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EDUCATION AND PROFESSIONAL DEVELOPMENT

Interprofessional education: the interface of nursing and social work

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Aims. To examine the influence of interdisciplinary seminars on undergraduate nursing and social work students' perceptions of their learning.

Background. Collaboration is considered to be important for health professionals in working towards good patient care, and interdisciplinary education is seen as one way of addressing this need for greater collaboration and team work. Today's health professionals are dealing with an increasing number of older and chronically ill patients. The biopsychosocial dimensions inherent in such chronic illnesses bring about a closer working relationship between the nursing and social work professions to foster good patient care. No local research in Hong Kong, however, has looked specifically at how these two professions can develop their collaborative skills and qualities through interdisciplinary education.

Design. Mixed methods design.

Method. Data from questionnaires, videotape recordings of the sessions and follow-up phone interviews were used for quantitative and qualitative analyses.

Results. The findings revealed three themes: an increased awareness of each other's professional values and personal judgement, a recognition of each other's disciplinary knowledge emphases and more, and an appreciation for, and learning about each other's roles for future collaboration.

Conclusions. Whilst, it is usual to identify health professionals as non-judgemental, it is also important to recognise the existence of their personal and professional values and beliefs that shape their decision-making. Equally beneficial for students is their reported understanding of the other discipline's emphasis on the physical or social aspects of care, and the interrelationships and complementary values that lead to students' appreciation of each other's roles and the possibility for their future collaboration in the holistic care of patients.

Relevance to clinical practice. The sharing of each other's knowledge and their appreciation of the corresponding roles enhanced students' decision-making capacity and the extension of the holistic approach beyond one profession, which is essential for good patient care.

Key words: collaboration, education, interprofessional, nurses, nursing, social work

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Introduction

Since the 1970s, many interprofessional education (IPE) initiatives have been launched internationally with the aim of developing and reinforcing the value of shared learning. The World Health Organization (WHO) started proactively to move this concept forward in 1978, as illustrated in its

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strategy to promote 'Health for All by the Year 2000' (WHO 1978). The Centre for the Advancement of Interprofessional Education (CAIPE) was created in 1987, providing a central platform for health professional educators to exchange and discuss ideas for new educational initiatives that would promote IPE. IPE, according to CAIPE's definition, refers to occasions when two or more professions learn from and about each other to improve collaboration and the quality of care (CAIPE 1997).

Thistlethwaite (2008) indicates an apparent growing international interest in IPE. A WHO Study Group on IPE and Collaborative Practice (Gilbert & Yan 2008) observe that there is currently a shortage of approximately 4·3 million health workers worldwide. Interprofessional collaboration is believed to have the potential to address this healthcare challenge and to offer a concomitant contribution to the enhancement of healthcare delivery. The Best Evidence Medical Education Group recently concluded that IPE is generally well received, enabling the acquisition of knowledge and skills necessary for collaborative work (Hammick *et al.* 2007).

The School of Nursing of our university in Hong Kong recognises IPE as a way to enhance collaboration with other healthcare colleagues. It likewise promotes our students' competence as they grapple with the increasingly complex health and social situations that result from technology, limited resources and other political and economic issues. The education of health and social care professionals is typically segregated in Hong Kong, posing a barrier to IPE (Lee 2003). However, the current ageing population, a global issue affecting both health and social care, provides a compelling reason for nurses to work with our social work (SW) colleagues. King and Ross (2003) indicated that health and social care workers often lack clarity regarding each other's professional roles. Wong *et al.* (1998) also examined the role expectations of health professionals such as doctors and nurses, finding that medical social workers in Hong Kong could work together with others. Despite the fact that nurses' contribution to healthcare has been brought more to the fore in recent years, many healthcare professionals are not familiar with the scope of the nursing role (Shugar *et al.* 1991). Given this backdrop, the authors proposed a teaching and learning project consisting of interdisciplinary seminars for students of nursing and SW. The approach was intended to enhance their learning about each others' conceptualisations of caring and their respective ethical decision-making processes, based on their profession-specific paradigms. The research team comprised eight faculty members: four from the School of Nursing and four from SW in the Department of Applied Social Sciences. All members had experience in teaching professional values, ethics or caring concepts.

