Canadian Social Workers and Complementary and Alternative Therapies:

A web based survey of their knowledge, use and attitudes.

by

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Finally and most importantly, my deepest gratitude and thanks to my family and friends, for their ever present love, encouragement and confidence in me and my abilities.

Dedication

This thesis is dedicated to all those who dedicate their time to caring for themselves and others in a compassionate and holistic way.

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Abstract

The growing interest and use of complementary and alternative approaches by the general public has created pressure on many health care providers to broaden their traditional scope of practice and integrate complementary and alternative therapies into their repertoire. This study examined the knowledge, attitudes, and level of integration of complementary and alternative approaches by Canadian social workers. Due to limited literature on social work use of complementary and alternative approaches, a broad operational definition of Complementary and Alternative Medicine (CAM) was utilized in the study and a wide range of approaches were listed in the questionnaire.

This cross-sectional, descriptive, quantitative research study included 311 Canadian social workers. A self-administered, web-based survey was developed for the study to examine social workers' level of knowledge, use, as well as attitudes toward complementary and alternative medicine.

Based on the findings of the study, Canadian social workers demonstrate general familiarity with CAM, however are less likely to be trained in the approaches. Despite lack of appropriate training, a significant number of social workers integrate complementary and alternative approaches into their practice. Overall, Canadian social workers hold a positive attitude toward complementary and alternative medicine. They express interest in broadening their knowledge in CAM as well as are open to integrating some approaches into their practice.

Implications of the findings and further research suggestion are offered at the conclusion of the thesis.

There are several implications from this study, most importantly the need for clear guidelines around integration of those approaches into social work practice and inclusion of complementary and alternative methods into social work educational curriculum.
There exists number of external and internal threats to validity of the study.

The limitations of the study include lack of participation from a number of Canadian provincial social work regulatory bodies. Also the use of web based, English only survey, and may have deterred some social workers. Self-selection process may have attracted those with extreme opinions about the topic. The descriptive nature of the study did not require manipulation of the variables, the analysis was bivariate, and, therefore could not account for confounding factors.

CANADIAN SOCIAL WORKERS AND COMPLEMENTARY AND ALTERNATIVE THERAPIES: A WEB BASED SURVEY OF THEIR KNOWLEDGE, USE AND ATTITUDES.

Chapter I

STATEMENT OF THE PROBLEM

Introduction

In pursue of health and well-being, general population has increasingly been utilizing modalities outside of allopathic medicine. In the last two decades, Complementary and Alternative Medicine (CAM) has received increased attention from the general population and consequently from the healthcare system. This increase of interest and rise in use of CAM has stimulated questions and research around frequency of use (who, when, why) (Esmail, 2007; Metcalfe et al, 2010; Millar, 2001; Statistics Canada, 1995; Verhoef & Findlay, 2003), safety and efficacy of approaches (Grant et al., 2009; Mamtani & Cimino, 2002; Russinova et al., 2009), and exploration of integration of allopathic (western) medicine and CAM (National Institute of Health, 2002; Tataryn, 2002; Verhoef et al., 2001) .

With an increased use of and demand for CAM by the public, sporadic integration has been observed within the healthcare system. Tataryn and Verhoef (2001) predicted "upward pressure" toward integration starting at the consumer level, pushing up and affecting first individual practitioners, then clinics, institutions, profession/regulatory bodies and finally both conventional and complementary and alternative healthcare systems.

"Globally, the approach of the World Health Organization (WHO) to CAM is encapsulated in its five-year *Traditional Medicine Strategy,* launched in 2002 (World Health Organization, 2002).

The strategy is a working document, yet to be adopted as official policy, with the stated aim of: (a) integrating CAM into the national health care system of the world's nations; (b) expanding the knowledge based on CAM; (c) increasing the availability and affordability of CAM; and (d) promoting the sound use of CAM" (Hughes, 2007).

In 2004, funded by Health Canada and the Canadian Institute of Health Research The Canadian Interdisciplinary Network for CAM Research (IN-CAM) was created to foster excellence in complementary and alternative medicine (CAM) research in Canada (IN-CAM, 2011).

Integration has been explored by many professions. In United States,

"A distinct trend toward the integration of complementary and alternative medicine (CAM) therapies with the practice of conventional medicine is occurring. Hospitals are offering CAM therapies, health maintenance organizations (HMOs) are covering such therapies, a growing number of physicians use CAM therapies in their practices, insurance coverage for CAM therapies is increasing, and integrative medicine centers and clinics are being established, many with close ties to medical schools and teaching hospitals." (National Institute of Health, 2005).

Tataryn (2002) argues that in order for the integration to occur in the health care system and institutions, each profession within the system must become holistic in their attitude and approach. Cook, Becvar and Pontious (2000) states that "(t)he ideal health care delivery system incorporates the best of both CAM and allopathic practices in order to best meet the needs of clients and their families" (p. 52). Over the years health professions have explored the feasibility of integration of complementary and alternative approaches with western methods successfully integrating specific techniques into their existing scope of practice.

There is recognition of "the effectiveness of alternative medicine's approaches to health, which blend body and mind, science and experience, and traditional and cross-cultural avenues of diagnosis and treatment" (Yusof, 1999, p. 30).

Social Work Theoretical Framework

In the book, "Unfaithful Angels: How Social Work has abandoned its mission" by

Specht and Courtney (1994) argue that social work has lost its roots in community-level intervention with underserved and dis-enfranchised populations in favor of individual psychotherapy in frequently private practice settings with mostly white, mostly middle-class clients. Social work has become a broad profession that seems to be present in most areas of social structure, including healthcare, however continue to work with underprivileged populations.

With an expansion of the social work scope of practice, the theoretical frameworks developed to fit the context. Ashcroft (2011) offers a pedagogical model, utilizing three social work-specific typologies developed by Payne (2005, 2006) of conceptualizing current, dominant health paradigms which influence understanding of health and wellbeing and inform social work practice. Payne (2006) claims that "Every bit of practice, all practice ideas, all social work agency organization and all welfare policy is a rubbing up of three views of social work against each other" (Ashcroft, 2011, p. 613). The three views of social work which are important for health include: the therapeutic view, the social order view and the transformational view (Ashcroft, 2011). "The therapeutic view is a foundational idea of social work and … is dominant in the social work health literature… conceives social work as pursuing and engaging in wellbeing of individuals, groups, and communities by promoting and facilitating growth and self-fulfilment" (Ashcroft, 2011, p. 613). The social order view sees social work as part of welfare system, to aid individuals in times of crisis by providing them with services that would enable them to fit into society and meet social expectations (Ashcroft, 2011). The transformational view of social work underscores the need for transformation of the society in order to bring benefit to all. Ashcroft (2011) claims that "The typology of social work is a pedagogical tool that can help us to critically assess how compatible approaches to health are

with social work values" (p. 613).

Social Work values diversity in beliefs, doctrines and practices (CASW, 2005). Ashcroft (2011) outlines six dominant health paradigms that currently operate and influence health discourse. The six currently known and influential paradigms of health include: biomedical paradigm, public health, biopsychosocial, social determinants of health, political economy and holism. Each health paradigm places social work within the dynamic triad of social work typology (Ashcroft, 2011). As described by Ashcroft (2011), holism is the only paradigm which connects and engages all three views of social work typology. "Social work practice influenced by the holism paradigm see that 'any client, be it individual, family, community, is by definition both a part and a whole'" (Ashcroft, 2011, p. 620).

Social work philosophies seem to naturally endorse an integrative and holistic (bio-psycho-socio-spiritual) approach to assessment and intervention, with the recognition of the interconnected and interdependent nature of the bio-psycho-socio-spiritual components within a person (Henderson, 2000; Lee et al., 2009). In addition, the fundamental social work perspective of 'person-in-environment' encourages a broad and in-depth contextual look at issues faced by individuals, families, groups and society (Germain & Gitterman, 1996). Social work pays close attention to determinants of health and strives to impact them in order to make healthy living available for all (Heinonen & Metteri, 2005; Marmot &Wilkinson, 2006). One of the determinants as defined by the Public Health Agency of Canada is 'Personal Health Practices and Coping Skills', which "refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health" (PHAC, 2013). Cartesian dualism and the biomedical model of health, which currently dominates the western healthcare system creates a split between mind-

body-spirit and supports social work approach that is equality dualistic (Specht & Courtney, 1994). Biomedical model also places "emphasis on improving the individual client's capacity for self-sufficiency… (and meet) individual needs in order for a hospital or medical facility to operate more effectively" (Ashcroft, 2011, p. 617). In the last two decades social work has recognized the need to pay more explicit attention to spiritual needs of clients (Canda, 1988; Keefe, 1996). Canda (1988) emphasizes spirituality as a basic and fundamental aspect of human experience. Spirituality is intrinsic in a holistic paradigm of health, which strives for balance and harmony within individual. Holism has been long rooted in eastern and indigenous traditions and approaches (Ashcroft, 2011; Lee et al., 2009). Currently, the Canadian Association of Social Workers states that the primary concern of a social worker is "the social well-being of all people equally with attention to their physical, mental and spiritual well-being" (CASW, Social Work Scope of Practice, 2008, p. 1).

The definition of spirituality is distinguished from that of religiosity. Generally, religion is defined as a social form: beliefs, values and rituals, while spirituality is viewed as a personal experience of connectedness with others and the universe (Dane & Moore, 2005). Burke and Miller (1996) state that "turning to the spiritual dimension may be an attempt to find some meaning and effective coping styles" (p.188). The concept of health, illness, and end-of-life issues are social constructs and are often intertwined with persons' spiritual and religious beliefs. These beliefs may have significant impact on understanding and treatment of illness, as well as coping with it (Reese & Kaplan, 2000).

Rousseau (2000) suggests various spiritual practices that social workers can employ (meditation, guided imagery, prayer, yoga, expressive therapies, such as art, music, and writing) when working with clients to explore the meaning of illness and life and promote healthy coping.

Many of these techniques have become a regular part of social work practice; yet they are what are identified as complementary and alternative approaches. Alternative approaches to physical, mental and emotional healing "have been recognized in countries like China, India, Asia and some parts of Europe as interventions that use holistic approaches to healing" (Yusof, 2001, p. 7). These alternatives are not generally taught in Canadian post-secondary institutions as part of social work curriculum. Yet, social workers are encouraged to participate in continuing education for the growth and relevancy of their practice methods, so too does the field of social work itself face an opportunity for growth and the betterment of practice (Dziegielewski, 1998; Gant, et al., 2009, Henderson, 2000; Runfola et al., 2006).

Clinical Social Work practice continues to be influenced by dominant health paradigms (Ashcroft, 2011), including "individual theories, human behaviour, social change to affect positive psychological, social, and economic change and resources" (Henderson, 1997, p.4). The Canadian Association of Social Workers acknowledges that social work practice "is broadening again to include new advances being made in the humanities and sciences", including CAM use (CASW, 2012, p. 4; Henderson, 1997). In addition to the presence of scientific evidence that suggest positive effects of CAM use on physical and emotional health, the increasing trend of use of CAM by the public, signals the prominence of the holistic paradigm of health. This urges social work profession to expand professional knowledge and skills.

Purpose of the Study

The study aims to explore and describe Canadian Social Worker levels of knowledge, personal and professional use, and attitudes toward complementary and alternative therapies. The research was stimulated by increased interest on the part of both consumers and practitioners

to explore the holistic approach to health and the use of Complementary and Alternative treatment methods for physical, emotional, and mental complaints. Limited literature on social work and complementary and alternative approaches and absence of Canadian data further impelled this exploratory study.

Definition of CAM

The definition of Complementary and Alternative Medicine (CAM) varies from one publication to the next. For the purpose of this study a broad definition of CAM is used as described by National Institute of Health (1997). In 1997 CAM was formally defined as " a broad domain of healing resources that encompass all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health systems of a particular society or culture in a given historical period" (NIH Panel on Definition and Description, 1997). Most often CAM is defined and understood as a "group of nontraditional medical systems, treatments and products that are used to either accompany or replace conventional medical treatments" (Strozier, 2008, p. 3). CAM can broadly be divided into five subcategories or domains:

1. Alternative Medical Systems (Chinese Medicine, Ayurvenda);
2. Biologically based therapies (herbal products, dietary supplements);
3. Manipulative and Body-based methods (Massage therapy, chiropractic services);
4. Mind-Body Interventions (meditation, creative arts, prayer);
5. Energy Therapies (Reiki, Therapeutic Touch), (Esmail, 2007).

Some complementary and alternative approaches are complete systems of assessment and treatment, while others are singular modalities of intervention. Some approaches have well-developed regulatory structures (e.g. chiropractors or massage therapy); others are less or not at

all organized or regulated. Despite the general lack of organization of CAM approaches, individuals have utilized them in conjunction with or instead of conventional treatments. Throughout the thesis the following terms will be used interchangeably: Complementary and Alternative Medicine (CAM), complementary and alternative approaches/therapies, and alternative/complementary treatments/modalities.

Chapter II

LITERATURE REVIEW

Introduction

The following section will explore the Canadian prevalence rates of CAM use, efficacy of CAM, motivation to use CAM and literature on integration of CAM into mental health professions psychology and marriage and family therapy. Finally literature specific to Social Work and complementary and alternative approaches will be explored.

General Prevalence

Reported prevalence rates of CAM use vary based on the functional definition used and which treatment modalities are included in the study. For example, chiropractic services tend to have the highest prevalence rates, and thus can increase the overall rates (Esmail, 2007). Also, some researchers and survey respondents view certain CAM modalities as mainstream (e.g. self-help groups) and may not include them in the responses. Some studies include complementary and alternative products; others only examine CAM practitioner use. Keeping these variations in mind, let us examine CAM prevalence rates in Canada.

"In 2006, nearly three-quarters of Canadians (74%) had used at least one alternative therapy sometime in their lives" (Esmail, 2007) .It has been estimated that 3.8 million (approximately 12%) Canadians have used a CAM practitioner in the past twelve months (Millar, 2001; Verhoef & Findlay, 2003). The Canadian National Population Health Survey revealed a 15 % rate of CAM practitioners use in the nineties, (Statistics Canada, 1995); later research indicated that 20% of Canadians use CAM (Park, 2004). These rates (12-20%) correspond to the varied findings for many other countries in the world, including US, Europe

and Australia (Sirois, 2008). Variations in the prevalence rates may be due to methodological differences between the studies and operational definitions of CAM.

Demographics of CAM use

In general, in Canada it has been found that:

i. Women are more likely to consult alternative practitioners,

ii. The rates vary regionally and increase as we move further west,

iii. Prevalence rates increase as income and education level increase,

iv. Individuals with chronic conditions are more likely to use CAM, and the use increases with an increase of number of chronic illnesses reported (Esmail, 2007; Kelner & Wellman, 1997; Millar, 1997; Millar, 2001). Studies have shown that children also engage in CAM use. Fifteen-percent of households with children under 18 used CAM, chiropractic care (43%) at the highest rate, followed by herbal remedies (22%) and massage (21%) (Esmail, 2007).

In 2006, the Fraser Institute conducted a Canadian National study of general use and public attitudes toward CAM (Esmail, 2007). The results revealed that nearly three-quarter (74%) of Canadians used at least one complementary and alternative therapy (CAT) sometime in their life (Esmail, 2007). Lifetime CAM use varied regionally, Alberta (84%) having the highest use of CAM in a lifetime, followed by British Columbia (83%), Saskatchewan and Manitoba (78%), Ontario (75%), Quebec (67%), and Atlantic Canada had the lowest rate of 63%. The most commonly tried modality was chiropractic service (40%), followed by massage (35%), relaxation (20%), and prayer (18%), (Esmail, 2007).

The same study revealed that in the past 12 months, more than one-half (54%) of Canadians used at least one type of CAM, an increase of 4% since 1997 (Esmail, 2007). The regional variations

persisted, with western provinces demonstrating a higher rate of use: Alberta (68%), British Columbia (64%), Saskatchewan and Manitoba (59%), Ontario (55%), Quebec (45%), and Atlantic Canada had the lowest rate of 39%. It is important to acknowledge that the use of CAM rates increased in all of the provinces since 1997. These rates translate into an estimated approximately $7.8 billion out of pocket spent in a 2005-2006 period, as compared to $5.4 billion in 1996-1997 (Esmail, 2007).

Use of CAM diminished by age, with the highest rate observed at the 18-34-age bracket (58%). The prevalence also increased with income (52% of CAM users earned $20, 000 or less, and 61% in those in $80, 000 + bracket), and education (37% of high school educated and 62% university educated individuals) (Esmail, 2007).

CAM types and health conditions

In 2006, the most commonly used therapies were massage (19%), prayer (16%), chiropractor (15%), relaxation techniques (14%) and herbal therapies (10%). The lifetime prevalence of use of those who used the approach in 2006 was highest for prayer (87%) and relaxation techniques (71%) (Esmail, 2007).

