AT THE COALFACE OF COVID-19

- Webinar Series for Medical Social Workers

20 June 2020 – 1 August 2020

Organised by:

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Preface

The webinar series for medical social workers (MSWs) titled "At the Coalface of COVID-19", provided valuable opportunities for health social workers to come together to share their practices as they undertook surmountable tasks of delivering services to meet critical needs of clients, innovate care delivery, and rethink social work practice in a pandemic situation. COVID-19 has impacted conventional social work practice, particularly in face-to-face interactions and casework interventions with vulnerable clients. The speed of change to protect citizens from the virus has disrupted work procedures and processes. Health social workers had to quickly put their acts together and work in close collaboration with the medical and other disciplines to protect the safety and well-being of the vulnerable clients. Beyond the clientele, social workers had to deal with emergencies when struck with positive COVID-19 cases in their own organisations.

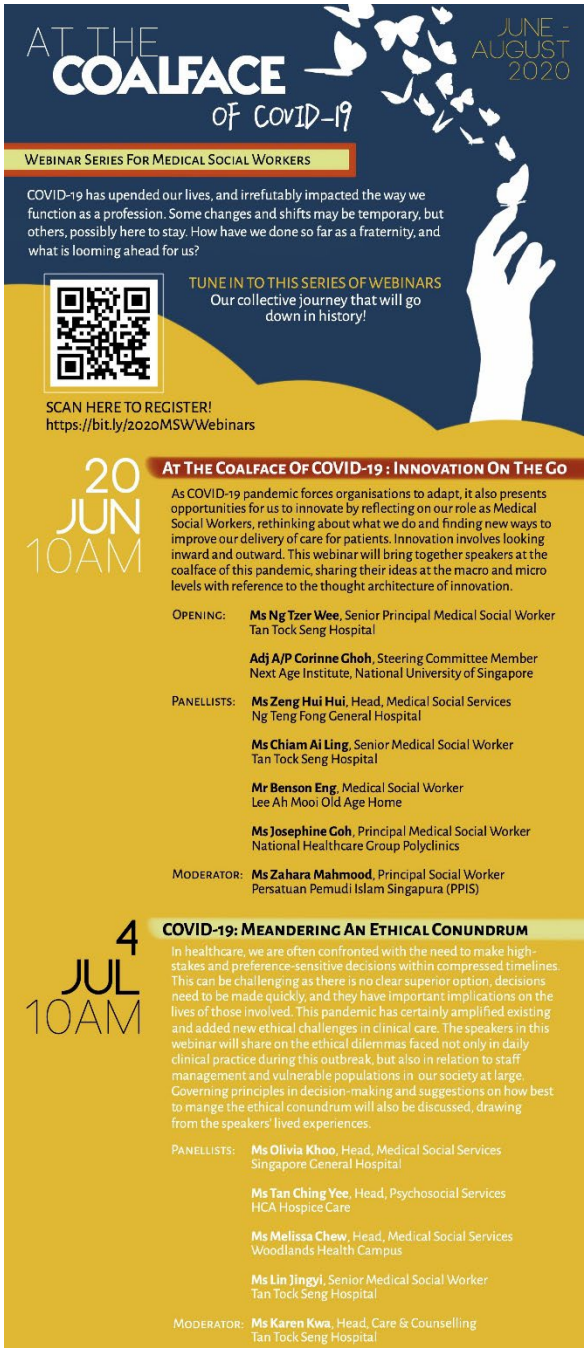
In total, 4 webinars were held between June and August 2020 with key topics focusing on innovation, ethics, leadership and futurology. A crisis may pose danger to lives and livelihood. But a crisis can also bring opportunities. Social workers need to ride on these opportunities, be innovative and strive towards new solutions to bring sustainable outcomes to clients. A crisis situation is also filled with uncertainty which presents ethical dilemmas in management and practice. Social workers have to continuously anchor management and practice on social work ethical principles and values so that the fundamentals of social justice and welfare of the individuals and families are adhered. Social work leadership is critical in steering organisations through difficult times, empowering staff to contribute meaningfully and in supporting them to navigating pathways for practice that is relevant and sustainable.

The MSW webinar series were very well received by social workers. More than 290 participants from the health and community social work field, academics, students and government institutions registered for the webinars. It is felt that the knowledge gained in the webinar series is very valuable for social work development and professional practice. The knowledge shared should be documented for education, practice and research purposes. It is with this in mind that we specially requested the speakers to spend some time writing out their pieces for this publication. We are indeed very grateful to the speakers for putting in the extra efforts in writing. This is possibly the first publication on social work practice in COVID-19 in Singapore. We hope that this publication will spur knowledge building in social work practice and encourage social workers to continue to strive, innovate and share their practices as they support the vulnerable clients impacted by the pandemic and advocate for their well-being.

Corinne Ghoh, Next Age Institute, National University of Singapore

Ng Tzer Wee, Tan Tock Seng Hospital

Webinar Program



Webinar 1: At The Coalface of COVID-19: Innovation on The Go

As COVID-19 pandemic forces organisations to adapt, it also presents opportunities for Medical Social Workers to innovate by reflecting on their roles, rethinking about what they do and finding new ways to improve delivery of care for patients. Innovation involves looking inward and outward. The webinar brought together speakers at the coalface of the pandemic, sharing their ideas at the macro and micro levels with reference to the 4 lenses of innovation – challenging orthodoxies, harnessing trends, leveraging resources and understanding needs.

Session 1: Innovation on the go at Ng Teng Fong General Hospital Medical Social Services

by Zeng Hui Hui, Ng Teng Fong General Hospital

About Ng Teng Fong General Hospital

Ng Teng Fong General Hospital (NTFGH) is a 700-bed public healthcare institution located in Jurong East, western region of Singapore. NTFGH is a member of the National University Health System (NUHS) cluster that delivers value-driven, innovative and sustainable healthcare.

The Medical Social Services (MSS) department has a team of 34 Medical Social Worker (MSWs) serving community, inpatient and outpatient services. The scope of services includes discharge and care planning, financial assessment and assistance, counselling and therapy, risk assessment and crisis intervention and information and referral.

Understanding Needs

Adapting Operations in Accordance with COVID-19 Restrictions

The Medical Social Services department (MSS) had drafted a pandemic plan prior to Covid-19 as part of their emergency preparedness planning. When the Ministry of Health (MOH) announced Disease Outbreak Response System Condition (DORSCON) alert to be Yellow in January, a change in operational procedures was necessary.

Regular roll-calls were conducted, and changes to workflows were easily accessible on bulletin boards for staff to refer to during emergency situations. This was done to ensure that there was proper and clear communication to all staff on MOH's and NTFGH's latest guidelines in handling suspected COVID-19 patients. NTFGH's outpatient MSS clinic first received a suspected COVID-19 patient on 24 January 2020. As MSS staff were informed on the workflow beforehand, this patient was successfully transferred to the Emergency

Department (ED) for follow-up. This encounter sparked the beginning of the MSS department's pandemic journey.

Responding to DORSCON Orange

Existing operational plans had to be reviewed and changed to fulfil DORSCON Orange requirements. Firstly, staff had to be segregated into new teams and the workload was redistributed accordingly. The office space was also redesigned to allocate certain office space and entrances to different teams in order to reduce cross contact. In particular, the MSS department was split into inpatient and outpatient teams.

Within the MSS inpatient team, staff were further segregated into hot-zones, clean-zones and standby teams. Standby teams primarily worked from home and served as back-up in the event that onsite teams were down. Through this team, they encountered first-hand the use of technology to enable them to work from home. For instance, the MSS department's IT representatives ensured that all staff had VPN access to allow continuity and connectivity in their homes, and physical meetings were replaced by virtual ZOOM meetings. In a short span of time, COVID-19 had catalysed these technological challenges, and MSWs had to adopt new and innovative ways to conduct their work.

Meticulous and effortful planning allowed the MSS department to be equipped to receive their first COVID-19 referral on 4 March 2020.

Meeting the Needs of the Migrant Worker Community

The height of COVID-19 infections in the month of April 2020 was a true test to healthcare institutions. In addition to caring for the COVID-19 patients in NTFGH, a portion of the hospital's manpower was deployed to the migrant workers' dormitories to support their care needs. In the true spirit of service, NTFGH had a team of 14 MSWs who volunteered their free time to assist these dormitories. Roles such as runners, pre-registration and registration personnel, swabbers and swab assistants were rotated amongst the volunteers.

During their time in the dormitories, the volunteering team had first-hand encounters with migrant workers. It was mainly observed that migrant workers appeared confused and displaced when they had to be quickly transferred to another care facility after testing positive for COVD-19. Thus, the team perceived that there was a need to address the migrant workers' health concerns and consistently provide information about the pandemic situation .

Making Adequate Preparations for Psycho-Social Interventions in Emergency Department (ED)

NTFGH's ED was one of the designated care areas to receive dormitories' migrant workers who tested positive for COVID-19. ED would receive daily batches of migrant workers, going up to as high as 90 in a day. The ED recognised an additional need to address the migrant workers' mental health concerns and requested for the MSS department to render psycho-social interventions.

In order to do so, a landscape and environment study of the ED was first conducted by MSS to assess the resources and space available to support these interventions. Additionally, hot-zone MSWs received instructions on infection control measures, such as the navigation of specific routes in ED to put on Personal Protection Equipment (PPE) and go to cleaning-down areas before returning back to main office.

Given that the migrant workers' length of stay in ED was short, it was perceived that they would benefit more from a quick and standardised psycho-social model of care. As such, a literature review was conducted to gather information on the relevant crisis interventions during a pandemic. This resulted in a triage form being developed, with the World Health Organisation's (WHO) 7 themes of Psychological First Aid (PFA) in mind. It was then translated and handed to all staff in ED.

The form guided MSWs to assess and understand the migrant workers in the following areas:

1) Current emotional state
2) Main concerns
3) Suicide risk
4) Coping mechanisms
5) Support system
6) Practical needs
7) Hopes
8) Need for information on health and care plan

MSWs were able to triage 98 migrant workers over a span of two weeks in the ED's holding space. It was gathered that a lack of information in the following areas heightened anxiety within migrant workers: health condition, care plan, accommodation arrangement, and their chances of returning to work. Thus, mitigating factors could be the timely provision of information regarding things such as their medical condition, mental well-being, and discharge destination.

Furthermore, ensuring social connectedness with their families and friends and receiving spiritual support was essential as well. MSWs ensured that telephone support was available to patients during their admission. To improve migrant workers' accessibility and connectivity to social support, posters of wi-fi set-up and support hotlines were also designed and placed in common areas used by migrant workers, such as the hand-washing sinks.

The hot-zone MSWs worked on different tasks but shared a common goal of serving and meeting the new needs of migrant workers. The strong teamwork allowed MSS to commence their service in the ED holding space on 27 April 2020.

Leveraging Resources

It was also understood that migrant workers would benefit from psychoeducation of COVID-19 – its illness trajectory and journey towards recovery. As such, COVID-19 information kits designed by MOH and non-profit organisation, HealthServe, were consolidated. These kits were translated to their common native languages for easy understanding. Thereafter, MSWs worked with the nurses in ED to ensure that migrant workers were given an information kit once they arrived. The nurses' station was also transformed into an information-kit kiosk for workers to self-service.

MSWs were also mindful to leverage on technology to aid in their tasks so as to reduce infection risk and improve efficiency. For instance, the earlier landscape study led MSWs to discover a projector in the ED, which was later utilised to showcase multi-media presentations. Specifically, COVID-19 videos created by HealthServe were pre-downloaded and screened on a regular basis. These motion graphic presentations helped to reiterate information on COVID-19 to the migrant workers, especially for those who were less literate.

On 21 April 2020, NTFGH also converted Jurong Community Hospital Basement 2 into a temporary 140-beds holding space for COVID-19 migrant workers, supplementing the one in ED. The utilisation of available facilities in the vicinity was crucial to expand operations and cater to the growing number of patients.

In addition, NTFGH collaborated closely with social workers from the Ministry of Social and Family Development (MSF), National Centre of Infectious Diseases (NCID) and National University Hospital (NUH) to ensure that integrated care was rendered to patients and their family members staying in different hospitals. This collaboration sparked further discussions on innovation among the MSW fraternity for upcoming COVID-19 work.

Reflections: Impact of NTFGH's Emergency Department Interventions

In conclusion, MSW interventions in ED centred around innovation and empowerment of ED staff and migrant workers. MSWs made use of the limited resources in ED and re-designed the existing space to meet the needs of the migrant workers. In order to sustain the care and service rendered, a supportive space within ED was established, which helped to empower ED nurses to conduct psychoeducation with the migrant workers in the absence of MSWs. This supportive space within ED also empowered migrant workers by enabling the self-service of information and resources. While mental and psycho-social health could be neglected in times of a pandemic crisis, the MSS department's two weeks of intensive intervention in ED showcased an important role that MSWs can play in bridging such gaps.

Session 2: The MSW Experience at NCID

by Chiam Ai Ling, Tan Tock Seng Hospital

Overview of the National Centre for Infectious Diseases

The National Centre for Infectious Diseases (NCID) is a purpose-built facility to handle and contain infectious disease outbreaks. It is a 330-bed facility which can be expanded to accommodate 500 beds. Various types of wards include:

- One high-level isolation ward
- Five negative pressure wards
- Five isolation wards
- Four cohort wards
- Two intensive care unit (ICU) wards.

NCID also houses the following:

- A screening centre
- Clinical services consisting of an outpatient clinic, operating theatres, a diagnostic laboratory and a pharmacy.
- The Department of Care & Counselling comprising a team of four medical social workers (MSWs) attending to patients with Covid-19, with the remainder tending to the Business-As-Usual workload.

Timeline of Events

NCID began preparing for the potential outbreak in early January 2020 (Figure 1). The first outbreak ward opened on 6 January 2020, followed by the screening center on 29 January 2020. The Department of Care & Counselling received their first referral on 31 January 2020. In total, as of mid-June 2020, more than 160 referrals were received.

Normal health care delivery was rescheduled so as to divert manpower and resources to handle the outbreak. For example, elective surgeries were postponed and surgeons were deployed to run the screening centre in February 2020.

The highest daily attendance recorded at the Screening Centre was 520 on 23 March 2020.

Figure 1: Timeline of Key Events in NCID During the Covid-19 Outbreak

Understanding Needs

MSWs had to stay abreast with frequently changing processes and guidelines. This included gaining medical knowledge in order to answer queries regarding COVID-19-related matters. Some frequently asked questions by patients and family members were:

- "When can I be de-isolated?"
- "Can I enter the room to see my father/mother already?"
- "My parent came in for COVID. He already tested negative for COVID-19, why is he still so critically ill?"
- "Why did the doctor say my oxygen level is low even though I feel fine?"

Attending to Patients

With regards to the above issues, patients and family members were thus provided with as much information as possible to allay fears and anxieties. As contact with patients were to be minimized as much as possible, MSWs adopted the practice of utilizing the telephones outside of each room to communicate with patients regularly and check in on how they were doing. This was especially important when patients' families were unable or not allowed to visit. Maintaining regular contact with patients helped MSWs to build trust and rapport in the working relationship, which would later go on to become crucial especially for patients without a good prognosis.

Very commonly, patients found hospital food very bland. Wherever possible, MSWs tried to purchase or receive food on their behalf. Other miscellaneous but important things also included helping patients to connect to Wi-Fi, obtain phone chargers, and remit money.

Managing Complex Emotions

In cases where the affected patient was infected by another family member, issues of blame and guilt had to be dealt with. MSW then had to engage the patient to process what had happened with the family members involved. In addition, ICU cases saw very strong emotions coming from patients and family members. When death occurred, MSWs had to facilitate the challenging process of saying good-byes via video call for a patient's loved ones.

In essence, MSWs in NCID provided psychosocial and practical support for issues such as:

- Accommodation for homeless patients
- Childcare and eldercare (e.g. when their caregivers were warded)
- Uncertainty, isolation and anxiety
- Stigma and blame
- Grief and bereavement

Leveraging Resources

Technology has been very helpful for NCID MSWs in facilitating some level of connection with patients. Every room in the NCID ward is fitted with a glass door and equipped with two telephones – one inside and one outside the room – to enable healthcare professionals to speak to patients without coming into contact with them. Family conferences were rearranged to take place in the MSW office instead of the ward to accommodate more people, and video call arrangements were made for families who were not able to come in person. The screening of videos for migrant workers was also made possible through the television in each room.

Working with Agencies

NCID received support from HealthServe, a non-profit organisation dedicated to serving migrant workers, to call patients in the wards to screen for issues which might require additional support from NCID.

Assistance was also provided to allow family members on Quarantine Order or Stay-Home-Notice to visit dying patients. This was made possible by liaising with agencies such as the Ministry of Health (MOH) and the Commercial & Industrial Security Corporation (CISCO). In one such instance, a family had to seek approval from MOH to allow them to visit their dying father in the ward and arrange for subsequent funeral services. However, the process of seeking approval was assessed to be distressing as they were grieving over the impending loss of their father. MSWs then tried to coordinate with MOH on the family's behalf and appealed for exceptions to be made in order to expedite the approval process. It was poignant for the family members to receive such assistance. Feedback was given that the whole team had shown the family a lot of kindness and compassion.

Challenging Orthodoxies

Making Exceptions to Meet Socioemotional Needs

At an earlier point in time, NCID allowed only four registered visitors for patients who were dying. Due to this restriction in visitor policy, MSWs received many requests to allow more family members to visit. There were two of such instances that involved some degree of case advocacy work. In these instances, the main consideration was to balance caution with compassion.

First, an unconscious and intubated patient in the ICU had to be cleared of COVID-19, but was unfortunately also dying from a severe brain bleed. This patient had a close-knit family of five members who were all described to be very close to her. However, the family had to choose four amongst them to visit and spend the last moments with her. A grand-daughter who was very close to the patient was left out. MSWs had to advocate for the grand-daughter and finally managed to obtain approval for her to visit the patient in her last moments.

In another instance, a patient had passed on while his wife was in another ward in NCID. MSWs had to break this upsetting piece of news to her and advocate for a photograph of the patient to be taken in order for the wife to accept the reality of the loss.

Reflecting on Assumptions of Health Inequalities

The COVID-19 pandemic has shown us that certain populations are more greatly affected than others, for instance, the escalation of cases amongst migrant workers. Various theories in literature have attempted to explain why health inequalities occur.

Psychosocial explanations posit that income inequality results in social fragmentation, that is, the breakdown in social support and trust. This perspective focuses on how social inequality has an impact on the way people see, define and evaluate themselves and their behaviors. In short, people's sense of control and subjective sense of social positioning is salient for their health, which possibly explains marked differences in health outcomes between different socioeconomic status (SES) groups. Subscribers of this perspective would seek to tackle social and income inequality, improve social cohesion, empower individuals, and reduce stress in workplace. The work of Sir Michael Marmot illustrates this perspective.

Alternatively, radical political theories emphasise political barriers to individuals in certain groups that hinder them from living healthy lives. Certain groups are actively discriminated, resulting in health inequalities. Subscribers of this perspective would focus on minimising or removing structural factors that result in discrimination.

Therefore, examining one’s beliefs and assumptions concerning health inequalities is important because it could frame the way one engages with their patients. It is important to be aware of how we see our role in enabling people to have good health. Some reflective questions would be: Do patients fall sick because they fail to take good care of themselves?

