Cover Sheet

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TASA Conference
Re-imagining the Contribution of Sociology

Primary Stream
Health

Title

Expanding Role of Clinical Sociology in Australia

Dr. Les Spencer PhD; BBSc. (Hon) (psychology); BSSc. (sociology).
C/o James Cook University, Townsville, Queensland.

Email: tccenablers@gmail.com
Biography

A clinical sociologist in private practice engaging in follow-up writing following completion of PhD in 2006; received fifteen years mentoring by clinical sociologist Dr. Neville Yeomans between 1985-2000; engaged in sustained longitudinal action research with Yeomans over those 15 years; completed PhD on Yeomans’ Life Work; a member of the global body, ‘Association of Applied and Clinical Sociology’. Appointed by Centre for Integrated Development Studies, Philippines University in 2002 to use clinical sociology praxis during 2002-2005 to carry out action research in East Asia setting up an eleven-country psychosocial emergency response network.

Keywords/ Key Terms

Biopsychosocial; Clinical Sociology; Fraser House; Health Care Providers; Neville Yeomans; Victorian Workcover.

(Words 2991)
Expanding Role of Clinical Sociology in Australia

Abstract

This paper introduces clinical sociology as a humanistic, multidisciplinary specialty seeking to improve the quality of people's lives. It traces the emergence of clinical sociology in the United States in 1931, and in Australia in the late 1950's in the context of Neville Yeomans' pioneering of clinical sociology research into social transformation at Australian society's margins. A contemporary illustration is given demonstrating how a biopsychosocial model of health is now being implemented as World Best evidence based practice within the Australian Health Care delivery system. Arguments are given in support of a proposal for TASA to engage firstly, in dialogues with Health Care Agencies with a view to establishing Clinical Sociologists as an integral part of their health care delivery system, and secondly, in proposals supporting the expansion of education and training in clinical sociology.
Clinical sociology has been evolving internationally since 1931 (Fritz 1989: 72-95; Wirth 1931: 49-66). An international body called Association for Applied and Clinical Sociology has been formed (2008). Fritz defines clinical sociology in the following way:

Clinical sociology is a humanistic, multidisciplinary specialisation that seeks to improve the quality of people’s lives. Clinical sociologists assess situations and reduce problems through analysis and intervention. Clinical analysis is the critical assessment of beliefs, policies and/or practices with an interest in improving the situation. Intervention, the creation of new systems, as well as the changing of existing systems is based on continuing analysis (1992: 1).

Clinical sociologists work in the following capacities: as self-help/mutual help enablers, supporting social networking for wellbeing, community facilitators/organizers, socio-therapists, mediators, focus group facilitators, social policy implementers, action researchers, and administrators (Reback & Bruhn 1991: 10-14). The terms ‘self-help’ and ‘mutual-help’ refer to contexts where individuals and/or groups of individuals are proactive in terms of generating meaning and actioning towards wellbeing. Clinical sociologists may have expertise in various settings such as health promotion, sustainable communities, as well as relational mediating, intercultural interfacing and peacehealing during and after social conflict (Spencer, Cramb and Wijewickrama, 2005).
Clinical Sociology in the Australian Context

In Australia, one of the foremost clinical sociology pioneers was Neville Yeomans (Yeomans 1961a; 1961b; Clarke and Yeomans 1969; Spencer, 2006a). As well as being a clinical sociologist, Yeomans (1928-2000) was a psychiatrist, psychologist, biologist, and barrister. Yeomans was the founding director in 1959 of Fraser House, a NSW Health Department funded Therapeutic Community based psychiatric unit in North Ryde Psychiatric Hospital in NSW. Yeomans also pioneered community mental health in Australia and engaged in action research on all aspects of clinical sociology mentioned above (1965a 12: 66). Fraser House accepted people with mental disorders and addictions as well as people transferred from prisons. It was an 80-bed Unit with 13,000 outpatient visits per annum. The focus of change was the person-and-their-social-network. Members of the client’s family/friend social network were required to commit to regularly attend the Unit as outpatients as a condition of client entry. Yeomans evolved clinical sociology praxis in creating Fraser House as a social space where people and their family and friends could genuinely find themselves at home, and were able firstly, to constitute their own functional space of their own mutual making, and secondly, to reconstitute their social networks towards functionality, and thirdly, to take these functional networks out and create their own functional social spaces back in wider society.

Fraser House Big group meetings were held twice daily five times a week with 180 staff, patients and outpatients attending. The group meetings acted as ‘enabling contexts’ that aimed to increase the quality of personal resilience and interpersonal
relations through experiential learning and socio-therapy activities in order to increase the wellness of participants (Spencer 2006a: 218-227).

Yeomans used ‘experience’ in an early sense of the word meaning ‘to test out’. Yeomans called Fraser House a ‘transition community’. Everything was open for change - people, policies, processes, rules and the like. Things that worked in context were pointed out to those present, then repeated or adapted as appropriate to context. Those things that continued to work became ‘policy’; hence, ‘policy’ was ‘things that worked’. If policy did not continue to work, it would be adapted or discarded.