The ten most common medical problems for which individuals sought alternative treatments were chronic in nature: allergies (29%), back/neck pain (28%), arthritis/rheumatism (21%), difficulty walking (17%), frequent headaches (14%), lung problems (13%), digestive problems (11%), gynaecological problems (9%), anxiety attacks (9%) and heart problems/chest pain (7%). Massage therapy, prayer and relaxation techniques were the most commonly used by respondents for those conditions (Esmail, 2007).

In their review of literature, Sparber & Wootton (2002) found that “(i)ndividuals with

panic disorders and major depression were significantly more likely to use CAM" (p. 95). In addition they found that CAM use was positively related to an increased consumption of conventional care (Bausell, et al., 2001; Sparber & Wootton, 2002; Untzer et al., 2000). Wang and colleagues (2001) estimated that in 1996 about 13% of Canadian residents with major depression visited a CAM practitioner in the previous year. In the study of 435 patients with bipolar disorder, Kilbourne and colleagues (2006) found that 54% used prayer/spiritual healing, 53% used meditation, 50% use vitamins and minerals, and 41% used relaxation and breathing exercises to manage their symptoms. Similar results were found by Elkins et al., (2005) in a general psychiatric population. Most of these studies also found that majority of the respondents did not discuss CAM use with their conventional medical care providers. Due to possible negative interactions, particularly with herbal/mega doses of vitamins and pharmaceutical medications, researchers urge that mental health providers be aware and ask about CAM use. Interestingly, most people chose CAM as prevention and wellness maintenance, and the respondents showed an increased confidence in their alternative health providers (55% had "total" or "a lot" of confidence in 2006, as compared to 43% in 1997)(Esmail, 2007). In a Canadian study, using semi-structured interviews (n=300), Kelner and Wellman (1997a) found that individuals in a higher socio-economic bracket sought CAM for spiritual and emotional concerns, self-development, and health maintenance rather than serious and chronic illness Ten years later, some demographic shifts were observed. Sirois (2008) found that "the 2005 CAM consumers were less educated, had slightly more chronic complaints, had been using CAM for longer, and were more likely to consult chiropractors, reflexologists, and therapeutic touch practitioners than the 1997-8 consumers" (Sirois, 2008, p. 1).

Efficacy of CAM

The proof of CAM efficacy has been hard to determine. Smith beautifully summarizes the shortcomings of current research approaches as applied to CAM,

> "The reductionistic approach of the randomized controlled trials may fail to allow for the holistic effect that is central to the philosophy of most complementary therapies. Further, the beneficial effects are often so obvious, the side effects so rare or mild, and the duration of effect so variable even after a single exposure that perhaps observational studies may be enough to prove benefit. If not, then randomized controlled trials that compare whole treatment or packages of care, rather than individual treatments may be a better approach. This would allow inclusion of the things that matter to patients rather than just those that matter to the investigators." (Smith, 1995, p.1151-1152).

The medical and scientific community seeks and encourages evidence of CAM efficacy. There is pressure to demonstrate effectiveness using a large sample, quantitative, randomized, controlled trials, where the results can be generalized. CAM researchers face methodological challenges in trying to use research approaches developed by and for the conventional biomedical issues, which differ and conflict in the philosophical framework (Smith, 1995). It is often unknown why or how CAM approaches work, for they do not always target physical aspects of a person in isolation, but rather have a holistic and individualized approach to healing. Due to the complexities and lack of clarity of the mechanisms behind many approaches, "researchers must become very familiar with the particular details of an alternative therapy they plan to evaluate"(Canadian Strategy on HIV/Aids, 2001, p.40). "(T)here is reliable data from clinical trials for some CAM therapies and this knowledge base is growing rapidly. However, the cumulative number of clinical trials is small, and at the moment, consumer demand has outstripped clear evidence of efficacy and safety for many CAM therapies" (Canadian strategy on HIV/Aids, 2001, p. 40).

An Institute of Medicine, 2005 Cochrane review of CAM effectiveness revealed that

"47% of CAM treatments have a positive or possibly positive effect, 56% have insufficient or inconclusive evidence of effect, 5% have no effect, and less than 1% to have a harmful effect" (Gant et al., 2009, p. 409).

In their literature review, Mamtani and Cimino (2002) found many controlled studies yielded promising results in the area of chronic pain, insomnia, anxiety and depression. They reported, "There is sufficient evidence, for example, to support the use of: a) acupuncture for addiction problems and chronic musculoskeletal pain, b) hypnosis for cancer pain and nausea, c) massage therapy for anxiety, and the use of d) mind-body techniques such as meditation, relaxation, and biofeedback for pain, insomnia, and anxiety" (Mamtani & Cimino, 2002, p. 367). Runfola et al. (2006) also found evidence to support CAM use to: boost the immune system, improve general quality of life, minimize side effects and toxicity of conventional treatments, pain management, and stress reduction.

Russinova et al., (2009) conducted a qualitative study of 255 individuals, who self-identified as living with serious mental illness (SMI) and employed CAM, and reported a wide spectrum of benefits that encompassed all major areas of human functioning, including physical, emotional, cognitive, self, social, and spiritual domains. Although the improvement of anxious and depressed mood emerged as a primary perceived benefit, participants felt that CAM use also enhanced their capacity for emotional self-regulation and the ability to work through negative feelings, including anger, guilt and shame" (Russinova et al, 2009, p. 69). These results suggest, "CAM practices can be a very promising adjunct to traditional psychotherapy modalities that target the fostering of a sense of identity and growth" (Russinova et al., 2009, p.72).

Motivation to use CAM

With the increase in CAM use in the world and Canada, researchers have been interested in learning about reasons for choosing Complementary and Alternative Medicine. Originally it was thought that CAM users were "mostly refugees from conventional medicine" (Fulder, 1988, p. 30), pushed toward alternatives due to dissatisfaction with conventional care (Furnham & Smith, 1988).

A Canadian study by Pawluch and colleagues (1994) looking at use of CAM by individuals living with HIV/Aids revealed that the decision to seek alternatives was motivated by shared beliefs and ideologies of CAM. Furthermore, use of CAM did not inhibit use of allopathic medicine.

In another Canadian study, Kelner and Wellman (1997b) studied 300 patients who used various alternative practitioners (chiropractors, acupuncturists/traditional Chinese doctors, naturopaths and Reiki practitioners) to examine the motivation for choosing these services. Kelner and Wellman (1997b) randomly selected four ppractitioners from each of the five treatment modalities and asked them to randomly select 15 patients. They used a model developed by Anderson et al., (1995), which describes three factors which facilitate or hinder the process of choosing a health service:

- Predisposing factors: gender, age, education level;
- Enabling factors: knowledge of and accessibility to services;
- The need for care, (Kelner & Wellman, 1997b).

Kelner and Wellman (1997b) found that all three factors influence peoples' decisions regarding their choice between medical and alternative practitioners. CAM ideology is not a reason alone for the choice. The predisposing factors for alternative service use include: urban residence, most

likely female, married, with higher level of education, and occupation, full time employment, higher income, spirituality, but not religious affiliation were similar to those found in other parts of the world (Kelner & Wellman, 1997b). Kelner and Wellman (1997b) also found that individuals who used CAM had community (availability of services) and personal knowledge (familial referral to a particular practitioner, proximity to services, financial resources, and chronic illness), enabling factors that facilitated the decision. Most of CAM users reported high levels of personal responsibility, taking "a proactive role in maintaining their own health and preventing illness" and they often used more than one approach at a time (Kelner & Wellman, 1997, p. 210). Kelner and Wellman observed that individuals tend to choose specific services to meet their specific needs and often use multiple practitioners to achieve an optimal sense of health and well-being. They found that at times individuals were pushed to use CAM out of desperation (Kelner and Wellman, 1997b). Yet, other times they felt pulled toward CAM because of their belief system, such as holistic care (Kellner and Willman, 1997b) The degree of pull/push toward CAM varied between services used, "Only 9% of the chiropractic patients mentioned desperation as the reason for their choice and 12% mentioned belief in this type of care. Among acupuncture/TCM (Traditional Chinese Medicine) patients, almost one third (30%) mentioned desperation while nearly one quarter (23%) mentioned belief. For naturopathic patients, desperation was mentioned by one third (33%) and belief by 30%. For Reiki clients desperation was reported by only 10% and belief by 38%" (Kelner & Wellman, 1997, p. 210).

Kelner and Wellman (1997a) concluded that "what we are seeing here is a pluralistic and complementary system of health care in which patients choose the kind of practitioner they believe will best be able to help their particular problems. What we do not see is an either/or decision" (p. 139). In 2006, similarly as in 1997, seventy-four percent of Canadians chose CAM

"because they believed that using alternative medicine together with conventional medicine was better than using either alone" (Esmail, 2007, p. 28). However, nearly half (49%) felt that CAM practitioners spent more time with them than their physician did. Forty-eight percent experienced "real and prompt physical relief from alternative medicine" compared to conventional treatment (Esmail, 2007, p. 28).

Despite only 16 percent of users feeling that alternative therapies are superior to conventional therapies in 2006, 76 percent of Canadians agreed that conventional medicine does not have 'all of the answers' to health problems, and 68 percent agreed that since alternative medicine has been used for centuries in other countries "there must be something good about it" (Esmail, 2007, p.30). Sixty-seven percent also agreed in 2006 that just because alternative medicines have not been scientifically tested and approved by Canadian and provincial medical bodies does not mean that they are not effective (Esmail, 2007. p 31).

Recent research has demonstrated that CAM users are increasingly motivated by the 'pull' factors (Bishop et al, 2006; Bishop et al., 2007; Sirois, 2008). Sirois (2008) found a shift in motivation for consulting complementary and alternative medicine practitioners from pull and push motivations in 1997-98, to pull motivation in 2005. In 1997-98 he found that the two top reasons for using CAM were: an ability to take an active role in health (51.8%) and conventional medicine's inability to manage their health problems (41.8%). In 2005 the two reasons for choosing CAM were, "the treatment of a whole person" (78.3%) and "taking active role in one's health" (76.5%) (Sirois, 2008).

Sirois (2008) argues that this shift in favour of the 'positive pull' is most likely due to increased knowledge and acceptance of CAM, as well as a shift in social values toward a holistic view of health and an integrated healthcare system. Most individuals use CAM to supplement rather than

replace conventional approaches, demonstrating an ability to integrate the two approaches, while recognizing the benefits and shortcomings of both, and pushing the system for integration (Sirois, 2008). This mirrors the 'Integration Pyramid" developed by Tataryn and Verhoef (2001).

Integration of CAM by Health Professions

Fundamental differences exist between complementary and alternative approaches and allopathic medicine. The nature of biomedicine is reductionistic, positivistic, and underlined by Cartesian Dualism (Barrett, 2001; Cook et al., 2000; Kleinman, 1980). Biomedicine views a physical body in isolation, distinctly separate from the mind and spirit. In the allopathic perspective disease is removed from the context of environment and individual experience, where illness is viewed as lack of health or malfunctioning (Kleiman, 1980). Biomedical professionals hold an expert and authoritarian position, with power and control over the diagnostic and treatment process, with a focus on cure (Kleiman, 1980).

On the other hand, CAM approaches tend to view individuals from a holistic perspective, recognizing an inherent interconnection of mind, body and spirit. From this perspective health is a state of harmony. Wellbeing is believed to be a product of balance between all the components of a person, as well as a good relationship with the environment (Cook et al., 2000). The relationship between a CAM practitioner and a client is collaborative in nature. Treatment is mostly individually based and each individual plays an integral part in the healing process (Chez & Jonas, 1997; Cook et al., 2000; YCHS, 1999). Many CAM approaches seek to empower individuals, providing them with the necessary knowledge and skills to become active agents in the recovery process and health maintenance (Cook et al., 2000).

The general population is increasingly seeking CAM healing approaches in addition to allopathic medicine treatments. Tataryn (2002) argues that "the growing use of CAM in Western society may be the manifest echoes of a plea to biomedical practitioners to meet patients in their own worlds: to go 'beyond disease to include illness, beyond pain to include suffering and beyond curing to include healing" (p.890). He and his colleague, Verhoef (2001) developed an "Integrative Pyramid" model which demonstrates the dynamic of the integrative process. The authors predict an "upward pressure" toward integration starting at the consumer level, pushing up and effecting: first individual practitioners, than clinics, institutions, profession/regulatory bodies and health policy. Tataryn (2002) further argues that in order for the integration to occur in the health care system, each profession within the system must become holistic in its attitude and approach.

Cook et al., (2002) argued that "(t)he ideal health care delivery system incorporates the best of both CAM and allopathic practices in order to best meet the needs of clients and their families" (p.52). The World Health Organization (WHO) also supports the integration and has developed a 5 year *Traditional Medicine Strategy*, which aims at: (a) integration of CAM into national health care systems of all nations; (b) expend the knowledge base of CAM; (c) increase the affordability and availability of CAM; (d) promote sound use of CAM (Hughes, 2007).

Since the WHO *Traditional Medicine Strategy,* The Canadian Interdisciplinary Network for CAM Research (IN-CAM) is an interdisciplinary, collaborative research network, was created to foster excellence in complementary and alternative medicine (CAM) research in Canada. The network is supported and funded by Health Canada and Canadian Institute of Health Research. The co-founders and co-directors of IN-CAM, Dr. Heather Boon and Dr. Marja Verhoef, have been involved in CAM research network development and implementation in Canada, through

the Toronto CAM Research Network, the CAM Education and Research Network of Alberta (CAMera) and the Sociobehavioural Cancer Research Network (IN-CAM, 2011).

In summery the public's push for integration and the recognition of the need for integration by the WHO create pressure on the healthcare system and its providers.

It is hypothesized that mental health professionals, including social workers experience the pressure from their clients. For the purpose of comparison, literature reviews were conducted on complementary and alternative approach use by psychology and marriage and family therapy, as well as social work.

Psychology

Hughes (2007) observes the 'pull-push' attitude within the profession of psychology toward CAM approaches. He articulates that some view psychology and CAM as sharing common principles of "person-centeredness, mind-body connectionism, and holistic exclusivity" (p. 658), while others are critical of "CAM's promotion of non-positivist scientific models of illness and well-being"(p. 658). In his literature review, he found only two significant academic articles in elite psychological journals on the implications of CAM for clinical psychology. One article by White (2000) urges psychologists to become educated on CAM principles, approaches and research, since many clients they encounter engage in such therapies on a regular basis (Hughes, 2007). Hughes as well as White (2000) encourages the establishment of a "new psychological sub-discipline -"integrative medical psychology"- which would seek to blend psychology and CAM" (p. 659). The second article reported on a preliminary survey, done by Bassman and Uellendale (2003), of members of the American Psychological Association, which demonstrated overall positive regard toward CAM, while urging for professional education, need

for ethical guidelines for the profession regarding use of CAM in practice, as well as outcome research of CAM modalities within psychology (Hughes, 2007).

Hughes (2007) acknowledges that a number of CAM techniques are mainstream psychological therapies, such as cognitive behavioural therapy, and other mind-body approaches, like relaxation techniques, mindfulness based approaches and biofeedback. Research has demonstrated the effectiveness of relaxation techniques on psychological problems, such as anxiety, depression and panic disorders; while biofeedback was found to be useful in treatment of migraine and arthritic pain (Hughes, 2007, p. 663). Energy therapies have been met with skepticism by psychologists due to "no scientific basis" (p. 666), since empirical research is strongly valued by the profession. Hughes (2007) questions whether "clinical psychologists could offer biologically-based therapies, such as herbal medicine, without requiring the legal privileges necessary for the prescription of psychiatric medications", due to the complexity of drug interactions (p.665). Other CAM approaches require specific training, as in the case of manipulative and body-based methods, such as chiropractic or craniosacral therapies (Hughes, 2007).

Hughes (2007) expresses fear that "the integration of CAM therapies may present a number of challenges by threatening the scholarly and applied standing of clinical psychology" due to "generally poor empirical evidence to support the claim that a given CAM treatment is uniquely or especially effective" (p. 667). Clinical psychology as a profession is strongly grounded in scientific methodology and "ethics codes frequently compel psychologists to imbue their work with scientific rigor" (p. 669).

The survey of the American Psychological Association, revealed that very few psychologists report direct use of various modalities; and only 10% (N=202) reported expert

knowledge of body work modalities (Bassman & Uellendahl, 2003). The study also demonstrated that psychologists were more likely to recommend, than to make specific referrals, to CAM practitioners. About half of the respondents expressed interest in learning more about alternative treatment methods, with a great number of them holding a positive or neutral attitude toward integration of CAM into psychological practice. Bessman and Uellendahl (2003) argue that "adoption of CAM into psychology practice would represent a significant paradigm shift", however "would offer increased effectiveness in psychology practice" (p.268). They support Hughes' (2006) argument for the need for empirical validation of complementary and alternative approaches, while recognizing the increase in CAM use and thus the need for psychologists' education on, research in holistic approaches and addressing ethical concerns around integration.

