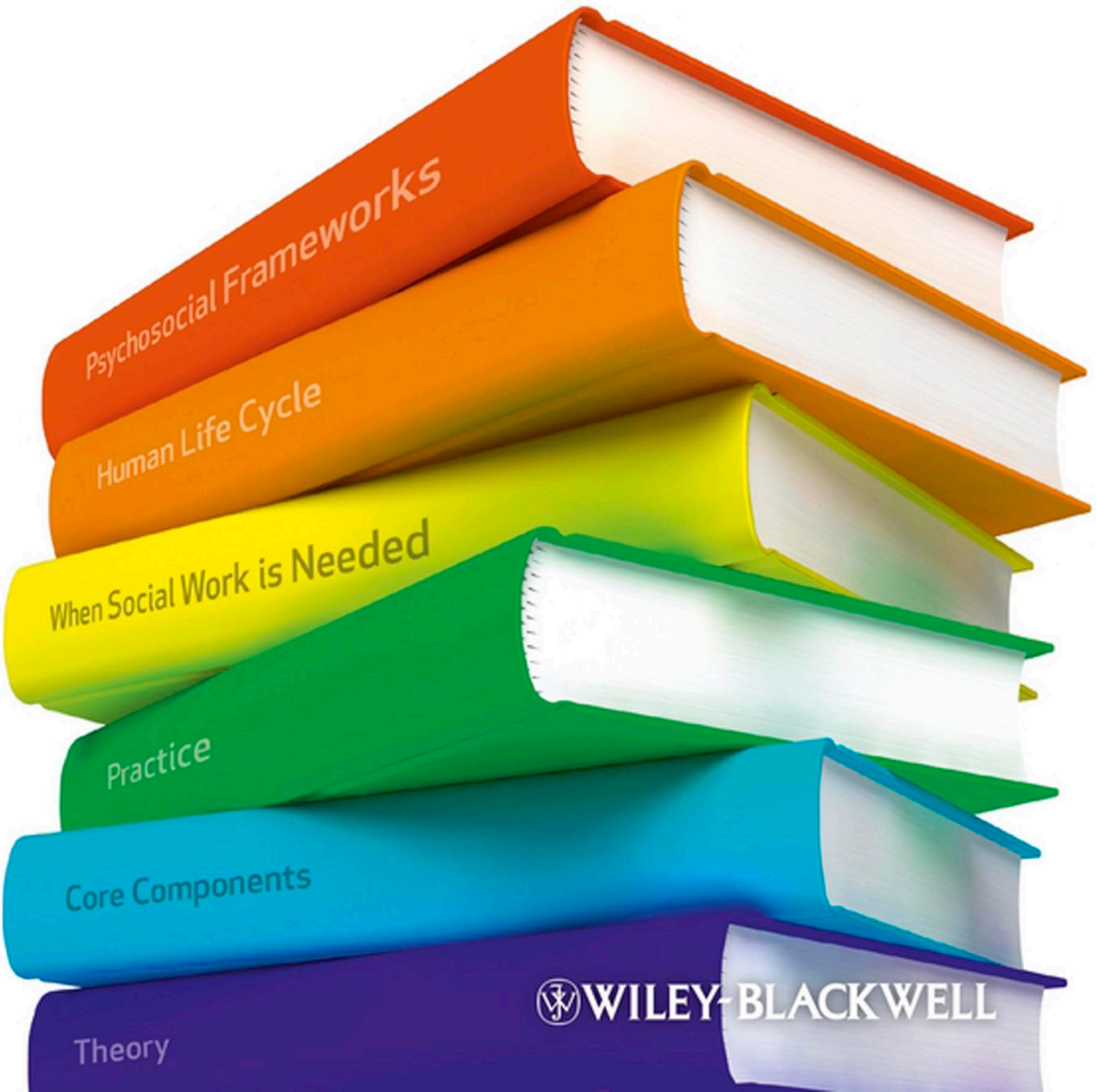
# The Blackwell Companion to Social Work

FOURTH EDITION

Edited by Martin Davies

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## Praise for *The Blackwell Companion to Social Work*