Or do they fall sick because of issues in the broader structure of society that contribute to poor health?

Questioning the Use of Technology as The Best Solution

Technology can be a bridge, but it can also be a divide. On one hand, while the use of Zoom video calls helped to facilitate contact between patients and family members, NCID also observed that some migrant workers faced difficulties with this technological shift to online platforms. For instance, some workers did not have smartphones to contact their families. Moreover, while QR codes were created for these workers to access educational videos on COVID-19, most of them did not use QR codes. Subsequently, NCID had to look at alternative methods such as screening videos through the television sets in their rooms. However, this probably met only a fraction of their needs while waiting to be cleared of COVID-19.

Moving forward, tele-social work may become a new norm. As human touch and relationships are central to the profession, it would be important to carefully consider how this would impact social workers and their clients. Innovative solutions that arose from this pandemic are raising questions on whether technology is the best solution to address human problems: Can the use of a mobile application or technological device really meet the core needs of clients? Can technology get to the heart of what social work seeks to accomplish? It is crucial to be sensitive to the needs of the clientele population one is working with and be explicit about what the use of technology seeks to achieve.

Harnessing Trends

Moving forward, it is imperative to anticipate future needs. The local healthcare system has diverted manpower and resources to deal with the COVID-19 outbreak. In doing so, there could be some aspects that were overlooked.

The Impact of Continued Social Distancing

While Singapore has transitioned to Phase Two of the 'Circuit Breaker', one cannot preclude the possibility of going back to stricter social distancing measures if a spike in cases were to occur. One of the many key considerations, then, would be to find ways to keep socially isolated elderly not just safe at home but also physically, mentally and socially engaged as the loss of cognitive and social well-being increase risk for dementia.

The Impact of a Shrinking Economy

With physical health, mental health and employment being closely interrelated, there is a need to consider how these three factors impact individuals and their families. As they continue to be affected by a shrinking economy, there is a need to examine how best to assist them in coping with issues such as the stress arising from unemployment and financial difficulties.

Serving the Vulnerable and the Oppressed

We believe that social work values can guide us in managing challenges presented in the pandemic. The case of COVID-19 infections amongst migrant workers has shed light on the values of service to humanity and social justice. It is essential to consider how the migrant worker community could be served better, and to advocate for changes such that they are not subjected to poor living conditions that put them at a higher risk in a next outbreak. While there may not be concrete answers to this yet, it is still necessary to reflect and have conversations about our role in serving the vulnerable and oppressed.

Concluding Remarks

While social work responses in this pandemic might be deemed innovative, it might also simply be us looking at possibilities within constraints and questioning where exceptions can be made to meet socioemotional needs. Innovative solutions might be needed, but should one innovate for innovation's sake?

Smaldino & McElreath observed that "In the years between 1974 and 2014, the frequency of the words 'innovative', 'groundbreaking' and 'novel' in PubMed abstracts increased by 2500% or more. As it is unlikely that individual scientists have really become 25 times more innovative in the past 40 years, one can only conclude that this language evolution reflects a response to increasing pressures for novelty, and more generally to stand out from the crowd."

Nevertheless, the goal of social work remains rooted in caring for and pursuing change for those who need it. We must not forget our role and time-tested strengths. We must recognise them and seek to apply them consistently in our work.

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Session 3: At the Coalface of Covid-19: National Healthcare Group Polyclinics

by Josephine Goh, National Healthcare Group Polyclinics

The National Healthcare Group Polyclinics (NHGP) forms the primary healthcare arm of the National Healthcare Group (NHG). NHGP provides a comprehensive range of health services for families – treatment for acute medical conditions, management of chronic diseases, women and children health services, and dental care. In addition, they have a team of allied health professionals comprising medical social workers (MSWs), psychologists, dieticians, physiotherapists and podiatrists. NHGP has six polyclinics that serve a significant proportion of the population in the central and northern regions of Singapore. During the pandemic, these polyclinics conducted Covid-19 swab tests for patients based on doctors' medical assessment.

Making Changes to Meet Patients' Healthcare Needs

Prioritisation of Services to Minimise Contact

A few days before the official announcement of the Disease Outbreak Response System Condition (DORSCON) Orange, leaders of NHGP's allied health professionals came together to discuss and plan for changes to operations. This included making changes to manpower allocation for all six polyclinics and NHGP headquarters, as well as determining essential and non-essential areas of patient care. It was crucial for information to be prompt and clear, and be accurately disseminated to all staff to ensure that decisions made were in line with the constantly changing protocols regarding safe distancing and other precautionary measures.

When DORSCON level rose from Yellow to Orange alert on 7 February 2020, doctors, nurses and allied health professionals in NHGP's polyclinics started making calls to patients to reschedule appointments so that physical visits to the polyclinics could be minimised. For instance, MSWs and social work assistants (SWAs) hastened to make phone screenings with patients in order to determine the urgency of appointments. By assisting patients remotely, MSWs helped reduced the need for patients to travel to the polyclinics.

Additionally, patients with stable medical conditions could arrange for medication delivery service or proceed with the usual self-collection at pharmacies. All staff, including MSWs, were not allowed to cross over to different polyclinics clinics to prevent cross infections. Thus, all staff reported to the same clinic for work.

MSW Assistance Provided to NHGP and Their Patients

While understanding patients' needs may not be totally unfamiliar to MSWs, the Covid-19 pandemic was still an uncharted territory for many. Many had to keep up with information on existing and new community resources as well as adhere to ever-changing protocols. The following summarises the various assistance provided by MSWs since the onset of DORSCON Orange (Table 1):

Psychosocial Management of Cases during DORSCON Orange	
1.	Assistance with accommodation issues for persons who were homeless during Circuit Breaker (CB)
2.	Management of suspected child abuse and marital violence for families
3.	Brief support for vulnerable cases identified by MSF Adult Protective Services & Family Violence Specialist Centres
4	Monitoring of frail elderly living alone via phone calls
5.	Counselling support for caregiver stress, emotional issues
6.	Referral for meals delivery assistance for persons on mandatory 5-day medical leave
7.	Referral to Social Service Office for financial assistance due to loss of employment and/or income

Table 1: Assistance Provided by NHGP's MSWs

Leveraging on Resources in NHGP and the Community

Virtual Meetings: Tele-consultations and Staff Engagement

The use of tele-consultation by NHGP doctors was expedited in this pandemic. It has now become a viable alternative to seeing patients in person. Even among NHGP staff, virtual meetings have replaced face-to-face meetings. Moving forward, virtual meetings may potentially become a new norm for patient care, staff meetings, and trainings. There is also great potential for tele-collaborations amongst agencies to meet virtually.

Contactless Patient Welfare Fund

Additionally, MSWs tapped on the Patient Welfare Fund (PWF), a pool of petty cash which can assist patients who have financial difficulties with emergency cash and transport fares.

As the virus may be spread via surface areas and objects, the usual process of PWF claims involving patients' signatures on the PWF Payment Voucher had to be reviewed to allow the process to be contactless. As such, changes were made for the process to be more flexible. For instance, MSWs would request for taxis via mobile applications for patients who require financial assistance with their taxi fares to return home after their Covid-19 swab tests. This eliminates the need for patients to sign on the PWF Payment Voucher, as MSWs would just have to state the reason and no signatures were required.

Social and Health Integration

NHGP's Ang Mo Kio Polyclinic had also initiated a collaboration with AWWA Community Home for Senior Citizens for the former's doctors to provide Tele-Consultation Services via Zoom. The residents of the sheltered home under medical follow-ups at Ang Mo Kio Polyclinic and with stable medical conditions were invited to enroll in this initiative.

Challenging Orthodoxies and Going Beyond

MSWs and SWAs alike had to juggle between psychosocial management for patients and frontline duties. Some were deployed to the front entrance of polyclinics to support patient registration and triage work. Others were deployed to NHGP's headquarters, working remotely from home to assist with administrative duties allocated by Clinical Services.

While video calls and teleconsultations may be the new norm, there were some concerns raised. Some questioned the possible lack of human touch in video calls which might impact the quality of therapeutic alliances that professionals seek to build with patients and their significant others. Others highlighted cyber safety issues. It was then a timely reminder for all to consider weighing the greater risk of patients being infected with Covid-19 in the polyclinics against the aforementioned concerns.

Concluding Remarks

Even when the exposure to a high volume of patients and caregivers was exhausting and induced fear of the risk of infection, it was heartening to see staff willing to move out of their comfort zones and even take on extra duties. Moreover, while strict infection control measures made work at the frontline more challenging, it was widely understood that these were in place for the safety and well-being of every individual. With everyone's cooperation and help to update one another on the ever-changing protocols, staff could swiftly adapt to these changes.

Despite the unprecedented challenges that the Covid-19 pandemic brings to healthcare professionals, NHGP's medical social services remains steadfast and supportive of one another in their work. Even with uncertainty becoming a part of their everyday lives, staff demonstrated resilience and bravery in the face of the unknown. Together with all other professionals in NHGP, the healthcare system remains in good hands to carry on their fight against Covid-19.

Session 4: Managing COVID-19 Cases in Nursing Home – Adapting Social Work Practice through Innovative Solutions

by Benson Eng, Lee Ah Mooi Old Age Home

Introduction

Lee Ah Mooi Old Age Home (LAM) is a family-run private nursing home which receives funding from the Ministry of Health (MOH) to care for subsidised residents. LAM caters to the low-to-middle income group, serving mainly families from the sandwiched class who are not eligible for government subsidies. Currently, LAM has expanded to 2 locations, namely in Thomson and Silat, with about 200 residents and 100 staff across the 2 homes. The mean age of residents are above 70 years old, and residents stay on average 3.5 years in LAM. 90% of

residents are in categories 3 and 4 in the Resident Assessment Form; indicative that they require high levels of care, and 43% of the residents have dementia.

Residents in LAM have a wide range of needs. Essentially, the social worker renders psychosocial and emotional support to residents and their families and provides palliative and bereavement care to residents who are unwell, dying or who may be separated from their families. For example, the social worker helps families and their loved ones navigate through issues of life and death by facilitating conversations about Advanced Care Planning (ACP). In addition, they provide financial counselling, as well as handle admissions, provide information, and make referrals. LAM also collaborates with various organizations such as hospitals, hospices, and social service organizations to provide a more holistic care approach for the residents.

Understanding Needs

LAM had its first COVID-19 case on 31 Mar 2020. This became a cluster of 11 cases on 1 Apr 2020, with a couple of residents eventually succumbing to the virus.

Impact of COVID-19 During the Initial Crisis Period

The emergence of the first Covid-19 case presented LAM with a new and unprecedented crisis. Residents and staff were greatly impacted during the initial crisis period, with everyone facing a similar fear of getting infected.

Residents felt fearful, anxious and depressed. They were greeted by unfamiliar people decked in full personal protective equipment gear. Moreover, they were not allowed to see their loved ones, and had their daily routines disrupted as group activities came to a halt. LAM also received many calls from distressed next-of-kin (NOKs), who were anxious to know if their loved ones were affected.

It was therefore crucial to provide sensitive, timely communication and support in times of such a crisis. In particular, LAM took steps to ensure that complex and distressing information was conveyed empathically and sensitively to residents and NOKs. For instance, scripts on how to inform NOKs in an appropriate manner and frequently-asked-questions expected from NOKs were disseminated to staff. NOKs who felt overwhelmed by the complex COVID-19 situation were then referred to LAM's social worker to receive psychosocial support.

For instance, there was a senior NOK who had many worries and concerns about her loved one whenever she read about new COVID-19 cases in the newspapers. She would then call up every other day to check and ask what measures LAM had taken. It was assessed that this NOK required a high degree of connection and emotional assurance during this distressing time. Thus, the social worker would acknowledge and respond to the NOK's anxieties over the multiple uncertainties arising from the unpredictable nature of the disease. This was in addition to empathising with the NOK on the multiple restrictions that resulted in a lack of opportunities for her to meet with her loved one and LAM's medical team.

On the other hand, staff who were infected with COVID-19 were struggling with feelings of both fear and guilt. It was essential that emotional support be provided to them as well. Affected staff had to be promptly quarantined, and remaining staff worked with new care teams and work around new routines and restrictions. Unfortunately, some staff were even evicted as their landlords were fearful about getting infected.

Impact of Covid-19 During the Circuit Breaker

Stricter work measures had to be enforced. This included:

- Split work zones
- Arrangements for staff to work from home
- Staggered work days and hours
- Telecommunication
- Arranging for accommodation and food delivery for staff
- All non-nursing staff to avoid entering all wards to protect residents and staff

The following observations were also made:

- Elderly residents were increasingly isolated from social distancing, circuit breakers restrictions. Residents were feeling increasingly restless, depressed and anxious.
- Families were also feeling frustrated and guilty as they were not able to visit their loved ones

With these restrictions and worrying observations arising from the circuit breaker, LAM was pushed to adapt their practices with innovative solutions. The home had to proactively develop, support and implement remote models of service delivery wherever feasible, so as to ensure safety. The transition away from face-to-face services led LAM to formulate new ways to manage with creativity, compassion and resilience.

Harnessing Trends and Leveraging Resources

For a start, LAM harnessed existing telecommunication channels such as email, Whatsapp, and videocalls for the purpose of disseminating important accurate information to staff as well as NOKs in a timely yet sensitive manner.

LAM's next few steps were as follows:

- Review the available technology for video call and teleconferencing.
- Decide what suits LAM's needs (e.g., system that allows NOKs to book the appointments on their own)
- Consider client's connectivity and availability of resources (e.g. some senior NOKs might not have smartphones, internet, and were not tech savvy)

- Consult client's or family's preferences on connecting with one another (e.g. some clients or families still prefer to talk on the phone)

LAM then started a new initiative 'FamilyCONNECT' for the residents to continue to connect with their loved ones. To date, LAM had managed to help connect 90% of their residents with their loved ones.

It is worth commending that LAM had to implement all these measures under the media's spotlight and the intense pressure of handling logistical issues. Fortunately, they received strong support from Tan Tock Seng Hospital's (TTSH) medical social workers, as well as the National Centre for Infectious Diseases (NCID) in managing the crisis and supporting the work.

Challenging Orthodoxies

LAM had to go out of the way to meet the needs and requests of the residents and their NOKs. In particular, there were two of such heart-warming instances.

During the circuit breaker period, a resident's son specially ordered a bouquet of flowers and requested it to be presented to the resident on her birthday. Upon knowing that, the social worker worked with the team to videocall the son when the flowers arrived and sang a birthday song together with him for the resident. It was an emotional moment for everyone in the team.

In another instance, there was a resident's daughter who was used to visiting her mother daily but could not do so due to the restrictions. The resident, who has dementia, was getting more restless and agitated. Her appetite became poor, and she kept asking for her daughter. The team decided to inform the daughter that they would wheel the resident out for her meals and activities, and place her near the window so that they could wave through the window. The team even placed a chair outside for the daughter to sit while watching her mother go about doing her activities. When the resident saw her daughter, she started to eat again. It was a touching sight.

Helping to make these connections and meeting these needs were practical, emotional and social in nature. These needs were met in the context of systemic work – supporting not just the individuals but their loved ones, around the issues and concerns that matter to them most.

Managing operations in such a crisis also gave rise to valuable insights and unique observations that would otherwise not surface. Firstly, using alternative platforms for communication enabled LAM to connect residents with NOKs who had children living in different parts of the world, something that LAM was unable to do in the past. Some NOK who did not bother much in the past, became more concerned and wanted to connect with their loved ones more during this period. Furthermore, the team was able to observe family

dynamics through these short interactions; enabling them to better understand the families in their work with residents.

Conclusion

Going forward, Phase 2 of the Circuit Breaker will bring new challenges. For one, LAM is currently looking at how best to arrange face-to-face visitations for NOKs with restrictions still in place, while simultaneously trying to accommodate and meet requests.

We are in uncharted waters.

> *"COVID-19 has had a profound effect on the ways we social workers support our clients. New and painful restrictions force us to transit from our familiar face-to-face services provisions to our clients to different forms through innovative solutions. These will lead us to formulate, experience and witness new ways of creativity, compassion and resilience as we emerged from this adversity. We must continue to advocate and support our clients and ensure that they are not adversely impacted when the provision of services become more difficult as we enter into post circuit breaker period and beyond."*
>
> Benson Eng
> 20 June 2020

However, every cloud has a silver lining for us and for us it is that one of our oldest residents, Mdm Yap, aged 102, managed to pull through this ordeal. The Home celebrated her return, as well as the rest of the recovered patients with their favourite food like ice-cream and durian puffs etc. The media uses her story to give hope that we all can get through this together.

Part 2: COVID-19: Meandering an Ethical Conundrum

In healthcare, we are often confronted with the need to make high-stakes and preference-sensitive decisions within compressed timelines. This can be challenging as there is no clear superior option, decisions need to be made quickly, and they have important implications on the lives of those involved. This pandemic has certainly amplified existing and added new ethical challenges in clinical care. The speakers in this webinar shared on the ethical dilemmas faced not only in daily clinical practice during the outbreak, but also in relation to staff management and vulnerable populations in our society at large. Governing principles in decision-making and suggestions on how best to manage the ethical conundrum were also be discussed, drawing from the speakers' lived experiences.

Session 1: Bioethics VS Social Work Ethics

by Lin Jingyi, Tan Tock Seng Hospital

Introduction

Social workers have been at the forefront of supporting individuals and families at the hospital and in the community throughout the COVID-19 pandemic. Amidst a public health emergency, medical social workers have duties and obligations not just towards the care of their patients and patients' families, but also their fellow colleagues, their healthcare organisation and the society at large. There is a duty to respond to the national crisis and protect public interests which includes the preservation of public health and scarce healthcare resources. However, the ethical principles guiding medical care and public health policies are not always aligned with the ethical values that inform our practice. These conflicts between core professional duties and ethics give rise to ethical dilemmas. In such situations, social workers have to decide which principles or values should take precedence.

Medical, Public Health and Social Work Ethics

In medical care, the widely adopted ethical framework is based on the four principles of autonomy, beneficence, non-maleficence and justice, put forth by Beauchamp and Childress (2013). Medical ethics accord priority to patient autonomy (Kass, 2001), where a patient has the right to refuse treatment, or consent to proposed interventions unless there are specific circumstances where obtaining of consent is not possible. This principle is upheld in social work ethics due to our emphasis on self-determination, seen as part of upholding the dignity and worth of the person. Our clients' autonomy may only be overridden under narrowly defined circumstances. One example would be the scenario where a client has no mental capacity and no legally appointed substitute decision-maker, the worker may act on patient's best interest under the principle of beneficence for the purpose of linking them to a place of care or protection. Another example would be a scenario where the client's autonomous actions and liberties potentially causes harm to self or others. Here, the power to override autonomy may be vested in legislations related to infectious disease - where

mandatory isolation, treatment or quarantine may be required, or mental health laws where compulsory admission and treatment are concerned. In the aforementioned examples, the public's benefit takes precedence over the client's self-determination.

One way that medical and public health ethics differ from social work ethics is the profession's definition of what is best interest of the individual. In medical ethics, the physician acts to further the interest and well-being of the patient by recommending evidence-based treatment. Likewise, public health policies are formulated to protect and maximise the health of the population at large. Such an approach can sometimes be construed as paternalistic, because what is good for the person or public is determined by the professional. However, the principle of beneficence is not explicit in the social work code of ethics. Instead, our code of ethics requires us to act with integrity and competence in line with an ethics of care, to "support (our clients) in working through their own problems within the scope of their own resources, and having due regard to their personal well-being" (SASW, 2017, p.3). Social workers often collaborate with clients, seeking to support and empower them to decide and act in ways that *they* think are best for themselves.