Marriage and Family Therapists

Coldwell, Winek and Becvar (2006) conducted a US national study of Clinical Members of the American Association for Marriage and Family Therapy to examine their knowledge of, CAM use and integration into practice. A total of 424 responses were received and analyzed, indicating that 71% of MFTs have knowledge of various alternative techniques. About 20% of the respondents felt qualified to use, teach and supervise the following modalities: relaxation techniques, guided imagery, meditation, diet/lifestyle changes, hypnosis, and prayer.
Most of the respondents (88.1%) recommended CAM use, and 45.6% referred their clients to specific CAM practitioners for a range of problems, including: pain, stress, anxiety, depression, other psychological/emotional difficulties, trauma, mind–body problems, eating disorders and other diet problems, addiction disorders, and spiritual problems.

About one-third of the respondents (31.7%) received referrals from a CAM provider,

including massage therapists, chiropractors, acupuncturists, naturopaths, pastors, hypnotherapies, homeopaths, movement therapists, physical therapists, and acupressure practitioners. The marriage and family therapists who were in private practice were more likely to recommend and refer to CAM practitioners.

The analysis of MFT's attitude toward CAM showed "an association between therapists' beliefs in a fit between CAM and psychotherapy and recommending CAM, referring to a CAM provider, and receiving referrals from a CAM provider" (Coldwell, Winek & Becvar, 2006, p. 110). Coldwell and colleagues (2006) acknowledge that many of the alternative approaches have become mainstream MFT practices, although many of those who include these approaches have learned them through personal exploration, not professional training. The authors state that the AAMFT website includes a section "Guidelines for Nontraditional Techniques". This section is not accessible to the general public, but its presence indicates that there has been formal acknowledgement made of CAM integration into MFT practice and ethical/legal considerations are examined.

Social Work

A literature review on Social Work and CAM knowledge, attitudes and use, produced only a few social work specific studies. As part of her PhD dissertation, Lorrie Henderson (2000) explored utilization of Alternative/Holistic helping strategies by social workers in the US. She found that social workers are most familiar with mind-body techniques, with 31% indicating expert knowledge of, and 50% indicating moderate knowledge of the approaches. Nearly 75% of respondents felt well versed in community health alternatives. Beyond these two categories, fewer than 10% of surveyed social workers possessed expert knowledge of other alternative approaches, and only thirty percent identified moderate knowledge in nutritional alternatives,

hands on healing and professional alternatives (Henderson, 2000). The majority of social workers had little or no knowledge of parapsychology, pharmacology or biological alternatives (Henderson, 2000).

In terms of provision of care, Henderson (2000) found that mind-body techniques were identified as most frequently administered by social workers directly to clients (60%) and about two-thirds (39.6%) of respondents made formal referrals to CAM providers. Only 21 (6.5%) social workers provided professionalized alternative techniques (e.g. acupuncture, homeopathy, Ayurvenda medicine), and 26.8% of social workers referred clients for these services (Henderson, 2000).

The data illustrated that meditation, imagery, and community-based alternatives have become part of mainstream social work practice, are accepted as legitimate techniques, and are commonly practiced by the professionals while other approaches are still viewed as "avant-garde practices engaged in by a minority of the profession (Henderson, 2000). These include the use of prayer, and mental healing techniques, hypnosis, yoga, biofeedback, art therapy, vitamin therapy, use of alternative diets, massage, chiropractic, acupuncture, and homeopathic medicine" (Henderson, 2000, p. 67).

Henderson (2000) argues that a larger number of social workers practice alternative techniques without sufficient knowledge, which raises ethical concerns. "The NASW (1990) Code of Ethics standard 1.04 states that workers should provide competent services within the boundaries of their education and training" (Henderson, 2000, p.69). The code also leaves the responsibility of obtaining appropriate training to individual social workers.

Larry Gant, PhD, professor of Social Work at the University of Michigan believes there is an "absence of a conceptual organizing framework of integrative health interventions and

treatments within current health-related social work curricula"; and he predicts that in the coming decades, "competent social worker and healthcare professionals will need critical-thinking skills to investigate and guide clients into integrating complementary therapies into their healthcare plans and to facilitate whole-person healing" (Kreitzer & Sierpina, 2006).

In his PhD dissertation, Yusof (1999) examined knowledge, training and attitudes toward alternative psychotherapies held by social work, counseling and psychology graduate students in a southwestern Michigan. He defined alternative therapies and psychotherapies as methods of physical or psychological interventions that include a combination of allopathic and alternative medicine, such as use of hypnosis, EMDR (Eye Movement Desensitization and Reprocessing), guided imagery, meditation, breath work, and others. In his review of universities' curricula and interviews with students, he found that no institution taught alternative psychotherapy, but this was at times briefly discussed in classes (Yusof, 1999). He also found that social work students had more positive attitudes toward hypnotherapy and guided imagery than psychology students (Yusof, 1999). Yusof (1999) also found that psychology students more frequently reported learning about alternative psychotherapy in their program than social workers. All graduate students (social work, counseling and psychology) expressed interest in learning more about alternative therapies and indicated that alternative psychotherapy should be integrated into the curricula. In conclusion, Yusof (1999) states that inclusion of alternative psychotherapies is timely, and necessary and does not mean replacement of existing approaches, theories and traditional treatment methods, but rather, follows the view point of "unity in diversity".

In a 2008 study of 622 members of the Association of Oncology Social Workers (AOSW), Zebrack and colleagues found that one third of respondents felt they had little or no competence in the area of complementary and alternative practices (Zebrack, et al., 2008).

Behrman and Tebb (2008) explored the need and efficacy of complementary and alternative interventions by social workers in their work with older adults with chronic conditions, like depression. Based on the prevalence of CAM use by that population, and the promising positive effects of the approaches, the authors urge for "collaboration among multiple disciplines of health care providers in creating a wide variety of resources and interventions" (Behrman & Tebb, 2008, p. 131). They reinforce that social workers need to expand their knowledge, clinical repertoire and research on CAM, in order to adequately guide clients through the health and mental health choices and provide holistic social work service, which, they believe, increases the possibilities for achieving desired outcomes (Behrman & Tebb, 2008; Strozier & Carpenter, 2008).

A number of studies have found that patients often do not communicate the CAM use to their physicians (Esmail, 2007; Runfola et al., 2006), which may put them at risk for adverse drug/herb interactions and serious side effects (Runfola, et al., 2006). Also, "The lack of disclosure and high use of CAM by ethnic and disenfranchised populations reinforce the importance of educating the social work profession in CAM" (Grant, et al., 2009, p. 410). Social workers can foster patient-physician communication, which has been shown to have positive effects in regards to adherence to treatment, attendance, satisfaction of care and health outcomes, increased sense of control and overall improvement in quality of life (Runfola, et al., 2006). Runfola et al. (2006) claim that "social workers are in a unique position in healthcare teams to facilitate patients' decision-making about CAM" to help design a treatment plan which meets all of their needs and preferences (p. 81).

The mediator position between client and system is not new to social work. The role also fits with the professional values of self-determinism, autonomy, empowerment and informed

consent (Runfola et al., 2006). Social workers are knowledgeable in the cultural, spiritual, ethnic, religious and racial influences on persons' health beliefs and practices. They are also aware of systemic barriers and are trained to work through and around them, to advocate for individual choices and rights. Social workers are skilled in providing a safe and non-judgmental space for clients to voice their beliefs, feelings and fears about their illness, treatment and outcomes and perhaps process the decision-making. In their literature review, Runfola and colleagues (2006) report that a number of studies found social workers to be the best health care providers to:

(a) Correctly identify patients, who used CAM,

(b) Discuss CAM with patients most frequently and

(c) Have patients referred to them by physicians to discuss CAM options.

Research suggests that there exists a gap between practice and knowledge of CAM within social work profession (Gant, et al., 2009; Henderson, 2000). Complementary and Alternative Medicine, which includes many traditional, indigenous approaches fits into holistic paradigm of health. Ashcroft (2011) clearly articulated that "Providing social work students with an understanding of influential values, historical and social processes that shape a health paradigms, provides them with the critical lens necessary to help determine the most effective intervention strategies to employ in their practice… to determine the best approaches toward health with individuals, communities, and larger populations" (Ashcroft, 2011, p. 612).

Gant and colleagues (2009) attribute the discrepancy between practice and knowledge due to the gap in social work curriculum. They suggest a development of curriculum that includes: "(1) Address integrative health from a broad theoretical perspective…rooted within general systems theory… (2) Reaffirm the role of social workers in healthcare… (3) Provide

exposure and extensive practice with a conceptually integrated skill set with specific application to social work" (Gant, et al., 2009). They further shared the two courses developed and implemented in a Midwestern school of social work: Foundations of CAM systems and modalities and Mind-Body practice-based skills (Gant, et al., 2009). These courses included topics on: methods and practice, human behaviour and social environment, social welfare policies and services, research and evaluation and field instruction as they pertain to CAM (Gant, et al., 2009).

Cook et al. (2000) also outline practice, education, and research and policy implications for social workers in the field. On a practice level, Cook and colleagues (2000) urge social workers to complete a holistic assessment (bio-psycho-socio-spiritual) to examine clients' values and beliefs around illness and treatment preferences. This suggests that social workers also need to develop adequate knowledge of and efficacy of CAM, to adequately serve and guide their clients. In addition, the profession needs to engage in an evaluation and research around efficacy of complementary and alternative techniques in the context of social work practice. In a broader context, social workers are urged to assist to establish and advocate for integrative healthcare, where services are available to clients of all beliefs, needs and capital resources. Dziegielewski (1998) argued that, "for further marketability and competition, it is believed that social workers need to move beyond the traditional definition and subsequent role of the health care social worker" (p. 31).

Ethical issues – CAM use and social work practice

Ethical issues in the context of complementary and alternative medicine have been examined in the framework of four basic principles:

1. Non-maleficence
2. Beneficence
3. Respect for personal autonomy, and
4. Justice (Crouch et al., 2001).

It has been described that non-maleficence and beneficence are closely related. The principle of non-maleficence instructs to "Do no harm". Beneficence on the other hand urges to do that which brings good to others and increases their well-being. These two principles have implications for practitioners to elicit information about use of CAM and for researchers to study the safety of the approaches. Both conventional and complementary health care providers are cautioned to be familiar with medical practices, possible risks associated with interactions and toxicities (Crouch et al., 2001). Social workers need to be educated not only about the availability of various CAM approaches, but also safety and their efficacy, in order to provide accurate information to clients and other professionals and to appropriately advocate for access to CAM resources.

Tension exits between the principles of non-maleficence and beneficence and that of personal autonomy. "The principle of respect for personal autonomy requires that we respect the choices and actions of those individuals who are competent, act voluntarily and with sufficient understanding of the existing information relevant to their choice" (Crouch et al., 2001, p. 49). Real autonomy requires reliable information about the risks and benefits of the alternative therapies, which implies education of patients and users. Research and information available can

be inconsistent and unreliable. Social workers need to be aware that some clients may engage in CAM treatment that may not have been shown to be effective. In fact, some individuals, as a last resort may engage in approaches that are highly experimental. This is also true of experimental allopathic treatments.

The two areas of justice that are identified as important in the context of complementary and alternative therapies are distributive justice and compensatory justice. "Distributive justice requires a fair distribution of burdens and benefits in society" (Crouch et al., 2001, p. 58). It has implications in the area of health insurance coverage and distribution of health-care research funds (Crouch et al., 2001). "The Canadian Health Act requires that, in order to receive federal contributions, the public-health insurance plan of each province/territory must cover "medically necessary" services provided by "hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners"" (Crouch et al., 2001). Which services are deemed necessary "has been determined largely by the requests of recognized health professions in negotiation with the provincial/territorial health ministries that pay these costs, and has been influenced by political negotiations between the federal and provincial/territorial governments over their respective contributions" (Crouch et al., 2001, p. 59). However, "without convincing evidence of benefits, it will be difficult to make the case that distributive justice requires coverage of a therapy - either conventional or unconventional - from the public purse" (Crouch et al., 2001, p. 59). This is where social workers can play an advocacy role and address the issues of equal access to healthcare, through efficacy research and policy development.

Lee and colleagues (2009) acknowledge that "A holistic perspective in social work practice brings a new set of considerations in ethical practice, because of the inclusion of therapeutic techniques pertaining to body process work and the spiritual domain, both of which are rather new to most models of conventional social work practice" (Lee et al., 2009, p. 298) They argue that Integrative Mind-Body-Spirit Social Work draws on and embraces core social work ethical principles and values of service, social justice, human rights and dignity, integrity and competence (Lee et al., 2009). They also believe and underline that "it is our ethical responsibility to (1) treat clients in a holistic manner that respects the connectedness of the body, the mind, and the spirit, and to (2) respect clients by developing and using treatment techniques that build upon their strengths, initiate self-healing potential, and effectively create change in their lives" (Lee, 2, p. 294).

The professional Code of Ethics as outlined by the Canadian Association of Social Workers (CASW, 2005) does not directly address the issues of CAM use or integration, however it does generally speak to issues of client safety, and to some degree, scope of practice and professional development. It is an integral social work role to protect the rights of all people, advocate for adequate treatment and equal access to resources and maintain their well-being, autonomy and self-determination. The code also calls for 'Competence in Professional Practice'. Social workers are told to provide the highest quality of service possible, which implies efficacy and safety. Not only is it the provision of quality service that protects the client, but also the profession, by maintaining and expanding professional knowledge. Social workers are held responsible to "maintain professional proficiency, to continually strive to increase their professional knowledge and skills, and to apply new knowledge in practice commensurate with their level of professional education, skill and competency, seeking consultation and supervision

as appropriate" (CASW, 2005). The Code of Ethics urges future social work professional development of knowledge and skills, to engage in research, while upholding the right of clients to the highest quality of care, safety, informed consent, and confidentiality. The code does advise social workers in "limiting professional practice to areas of demonstrated competence" (CASW, 2005). "A holistic perspective also emphasizes the utilization of a wide range of treatment techniques in the domain of the body, mind, and spirit. Without setting unrealistic standards or crossing professional boundaries… it is helpful for social work professionals to pursue a wider range of knowledge, to develop creative arts, skills, and hobbies, and to develop personal skills that they can utilize for therapeutic purposes" (Lee et al., 2009, p. 298)

The CASW guidelines are broad and often vague, which leaves much room for interpretation. The code does acknowledge that "reasonable differences of opinion exist among social workers with respect to which values and principles should be given priority in a particular situation" (CASW, 2005). It is also acknowledged that differences may exist between personal and agency policies. As professionals we are asked to resolve the conflict in a way that preserves social work values (CASW, 2005).

Chapter III

RESEARCH METHODOLOGY

Introduction

The aim of the study was to explore and describe Canadian social workers' levels of knowledge, personal and professional use, as well as attitudes toward complementary and alternative therapies. For this purpose an exploratory, descriptive research design was used in the form of an electronic survey. A descriptive study allowed for initial exploration of the knowledge and use of complementary and alternative approaches by Canadian social workers, and provides a point of departure for examination of the topic, since very little is known on the subject. In this case a descriptive study was an appropriate design as the research question did not require that independent variables be manipulated or interventions or treatment be provided.

Study questions

The purpose of the study was to explore and answer the following seven study questions:

1. How knowledgeable are Canadian social workers about complementary and alternative medicine?
2. How are Canadian social workers learning about complementary and alternative medicine?
3. To what extent (frequency) and which types of complementary and alternative medicine methods are Canadian social workers integrating into their practice?
4. How open are Canadian social workers to learn and incorporate complementary and alternative medicine into their practice?
5. What are Canadian social workers identifying as barriers to the integration of complementary and alternative approaches into their practice?

6. What are the attitudes of Canadian social workers toward complementary and alternative medicine?
7. Do knowledge, integration levels and attitude levels differ across demographic criteria?

Data gathering

The regulation of Canadian Social workers' is legislated provincially/territorially. In most Canadian provinces, social workers are legislated to be registered/ licensed with their provincial regulatory body. For the purpose of this thesis, a social worker is operationally defined as one who is registered with a social work provincial licensing body.

The study intended to reach Canadian social workers from east to west coast, as well as the northern regions. The sample for the research study was drawn from the population of the registered social workers in the provincial and territorial regulatory bodies (Appendix).

Because the majority of the provinces require registration, the provincial associations have contact information of practicing social workers. In order to maintain respondents' anonymity, a "Letter of Invitation" (Appendix D) was distributed to all provincial and territorial social work regulatory bodies; including a cover letter (Appendix C) which was electronically distributed to each executive director of all Canadian provincial and territorial social work associations. The cover letter requested a distribution of the "Letter of Invitation" to the members of the social work provincial licensing body either electronically or by publishing the request and link in an association's newsletter. A follow up telephone call was made to the associations if no response to the request was received.

Procedures

Following approval of the proposal by the thesis committee and a University of Manitoba, Psychology/Sociology Research Ethics Board, the cover letter, including the "Letter of Invitation" was sent out to the provincial and territorial social work associations. Non-probability, convenience sampling was utilized. The social workers self selected to participate in the study and were required to indicate consent as a first part of the online survey. A hardcopy of the survey was made available upon request. No such requests were made. The electronic survey was accessed utilizing the internet and SurveyMonkey, online agent (www.surveymonkey.com). Data were collected over a one-month period. Collected data were securely stored and was accessible only to the principle researcher and the thesis advisor. Following data collection, the data were organized and analyzed using the SPSS (version 19.0) statistical program.

