After reading this chapter you should be able to:

• discuss the nature of reflective social work practice and the place of values in social work with older people;
• describe some key sociological and psychological concepts relating to ageing and their impact on practice;
• express some ongoing debates surrounding the nature of social work with older people;
• understand the impact of legislation and policy on organizations and professional practice;
• consider the implications of a systemic perspective on social work practice with older people.

Introduction

This chapter introduces the reader to reflective practice and the impact of personal and professional values and stereotypes on social work practice with older people. The chapter argues that reflective social work practice is one part of the jigsaw of effective service provision and that organizations have responsibilities to create environments where social workers can practise effectively. Consideration is given to some key sociological and psychological perspectives which impact professional practice, policy development and implementation. The chapter charts some of the historical development of social work practice with older people and some key theoretical perspectives that impact both policy and practice development. In looking at earlier ‘watershed’ reports we question why so many policy initiatives have failed to be implemented adequately. Finally the chapter offers a brief consideration of the impact of understanding organizations as systems and what that might mean for social work practice with older people. The final part of the chapter offers opportunities for further exploration of systemic approaches in social work and social care.
Learners and learning

Entwistle (1984) suggests there are two key types of learner. First there are ‘information seekers’, who focus on the accumulation of facts and learn through creating patterns. Then there are the ‘understanding seekers’, who search for personal meaning, relating what they learn to their past experience, and exploring potential connections and potential discrepancies. In other words, they are reflecting. Marton and Säljö (1984) show that deep learning is more likely when a reflective approach is used. They differentiate between a deep approach and a surface approach to learning. The first is characterized by an intention to understand material for oneself, a vigorous and critical personal interaction with knowledge content, relating ideas to one’s previous knowledge and experience, relating evidence to conclusions, and examining the logic of arguments. This approach to learning they considered to be ‘knowledge transforming’. A surface approach, however, they describe as being ‘information reproducing’, where ideas and information are accepted passively, where there is no reflecting on purpose or strategy and the memorizing of facts and procedures becomes routine.

What is reflection?

Reflection is about deep learning. It is a thought process which involves looking back at events and asking questions retrospectively or looking forward (crystal ball gazing) and asking questions prospectively. It also involves a self-assessment of practice and a search for learning points and the identification of learning and development needs. Boud et al. (1985: 19) define reflection as ‘an activity in which people recapture their experience, think about it, mull over it and evaluate it’.

This way of understanding the process of reflection has the advantage of connecting with the ways social workers work, particularly through the process of supervision, and, as a student, the keeping of reflective journals and logs.

What is reflective practice?

Reflective practice is the application of the skill of reflection with the intention to improve our professional practice. Schön (1983) suggested that the capacity to reflect on action in order to engage in a process of continuous learning was one of the defining characteristics of professional practice. The cultivation of the capacity to reflect in action (while doing something) and on action (after you have done it) has become an important feature of professional development programmes and professional practice.

Reflection on action is where the practitioner analyses their reactions to the situation after the event and explores the reasons for their behaviour at the time, and the consequences of their action. This is usually a process undertaken in case reviews and in supervision. Reflection in action can be described as a practitioner’s ability to ‘think on their feet’. It revolves around the notion that within any given moment, when faced with a
professional issue, a practitioner usually connects with their feelings, emotions, prior experiences and knowledge and brings these to bear on the situation they are facing.

Some argue that ‘real’ reflective practice needs another person as mentor or supervisor who can ask appropriate questions and challenge thinking and also challenge practitioners’ underlying beliefs and values, as these impact decision making where risk is a central feature. Reflective practice capability when working with older people is a critical skill. Older people who become the focus of social work practitioners are usually the most vulnerable of the age group, and as such, issues concerned with risk, capacity for informed decisions and safeguarding can often be central to decisions about an older person’s future safety and welfare. Alongside those considerations practitioners will also be trying to balance the rights that older people have to expect the least intrusive intervention to ensure their maximum independence. Moon (2004) suggests:

- Emotion is central to the reflective process.
- Reflection is always about ‘my own’ process (i.e. always in the first person).
- Some people cannot reflect.

Yip (2006) crucially argues however that self-reflection can only be constructive under the right circumstances. In hostile circumstances where you are unsupported or oppressed, then self-reflection needs to be approached with caution. A safe and supportive learning environment where mistakes are perceived as opportunities for learning needs to be in place for constructive reflection to take place. Argyris (1982) supports this view and encourages organizations to create learning environments where what he calls ‘double loop learning’ encourages the questioning of processes, procedures and policies which do not work well, particularly from the perspective of the service user. An example of this might be a referral process that requires the service user to have to frequently repeat their story to different practitioners.

**Mental maps, single and double loop learning**

Argyris and Schön (1974: 30) argue that people have mental maps with regard to how to act in situations. They suggest it is these maps that guide people’s actions rather than the theories they espouse. Argyris (1982) was of the view that people are generally unaware of the maps or theories they use. He described these two aspects as ‘theories in use’ and ‘espoused theory’. Argyris argued that effectiveness results from congruence between the two theoretical approaches.

Argyris also identified what he called ‘single loop’ and ‘double loop’ learning. Single loop learning can be described in terms of exploring improvements to existing rules or processes and procedures for working in an organization, known as ‘thinking inside the box’. Single loop learning poses the question ‘how’; how could things be done better, how could processes and procedures be improved?