'Since its first appearance *The Blackwell Companion to Social Work* has never been off our recommended reading lists. It provides a comprehensive and in-depth "one-stop" for students, academics and practitioners seeking the most thoughtful contemporary insights to the complexities of modern social work practice. Look no further.'—***Gary Clapton, University of Edinburgh***

'This book continues to be an important source of reference both for the discipline and the profession of social work. In its revised form, the book manages to keep pace with the rapid changes that are taking place in social work without sacrificing breadth or depth. It will prove an invaluable teaching tool and a reliable starting point for more sustained and detailed inquiry.'—***Ian Butler, University of Bath***

'The new edition of this highly popular edited volume will undoubtedly ensure that it maintains its status as a must-have textbook for social worker students. The chapters within the volume are organised into six "books" – an indication of the breadth of issues covered. The reader will find updated material on key aspects of social work written by respected academics, writers and practitioners. Each chapter closes with three questions that focus on the core ideas contained within the chapter. These provide a helpful starting point for seminar or small group discussion. The comprehensiveness of the text has also been further developed with the inclusion of a collection of twenty-four papers that introduce theories and concepts central to the discipline of social work.'—***Christine Jones, Durham University***

For David Howe, whose creative career from doctoral student to theorist of renown I have been privileged to share

# THE BLACKWELL COMPANION TO SOCIAL WORK

Fourth Edition

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WILEY-BLACKWELL
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*All authors write in a personal capacity. Their expressed views do not necessarily reflect the policy of their employers.*

# Introduction

*The Blackwell Companion to Social Work*, in its fourth edition, is significantly different from its predecessors. Of course, many of the excellent chapters that have earned the Companion its high reputation are still here in a revised and updated form.

But this time, major restructuring of the contents and the arrival of two new sections on Practice and Theory mean that the volume has been transformed into a collection of six 'books', each of modest length and each capable of being separately read in its own right. Together the six books provide a comprehensive review of all important aspects of the subject of social work.

## Book 1 Social Work's Psychosocial Framework

All professions or occupational groups work within a psychosocial context. But because social workers lay great emphasis on the need for a holistic approach to their work with service users, it is argued that there is a particular need for them to be fully aware of the framework that surrounds their work. In Book 1, authors with specialist knowledge and experience in seven different fields indicate how their world relates to and impacts upon social work practice.

## Book 2 The Human Life Cycle

There are libraries full of journals and books that describe aspects of human life at different points in the life cycle from birth to death. Here we have five authors of international renown who discuss succinctly the current state of knowledge in regard to infancy, childhood, adolescence, partnership and parenting and late life ageing. Social workers, whatever their specialism, need to understand the realities

of life at all ages, and the chapters in Book 2 give readers a fascinating insight into matters of central import to their daily duties.

## Book 3 When Social Work is Needed

It is never easy to answer the question often put to social workers: 'But what do you actually do?' Book 3 makes a start on providing an answer to the question by outlining the fields of practice in which social workers are called upon to operate. The chapters describe ten areas of life in which social workers find themselves needed.

## Book 4 Social Work in Practice

Having, in Book 3, pinpointed ten areas of need for social work, Book 4 focuses on the same ten fields; authors with extensive and detailed experience of working in these areas outline just what it is that social workers do in response. The chapters all contain practice examples, so that the reader can be left in no doubt about the nature of the task that social workers undertake on the ground.

## Book 5 Social Work's Core Components

Social work is not a unidimensional activity. Social workers use different skills and source different fields of knowledge in the course of their everyday work. In Book 5, eight 'core components' are identified, and the literature underpinning each of them is expertly explored and summarized by the contributors.

## Book 6 Social Work's Theory Base

It would be wrong to pretend that social work's theory base is straightforward; it is not. But David Howe's introductory chapter gives it a shape, and the 24 short chapters that follow provide a fascinating introduction to the theoretical framework that makes social work the rewarding vocation that it is.