Yeomans was exploring how clinical sociology could contribute to societal transition at the personal, family and community level. Yeomans accepted half of the Fraser House intake from Mental Asylums and half from prisons. Fraser House demonstrated that dysfunctional people on the fringe of a society, with support, could be very effective in evolving new social forms together. Residents typically arrived at Fraser House with a small dysfunctional social network - usually with less than five members - and left in 12 weeks with a functional network of around seventy people (Spencer 2006a: 183).

Yeomans particularly adapted Australian Indigenous social cohesion processes in creating cultural locality - people connecting together through their connection to place. He also evolved relational mediating, where social and community relational mutual help processes are used in transforming individuals, groups, social networks, communities and societies towards wellbeing and new cultural ways of living together. Renowned anthropologist Margaret Mead, founder of the World Federation
of Mental Health visited Fraser House in the early 1960’s describing it as the best example of a therapeutic community she had ever experienced (Yeomans, 1965a: 68-69).

In the early 1960s, Yeomans set up the Clinical Sociology Research Study Group, also called the ‘Psychiatric Research Study Group’ in its liaison role with the Health Department. Yeomans and the Study Group existed as a multidisciplinary network including students of sociology, social workers, criminologists, community psychiatrists, socio-medicine students, social/community psychologists and educators. Consistent with its interests, the Study Group became a vibrant therapeutic community in its own right with a close working relation with Fraser House. Prison officers and parole officers with whom Yeomans had been working within the prison and corrective system also attended the Study Group. At one time there were 180 members on the Research Study Group mailing list (Yeomans 1965b 4: 24).

A comprehensive review of referenced scientific literature (in particular, a detailed examining of the contributions of Fritz (1982; 1989b; 1991a; 1991b; 1991c; 1992b)) demonstrating evidence-based efficacy of clinical sociology may serve in the further developing new and culturally relevant roles for clinical sociologists in Australia (Spencer 2008). The following section explores one such new role, namely, being included as Professional independent Health Care Providers by the Victorian Workcover Authority in providing sociological assessment and intervention in an area with a $425 million annual expenditure.
Social Reform of Workplace Health Care – Possible Roles for Clinical Sociologists

Since 2004, changes to Victorian WorkCover Authority’s guidelines brought in a ‘Clinical Framework’ that encompasses a biopsychosocial approach and classifies factors in, and potential barriers to recovery as:

- **Bio:** Body structures and functions
- **Psycho:** Personal and environmental factors
- **Social:** Activity/participation and environment

Victorian WorkCover is a world leader in instituting a biopsychosocial approach based upon the very latest evidence-based understandings of how biological, psychological, and social domains and processes are interlinked. What happens in one or more of these domains can affect the other(s). Biological intervention can have sociological and psychological consequences. The same cross-effects can come from intervention in the other two domains. As examples of biopsychosocial linkages, work stress is linked to accidents and injury. Depression, a problem for 800,000 people in Australia (Hickie 2002), is linked in part to work related stress. Research in 2003 found a link between depression, social isolation and lack of social support being significant risk factors for coronary heart disease (National Heart Foundation of Australia, 2003).

The investigation of the social domain calls for sociological assessment. Wellness in social relating tends to act as a wellness-promoting factor in other domains. The 2004 WorkCover change to a bio-psycho-social framework has extended the scope of
practice creating a potential role for clinical sociologists as Workcover professional care providers. Workcover Senior Policy Advisers have indicated that representations from the Australian Sociology Association about creating such a category would allow further dialogues to proceed. This paper recommends that the Association consider making such representation. The following section makes the case for using clinical sociologists as Workcover professional care providers.

Victorian Workcover Authority uses a ‘flags model’ whereby the existence of particular types of issues is a flag to take action. Flags are about:

.....significant barriers to recovery and can be used as an effective tool to guide decision making in clients/workers failing to improve. The development of persistent pain can be prevented by addressing the relevant barrier to improved function and return to work with the appropriate management strategy (2005: 6).

The Flags used by Workcover (2005: 6):

<table>
<thead>
<tr>
<th>Domain</th>
<th>Flag</th>
<th>Examples:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological</td>
<td>Red</td>
<td>Serious pathology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Co-morbidity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Failure of Treatment</td>
</tr>
<tr>
<td>Psychological</td>
<td>Yellow</td>
<td>Beliefs about pain and injury</td>
</tr>
</tbody>
</table>
Unhelpful coping strategies
Anxiety or depression
Passive role in recovery

Social
Blue
Low social support
Unpleasant work
Low job satisfaction
Excessive work demands

Other factors
Black
Threats to financial security
Litigation
Compensation thresholds

The existence of any one or more of these flags is a signal to carry out intervention in the respective domain by people skilled in that domain. A client/worker failing to respond to biological treatment is also a flag for sociological as well as psychological investigation.