‘Double loop’ learning is potentially uncomfortable for the individual and the organization as it can mean challenging the organization’s underlying principles and assumptions. It is about ‘thinking outside the box’. Double loop learning fosters
questions about ‘why’ things are done in the way they are. Most organizations do not foster this kind of fundamental challenge to their thinking and their ways of doing things. The ‘why’ questions were the focus of much of Argyris’s work which has been about exploring how organizations can increase their capacity for double loop learning as part of the reflective process.

**The personal experience of reflection**

Cottrell (2003: 170) talks about the value for individuals of being able to stand back occasionally and reflect about such things as our aims, responses, feelings and performance. In considering the question ‘What is reflection?’ she argues that ‘reflection is a type of thinking. It is associated with deep thought aimed at better understanding.’ She helpfully explores eight headings, which unpack the personal experience of reflection and help identify the reflective process in some of its constituent elements, amongst which are: the process of making sense of the experience through its analysis; weighing up the experience; going over the experience looking at it from different perspectives; achieving a deeper honesty. She suggests that it is through reflection that we can come to acknowledge things we find difficult to admit to ourselves. ‘In other words, we review what was said or done, weighing up the consequences and considering what the alternatives might have been. We evaluate whether we would do things differently if given the chance again or whether we were right first time’ (Cottrell 2003: 173).

Scragg (2009: 143) highlights the view that reflective practice is an essential skill that all social work practitioners should develop alongside other health and education professionals: ‘This questioning approach, which looks critically at your thoughts and experiences, is an essential element in thinking about your practice and deciding how you can make changes in your approach that could improve your practice in the future.’

**The responsibility of the organization**

These approaches to reflection centre mainly on the capacity of individual practitioners to consider and explore their work in depth and detail, as a personal learning journey. Reflection is a very helpful process but it also needs to be considered in the light of the impact of the system within which the practitioner works. As in social work practice, where psychopathology and systemic perspectives offer balance to understanding complex situations, a similar balance needs to be struck between the impact of an individual’s professional practice (values, beliefs, capacity for reflection, etc.) and an understanding of the constraints imposed by the system and how they affect the practitioner’s capacity to practise effectively.

**Some organizational conditions for person-centred planning**

Person-centred approaches require practitioners to engage in ongoing critical self-reflection and to be supported by their employing organizations to do so. It is an emotionally and intellectually demanding approach, which as well as needing
appropriate and sufficient resources, also requires good supervision and support for the practitioner to enable them to reflect, question and develop a different approach to practice, particularly with regard to the use of their professional power. Such person-centred approaches need to be supported fully by organizational processes that are person-centred, and developed and designed around the needs of service users. In some circumstances, person-centred practice requires a reframing of one’s beliefs and approaches to the work and a questioning and appraisal of one’s underpinning values. For practitioners working with older people, it can mean questioning one’s personal value base about growing older and older age. Some social workers would argue strongly that person-centred practice offers real opportunities to revive and to practise skills that have been shelved for some time because of the impact of care management.

The implementation of effective person-centred social work approaches in non-person-centred organizations, where practitioners are not encouraged or given time to reflect, to question, to explore mistakes, or to explore ‘double loop’ learning, would be very difficult indeed.

**Values and practice**

A dictionary definition is that values are ‘a principle, standard, or quality considered worthwhile or desirable. One’s principles or standards, one’s judgment of what is valuable or important in life’ (www.dictionary.com).

Knowing the nature of our values is actually quite difficult and understanding their impact even more so. They (values) come in the first instance from our families, from school, and from what we learn as we are educated; then professional values impinge, and values at work join the mix. What is the impact of this values ‘stew’ on how we perceive older people, and how does it impact our practice?

Egan (1998) suggests that we need to develop empathy, which requires the social worker to be able to put themselves in the clients’ shoes, or to enter their epistemological and ontological worlds. This can be quite difficult to do, particularly when one’s personal values are transgressed or challenged as in the case of abuse of older people, or child abuse, for example. It seems in these challenging circumstances that our professional values do have the capacity to change within acceptable professional and social parameters, especially where those transgressions and challenges are rooted in what feels like ‘social justice’.

Banks (2001: 6) suggests social work values are ‘a set of fundamental moral/ethical principles to which social workers should be committed’. Pattison (1998: 344) however contests that the concept of values derives its popularity and legitimacy from the fact that it is an apparently simple, universally acceptable concept ‘delighting all and offending none because most people do not take the trouble to think about what it actually means in their own lives and that of others’.

**Person-centred practice**

Person-centred practice is a values-based perspective about what each of us would wish to experience with regard to choice, independence and dignified treatment if we were
cast in the role of the service user. Person-centred planning is designed specifically to ‘empower’ people, to directly support their social inclusion, and to directly challenge their devaluation. As a social worker, we may well hold person-centred values, but might work in an organization where services still define need and thus compromise our values and capacity to remain person centred. As professionals we may also find ourselves challenged by older people who have a different view about their needs and how they might be met. It may be that the latter is a scenario likely to be met more frequently as the so-called ‘baby boomers’ become the older people requiring services.