Another way that public health ethics might differ is in the conception of justice. In public health emergencies, the approach may become primarily utilitarian where the focus is on achieving maximum health for the overall population. On the other hand, social work's concept of social justice requires us to "pursue social change, particularly with, and on behalf of, vulnerable and oppressed individuals and groups of people." (SASW, 2017, p.1). Such an approach tends to be more egalitarian - with the imperative to not only increase the overall health of the population but to reduce health inequalities - as opposed to utilitarian or libertarian. Social workers have a calling to challenge social inequalities and uphold human dignity including fundamental human rights. Where our ethical responsibility to society is concerned, we have a professional obligation to not only respond to national crises - through our commitment to preserve the welfare of society - but also advocate. This includes "giv(ing) feedback on policies and social conditions that are deemed detrimental to individuals, families and communities". (SASW, 2017, p.9)

There is strong impetus for public health and interests to trump over respect for individual autonomy and liberties which may be a derogation of obligation to uphold certain individual rights or provide individuals with access to non-essential services in order to conserve scarce national resources, preserve the aggregate public interests or protect public safety. Most people would therefore not find it objectionable for the imposition of restrictions on certain individual rights, autonomy or liberties if it is necessary for the protection of public interests. This does not mean that the interests of clients, especially the vulnerable and marginalised populations, should be sacrificed for the sake of public health.

There has been evidence that the lockdown measures used to reduce the spread of COVID-19 have disproportionately affected disadvantaged populations, widening health

inequalities and social injustice (Bergamini, 2020; Vesoulis. 2020). When a lockdown requires non-essential workplaces to close, people engaged in precarious work risk losing their employment and suffering financial hardship. Where people are asked to work or study from home, disadvantaged individuals with no access to internet and relevant technological devices may be at a disadvantage. When social services such as day care, day rehabilitation or senior activity centres are asked to temporarily shut down, elderly or persons with disabilities who utilise such services may begin experiencing functional decline or social isolation. Such restrictions also mean that family members might not be able to visit their loved ones in the hospital or nursing home. In this instance, social workers may be caught in an ethical dilemma between keeping in step with the public health policies that also protect the marginalised population, and advocating for the interests of our clients who may be disproportionately affected by these policies compared to the general population.

Ethical Framework for Decision-Making

To reconcile these ethical dilemmas and conflict between public interest and individual needs, national crises and public emergencies, it is important to have an ethical framework to help guide decision-making in both its processes and outcomes. The framework is made up of both procedural and substantive values. Procedural values are values that guide the process of deliberation and decision-making while substantive values are values that can be realised through the outcome of a decision (Xafis et al, 2019).

In ethical conundrums, there is often no clear right or wrong. The social, cultural and political context of the situation, and facts of the case are pertinent to the decision. Where there is an intersection of social work, medical and public health ethics, we often consider all the relevant values in the decision and try to strike a balance between the competing substantive values. These values may include the principles of beneficence (or public benefit), non-maleficence (or harm minimisation), social justice, respect for persons (including autonomy and dignitary interests), proportionality, solidarity, reciprocity and stewardship of resources. However, we should also consider what constitutes as ethical values in the process of decision-making. Such values include the need for public accountability, consistency of decisions, inclusiveness by engagement of relevant stakeholders, responsiveness through regular review according to the changing circumstances, and transparency through openness in communicating the rationale behind the decisions.

Procedural Values	**Substantive Values**
Accountability	Beneficence Public Benefit
Inclusiveness/ Engagement	Non-maleficence (or harm avoidance/ minimization)
Transparency / Openness	Social Justice

Trustworthiness	Respect for Persons (including autonomy and dignitary interests)
Consistency	Proportionality
Responsiveness	Solidarity
	Reciprocity
	Stewardship of resources

(The values are adapted from the works of Thompson et al, 2006)

In ethical decision-making, we identify the conflicting substantive values that are engaged in the decision, and apply ethical decision-making processes in seeking to reconcile the competing values. For example, when the risk of community transmission is high, or when there are limited healthcare resources to deal with the pandemic situation, there is a strong case to uphold public benefit and ensure stewardship of resource. In this case, respect for autonomy may take a backseat, and a utilitarian approach to preserving as many lives as possible may be warranted. Social workers may communicate to affected parties the rationale behind the decisions, while also helping them understand the impacts of such policies on their well-being. However, in scenarios where the harm caused to clients - by the prevailing policies - outweighs the anticipated benefit to public health, social workers should advocate for the needs of clients, or seek ways to uphold their rights and interests.

While prolonged lockdowns result in an increase of interpersonal violence or severe mental health issues such as depression or suicidal thoughts (Taub, 2020), social workers have a duty to protect the immediate safety of affected vulnerable individuals. The principle of proportionality - that require the balancing of our ethical responsibility to both our clients and society - should apply. Proportionality means that the degree of interference to individual rights or access to services must commensurate with the magnitude and severity of the national crisis, and the public benefit that the interference is purported to bring. Severe restrictions can only be justified if the crisis is severe and if there are no less restrictive ways which may bring about the same level of public protection or benefit. An example would be how certain countries may have to deny specific classes of patients from access to ventilators based on their projected poor health outcomes in order to conserve ventilators for others who may have better outcomes. However, public health and safety should not come at the expense of the lives or safety of individuals, especially if these individuals belong to marginalised populations of our society. Social workers should be responsive in highlighting the needs of these individuals, or to ensure these individuals can still access health or social services, or go to a place of safety. Social workers may advocate for certain groups of at-risk or vulnerable individuals to be granted an exemption from movement restrictions in order to seek help. Exemption guidelines must be clear and transparent so that they can be applied consistently by relevant officers or practitioners, and information about community resources or helplines must be promptly and widely disseminated so that individuals in need know where they can turn to.

Another common issue in the Covid-19 pandemic is the imposition of visiting restrictions in hospitals and care homes. Family members who are unable to physically visit a terminally-ill patient may be at risk of having complicated grief, as their emotional needs may not be adequately met through alternative means like video calls. Social workers should hence assess the potential risk to the individuals, and if necessary, decide with the multi-disciplinary team if the burden imposed on the individual is disproportionate to the amount of public protection conferred by the restrictive policies. If restrictions must persist, then the principle of reciprocity must apply through finding ways to meet the emotional and relational needs of the patient or family even if it is only to a limited extent. If the distress caused to the affected individual(s) is high (or even life-threatening), social workers should advocate for their clients for changes or exemptions in these public health policies. This is also where policy makers or decision-makers must also be open and responsive in reviewing the policies according to the latest pandemic situation and considering appeals or exceptions when there are strong valid reasons. Procedural values would be pertinent as decision-makers must be transparent in articulating the basis for their decisions (regardless of whether changes or exceptions are granted) and formulating clear guidelines which can be consistently applied by practitioners.

Conclusion

As social workers operating in a public health crisis, we carry different ethical lens from our medical or public health colleagues. With our calling to act for and on behalf of vulnerable populations, we should constantly reflect on how our social work values fit with medical ethics and public health values. When faced with ethical dilemmas and competing values, we should not overlook the importance of ethical decision-making processes which is where a framework of both procedural and substantive values can guide us in our negotiation with other stakeholders and help us strike a balance between the interests of our clients and the society.

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Session 2: Social Work in A Unique Space of Healthcare

by Olivia Khoo, Singapore General Hospital

Introduction

Amidst the COVID-19 pandemic, there are several words that have been utilised to categorize the roles and responsibilities of professionals in the healthcare setting – "essential" versus "non-essential", "frontline" versus "non-frontline", "clinical" vs "administrative". With the surfacing of such definitions, we begin to find that the practice of medical social work in Singapore sits on a unique space in the healthcare landscape, seen while we attempt to navigate through this pandemic. As a social work department in the hospital, we seek to complement and address the key psychosocial-emotional needs of patients through our services. The department administers financial assistance for healthcare cost, ensures proper care plans are in place when patient is home and supports the emotional and psychological needs of patients who require support, especially when faced with a traumatic or distressing health incidence.

At a systemic level, the department provides ground-up feedback on operational processes and policies that require refinement during this unprecedented time. Herein lies the question - Are we therefore considered essential, frontline and clinical? Or can our role be seen as complementary given its administrative nature and remote access possibilities. Inevitably, the course of meandering this uncharted and unprecedented crisis has also presented dilemmas in practice.

In this paper, I seek to focus on the conundrum of leadership and management of a 100-strong team at the Singapore General Hospital, an acute 1700-bed tertiary hospital that received Singapore's first COVID-19 patient on 23 January 2020.

When COVID-19 Knocked On Our Doors

What became more unprecedented for the department was having a staff diagnosed with COVID-19 on the night of Friday, 13 of March 2020. She had presented the onset of symptoms since 3 March 2020 at the staff clinic and was given medical leave to rest. She returned to work after a week and her symptoms persisted before she was officially diagnosed.

Back then, as it was barely six weeks after COVID-19 hit our shores, many of the measures were yet to be concretized such as the donning of masks, which was encouraged only when one was unwell while practices such as safe-distancing was still a foreign behaviour. As a result, almost 40% of the staff were placed on home quarantine by the Ministry of Health while others were placed on either home isolation or phone surveillance by the hospital. This was because mask was not donned when the staff was at the administrative area and staff could still inter-mingle rather freely.

When contending an unknown enemy like COVID-19, the fear of the virus becomes even more real especially exacerbated by the intimate experience of it affecting our own colleagues while having to be placed on quarantine. Not to mention how colleagues might be especially concerned about how being placed on quarantine could affect their loved ones.

From a psychoanalytic perspective of the ego at play, it is absolutely vital to develop empathy during this difficult time and subsequently during the Circuit Breaker where the country is expected to come to almost a complete halt. Following the announcement of the infected staff, there were about 25 staff members who felt unwell and about six were admitted for observation the next day. Subsequently, another staff was diagnosed with COVID-19. As the staff work through their fears, the care and concern from the department's peer support team and supervisors helped to provide an avenue to articulate their concerns. The use of technology such as a group chat was setup for those who were on Home Quarantine Order which injected much fun and support for one another.

Five staff were cleared for work as they did not have contact with the infected staff. The department was challenged to reorganize itself to work remotely the following Monday. The skeletal staff strength worked to service the walk-in patients while the home team were split into two teams to support namely the inpatients through phone consultations and interviews, and the outpatients for financial assistance. The whole-of-hospital approach to support the department was deeply felt when the staff received notes of care and concern from colleagues from all the different departments such as the information technology team for effecting the virtual private network overnight, the multidisciplinary clinical teams for triaging the cases and the operations team like call-centre for answering patients' queries. Despite the limited staff on-site, the team was able to continue providing round-the-clock crisis and grief support during the two weeks. Telecommuting became a cornerstone for

financial applications and care planning. It was truly supererogatory with focus on what is the best for patients and the department.

The Head-On Gave Head-Start

This gave the department a head-start to deal with the Circuit Breaker where the reality of the virus hitting home meant that more changes had to be made to our work processes. By then, the department had become more responsive and was able to customize work arrangement even further to cater to staff with varied needs.

The first group of staff affected were those with children who had existing childcare arrangements and those with school-going children. While contending with the uncertainty of caregiving and home-based learning, the fear of getting infected by coming to work becomes heightened in some colleagues. One-on-one engagement was being done the hour after the announcement of Circuit Breaker was made on 3 April 2020, especially with those with children and required special work arrangements to accommodate the limitation in caregiving. Those who expressed no issue with child-care continued with their current work arrangement and the department explored alternative work arrangement such as working from home or staggered hours for those who expressed challenges managing the demands of family and work. Balancing between professionalism in ensuring that work is done while keeping to the sanctity of family becomes paramount to managing staff morale.

Leading the team through the Circuit Breaker calls for leadership in effecting the expectations of our professional duties, meeting the needs of the team and navigating through the demands of the environment and unprecedented changes.

At the other side of the team are staff who do not have children but remain fearful for themselves and their families. The first task was to ensure that staff reduce their time onsite where possible. The department introduced a four-day compressed work-week for the support staff to reduce travel, staggered hours for the inpatient MSW team to avoid peak-hour travel where possible and made work-from-home a possibility for those who were managing outpatients for financial assistance. It involved a change in practice from face-to-face to phone assessment which was put in place when the department's manpower was affected by the quarantine.

An Attempt at Balancing Fairness

As leaders in a pandemic, we are challenged to an awakening experience to deviate from our traditional way of understanding and doing things. This is especially so when the department had a high regard for punctuality. It was rather disconcerting to effect a work arrangement that did not clock 42-hours, no requirements for physical reporting and having different variations of working shifts and patterns with an attempt to ensure fairness. Patient-

care no longer requires actual face-to-face contact but remote connection through phone and video calls.

From the above, fairness can be viewed as subjective when there is an attempt to be equal. However, during a crisis where actions needed to be swift to meet the best outcome of ensuring safety and service continuity, the leadership needs to accept that it is not possible to exercise fairness and provide everyone the same treatment in work arrangement.

In communications, the focus was to articulate the broad policy intent and cite examples of what was done in other teams and environment and then linking those examples back to how it affects the staff and their work. It was critical to exhibit empathy and concern for staff safety and what was being done to address these concerns by the department's best ability. There is always a need to keep the communication channel open and be prepared to address concerns at any time. Staff should be made to feel that things are not cast in stone and that there is always room for further discussion.

Leadership should strive to do their best in communicating and accepting a diversity of views. Undergirding the words and intent in communication should be the aim in producing the greatest good, perform the right action and strive for eventual growth for the team.

The Conundrum of Decisions

Every decision yield different reaction, and rather than evaluating if a decision is right or wrong, it would be more constructive to consider that many things are permissible actions from the ethics point of view – where it is neither right nor wrong. The key is to always tend towards a supererogatory action where possible, where the greatest good can be achieved. In such times of crisis, emotions can be raw and high as one is confronted with many uncertainties and yet challenged to make unprecedented changes, on the personal front, professional realm and most of all, one's perspective on existentialism.

The role of leadership in such times of crisis should be aimed at stabilising and unifying the team. The teams could generate ideas which may run contrary to the leader's perspectives. It is helpful for leadership to facilitate these ideas and remove the barriers, including barrier of the leader, in order to allow the ideas to become decisions as much as possible. This creates opportunities for empowerment and leadership growth in these teams.

In navigating these uncharted waters of the management of a social work service and team in the face of COVID-19, the tenets of social work philosophy invariably become an important guide both in ensuring service rendered to the clients and managing the teams. In all things done, there must be a focus towards ensuring fairness. Fairness is not about equality but equity, to help everyone level up as much as possible. As every circumstance provides

opportunities for change and growth, COVID-19 can yield possibilities for an evolution of how work is structured in a client-fronting practice.

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Session 3: Navigating the Ethical Conundrums in the Community Palliative Care Setting in Singapore during the COVID-19 Pandemic

by Tan Ching Yee, HCA Hospice Care

Introduction

The community palliative care services in Singapore provide home hospice and day hospice services. It caters to patients with life limiting illness; have prognosis of less than a year and who are cared for at home or in a long-term care facility. The services are mostly managed by non-profit voluntary welfare organisations (VWOs) funded by government grants and donations. There are currently eight organisations providing home palliative care and four centres providing day palliative care services in Singapore (Palliative Care Services – Singapore Hospice Council, n.d.). The palliative care teams are staffed with at least a multi-disciplinary team of doctors, nurses and medical social workers.

Impact of COVID-19 on Community Palliative Care

As COVID-19 became widespread with the increasing number of community transmission in March 2020, (*Singapore's Circuit Breaker and beyond: Timeline of the COVID-19 Reality - CNA*, n.d.), strict measures were implemented to curb spread of the disease. Restrictions were placed on health and social care services as well as businesses. Community palliative care services were deemed as essential services, thus home hospice services remained accessible to patients within strict infection control and safe distancing measures. For day hospice services, it was stipulated to run at reduced capacity. Social workers had to deliberate and decide which patients would continue to access day hospice services.

There were also restrictions on cross institution visits which meant that the palliative care team could not provide care to nursing home residents. Strict visitation policies and workplace team segregation practice also affected the transition and co-ordination as patients saw different social workers and healthcare professionals who were not familiar with their situation. Certain social and healthcare supporting the patients and families in need were designated as non-essential and were bounded by stringent criteria for admission while service provision such as home visits were permitted for crisis and urgent situations. To circumvent these limitations, social workers were encouraged to provide monitoring through video consultation and phone calls.

The impact of these measures challenged care delivery, decision making and also co-ordination of care of patients. Table 1 summarizes the some of the key challenges experienced by patients and families as well as the healthcare professionals.

Challenges experienced by patients and families	**Challenges experienced by healthcare professionals**
1. Fear of contracting COVID-19 and thus reluctance to go to hospital for treatment and/and refuse visits by home palliative teams.	1. Patients/Families refused visits by healthcare professionals for fear of contracting COVID-19 from staff.
2. Strict visitation policy in hospitals and hospices give rise to fear of not being able to be close to the patient and risk of dying alone. Thus, patients and families delay and at times refused admission into hospital and hospice despite inadequate care at home.	2. With reduced capacity in day hospice, social workers with healthcare team had to decide who remained on day hospice care
3. Patients who were admitted into hospitals during COVID-19 felt abandoned and isolated during the admission. This led to resistance in seeking treatment in hospital when subsequent needs arose and brought about risk associated with delayed interventions.	3. Not all social service and care providers were whitelisted. These providers conducted visitations only for high-risk cases. With varying definitions of high risk, there were implications on accuracy of assessment and timeliness of intervention and access to services for patients and families who were known to multiple service.
4. Primary caregivers who were lone caregivers especially experienced increased stress due to limitations on visitations by other family members during circuit breaker period. With	4. Negotiating between respecting patient's wish to die at home and yet being aware of caregiver's inability to cope and the reluctance to consider

limited family supported, they struggled to provide care with the hope to fulfil patient's wish to die at home with limited support.	admission into hospice due to strict visitation policy.
5. Families have to accept and adjust to the limited nature of funeral rituals and practices and its symbolic meaning as they bid goodbye to the deceased.	5. Staff's worry over personal safety and well-being of their family members while at the same time recognise their duty to care for patients and families.

Table 1: Summary of key challenges experienced by patients and families as well as the healthcare professionals.

Approach to Ethical Deliberation

When faced with ethical dilemmas, decisions are often made through multi-disciplinary team discussion. This involves evaluating the needs of the patients and families, understanding the circumstances involved and arriving at a decision that is within the ethical, legal and moral boundaries.

Social workers are guided by the core values of social work described in Code of Ethics for Social Workers in Singapore (*SASW Code of Professional Ethics - 3rd Revision (Online).Pdf*, n.d.). The ethics principles guiding social work practice are derived from these core values as described in Table 2.

1. Service to Humanity	Social workers put service to others above self-interest.
2. Social Justice	Social workers pursue social change, particularly with, and on behalf of, vulnerable and oppressed individuals and groups of people.
3. Dignity and Worth of the Person	Social workers treat each person in a caring and respectful manner, mindful of individual differences, and cultural and ethnic diversity.
4. Importance of Human Relationships	Social workers understand that relationships between, and among people are an important vehicle for change.
5. Integrity	Social workers act honestly and responsibly, in accordance to the profession's mission, values and ethical principles.
6. Competence	Social workers continually strive to increase their professional knowledge and skills, and to apply them in practice.