Instrument

A self-administered, web-based survey (Appendix B) was used, utilizing similar studies found in the literature as a guideline (Brown, et al., 2007; Coldwell et al., 2006; Henderson, 2000), the developed survey consisted of four broad sections:

1. Knowledge level of CAM
    a. Means of knowledge acquisition
2. Personal and professional use of CAM
    a. Barriers to integration
3. Attitude toward CAM

This section consisted of a set of 15 attitude type statements rated on a five-point Likert scale. A question about openness to learn and integrate CAM into social work practice was also included in this portion of the survey.

4. Demographic information

For the purpose of this exploratory study a select but broad number of complementary and alternative approaches from each of the five classifications (mind-body therapies, biologically based therapies, manipulative and body base methods, and whole/alternative medical systems) have been used as an index for responders to identify their knowledge and use of the approaches (National Cancer Institute, 2011; National Centre of Complementary and Alternative Medicine, 2012). Respondents were encouraged to identify additional approaches not listed in the survey. Respondents were asked to indicate the level of knowledge (familiar, trained or expert) of each approach. These levels are thought to capture the degree of knowledge, ranging from familiarity or common knowledge, to formal training and expert knowledge, thus used as an ordinal scale. The researcher was also interested to discover the context in which respondents acquired their knowledge of CAM. Of particular interest was whether social workers learned of CAM as part of social work curricula, employment training or personal interest. This information was thought to shed light on the extent and means of CAM integration into social work profession.

The same list of CAM approaches was used in second section of the survey pertaining to use of the techniques. Multiple levels of utilization of CAM were explored, from contemplation, recommendation, integration, direct referral and personal use. The rationale behind these categories was to differentiate between the levels of CAM utilization: personal use, passive professional use (contemplation and recommendation), direct integration of CAM into social

work practice and referral, which indicates a collegial relationship with a CAM provider. These measures were conceptualized and used as nominal measure.

Furthermore, the researcher was interested to determine possible barriers to CAM integration into social work practice. A list of possible barriers, ranging from personal, institutional and professional barriers was suggested, attempting to capture micro and macro influences.

Section 3 explored the attitude of respondents toward complementary and alternative approaches. Based on Caldwell et al. (2006) survey, fourteen questions pertaining to fit of CAM within social work values and scope of practice, openness to integration of CAM, and perception of client use of CAM were used.

Finally, the demographic section inquired about gender, age, province/territory of practice, highest level of education, years of social work experience, and setting of practice to allow for comparison between groups.

The survey was kept as concise possible as to encourage completion. It was estimated that the survey will take 20 minutes to complete.

Data analysis

For the purpose of the study, the data were organized and analyzed utilizing the Statistical Package for the Social Sciences (SPSS v. 19.0) computer software. Frequency distributions on all dependent and independent variables were examined to identify any outliers, missing data and errors in coding. Descriptive and inferential statistics were then explored.

Descriptive statistics

Descriptive statistics were used to organize and describe the data. Frequencies, percentages, measures of central tendency and variation were used to describe and summarize the independent variables (demographic information) and dependent variables (knowledge, use and attitude).

Statistical Tests

The writer examined any between group differences in knowledge (familiar, trained, expert) of CAM, utilization (contemplated, incorporated, referred out, recommended, personal use) of CAM; as well as attitudes based on age, gender, education level and years of experience, geographic location, and area and focus of practice. Cross tabulations were constructed to examine the difference in frequencies in each level of knowledge (familiarity, training and expert knowledge) and extent of use (contemplation, integration, referral, recommendation, personal use) between groups. In addition contingency tables, chi-square tests were used to examine significant statistical differences between groups. This is an appropriate test, since the dependent variable data are categorical, and variables are measured at the nominal level. The Phi and/or Cramer's V coefficient (depending on the number of groups compared) were used to measure the correlation between the independent and dependent variables.

Limitations of the Methodology

Inherent limitations exist in all web-based survey research. Not everyone is connected and not everyone feels computer savvy. It is possible that younger respondents feel more comfort with the survey software, thus were more willing to participate. Additional threats to external validity exist related to the response bias. The respondents self-selected to participate in the study. Social workers' high interest or disinterest in the topic may have impacted their decision

to participate in the study and the responses. Use of a web-based survey in English only, may impact participation from Francophone Canadian social workers, those without computer access and those who feel uncomfortable with computer use. It appears that certain social work groups were over represented (private practice) and underrepresented (Child welfare). According to information received from MIRSW, 13% of registered social workers engage in private practice to some degree, compared to 6.6 % in Alberta. The Ontario association, OCSWSSW does not have private practice category, but rather clinical practice and counseling category, both could be private practice or institution based. Based on limited factual information it may be assumed that private practice participation in the study may be over represented.

The set structure of the survey questions and answers provide limited opportunity for open ended answers, outside the limited option for a narrative in the qualitative portion of the survey. The survey instrument was based on a similar study (Coldwell et al., 2006) however it was altered to fit social work profession, however it was not pre-tested, thus it raises issues of construct validity.

In addition, the use of bi-variate tests poses a threat to internal validity because other factors are not controlled.

Chapter IV

RESULTS

Sample Characteristics

The Canadian Institute for Health Information reported 36,868 registered Social Workers in Canada, including provinces where registration with a regulatory body is not legislated (CIHI, 2009). According to Ontario College of Social Workers and Social Service Workers (OCSWSSW), 14, 160 social workers are registered members. Alberta Collage of social workers (ACSW) reported 6, 665 registered members and Manitoba Institute of Registered Social (MIRSW) workers currently has 914 registered social workers.

A typical response rate for a survey ranges from 25-40%. Based on the expected response range the sample size of the study was expected to range from 9,217 to 14,747. The study consisted of 311 valid responses, which is a response rate of less than one percent.
A total of 359 social workers consented to participate in the study, however 48 (13%) of the surveys were incomplete and thus were not included in the analysis, leaving 311 valid surveys for analysis. The incomplete surveys lacked an entire demographic information section and/or section 3- attitudes. This translates into 44 cases missing 22 essential variables, and 5 cases missing 7 or more responses.

The vast majority of the respondents were female (87%, n=271). The age of respondents varied from 20 to 70 years of age, with over half of the sample above the age of 41 (55%, n=172, mode=51-60, median=41-50).

Nearly half of the respondents were from Ontario (44%, n=136), followed by Alberta (23%, n=73) and Manitoba (22%, n=68). Regrettably, the response rate from the remainder of the provinces and territories was very low and nil.

The majority (62%, n=188) of the participants held a Master's degree and had over 10 years of experience (70%, n=216). The respondents had many years of experience, with a mode of over 20 years of practice and median 15-20 years of practice. The top three most indicated settings of practice were: healthcare (26%), mental health (23%) and private practice (18%). Child welfare appears under-represented, while private practice over-represented.
Please see Table 1 for the detailed demographic information.

In order to provide an empirical assessment of external validity using the CIHI data, one sample chi-square tests was conducted to assess whether the sample significantly differs from the population on gender and province (CIHI, 2009). Proportions for gender and provide was calculated based on the CIHI data and used in the analysis. The results reveal that on gender, the sample reflects the characteristics of the registered social workers as portrayed by CIHI data ($\chi 2=2.04$, df=1, p=.153). Comparing the observed and expected frequency between provinces, revealed significant differences ($\chi 2=712.51$, df=10, p=.000) from the registered social work population. This is not surprising since there were provinces which had very low or nil participation rates, namely British Columbia, Quebec, Nova Scotia, New Brunswick and PEI. Furthermore, it appears that Manitoba was overrepresented in the sample. This variation may have impact on the generalization of the results.

Table 1
Demographics: Participant Profile (N=311)

Gender	N (%)
Male	40 (12.9)
Female	271 (87.1)
Age	
20-30	38 (12.2)
31-40	64 (20.6)
41-50	77 (24.8)
51-60	95(30.5)
61+	37 (11.9)
Years of Experience	
<1	9 (2.9)
1 to 5	48 (15.4)
5 to 10	36 (11.6)
10 to 15	54 (17.4)
15 to 20	49 (15.8)
20+	113 (36.3)
Missing	2 (.6)
Degree	
BSW	97 (31.2)
MSW	181(58.2)
PhD	14 (4.5)
BA	3 (1.0)
MA	7 (2.3)
missing	9 (2.9)
Province	
British Columbian	8 (2.6)
Alberta	72 (23.2)
Saskatchewan	18 (5.8)
Manitoba	68 (21.9)
Ontario	136 (43.7)
Quebec	2 (.6)
Nova Scotia	0(0)
New Brunswick	2(.64)
Newfoundland/Labrador	3(1.0)
Prince Edward Island	2 (.6)
NWT	0(0)
Yukon	0(0)
Nunavut	0(0)

Setting of Practice	N (%)
Child Welfare	16 (5.1)
Probation/Justice	0 (0.0)
Mental Health	72 (23.2)
Health (inpatient)	28 (9.0)
Health (outpatient)	54 (17.4)
Education	23 (7.4)
Community	17 (5.5)
Non-profit	30 (9.6)
EAP	4 (1.3)
Private Practice	55 (17.8)
Missing	12 (3.9)
Primary area of practice	
Adult	93(29.9)
child/adolescent	42 (13.5)
couple/family	21 (6.8)
mental health	49 (15.8)
rehabilitation	6 (1.9)
school system	8 (2.6)
substance abuse	10 (3.2)
chronic illness	10 (3.2)
palliative care	6 (1.9)
aging	23 (7.4)
criminal justice	1 (.32)
child welfare	11 (3.5)
immigration	4 (1.2)
Aboriginal	6 (2.1)
Missing	21 (6.8)

Social worker's knowledge about complementary and alternative approaches

Canadian social workers report a higher level of familiarity with CAM than actual training or expert knowledge. Participants indicated training and expert knowledge most frequently in: Relaxation techniques, MBSR, Meditation, Imagery, Reiki and Hypnosis. Four out of the five of the approaches are in the Mind-Body Interventions category of CAM and one is in an Energy Therapy category.

Table 2
Frequency of responses to three levels of knowledge of Complementary and Alternative Approaches (N=311)

CAM	Familiar		Trained		Expert		Mainstream	
	N	%	N	%	N	%	N	%
Tai chi	222	71.38	7	2.25	2	0.64	5	1.61
Yoga	255	81.99	21	6.75	7	2.25	20	6.43
Biofeedback	164	52.73	7	2.25	4	1.29	9	2.89
Hypnosis	172	55.31	20	6.43	9	2.89	21	6.75
Imagery	162	52.09	51	16.40	12	3.86	57	18.33
Meditation	186	59.81	65	20.90	17	5.47	51	16.40
Mindfulness Based Stress Reduction	153	49.20	67	21.54	8	2.57	70	22.51
Art therapy	200	64.31	15	4.82	2	0.64	51	16.40
Prayer therapy	113	36.33	9	2.89	2	0.64	4	1.29
Relaxation techniques	142	45.66	74	23.79	31	9.97	95	30.55
Music Therapy	182	58.52	9	2.89	1	0.32	28	9.00
Movement Therapy	118	37.94	8	2.57	3	0.96	14	4.50
Therapeutic touch	168	54.02	22	7.07	3	0.96	7	2.25
Reiki	160	51.45	34	10.93	11	3.54	6	1.93
Qi gong	97	31.19	8	2.57	0	0.00	5	1.61
Electromagnetic therapy	87	27.97	3	0.96	0	0.00	2	0.64
Oriental Medicine	122	39.23	2	0.64	0	0.00	10	3.22
Homeopathy	176	56.59	2	0.64	0	0.00	11	3.54
Naturopathy	200	64.31	2	0.64	0	0.00	15	4.82
Ayurvedic medicine	98	31.51	2	0.64	0	0.00	3	0.96
Native American medicine	133	42.77	11	3.54	1	0.32	15	4.82
Chiropractic	214	68.81	2	0.64	0	0.00	23	7.40
Massage therapy	238	76.53	8	2.57	1	0.32	28	9.00
Reflexology	185	59.49	5	1.61	1	0.32	11	3.54
Cranial-Secral OMT	135	43.41	1	0.32	0	0.00	3	0.96
Light/Colour therapy	104	33.44	8	2.57	0	0.00%	4	1.29
Diet and nutrition/Lifestyle changes	189	60.77	30	9.65	5	1.61	78	25.08
Herbal medicine	173	55.63	5	1.61	1	0.32	11	3.54
Nutritional supplements	189	60.77	5	1.61	2	0.64	21	6.75

*Familiar = I have basic knowledge of the approach through general reading and/or personal use Trained = I am trained and received a certificate or diploma in this approach and am able to practice it Expert = I have expert knowledge of this approach, and am able to practice, supervise and train others in this modality. Mainstream= I consider this approach mainstream in social work practice.

How are social workers learning about complementary and alternative therapies?

The majority of respondents (93%, n=286) indicated they learned about CAM through personal interest and/or personal use of the approach(es). Sixty-six percent (n=205) of the respondents learned about CAM in a workshop. About a third (32%, n=97) of respondents participated in formal training leading to a certificate, diploma or a degree in a particular approach. Twenty-seven percent (n=82) of participating social workers acquired their CAM knowledge as part of their employment and 12% (n=37) indicated they learned of CAM as part of a social work curriculum.

What is the extent (frequency) and types of complementary and alternative approaches Canadian social workers integrated into their practice?

Only 14% of respondents indicated contemplating any one complementary and alternative approach into their practice. The most frequently contemplated approaches were from the Mind-Body Therapies: MBSR (14%, n= 43), Art therapy (11%, n=42), Hypnosis (11%, n=42), Imagery (8%, n=30) and Meditation (8%, n=30) (Table 3).

A considerably greater number of respondents indicated they have already incorporated some approaches into their social work practice. The five most frequently incorporated were Mind-Body therapies: Relaxation (63%, n=196), Imagery (47%, n=136), Meditation (38%, n=119), MBSR (36%, n=113), Diet/Lifestyle changes (29%, n=91).

Respondents also indicated they recommended Mind-Body therapies to their clients. The most frequently recommended approaches were: Yoga (40%, n=124), Diet/lifestyle changes (39%, n=121), Meditation (34%, n=105), Relaxation (31%, n=97) and a Manipulative Body-based method: Massage Therapy (35%, n=109).

Direct referrals were made with a lower frequency. The respondents indicated they most frequently referred to providers of: Diet/nutrition and lifestyle changes (26%, n=81), Massage

therapy (23%, n=70), Yoga (20%, n=63), Meditation (14%, n=43) and Nutritional supplements (13%, n=40). This could suggest that some social workers have collaborative relationships with CAM practitioners.

Up to half of participating social workers have personally used complementary and alternative therapies. The most frequently used approaches were: Massage therapy (59%, n=184), Yoga (56%, n=173), Relaxation techniques (52%, n=161), Diet/lifestyle changes (51%, n=158) and Meditation (46%, n=143).

In general, it appears that Canadian social workers contemplate and integrate Mind-Body approaches, such as Meditation, Imagery, MBSR and Relaxation most frequently. Perhaps this speaks to their beliefs on appropriateness or fit of Mind-Body approaches with social work practice.

How open are social workers to learning about and incorporating complementary and alternative therapies into their practice?

Using a four-point Likert scale, respondents were asked to indicate their openness to learn about CAM, as well as their openness to incorporate CAM into their practice. Half of the respondents indicated they were open to both: learn about CAM (52%, n=162) and incorporate CAM into their practice (51%, n=157). A significant number of social workers acknowledge being eager to learn about CAM (42%, n=132) and eager to incorporate CAM (32%, n=98). Only 17% of respondents showed reluctance or lack of openness to incorporate CAM into their practice and even fewer (3%, n=10) indicated reluctance and/or lack of openness to learn about CAM (Figure 1).