Dominelli, quoted in Adams et al. (2002: 18) suggests that social workers have to become skilled mental acrobats who can juggle contradictory positions with ease when it comes to putting their values into practice.

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<td>What aspects of person-centred planning do you find most challenging?</td>
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<td>Are there any work processes that make person-centred approaches more difficult for you as a practitioner, or for service users?</td>
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**The perspective of ‘selfhood’**

The following discussion provides an opportunity for practitioners to reflect on the concept of selfhood as a useful approach to understanding aspects of ageing that impact us all and the importance and significance of affirmation as an empowering intervention, regardless of the presenting problem.

In trying to grasp more personal aspects of growing older the notion of selfhood has been studied extensively across disciplines. In gerontology the notion of ‘loss of self’ has been prevalent in discussions about ageing; this is particularly so with regard to dementia, but also with regard to the notion that ageing itself diminishes an individual’s self value. Bastings (2003: 96) found that ‘the cultural value of the self is deeply connected to one’s usefulness to society’.

Moore (1980: 159) suggests that ‘It is not a cynical observation that society is only interested in ‘successful’ agers who do not stress the community or make demands on its resources’ and also descriptively contends that:

Frequently a transition to senior years or into retirement exposes an individual to social attitudes which make a capable person feel unintelligent, unemployable, asexual and socially inadequate. Modern research indicates that many of the mental and human changes seen in senior people are not biological effects of ageing but are due to their fateful existence of a part imposed on them by an unfeeling society. It has been said that society's prejudices against the elderly indoctrinate us while we are young, but affect us
when we are old . . . by ignoring the needs of a vulnerable minority which we are inevitably going to join, we are burying ourselves.

(Moore 1980: 159)

The notion of ‘selfhood’ is based on the seminal works of William James (1918) and G.H. Mead (1934) who define the notion of self within social contexts. Mead (1956: 212) defined the self as ‘a character, which is different from that of the physiological organism proper . . . it comes into being through social processes’.

Aquilina and Hughes (2006: 150) present a distinction between ‘inner’ and ‘outer’ selves, the former denoting ‘the private and subjective experience of being self aware’ and the latter signifying ‘public observable aspects of self, which depend on psychosocial structures including social relations’. Discussions concerning ageing benefit from these perspectives and provide a conceptual framework for working with older people which sees communication skills at its core, and life experience and ageing as a mechanism for learning, development and wisdom, both for the older person and the practitioner.

Sabat and Harré’s influential work (1992) on selfhood and dementia suggests that we work throughout our lives on constructing our self-identity. Their social constructionist approach argued against the dominant assumption of loss of self in the ageing process and as dementia progresses. They used two in-depth case studies to show how self remains intact despite severe cognitive decline. ‘The threatened disappearance of selves is not directly linked to the disease process, but to the behaviours and reactions of others’ (1992: 249).

Sabat (2002: 109) went on to develop ‘a social constructionist tripartite approach to personhood’, known as the Selfs 1–3 framework.

**Self-1** comprises one’s personal identity (the I, me, mine, myself and my selves).

**Self-2** comprises one’s mental, emotional and physical attributes (for example, my past achievements in terms of what I can do and my beliefs and desires about them).

**Self-3** is the socially presented self/selves or personae, the roles we take on and the appropriateness with which we behave in social situations.

We have lots of Selves-3 related to our different roles and social circumstances (parent, friend, colleague, student, lover, partner, professional, carer, cared for). Self-3 is constructed and nurtured through interaction with others and is thus more vulnerable than Self-1 and Self-2.

Self-3 very much depends on the affirmation and reciprocity of others to nurture it; without that from others we become vulnerable. It is thus easy to see how Self-3 can become fragile without affirmation, and can be destroyed through lack of nurturing. For many older people social isolation will deny opportunities for such affirmation.
Some sociological perspectives

Three commonly expressed sociological perspectives for consideration now follow. Each perspective is underpinned by a set of values and implications for practice. With regard to Argyris’s (1982) work, they could be regarded as ‘theories in use or espoused theory’: it will depend on the practitioner. Nonetheless there are likely to be elements of each of these perspectives that underpin our practice with older people.

Disengagement theory

Sociological literature presents a range of competing theories of ageing: disengagement theory at one end of the spectrum and successful ageing theory (sometimes described as activity theory) at the other. The genesis of the disengagement viewpoint is that older people themselves initiate the disengagement process. It does not take into consideration any societal processes and structures that curtail older people’s opportunities for engagement.

Disengagement theory (Cumming and Henry 1961) though extremely controversial then and now and offering a bleak portrayal of old age, nonetheless has had a profound effect on views about ageing. Disengagement theory sees the older person’s withdrawal from society as part of the natural ageing process, and as part of the normal pattern of life. This theoretical perspective essentially sees old age as the time when people are preparing themselves for death. This includes the severing of relationships and ties. Ageing from this theoretical perspective naturally brings with it a growing sense of powerlessness, loneliness, loss of role, loss of sense of purpose and with it increased dependency. From this theoretical perspective the position of older people as a non-productive and costly burden on society is easily assimilated as the cultural norm and becomes implicit in political and economic arguments (this is explored further in Chapter 2).