Aim

This study examines the influence of the interdisciplinary seminars on both undergraduate nursing (N) and SW students' learning about each others' disciplinary knowledge in the ethical decision-making process and caring practice through a case scenario on elder abuse.

Method

The increasing success of problem-based learning (PBL) in the healthcare education system befits its use in IPE (Gosling 2005), hence this IPE initiative was structured with a PBL approach using an authentic case. A case scenario on elder abuse in Hong Kong was developed (Appendix 1), reflecting the ethical and medical issues with direct relevance to nursing and SW students' (SWS) educational training and their current and future practice (Parsell & Bligh 1998). This case was validated by clinical and academic experts in this area. Four cross-disciplinary seminars were conducted in total, with two concurrent sessions for two groups of mixed N and SW students. Each session lasted about three hours. The two seminars were conducted a week apart, allowing the students to search for necessary information for their subsequent discussion. A total of 32-senior year undergraduates – 16 N and 16 SW – participated on a voluntary basis. The N students had completed their courses on ethics and caring and their SW counterparts had completed an integrative assignment focusing on professional values, self and the professional context in SW. Prior ethical approval was sought from the university. Six lecturers from the nursing and SW departments, who were also members of the research team, were invited to be facilitators for these seminars.

Preparation of the student seminars

Prior to the first seminar, a project information sheet, the case study, a copy of an article on the ethical decision-making process and a set of four questions related to the case were sent to all student participants to stimulate their independent thinking. The questions focused on identifying the issues, the process of communication with the clients and the proposed care for the older person based on ethical reasoning. The facilitators received the same information as the students in addition to the facilitator's guidelines and a reference copy of the Procedural Guidelines for Handling Elderly Abuse Cases in Hong Kong.

First seminar

At the first session, the purpose of the project was explained to the students and their signed informed consents were obtained for both the project and the videotaping. After a brief introduction, six small groups were formed in the concurrent sessions. An equal balance of N and SW students was established in each group, except for two groups which had one more N or SW student. The facilitators listened to the small group discussions. After approximately one hour, the students reconvened in a large group. Each group shared its discussion and the floor was opened for further questions and comments from the other groups. Discussions, thereafter, were more spontaneous and student-led. The facilitators served as content experts or guided the process through questions that prompted the group to think more deeply about the content or to examine evidence that would substantiate their decisions. Facilitators devoted the last 15–20 minutes to a discussion of the learning process and of the knowledge acquired from each other.

Second seminar

The second seminar took the form of a small to large group meeting, or started off with a large group discussion, based on the group's preference. The same groups of students attended both the first and second seminars. Role play was used spontaneously. At the end of this seminar, students were asked to fill in the questionnaire and to provide some qualitative response to their learning from each other.

Data collection and analysis

Data were collected from the following sources:

1 A self-reported questionnaire comprising 14 questions, with the first five addressing the student's view of the interdisciplinary approach and the remaining nine on whether this approach was effective in furthering their learning about caring values and actions and the ethical decision-making process; it was anonymous. We used a five-point Likert-type scale anchored by 'very effective' (1) and 'very ineffective' (5).
2 Qualitative feedback from students at the end of the seminars.
3 Transcribed field texts from the video-taped students' discussions at the two seminars.
4 Two follow-up telephone interviews with students that were conducted by the research associate to clarify some of their discussions from the transcripts after the research team had reviewed the transcribed data.