Table 3

Frequency of responses to degree of integration and use of complementary and alternative approaches (N=311) (N/%)

	Contemplated		Incorporated		Recommended		Referred		Personal use	
	N	%	N	%	N	%	N	%	N	%
Tai chi	24	7.7	6	1.9	59	19.0	22	7.1	57	18.3
Yoga	24	7.7	34	10.9	124	39.9	63	20.3	173	55.6
Biofeedback	28	9.0	14	4.5	26	8.4	20	6.4	24	7.7
Hypnosis	42	13.5	23	7.4	26	8.4	21	6.8	48	15.4
Imagery	30	9.6	136	43.7	47	15.1	12	3.9	92	29.6
Meditation	30	9.6	119	38.3	105	33.8	43	13.8	143	46.0
Mindfulness Based Stress Reduction	43	13.8	113	36.3	86	27.7	38	12.2	110	35.4
Art therapy	42	13.5	65	20.9	49	15.8	38	12.2	42	13.5
Prayer therapy	16	5.1	23	7.4	32	10.3	19	6.1	42	13.5
Relaxation techniques	20	6.4	196	63.0	97	31.2	35	11.3	161	51.8
Music Therapy	27	8.7	27	8.7	40	12.9	37	11.9	31	10.0
Movement Therapy	28	9.0	14	4.5	23	7.4	13	4.2	16	5.1
Therapeutic touch	27	8.7	19	6.1	27	8.7	21	6.8	38	12.2
Reiki	26	8.4	16	5.1	29	9.3	23	7.4	59	19.0
Qi gong	19	6.1	7	2.3	14	4.5	12	3.9	23	7.4
Electromagnetic therapy	16	5.1	2	0.6	2	0.6	5	1.6	4	1.3
Oriental Medicine	24	7.7	4	1.3	20	6.4	19	6.1	38	12.2
Homeopathy	12	3.9	2	0.6	28	9.0	20	6.4	66	21.2
Naturopathy	15	4.8	2	0.6	51	16.4	30	9.6	89	28.6
Ayurvedic medicine	10	3.2	2	0.6	13	4.2	7	2.3	20	6.4
Native American medicine	27	8.7	15	4.8	35	11.3	30	9.6	40	12.9
Chiropractic	8	2.6	3	1.0	43	13.8	31	10.0	112	36.0
Massage therapy	13	4.2	10	3.2	109	35.0	70	22.5	184	59.2
Reflexology	10	3.2	3	1.0	31	10.0	20	6.4	79	25.4
Cranial-Sacral OMT	15	4.8	1	0.3	25	8.0	20	6.4	41	13.2
Light/Colour therapy	21	6.8	9	2.9	12	3.9	10	3.2	23	7.4
Diet and nutrition/Lifestyle changes	22	7.1	91	29.3	121	38.9	81	26.0	158	50.8
Herbal medicine	12	3.9	8	2.6	33	10.6	29	9.3	79	25.4
Nutritional supplements	13	4.2	17	5.5	55	17.7	40	12.9	108	34.7

*Contemplated= I contemplated using this approach in my practice Incorporated= I have incorporated this approach into my practice Recommended= I have recommended this approach to a client Referred =I have referred clients to a provider of this approach Personal use = I have personally used this complementary and alternative treatment modality

Table 4
Openness level to learn about and incorporate Complementary and Alternative Therapies (CAT) into practice (n=311)

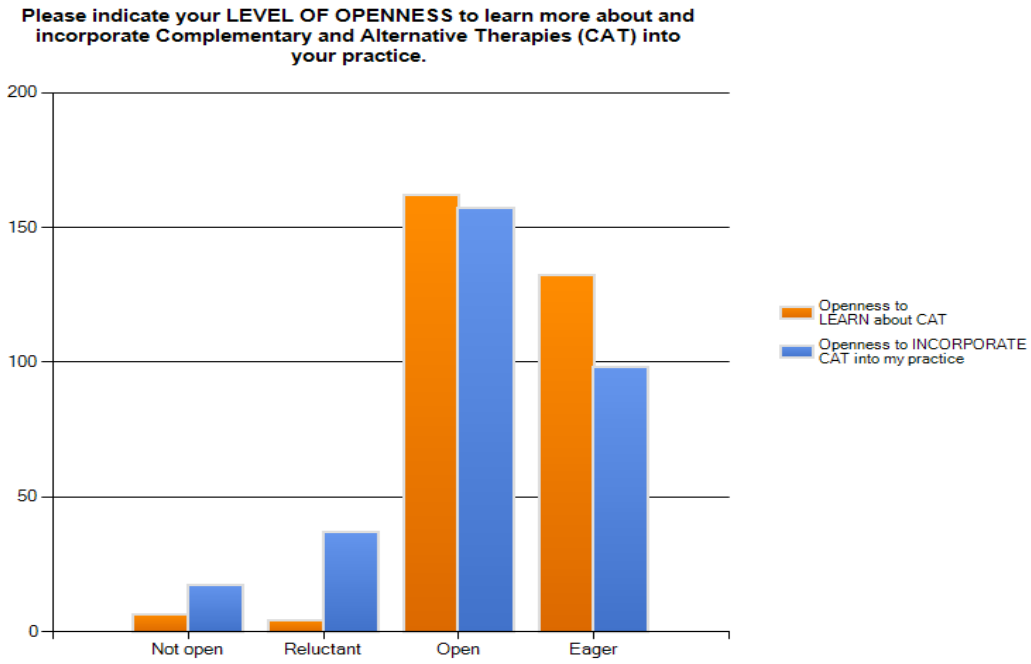
Answer Options	Openness to LEARN about CAT (N/%)	Openness to INCORPORATE CAT into my practice (N/%)
Not open	6 (1.9)	17 (5.5)
Reluctant	4 (1.2)	37 (11.9)
Open	**162 (52.0)**	**157 (50.5)**
Eager	**132 (42.4)**	**98 (31.5)**

Openness to learn as well as openness to incorporate CAM were not normally distributed, thus non-parametric tests were employed. Openness to learn and openness to incorporate complementary and alternative therapies was found to have a positive correlation (Spearman rho= .721, p=.000).

The Kruskal-Wallis test showed no significant differences in Openness to Learn across the age category ($x^2(4, n=290)=7.61$, p=.107).

The Kruskal-Wallis test identified significant differences within Openness to Incorporate across the age category ($\chi 2$ (4, n=293)=12.05, p=.017). The post hoc Bonferroni test shows no significant differences within openness to incorporate between the age groups. However post hoc Mann-Whitney test detects significant differences between the 20-30 years and 61-70 years of age groups (U=468.0, p=.045). However, utilizing the Bonferroni adjustment (alpha divided by number of categories), the new p value=.05/5=.01. Therefore, the Mann-Whitney test is insignificant.

Figure 1
Bar graph indicating level of openness to learn about and incorporate Complementary and Alternative Approaches into Social work practice



Barriers to CAM integration

Respondents were asked to indicate which specific factors posed as barriers to CAM integration into their practice. Despite their familiarity with CAM, social workers felt the lack of training was the number one barrier to integration (75%, n=228). Over a half of respondents also questioned the scope of practice fit with CAM (59%, n=181). Institutional concerns (48%), lack of time (44%) and legal concerns (39%) were also frequently indicated as barriers. A quarter of the respondents felt personal reluctance to incorporate CAM into their practice.

Table 5
Identified barriers to integration of CAM into Social work practice

Barriers	**%**	**N**
Lack of knowledge	24.51	171
Lack of training	**74.75**	228
Lack of time	**43.93**	134
Lack of equipment	23.61	72
Lack of reimbursement	34.10	104
Peer reluctance	28.52	87
Institutional concerns	**47.87**	146
Scope of practice	**59.34**	181
Legal concerns	**39.34**	120
My own reluctance	24.59	75
NO barriers perceived	2.95	9

Social work attitudes toward CAM

Respondents were asked to indicate their agreement or disagreement with fourteen statements on attitudes about CAM. A 5-point Likert scale was used, where 1 indicated strong disagreement and 5 indicated a strong agreement with a statement.

The items respondents disagreed most strongly with were: (item 1) Client's use of complementary and alternative approaches is irrelevant to the conduct of social work (M=1.71, SD=1.00); (Item 8) I have serious concerns about social workers who attempt to incorporate complementary and alternative treatments into their practice (M=2.2, SD=1.02); (Item 6) Most complementary and alternative practices are outside the scope of social work practice (M=2.62, SD=1.13); (Item 9)I rely primarily on my intuition and general knowledge when recommending any treatment approach to clients (M=2.76, SD=1.17).

The statements that showed the highest agreements were: (Item 11) Social workers should take into account the connection between body, mind and spirit (M=4.66, SD=.59); (Item 4) It is important to know about client's use of complementary and alternative approaches to

better understand what they believe will support their good health (M=4.38, SD=.64); (Item 7) It is important to expand the health care infrastructure to include complementary and alternative approach practitioners (M=4.27, SD=.84); (Item 14) If clients believe a CAM treatment would help them, I would explore this treatment option with them (M=4.24, SD=.73);
(Item 3) I would refer clients to a complementary and alternative therapy practitioner only if I thoroughly knew about the practice and practitioner (mean=4.09, SD=.87); (Item 5) the assumptions of complementary and alternative medicine fit well with my approach to social work (M=3.92, SD=.91); (Item 13) It is important to expand social work scope of practice to include relevant complementary and alternative approaches (M=3.93, SD=.95) (Table 6).

Table 6 *Attitude toward Complementary and Alternative Approaches*

	SD	D	N	A	SA	**Mean (Median)**	**SD***
1. Clients' use of complementary and alternative approaches is irrelevant to the conduct of social work.	**55.0% (169)**	28.3% (87)	10.4% (32)	2.6% (8)	3.6% (11)	1.71 (1)	1.001
2. Most clients are interested in complementary and alternative treatments.	1.3% (4)	11.4% (35)	35.4% (109)	**42.5% (131)**	9.4% (29)	3.47 (4)	0.863
3. I would refer clients to a complementary and alternative therapy practitioner only if I thoroughly knew about the practice and the practitioner.	1.3% (4)	6.5% (20)	6.8% (21)	**52.9% (163)**	32.5% (100)	4.09 (4)	0.874
4. It is important to know about clients' use of complementary and alternative approaches to better understand what they believe will support good health.	0.6% (2)	0.3% (1)	3.6% (11)	**51.0% (157)**	44.5% (137)	4.38 (4)	0.638
5. The assumptions of complementary and alternative medicine fit well with my approach to social work.	1.6% (5)	3.6% (11)	24.9% (76)	**40.7% (124)**	29.2% (89)	3.92 (4)	0.911
6. Most complementary and alternative practices are outside the scope of practice of social work.	16.1% (49)	**37.5% (114)**	19.4% (59)	22.4% (68)	4.6% (14)	2.62 (2)	1.134
7. It is important to expand the health care infrastructure to include complementary and alternative approach practitioners.	1.0% (3)	2.3% (7)	12.3% (38)	38.0% (117)	**46.4% (143)**	4.27 (4)	0.835
8. I have serious concerns about social workers who attempt to incorporate complementary and alternative treatments into their practice.	24.9% (76)	**40.0% (122)**	23.0% (70)	9.5% (29)	2.6% (8)	2.25 (2)	1.018
9. I rely primarily on my intuition and general knowledge when recommending any treatment approach to clients.	14.9% (45)	**32.5% (98)**	19.2% (58)	28.8% (87)	4.6% (14)	2.76 (3)	1.158
10. Complementary and alternative approaches should be included in social work curricula.	2.9% (9)	10.1% (31)	18.3% (56)	**43.5% (133)**	25.2% (77)	3.78 (4)	1.029
11. Social Workers should take into account the connection between body, mind and spirit.	0.3% (1)	0.6% (2)	2.3% (7)	26.6% (82)	**70.1% (216)**	4.66 (5)	0.592
12. I ask clients about their use of complementary and alternative treatments as a regular part of my assessment.	3.9% (12)	17.3% (53)	17.3% (53)	**40.7% (125)**	20.8% (64)	3.57 (4)	1.116
13. It is important to expand social work scope of practice to include relevant complementary and alternative approaches.	2.0% (6)	5.9% (18)	19.2% (59)	**43.3% (133)**	29.6% (91)	3.93 (4)	0.947
14. If clients believe a CAM treatment will help them, I would explore this treatment option with them.	0.7% (2)	1.6% (5)	8.5% (26)	**51.1% (157)**	38.1% (117)	4.24 (4)	0.729

Note: SD=strongly disagree, D=disagree, N=neutral, A=Agree, SA=strongly agree
SD=Standard Deviation*

Knowledge, use, integration levels and attitude variations across demographic criteria

There were variations in the level of knowledge in the five CAM approaches most trained in CAM approaches (Imagery, Meditation, MBSR, Relaxation and Reiki) and were examined across demographic criteria utilizing Chi-square of association, utilizing alpha level of .01. Due to the small sample size and high homogeneity of the sample size, alpha of .01 was chosen to reduce Type I error. Furthermore, because each category was tested against all others, Bonferoni correction was used.

Results indicated that social workers who possessed formal and expert knowledge in those top five approaches where significantly more likely to be 41 years of age or older, hold a Master's degree, have over 10 years of practice, reside in Ontario and practice in healthcare, mental health or private practice.

The majority of respondents that acquired their knowledge through formal training leading to certificate, diploma or degree were over 51 years of age (59%, n=57, $\chi 2$ (2) =21.927, p=.00), had over 21 years of experience (50%, n=48, $\chi 2$ (2)=16.606, p=.00), resided in Ontario (58%, n=52, $\chi 2$ (2)=6.448, p=.04) and were in private practice (33%, n=30, $\chi 2$ (8)=25.368, p=.001).

In contrast, respondents who acquired CAM knowledge as part of their social work education had under 10 years of experience (73%, n=27; $\chi 2$ (2)= 36.995, p=.000), were 40 years old or younger (59%, n=22; $\chi 2$ (4)=17.568, p=.001).

The McNemar binominal test for two related nominal variables was utilized to examine the relationship between personal use of and recommendation of, and referral to CAM approaches. Yate's continuity correction was utilized to prevent overestimation of statistical significance and thus reducing the change of Type I error. The analysis reveals statistically

significant results between personal use and recommendation of CAM approaches, as well as personal use and referral to each top CAM approaches of the study: Yoga, Imagery, and Relaxation, Massage Therapy, as well as Diet & Nutritional/lifestyle changes.

As see in tables below (Table 7 -16), out of 20.3% (N=63) of respondents that referred their clients to Yoga practitioners, 66.7 % used Yoga personally versus 33.3% who did not use this approach in their personal life ($\chi 2=78.76$, p=.000). Similarly, out of 39.9% (N=124) of respondents that recommended Yoga to their clients, 69.4% used Yoga personally ($\chi 2=23.33$, p=.000).

Only 3.9% (N=12) of respondents referred their clients to practitioners of Imagery; 66.7% of them used this approach personally as well ($\chi 2=70.92$, p=.000). A greater percentage of respondents recommended Imagery to their clients (15.1%, N=47) and 59.6% of them used the approach personally ($\chi 2=23.33$, p=.000).

Relaxation was recommended by 31.2% (N=97) respondents. Out of those 76.3% used relaxation personally ($\chi 2=36.08$, p=.000). Referrals to practitioners of relaxation we done by only 11.3% (N=35), however 77.1% were done by respondents who used relaxation personally ($\chi 2=110.04$, p=.000). Massage therapy referrals were done by 22.5% (N=70) of respondents, 70.0% of them done by those who used massage therapy personally ($\chi 2=81.85$, p=.000). A greater portion of respondents recommended massage therapy (35.0%, N=109), 73.4% of whom used it personally ($\chi 2= 41.17$, p=.000).

Diet, nutrition and lifestyle changes were referred to by 26.0% (N=81), out of those 72.8% used the approach personally ($\chi 2=47.73$, p=.000). A greater number of respondents recommended diet, nutrition and lifestyle change (38.9%, N=121) and 71.9% of them used the approach personally ($\chi 2=12.34$, p=.000).

Table 7

Cross tabulation of Imagery personal use and referral

		Did not refer	Referred
No Personal use	N	215	4
	%w/in personal use	98.2	1.8
	% w/in referral	71.9	**33.3**
personal use	N	84	8
	%w/in personal use	91.3	8.7
	% w/in referral	28.1	**66.7**

$\chi 2=70.92$*, p=.00

Table 8

Cross tabulation of Yoga personal use and referral

		Did not refer	Referred
NO Personal use	N	117	21
	%w/in personal use	84.8	15.2
	% w/in referral	47.2	**33.3**
personal use	N	131	42
	%w/in personal use	75.7	24.3
	% w/in referral	52.8	**66.7**

$\chi 2=78.16$*, p=.00

Table 9

Cross tabulation of relaxation techniques personal use and referral

		Did not refer	Referred
NO Personal use	N	142	8
	%w/in personal use	94.7	5.3
	% w/in referral	51.4	**22.9**
personal use	N	134	27
	%w/in personal use	83.2	16.8
	% w/in referral	48.6	**77.1**

$\chi 2=110.04$*, p=.00

Table 10

Cross tabulation of Massage Therapy personal use and referral

		Did not refer	Referred
NO Personal use	N	106	21
	%w/in personal use	83.5	16.5
	% w/in referral	44.0	**30.0**
personal use	N	135	49
	%w/in personal use	73.4	26.6
	% w/in referral	56.0	**70.0**

$\chi 2$=81.85*, p=.00

Table 11

Cross tabulation of Diet&nutrition/Lifestyle changes personal use and referral

		Did not refer	Referred
No Personal use	N	131	99
	%w/in personal use	57.0	43.0
	% w/in referral	85.6	**62.7**
personal use	N	22	59
	%w/in personal use	27.2	72.8
	% w/in referral	14.4	**37.3**

$\chi 2$=47.74*, p=.00

Table 12

Cross tabulation of Imagery personal use and recommendation

		Did not recom.	recommended
NO Personal use	N	200	19
	%w/in personal use	91.3	8.7
	% w/in recommend	75.8	**40.4**
personal use	N	64	28
	%w/in personal use	69.6	30.4
	% w/in recommend	24.2	**59.6**

$\chi 2$=23.325*, p=.00

Table 13
Cross tabulation of Yoga personal use and recommendation

		Did not recom.	recommended
NO Personal use	N	100	38
	%w/in personal use	72.5	27.5
	% w/in recommend	53.5	**30.6**
personal use	N	87	86
	%w/in personal use	50.3	49.7
	% w/in recommend	46.5	**69.4**

$\chi 2$=23.325*, p=.00

Table 14
Cross tabulation of Relaxation personal use and recommendation

		Did not recom.	recommended
NO Personal use	N	127	23
	%w/in personal use	84.7	15.3
	% w/in recommend	59.3	**23.7**
personal use	N	87	74
	%w/in personal use	54.0	46.0
	% w/in recommend	40.7	**76.3**

$\chi 2$=36.08*, p=.00

Table 15
Cross tabulation of Massage therapy personal use and recommendation

		Did not recom.	recommended
NO Personal use	N	98	29
	%w/in personal use	77.2	22.8
	% w/in recommend	48.5	**26.6**
personal use	N	104	80
	%w/in personal use	56.5	43.5
	% w/in recommend	51.5	**73.4**

$\chi 2$=41.17*, p=.00

Table 16
Cross tabulation of Diet&nutrition/Lifestyle changes personal use and recommendation

		Did not recom.	recommended
NO Personal use	N	119	34
	%w/in personal use	77.8	22.2
	% w/in recommend	62.6	**28.1**
personal use	N	71	87
	%w/in personal use	44.9	55.1
	% w/in recommend	37.4	**71.9**

$\chi 2$=12.34*, p=.00

* McNemar Test with Yates Continuity correction

Utilizing the Chi-square test, association between formal training and integration of CAM approaches was examined. The results revealed that social workers integrate approaches without formal training. Five most integrated approaches in the study (Imagery, Meditation, MBSR, Relaxation and Reiki) were used by at least half of the social workers without formal training.