Olsen (1982) criticizes the disengagement approach for ignoring the impact of social class on ageing experiences and how class structure and its social relationships prevent the majority of older people from enjoying a variety of opportunities or advantages. The disengagement perspective, it could be argued, feeds the negative stereotypes of ageing as the part of life to be feared, which in turn creates the circumstances driving disengagement and the negative stereotyping of older people, impacting their quality of care.

Activity theory

At the opposite end of the spectrum, activity theory is about successful ageing and contends that people develop ideas about themselves and their identity from two
major sources: the things that they do, and the roles they fulfil in life. This theory identifies the many roles that people give up as they age, and the impact this has on people's identity. Hence this theoretical perspective argues that new and meaningful activities need to be substituted for those that have been lost. The view from this theoretical perspective is that activities in later life are essential to restore one's sense of well-being and value. To be worthwhile, activities need to have personal meaning; they can be solitary, with people, formal and informal – anything that gives meaning and value to the individual. Successful ageing begins then to equate with active ageing, denying the limitations of old age as long as possible.

This theoretical perspective needs to be tempered with the reality that some older people cannot maintain an active lifestyle, and some may not have the resources to maintain active roles. The danger of this theoretical perspective is that in an increasingly judgemental society, strapped for cash to support health and well-being, older people who do not remain active are perceived as responsible for their own decline and are therefore blameworthy. Activity theory has also been criticized for being overly idealistic and for forcing ‘middle-class moral and family-oriented’ activities onto older people (Katz 2000: 143).

Continuity theory

The last of the sociological theories we will consider in this chapter is the continuity theory of ageing. This theoretical perspective contends (Atchley 1989) that our values, preferences and patterns of behaviour remain consistent over our life span regardless of the life changes we experience. Continuity theory argues that the latter part of life is simply a continuation of the earlier part of life: how we are as younger people will be how we are as older people, and the patterns we have developed over a lifetime will determine our behaviours and beliefs and values in older age. This does not deny the capacity for change over a lifetime but values the developments made and their impact on us as older people.

Andrews (1999) challenges the ageist culture that pervades and argues that old age should not be wished or theorized away, and that doing so is in itself an ageist activity. She suggests that the challenge is not to conquer old age but to challenge the ageist culture to which we belong. Without a lifetime behind us she argues that we have no history, no story and no self.

Stereotyping older people

Some writers have argued that the growing use of the term ‘elderly’ is indicative of society's, professionals' and policy makers' tendency to lump older people together as though they have homogenous needs which warrant only the need for homogenous political and policy responses. This is compared to the less frequently used term in Britain of ‘elders’ which signifies and dignifies older age as bringing with it wisdom, and a value to society that could only be offered through the individual process of ageing and maturity.
Stereotypes are essentially sets of beliefs which shape the way we think and behave in everyday life. They affect the way we see ourselves and the way in which we see and understand others. It is clear that negative stereotypes about ageing begin to influence people’s perceptions a long time before the ageing process sets in and can leave people feeling pessimistic about their future as well as stifled when they eventually reach old age (see Moore’s quotes earlier). So a rather miserable summary of stereotypical views of ageing and older people is that older people are negatively stereotyped both as individuals and as a group/strata of society. They are stereotyped as being dependent and thus a drain on resources, unhappy and tired with life, senile, disengaging from relationships and consequently waiting for death.

Negative stereotypes unsurprisingly can interfere with older peoples' enjoyment and flourishing in the latter part of life and they can also have a detrimental impact on people’s health and well-being as they age. Stereotypes about ageing are subtly internalized years before people become old and can become deeply embedded and taken for granted. This is so for social workers as well as for the general population.

There are studies that support the idea that stereotyping older people has a direct link to the health and well-being of older people. Levy et al. (2000) found that older people who hold negative stereotypes about themselves (e.g. viewing themselves as senile as opposed to wise) display a more negative response to stress, have lower self-efficacy and impaired cognitive function, and are more likely to have a negative view of other older people.

Levy et al. (2000) also reported that negative stereotypes affected older people’s performance and attitudes, and that these negative beliefs contributed to serious illness and even death (because of the impact on people’s will to live, and the meaning and value they placed on their life). Holding negative perceptions of the ageing process is thus not a minor problem for older people as it impacts upon many areas of life such as their motivation, mental health, physical health and even mortality. It is imperative that social workers are mindful of the impact of these stereotypes on individuals’ self value, worth and health.

There is some good news though, and it is that holding positive views about ageing has a beneficial impact on older people. Levy et al. (2000) also found that by holding positive views about ageing, life expectancy increased by about 7.6 years. This added more years to life than low blood pressure, low cholesterol, not smoking and taking regular exercise – these only add one or two years of life expectancy.

So what does all of this mean for the role of social workers and social work with older people? What we have explored so far are the perspectives that influence the individual practitioner’s personal approach to practice. To understand social work with older people more fully we need to explore the conceptual frameworks that influence practice, and also the contextual factors that shape social work practice with older people.

Differing perspectives on the nature of social work with older people

Healy (2005) cited in McDonald (2010: 42) explores a range of perspectives identified through discourse analysis that offer a framework within which social work with older people...
people can be understood. McDonald’s outlines (pp. 42–4) have been slightly adapted below:

**Biomedicine** Power lies in the expertise of the knowledgeable physician in this medical model of disease detection and management. Evidence suggests however that health inequality is largely governed by social and economic factors.