The Framework provides the following caution:

Failure of a client/worker to respond to early injury management can lead to persistent pain and functional loss. To minimize the likelihood of this occurring, selecting a management approach specific to the individual client/worker’s needs is crucial (2005: 6).
It follows that if the need is sociological, sociological intervention is indicated. If the needs are unknown, sociological investigation is again indicated along with further investigation in the other two domains. Workcover’s Clinical Framework provides the following caution:

Pain of longer than three months duration can be referred to as persistent pain, and is usually the result of a complex relationship between physical and psychosocial factors. Psychosocial factors such as personality traits, mental health issues, counterproductive beliefs, and past experience often result in a set of behaviours that can affect and reinforce the pain experience. The client/worker’s presentation can vary enormously depending on the client/worker’s personal interpretation of this pain experience (2005: 7).

The Framework includes asking the following questions (2005: 6):

Which barriers are preventing the client/worker from returning to function and work today?

Would another form of treatment improve the client/worker’s rate of recovery?

Specific treatment modalities to overcome persistent pain include (2005: 7):

a) Challenging counter-productive beliefs about the injury, appropriateness of different treatment types and the importance of return to work
b) Reinforcing wellness behaviours and promotion of self management strategies

Again, if a client/worker has counter-productive sociological beliefs, experience, milieu, or behaviours, then a sociological investigation is called for, as well as sociological support in reinforcing wellness behaviours and promotion of self-management strategies. Speaking of those with persistent pain, the Framework states:

In light of the nature of persistent pain, a client/worker’s individual response and understanding of pain must be actively managed (e.g. appropriate activity may be useful rather than harmful). A bio psychosocial approach is imperative to achieving successful treatment outcomes in this difficult client/worker group (2005: 7).

As discussed earlier in this paper, clinical sociologists have the professional experience firstly, to provide the above-mentioned sociological interventions and secondly, to work closely with the professionals in the other domains.

Victorian Workcover (2008) reports that of 18,000 Workcover claimants in 2007, 5,300 claimants (29.4% of the total) were in the ‘over 12 weeks in chronic disability with or without chronic pain syndrome’ category. These 5,300 claimants received $425 million in payments – 80.4% of the total 2007 payments. Research indicates that these 5,300 belong to a group who may have a very high incidence of sociological and socio-emotional dysfunction contributing to the ongoing claim.
There is a need for sociological assessment, intervention, and socio-therapy supporting recovery for these 5,300 longer-term claimants, and for all claimants where the blue flag is triggered, or where the claim has exceeded six weeks. Awareness raising is also needed among care-providers in the other domains to recognise ‘blue flag’ and ‘black flag’ issues and recommend referrals to clinical sociologists.

It is proposed that as one example of evolving the clinical sociological role in Australia, clinical and other sociologists form a Working Group to research and prepare a document entitled:

Request to Include Clinical Sociologists as Health Care Providers

It is further proposed that TASA use that document to make representations to Victorian Workcover, Medicare and Private Health Insurers, Transport Accident Commission, and Veterans Affairs (Spencer 2006b: 15).

Background Briefing for Working Group

Along with the above discussion on clinical sociology, the following provides a background briefing for preparing the above-mentioned document and representations.

The clinical sociologist role entails becoming immersed in the social-life-world of others, and creatively supporting the active development of sociological perspectives,
behaviours and structures serving to facilitate improvement in the quality of people's lives. This role has been evolved by Dr Neville Yeomans and others in Australia and overseas. Clinical sociologist may operate at the micro (e.g. individual), mezzo (e.g. organizational) and macro levels (e.g. societal). Clinical sociology has evolved stand-alone praxis based upon the discipline of sociology, and primary re-socialising processes that complements, though differs from praxis within clinical and social psychology, community psychiatry, or social work.

A 'sociological intervention' by a clinical sociologist in the professional health care provider role would involve some or all of the following:

a) An initial examination and assessment of the individual’s relational dynamics in terms of their social resources and resiliency within a wellness context, especially identifying the presence of ‘flags’ as defined above

b) Sociological interventions actioned with the view to strengthening wellness promoting resources, and structuring illness and illness promoting factors as resources for wellness

c) Implementation of biopsychosocial standardised outcome measures to help guide and assess the efficacy of sociological interventions.

It is envisaged that clinical sociology undergraduate and postgraduate courses be evolved based upon Australian experience in the area and drawing upon overseas experience. The working group could work towards establishing recognition and
remuneration processes of clinical sociologists in the health provider area that are on parity with those of clinical psychologists. It is proposed that clinical and other sociologists form a Working Group to research and prepare a further document titled:

Strengthening Post-graduate Education and Training in Clinical Sociology

It is proposed that the research and the further document be used to evolve and make representations to relevant bodies to increase education and training in clinical sociology.

Summary

This paper has introduced clinical sociology as a humanistic, multidisciplinary specialisation seeking to improve the quality of people’s lives. It traced the emergence of clinical sociology in 1931 in the USA, and in Australia in the late 1950s. It introduced clinical sociologist Neville Yeomans’ action research on social transformation at the margins of Australian society, and outlined his contribution to the evolving of clinical sociology praxis through his work at Fraser House. This paper has outlined proposals for expanding education and training in clinical sociology and has made a case for TASA making representation to Victorian Workcover to create a category for clinical sociologists as professional care providers as one of many areas where clinical sociologists could play a significant role in contributing to the resiliency, health and wellness of the Australian Society.
References


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