The mean score of the quantitative data was tabulated and cross-referenced with the qualitative data, lending credence to the subsequent findings and interpretations. All data of a qualitative nature were read and re-read for themes and patterns. Sections in the text that yielded certain themes were eventually collapsed into various theme clusters. Members of the research team would then meet and engage in in-depth discussions of the themes and conduct further analyses where needed. This process continued back and forth until four theme clusters were identified: the ethical decision-making process, caring dispositions, interprofessional collaboration and logistics. Owing to the limited word count, this article will focus primarily on the aspect of interprofessional collaboration as its main theme, with findings on the other aspects reported elsewhere.

Findings

Through the interdisciplinary seminars, the collaborative learning by SWS and nursing students (NS) revolved around the following aspects:

1 An increased awareness of each other's professional values and personal judgement.
2 A recognition of each other's disciplinary knowledge emphasis and more mutual learning relating to the patient and family.
3 An appreciation for, and learning about each other's roles for future collaboration.

An increased awareness of each other's professional values and personal judgement

The interdisciplinary seminars provided an opportunity for the NS and SWS to engage in a process of problem solving, critical thinking and decision making. The sharing of their perspectives based on their personal experience and professional knowledge from their specific disciplines enabled them to reflect on their values, beliefs and professional and personal bias, to which many had given no thought, as demonstrated by the following students' comments:

> I also have a clearer picture about how I make decisions and which of my values are inherent in the discussion. Normally I would not think about them much. But …I became aware that I placed much emphasis on what the older patient wanted and the possible reasons for her choices based on her traditional Chinese family values. And I did not think too much about her health problem as addressed by our N peers. (SWS 1)

> When we discussed what would happen if the older patient valued something more than her life, I realised that I normally believe in 'doing no harm', so I would have tried to stop her from going home

and supported the calling of the police to arrest the daughter-in-law. Thanks to the SWS, I am now more aware of the need to respect the autonomy of the older patient and have come to realise that she might consider having an 'intact' family, being with her grandson, as of utmost importance. Our SW peers have also taught me the value of family counselling. (NS13)

I have come to recognise my own bias. Originally, I thought that the daughter-in-law was certainly the bad person. I didn't care what her motives were. But through our discussions with social work students, I see that she might also be a victim in this case. (NS7)

Quantitative data also show that students reported that this workshop had helped them greatly in the understanding of their own positions. For the question 'How would you rate the seminars in helping you to reflect on your position and on the analysis of the older abuse case?', a mean score of 1·93 between the descriptors 'very effective' and 'effective' was tabulated on the five-point Likert-type scale.

A recognition of each other's disciplinary knowledge emphases and more

Through the interdisciplinary exchange, SWS and NS learnt more about each other's emphases in decision-making processes. This recognition enabled them to learn about each other's unidisciplinary emphases. As psychosocial issues were the primary focus of the SWS, it was quite clear that NS socialisation at work might have inadvertently led many to focus on the biomedical aspects, with the psychosocial issues a distant second and referral to others also common. The following comments illustrate this point:

NS do study the psychological dimensions of health in class but we can't integrate them into our work, as most of the time on the ward we are concerned with the pathological aspects such as the medications and treatments that the patients are to receive from us. We might talk to the patients little and be unable to follow up. Also, once we have referred a patient to other professionals, we don't often follow up on the patient. (NS8)

I now understand more about the decision-making process of our N peers, who focus on health as the patient's basic need in relation to their duty: nurses have to attend to the patient's physical functions first and hence are less likely to intervene in the social aspects. For example, in this case, they talked about the patient's problem with nutrition and its management. They were not as inclined to address the abuse or the patient's social circle. Since we weren't taught such things, I would not be aware of what our N peers aptly pointed out, namely the fact that a lack of food intake would have made the older person malnourished and in need of attention. So this seminar was good: the discussions between different disciplines expanded my views. (SWS1)

I realised from our discussions with the SWS that, whilst nurses often talk about holistic care, we often focused primarily on the older patient's physical health.