Table 17
Significant association between lack of formal training and integration into practice

CAM	N (%)	Chi-square	df	p
Imagery	90 (66.2)	29.205	1	0.00
Meditation	60 (50.4)	53.5	1	0.00
MBSR	61 (54.0)	46.545	1	0.00
Relaxation	118 (60.2)	12.952	1	0.00
Reiki	9 (56.3)	20.459	1	0.00

*Alpha level set at .01

In order to compare the attitude scale across the demographic criteria a multivariate factor analysis with direct oblimin rotation was administered. The scale variables were examined for normality, linearity and outliers. By examining the Skewness and Kurtosis coefficients, as

well as the boxplot, it was identified that most of the variables (excluding attitude 9) were not normally distributed.

Attitude 6, 8 were positively skewed, while attitude 1 was severely positively skewed. Also, attitude 2, 3, 4, 5, 7, 10, 12, 13, 14 were negatively skewed, attitude 11 was severely negatively skewed. The variables were transformed appropriately to reach normal distribution. Moderately positively skewed scores were transformed using square root(x), substantially positively skewed scores were transformed using lg10(x) computation, and severely positively skewed scores 1/x. Attitude scores that were negatively skewed were transformed using square root (6-x), severely negatively skewed scores utilizing 1/(6-x).

The transformed attitude scores transformed into z scores and examined for univariate outliers (z scores >3.29 and <-3.29). Four univariate outliers were found. The variables were then appropriately further transformed. The scores were then examined for multivariate outliers using Malhomabis' distance regression. One multivariate outlier was revealed and it was eliminated.

A factor analysis with Oblimin rotation was applied. A three-factor solution was found accounting for 51.88% variance; however two of the fourteen variables did not load above .32. These two variables (att 1 and att 9) were then removed from the analysis and the calculation was repeated. The regression factor scores were saved and used for inferential statistics.

Three-factor solution was once again found accounting for 58% of variance this time. The Kaiser-Meyer-Olkin Measure of Sampling Adequacy measured .884 and the Barlett's test of Spheriticy was significant ($\chi 2$ =1120.809, df =66, p=.000). Kaiser measure exceeds .6, indicating that the matrix is factorable.

Utilizing Principle Component extraction with varimax rotation, using the criteria of eigenvalues greater than 1.0, a three-factor solution was determined to account for 51.88% of the variance (Table 18).

Table 18
Principle Component Analysis: Total Variance Explained

	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
Component	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	4.832	34.511	34.511	4.832	34.511	34.511	3.931	28.078	28.078
2	1.386	9.901	44.412	1.386	9.901	44.412	2.205	15.752	43.83
3	1.045	7.465	51.876	1.045	7.465	51.876	1.127	8.047	51.876
4	0.987	7.047	58.923						
5	0.859	6.133	65.056						
6	0.825	5.893	70.949						
7	0.761	5.438	76.387						
8	0.683	4.882	81.269						
9	0.573	4.093	85.362						
10	0.51	3.643	89.005						
11	0.449	3.206	92.211						
12	0.427	3.052	95.263						
13	0.378	2.703	97.966						
14	0.285	2.034	100						

Following the principle factor extraction with oblique rotation specifying three factors was performed using three factors. Items that loaded higher than .32 within each factor were identified.

Table 19
Results from Oblimin Rotation Factor Analysis

Factor	Item	Loading	Eigenvalue
1	4	-0.356	3.628
	5	0.430	
	7	-0.786	
	10	0.560	
	11	-0.586	
	13	0.662	
	14	0.433	
2	2	0.348	1.766
	3	0.480	
	12	0.619	
3	6	0.505	2.606
	8	0.763	

Multiple regression analysis was used to test if the attitude item significantly predicted the corresponding factor. The results of the regression indicated the attitude items 4, 5, 7, 10, 11, 13 and 14 explained 99.9% of the variance

Table 20
Results of Multiple Regression analysis – Predictors of Attitude Factors

Factor	R Square	df	F	p
1	0.998	7	1794.6	0.000
2	0.865	3	618.55	0.000
3	0.925	2	1794.6	0.000

alpha set a .05

Three factors were identified and labeled to reflect the nature of the items they represented. Factor one (Items 4, 5, 7, 10, 11, 13, 14) was labeled as ‘Openness and Fit’ because items within the factor indicated general openness to CAM, integration and fit with social work practice. Factor two(Items 2, 3, 12) was labeled ‘Client use of CAM’ because it reflected social

worker's impression of client's interest in and use of CAM. Factor three (Item 6, and 8) was labeled as 'Skepticism' because agreement with these items reflected cynical attitude toward CAM.

The regression scores for each factor were recoded into three groups: high, moderate and low scores. High scores were those that fell one standard deviation or more above from the mean; moderate scores fell between one positive and negative one standard deviation; and low scores were scores that fell below negative one standard deviation.

No statistically significant difference of attitude factor 1, 2 and 3 scores between groups across demographic information.

Chi-square test of association was then used to determine if significant results exist between the attitude factors and integration or recommendation/referral and personal use of the top five utilized complementary and alternative approaches in the study.

Table 21
Frequency distribution of attitude factor scores (n/%)

Factor	Hi score	Mod score	Low score	Missing	Total
1	41(13.2)	197(63.3)	56 (18.0)	17 (4.5)	311 (100)
2	32 (10.2)	217 (69.8)	45 (14.5)	17 (4.5)	311 (100)
3	38 (12.2)	197 (63.3)	59 (19.0)	17 (4.5)	311 (100)

Factor One – "Openness and Fit"

Statistically significant results revealed that individuals, who scored moderately on the openness and fit factor, were most likely to incorporate complementary and alternative approach into their practice, than those that scored low or high.

Table 22
Frequency distribution of factor 1 score level and incorporation of CAM approaches (n/%)

Approach	Hi score	Mod score	Low score	Chi-square	df	p
Mediation	7 (6.1)	74 (62.2)	33 (28.9)	17.837	2	0.000
Imagery	6 (4.8)	88 (70.4)	31 (24.8)	17.194	2	0.000
Relaxation	16 (8.9)	131 (70.4)	39 (21.0)	12.232	2	0.000
Diet/lifestyle	6 (7.0)	54 (62.8)	26 (32.2)	12.539	2	0.002

*alpha set at .01

Significant results were also found between personal use of relaxation, meditation and diet.

Table 23
Frequency distribution of Factor 1 score levels and personal use of CAM (n/%)

Approach	Hi score	Mod score	Low score	Chi-square	df	p
Relaxation	14 (9.0)	101 (65.2)	40 (25.8)	13.7	2	0.001
Meditation	15 (10.9)	87(63.0)	36 (26.1)	9.14	2	0.010
Diet	12 (7.7)	108 (69.7)	35 (22.6)	11.545	2	0.003

*alpha set at .01

Factor Two – "Client use of CAM"

Respondents who scored moderately on 'client use of CAM' factor were more likely to recommend and/or refer their clients to CAM practitioners, compared to those that scored low or high.

Table 24
Percentage of respondents recommending CAM across score values on factor 2 (n/%)

Approach	Hi score	Mod score	Low score	Chi-square	df	p
Yoga	7 (6.10)	78 (67.8)	30 (26.1)	19.253	2	0.000
Meditation	5 (5.1)	75 (75.8)	19 (19.2)	6.216	2	0.045
Massage	4 (3.9)	77 (75.5)	21(20.6)	9.864	2	0.007
diet/lifestyle	6 (5.1)	88 (75.2)	23 (19.7)	8.373	2	0.015

*alpha level set at .01

Factor three – "Skepticism"

Individuals who scored high on 'skepticism' factor were least likely to integrate complementary and alternative approaches into their practice. Social workers who scored moderately on 'skepticism' factor still referred patients to practitioners of complementary, as did those that scored low on 'skepticism'.

Table 25

Frequency of respondents referring to CAM practitioners across score value on factor 2 (n/%)

Approach	Hi score	Mod score	Low score	chi-square	df	p
Meditation	4 (9.8)	21 (51.2)	16 (39.0)	16.643	2	0.005
MBSR	5 (13.5)	16 (43.2)	16 (43.2)	14.907	2	0.001
Massage therapy	5 (7.4)	40 (58.8)	23 (33.8)	11.35	2	0.003
Nutrition supplements	15 (38.5)	23 (59.0)	1 (2.6)	11.748	2	0.003

* Alpha set at .01

A Chi-square test of association was run to examine relationships between factor one (openness to and fit of CAM) and factor three (skepticism toward CAM) level of knowledge of top five CAM approaches, however no significant associations were found.

No statistically significant results were found between factor 3 and personal use of CAM.

<u>One-way analysis of variance</u>

The one-way ANOVA was utilized to examine the null hypothesis which states there is no significant difference between primary areas of practice with regards to attitude scores. The results show an overall significant difference in mean scores of factor two of the attitude scale between at least two primary areas ($F(12, 261) = 3.167$, $p = .000$). The Levene test of homogeneity of variance indicates that the data met the assumptions of variance (Levene statistics $(12, 261) = 1.526$, $p = .114$). The robust test of equal of equal means, demonstrated a scientifically significant difference between groups (Welch=3.153, df1=12, df2=37.974, p=.003). A Tukey post-hoc test revealed that social workers who work with child/adolescent population

scored higher on factor two attitude test then those that worked with adults (mean difference=.595, SE=.144, p=.003).

Kruskal-Wallis H test was utilized to examine the overall significant difference between settings of practice and factor two attitude scores, because the Levene test of homogeneity of variance indicates that this data set does not meet the assumptions of variance (Levene statistics =2.608, df=8, 274, p=.009). The results show an overall significant difference in mean scores of factor two

($\chi 2$ =27.014, df=12, p=.008)

Follow-up tests (Mann-Whitney U) were conducted to evaluate pair wise differences among the nine groups, controlling for Type I error across tests by using the Bonferroni approach (p/number of tests=.05/35=.014). The results of these tests indicated a significant difference between the healthcare inpatient setting and private practice (p=.000), as well as healthcare outpatient setting and private practice (p=.000).

Chapter V

DISCUSSION

The findings of this exploratory study shed a new light on Canadian social workers' level of knowledge, personal, and professional use and attitudes toward complementary and alternative therapies. The results of the study demonstrate that Canadian social workers are familiar with a wide variety of complementary and alternative approaches, however much fewer possess formal training and expert knowledge in any of the approaches. In contrast, Henderson (1997) found at least two times greater knowledge level in her sample of New York state social workers. Similar results were found by Coldwell, et al (2006) among Marriage and Family Therapists in the USA. Research demonstrates that population use of CAM increases as we move toward the west coast. British Columbia was grossly underrepresented in the current study, which might have contributed to this difference.

Canadian social workers most often reported having formal training and expert knowledge in Mind-Body Techniques. These approaches were also considered mainstream in social work practice by a third of the respondents. The study also demonstrates that Mind-Body Techniques (Relaxation, Imagery, Meditation, MBSR, diet/lifestyle changes) are also most frequently integrated into social work practice. Similarly to the current study, Henderson (1997, 2000) found the Mind-Body approaches were viewed as mainstream in social work practice and were most frequently administered directly to clients. In a study by Hughes (2007), psychologists also viewed certain Mind-Body approaches as part of mainstream therapeutic approaches.

Psychologists (Bassman & Uellendahl, 2003) and MFT's (Coldwell, et al., 2006) recommended and referred their clients to CAM providers about twice as frequently as social workers in the current Canadian study.

The study discovered that Canadian social workers express an overwhelming interest in learning more about CAM (95%), as well as show openness to incorporate complementary and alternative approaches into their practice (82%). Lack of training and knowledge however was identified as the main barrier to integration. The study revealed that the vast majority (93%) of Canadian social workers learn about CAM as part of their own personal interest in the subject and only 27% as part of their employment and fewer yet as part of social work education (12%). The respondents agree that CAM training should be included in social work curricula (68.7%). The study demonstrated that younger respondents were more likely to have learned about complementary and alternative approaches as part of social work curriculum, which demonstrates that some schools have incorporated such training to a small degree.
Social workers who personally used an approach (Yoga, Imagery, Relaxation, Massage therapy, diet/nutrition/lifestyle change) were more likely to recommend those approaches to their clients and refer them to practitioners of those approaches.

Furthermore, older and more experienced social workers had more training and expert knowledge in CAM, yet were not more likely to actually integrate complementary and alternative approaches into their practice. This could reflect an exposure and internalization by the younger social workers of the shift observed in general population toward interest and openness to CAM. In addition, the personal and professional experience with complementary approaches by older social workers could be representative of a greater confidence associated

with established reputation within the organization or freedom within private practice by the more experienced professionals.

It is my assumption that private practitioners are often faced with the upward pressure from the market and clients to incorporate complementary approaches because they compete for the clients in the private sector. Although also obligated by Code of Ethics, private practitioners also tend to have less of or no institutional regulations and barriers to contend with. This dynamic reflects Tataryn and Verhoef (2001) "Integration Pyramid Model" of upward pressure from healthcare consumers to individual practitioners first.

Tataryn (2002) states that a holistic approach and attitude to practice supports a systemic integration of Complementary and Alternative Medicine (CAM). It appears that the social work profession is primed and ready to integrate complementary approaches directly into practice. The current study revealed that a vast majority of the sample (97%) believe that social work should consider a holistic, mind-body-spirit approach to practice. As well, 70% of respondents' approach to social work fit well with the assumptions of CAM. Canadian social workers demonstrate an overall positive attitude toward complementary and alternative medicine; they recognize their client's interest in CAM and the importance of being aware of client's use of CAM. However, only 60% of social workers assess client's CAM use as regular part of their assessment.

Echoing the results of Henderson (1997), US based study, the current study found that well over a half of Canadian social workers incorporated complementary and alternative therapies into their practice with NO formal training in the approach. These results pose great practice and ethical concerns.

Generally speaking, social workers and MFT's in the US seem to have more knowledge and higher skill level in complementary and alternative approaches than Canadian social workers do, yet in both nations, the rate of integration tends to exceed the knowledge and skill level.

Upon a review of national Canadian (CASW) and US (NASW) regulatory code of ethics and practice guidelines, it appears that there are clear variations between the two, in the openness level to integration of complementary and adjunct therapies into social work practice at the licensure level.

Social workers in US received distinct guidelines around CAM integration. The New York State Social Work practice guidelines speak on professional competence, "Before using a modality not included in your professional training (e.g., biofeedback or hypnosis), enroll in and successfully complete programs of study in recognized institutions and/or with recognized authorities to ensure competency." (New York State Education Department and the State Board for Social Work, 2012).

Furthermore, NASW states:

" 1.04 Competence (a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.(b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques. (c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm." (NASW, 2008).

In Contrast, the Canadian Association of Social Worker's (CASW) Code of Ethics (2012) does not make mention nor does it allude to use of complementary or new approaches, which seems to imply lack of openness to CAM use and integration. CASW generally

encourages expansion of knowledge and skills, by stating in regard to social work value 6 – 'Competence in professional practice':

"Social workers analyze the nature of social needs and problems, and encourage innovative, effective strategies and techniques to meet both new and existing needs and, where possible, contribute to the knowledge base of the profession. Social workers have a responsibility to maintain professional proficiency, to continually strive to increase their professional knowledge and skills, and to apply new knowledge in practice commensurate with their level of professional education, skill and competency, seeking consultation and supervision as appropriate" (CASW, 2012).

