals and families.
- Looking at the meanings of loss and change with people who are dying, bereaved, sensory-impaired, facing loss by separation or as a result of substance use.