We emphasised the way to dress her wounds but failed to look at how this information could help with other aspects of her care. It also made me realise that we were not good at communicating with the family. (NS10)

The seminars gave us an opportunity for exchange with SWS and together we were able to use different perspectives to see the same case. When talking about the elderly patient in the hospital and her not wanting to go into the elderly home, I noticed that because we focused on the potential physical harm to the patient due to the risk at home, we were strongly inclined to persuade her to go into the nursing home. SWS on the other hand would consider the consequences of her going to the elderly home, e.g. the fact that in an elderly home, she would be separated from her grandson. They looked at how she wanted to be with the grandson and considered that forcing her to go into an elderly home may worsen her already mild depression. (NS12)

NS and SWS reported learning from each other's knowledge emphases on the physical and psychosocial dimensions in their care. Emerging from the differences was SWS' recognition of the way NS used their knowledge in relating to the patient, which merited SWS' emulation in practice. Reciprocally, SWS also taught the NS about communication as both an attitude and a skill in relating to the family. The following comments illustrate this point.

Mutual learning about relating to the patient and the family:
I am more aware of the actual situation of how nurses care for patients. It was a very natural process. Nurses see their patients several times a day, so they are able to build better relationships only by saying a few words to show concern, which is a significant step in the relationship-building process. But for social workers, when we visit a patient, we normally have a goal. First is an assessment, followed by trying to understand and get an in-depth background history. So for us the care is very functionally oriented. (SWS2)

I am more appreciative of how nurses first address the patient's physical health.... They will first talk to the patient to show their care, to establish a relationship and thus gain their trust so that they can help the patient (in this case) to eat better and thus improve the problem of malnutrition. (SWS4)

Social workers can use the topic of health as an ice-breaker when trying to establish a relationship with the patient. Nurses could provide this information to us so that the patient may feel that the

social workers also care for and about them. This would help to establish a rapport with the patient, which is critical for our later follow-up work. (SWS3)

Through role play and listening to NS' comments about the locations of the bruises and how the patient would be unlikely to have sustained these injuries from a fall as stated by the daughter-in-law, I have learnt to think beyond the often open and non-judgmental approach that social workers adopt. We could complement this with a stance of 'confronting' the daughter-in-law when sufficient good reasons were there for us to conduct an assessment of a suspected case of elderly abuse. This would make the daughter-in-law more self-aware and able to face the issues and their management. (SWS4)

…social work students seemed to view the situation with a wider lens and were more open-minded than us. They saw a need to explore a situation with other stakeholders before arriving at a conclusion. I have developed a new perspective. For instance, I used to think that the daughter-in-law was wrong, but now the social work students have taught me to keep an open mind. (NS2)

The social work students have taught me a lot about how to approach and talk to the patient or her family. This helped me to transfer some of the communication skills I had learnt from books into practice. For example, the meaning of empathy, the tone of our voice, etc. Equally importantly, I also learnt that SWS were more skilful in their approach with the daughter in-law, finding out her view of the situation; they would use words which were not too threatening and would not put the daughter-in-law on the defensive. (NS6)

From the exchange, the SWS and NS reported a greater appreciation of each other in terms of what they had learnt. They indicated that they had gained a better understanding of each other's emphases in care, whilst recognising that at times, although nurses and social workers would give attention to similar psychosocial and physical issues, which issues would have first priority might vary. Learning about each other did facilitate their better understanding of each other's roles, serving to remind the nurses of the importance of the psychosocial issues of care and raise the awareness of the social workers of the potential use of a relatively less sensitive area of the patient's physical health to probe into the abusive situation. It further allowed NS to learn about ways to follow the lead of the family and not to make them feel threatened and defensive in cases of abuse.

Whilst it was not easy to be totally non-judgemental, the SWS' training to be open to each version of the story from different stakeholders of the situation might have enabled them to keep their own bias in abeyance. The SWS recognised at times that they might need to have more hard evidence, e.g. on the location of the bruises – information that they could receive from the nurses in their assessment of an abusive situation with the family. The SWS also reckoned that their collaborative effort with the NSs could begin with the transfer of the patient's trust in the nurses to them through their close working relationship with the nurses. In addition, the sharing of information about the physical injuries broke the habit of working in their own disciplines, thereby promoting better patient care.