## In Conclusion

It is an enormous privilege to have been able to take this collection of chapters into a fourth edition – a privilege made all the more rewarding by the enthusiasm of all my authors. No editor could have asked for more from them. I particularly appreciate how, for this edition, they have risen to the challenge that I set them (and myself) of building strong bridges between the realities of practice and the nature of theoretical and empirical knowledge. As in any practice discipline, that is the only

way in which true progress can be made. And I like to think that *The Blackwell Companion to Social Work* is not 'just an introductory text for students' (though it certainly is that) but that it also plays an active part in the continuing development of our practice discipline.

Martin Davies,
Norwich

# BOOK 1

# Social Work's Psychosocial Framework



*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

CHAPTER 1.1

# Social Work and Society

*Viviene E. Cree*

Social work and society are caught in an intense and changing relationship. Just as social work seeks to influence society (and individuals and families within it), so society in its many guises seeks to control social work, by setting limits on what social workers can and should do. Social work is situated in the middle, pulled between the individual and society, the powerful and the excluded, negotiating, and at times in conflict, with both.

This chapter examines social work and society from the perspective of a history of social work in the United Kingdom. This does not presume that the United Kingdom is the only country which might offer insight into this topic. Instead, it is argued that the United Kingdom provides a useful case-study example for exploring the changing relationship between social work and society over time. Nor is it to suggest that this is the only 'true' history of social work in the United Kingdom. There are many possible ways of presenting history, and many voices which have often been excluded from social work histories, such as the voices of the many people who have used social work services. This account should therefore be regarded as one attempt to do justice to the histories of social work in the United Kingdom, demonstrating as it does the complexities and contradictions at the heart of the relationship between social work and society.

## What is Social Work?

There have been many attempts to define social work in recent years. One definition is widely quoted:

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> 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 the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work. (IFSW 2012, http://ifsw.org/policies/definition-of-social-work/, accessed 13 October, 2012)

This definition was negotiated and adopted at separate meetings of the International Federation of Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW) in Montreal, Canada in July 2000, and then agreed as a joint definition in Copenhagen in May 2001. The definition has not been without its critics. For some, it is aspirational rather than practical; it tells us little about the realities of social work practice, especially in government agencies where the focus may be more on social control and safeguarding the public than on personal liberation. For others, it is seen as relying too heavily on 'Western' (or 'Northern'?), developed-world ideas about rights and justice. Interestingly, the IFSW web site provides a rider to the definition: 'It is understood that social work in the 21st century is dynamic and evolving, and therefore no definition should be regarded as exhaustive' (http://ifsw.org/policies/definition-of-social-work/, accessed 13 October, 2012). This captures well the contested and changing nature of social work, as does the story of the historical development of social work.

As I argued in my first book, historical analyses demonstrate that social work has always been subject to competing claims of definition and practice; it is only by exploring some of the discourses within social work that we can begin to understand what social work is and what it might be (Cree, 1995, p. 1). Social work cannot be separated from society – we cannot explain or understand social work without locating it within society.

## What is Society?

The Oxford English Dictionary suggests that society is 'the aggregate of people living together in a more or less ordered community'. But what is an 'aggregate of people'? How many people must this include for it to be considered a 'society'? Does the definition assume a homogeneous or a heterogeneous group of people? What is a 'community'? What does it mean to be 'more or less ordered'? Most importantly, whose answers should we accept, and what are the implications of holding a particular position?

Classical sociologists had no problem in defining society. They worked from the assumption that 'society' (sometimes presented with a capital as 'Society') could be examined and analysed, much as any material object could be investigated in a laboratory. As the physical sciences studied the physical world, so sociology was the 'science of society'. In the late nineteenth century and early twentieth centuries in Western Europe and the United States, sociologists' main priority was to examine and explain what they saw as the new, 'modern' society in which they were living. Industrialization and urbanization had brought a new way of life:

**Table 1** *Conceptualizations of society.*

| *Pre-industrial society* | *Modern society* | *Postmodern society* |
|---|---|---|
| Feudalism | Capitalism | Global capitalism |
| Agrarian | Industrial | The information society |
| Rural | Urban | Decentralized |
| Simple | Complex | Fragmented |
| Religious | Secular | Pluralist |
| Faith | Science | Scepticism/relativity |
| Superstition | Reason | Diverse beliefs/ambivalence |
| Tradition | Universal truths | Contingencies/contradictions |

society had shifted from a feudal, agrarian, 'simple' society to a capitalist, industrial, 'complex' society. Sociologists saw this positively: the 'modern' world signified progress, scientific reasoning and enlightened thinking. They were also concerned, however, about the negative consequences of modernization, including the loss of traditional values and social networks. They therefore sought to find ways of ameliorating the worst aspects of industrialization and so create a better society. Capitalism and socialism represented two very different ways as to how this might be achieved.