Table 2. Six social work core values (*SASW Code of Professional Ethics - 3rd Revision (Online).Pdf*, n.d.)

A framework that is helpful in guiding social workers in their clinical ethics case analysis is the four topics approach (Schumann & Alfandre, 2008). Schumann & Alfandre (2008) explained that the four topics approach was developed to help clinicians in ethics decision making process by examining the circumstances of a case and linking it to their underlying ethical principles namely beneficence, nonmaleficence and respect the patient's autonomy. The authors presented a set of questions as described in Table 3, which may be asked in case analysis in relation to the four topics i.e., medical indications, patient preferences, quality of life, and contextual features. Through the analysis of the various points on the case, it will help guide professionals in their discussion with patients and families to arrive at a decision that respects the patient's preference and values.

MEDICAL INDICATIONS	**PATIENT PREFERENCE**
Beneficence and Nonmaleficence • What is the patient's medical problem? History? Diagnosis? Prognosis? • Is the problem acute? Chronic? Critical? Emergent? Reversible? • What are the goals of treatment? • What are the probabilities of success? • What are the plans in case of therapeutic failure? • In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?	**Respect for Patient Autonomy** • Is the patient mentally capable and legally competent? • Is there evidence of capacity? • If competent, what is the patient stating about preferences for treatment? • Has the patient been informed of benefits and risks, understood this information, and given consent? • If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making? • Has the patient expressed prior preferences (eg, advance directives)? • Is the patient unwilling or unable to cooperate with medical treatment? If so, why? • In sum, is the patient's right to choose being respected to the extent possible in ethics and law?
PATIENT PREFERENCES	**CONTEXTUAL FEATURE**
Beneficence, Nonmaleficence, and Respect for Patient Autonomy • What are the prospects, with or without treatment, for a return to normal life?	**Loyalty and Fairness** • Are there family issues that might influence treatment decisions?

• What physical, mental, and social deficits is the patient likely to experience if treatment succeeds? Are there biases that might prejudice the provider's evaluation of the patient's quality of life? • Is the patient's present or future condition such that his or her continued life might be judged as undesirable? • Is there any plan and rationale to forgo treatment? • Are there plans for comfort and palliative care?	• Are there provider (physician, nurse) issues that might influence treatment decisions? • Are there financial and economic factors? • Are there religious or cultural factors? • Are there limits on confidentiality? • Are there problems of allocation of resources? • How does the law affect treatment decisions? • Is clinical research or teaching involved? • Is there any conflict of interest on the part of the providers or the institution?

Table 3. Specific questions on four topics used in clinical ethics case analysis (Schumann & Alfandre, 2008)

Applications to Practice

The following section demonstrates the application of the social work core values and the four topics approach in deliberating and decision making on the challenges experienced by healthcare professionals due to COVID-19.

Challenges	Core social work values applied	Ethical principles applied
1. Patients/Families refused visits by healthcare professionals for fear of contracting Covid-19 from staff.	**Service to Humanity; Dignity and Worth of the Person; Importance of Human Relationships** Social workers acknowledge the fear and concerns of the family and continues to work on maintaining a supporting working relationship with family by offering options of connecting via phone calls and video consultations.	**Beneficence and respect patient's autonomy** The team considered the factors such as medical condition, prognosis and possible trajectory of illness and educate the family on treatment options and avenue of help if urgent need/crisis arises.
2. With reduced capacity in day hospice, social workers with	**Social Justice; Competence** Social workers reviewed the list patients and identified patients	**Beneficence, Nonmaleficence**

Challenges	Core social work values applied	Ethical principles applied
healthcare team had to decide who remained on day hospice care	who have greater social risks and vulnerability such as isolation, neglect/self-neglect, emotional and psychological distress etc. in the deliberation. Consulted medical and nursing professionals and supervisors to ensure all needs are addressed. Patients who could not attend day hospice receive regular monitoring and support with help of volunteers.	While there are benefits of patients attending the day hospice due to their social needs, measures were taken to ensure safety of all patients through stringent screening of every patient before they embark on their travel to the day hospice centre.
3. Not all social service and care providers are whitelisted. These providers conduct visitations only for high-risk cases. There were implications on accuracy of assessment and timeliness of intervention as well as accessibility to care.	**Service to Humanity; Social Justice; Importance of Human Relationships; Integrity; Competence** Multi-agency conferences were held on virtual platforms to share assessment and plan of action. Taking a collaborative approach which recognises the limitations and boundaries of service providers yet clarifying options for exceptions to be made, social workers sought to advocate and appeal for timely interventions to ensure needs are addressed. Escalating the issues to higher authority for advice and directions may be needed to address barriers to interventions.	**Beneficence, Nonmaleficence** Sharing pertinent information with service providers to facilitate holistic understanding of the complexity and urgency of needs help other service providers to prioritise interventions. This ensure that patient and family members are not disenfranchised as a result of the measures implemented to curb COVID-19.
4. Negotiating between respecting patient's wish to die at home and yet caregiver is unable to cope and the reluctance	**Dignity and Worth of the Person; Importance of Human Relationships; Competence** The social worker plays an integral role in facilitating communications between patients and family members in	**Respect patient's autonomy, Beneficence, Nonmaleficence** Conflict between patient and family members, between family members; or family members with healthcare

Challenges	Core social work values applied	Ethical principles applied
to consider admission into hospice due to strict visitation policy.(*More Terminally Ill Patients Staying at Home or in Hospice, Partly Due to Hospital Bed Crunch, Fear of Covid-19 Infection, Singapore News & Top Stories - The Straits Times*, n.d.)	the care planning process. It involves respecting that both patient and the family have their views and perspectives. Depending on the family dynamics, social workers use skills in facilitation, mediation, education to help patients and family work through the challenges. In the process, social worker ensures patient's interest and well-being are considered while facilitating understanding of the limitations faced by caregivers. The goal is to help patient and caregivers arrive at a consensus.	professionals can arises in the process of care planning. The role of the social worker and the healthcare team is to provide information on the trajectory of the illness, the anticipatory care needs so as to appraise the feasibility of the current care arrangement and rally resources to support patient at their preferred place of care where possible. The goal is to ensure the plan of care is sustainable, patient's safety and care needs are protected, and caregiver's needs is supported.
5. Staff's worry over personal safety and well-being of their family members while at the same time recognise their duty to care for patients and families.	**Service to Humanity; Integrity** It is important to acknowledge the fear and concerns of social workers. Organisations can provide information and offer assistance to alleviate their fear and increase their sense of safety. Ensuring sufficient supply of masks, hand sanitizer and provisions for safe travel during home visits etc. are some examples of interventions. Continuous affirmation from supervisors and management as well as establishing routines that support social workers' learning and platform for sharing help the team to return to a level of normalcy amidst the evolving uncertainties.	**Beneficence, Nonmaleficence** Providing facts of any arising situations and information to staff would help to alleviate fears that arises from misinformation or misperception. As staff might experience near miss situation such as transient contact with a suspected COVID-19 case, timely advice to staff on the required self-care measures will alleviate the worries and regain a sense of control over the situation. As we serve to care for the patient and their families, we need to be committed to ensure staff's

Challenges	Core social work values applied	Ethical principles applied
		safety is not compromised in the process.

Conclusion

COVID-19 brought about many challenges for patients, families, social workers and the healthcare team. Addressing these challenges require us to have the knowledge, skills and the aptitude to assess the context. In seeking resolutions of the ethical dilemma, the key factor that helps in decision making is to have an open, factual and honest communication with stakeholders – patients, families, teammates and partners in care. Only through seeking to understand the strengths, limitations and possibilities presented in the persons and context, will it help us formulate a plan towards an amenable outcome.

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Session 4: Ethical Challenges in Social Work Practice in working in a Community Care Facility in Singapore.

by Melissa Chew, Woodlands Health Campus

Introduction:

This paper is a reflection of the ethical challenges faced by medical social workers (MSW) in Woodlands Health Campus[1] during COVID-19 in a Community Care Facility in Singapore. In late March 2020, Woodlands Health Campus' Medical Social Work Department[2] was informed that it had been tasked to set up and run the Community Care Facilities[3] to provide care to stable or asymptomatic COVID-19 patients.

Key Presenting Issues Faced by COVID-19 Patients in A Community Care Facility:

Emotional coping

Patients with COVID-19 were having challenges coping with prolonged isolation, resulting in some missing special events in their lives or not being there for their loved ones when crises happened at home. For example, one of the patient's father had a major stroke and was very ill and the patient was unable to visit him. This was distressful for both patients and their next of kin during the period of isolation.

Being away physically from their loved ones for a prolonged period or from their normal daily routine, also greatly affected their emotional states. For some of the patients, they were moved repeatedly through various sites of care due to changes in their medical conditions. The common theme of feeling displaced, and lack of support further added on to their emotional distress. Some shared that they had insomnia and in more serious cases with prolonged social isolation, there were suicide ideations. Despite measures such as accessibility to Wi-Fi so that they could connect virtually with their loved ones, availability of food to show encouragement, and the provision of entertainment, exercises, and communal activities to keep them constructively occupied, some patients felt that these measures were insufficient as they continued to be emotionally upset.

Many were anxious over their medical conditions as COVID-19 brought uncertainties with regard to the impact on their current health and future well-being. Moreover, due to the economic situation impacted by the pandemic, many companies had to close, resulting in the loss of jobs which the patients were very fearful of. This sense of insecurity was experienced

[1] Woodlands Health Campus was found in 2017and was envisioned to be a campus with (1) a fully integrated acute and community hospital and intermediate and long term care facility that can offer seamless care for patients, and , (2)the practical technology to support a leaner healthcare manpower to deliver safe and effective care in Singapore. Though the campus will start operations only in 2022, it has started running its pre-operational work in both Tan Tock Seng Hospital and Yishun Community Hospital as it pilots its different models of care.

[2] Woodlands Health Campus' Medical Social Work Department[2] has a total staff strength of 24 Medical Social Workers and 7 Social Work Coordinator and Assistant and being nested in the two nesting hospitals, supporting both hospitals' pre-operations work in the wards and also the planning of processes in getting the Campus ready in 2022.

[3] Community Care Facilities (CCF) house both locals and non-locals in Singapore.

more predominantly by migrant workers who knew they would have to return to their home countries should they lose their jobs.

Financial Matters, Employment and Future Planning

Even though there were provisions for their basic pay, some of the patients who used to work extra hours to earn more pay, found themselves with lesser pay now as they were not able to work. This affected those who had outstanding loans or were the sole breadwinners for their families. There were also concerns that their companies might have to shut down and they would be unemployed.

Lack of Support for The Marginalised and Vulnerable

COVID-19 further escalated the dire state of the marginalised and vulnerable populations in Singapore. Besides the migrant workers' poor living situation in the dormitory, the medical social workers at the Community Care Facilities also had to support the financially vulnerable elderly who had no access to phones or technology which could enable them to stay connected and the homeless on the streets who were at risk of being infected.

Social Work Ethical Challenges Faced in The Community Care Facilities:

Continuity of care

One key ethical responsibility of social workers in practice was to ensure the continuity of care for patients after the termination of interventions. However, in the context of the pandemic situation, continuity of care - be it social or medical care - was impossible in such "war" times with ever changing rules, uncertainties and limitations of resources.

There were non-locals in the Community Care Facilities who had decided to return to their home countries after discharge from the facilities. However, some were diagnosed with chronic diseases during their admission to the facilities. There were concerns if they could receive medical care at their home countries, and whether medications would be available. As such, together with the multi-disciplinary team, the MSWs conducted checks if the countries that they were returning to have the required medications. However, this was inadequate as there were issues of the patients' ability to afford the treatment or have access to treatment after returning to their home country.

There were also situations where the patients needed to return home urgently after recovering due to their loved ones being critically ill. The MSWs had to work closely with the Ministry of Manpower and employers to assist with their return. In some instances, MSWs had to appeal to the various embassies to request for waiver of quarantine post return to the home country due to the urgency of the issue such as impending death of a loved one. However, the MSWs might not be successful all the time in the appeal as the final decision still laid with their home countries. There were cases where the patients were quarantined again back in their home countries and missed the chance to bid goodbye to their loved ones

who passed on. Despite the best effort to ensure continuity of care for clients, it might not happen cross jurisdiction which is beyond the means of MSWs.

Maintaining Privacy and Confidentiality in COVID-19 and Respecting the Patient's Rights to Self-Determination and Autonomy.

Maintaining privacy and confidentiality during COVID-19 was challenging as there was a need to use tele-consult as the main intervention method. In instances where the Community Care Facility lacked rooms for counselling, there were limits to maintaining privacy of patients. Under such situations, MSWs had to work within the space constraints as the harm of not seeing the patients for counselling outweighed the need to maintain privacy and confidentiality. MSWs had to find means to ensure that patients were comfortable and consented to the proposal before proceeding with the interventions.

In addition, there were lots of heightened emotions. It was common to come across patients who were very distressed, anxious and verbalizing thoughts of self-harm. The reactions were normal considering the abnormality of the situation. COVID-19 was a shock to everyone, and the situation was volatile. The rules kept changing, there were no clear guidelines and things continued to evolve. This was especially challenging for those with pre-existing mental health illnesses or mental health issues. There was an increase in cases with suicide ideation during COVID-19 which begets the question - "How do we balance working with patients in a therapeutic relationship and therefore continue working with them without the need to escalate further or should MSWs break confidentiality and call in for urgent psychiatric interventions?".

There were also challenging issues at hand when MSWs assessed that the patients may have mental health illnesses and yet realising that they trying to hide their symptoms to avoid treatment fearing the implications of losing their jobs or being stigmatised. A lot of work had to be done to engage the patients especially if their conditions could affect their work in future.

Advocacy and Social Justice

Key issues affecting the marginalised and vulnerable population in Singapore were highlighted during COVID-19. The key groups were the migrant workers, the homeless, the financially vulnerable and the elderly. These vulnerable individuals faced issues relating to access to provision of chronic disease treatment, living arrangement and conditions

However, during the pandemic, MSWs faced competing demands of work such as dealing with urgent need to facilitate the return of patients back to their home countries due to family crises, and in ensuring that the patients' basic physical and emotional needs were met in the Community Care Facilities. MSWs' resources were limited and had to focus on crisis at hand. As such, the struggles to advocate for social justice had to be balanced with the need to attend to urgent human needs. Advocating for matters such as ease of access to technology had to take a backseat.

Strategies to Support Working Through Social Work Ethical Challenges in Covid-19

Social Work Skills in Crisis Management and Ethos

Social work knowledge and skills in crisis management were essential in managing the ethical challenges due to the dynamic situation, uncertainty and strong emotions that arose from the patients due to impact of COVID-19. The experiences provided MSWs with insights to discern what was acceptable at intervention level and what needed further escalation to obtain support. In addition, the social work code of ethics guided practice and in empowering MSWs to make difficult ethical decisions, especially in areas pertaining to potential risk of harm.

Support

The sharing and discussion with fellow healthcare professionals who face ethical challenges in their daily work were helpful in resolving ethical dilemmas. Working in multi-disciplinary team members enable the taping on various subject matter experts in areas of crisis management, mental health or working with specific vulnerable or marginalised population. The sharing of experiences provided clarity and provided additional information that helped MSWs in thinking through the ethical challenges.

Future ahead in management of ethical challenges

Moving forward, it would be helpful for social workers to ensure :

a. Training and education in ethics and crisis management is an important part of training for social workers,
b. Informed practice, which calls for the constant need for social workers to learn not only new skills in social work but also in other areas of discipline,
c. Advocacy is taught as an essential part of social work training. Advocacy is an ongoing process in practice and social workers' skills in advocacy need to be strengthened.
d. Innovation in practice, which requires the constant thinking of ways to harness technology to improve practices. For example, in COVID-19, the use of tele-communication tool for counselling.

Through these preparations, it is hoped that social workers are better equipped and prepared for crisis in the near future, and are well placed to handle ethical challenges in crisis interventions.

PART 3: Medical Social Work Leadership on Trial

Leadership in crisis and change management are critical during COVID-19 times. The webinar explored the proactive strategies deployed, and innovation that had taken place in the process. The tension between managing the crisis and implementing the safety advisories, while ensuring investment in effective communication, are explored. With the theme of collective leadership in mind, we looked at how these leaders balanced the task at hand with the care and morale of their teams. The panellists also shed light on qualities essential for leadership during crisis times, and how leaders managed self-care even in the midst of it.

Session 1: Leadership on Trial: Reflections of a Social Work Leader in An Acute Setting

by Karen Kwa, Tan Tock Seng Hospital

Introduction

Founded in 1844 as a hospital for the poor, Tan Tock Seng Hospital (TTSH) is today, one of the largest multidisciplinary hospital in Singapore. TTSH operates more than 1700 beds with 5 centers of excellence, which includes the National Centre for Infectious Diseases (NCID). As NCID is a specialist center for treatment of infectious diseases, TTSH-NCID therefore have the national mission to be at the forefront of outbreak management.

The Medical Social Work (MSW) department in TTSH, termed as Care and Counselling Department, provides psychosocial care for patients receiving treatment from 36 medical disciplines in TTSH, including infectious diseases. As the Head of Department (HOD), my key role is to ensure that the department is able to deliver its scope of service optimally and ensure the well-being of my staff especially during trying times, such as a pandemic.

Challenges during COVID-19 outbreak

Singapore had its first COVID-19 imported case on 23rd January 2020, which was 2 days before Chinese New Year. I remembered having to attend a somber meeting conducted by TTSH senior management on Chinese New Year eve and thereafter call for an urgent meeting with all my staff to alert them about the situation. All I could tell them then was that there was an unknown virus and nothing more. At that point in time, there was little understanding of the virus and what we could expect next.

Right after the festive holiday, TTSH-NCID began our aggressive battle against COVID-19 as the number of infected patients soar. TTSH-NCID sprung into quick actions to prepare staff, our facilities, equipment, and services for the outbreak management. Leading my team in the battle against COVD-19 was certainly not easy. There were various challenges I had encountered and to overcome. They were as follows:

Challenge 1: Managing multiple demands

As a Head of MSW Department (HOD), I had to manage the many demands at staff, service and policy levels. TTSH was the first hospital to implement leave and travel restrictions even before the Ministry of Health (MOH) provided guidelines to all hospitals. Such restrictions were required in order to ensure that TTSH would have sufficient manpower resource to manage the crisis and ensure the well-being of staff. This naturally had impacted staff significantly, especially those who had to cancel their pre-booked holidays. I also had to manage the inevitable comparison some staff would make when they learnt that such restrictions were not impose at other hospitals and society at large. As a HOD, I had to enforce the restrictions knowing that it would not be favorable to staff. Fortunately, my staff were understanding and accepted the explanations given to them. Supportive letters were drafted to facilitate staff in their appeals to get refund for their paid holidays. Along the way, I also had to institute various other staff safety and surveillance policies (e.g. temperature monitoring, mask up, segregation and work from home), which required staff to make many adjustments both at work and in their personal life.