On the whole, students thought that the workshop was highly beneficial to them, as demonstrated in their responses to the question 'How would you rate the use of the cross-disciplinary approach through group discussion in facilitating your learning?', which yielded a score of 1·93, between the responses of 'very effective' and 'effective' on the five-point Likert-type scale. Students were satisfied that learning through the interdisciplinary seminars had yielded an understanding of the nature of their collaborative efforts in practice.

An appreciation for, and learning about each other's roles for future collaboration

The quantitative data for the question, 'How would you rate the cross-disciplinary approach in enhancing your understanding of the roles and practices of the other discipline?' revealed a mean of 1·77, landing a score between 'very effective' and 'effective' on the five-point Likert-type scale. This finding is also reflected in the qualitative feedback:

I liked this interdisciplinary discussion much better than the unidisciplinary discussion, particularly because we don't have a close co-operative relationship and only collect information pertaining to our own professional needs without much dialogue. I know nurses are quite busy and usually don't have the time to discuss a patient's situation. I also think that as professionals we might all think that we are right. But without more communication we are blinded by our profession and our socialisation and knowledge will inadvertently shape our thinking in certain directions. The seminars helped us to understand each other's professional assessment of the situation. They made me think about how both disciplines could contribute to the care of the older person. (SWS7)

In students' learning about each other's roles in future collaborations, there is also an optimisation of the use of time, which is often limited, for good patient care:

Even if we had more time to spend with the patient, we still would not be able to spend the kind of time that nurses do with their patients. So, by understanding what the other profession thinks, we are better able to work together because we will be less insistent on our views and thus better communicators. (SWS9)

The discussions with the SWS helped me to see how nurses functioned in their professional realm, e.g. when we saw the bodily injuries, we would focus primarily on the treatment through the application of the medication and monitoring its effect, rather than, like the SWS, wondering about the cause of the injury. So, for N, we could ask more questions during the treatment process and could gather more information that would be helpful to the social worker. Alternatively, if we had suspicions about what had happened to the older patient and didn't have the time to talk to her about the matter for too long, we would be able to work together with the social workers as they would be able to fill in the gaps. (NS12)

The above describes students' learning about interprofessional support to provide good care. This aspect enhanced their decision-making capacity as SWS and NS were able to work across professional boundaries with their role awareness and negotiation, focusing on how to enhance and not to duplicate their efforts. Time spent with the patient is an issue in a clinical environment where health professionals as human resources are limited. Finding a way to optimise our patient care through collaboration may address the time issue. Whilst some SWS thought that nurses could be spending relatively more time with their patients and hence providing more information to the social workers, others understood the busy nature of nurses' work and appreciated that each nurse might not 'have time to talk to the patient about the matter for too long.' SWS were also appreciative that it might be more natural for nurses to find out more about the older patient's background and the relevant issues in a conversational manner, compared to the way that social workers visit the older patient to conduct an assessment of the abuse.

Discussion

An opportunity for learning about different emphases in the management of older abuse was created through interprofessional seminars in the nursing-social care interface. The interprofessional seminars raised students' awareness of cross-boundary work through the sharing of discipline-specific knowledge and their collaborative potential and possibilities. The sharing and consequent better understanding of each other's roles and skills enabled them to view patients' issues from a wider perspective. The inherent benefits from interprofessional work (such as our nursing-social care interface) include not only an enhanced decision-making process but also, importantly, a timely referral of services for patients (Cook *et al.* 2001). Our student participants reported that this interprofessional exchange had enhanced their understanding of their decision-making process in their assessment and management of the older patient in an abusive situation. The nature of the decision-making process reflected the discipline-specific knowledge and its corresponding reasoning approach. The discussions between the disciplines in terms of the patient's biomedical and psychosocial needs led to a more comprehensive decision-making process that was patient-centred. The enhanced decision-making capacity in the addressing of problem identification and solving was also apparent. Whilst the SWS were more inclined to think of the different stakeholders' perspectives of a situation, working from an inductive approach for problem identification, the NS seemed to be more solution-oriented. The practical constraints in the hospital wards and the professional socialisation of nurses in Hong Kong might have led to an expectation of task completion and a focus on solutions. One needs to re-examine this reality since much of nurses' experience with biomedical knowledge involves logic and analysis that would inadvertently move us away from the meaning of a patient's experience and her/his environment.