In more recent years, the idea of society as a single entity has been severely criticized. Pluralist approaches present society as a mosaic of competing worlds. Postmodern analyses have taken this further, emphasizing the contingent nature of existence and the chaotic, unexpected characteristics of late capitalist society. Society is here perceived as being complex and fragmented: just as we all have more than one identity, so we live and move in many diverse societies. The different ways in which society has been conceptualized are illustrated in Table 1.

The history of social work in the United Kingdom offers unique insight into the social, economic and political changes which have taken place in the past and are being lived through in the present. It provides a window onto the modernization process; we can see at first hand the social changes which led to the emergence of 'modern' social work and the struggle within social work to professionalize and live up to the 'modern' ideal. An examination of social work's current position throws postmodern ideas and analyses into sharp relief. The complexities and uncertainties which seem to be endemic in social work are inevitable given the dynamic and contested nature of post/late modern/risk society.

## Social Work and 'Pre-Industrial' Society

There have always been those who need help from others, though this help was not always called 'social work'. In pre-industrial society, poverty was widespread. However, there was no notion at this time that the state should have any part to play in alleviating hardship. It was accepted that it was the family's responsibility to care for those in need. The 1601 Poor Law Act confirmed this:

> It should be the duty of the father, grandfather, mother, grandmother, husband or child of a poor, old, blind, lame or impotent person, or other poor person, not able to work, if possessed of sufficient means, to relieve and maintain that person.

Beyond this, churches and monasteries provided residential services for older and infirm people without family support through almshouses, infirmaries (for the care and treatment of the sick), and hospitals (literally 'hospitality' for the poor, especially the old, and for travellers in need of temporary shelter). At the same time, landowners gave extra help (sometimes financial and often in kind) to tenants and their families at times of sickness or poor harvest.

The social and economic changes known as the 'agrarian revolution' changed established systems of social support for ever. The process of enclosure which converted arable land to pasture led to mass unemployment for rural labourers, rural depopulation across vast areas of the countryside, and a decline of traditional obligations between landowners and tenants. Simultaneously, the dissolution of monasteries destroyed the provision of institutional social care services and led to hundreds of older and disabled people being thrown out onto the streets. Fears of social disorder led to the passing of the 1601 Elizabethan Poor Law Act (England and Wales). The Act reaffirmed the principle of family responsibility, while authorizing parishes to levy rates on property to pay for services for the poor and needy who had no family support. It also determined what help should be provided:

- the 'impotent poor' (the aged, chronic sick, blind and mentally ill who needed residential care) were to be accommodated in voluntary almshouses;
- the 'able-bodied poor' were to be set to work in a workhouse (they were felt to be able to work but were lazy);
- the 'able-bodied poor' who absconded or 'persistent idlers' who refused work were to be punished in a 'house of correction' (Fraser, 2009).

Parishes were never able to raise sufficient funds to make this a realistic programme of social support. Nevertheless, what the act demonstrates is a series of propositions about a new relationship between the individual and society. Firstly, it recognized that individual and charitable efforts were no longer sufficient to meet need; the state must therefore intervene to provide services. Secondly, it formalized the notion that there were different types of poor people, requiring different kinds of intervention. Finally, it presupposed the idea that the state's responsibility should be limited to the control, punishment and deterrence of the 'bad' poor, whilst 'good' poor people would be helped by voluntary agencies. Subsequent legislation and social welfare policy in the United Kingdom built on these ideas, with significant implications for the development of social work practice.

## Social Work and 'Modern' Society

If the agrarian revolution of the sixteenth and seventeenth centuries marked the beginnings of a transformation in the relationship between individuals and society, it was the social crisis known as the 'industrial revolution' in the eighteenth and

nineteenth centuries which consolidated this shift across Western Europe and North America. Social work emerged as a response to this crisis, and as a compromise between different views about what form that response should take.