At the service level, we had to care for both our COVID-19 and business as usual (BAU) patients. Maintaining BAU services during COVID-19 certainly had its added challenges, especially with the various policy requirements, such as contact tracing and safe distancing. We had to quickly set up screening station at our clinic as well as designated room and workflows to attend to patients who presented to our clinic with acute respiratory infection/COVID-19 like symptoms. We also had to set up tele-conference, so as to minimise the need for our BAU patients to come to the hospital to receive the help they require and exposure risk. In addition, there were also requests for my staff to augment frontline functions such as COVID-19 screening at the hospital entrances and NCID screening center. Any staff deployed to these frontline functions means lesser manpower resource to manage my department's work demands. Nevertheless, we had a role to play to support the hospital's needs. As a HOD, it was indeed not easy for me to juggle requirements from BAU and COVID-19, especially in areas of manpower resourcing as well as ensuring that patient care and staff's well-being were not compromised.

Challenge 2: Managing uncertainties

Another challenge I faced was managing uncertainties. Together with some of my staff, we drafted an outbreak response plan before COVID-19 hit our shores. The plan was drafted based on our previous experiences with outbreaks such as Severe Acute Respiratory Syndrome (SARs). While some of the learnings from past outbreaks were helpful in our preparation for COVID-19 management, however, we had to revise our response plans to cater to the unique characteristics of COVID-19. Such revisions were difficult, especially in the early days when we had little understanding of what the COVID-19 virus would be like and could not readily anticipate the steps ahead. Leading the team into battlefield with lots of

uncertainties was difficult. We could only learn how best to manage the COVID-19 situation as we experience it.

Challenge 3: Managing rapid changes

With uncertainties came many rapid changes. We shifted from DORSCON green to DORSCON orange; circuit breaker to phase 2 within short notice and without much preamble. BAU wards at TTSH were converted to COVID-19 wards within short days in order to meet surge demands. Consequently, we had to respond quickly, and it felt to me at times like a whirlwind. Managing rapid changes was difficult for my staff and I, as before we could fully adjust to a change, we had to implement and adjust to another. As a HOD, I had to constantly think about the best way to navigate through changes with as little negative impact on my staff and patient care as possible.

Challenge 4: Managing competing priorities

Navigating through multiple demands, uncertainties and rapid changes were made more challenging when there were competing priorities. For instance, as a member of a taskforce managing the visitor policy, I had to deal with appeals by families to visit their sick loved ones in the hospital. Some of the more challenging appeals to manage were requests by family members who were on quarantine/Stay Home Notice (SHN), to visit their loved ones who were dying. While we understand that their journey back to Singapore to see their sick loved ones was not easy and that it is critical for them to have an opportunity to bid their farewell before the passing of their loved ones, we had to consider the risks involved and duty to protect all the vulnerably ill patients under our care as well as other visitors and staff in the hospital. Managing the ethical conundrum of compassion versus safety was often challenging, especially when many of Singapore's COVID-19 cases (with the exception of the migrant workers) were imported cases. We therefore had to prioritise safety over compassion and only permit exceptional visit when criteria were met. For those who did not meet the criteria for exceptional visit, we had to make the difficult decision to deny their entry to the hospital and manage their discontentment as well as complaints.

Challenge 5: Policies disconnect

There were many policies arising from the COVID-19 situation. Implementation of these policies on the ground could, however, be challenging at times in view that policies were sometimes crafted and rolled out without much consultation and communication with the ground. For instance, when SHN was first instituted, we had encountered Singaporeans who were put on SHN when they returned from neighbouring countries for their medical appointments. They were told that they could not return to where they came from until they had completed their quarantine. They were, however, homeless and did not have much money on hand to afford hotels. I had tried calling MOH for assistance, but they were unable to offer me much advice. They did not anticipate the needs of this group of patients and were, at that point in time, still formulating the workflows and resources for SHN. Eventually, I had

to rely on my own networks to resolve the issue. The process, however, required a lot of time and effort to convince relevant stakeholders to address the needs of this group of patients.

Challenge 6: Needs areas of needs

Another challenge I had encountered was new areas of needs arising from the COVID-19 situation. For instance, a senior consultant had shared with me that he was experiencing great fears and anxieties, as the COVID-19 situation had evoked his bad memories of SARs. From his sharing, I noted the importance of staff support in this pandemic but addressing staff welfare matters at the hospital level was taxing to my department's already stretched bandwidth. Such new areas of needs certainly post dilemmas. I had to deliberate how we could accommodate new service requirements without running the risk of over stretching my staff, which could lead to staff burnout.

Strategies to Manage Challenges

I had adopted eight key strategies to manage above challenges. They were as follows:

Strategy 1: Create structure and stability

It was important to stay calm and create structure and stability for my department amidst the chaotic situation, and to do so in a systematic fashion. Nevertheless, it was inevitable that I felt nervous or worried in the face of a crisis. It was, therefore, important for me to establish good support systems that could help me regulate these emotions, so that I could be an effective calming and stability force for my staff.

Strategy 2: Optimal decision-making

Mastering the art of weighing complex tradeoffs and deriving at a well-considered decision could help my staff and I better manage changes and high stakes in decision-making. We needed to develop the ability to do so within compressed timelines, as a crisis situation did not accord us the luxury of time to deliberate. Some of the factors that enabled us to optimise decision making include i) establishing the options we had at hand; ii) being clear of the benefits and harms of each option; iii) being mindful of the interplaying values and ground deliberation on right and shared principles as well as; iv) establishing a clear logic of reasoning and being open to share this with staff, so that they could better understand how a decision was made.

Strategy 3: Adopt both a preventive and remedial approach

In the face of uncertainties and rapid changes, it was important that we developed prevention strategies for foreseeable issues, as much as we needed to develop effective mitigation strategies to manage issues that arose. In TTSH COVID-19 staff wellness framework, for instance, we had prevention strategies to minimise staff psychological stress and mitigation strategies to support staff who were in distress. We felt that it was important to

utilise a two-prong approach to enable us to be responsive to staff's needs as well as minimise the development and exacerbation of issues till one reaches a breaking point.

Strategy 4: Effective communication

Effective communication is one of the cornerstones of management. Some of the important characteristics of effective communication included timely and comprehensive communication of critical information through mediums that could help staff receive and retain the information effectively. There were a lot of news about the COVID-19 situation on social media and some of the news were fake news. It was therefore important for us to curate the information we received and not share fake news and cause unnecessary panic. Safe distancing policy had also restricted the conduct of large size physical meetings. We therefore had to explore alternative ways of maintaining communication. For the past 6 months, I had been meeting my staff on every Wednesday instead of our traditional once a month departmental meeting, so that I could provide them with timely updates and check in on how they were doing. I also believe in the two ears and one mouth concept where, as leaders, we should listen more and speak less. We need to be mindful of our natural tendency to be more directive than consultative. It is therefore important for us to discern when we should create space for staff to have a voice on issues at hand or implementation of changes.

Strategy 5: Effective change management

In view of the rapid changes, it is important that we have effective change management strategies. Jo Owen, in his book: 'The definitive guide to effective leadership', talked about 3 key components of effective change management. They are: i) Setting up change to succeed; ii) Manage change process and iii) Manage change networks. He shared that it is important to set change up for success by helping people to understand how the change relates to them, what are the associated tradeoffs, ensure there is the capacity and resources to support change, celebrate early success so that we are motivated to change and reduce the risks associated to the change. He also shared about managing the change process well by recognising that change entails rational, political and emotional components. The valley of death is an interesting concept where he shared about how people may at times only embark on real change when they are at the bottom of the valley. Lastly, he shared about the importance of working with people who are ready for change first and building the right alliances and network in support for change.

Strategy 6: Fostering collective leadership

As a HOD, there was no way I could be everywhere at the same time and know in detail about all areas of work. I therefore strongly believe in collective leadership and that they could be leaders in all job grades. However, to achieve collective leadership, it is important for me to be willing to share power and control. At the same time, staff must also be willing to assume power and control as well as share responsibility for outcomes. To develop a

collective leadership culture, it was also important for me to role model and nurture shared decision-making as well as openness, trust, and mutual respect amongst staff.

Strategy 7: Be creative and explore new ways of working even in a crisis

The COVID-19 situation had thrown us with unprecedented issues and demands that called for creative solutions. For instance, in view of visitor restriction, we had set up a family communication facility, so as to enable family members to connect and communicate with their sick loved ones and the medical team in the ward. To manage the well-being of the high volume of migrant workers who were at TTSH-NCID for COVID-19 for treatment, we developed a Stay In Health (SIH) programme aimed at equipping the workers with the necessary health knowledge and skills, so that they could be better agents of their own health and healthcare.

Strategy 8: Attending to both objective reasoning and subjective affect

Lastly, I feel that it is important for leaders to be able to strike a balance between our heart and mind in management of issues. It would not be ideal if we only rationalise without attending to staff's affective needs or and vice versa. If we approach a crisis with only logic and relate to staff cognitively, they may consequently feel that the leader does not care and empathise with their struggles.

Conclusion

In conclusion, my leadership journey for the past 6 months had been full of ups and downs. Sometimes I felt sandwiched, sometimes I felt like I am pulled in many directions, sometimes I felt misunderstood and often times I worry for my staff's well-being and whether the services we had provided were meeting the needs of the patients we serve. Nevertheless, my leadership journey in the battle against COVID-19 was a rewarding experience as I have grown stronger and more resilient through adversities. Overall, I was able to develop my capabilities and qualities as a leader, create opportunities for departmental change, learn to appreciate my team and service needs better as well as foster working relationships in a whole different way. As the saying goes: "Never let a good crisis go to waste." (Winston Churchill)

Session 2: These Things I Must Do: Lessons from Ground Leadership during COVID-19

by Gideon Ng, Institute of Mental Health

Introduction

The Institute of Mental Health (IMH) is a tertiary psychiatric hospital that provides inpatient and outpatient services for the mentally ill in Singapore. As part of its efforts to allow persons with mental illnesses to remain in the community as far as possible, IMH provides outreach services alongside its Emergency Services (ES). The ES serves as the touchpoint when the illness necessitates crisis interventions.

The Medical Social Workers (MSW) is part of the multidisciplinary team that attends to cases presented at ES. MSWs are available at all times to provide social support for patients and their family members. The key mission of MSWs at ES is to provide emergency psychiatric crisis cases[4] so as to prevent unnecessary social admissions into the hospital.

Impact of COVID-19 on MSW@ES

The pandemic situation brought by COVID-19 necessitated several changes in service delivery at ES. Beyond a double fold increase in case referrals, there was also an increased complexity of cases seen by the MSW. Specifically, cases relating to foreign domestic workers and children tripled as some of them adjusted poorly during the period of Circuit Breaker.

Other new challenges that surfaced during this period, pertained to infection control measures which were non-negotiable. These constraints required quick thinking and adjustments almost on a daily basis. Some examples include :

- Segregation of the ES team from the main office which resulted in the lack of office space to house the ES MSWs even while they were subject to the high exposure risk of exposure as well as the perceived sense of "isolation".
- New work arrangements as the increased need for MSW presence saw a 24/7 coverage that required new work rosters and protocols, besides having to increase staffing for the team.
- Intra and interdepartmental communication and coordination became critical to move work changes along, to maintain stability in the midst of changes while ensuring staffs' morale at the same time.

Learnings from the Crisis

Another new situation which arose was the need for additional manpower in order to address the surge in complex referrals. In order to step up to the occasion, an additional of 2

[4] Crisis cases are defined by the SAVE acronym: Suicide risk due to social issues, Accommodation crisis, Violence & abuse risk and, Emotional Distress.

more MSW headcounts were added to the team by manoeuvring manpower structure within the department. With this new team, the onsite MSW services were extended beyond office hours to 10pm during weekdays as well as weekends and public holidays.

Besides that, new initiatives were introduced to ride on the momentum for statistics and data to be tracked for trend observation, and routine multi-disciplinary team meetings were established with the emergency colleagues to enhance timely and constant communication. A new internal COVID resource guide was also developed by the ES MSWs to address presenting issues and network initiatives were made with partners from Ministry of Social and Family Development as well as the Ministry of Manpower to address new issues arising among domestic workers and child patients. New spaces were explored within the hospital to provide the ES MSWs a safe and conducive working environment. At the same time, new leaders emerged from within the ES MSW team with members taking initiatives and generating creative solutions to meet the challenges at work.

Lessons on Leadership

As I looked back at my learning as a young leader while during this pandemic crisis, there are 4 leadership lessons which helped me in navigating through this most uncertain time. I have termed these 4 lessons as “These things I must do”.

1) I must make sense with them

It is normal for people to look at their leaders for directions, especially during crisis. However, I have learnt that it is not always easy to find a probable solution during a crisis as the situation can be rather dynamic. Back at the ES, I recalled the numerous work-related questions raised by my team in face of uncertainties and how I often find myself in the dilemma of deciding whether to prove that I have a solution for everything, or to honestly say “I don’t have all the answers”. Choosing the latter made more sense to me as I thought that leaders should be allowed to share our vulnerability even while dealing with a crisis. However, while I am unable to promise solutions to my team, I could definitely make sense with them to co-generate solutions through our joint efforts and strengths. One such solution came through the idea of a “Brown Bag” learning initiative, where my team decided to organize online lunch platforms as we invited colleagues to share with us on their practice knowledge to better equip us in managing the diverse clients seen at our emergency services.

Besides that, the other area that I needed to make sense with my team was the work adjustment and new norms that we had to grapple with during this uncertain time as it disrupted many of our work and personal life routines. There was a need to look out for my team’s well-being, and to acknowledge their sacrifices as a gesture of their professionalism and goodwill which must not be taken for granted. The principle of fair-exchange value (Hybels, 2012) comes into place here as I introduced work flexibility towards my colleagues’ work schedule to ensure sustainability and avoid burnout. With that, an interim office was set up to provide a conducive working environment for the ES MSWs who were unable to work with the main department due to safety distancing measures. Intentional efforts were made

to help the ES MSWs to stay connected with the department through facilitating regular updates and sending encouragements between the main department and the ES MSW team.

2) I must be predictable

There were many work norms which were destabilised by the pandemic crisis- from work routine to the quantity and nature of case referrals. This period has taught me that while work situations may be uncertain during a crisis period, leadership direction and responses in the midst of changes must remain clear and predictable. Adding to that, a 2018 article titled "Leadership in crisis situations: Merging the interdisciplinary silos" also reminded on the need to emphasise values at work to help staffs cope with the new challenges and to make sense of their work in a changing world. As a social worker where my work is guided by values and ethics, I found it rather natural to emphasise values through my leadership style to explain the purpose of our work as emergency MSWs as well as the rationales for every work and manpower changes we were making to address the pandemic concerns. Along with my team, we also developed clear work protocols which helped to introduce predictability in our work as well as sense of stability towards the patients we serve at the emergency department.

3) I must set the culture

In line with providing predictability in an unpredictable new world, culture setting was another crucial consideration to manage the changes at work. There were a few cultures which we wanted to establish specifically within the emergency team. First, we wanted to have a culture of honour where staff feel appreciated for their work especially as they step out of their comfort and work norm to meet the demands brought by the pandemic crisis. One example of this honour culture was demonstrated through a staff send-off after her resignation as we organised a 10-days' appreciation line-up till her last reporting day as the team expresses our heartfelt appreciation and memories while working alongside with her at the emergency services.

We also emphasised on the culture of WE in the team as we acknowledge that emergency work requires teamwork and flexible support among members to manage unpredictable nature of our work. During this period, the ES team demonstrated tremendous support and initiative to help one another at work, even to the extent of having off-duty staff stepping up to help the duty MSWs in making phone-calls when referrals became too over-whelming at the emergency department. It was with such culture that members feel supported and motivated to carry on working, knowing that they are not alone in this battle against COVID.

The last culture which we put in efforts in building was the culture of fun, by allowing staff to fellowship and laugh through online communication and meeting platforms, and that certainly helped in making work a lot more enjoyable and refreshing.

4) I must set example

The other thing that I must do in a crisis work situation, is to be an exemplary leader to my team members. There were a few areas where I had to be deliberate in setting an example in, such as remaining realistically hopeful by lifting my own morale to encourage myself first as a team lead that the situation will only turn better even in the midst of daily work challenges. This notion of remaining realistically hopeful was borrowed from the concept of Stockdale paradox termed by Jim Collins (2009) after his interview with Admiral Stockdale on his coping as a prisoner of war during the Vietnam war as Stockdale shared that those who survived during his times as prisoners-of-war turned out to be the same group of people with faith that one shall prevail in the end, yet having the discipline to confront the most brutal facts of current reality.

Besides that, I have also learnt what it means to display humility in my leadership and work, by admitting to my mistakes, bad decision calls and personal learnings derived on hindsight reflection. I have come to realise that staff do not expected a perfect leader though they look upon someone whom they can trust; a leader who has the integrity to own up and apologise, and a leader who is willing to grow and develop to becoming a better leader. More often than not, I found myself admitting to my team on my inadequacies, limitations, and learnings based on my mistakes and reflections, which they often appreciate.

Finally, I learn to work as hard as my team, even though in different roles sometimes, such as demonstrating coordinative leadership (Fazio & Briggs, 2020) to navigate through system barriers in an unstructured work environment during crisis period while generating solutions to address work issues such as workspaces, manpower needs or working with other departments and government bodies to generate solutions that aptly address new work trends and challenges.

Conclusion

In a nutshell, these are the 4 things I will do, over and over again as a leader if I ever have to face yet another pandemic crisis:

I must make sense with them.

I must be predictable.

I must set the culture.

I must set example.

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Session 3: Towards a Dementia Inclusive Society

by Ng Jek Mui, Alzheimer's Disease Association

Introduction

Alzheimer's Disease Association was founded in 1990 because of a growing concern for the needs of persons living with dementia and their caregivers. Through our work, the Association hopes to reduce stigma by increasing awareness and understanding of dementia; enabling and involving persons living with dementia to be integrated and accepted in the community; and leading in the quality of dementia care services for persons living with dementia and their families.

Our vision is striving towards a dementia inclusive society through our four strategic service pillars; Centre-Based Care, Caregiver Support, Academy and Community Enabling, the Association aims to advocate and inspire the society to regard and respect persons living with dementia as individuals who can still lead purposeful and meaningful lives.

The date 23 January 2020 is when we heard about the news of the first confirmed COVID-19 case in Singapore. Little did we know that this was the beginning of a litmus test. A test not just limited to an individual, a member of the society, a nation and globally. A test of where we were at – our resilience, resources, rolling with the unknown and uncertainties.

A time where our fears, worries and anxiety surface. A time to recognise our strengths. A time where there were new developments happening locally and internationally. A time for us to respond promptly and dynamically, be it personally, professionally, or as an Association for the people we support and care for. A time where there was heightened awareness in personal hygiene, personal responsibility, public health safety and safe distancing measures. A time where we tried to understand the meaning of toilet paper and empty shelves. A time

of tension, adjustment and balancing. A time where we stay united as a nation. A time of inclusion – extending help and not leaving anyone behind.

Tapping on Strengths

One of our priorities was to gather and organise information about COVID-19 for persons living with dementia ("PLWD") and their caregivers and educate them about the symptoms, the many "how to" such as, maintain hygiene, wearing of masks, safe distancing measures, going for follow-up appointments, when and where to see doctor, continuation of activity engagement at home, tips, financial support available and resources. Using the strengths-based and resource management approach, our many fellow colleagues took part in the co-creation and development of the dementia care tips guide in English. This was shared with caregivers and community partners through electronic mails and website. A Mandarin version was also made available.