As for the time engagement, collaboration in the form of teamwork becomes a means of ensuring the most effective and efficient provision of health and social care. Teamwork means better communication between N and SW, with more prompt referrals and less likelihood of patients falling between services. Mizrahi and Abramson (2000) noted that one often-cited barrier to the development of collaboration is the lack of time for different disciplines to work together. The introduction of the interprofessional learning paradigm with undergraduate students may help to develop their propensity to collaborate with other health professionals, encouraging them to see it as necessary rather than time-consuming. Findings from our study show that students perceive that the collaborative effort can actually help them to optimise each other's time in their contribution to patient care. The intention is not to dilute professional roles and identities. Rather, it is to promote team-working skills that enable health professionals to develop knowledge of each other's roles, better communication, a willingness to work together, trust related to self-competence and confidence in others' abilities and mutual respect (D'Amour *et al.* 2004) as the key determinants for collaborative practice. In addition, holistic care is a valuable concept that health professionals embrace in their care of patients. Given the complex nature and the multiple needs of patients, the interprofessional collaborative effort could facilitate our endorsed holistic approach to a patient's care beyond our own disciplinary knowledge (Fowler *et al.* 2000), whereby a contribution from, in this case, nurses and social workers, is enhanced. In particular, patients' psychosocial needs could be better attended to

through this collaborative effort in the context of clinical demands and expectations of nurses' time. Concomitantly, learning about each other's roles in the management of the patient not only emphasises how teamwork could be possible in collaboration, but also offers an understanding of the decision-making process from other alternatives such as the available community resources; more attention to the bio-psychosocial dimensions was better appreciated in this interprofessional discourse. Finally, the students' increased awareness of their professional values and personal judgement in shaping their assessments and decisions is important for their learning about being 'situated' in a meaningful world that is informed, for instance, by our experiences with family, culture, sets of relationships and practice. This critical consciousness of values and beliefs is important to health professionals, since neutrality makes it less likely that implicit norms and assumptions will shape the students' decisions (Doane & Varcoe 2005).

It is not our purpose to claim that a focus on IPE alone will provide answers to the problems of collaboration across the social-health care boundary. We would argue, though, that a neglect to afford students such opportunities may well lead to a potentially less-effective collaboration than patients deserve. Whilst there might be issues with turf boundaries (D'Amour *et al.* 1996) and a threat to the autonomy of health professionals as they become more interdependent of each other (Quartaro & Hutchison 1976), the students in our studies valued each other's disciplinary knowledge as complementary. For health professionals to collaborate, there needs to be a sense of commitment to the process, which is not easy. Skei (2008) contends that 'the capacity and will to collaborate lies in each professional in the given encounter' (p. 1908). Hence, an earlier integration of this experiential learning into the undergraduate programme not only as a theory but rather as a curriculum redesign is essential to enable students to truly appreciate and understand what collaboration means.

The education process for this interprofessional planning remains contentious; as Thistlethwaite (2008) asks, when is the best time to introduce IPE and how? As our local IPE is emphasised only at the graduate level (Lee 2003), we would support the development of interactive shared learning modules for nursing and SW in the senior years of their undergraduate curriculum. Further, given the hierarchies (Chase 1995) and specialisations in the health professions, collaborative efforts among some health professionals, for instance the interactions between nursing and SW, could be considered to be relatively less complex and difficult (Quartaro & Hutchison 1976, Mizrahi & Abramson 2000, Cook *et al.* 2001).