**Economics** This perspective is about rationing and allocating scarce resources to those at greatest risk of admission to hospital or residential services. This was and continues to be a key cornerstone of community care policy. Individuals’ capacity to pay for care services determines how much service will be provided, and the increase of eligibility criteria levels is a regular response to decreasing local authority budgets.

**Law** This is presented as objectively setting out rules, however critics see it as a system based on class, gender and status inequalities. Older people may be perceived as being subject to excessive surveillance/intervention on the basis of assumed legal ‘duties of care’.

**Psychology** Psychological theories explain human motivation and functioning. Psychology considers sources of continuing disadvantage over the life course which become manifest in old age and this insight may be used for therapeutic intervention. Critical practice requires an ability to analyse the impact of personal biases on professional practice (as we have noted above with regard to ‘espoused theory’, ‘theory in use’ and stereotypical bias).

**Social science** An example of this perspective is the ‘social construction’ of dementia, which acts as an alternative explanation of dementia as a cognitive deficit or as an organic disorder of the brain. The ‘problem’ is thus located outside the individual as an outcome of social structures or socially created rules (or at least exacerbated by them).

**Consumer rights** Older people are seen as consumers of social goods, which are quality assured through the operation of ‘quasi’ market systems, the notion being that only the effective and efficient suppliers of care services will survive. The role of the social worker as care manager becomes aligned as the purchaser of services, and the state becomes the quality assuring regulatory authority. Within this perspective also lie organizational approaches that are consumer based rights movements trying to secure a better deal for their members.

**Spirituality** Social work has evolved from philanthropic and religious organizations and this is particularly so with regard to welfare services for older people. At an individual level the valuing of non-material things may have a particular congruence with older people’s lives and priorities.

McDonald (2010: 44) surmises that these different perspectives underpinning interventions in social work ‘lead to different and sometimes conflicting understanding of the issues that affect older people’. She suggests that choice ‘will depend partly upon
the orientation of the practitioner, and to a large measure on the orientation of the organization or team within which they work’.

Alongside this mélangé of theoretical approaches to practice, and the impact of organizations on practice, lies the indisputable impact of changing demographics.

The impact of demographic change

The 2010 Dartington review on the future of adult social care highlights that population change is the most frequently cited factor that affects demand and expenditure on adult social care and that most policy documents refer to the challenge of an ageing population. The review notes that:

This is not a new notion. The expression ‘demographic time bomb’ is now over thirty years old and predictions that in its wake the welfare state would become unaffordable or unsustainable have not been borne out by actual experience. We persist in seeing ageing as a burden rather than a benefit, and that increased longevity is a problem not a success. Nevertheless current and future projections are sobering.

(Humphries 2010: 25)

The UK 2001 Census of population (ONS 2003) showed that there were more than 11 million people aged 65 and over in the UK, and that 18.6 per cent of the population was over pensionable age. The increase in the proportion of older people is sadly not applauded as the result of significant social and medical progress giving people the opportunity to live longer and more productive lives; rather, the demographic changes are being heralded politically (implicitly, if not explicitly) as the next ‘scourge’ on society, with the next generation of older people (the 1945–1965 post war baby boomers) being increasingly demonized as the thieves of their children’s futures and their children’s future burden because of their cultural, demographic, economic and political dominance (Willets 2010).

McDonald (2010: 6) more positively suggests:

older people occupy a strategic civil, economic and political position, the ramifications of which will pose major issues for policy makers and service providers. It also means that debates about the ‘meaning’ of old age in terms of citizenship, rights and individual well being are ripe for debate.

Thus the context of social work with older people is challenged by an unprecedented change in demography, and will be challenged by the impact of the life experiences and expectations of the next up and coming generation of older people. This challenge to social work is also set in the context of the critical economic downturn of 2008, with significant cuts in public sector funding impacting access to social care. Additionally the complexity of funding and the costs of care make concerns about dependence in old age even more worrying.
As far as local authority social work practice is concerned, Glendinning (2007: 453) points out:

England is relatively unusual in international terms, in that access to publicly funded social care and support is restricted to those who have both high levels of need, as measured by Fair Access to Care Services (FACS) criteria, and who also have very low levels of assets and incomes. People with resources (including housing) over £23,000 cannot access publicly funded social care, however great their needs for support. Despite the national assessment framework provided by FACS, its application varies between local authorities depending on the resources available locally. Access to other social care services and resources (including the Independent Living Fund, NHS-funded continuing care and housing-based support) depends on a complex range of eligibility criteria that variously take into account medical and nursing care needs; capacity for self-care; risks of harm; financial circumstances; and the availability of informal care.

Social work practice that has essentially had its focus on this small minority of older people and their access to publicly funded care has inevitably had its impact, scope and transforming potential narrowed. Some would argue that that has been the intended consequence of the introduction of care management.

The international definition of social work

Having looked at some theoretical models of ageing, and some context, we turn our attention now to definitions and conceptual frameworks for social work practice with older people.