Discussion and Support

Through the collaboration of Agency of Integrated Care (AIC) and fellow agencies, there was the development of SPOC-19 (Support for Persons living with dementia Over COVID-19 period). Our aim was to help families who had concerns about their loved ones living with dementia who unintentionally "broke" circuit breaker rules. There were three identifiers that persons living with dementia and caregivers could show the ADA Memo, the Safe Return Card, and the ICED Sticker ('In Case of Emergency, Dial').

We had shared tips and guidance from the Elections Department Singapore about the legal implications and support available to PLWD and their caregivers in our website, regarding the Singapore General Elections that was held on 10 July 2020.

Working from Home and Online

During the circuit breaker period, our Centres were closed, and we had to work from home. Most of our services went online. The creation of online log-in accounts to support us in conducting online sessions, team discussion, supervision and meetings. There was early preparation from our colleagues conducting centre-based services. They had started to film "Stay Home Workout" videos in the Centre with familiar songs in the background. There were activity packs packed with handicraft, games and art materials, and the loaning of tablets to some PLWD to aid in maintaining the social connection. There were arrangements to contact PLWD and their caregivers to find out how they were adjusting at home during the circuit breaker period. There were a series online sessions including " #StayHome Fun with ADA" for PLWD, "HEY@HOME - How arE You @Home" support group for caregivers, webinar session, "The New Norm in Caring for Persons with Dementia", during circuit breaker and "Live Streaming" of Memories Café from Phase 1 onwards.

Our fundraising department had secured care packs, transport and groceries vouchers to distribute to families requiring support during this period. Together with our finance

department, we were notified on available funding for caseworkers to purchase telephone cards. This aided us in continuing to reach out to the people we serve. Together with our volunteer management and community enabling team, we received tablet donations from corporations and the tablets were given to families for activity engagement. There were volunteers who helped in arranging online sessions for our PLWD. Our advocacy "work" did not take a break, we remained engaged in interviews through printed media and live radio during circuit breaker time.

One of the things that was helpful during the changing times, was the constant communication from our Management; which kept us updated on the Ministry of Health's advisories and our Association's plans.

Rethink and Reachable

We had to rethink on how to continue the Dementia Helpline during circuit breaker period, so that PLWD or caregivers could reach us. There were trials and errors on how to activate call-forwarding functions to our mobile handphones, how to ensure seamless connections while on duty, and how to retrieve voice messages. We also had to rope in fellow caseworkers to support the Helpline operations. There were considerations if we should do triage of calls and the constant monitoring and analysing of number of calls and type of enquiries received. There were regular check-ins on how we were taking care of ourselves while taking care of others. As our services rendered were not considered essential services, we had to think of ways to continue to support PLWD and caregivers using telephone and technology, instead of face-to-face contact.

Common Humanity

There is this moment of understanding that we were going through this pandemic together in different ways – the times of struggles and in overcoming them. We witnessed the caring support from our caregivers asking us how we were doing and adjusting. It was a time of vulnerability that bridged the connection. It was a time of knowing that we were humans going through this and how we could adjust and rise up in our own ways.

Connecting

Even with the arrangements of working from home and social distancing, we remained connected virtually. Our team tried out a virtual lunch, which was done before one of our colleagues went on maternity leave. I remembered that I was being cheeky as I had wanted them to hear the crunchy sounds I made over my lunch.

Compassion

A definition of compassion is, "*a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it."* Using this lens to feel for another person's pain during such times helped us understand and connect with them while wishing them to be well and at ease at the same time. Acts of listening with full attention or the offering of

our physical presence could also bring comfort to the person "in front of you". One of the ways I adopted was to have regular check-in with clients and colleagues and offering them a listening ear when needed.

Confidence and Humility

3 April 2020 came the announcement of the circuit breaker starting from 7 April. Not knowing what to say, I had to instruct my colleagues: "I do not know when and if it will be a month that we will be able to go back to office. Please bring what you need home. If you need to bring glue, just pack it." The management had to break the news to us that there would be no increment and bonus in 2020. They would try their very best to ensure there was no pay freeze or retrenchment.

Let's Learn to Surf

John Kabat Zinn shared that, *"you cannot stop the waves, but you can learn to surf"*. I had realized that this was the time to practise my surfing skills so that I could ride the waves. It was an opportunity to practise and hone my skills. I have to be willing to practise, fall, dunk into the water, get up again and again. The understanding gained was how one could not control nor influence the movement of the waves. This was also part of learning on how to balance and manage uncertainties.

Litmus Test

Someone said that resilience is the adaptability amidst adversity. To me, COVID-19 is like a litmus test, it was a time to re-evaluate: "How are we doing?", " Are we there yet?" "Maybe a bit short", "Wow, I can do that!", "Amazing!".

To sum up, it is with the many helping hands that we could co-create the COVID-19 support for one another. The inner desire to help another person motivated us in the work. The interconnectedness between us, and the thoughts that we were in this together, meant a lot to the work. As one said, "There is no "I" in a team." There are times I (we) need you and you need me (we). Let us continue this work (support) and be part of the change.

Session 4: Leadership in Crisis and Change Management

by Long Chey May, National University Health System

Introduction

As I prepared for this talk, I was reminded of the leadership course I attended in 2018, where I learnt what real leadership was about, and what adaptive leaders did compare with technical leaders. I quote from Chapter 8 of Dean Williams' book *Real Leadership*, while

reflecting on how COVID-19. It is indeed a crisis challenge that real leaders must face throughout the world.

"A crisis challenge is a perilous predicament in which the group is under attack from forces within or without. It is a sudden, unpredictable event that jeopardizes the accrued value and resources of the group or enterprise. In such a context, wise and responsible leadership is critical if the people are to overcome the immediate danger and return to a state of normalcy." (p. 189).

I shall share some examples of how I made sense of the situation and exercised leadership since Feb 2020 in my several job roles. The discussion on the context of leadership is framed using roles and responsibilities from my four job appointments as follows:

- Group Chief Patient Officer, National University Health System (NUHS)
- Senior Principal, Project Administrator, Chief Allied Health Officer's Office, Ministry of Health (MOH)
- Deputy Director, Allied Health, Ng Teng Fong General Hospital
- President, Singapore Association of Social Workers (SASW).

In exercising leadership, whether assigned or personal, one is required to be adaptive and to stay calm. I would like to share three opportunities that make a difference during COVID-19.

Three Areas of Focus – Leadership in Crisis and Change Management

1. Effective Communication– Response to crisis

Was I tuned in or not? Was I a leader who was firm and consistent? (Power, Affiliation, & Achievement)

COVID-19 has shown us the importance of preparing for crises and emergencies, and that conveying plans and adjustments at short notice is important. People need time to adjust and if communication is unclear or slow, it gravely impacts social workers who are tasked to attend to patients and require instructions regarding work distribution. Also, team-based care requires us to be familiar with instructions.

There is also the issue of what and how we should transmit information. At the SASW and Accreditation Board level, MOH relied on the board to disseminate circulars to registered social workers. At the hospital level, instructions for team segregation, social distancing, and working from home, as well as information for vulnerable clients/patients, have to be discussed. New workflows and instructions have to be transmitted to other team leaders or Allied Health Heads for dissemination. Besides information dissemination, there was a need to emphasize adherence. I noted that some staff struggled to follow instructions. When there is a breach, how should the leader respond to ensure better compliance, yet without

disengaging staff? Are the leaders comfortable in being firm? Do they value popularity and hence refrained from admonishing staff who failed to comply? In such times, one can tell how adaptive the leader is by the behaviours and willingness to communicate essential information. Roll calls, emails, and circulars are means to this end, and timeliness is important as well. Decisions must be made on whether to disseminate information, as some agencies/staff receive multiple instructions. Leaders must make the call and be accountable.

2. Streamline Processes

During COVID-19, as a part-time professional consultant in MOH, I was able to advocate for streamlining of processes with other agencies. One example was the homeless situation during circuit breaker. Usually, the Family Service Centre (FSC) social workers and Social Service Office officers would liaise with PEERs network or the Singapore Tourism Board (STB) to allow homeless individuals and families to be placed at hotels and hostels due to the shortage of shelters. I took the opportunity to highlight to STB that they should also recognise social reports by the medical social workers (MSW) for placements of the homeless. This would expedite the processes as FSCs were closed during circuit breaker. Colleagues from the Ministry of Social and Family Development (MSF) agreed, and this arrangement was quickly confirmed. Other examples included the increased rate of use of video chat for tele-consults, and a review of financial and psychosocial assessments.

3. Integration

COVID-19 presented the opportunity to break down silos and burst boundaries. SASW and other allied health professional associations had a chat group to share about COVID-19 related issues ranging from how to conduct annual general meetings virtually to how to support members in their practice, which fostered a sense of cohesiveness. This was also facilitated by staff from Chief Allied Health Office, MOH, as several of us were also connected via work. There were role changes where, in community care facilities set up to do swabbing of migrant workers, we see the traditional role of doctors and nurses doing swabs being passed on to allied health colleagues and even MSWs. As the Group Chief Patient Officer, I also explored having MSWs worked with psychiatrists and psychologists under oneNUHS on support structures for migrant workers, affected staff, etc. COVID-19 also highlighted that staff in social and health services must work together to support those affected. A model of patient partnership care was needed to better understand the voice of clients and family members. There would be more synergy if client and family voices and needs were amplified.

4 Tensions in Leadership – How much is enough, to sanction or not?

In crisis, there were challenges that highlighted the tensions faced by the leaders. In the area of staff management, as Deputy Director, Allied Health, there was a need to intervene in space allocations and sharing to make segregation feasible or meet safe distancing requirements within the workspace. Leaders also needed to step in where, for example, it was observed that younger staff who had a high need for social interaction were

found to have breached safe distancing or had meals together. Leaders must confront with care, ensuring that relevant Heads of Department were supported in staff compliance.

Regarding staff support, I had to educate colleagues in charge of human resource on the informal network of support such as the Crisis Relief Alliance (CRA) hotline support for healthcare workers. In view of confidentiality issues, there were reservations about using informal or yet-to-be-established organisations to extend help to healthcare staff. Some persuasion and advice were needed to allow CRA to publicise their services, as we knew healthcare staff were experiencing a high workload, and some required assistance or were uncomfortable using internal support systems.

Another area of tension was the SASW – EXCO perspectives of sector response. Social workers in different settings have different appreciation for infection control, emergency planning, and crisis response and management. As a result, there were tensions regarding the ability to comprehend the crux of the issue. Social Service Agencies were receiving circulars from their parent Ministries and statutory boards. There were differing views regarding decisions on what information to share and when to share it. On the other hand, social workers in private practice might not receive up-to-date information. There was also a risk of social workers breaching or wrongly interpreting directives. Leaders were making decisions based on their limited exposure and knowledge, and some were adamant about minimising the potential risk. Suggestions were quickly made to provide resource information via the website for members to refer to if necessary. In this process, I learnt that from the stage of understanding the situation to intervention and mobilisation, leaders had to quickly adopt a systematic approach to manage the issues, while considering various aspects such as aspiration, analysis, attention, agreement, action, and assessment. It was noted that not everyone had the proper training to lead the team through a crisis situation.

Amidst the fact-paced changes in information and instructions, I reflected on some key principles that guided my decisions in a crisis challenge. I used the acronym of RACE as I embrace diversity and agility in dealing with change and in good crisis management.

Reflections on what anchors me as a leader? – "RACE" (Diversity & Agility)

In dealing with **change**, it is important for the leader to possess the following:

- **R**esilient Character & Leader's Relationships
- **A**daptive leadership
- **C**ourage, calmness and conviction
- **E**mpowering self and emboldening others

In **coping with crisis**, it is important to do the following:

- **R**esponsive
- **A**ccurate

- **C**alculated, with confidence
- **E**valuate

In adapting to change and coping with a crisis situation, the above key qualities are what real leaders should demonstrate. This also means that the social worker can seize the opportunity to exercise leadership when faced with adversity.

Definition of Leadership

"Leadership is the activity of mobilising people to face reality, solve tough problems and create what is needed to generate progress and improve the human condition"

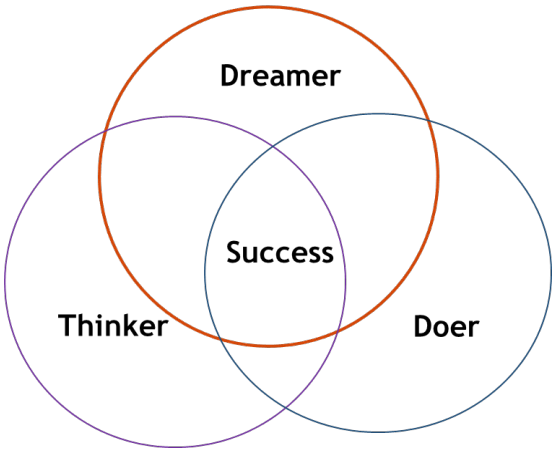
When I first saw the definition in the leadership course I attended, I realised my fellow social work colleagues do this in their day-to-day work. Social work's core values and code of practice provided us guidance on empowering clients to face their reality, journeying with them to resolve tough problems and supporting with them to make progress in their lives. We support the clients by developing their strengths so that they could learn new knowledge and coping skills, and move forth to be independent even when another crisis was to strike again.

I was heartened to see many good examples of social workers exercising leadership. These include:

a) Holding space – which was initiated by a few social workers to enable social workers to call in on specific sessions for support and to share; thereby providing a safe and supporting space for social workers.

b) Here with you – which was initiated by social workers and allied health officers to provide telephone support and other practical help to migrant workers.

Lastly, I would like to share my thoughts on what is necessary to be successful and be daring in all that we do. The diagram below shows a framework that I found insightful, with qualities worth honing.



Thinker + Dreamer : No real action

Dreamer + Doer : Build something nobody wants

Thinker + Doer : No Vision

Patience and Persistence

"From Doing to Dreaming"

(做事，做人，做戏，做梦）

Diagram 1 on qualities of success

Volunteerism, Partnership and Collaboration

Another reflection of my leadership journey has to do with my belief in volunteerism, forming partnerships, and collaborative practice. I did not have good supervisors or role models in my career and many of the insights are from my active participation as a grassroots volunteer in my younger days, volunteering my social work expertise in professional roles such as sitting in review boards, and participating in projects that required me to work with others to gain breadth of perspective.

Finally, I would like to share with you the Situational Leadership model, which I found the concepts helpful. There is no one size fit all in this model. If leaders are flexible and tuned in to their colleagues and supervisees, their leadership will be enhanced to grow more leaders and hone their own style through changes and crisis situations.

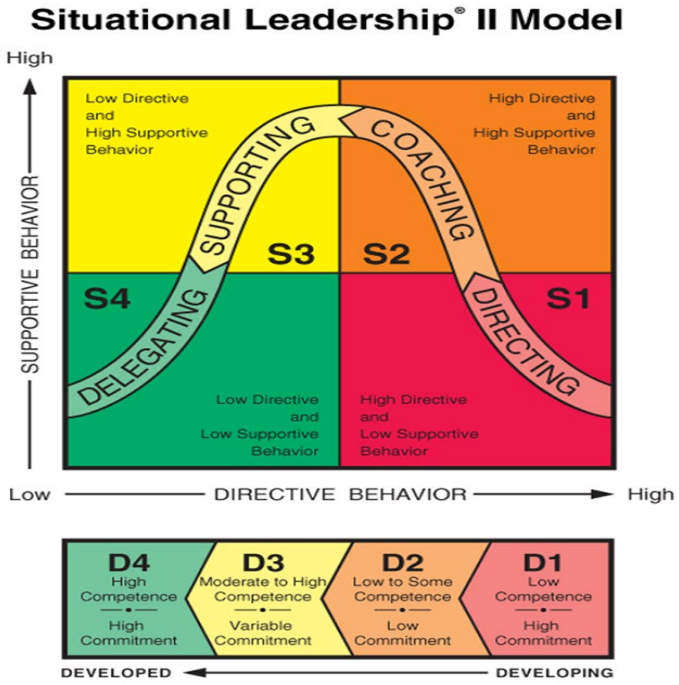


Diagram 2: Situational Leadership

Dean Williams concluded in Chapter 8 that politicians and presidents make errors all the time. Nevertheless, times of great danger require a particular kind of leadership that is more sensible and sensitive than what one might provide during a time of peace or relative calm. No single authority figure should be so brazen as to think that he or she alone has "the answer" and can "show the way forward" in such a foggy predicament.

He went on to say that "*taking on a crisis challenge requires the capacity to remain calm in a volatile, hot, and foggy environment that is riddled with competing emotions and sensations, and to carefully intervene to reduce the heat and keep people from acting irresponsibly by exacerbating the danger."* Leadership can be exercised in such trying circumstances like COVID-19, and one can succeed in seeing through the fog to identify the real work that must be attended to if the conflict is to be resolved and progress is to unfold.

I would like to share with all social workers that everyone can potentially be a leader if in some ways, he or she acknowledges the limitations and attempts to do the following:

- Dissipate the explosive fumes, and create some time to think,
- Hold steady – don't get pulled into the fracas
- Keep people from striking a match; remind them of the higher purpose,
- Don't be pigheaded or naïve – explore every alternative.

As a fraternity, we can weather this crisis and turn out stronger if we stay united and contribute in our ways, holding on to the few pointers that Dean Williams so clearly articulated.

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Part 4: The Next Wave – Are We Ready?

The webinar brought together speakers who attempted to map out a future landscape for health social work in Singapore, taking into consideration disruptive impact created by the COVID-19 crisis. Guided not by a crystal ball but the discipline of future studies, the webinar offered a systemic understanding of the past and present in the healthcare ecosystem to justify what was likely to change and what could possibly continue, which would aid the prediction of future lives of the people cared for by health social workers.

Session 1: Beyond Casework

by Ho Lai Peng, Tan Tock Seng Hospital

> *"An important goal to set for ourselves lies in changing the narrative – our national narrative and our internal biographical narratives. If we can do that – face up to how we are all implicated and entangled, confront how the narrative we hold onto upholds our own privileges at the same time that it maintains the disadvantages of some of our fellow residents in this country – then we can really talk about solutions."* (Teo, 2018, p. 35)

Introduction

Casework and the systems approach have been very much the staples of social work education and practice in Singapore. The idea of going beyond casework challenges social workers to go beyond the person to understand his or her socio-ecological context which includes the person's proximate environment (microsystem), the community (mesosystem) as well as the larger cultural context (macrosystem).

Some may claim that casework and systems approach are sufficient in addressing the issue of going beyond the individual since integration of both would take into account the person in environment. In reality, the systems approach is not evident in social work practice,

at least not beyond the micro and meso systems. Even practice at the meso system level seems like a mere extension of micro practice to deliver service to our patients. It has been argued that social work education in Singapore has been tailored heavily towards direct and micro-practice with much less of an emphasis on critical analysis of policies (Shaw & Ow, 2020).

The pandemic has exposed and accentuated vulnerabilities and inequalities (Marmot & Allen, 2020). An important role of social workers as delineated by the SASW code of professional ethics is to pursue social change on behalf of the oppressed and vulnerable populations. Focusing on individuals and their problems is, thus, not sufficient to fulfil this mission of our profession.