Canadian social workers lack clear guidelines and polices around CAM integration and use of it within direct practice, which leaves too much room for subjective interpretation and possible breach of code of ethics.

In December 2011 the Newfoundland and Labrador Association of Social Workers (NLASW) developed the "Complementary & Adjunct Therapies & Techniques: A Guide for Registered Social Workers" (NLASW, 2012). This appears to be the very first explicit Canadian based guidelines for social workers around use of complementary therapies. The guidelines acknowledge that social workers do incorporate complementary therapies into social work practice and provides the members strategies to do so ethically. NLASW encourages its members to

"when choosing to utilize complementary or adjunct therapies and techniques within the context of social work practice, social workers need to:

- Engage in a process of clear informed consent with the client
- Determine that the form of intervention is the best interest of the client
- Clearly assess personal competence to engage in the use of specific therapy
- Maintain appropriate professional boundaries." (NLASW, 2012, p.2)

Furthermore, the document offers a list of questions for consideration by a social worker around issues of self-competence (knowledge, skills, certification/registration, supervision), research based efficacy of technique, informed consent, consultation, boundaries, transparency

with employers, and documentation (NLASW, 2012). An article written by Pamela Blake (2009) further expands on the self-evaluation questions as she also encourages social workers to conduct comprehensive assessment of client needs, suitability of the approach, including risk factors and contraindications, options for referral out and "clarifying that these approaches are not social work or social services work practice" (p.3).

Across professions, MFT's developed guidelines around integration of complementary approaches and have been advised to ""be aware of new developments, learn about them in detail, evaluate them carefully, and implement them in practice only with suitable training and supervision" (Coldwell, et al., 2006, p. 111).

Although a different profession, nursing presents as a good example of integration of CAM into their practice and creation of policies and regulations around the same. The College and Association of Registered Nurses of Alberta (2008) also has developed standards for Registered Nurses around Alternative and/or Complementary Therapy, which could be used as an example to other professional associations. The standards outline requirements when engaging in complementary and alternative healthcare (CAHC): necessary knowledge, skills, attitudes and competencies to provide the therapy in a safe, competent and ethical manner; holding appropriate education or certification; knowledge of efficacy and risks of an approach; documentation; encourage client to inform health-care provider of CAM use; informed consent (CARNA, 2008, p.3). Furthermore, the document states that "nurses in self-employed practice who wish to use alternative/complementary therapies as an adjunct to their nursing practice must submit documentation to the Registration Committee for approval" (CARNA, 2006, p. 4)

The standards emphasize that "CAHC therapies 'are not specific to any one discipline and are often used by individuals who are not health-care professional. CAHC therapies 'by themselves do not constitute nursing practice' (NANB, 1996, p.1)" (CARNA, 2006, p. 3).

Problematic to Canadian context is the fact that there does not appear to be open acknowledgement of complementary and adjunct therapy use within social work practice and no agreement around which therapies are deemed mainstream and complementary. Recognition of integration and open dialogue would open up doors to conversation around scope of social work practice, need for training and education, as well as development of professional guidelines and policies around integration. It appears that enough pressure has been created at the clinician level to generate a push at the institutional and professional regulatory level as predicted by Tataryn and Verhoef (2001).

Implications for Social Work

The lack of knowledge, lack of guidelines and expectations on training levels, as well as lack of policies around complementary and adjunct therapy use and integration in social work practice may create an environment for potentially incompetent and unethical practice, which puts clients at risk for harm. Lack of recognition at the regulatory level and clear agreement around mainstream and complementary approaches in social work may create an unsupportive environment that leads to secrecy, fear and lack of professional adhesion. In addition, the unsupportive and unclear environment places the social work profession in a vulnerable position and at risk to be devalued and delegitimized. It is time for social work educational systems and professional and regulatory bodies to meet the needs of the clients and professional members, increasing viability and marketability of the profession, as well as supporting the WHO's

strategy to integrate CAM into healthcare system, expending the knowledge base on CAM, increasing availability and promoting sound use of CAM (Hughes, 2007).

The Agreement of internal trade dispute on differences in material scope of practice and academic training of social workers across Canada ought to also consider the knowledge and training of social workers in Complementary and Alternative approaches. Discussion and agreement is required at the practice, academic training and policy level around which complementary and alternative approaches are currently mainstream in social work practice and which approaches are appropriate for integration at this time.

Education

Social work core competencies for research informed practice should be upheld by providing the opportunities to learn about CAM and efficacy of the methods in the context of social work and mental health.

BSW level training aims to generate social workers capable of generalist practice. Thus, schools of social work should consider inclusion of courses which can provide social workers with a fundamental understanding of holistic health paradigm and practice and CAM approaches, general knowledge of application and efficacy of relevant approaches and research issues in CAM. Perhaps knowledge of and basic skills in the often deemed mainstream approaches such as relaxation, meditation and visualization, would be beneficial at the BSW level.

An MSW level curriculum could offer more in depth knowledge and skill set in CAM, which would provide social workers with the ability to specialize and develop expert level knowledge and skill set, which would enable them to evaluate the practice, conduct research and teach a modality.

Faculties and schools of social work, as well as regulatory bodies should provide appropriate, affordable opportunities for professional development and after degree training on complementary and alternative methods. Information on seminars, workshops and symposium on complementary and alternative approaches should be widely advertised and used as credits toward profession accreditation.

Policy

National and regional associations of social workers should actively work on examining social work scope of practice, identifying mainstream techniques and relevant complementary and adjunct approaches and creating guidelines and policies on training requirements and competencies around CAM use in the context of social work practice.

Regulatory bodies could create a list of social workers and other mental health professionals that hold expert knowledge in complementary and alternative approaches, which would be open to provide training, consultation and supervision to social workers interested in integration.

Practice

Ethical social work practice can be sustained only by education, research informed practice, clear guidelines and policies around integration of complementary and adjunct approaches which protects clients and the profession at large.

Holistic approach to practice, which includes assessment of client's CAM use is necessary to identify client's values, believes around health, health maintenance and approach to healing, in order to provide services according to their needs. Being heard and understood creates a therapeutic alliance, which enables us to advocate for clients, support them in the process of self-determination and informed decision making. In addition, assessment promotes understanding of

client issues and context of the situation, which in turn enables creation of a meaningful care plan, implementation and evaluation of that plan.

A trusting therapeutic relationship with a client supports an environment where clients feel safe to disclose CAM use. This provides an opportunity for a dialogue with healthcare providers and advocacy in the health care system for client specific treatment.

Research

Practice informed research is essential in the development and growth of the social work profession. Literature review on CAM integration in other professions and specific social work research on efficacy and appropriateness of CAM in the context of social work practice would guide practice, policy and curriculum development.

Possible limitations of the study

The major limitation of this study is related to sampling and small sample size and lack of complete national participation. Participation in the study was probably influenced by the interest in and attitude toward the topic, which might have skewed the results. It also appears that private practice social workers were overrepresented, while child welfare and community social workers were underrepresented. These limitations need to be considered when considering the findings until further research is conducted.

Recommendations for Further Research

Research on complementary and alternative approaches in social work is very limited. Further research is needed to gain a greater understanding where the needs lie in education, practice, and research and policy development to mindfully expand scope of social practice to include integration of complementary approaches.

- Duplication of this study in provinces which were not able or willing to participate in the current study, to examine the trends and have a fuller understanding of the Canadian social work perspective.
- Further exploratory research is needed to expand the understanding and breadth of complementary and alternative approaches that became mainstream, as well as examination of approaches that would be appropriate for integration into social work profession.
- Much research could be done on efficacy of any of the approaches in social work context.
- Examination of how the guidelines developed by Newfoundland and Labrador Association of Social Workers impacted social work generalist practice, integration of complementary and adjunct therapies, education and regulation in the region.

Chapter VI

CONCLUSION

The general population increasingly seeks health maintenance and healing approaches that are holistic in nature. Healthcare systems have been impacted by the pressure from the public and consequently most professions have begun to expand their scope of practice to include complementary and alternative approaches to healing. Social work and other mental health professionals have also taken action toward the expansion.

Significant gaps exist in literature on the topic of complementary and alternative approaches in social work. While Canadian social workers demonstrate high openness to expand their knowledge on CAM and report great interest in integration, a significant lack of adequate knowledge and expertise exists in the area.

It appears that the upward pressure described by Tataryn and Verhoef (2001) has impacted social work practitioners. It is believed that this pressure will continue to move upward toward the clinic, institutional, regulatory and policy level.

Social work profession seems to be in a transition where the pressure is shifting toward the institutional and regulatory direction. It seems that at the very least an open dialogue between practitioners, agencies, educational institutions, and regulatory/licensure bodies on the issue of integration is required. An opportunity for professional growth also exists by offering the highest quality of service by increasing professional knowledge and skills, while demonstrating interest in client's needs.

Purposeful expansion of social work curriculum to include education on complementary and alternative approaches would allow social workers to enter the workforce with basic

knowledge of the approaches and efficacy to provide best practice. This knowledge would at the very least allow them to have broad background of information to have meaningful and informed discussion to adequately guide clients in their decision making. Also, there is number of complementary and alternative approaches that are considered mainstream in social work and other helping profession; and have been scientifically proven to be effective in treating various ailments. Thus, social work education and scope of practice supported by furthering knowledge of these approaches and adequacy to deliver the techniques, guided by policy is crucial to remain current and provide evidence based practice.

Knowledge and practice stimulate evaluation and inquiry and thus further research. Providing social workers with knowledge on CAM, current evidence and research gaps, may stimulate further investigations and research, which may lead to evidence and integration that is based on best practice approach rather than anecdotal evidence. Further, specific policy development by social work governing bodies around CAM integration is required to foster a proficient and ethical use of CAM in direct social work practice. The regulations around certification and integration not only protect the public but also the professional liability and the credibility of the profession at large.

Knowledge of CAM isn't supposed to replace current theories and therapeutic approaches, but rather add to the existing repertoire. These initiatives would protect the reputation of the social work profession and allow it to expand as the system changes and remain marketable in an ever competitive environment.

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Appendix A

Ethics Approval Certificate

UNIVERSITY OF MANITOBA | Ethics
Office of the Vice-President (Research)

CTC Building
208 - 194 Dafoe Road
Winnipeg, MB R3T 2N2
Fax (204) 269-7173
www.umanitoba.ca/research

APPROVAL CERTIFICATE

October 11, 2011

TO: **Ela Minaker** (Advisor K. Levine)
Principal Investigator

FROM: **Bruce Tefft, Chair**
Psychology/Sociology Research Ethics Board (PSREB)

Re: **Protocol #P2011:058**
"Canadian Social Workers and Complementary & Alternative Therapies: National Descriptive Study of their Knowledge, Use and Attitudes toward Complementary and Alternative Approaches"

Please be advised that your above-referenced protocol, as revised, has received human ethics approval by the **Psychology/Sociology Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement (2). This approval has been issued based on your agreement with the change(s) to your original protocol required by the PSREB. It is the researcher's responsibility to comply with any copyright requirements. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- **If you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to the Office of Research Services, fax 261-0325 - please include the name of the funding agency and your UM Project number. This must be faxed before your account can be accessed.**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba Ethics of Research Involving Humans.

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/ors/ethics/ors_ethics_human_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**

Appendix B

Survey

CAM

1. Introduction and Consent Form

Principal Investigator: Ela Minaker, Master's student, Faculty of Social Work, (204)837-0752/umpartyk@cc.umanitoba.ca
Research Supervisor: Dr. Kathy Levine, Faculty of Social Work,(204)474-7461, levinka@cc.umanitoba.ca
Sponsor: None

This is a consent form, a copy of which you may save or print for your records and reference at this time (it will not be available later), is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to contact us. Please take the time to read this carefully and to understand any accompanying information.

Ela Minaker is conducting this study as her Master's Thesis, under the supervision of Dr. Kathy Levine, Faculty of Social Work, University of Manitoba. The purpose of this research is to examine social workers' degree of knowledge, use of, and attitudes toward various complementary and alternative approaches.

This is an online study that has five general sections, which explore social workers' use, knowledge of and attitudes toward various complementary and alternative approaches. It is estimated it will take about 15 minutes to complete the survey. This is an ANONYMOUS SURVEY. Your participation in this study is completely voluntary.

All of the answers you provide in the survey will be kept anonymous. Any information you provide will be stored on the encrypted and password protected site, Survey Monkey. Only the principal investigator and her supervisor will have access to your data.
The data collection and analysis for this project is expected to be complete in March 2012. I plan to share the summary of findings with your association and the research community through seminars, conferences, presentations, and journal articles. When presenting the results of this research, I will in no way focus on individual participants' responses and will instead present the findings in summary form. If you would like to received a copy of the summary results please follow the link at the end of the survey. The link will take you to a separate page where you can choose to share your contact information. Your contact information will be kept confidential and independent of your survey answers. This information will be destroyed as soon as a summery of results is sent.

Clicking "I agree" at the bottom of this page indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. If you wish to withdraw, simply close the browser window at any time.

The University of Manitoba Research Ethics Board(s) and a representative(s) of the University of Manitoba Research Quality Management / Assurance office may also require access to your research records for safety and quality assurance purposes.

This research has been approved by the Psychology/Sociology Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at (204)474-7122.
If you have read the information presented in this form and do not have any questions about this study, please click "I agree" when you are ready to begin. You should only click "I agree" if you agree to participate with full knowledge of the study presented to you in this information and consent form and of your own free will. We suggest that you be in a quiet place, when you have up to 15 minutes free, and where you can complete this survey on your own and without interruption. We would appreciate it if you could turn off all instant messaging programs, as well as any other programs, currently running on your computer before continuing. Thank you for your consideration.

CAM

Please indicate your consent to participate in this research study.

◯ YES, I AGREE (proceed to the survey)

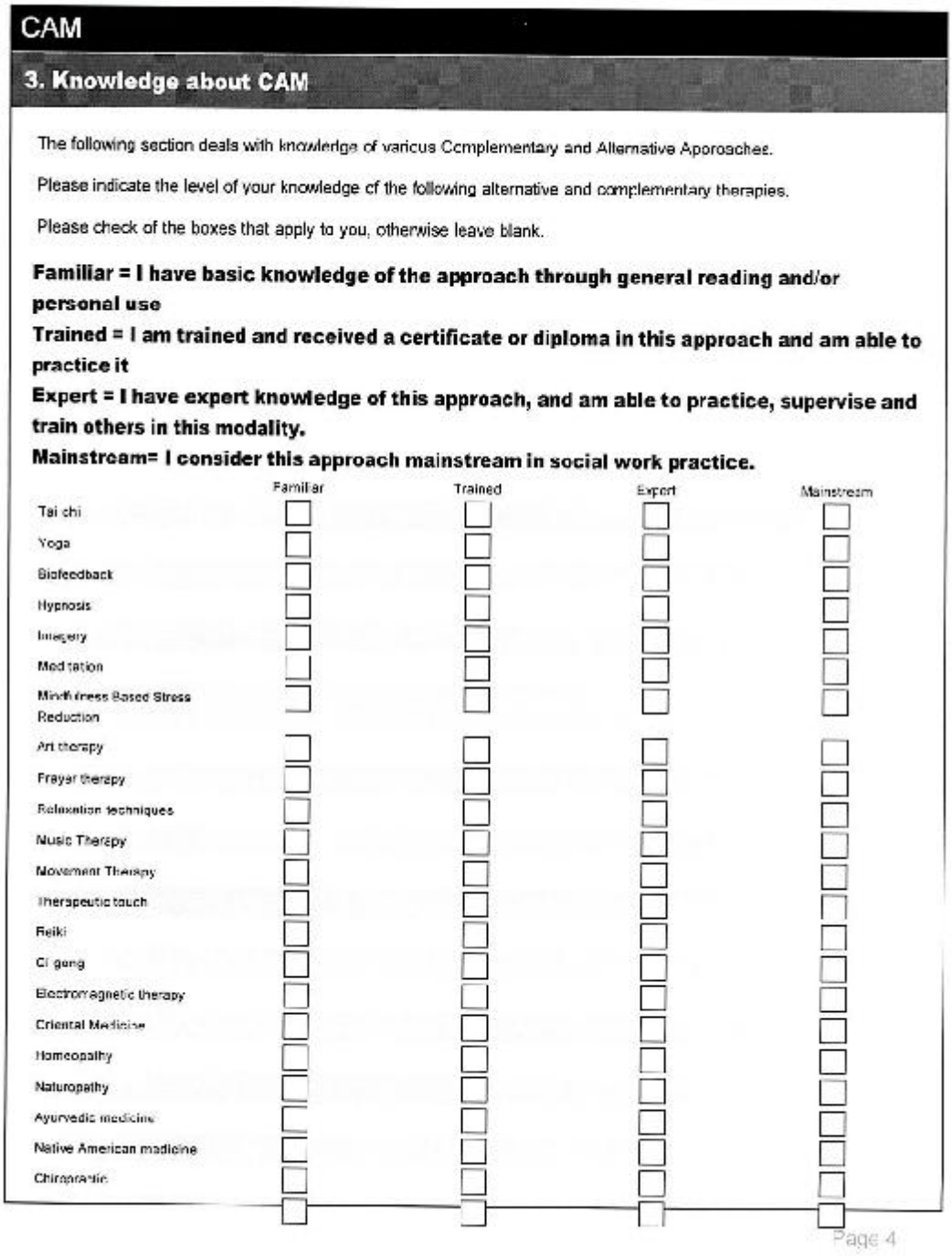
◯ NO, I DO NOT AGREE (exit the website)

CAM

2. Definition

For the purpose of this research study, I have acopted the following definition of Complementary and Alternative Therapies

"a broad domain of healing resources that encompass all health systems, modalities, and practices and their accompanying theories and belie's, other than those intrinsic to the politically domain health systems of a particular society or culture in a given historical period" (NIH Panel on Definition and Description, 1997)



CAM

3. Knowledge about CAM

The following section deals with knowledge of various Complementary and Alternative Approaches.