The industrial revolution brought with it rapid industrialization and urbanization which changed for ever the lives of all people, rich and poor alike. Social problems that had been dispersed and largely invisible in the countryside (for example, poverty and overcrowding, poor housing, ill health and disease, alcohol and drug abuse, prostitution, unsupervised children) became more concentrated and more visible in the new towns and cities. Working-class freedom and social deprivation spelt danger to the middle-class city dwellers who clamoured for something to be done to contain and control the threat from the 'dangerous classes'. This is clearly illustrated in the following excerpt from a sermon preached by the Reverend Thomas Chalmers in 1817:

> on looking at the mighty mass of a city population, I state my apprehension, that if something be not done to bring this enormous physical strength under the control of Christian and humanised principle, the day may yet come, when it may lift against the authorities of the land, its brawny vigour, and discharge upon them all the turbulence of its rude and volcanic energy. (Quoted in Brown, 1997, p. 95)

Something *was* done. The nineteenth century saw the introduction of a vast array of social welfare initiatives, including the establishment of new social work agencies. These initiatives were promoted by a range of stakeholders: public bodies, voluntary agencies, and private individuals, often, but not exclusively, members of the new urban middle class (see also Cree and Myers, 2008).

### *Statutory (public) initiatives in the nineteenth century*

At the statutory or public level, there was innovation in the nineteenth century across many spheres of life. Schemes for public sanitation, education, policing, prisons, juvenile correction, public workhouses and mental asylums accompanied legislation governing working conditions and the treatment of children as well as new mechanisms for recording population change. The social welfare initiatives demonstrate both continuity and change in thinking about the relationship between the individual and the state.

The Poor Law Amendment Act of 1834 (England and Wales) divided the poor into two groups:

- the 'deserving poor' (e.g. elderly, sick or disabled people, orphans and widows) who were to receive financial and practical support (often home-based) from charitable or voluntary organizations;
- the 'undeserving poor' (e.g. able-bodied unemployed men, single mothers, prostitutes) who were forced to turn to the state, and thus to the workhouse, since there was to be no poor relief outside the institution (Mooney, 1998).

The Act thus built on the distinctions created in earlier Poor Law legislation, confirming the separation between the 'deserving' and 'undeserving' poor and furthering the idea that it was the state's job to exclude and discipline the 'residue' (the

'underclass' in today's language). They were to be removed from society, in common with those others who did not have a place in the new, modern, industrial society: the mentally ill, the disabled and the criminal.

The nineteenth-century initiatives also illustrate new ideas about the role of the state. For the first time the state was to take action to set social conditions for *all* people, not just those who had transgressed society's rules. Free education was to be available for all children up to the age of 11 years; public sanitation would benefit all classes of people; employment legislation would control the economic and work practices of all factory and mine owners. And legislation allowed the state to intervene in the heart of private lives, that is, the family. The 1889 Prevention of Cruelty and Protection of Children Act for the first time made cruelty towards children illegal and introduced provisions for children to be removed from their families to a place of safety.

This new conceptualization about the role of the state was not reached easily, and was not accepted by all. Individuals and groups fought against state encroachment into individual liberty and the right to live (and work) without statutory interference. Those who were most unhappy were often the new middle classes who bore the burden of rising taxes to pay for social improvements. Scotland showed marked reluctance to go down the road of statutory intervention. Although Scottish parishes were permitted by a Poor Law Act of 1579 to raise taxes through rates, few did, and the chosen means of support remained the church or the estate (Levitt, 1988). Where relief was given, it was targeted at those who could not work (the 'destitute' and 'disabled'); financial support of the 'able-bodied', by either voluntary or public agencies, was discouraged.