Confronting narratives

> *"Each society has its regime of truth, its "general politics" of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true*." (Foucault & Gordon, 1980, p.131)

Foucault (1991) argued that power is embedded within discourse, knowledge and truth. Thus, in this way, power produces reality so social workers ought to interrogate this reality rather than accept it as truth. However, Foucault (1991) believed that power is not all negative and it can be productive as well.

In order to go beyond casework, it is imperative that social workers look at ourselves and the narratives which have been ingrained in our reality. As suggested by Teo (2018), we need to examine how we have unwittingly bought into narratives which privilege us and disadvantage others, most notably, the patients we have chosen to serve. These narratives are so entrenched that they appear subconsciously in our everyday speech.

> "*Mr Chan shared that the richest and poorest people in Singapore reside in his Buona Vista ward, and he would be asked by the rich how they can help. … The minister explained that his wish was for them to each adopt a family in the neighbourhood, reach out to them and be good role models for the children."* (Kwang, 2018).

Although this might not be intended, the minister's suggestion presumed that the rich could be good role models for the children of the poor by virtue of their socio-economic status. In another instance, when a group of well-meaning students came to my neighbourhood to collect canned food for the poor, they told me it did not matter that what I had was unhealthy because they were for the poor. They implied those who are poor have to receive what is

given to them because they cannot choose. These narratives can be so insidious that even people with good intentions may not know the implications.

As social workers, we need to be cognisant of how these narratives influence our thoughts and philosophies which might inadvertently be transferred to our patients through our words and actions. It is, thus, our professional responsibility to continually examine ourselves and it may take a lifetime to undo these narratives.

Migrant workers

Migrant workers appear to be at higher risk than Singaporeans for specific infectious diseases, probably due to a complex interplay of several factors, including higher disease prevalence in their countries of origin, socio-economic factors, their living conditions in Singapore and financial, language and cultural barriers to healthcare access. Receiving countries need improved surveillance, expansion of preventive measures and decreased barriers to healthcare access for migrant workers. (Sadarangani, Lim, & Vasoo, 2017)

In particular, this pandemic has highlighted the predicament of migrant workers who have long been an essential part of our landscape but treated as if they are easily dispensable and a separate entity from the local population. In light of the pandemic, the findings from the study by Sadarangani et al. (2017) seem almost prophetic. The stories we have heard from migrant workers who were admitted to the hospital bore witness to the difficulties they face in adjusting to and negotiating the systems in Singapore.

The following narratives of three migrant workers who were admitted to the National Centre for Infectious Diseases represented the lives of migrant workers at different stages of their journey in Singapore. Muthu (pseudonym) was referred to us for self-harm. He was 19 years old and had come to Singapore a year ago. However, Muthu did not expect the working conditions to be so hard. He could not adjust to the demands of his job and his resistance to the long working hours made him unpopular with his company and colleagues. As a result, his contract was not renewed, and he was sent back to India. Pillay (pseudonym), 28, has been working in Singapore for the past nine years. When we saw him, he had anxiety from being isolated in a hotel room for more than two months. Although he had to work 12 hours or more a day for at least 26 days a month, he was eager to return to work. He accepted the working conditions and the money he earned had accorded his family a better life. He was very proud as he showed photographs of a house he and his brother (another migrant worker in Singapore) were building for their family. Hossein (pseudonym) was 41 years old and had worked in Singapore for 11 years. He was married with a son and was the sole breadwinner in his family. He recovered from COVID-19 but was diagnosed with terminal cancer. He went home to live out his last days with his family.

Indeed, the sole purpose of migrant workers is to provide low-wage labour and they are expected to work long hours (Ye, 2016). The working conditions which they are subjected

to can take a toll on their physical and mental health. During the pandemic, many migrant workers were found to have chronic illnesses which were undiagnosed or untreated. The high medical costs and the fear of being sent home if employers were to find out about their medical conditions are barriers to seeking treatment (Rajaraman, Yip, Kuan, & Lim, 2020). They are often at the mercy of employers and though they have the option of going to the Ministry of Manpower when they face workplace issues, the system is often difficult to negotiate and they often do not know their rights.

The plight of these migrant workers accentuates issues of social inequality. Sadly, most migrant workers accept their situation for the sake of their families. Some may even be appreciative of what they have been given during the pandemic. Although government and non-governmental organisations have stepped forward to improve the well-being of our migrant workers during the pandemic, it does not excuse the treatment the migrant workers have been subjected to or justify the policies which continue to place them in a disempowered position. We would be remiss if we were to only focus on the presenting issues and ignore the structural issues which contributed to the issues migrant workers face.

Social Work Education and Practice

> *"While the focus on building skills and competencies immerses the social work student in the realm of direct practice, there is, resultantly, a lesser focus on a critical analysis of social and economic policies which directly affect many of the disadvantaged populations social workers encounter in their work. The latter are thus primarily educated to create change not so much at the level of policies, but more at the level of working with individuals and families.*" (Shaw & Ow, 2020, p. 103)

Social work cannot be just about direct practice and social workers must understand that we are not merely gatekeepers of resources. We need to move away from the perspective that problems are mainly due to individual deficiencies and examine structural issues, critically appraise policies and understand their underlying philosophies. To this end, there should be a place for structural social work or social work with a focus on social justice and change (George & Marlowe, 2005). The practice of structural social work would undeniably be challenging but it is inevitable, and it has to be incorporated into social work education and practice albeit in a way which would be palatable.

Conclusion

> "*It is not 'can any of us imagine better?' but, 'can we all do better?' The dogmas of the quiet past, are inadequate to the stormy present. The occasion is piled high with difficulty, and we must rise - with the occasion. As our case is new, so we must think anew, and act anew.* " (1862, as cited in Abraham Lincoln Online, 2020)

The pandemic has affected all of us but none more so than those who are already disadvantaged. In the present uneasy lull, it is perhaps timely to reflect on what has passed and envision the future of social work. Although many of us yearn for the world to go back to what it was, we cannot ignore the issues which this pandemic has laid bare to us. Just as President Lincoln had exhorted the congress to think and act anew in the wake of The Emancipation Proclamation, the pandemic is an opportunity for us to "imagine better" and "do better".

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Session 2: Telehealth in Medical Social Work

by Chan Lay Ling, Institute of Mental Health

Introduction

Discussions on the use of electronic tools in information technology emerged in social work literature in the late 1900s, with regard to the use of (a) Internet resources in online chat rooms, professional networking sites, and e-mail, (b) the clinical realm, (c) education, supervision, and (d) administration (Reamer, 2018)

Until the COVID-19 pandemic, the use of telehealth in local clinical medical social work practice had been mainly limited to the use of telephone and email interactions. However, the requirements for social distancing and work from-home arrangements during the pandemic have led to a tremendous acceleration in the use of telehealth.

This paper outlines the potentials and limitations of telehealth in medical social work practice, and its role in the new norm, beyond the COVID-19 pandemic.

Telehealth Services in Medical Social Work

The Singapore Ministry of Health (MOH) launched the National Telemedicine Guidelines in 2015 following the emergence of telemedicine projects in the country. The guidelines for telemedicine were also developed with the aims of expanding telehealth medicine to meet the gaps in the shortages of healthcare professionals, specialists, and caregivers, as well as providing better access to care or increasing the overall level of care (MOH, 2015).

Telemedicine (also commonly referred to as telehealth) is defined as a systematic provision of healthcare services over physically separate environments via information & communications technology. Information and communication technology include the use of telephone, mobile devices, interactive video conferencing, emails, chats, texts, internet, and so on. (MOH, 2015).

During the Circuit Breaker of COVID-19 pandemic between April and June 2020, the previously limited application of telehealth in clinical MSW practice crescendo into a flurry of telehealth activities to cope with the ongoing, if not increased demands for care for patients and their families. Video consultations swung into the fore and replaced in-person casework interviews, multi-disciplinary case conferences, patient and family psychoeducation, counselling services, and supervisory practices.

MOH anticipated this trend and, in March 2020, launched the Telemedicine e-Training programme to guide healthcare professionals on designing and delivering telemedicine services that prioritise patient safety and welfare. Many MSWs have completed this programme, but there is still a need for the profession to contextualise the training and existing guidelines into social work practice.

Since we are already using some aspects of telehealth prior to the pandemic, telehealth is, therefore, not an entirely new mode of intervention but a tool to extend the services that social workers are already conducting.

Potentials of Telehealth

Let us examine the tremendous potential that brought on by the Covid-19 pandemic that has expanded telehealth as a mode of practice in social work.

1. Telehealth potentially offers privacy to patients with highly stigmatised conditions or situations, who would otherwise fall through service gaps. This applies to persons with highly stigmatised psychiatric, medical and psychosocial conditions, and persons who would feel stigmatised if they were seen seeking help.

2. Telehealth allows persons with ambulatory challenges such as the frail elderly, persons with disabilities, and those with difficulties taking leave from work to receive social work services. These persons would otherwise be lost to social work service.

3. Telehealth potentially offers an alternative, more convenient, and efficient service delivery option in areas such as psycho-social care, clinical care monitoring, social work administration, case conferences, supervision, psychoeducation, and so on. It can efficiently bring together clients and stakeholders to hold meetings, and improve communication and coordination in care teams. In clinical care monitoring, it allows social workers to virtually enter the homes of vulnerable persons to assess care issues.

4. Telehealth allows for efficient psychoeducational outreach to large populations from various parts of the country at one time. This means that mental health and public education can now be outreached to the general or even special populations such as parent groups, caregivers, and migrant workers.

5. Telehealth offers a viable option for social workers in non-clinical roles to work from home, allowing for a hybrid and more flexible work arrangement which was not seriously considered until the pandemic.

The New Norm: Telehealth Practices in Social Work Beyond the Pandemic

Let's look at the road ahead for us, in the months to come and beyond the COVID-19 pandemic. While we are excited about the potentials of telehealth, we need to stop and reflect on its limitations, and the implications of telehealth on our service and client outcomes.

1. Need for the Development of Guidelines for Telehealth in Medical Social Work

A regulatory framework in telehealth is being developed, with the Health Care Services Act expected to be passed in 2022 (MOH, 2015). In the meantime, the challenge remains for MSWs to evaluate telehealth, and contextualize existing guidelines into MSW practice.

The Singapore Association of Social Workers' (SASW) ethics guidelines has limited coverage on telehealth. Guidelines on the use of digital communication is covered under the Electronic Technology section, where it is stated to "not do harm, use telehealth for work purposes, refrain from social networking sites, and inform clients of the risks of telehealth". In view of the ubiquitous and potential of social media, there is an urgent need to review and update these guidelines.

Hence, the profession, respective medical social work departments, and agencies would need to develop clinical and ethical practice standards so as to operationalise telehealth in their respective contexts. With this, social workers can better be guided in applying telehealth in their practice.

The following factors are recommended for considerations in the practice guide:

a) MOH (2015) guidelines stated that the overall standard of care delivered in telehealth should not be any less compared to a service not involving telehealth. In view of this, telehealth modes that compromise in-person verbal and non-verbal cues (affect, speech, etc), which are critical in treatment assessment and intervention, would have to be evaluated carefully before they are used in clinical care. For example, conducting groupwork via video platforms may not be an appropriate option if harnessing group dynamics is critical as a means to achieve the group's outcome goals.

However, where in-person sessions are not reasonably practical, delivery via telemedicine would be deemed better than not having any access to care at all.

b) To ensure that telehealth delivery is appropriate and safe for clients, guidelines on client exclusion criteria and the nature of the presenting issues that are deemed unsuitable, need to be considered. Clients who might be excluded would involve individual, family or groupwork programmes with presentations of high risk of violence to self and others, and when clients are presenting with acute and vulnerable mental health conditions.

Guidelines are important in, for example, the management of crisis situations during video consultations with client(s). As some social workers are still working from home, this is even more critical if a crisis involving risk to life is triggered while the social worker is engaging a client.

c) Informed consent, client privacy, and confidentiality issues cannot be emphasised enough. The increased risk to confidentiality occurs both at the practitioner's and client's end. The risk of the presence of unauthorised individuals in telehealth sessions or the unauthorised recording of these sessions are present, which calls for careful

management by both practitioners and clients. Risk in the transmission of information and the possibility for legal subpoena of records also exist.

Hence, how able and fully-informed clients are of this technology forms a part of the consideration as practitioners weigh the degree to which potential benefits outweigh the risks (Craig, 2000). Procedures involved in obtaining consent for telehealth services would need to be specified.

d) Training and supervision in the use of telehealth should be considered to ensure that social workers practise within their areas of competence, and receive supervision from persons competent in the use of this technology.

e) Organisations and social workers would have to ensure that telehealth services are used on devices and software with cybersecurity features, to protect client privacy and confidentiality.

2. Managing the Digital Divide

Managing the digital divide to allow for greater inclusivity would be a challenge in using telehealth as a mode of intervention. Telehealth needs to be extended to those who need it most, such as resource-deficit clients who lack the equipment and connectivity, the frail elderly living alone, clients who are illiterate in digital communication, and so on.

Locally, we could consider expanding the use of “telesuites”, a simpler version used by our local Adult Protection Specialist Centres, where social service agencies can facilitate resource-deficit clients to receive health and other social services in the country.

3. Towards Efficacy Studies in Telehealth

Locally, the pandemic has contributed to a flurry of research studies using digital means, opening the potential to use virtual means such as videos in qualitive data collection. This includes a study exploring the impact of the pandemic on social workers.

It is hoped that research studies could also evaluate the efficacy of applying telehealth in clinical social work practice, and its effects on therapeutic relationships and overall service outcomes.

4. Towards the State of the Art in Education AI Technology

The pandemic has made social work trainers and educators switch to online platforms in the early stage of the pandemic in Singapore. A hybrid teaching arrangement is probably here to stay, although educators need to evaluate their efficacy to ensure that the learners’ training outcomes are not compromised.

To stay relevant, social work trainers and educators would have to apply the latest online and web-based technology, and evaluate their efficacy in social work education to ensure effective and ethical use.

5. Leverage on the Potentials of Telehealth to Enhance Community Resilience

Community resilience refers to a community's sustained ability to respond to, withstand, and recover from adverse situations. Through a systemic collaboration with various community systems such as schools, employers, religious and civil organisations, telehealth as a mode of practice can offer huge potential to enhance community resilience.

The profession could look into how we could leverage on telehealth, for example, through the power of social media to reach out and work with social systems in community development programmes to meet this challenge.

Conclusion

In spite of the huge potential that telehealth promises and even as organisational guidelines for social work practice are developed, it remains the personal responsibility of social workers to appraise the potential ethical pitfalls and evaluate its efficacy as a mode of intervention.

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Session 3: The Next Wave – Are We Ready?

by Zahara Mahmood, PPIS Family Service Centre East

Introduction

Founded in 1952, PPIS (Persatuan Pemudi Islam Singapura or the Singapore Muslim Women's Association) is a non-profit organisation focused on services for women, family, and children. Our focus is on working with women of all ages in carrying out their multiple roles

in society. PPIS runs three core community services namely, Family Services, Student Care and Early Childhood Education.

With 16 centres island wide, the services work together to provide quality and holistic support as well as developmental programmes for women and their families across the different phases of their lives.

COVID-19 Pandemic and Its Impact

Life has been different since the rapid spread of COVID-19 pandemic in early 2020. The pandemic has impacted multiple systems in our society. Uncertainty is the biggest psychological challenge individuals, couples, and families face during the COVID-19 crisis. (Michael Mc Nulty, 2020)

The pandemic has resulted in feeling of "ambiguous loss", a theory developed by Dr Pauline Boss of the University of Minnesota, where individuals experience altered sense of safety and loss of control of their daily lives due to the uncertainty and unpredictability brought about by it. The pandemic has disrupted the family norms and created a sense of disconnectedness between extended family members. At the community level, the pandemic has also disrupted various community activities and gatherings due to social distancing and safety protocols being put in place.

Impact on "Digitally estranged" Elderly Clients

The impact of the pandemic hit the hardest amongst the elderly clientele group whom we serve. We saw an increase in the number of our elderly clients who were struggling with the sense of displacement in pandemic-hit offline world. Being "digitally estranged" and cut-off from their social circles in the community, our elderly clients were not prepared to face the pandemic alone and adjusting to the new norms based on the safety restrictions. For example, our Malay/Muslim elderly clients had to adjust to celebrating Hari Raya via Face Time and Zoom platforms instead of being able to interact physically with their non-live in children and grandchildren during the circuit breaker. They also had to use internet banking to send virtual green packets to their grandchildren through their use of smartphone. However, our Social Workers notice that not all of our elderly clients were motivated to learn and were ready to adapt during the crisis. Some of they were emotionally affected because of the isolation / separation from their family members and thus, required mental health support assistance.

Impact on Low-Income Families with School-going Children

The pandemic has also impacted the low-income families with school-going children who had to undergo the Home-based Learning (HBL) programme. Our Social Workers worked closely with IT organisations to provide loan devices and to install Wi-Fi connectivity for the families-in-need. The patchy Wi-Fi connectivity and shared devices amongst the children at

home were some of the challenges faced by the low-income parents besides having to grapple with their children's school assignments on their own.

Impact on Couple

Our agency also saw an increased number of transnational couples who sought help for the violence and abuse inflicted upon them by their Singaporean spouses during the circuit-breaker period. The challenge for our Social Worker was how to keep our clients and their children safe while at the same time, engaging the perpetrators in counselling through remote session.

Impact on Sandwiched Couples

The dual burden of caring for elderly parents and children during the circuit-breaker period was really felt by the sandwiched couples in the community. The caregivers' stressors have somewhat affected the relationships between couple and their mental health issues.

Impact on the Homeless and Rough Sleepers

The homeless persons and rough sleepers were also not spared during the pandemic. An increase number of cases was seen at our agency. Our social workers worked closely with MSF PEERS (Partners Engaging and Empowering Rough Sleepers) Network to provide shelters and social intervention for the clients so that they would remain safe and protected from the COVID-19 virus.

Beyond Casework Intervention

Beyond providing on-going casework and counselling services to the individuals, couples, and families facing financial, emotional and psychological impact of the COVID-19 pandemic, our team of social workers and family therapists was also involved in delivering the targeted services to the Malay/Muslim community under the *SGTeguhBersatu* Taskforce chaired by Minister Masagos Zulkifli.

The *SGTeguhBersatu* Taskforce, which was set up on 4 April 2020, is made up of representatives from MCCY, MSF, People's Association, NTUC, M3 (MUIS, MENDAKI, MESRA), and other Malay/Muslim organisations – AMP (Association of Muslim Professionals), Club HEAL, PERGAS (Singapore Islamic Scholars and Religious Teachers Association), DPPMS (Singapore Malay Chamber of Commerce and Industry), MHPA (Muslim Healthcare Professionals Association) including PPIS.

It was set-up to strengthen the last-mile delivery of national COVID-19 support measures outlined in the Resilience Budget to the Malay/Muslim community; and to develop and coordinate the implementation of community measures to complement national measures for the vulnerable and at-risk groups.

PPIS Psycho-Social Resilience

In line with PPIS' key organisational goals of building resilient and forward-looking families, we understand that the needs of the individuals, families, and community may change and become more challenging over time, especially with the impact of COVID-19 pandemic. Such difficulties and challenges serve as opportunities for the individuals, families, and community to build up their resilience and emerge stronger from the crisis.

PPIS helped to conceptualise the Psychosocial Resilience Framework (refer to Table A below) for the *SGTeguhBersatu* Taskforce to focus on building individual, family, and community resilience within the Malay/Muslim community.