Please indicate the level of your knowledge of the following alternative and complementary therapies.

Please check of the boxes that apply to you, otherwise leave blank.

Familiar = I have basic knowledge of the approach through general reading and/or personal use

Trained = I am trained and received a certificate or diploma in this approach and am able to practice it

Expert = I have expert knowledge of this approach, and am able to practice, supervise and train others in this modality.

Mainstream= I consider this approach mainstream in social work practice.

	Familiar	Trained	Expert	Mainstream
Tai chi	☐	☐	☐	☐
Yoga	☐	☐	☐	☐
Biofeedback	☐	☐	☐	☐
Hypnosis	☐	☐	☐	☐
Imagery	☐	☐	☐	☐
Meditation	☐	☐	☐	☐
Mindfulness Based Stress Reduction	☐	☐	☐	☐
Art therapy	☐	☐	☐	☐
Prayer therapy	☐	☐	☐	☐
Relaxation techniques	☐	☐	☐	☐
Music Therapy	☐	☐	☐	☐
Movement Therapy	☐	☐	☐	☐
Therapeutic touch	☐	☐	☐	☐
Reiki	☐	☐	☐	☐
Qi gong	☐	☐	☐	☐
Electromagnetic therapy	☐	☐	☐	☐
Oriental Medicine	☐	☐	☐	☐
Homeopathy	☐	☐	☐	☐
Naturopathy	☐	☐	☐	☐
Ayurvedic medicine	☐	☐	☐	☐
Native American medicine	☐	☐	☐	☐
Chiropractic	☐	☐	☐	☐
	☐	☐	☐	☐

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CAM

Massage therapy	☐	☐	☐	☐
Reflexology	☐	☐	☐	☐
Cranial-Secral OMT	☐	☐	☐	☐
Light/Colour therapy	☐	☐	☐	☐
Diet and nutrition/Lifestyle changes	☐	☐	☐	☐
Herbal medicine	☐	☐	☐	☐
Nutritional supplements	☐	☐	☐	☐
Other (please list)	☐	☐	☐	☐

Other (please specify)

I have had an opportunity to learn about Complementary and Alternative Therapies through:

- ☐ Formal training leading to certificate, diploma or degree in in the approach
- ☐ Workshops
- ☐ As part of Social Work curriculum
- ☐ Component of my employment
- ☐ Personal use and/or interest
- ☐ Other (please specify)

CAM

4. Use of Complementary and Alternative Therapies

The following section deals with your personal and professional use of various Complementary and Alternative Therapies.

Please indicate by checking appropriate box which of the following reflects the level of your personal and professional use of complementary and alternative therapies.

Please check off the boxes that apply to you otherwise leave blank.

Please indicate appropriately as it pertains to you

Contemplated= I contemplated using this approach in my practice
Incorporated= I have incorporated this approach into my practice
Recommended= I have recommended this approach to a client
Referred =I have referred clients to a provider of this approach
Personal use = I have personally used this complementary and alternative treatment modality

	Contemplated	Incorporated	Recommended	Referred	Personal use
Tai chi	☐	☐	☐	☐	☐
Yoga	☐	☐	☐	☐	☐
Biofeedback	☐	☐	☐	☐	☐
Hypnosis	☐	☐	☐	☐	☐
Imagery	☐	☐	☐	☐	☐
Meditation	☐	☐	☐	☐	☐
Mindfulness Based Stress Reduction	☐	☐	☐	☐	☐
Art therapy	☐	☐	☐	☐	☐
Prayer therapy	☐	☐	☐	☐	☐
Relaxation techniques	☐	☐	☐	☐	☐
Music Therapy	☐	☐	☐	☐	☐
Movement Therapy	☐	☐	☐	☐	☐
Therapeutic touch	☐	☐	☐	☐	☐
Reiki	☐	☐	☐	☐	☐
Qi gong	☐	☐	☐	☐	☐
Electromagnetic therapy	☐	☐	☐	☐	☐
Oriental Medicine	☐	☐	☐	☐	☐
Homeopathy	☐	☐	☐	☐	☐
Naturopathy	☐	☐	☐	☐	☐
Ayurvedic medicine	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

CAM

Native American medicine	☐	☐	☐	☐	☐
Chiropractic	☐	☐	☐	☐	☐
Massage therapy	☐	☐	☐	☐	☐
Reflexology	☐	☐	☐	☐	☐
Cranial-Sacral OMT	☐	☐	☐	☐	☐
Light/Colour therapy	☐	☐	☐	☐	☐
Diet and nutrition/Lifestyle changes	☐	☐	☐	☐	☐
Herbal medicine	☐	☐	☐	☐	☐
Nutritional supplements	☐	☐	☐	☐	☐
Other (please list)	☐	☐	☐	☐	☐

Other (please specify)

Which of the following do you perceive to be the BARRIER(S) to integration of complementary and alternative therapy into your Social Work practice?

Please check off as many boxes as it pertains to you.

	Barriers
Lack of knowledge	☐
Lack of Training	☐
Lack of time	☐
Lack of equipment	☐
Lack of reimbursement	☐
Peer reluctance	☐
Institutional concerns	☐
Scope of Practice	☐
Legal concerns	☐
My own reluctance	☐
NO barriers perceived	☐

Other (please specify)

CAM

5. Attitudes about Complementary and Alternative Medicine

The following section deals with attitudes toward Complementary and Alternative Approaches.

Please indicated the level of your agreement or disagreement with each statement using the following scale:

SD= Strongly Disagree
D= Disagree
N= Neither Agree or Disagree
A= Agree
SA= Strongly Agree

Please indicate your agreement or disagreement with these statements.

	SD	D	N	A	SA
1. Clients' use of complementary and alternative approaches is irrelevant to the conduct of social work.	○	○	○	○	○
2. Most clients are interested in complementary and alternative treatments.	○	○	○	○	○
3. I would refer clients to a complementary and alternative therapy practitioner only if I thoroughly knew about the practice and the practitioner.	○	○	○	○	○
4. It is important to know about clients' use of complementary and alternative approaches to better understand what they believe will support good health.	○	○	○	○	○
5. The assumptions of complementary and alternative medicine fit well with my approach to social work.	○	○	○	○	○
6. Most complementary and alternative practices are outside the scope of practice of social work.	○	○	○	○	○
7. It is important to expand the health care infrastructure to include complementary and alternative approach practitioners.	○	○	○	○	○
8. I have serious concerns about social workers who attempt to incorporate complementary and alternative treatments into their practice.	○	○	○	○	○
9. I rely primarily on my intuition and general knowledge when recommending any treatment approach to clients.	○	○	○	○	○
10. Complementary and alternative approaches should be included in social work curricula.	○	○	○	○	○
11. Social Workers should take into account the connection between body, mind and spirit.	○	○	○	○	○
12. I ask clients about their use of complementary and alternative treatments as a regular part of my assessment.	○	○	○	○	○
13. It is important to expand social work scope of practice to include relevant complementary and alternative approaches.	○	○	○	○	○
14. If clients believe a CAM treatment will help them, I would explore this treatment option with them.	○	○	○	○	○

Please indicate your LEVEL OF OPENNESS to learn more about and incorporate Complementary and Alternative Therapies (CAT) into your practice.

	Openness to LEARN about CAT	Openness to INCORPORATE CAT into my practice
Not open	☐	☐
Reluctant	☐	☐
Open	☐	☐
Eager	☐	☐

CAM

6. Demographic information

This last section deals with general, non-identifying demographic information about you and your practice.

Please select the appropriate demographic options

	gender	age
Demographic info		

Demographic information

	Province/Territory	Urban/Rural
Location		

Please indicate the your highest degree and years of social work practice

	Degree	Years of social work practice
Please choose one in each category		

Other (please specify)

Please describe your practice setting and primary area of your practice

	Setting	Primary area of practice
Please choose one in each category		

Other (please specify)

CAM

7. THANK YOU!

Thank you for taking the time to complete the survey!

If you would like to receive a summary of the study results, please click on the link provided below and it will redirect you to a page where you can leave your contact information in confidence. Please note that your contact information will be kept confidential and completely separate from your survey response. This information will be discarded after the summary of results is distributed. You can choose to leave your contact information HERE.

If you have any questions or comments about this survey please e-mail Ela Minaker, Graduate Student, Faculty of Social Work, University of Manitoba umpertyk@cc.umanitoba.ca or call (204)837-0751
OR
Dr. Kathy Levine, Thesis Advisor, Faculty of Social Work, University of Manitoba, levinka@cc.umanitoba.ca (204)474-7461.

Appendix C

Cover Letter to the Canadian Associations

Ela Minaker
PZ 268 – 771 Bannatyne Avenue
Winnipeg, Manitoba
R3E 3N4
Phone: (204) 787-5178
Fax: (204) 787-7480
e-mail: eminaker@hsc.mb.ca

Dear Madam/Sir:

I am a graduate student at the School of Social Work at the University of Manitoba presently engaging in thesis research project focused on the Canadian Social Workers' knowledge, use and attitudes toward Complementary and Alternative Therapies.

I am hoping to conduct a national study, inviting registered social workers from all regions to participate in the survey. In this regard, I would appreciate you assistance in electronically distributing the invitation to participate in my study to the members of your association. The survey is web based (via survey monkey); it is a confidential and ANNONYMOUS study. Participants are given a web site address where they can access and complete the survey. The information provided by the participants will be securely stored and available only to me and my thesis advisor, Professor Kathy Levine, PhD at University of Manitoba. The final survey results will include group averages only and will be shared with you.
If electronic distribution is not possible, I would like to advertise the study in your newsletter as soon as possible. Please find enclosed the Letter of Invitation.

I appreciate you assistance in helping me make my thesis research project a success. If you have further questions, please feel free to contact me at the above address or alternately, you may contact my thesis advisor, Dr. Kathy Levine at (204) 474-7461.

Sincerely,

Ela Minaker, B.A., BSW, RSW

Appendix D

Letter of Invitation

Letter of Invitation

Research Study:

Canadian Social Workers and Complementary & Alternative Therapies: national descriptive study of knowledge, use and attitudes.

Dear Colleague,

You are invited to participate in a national survey of Social Work Professionals around the issue of use and integration of Complementary and Alternative Therapies within Social Work practice.

Over the last two decades Complementary and Alternative Therapies have become increasingly used by the general population to treat and manage various ailments, as well as to maintain well being. Various professions have began to explore the validity of CAM integration and in some cased successfully integrated various techniques into their practice. The purpose of this study is to explore the current integration level of various Complementary and Alternative approaches into Social Work practice, as well to explore the opinions of Social Workers across Canada regarding the validity and need for integration.

Your participation in the study is ANNONOMOUS and involves completion of an online survey. The survey will take 15 minutes of your time to complete. The questionnaire will be available on-line from March 1, 2011 to April 1, 2011. If you prefer to complete the survey on paper, the questionnaire is available upon request.

To access the survey, please follow this link https://www.surveymonkey.com/s/CndSWandCAM and follow the instructions.
Thank you for your participation; your input is a valuable to the success of the study and expansion of knowledge on Canadian Social Work scope of practice. Should you have any questions, please feel free to contact me at eminaker@hsc.mb.ca or (204) 787-5178.

Warm Regards
Ela Minaker, BA (Adv), BSW, RSW
Graduate Student
School of Social Work
University of Manitoba

Appendix E

Phone Script

Script of the follow up telephone call to Executive Directors

Hello (*ED name),* my name is Ela Minaker, a graduate social work student at University of Manitoba. I am calling to follow up on the e mail I've send to you on *(date).*
I am working on my Master's Thesis research project and am looking for support from your association in reaching all registered social workers. I would like to request distribution of my invitation later to all of your members electronically. Is that possible?

(a)
[If NO] I would like publish the "Letter of Invitation" in your next newsletter. When is the dateline? Is there a cost associated with it? Do you need me to provide you another copy of the letter? (If yes) which e mail address do I forward it to?
(If No) will you submit it to the publisher?
(If yes) what is the name and contact information of the publisher?
At this time do you need my contact information?
(If yes) Ela Minaker, (204) 837-0752 or umpartyk@cc.umanitoba.ca
Thank you for your time and information. Good bye.

(b)
[If YES] do you have the copy of the "Letter of Invitation"?
(If yes) which address would you like me to send it to?
When will you be able to send out the e-mail to your members?
At this time do you need my contact information?
(If yes) Ela Minaker, (204) 837-0752 or umpartyk@cc.umanitoba.ca
Thank you for your assistance and support. Good bye.

Appendix F

List of Provincial Social Work Associations

British Columbia Association of Social Workers
Suite 402, 1755 West Broadway
Vancouver, BC V6J 4S5
Tel: (604) 730-9111 1-800-665-4747 (BC residents only)
Fax: (604) 730-9112
E-mail: bcasw@bcasw.org
Website: www.bcasw.org
Executive Director: Ms. Linda Korbin

Alberta College of Social Workers
#550, 10707 100 Avenue NW
Edmonton, AB T5J 3M1
Tel: (780) 421-1167 1-800-661-3089 (Alberta residents only)
Fax: (780) 421-1168
E-mail: acsw@acsw.ab.ca
Website:http://www.acsw.ab.ca
Executive Director & Registrar: Mr. Rod Adachi
E-mail: acswexd@acsw.ab.ca
Associate Registrar: Alison MacDonald
E-mail: acswreg@acsw.ab.ca
Professional Affairs Coordinator: Lori Sigurdson,
E-mail:lsigurdson@acsw.ab.ca

Saskatchewan Association of Social Workers
2110 Lorne St.
Regina, SK S4P 2M5
Tel: (306) 545-1922
Fax: (306) 545-1895
E-mail: sasw@accesscomm.ca
Website: www.sasw.ca
Executive Director: Mr. Richard Hazel
E-mail: rhazel-sasw@accesscom.ca
Registrar: Ms. Joyce Reid

Manitoba Association of Social Workers/
Manitoba Institute of Registered Social Workers
Unit 101-2033 Portage Ave.
Winnipeg, Manitoba R3J 0K8
Tel: (204) 888-9477
Fax: (204) 831-6359
E-mail: masw@mts.net; Website: www.maswmirsw.ca
Executive Director and Registrar: Ms. Miriam Browne

Ontario Association of Social Workers
410 Jarvis St.
Toronto, ON M4Y 2G6
Tel: (416) 923-4848
Fax: (416) 923-5279
E-mail: info@oasw.org
Website: www.oasw.org
Executive Director: Joan MacKenzie-Davies

New Brunswick Association of Social Workers
P.O. Box 1533, Postal Station A Fredericton, NB E3B 5G2
Tel: (506) 459-5595
Fax: (506) 457-1421
E-mail: nbasw@nbasw-atsnb.ca
Website: www.nbasw-atsnb.ca
Executive Director:Miguel LeBlanc
E-mail: mleblanc@nbasw-atsnb.ca
Registrar: Ms. Suzanne McKenna
E-mail: smckenna@nbasw-atsnb.ca
Courier: NBASW, 403 Regent Street, Suite 100, Fredericton, NB E3B 3X6

Nova Scotia Association of Social Workers
1891 Brunswick St., Suite 106
Halifax, NS B3J 2G8
Tel: (902) 429-7799
Fax: (902) 429-7650
E-mail: nsasw@nsasw.org
Website: www.nsasw.org
Executive Director: Robert R. Shepherd
Registrar: Joyce Halpern

Newfoundland and Labrador Association of Social Workers
P.O. Box 39039, St. John's, NL A1E 5Y7
Tel: (709) 753-0200
Fax: (709) 753-0120
E-mail: info@nlasw.ca Website: www.nlasw.ca
Executive Director & Registrar: Lisa Crockwell lcrockwell@nlasw.ca
Courier: 177 Hamlyn Rd. St. John's, NL A1E 5Z5

Prince Edward Island Association of Social Workers
81 Prince Street
Charlottetown, PE C1A 4R3
Tel: (902) 368-7337
Fax: (902) 368-7080
E-mail:vrc@eastlink.ca
President: Kelly MacWilliams

The Association of Social Workers of Northern Canada (ASWNC)

c/o Geri Elkin
Box 2963
Yellowknife, NT X1A 2R2
Tel: (867) 920-4479
Fax:(867) 669-7964
E-mail: ed@socialworknorth.com

Website: www.socialworknorth.com