The International Association of Schools of Social Work and the International Federation of Social Work agreed a definition of social work in 2001 which espouses a systemic definition of social work:

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

(IASSW 2001)

Theoretical frameworks for social work practice

Payne (2006) presents a helpful account, both from an historical perspective and a position informed by current debate about the nature of social work today. He presents
social work as a territory bounded by three main roles. Such roles are of course not linear; there may be elements of all three roles in any work with one service user or family:

1. **Individualism-reformism**: this refers to social work as an activity that aims to meet social welfare needs on an individualized basis. Social work performs a social order role helping to maintain social cohesion by providing welfare services effectively.
2. **Socialist collectives**: this approach focuses on promoting cooperation within society in order that the most oppressed and disadvantaged can gain power and take control of their own lives. Social work is seen as having a transformational role, helping to change societies to be more inclusive and supportive.
3. **Reflexive-therapeutic**: this approach is focused on promoting and facilitating personal growth so that people are enabled to deal with the suffering and disadvantage they experience. It is a therapeutic role, helping individuals develop their capacities in social relationships.

It is clear from the literature that social work can be conceptualized in a range of different ways. Thompson (2005) argues that what constitutes social work is ‘up for grabs’. He emphasizes the extent to which powerful groups and institutions not only define what constitutes social work but also define the limits of policy and practice. He seeks to identify key themes related to existentialism (‘a philosophical theory emphasizing the existence of the individual person as a free and responsible agent determining his own development’ – OED). In doing so he argues that social work premised on the principle of existentialism should be:

- **ontological**: sensitive to the personal and social dimensions and the interactions between the two;
- **problem focused**: sensitive and responsive to the existential challenges we all face, but particularly those that are related to social location and social divisions;
- **systematic**: with a clear focus on what we are doing and why (our goals and our plans for achieving them);
- **reflective**: open minded, carefully thought through and a source of constant learning rather than a rigid, routinized approach to practice;
- **emancipatory**: attuned to issues of inequality, discrimination and oppression, and geared towards countering them where possible.

(Thompson 2005: 24)

None of these approaches to understanding social work is static, and none focus on the significant ‘control and safeguarding’ and statutory powers of the social work role. The nature of social work is clearly shaped by the society within which the practitioner exists, and the prevailing value base/s and beliefs about ‘what works’. The notion of ‘what works’ for service users, however meaningfully described in the
language of person centredness, will inevitably (in our current way of seeing things) have at its heart the following vexing questions: What does the intervention cost? Is it cost effective? Can it be delivered more cheaply? It is an ‘organizational cost’ rather than a ‘service user value’ driven form of social work practice, and thus not necessarily practice which is guided by evidence of what works for service users, rather what the organization considers it can afford to offer?

Thompson (2005: 8–9) also suggests that social work can be seen as distinctive in terms of:

- the central role of statutory duties;
- the challenge of managing the tensions between care and control;
- the dilemmas of being ‘caught in the middle’ (between the needs of the individual and society’s needs, where sometimes societal ills are the underlying issues, for example, poverty, inequalities and discrimination, social exclusion);
- the need to do society’s ‘dirty work’ (by this Thompson (p. 6) refers to social work as a ‘sweeping up’ operation, clearing up the problems caused by the failure or gaps in other social policies or systems); and
- the primacy of a commitment to social justice.

These care and control tensions – and the balancing of individual and societal need and this idea of doing society’s dirty work and ‘sweeping up’ issues – sharply highlights the need for practitioners to have opportunities to reflect on the complexity of social work with older people, and indeed the potential tensions that practitioners may experience with each of the key players (the service user, the family, the GP, the employing organization).

**Key roles in social work**

Asquith et al. (2005) have identified the following as key roles in contemporary social work practice:

- counsellor
- advocate
- assessor of risk and need
- care manager
- agent of social control.

These differing complex roles can create tensions for both social workers and the older people with whom they work, particularly in the context of the employment of social workers in statutory services. McDonald (2010: 41) cites the research of Manthorpe et al. (2008) noting that that this is one of the few sources of information derived from interviews with older people themselves about their perceptions of the social work role. For ease of reference and to give weight to their importance, their perceptions are given here:
Social Workers’ roles are seen as unclear and variable.
Older people look for an approach that is knowledgeable about their needs.
They look for an approach from the social worker that is ‘on their side’.
Criticism is directed at social workers who appear not to understand the needs of older people.
Criticism is directed at those social workers who are obviously driven by agency agendas.
Of critical importance to acceptable social work practice is the knowledge of physical, social, psychological and economic issues that older people experience.

Additionally, and compellingly, McDonald (2010: 41) notes: ‘Social workers who are driven solely by an organizational mandate are easily “rumbled” by older people, and may deliver services that are not wanted and not needed’.

The administrative focus of social work with older people

Lymbery (2005: 2) drawing on the work of Payne (1996) discusses the three different strands of social work theory and action (noted above) labelling Payne’s welfare orientated approach (individualism-reformism) as an ‘administrative’ approach. Lymbery argues there have been eras when these models have had more agency, but the administrative model has generally typified social work with older people and this is particularly so post-‘community care’.

Lymbery argues that the ‘administrative’ focus has had the following effect: ‘This has created a climate of practice which can often be experienced as arid and unfulfilling by practitioners, bearing relatively little relation to the genuine needs or desires of older people’ (2005: 2).

What can we learn from the recent history of social work?