Table A: PPIS Psychosocial Resilience Framework

GOAL: A Resilient and Forward-Looking Malay/Muslim Community

COHERENCE	**CONNECTION**	**COHESION**
To address confusion and achieve tranquillity. ***(Self-Mastery)***	To prevent conflict and achieve affection. ***(Family Mastery)***	To diffuse chaos and achieve compassion ***(Organisation/Community Mastery)***
Strive for self-coherence for sense-making amidst of chaos and confusion	Establish connection in meaningful relationships to garner support and develop strength	Enhance cohesion in the community through collaboration and interdependence for mutual growth and solidarity.
3 KEYS MESSAGES FOR SELF-COHERENCE	**3 KEYS MESSAGES FOR CONNECTION WITH FAMILY**	**3 KEYS MESSAGES FOR COMMUNITY COHESION**
1. Surface Strengths amid Struggles All of us possess strengths. Unleash it and develop new skills to rise above the challenge by creating and embracing the new normal ***(Sense-making and self-efficacy)***	**1. Make Relationships Matter** Strengthen social support to prevent isolation. Deepen family relationships and stay connected for emotional / mental wellness. Involve family members in meaningful activities. ***(Promote healthy attachment)***	**1. Encourage Empathy, Inspire Inclusivity** Inculcate empathy in our daily living and action. Practice giving and receiving despite differences. Practice being compassionate to self and others. A strong, inclusive, and caring community is a foundation to prevent chaos during crisis. ***(Appreciate diversity and encourage inter-dependency)***
2. Seek Spiritual Solace	**2. Always Affirm, Attend and Adapt Accordingly**	**2.Collaborate to Complement Community** Demands for resources during

Balance the temporal and the spiritual. Seek spiritual solace to strengthen the souls and hope. ***(Optimism and Spirituality).***	During crisis, family' resources can be depleted and may lead to members reacting out of character. Practice gratitude and affirm good efforts by members. Be attentive to the members' needs, adjust accordingly to the new norm in family living. ***(Mutual Trust / Respect)***	crisis can strain community institutions. Therefore, Malay/Muslim organisations should adapt organisational goals and embrace inter-organisational collaborations for collective good. ***(Improve organisational permeability and collaboration among subsystems)***
3. Focus on Facts Keep up with current affairs and verify information are from credible resources before sharing responsibly. Accurate facts reduce ambiguity and correct confusion. Avoid overloading self with only the negative information when in crisis. ***(Mutual Learning)***	**3. Communicate with Compassion in Learning Life Lessons** Embrace members' experience and reaction of the crisis equally. Encourage members' cross-learning by listening to one another with compassion and understanding, for everyone has the right to understand and be understood. ***(Encourage Shared Learning)***	**3. Contribute to Cross Cultural Engagement** Embark on cross cultural learning by forging new engagements to honour multicultural Singapore. Malay/Muslim organisations to expand partnerships with schools, workplaces, and other social agencies to increase shared social and emotional competencies to foster community solidarity. ***(Instil cross cultural learning and for community solidarity)***

The framework lies in the efforts to create mutual learning amongst the individuals and families, so as to promote inter-connectedness and interdependency of each other during the challenging times.

The **3Cs** in the framework refer to:

i) Individuals who strive for self-**Coherence** for sense-making amidst chaos and confusion brought about by the pandemic;

ii) Families who establish **Connection** in meaningful relationships to garner support and develop strength in facing the crisis; and

iii) Organisations who enhance **Cohesion** in the community through collaboration and interdependence for mutual growth and solidarity.

The confluence of the 3Cs is to nurture a new norm of a resilient self, family, and community. The above **3Cs** are aligned to the community's cultural competency of:

a) ***Sakinah*** - to address confusion and achieve **tranquillity**.
b) ***Mawaddah*** - to prevent conflict and achieve **affection**
c) ***Rahmah*** – to diffuse chaos and achieve **compassion**.

PPIS Initiatives

As part of *SGTeguhBersatu Taskforce,* PPIS embarked on a few initiatives towards internalising the 3Cs' concept within the community. The following initiatives were carried out during the circuit-breaker period to reach out to the Malay/Muslim community in general:

- E-Info-toolkit to assist the individuals, families, and community to overcome the challenges and difficulties that COVID-19 bring to their lives. The toolkit which is titled, "Navigating the New Normal Amid COVID-19 Pandemic and After", provides parenting tips to families on managing stress during crisis. Most importantly, it provides tips to couples on strengthening marriages and families during and post-circuit breaker period.
- A series of four videos to address the concept of 3Cs was also produced by PPIS in-house production. The videos featured PPIS's social workers and family therapists explaining the concept of 3Cs and imparting skills on self, family, and community mastery.
- Podcast on BH (*Berita Harian*) with community influencers like DJ Suhaimi, was aired over the radio to discuss family violence issues faced by the community during the circuit breaker period. PPIS social worker and family therapist also shared the Psychosocial Resilience 3Cs' concept and motivated the listeners to remain resilient during the challenging times.

Volunteers Build Resilient Communities

PPIS believes in building resilient communities with the support from volunteers who become the hands, ears, and eyes in reaching out to the individuals and families-in need during the crisis. The organisation also sees the importance of developing assets in the community especially amongst the youth volunteers who have more time to volunteer during the crisis than in the past. They helped to do basic marketing and groceries shopping for the elderly clients, and troubleshoot technical problems of the clients' mobile devices so that our social workers could continue to have the remote connections with the vulnerable and at-risk clients at their homes. Tapping on the informal social networks in the community to coordinate food delivery and to distribute safety kits like hand sanitisers, masks, and gloves to beneficiaries has proven to be more efficient and effective during the circuit-breaker period.

Partnerships

Mobilising community resources and partners like Free-Food-For-All and Muhammadiyah Association for daily and monthly food distribution to our elderly clients and low-income families have helped to minimise the latter's exposure to the COVID-19 virus in the community. Partnering with local businesses like Hao rice and Suchi Success has helped to raise organisation's funds through the sales of the companies' products in the market. For example, for very packet of rice bought by member of the public at the cost of $12.90, $2 is channelled to PPIS Charity Drive for our beneficiaries.

Women-In-Need (WIN) Fund

The WIN Fund was launched by Associate Professor Dr Mohammed Faishal on 8 April 2020. The fund was set-up to support women who have lost their jobs due to the COVID-19 situation or those who had to leave the workforce to care for the elderly / children in their families during the crisis.

Future Landscape

The impact of the COVID-19 has and will continue to have tremendous impact on the social and health well-being of our local and the global populations. Social Workers, like many other professions, are addressing these needs in direct service provision and continuously planning efforts to ameliorate unprecedented disruptions across, not just from the social service systems but also from the economic and healthcare systems.

The emergence of the pandemic has further shown the impact on the social determinants of health on individual and population level health outcomes. It is therefore a critical time to address both social needs within the context of health care service delivery more so now in order to be better prepared for the future.

"More will need to be done to integrate help, services and programmes to achieve client satisfaction. Structures, systems and processes led by human service practitioners who mindfully and purposefully integrate services and innovate will better prepare us for the current reality and the future."

Ms Ang Bee Lian, Office of Director-General of Social Welfare, MSF, on "Medical-Social Integration", 18 July 2019, Social Insights

Our goal is therefore to ensure vitality of the entire social-healthcare ecosystems that :

- Leverage on the power of the community, volunteers, influencers, and social networks to support and drive health behaviour change,
- Encourage multi-stakeholder involvement which includes public and private sector partnerships across the social-health care ecosystem,
- Adopt remote monitoring and self-care technologies to support and empower individuals, especially the elderly population and establish linkages to the medical social

workers in the healthcare setting and social workers in the community, together with the clinicians and the other important stakeholders.

Are We Ready for the Next Pandemic?

COVID-19 is not the last global-scale pandemic we will face; there will be more to come in future. If we remain resilient and stay united, whatever that comes our way, we will be ready because pandemics like COVID-19, are set to become part of our new normal.

Social work is a profession that has a deep history and vast knowledge, values and skills concerning human behaviour and systems thinking. We have what it takes to help our communities prepare, engage, and acknowledge each other to move through and heal from whatever the pandemic brings. No matter how "prepared" we might think we are, we will learn as we face the next pandemic, with our social work ethics and principles leading the way.

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Session 4: The Aftermath: Are You Ready? "It's I Who Built Community"

by Goh Soon Noi, Changi General Hospital & Ng Tzer Wee, Tan Tock Seng Hospital

Introduction

One year on, 84.8 million worldwide have been infected by COVID-19 with 1.84 million fatalities as of 31 December 2020. While Singapore has entered Phase 3 of re-opening in the community and resumption of economic activities, many countries across the globe continue facing surge of infections that necessitate reversal of plans to re-introduce lockdown in their countries. The scale of impact in all spheres of life wrought by this pandemic is colossal. Businesses close down, borders are shut, supply chains curtail, regional and international trade falls, high job losses, restrictions in movement and emergence of new at-risk groups. We are not out of the woods yet. The rapid changes to legislation, national and organization policies to control transmission affects individuals and families resulting in increase and intensifying of mental health, family violence and financial problems. We cannot underestimate the "carnage" – unemployment, displacement, law and order problem, even our crown jewels such as Changi International Airport and Singapore International Airlines face decimation. The unprecedented speed that vaccines have been developed and rolled out promises a return to normalcy. We are all looking forward to post COVID-19, harbouring hope it will be like pre-COVID 19. It will never be the same and many have advised against reverting to pre-COVID-19 for as much as the impact has been devastating, never have we witnessed how rapid the positive transformation in the physical, social, economic and geo-political in communities and countries that have taken place. It is equally important to invest in institutionalising these changes. Medical Social Workers (MSWs) can further contribute to this transformation, and to ensure that the positive changes remain enduring and relevant.

OBSERVATIONS AND OPPORTUNITIES FOR TRANSFORMATION IN MEDICAL SOCIAL WORK PRACTICE

(A) Community Alive & Solidarity

This period we witness lots of ground-up movement of people and communities, thousands of individuals, civic organisations and private organisations stepping up on their own, displaying a strong collective spirit – providing meals, doing food and other deliveries, helping with translation, raising funds and in kinds, garnering community spirit. We witness a kinder society. The Straits Times reported Giving.sg received more than $84 million in 2020, more than twice the sum collected in 2019 (Tan, 2021). The number of people who signed up as volunteers at various charities through Giving.sg also increased from 28,000 in 2019 to 32,000 in 2020.

Our social work counterparts all over the world also witnessed this ground swell of community involvement and acknowledged social work practice must move beyond casework. The high touch case work is important, but the dimension of our work is such that we need

to actively partner the community efforts – whether it is volunteering directly in their cause, initiating projects in local communities, working alongside and with them, or connecting the beneficiaries & providers. This calls for a mind-set change, especially for institution based MSWs the importance of working at the community level, to work with volunteers and act collectively, collaborate to strengthen social ties, and together weave hopes amidst this climate of gloom. Where we live, where we work, as member of the faith community, professional body or civic society, as professionals we can extend ourselves and get into the collective actions and foster community solidarity. Equally important as the private sector also steps forward in solidarity, social workers need to invest in building deeper partnership in the private sector to sustain community efforts. Social workers must learn how to be savvy to interest and engage the private sector in co-ownership of the helping efforts.

(B) Vulnerable Groups

- Violence in the family

The pandemic has worsened the conditions of some vulnerable groups for instance those who need special care, support, or protection because of age, disability, or in abusive relationships. The Police revealed that in 2020, there were 5,135 reported family violence cases; or an average of 10% rise every month between April to December 2020 (Wong, 2021). It was reported that during the circuit breaker, the police have taken a more proactive stance in referring to social services even when they did not ask for help or shelter, to advise them to apply for protection orders and keeping tap on them (Wong, 2020). They have also started a pilot Home Team Community Assistance and Referral Scheme (HT CARES) at the Bedok Police Division in May 2020 to refer identified perpetrators to social workers for assessment and intervention to break the cycle of violence. Such collaborations with the police - which is an essential service - is very useful and should be extended to other geographical areas and to victims as it will ensure that both perpetrators and victims have access to social workers in the community in particular and in the hospitals during and post pandemic.

-Elderly

The elderly population in Singapore is not homogenous and they experienced a diverse range of issues during the pandemic. They were told to stay home, avoid going out as their infection and hospitalisation risks were high. Those who lived alone had difficulties purchasing their basic necessities; those living with chronic medical conditions refrained from going for their follow-ups; home services or day care services were also disrupted; their elderly caregivers experienced further stress when they had high physical care needs and/or behavioural issues. Some have homes or their caregivers were overseas for example in Batam or Johore Bahru and returning to their familiar physical and social home environment post hospitalisation were challenging due to travel restrictions.

MSWs took a remedial approach, very targeted, operated at micro level and even customised their interventions - working with these elderly clients, their significant others, social service agencies, volunteers, authorities and embassies. The pandemic taught us to look beyond problems, risks and deficits, and to draw on strength-based principles to guide our interventions. MSWs could turn from just problem solving of all these private woes to investing in building the assets and strengths of our clients and the community they lived in. Such approach will require a major shift in our conversations, assessments, interventions, and engagement with the authorities from a deficit model to enabling and empowering the vulnerable.

-Low-income families

It was heartening to see the rolling out of the range of financial support schemes for the displaced and low-income families. The Social Service Organisations (SSOs) disbursing these aids turned into an oasis and our colleagues in these organizations were swarmed by the problems that these disadvantaged families encountered in this pandemic. These families lacked access to technological know-hows such that applying for assistance remotely and home-based learning for their children became more challenging. Many of them did not have decent living or working conditions at home; their constrained physical space at home made social distancing difficult. These existing social economic inequalities could deepen inter-generational inequities and prevented social mobility. SSOs partnered social service agencies in their regions, civic and volunteer groups, private organizations, resident associations and other public organizations to intervene at developmental, preventive and remedial levels, initiating programmes and improving infrastructure to uplift the low-income families and the community in which they lived. Some of these families have health related issues which can interfere with the intervention that SSOs and their partners have for them. MSWs can contribute jointly to the efforts that these community partners are making to improve their circumstances.

-Migrant workers

We have a migrant worker population of around 1.4 million or 25% of the resident population. They are employed in industries such as finance, IT, construction, shipping, maintenance, healthcare and cleaning. We are highly dependent on them; they cleared our garbage, cleaned our corridors, built our homes and roads, took care of our trees, provided childcare support, took care of our elderly in institutions and at home and many others. The pandemic brought to the fore their poor living conditions, their crowded communal lifestyle, the discrimination they faced in our society, and the abuse of workers' rights endured from their employers. MSWs have all along felt disempowered as much as these migrant workers who used the healthcare services as a result of work / non work injuries, sudden onset of acute illnesses or chronic illnesses. As far as they could, MSWs tried to help facilitate the provision of healthcare, the access to financial schemes if applicable, the involvement of these

workers' employers and their respective embassies, post discharge care planning and coordination.

The pandemic has exposed many areas of need in our migrant workers' community. There is currently attention from the authorities, civic organisations and volunteers to work jointly on these workers' employment related, housing, mental and physical health issues. MSWs can seize the prevailing climate, moving away from marginalising the workers' issues to an enduring and sustainable approach to insure their health, well-being, dignity and fair treatment in the workplace.

-Mental Health

The pandemic has contributed to many experiencing mental health issues when the services which they normally used were disrupted; when they became homebound and feeling cooped up at home; faced increased tension in relationships at home; experiencing loss of employment and financial woes. Feelings of isolation, helplessness, anxiety and depression especially for those with limited family support and those who were already suffering from mental health issues pre-COVID 19 intensified.

During the pandemic, MSWs provided counselling through the hospital mental health services and the national care hotline. With the amplified need in mental health services that the pandemic has generated, it will be apt for the profession to extend mental health first aid knowledge and skills promulgated to social service agencies providers to possible inclusion of lay persons / volunteers such as neighbours, retirees, homemakers, family members. The Friendship Bench project in Zimbawee and the peer support programme in all hospitals are good examples of an effective lay mental health support services in the community and workplace respectively.

(C) Hybrid Form of Work & Intervention

The pandemic wrought changes across the whole economy, where staggered shift work, split teams, work from home, telecommuting became the new work norms. Health social services sector were also affected. These new work arrangements created new manpower supply of a group who otherwise were homemakers to re-enter into the job market, provided work life balance, improved quality of life and human relationships at home and shared parenthood. However, as it is a high touch service that MSWs provide, a hybrid form of work is more applicable where seeing their patients and their families in the wards, at the clinics and at their homes continue to be as important.

The change in our work environments have also impacted how we deliver our services to our patients and their families. The digital transformation that has taken place in National Electronic MSW system (NeMSW) enables work from home, communication within and outside teams within the fraternity during the pandemic. MSWs can "see" their patients and their families remotely through phone calls and video conferencing. Family members are taking initiative to engage MSWs, and community partners on Zoom platforms to discuss care

plans for their loved ones pointing to an emergence of family as patient's case manager. Zoom platforms have cut travelling time for meetings, bridge distances, enabling MSWs to have good quality case discussions with their community partners, thus improving care to their patients and their families.

Conclusion

In Chinese language, the character "crisis" [危机] contains another word "opportunity" [机]. The scale of the impact of the pandemic and the corresponding scale and speed of transformation are unprecedented. It is therefore apt to close this discussion with a clarion call to MSWs to commit to celebrate the strengths of all people and to "co-build an inclusive social transformation" (IFSW, 2021) over the next decade.

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Closing Remarks

by Corinne Ghoh, Next Age Institute

The MSW webinar series have illuminated how medical social workers (MSWs) worked under difficult situations in a pandemic. They struggled with decision making in meeting clients' needs and balancing the requirements of the agencies and the state on safety measures. The dilemmas faced put MSWs in a flux; having to make critical decisions to meet clients' urgent needs and having to find other means to confront emerging issues of the marginalised. When COVID-19 struck at the workplace, social work leadership had to act expeditiously to ensure staff's safety and well-being and at the same time, continue to manage the increasing workload. It is certainly not an easy feat and collective leadership played an instrumental role in managing the challenging situation.

There are 3 key takeaways from the learning. First, we should master the courage to speak and advocate for change. As a profession, it is our responsibility to understand, diagnose and communicate the challenges of the clientele and help them navigate the system of support. Innovation and change need not be notions that are far from reach. They can be small steps that make a difference in the lives of the vulnerable individuals. The collective impact cannot be undermined if each one of us takes a small step towards positive change. Second, in times of a difficult situation when we are faced with dilemmas in practice and management, we must remember to go back to the fundamental values of social work and its code of ethics. The knowledge base will guide us in decision making and in upholding our professional identity. Finally, as a profession, we need to constantly ask ourselves: "*why do we do what we do?"*. COVID-19 has exposed many gaps and vulnerabilities in human services and policies. These issues are both intra and interpersonal related, as well as systems related. Social work practice requires us to embrace reflexivity. We need to reflect on our assumptions if we have done justice to our clients, addressed the root of the problem, and being the change agent for the marginalised.

COVID-19 has highlighted how medical social work interventions cannot stop at the doorstep of health care institutions. The veteran social workers have shared the need to move beyond casework and embrace other creative methods of intervention to bring more sustainable outcomes to the clientele. To ensure a continuum of care, medical social work has to break new boundaries and move practice beyond the hospital to the community. The need for health-social integration is critical in the work forward.