Limitations

Whilst the findings are positive, there are limitations to this study. First is the method of purposive sampling. Students who volunteered to participate, from one university, might already have the openness and motivation to learn from peers of another discipline. A second limitation is that whilst the study comprised a qualitative core component with a quantitative strategy and 30 participants meets the minimum number required to estimate a mean score (Pett 1997) the sample size was nevertheless small for the quantitative part.

Relevance to clinical practice

The interprofessional seminars provided students with a reflective glimpse into their clinical encounters with each other, which are otherwise limited; the way the clinical context establishes the nature of interprofessional communications and relationships is considered to be minimal between nurses and social workers. Many simply communicate through the patient's chart.

Conceptually, interprofessional seminars could make a difference to student participants' ways of thinking and working together, which would lay the groundwork for changes in practice. The latter would merit our further study, especially in the areas of the optimisation of time and improvement of the holistic approach in their collaboration. Undoubtedly, the idealistic goal of collaboration is often hard to achieve given the practical constraints on hospital wards (Reeves & Lewin 2004). SWS' expectations of nurses' shared findings regarding patients' needs would, therefore, demand both practitioners' commitment and support within the clinical structure. Patient-centred care demands a concerted effort by both nurses and social workers towards an understanding of the total pattern of the abusive situation based on the patient's meaning of the situation and the family issues in the social context (Newman 2008).

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Contributions

Study design: EAC, MCSP, SKSL; data collection and analysis: EAC, SP, SC & SKSL and manuscript preparation: EAC with the help of the research assistant NL.

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Appendix 1 A case scenario on elderly abuse in Hong Kong for the interdisciplinary seminars

Mrs Leung was a 75-year-old widow who lived with her son, daughter-in-law and a 3-year-old grandson on a government housing estate. Her daughter-in-law was a housewife. The relationship between Mr Leung, her son (Mr Leung) and her daughter-in-law had previously been fine. However, not long after the grandson was born, Mr Leung was laid off. He could not find a full-time job, and he had been working part-time ever since. The home felt more crowded as the grandson grew older. The couple frequently quarrelled because of family and financial matters.

Mrs Leung once complained to her son that her daughter-in-law was always going out to play mah-jong and did not do any housework. Her daughter-in-law was very angry and hit her with a wooden stick the next day. She had not allowed Mrs Leung to talk to or touch her grandson since then. The daughter-in-law often criticised Mrs Leung, saying she was old, useless and dirty, and asked her son to send her to a nursing home. They each complained about the other to Mr Leung but he did nothing to solve the problems. He only asked his mother and his wife not to cause him any headaches.

Mrs Leung was only provided with one meal a day and was given the leftovers. She was seldom allowed to go out or to make any phone calls. She sneaked out sometimes and wandered in shopping malls or stayed in parks until late at night. Sometimes Mrs Leung told her neighbours about how she was treated by her family, but when people asked her to seek help from social workers or the police, she flatly refused because she felt ashamed.

One day, Mrs Leung was crying and wandering in the corridor outside her flat. Her neighbour, Mrs Chan, saw her and asked her what had happened. Mrs Leung looked very pale. As she sobbed, she started to feel dizzy and collapsed. Mrs Chan took Mrs Leung to the hospital. Bruises were found on her arms and legs, and she was also diagnosed with mild depression.

Mrs Leung and her family had not been seen by any social workers before. Given their financial situation, Mrs Leung's case was referred to the social worker during her hospitalisation, to assess and to identify any family problems. The nurse monitored Mrs Leung's physical condition and noticed her interactions with her family members in the hospital. She was found to be emotionally unstable at times, and her son blamed her for the trouble she had created. Mrs Leung claimed that she did not want to move into a nursing home, and refused the social workers' follow-up visit.