There is agreement that it is critical for social workers to have an understanding of the social and political contexts of their work and a clear understanding of how political ideologies influence social work practice and shape its direction. Key reports in the relatively recent history of social work (Seabohm 1968; Barclay 1982; Griffiths 1988) have surprisingly articulated similar criticisms of, and aspirations for, the ‘social services’ system, including the practice of social work, the importance of focusing on preventative work, the centrality of the development of collaborative partnerships across health and social care and the importance of community development.

It is worth recounting some of the aspirations of the Seabohm Report (1968) and Barclay (1982) as they provide some insight into the frustrations of recent governments, concerning the lack of speed of implementation of more recent reforms enshrined in Modernising Social Services (DH 1998), Our Health, Our Care, Our Say (DH 2006), Putting People First (DH 2007) which lays the ground for the personalization of
services and self-directed support, and the most recent Health and Social Care Bill (2011) which aims to change the landscape of health and social care commissioning.

The implementation of Seebohm (1968) had significant expectations of the development of the then new Personal Social Services Departments, based within local authorities (and thus responsible and accountable to elected members). ‘This new department will, we believe, reach far beyond the discovery and rescue of casualties, it will enable the greatest possible number of individuals to act reciprocally, giving and receiving service for the well being of the whole community’ (Seebohm 1968: 15).

The Barclay Report (1982: 35–61) saw the functions of social workers to:

• ‘see people and their needs as a whole and take account of their views about what services, if any are to be provided’;
• ‘acknowledge the value of individuals and recognise their right to self determination’;
• promote community networks and engage in ‘social care planning’ (that is, work to alleviate existing and future social problems through responding to individual need, planning responses for a local population, working with other agencies and strengthening voluntary organizations);
• act as a ‘broker and negotiator’ with a knowledge of local community resources, balancing casework with wider patch based community work;
• work with other services, negotiating and advocating on their clients’ behalf.
• act as ‘rationers and gatekeepers’ of scarce resources.

Reading these excerpts from influential past reports demonstrates the clear foci that have recurrently emerged, and still emerge to the present day. Different administrations have attempted to shift the focus of social care and social work and to curtail costs, but none more profoundly than the implementation of care management and the new public management ethos of the 1990s. Prior to the introduction of care management the post war emphasis had been on residential, nursing and hospital provision. However, as early as the 1950s there was reaction against these institutional forms of care; some of the reasons were to do with cost, some to do with the inhumane nature of some of the care provided. A particular prompt was a change in Social Security regulations in the early 1980s, which made it easier for people with low incomes entering independent homes to claim what is now known as Income Support towards the cost of their care. With access to this source of funding based on financial entitlement rather than any objective assessment of people's needs, the number of independent residential and nursing homes rocketed (12,000 in 1979, 46,900 in 1982 and 161,200 in 1991). Of the calls for reform, the most significant was that of the Audit Commission (1986) which provided a scathing critique of the failure of government policy to achieve care in the community (Glasby and Littlechild 2004).

**The impact of care management**

Care management was introduced following the NHS and Community Care Act 1990. Lymberry (2005: 180) suggests that it was quite different to its origins in the USA where:
Particular emphasis had been placed on the role and skills of the social worker not just in coordinating packages of care but in building and sustaining high quality interpersonal relationships with service users. This element of the care management role has been actively discouraged in the British context.

Preston-Shoot (1996: 26) also articulates these concerns:

Social workers have been drawn into routines rather than professional servicing; into implementing agency procedures, such as case management, contracting and purchasing and budgeting, rather than engaging, investing emotionally in and being with clients. Social work is at risk of ceasing to be a vision, a system of values and principles, imbued with and concerned with the implementation of a critical value frame and knowledge base . . . and of losing human contact as its core purpose.

Because of the administrative and procedurally driven focus of care management, many argued there was no longer a need for skilled or qualified social workers. Appointing care managers who were not qualified social workers became commonplace, and this contributed bilaterally to the devaluing of social work with older people, and it could be argued to older service users themselves. The impact of closer collaboration with health has also generated the view that social workers were in danger of losing their professional identity.

It is certainly true that care management for older people has become highly bureaucratic, and this is linked to the model of care management that was adopted: that of ‘social care entrepreneurship’ (Payne 2000: 82–91) where a range of care services from different providers are coordinated by the social worker. The notion that care management would assist the social worker to put the service user’s needs first has been challenged by the continuation of service driven decisions, partly because of the lack of creative service provision in an underdeveloped market, the speed with which social workers are required to operate (delayed discharges and associated financial penalties are an example here), burgeoning case loads which work against creative relationship based practice, and the overemphasis on assessment to the detriment of the monitoring and review aspects of care management.

**Command and control management and its impact on practice**

Although the International Association of Schools of Social Work and the International Federation of Social Work agreed definition of social work (IFSW 2001) above espouses a systemic definition of social work and echoes Payne’s (2006) three social work and social action categories, it does not include any hint of the implications on social work practice of ‘command and control’ (hierarchical) management with its emphasis on performance management. Nor is there very much literature concerning systemic approaches, or understanding the impact of command and control organizational
approaches on the delivery of social work with older people. Systemic approaches to therapeutic interventions in social work contexts are well documented with regard to psychodynamic vs. systemic family therapies but organizational/management paradigms and their influence on social work practice is little researched. However, Parsloe writing in 1996 (p. 112) highlights the impact of managerial control versus professional control on the practice of social work arguing that:

Control stifles ideas and routinises practice, as is all too clearly illustrated by some of the social work which is now carried out by overworked and over managed front line staff in social services departments. Professionals must feel that their first and paramount responsibility is to those they serve, their students, clients or patients, to themselves and to their professional peers. This responsibility must take precedence over their accountability to the organisation for which they work. I am not arguing for individual professional anarchy but for recognition of the dual role of many people, especially those who work in the service industries. They are essentially bureau professionals and the challenge for them, and for those who are managers in service organisations, is to recognise the two aspects of the job, and frame the appropriate structures and organisations to support both.

Parsloe’s quote emphasizes the impact of ‘managerialism’ which has been central to ideas about the effective provision of public services, and underpins ‘New Public Management’ thinking which has been at the core of the ‘development’ of the public sector since the 1980s. If reforms outlined in 1968 (Seebohm) and emphasized in different decades through influential reports up to the present day have not been successfully implemented, and where countless restructurings of organizations still result in the same issues being problematic (child and adult protection issues, poor quality care and support, spiralling costs) it begs the question whether a radical and fundamental rethink is required of the way that service sector ‘command and control’ hierarchical organizations work. Einstein is attributed as having defined insanity as ‘doing the same thing over and over again, and expecting different results’.

Thompson (2005: 176) comments that ‘there is an emphasis on the manager’s right to manage, a focus on managerial power (that) has been part of a broader process of deprofessionalisation, attempts to reduce the autonomy and professional standing of social workers’. Critics would argue that this has also been the case for the majority of public sector professionals, as a result of the performance-managed target-driven tick box culture.

Case study
Mary has recently joined an older people’s social work team from a neighbouring local authority. She has been in post for three months and can see that the way things are done in her new team are not efficient and have a detrimental affect on older people. Many of the systems in place create delay, add work, and require the passing of the case from
practitioner to practitioner before any decisions are made. Sometimes the delay in decision making has a marked impact on the older person’s quality of life.

- What would you advise Mary to do?
- How easy or difficult is it for practitioners who can see new or different ways of doing things to implement new approaches in the work place?
- Are there working practices in your service which could be changed to improve outcomes for service users?

**Comment**

*These are the types of questions which will help you to understand which parts of the system are adding value to the service user experience, and which are processes that serve the organization (in systems terms, what is value work, and what is waste?). The evaluation of internal processes is likely to raise ‘double loop learning’ questions, and will need an environment where reflection is safe.*

**Understanding organizations as systems**

It is encouraging that approaches to understanding social work and social care organizations as systems are becoming more mainstream; this is particularly noticeable in the field of child protection (Munro 2011) but also increasingly so in social care with adults, including older people (see access links to the May 2011 Care Conference Report below). Thinking about organizations as systems means a different way of thinking and a different way of managing and doing the work. For service users and social workers it has the potential for transforming the work and the design of the service, and more importantly, improving outcomes for service users.

The manifestation of command and control thinking sees organizations as:

> Top down hierarchies, work is designed in functions, managers make decisions and workers do the work. Managers make decisions using budgets, targets, standards; they seek to control the workers with a variety of management practices – procedures, rules, specifications and the like. The management ethic is to manage budgets and manage people.

*(Seddon 2003: 47)*

Seddon’s diagram (see Table 1.1) shows the key differences between ‘command and control’ driven organizations, and those underpinned by systems thinking. Think of the middle column as the factors that underpin the functioning of the organization, the way in which it gets the work done, its focus.

You can see from the table that taking a systems view is to think about the organization from the ‘outside in’. That means having a very clear understanding of customer (service user) demand and designing the organization (the system) around those needs.
If the customers’ (service users’) demands change, the organization of the system needs to change to accommodate it. The organization works and adapts to become as responsive as possible to service user needs.

To enable control in this high variety environment it is necessary to integrate decision making with work (so workers control the work) and use measures derived from the work. These ‘real’ measures are of much more use than arbitrary measures like targets and standards. The role of management shifts from an adversarial, hierarchical one to a complementary one: working on the system.

(Seddon 2008: 71)

One senior adult services manager presenter at the 11 May Care Conference put it like this: ‘Our staff are customer focused, our current system of work is not.’ An organizational system aligned to the needs of service users and the aspirations of social workers would be very powerful.

**Summary**

The chapter commenced with a discussion about the importance of reflective practice and also outlined some common sociological and stereotypical perspectives about older people which can and do impact practice. After considering the impact of demographic trends the chapter considered some theoretical perspectives concerning social work practice with older people. The chapter argues that social work practice, as well as being a personal activity bound by professional perspectives and values, is also bounded by organizational requirements and procedures, which reflect political, economic and policy considerations. The management paradigm delivering this was noted as the command and control paradigm. After a review of some of the landmark
reports and a critique of care management the question was asked, why does so much change ideologically and yet so little change when it comes to outcomes for service users? Finally the chapter briefly introduces the notion of organizations as systems, linking to the opening view of the chapter that organizations need to be aligned to customer need to allow social workers to practise effectively, and reflect meaningfully and holistically on their practice.

Further reading


References