## *Voluntary (philanthropic) initiatives in the nineteenth century*

There was an explosion of voluntary activity in the nineteenth century, with the creation of hundreds of new philanthropic agencies. These included police court missionaries; rescue societies for 'fallen women'; housing associations; university settlements; children's charities; hospital almoners; caseworkers from the Charity Organisation Society (COS) and other relief agencies; visitors on behalf of churches of all denominations and many other secular visiting organizations. Large numbers of middle-class people and some working-class people were involved in some form of philanthropic effort, either as fund-raisers, visitors, managers or activists. Some philanthropists restricted their involvement to small-scale action, such as visiting people at home. Many others were also involved in large-scale campaigning work. They saw no contradiction between 'personal troubles' and 'public issues' (Mills, 1959). Instead, their work with individuals and families was a key part of their mission to change society. Helen Bosanquet, a COS District Secretary for many years, expressed this as follows:

> What we aim at in all social work . . . is that both the whole community and every member in it shall be progressive, on the rising scale. We shall not be satisfied if the community as a whole can show a momentary increase in wealth, or learning, or culture, unless all classes within it are partaking intelligently in the social life, sharing in its progress, a source of strength and not of weakness. (1902, pp. 5–6)

Much of the philanthropic work took place on the margins of public agencies; the workers saw their task as mediating between individuals and the state (Clarke, 1993). They also, however, frequently sought to set limits on the state's involvement in the lives of individuals, by working as both Poor Law Guardians and 'friendly visitors', or by passing on information about individuals' circumstances to Poor Law boards. Most philanthropists believed passionately that statutory measures encouraged dependency and that the only way people could be helped to help themselves was through the reciprocal relationship between an individual and a trained volunteer. Octavia Hill, manager of a large number of Housing Associations in London, wrote in 1886:

> The more I watch the more the action of the public puzzles me. By rashly pouring vast sums into new largely advertised, wholescale schemes, their feverish excitability is creating a body of thriftless, ungracious, mendicants, living always on the brink of starvation, because taught to look to what may turn up. And those who love and know the people have to stand sadly aside, feeling that all giving is fatal until such rushes be over. (Reprinted in Whelan, 1998, pp. 93)

Octavia Hill's words show that philanthropy was not envisaged simply as a neutral alternative to state intervention; it was a deliberate attempt to hold back the increasing role of the state. From this perspective, philanthropy (and later social work) was not an apolitical, private intervention into social problems but was a 'deliberately depoliticising strategy for establishing public services at sensitive points midway between private initiative and the state' (Donzelot, 1980, p. 55). It offered a way of intervening in the lives of individuals and families to 'fit' them for the new industrial society without undermining individual responsibility and the role of the family (Parton, 1994).

The principal actors in this new sphere were middle-class women. While men busied themselves with political and economic affairs, and in the management of charitable organizations, it was largely women who performed the visits to people at home and in institutions. A survey carried out in 1893 estimated that approximately 500,000 women worked 'continuously and semi-professionally' in charitable activity, with another 20,000 employed as paid officials in philanthropic organizations (Prochaska, 1980, p. 29). These women brought to their voluntary work specific (middle-class) ideas about class and gender, family and work, age and sexuality. They believed that their own, bourgeois culture and beliefs were superior to those of working-class people; their goal was to make them more 'middle-class'. They also believed that men and women had different 'natural' qualities and abilities; that as women, they had a special contribution to make to the management of poorhouses and workhouses, school boards and prisons, as well as to the daily household management of poor families.

There was a fundamental contradiction here. Middle-class women, through educating the working classes in domesticity, also freed themselves from their own domestic confinement. Philanthropy brought opportunities for useful work, recreation, and creativity to middle-class women excluded from the world of paid employment. As Florence Nightingale declared: 'Charity work, free from chaperons and prying relatives represented deliverance from the stitch-stitch-church-stitch routine

of female existence. It was adventure' (quoted in Prochaska, 1980, p. 11). The 'private' world of the working classes was thus the point of entry for middle-class women into the 'public' world of work and politics. At the same time, the 'private' work carried out by working-class women in middle-class households (as domestic servants, cooks and nannies) gave middle-class women the leisure time they needed to indulge in charitable work with the working classes (Summers, 1979).

## Social Work in the Twentieth Century

It has been stated already that the nineteenth century witnessed the introduction of a wide range of social support initiatives, instigated by both statutory and voluntary agencies. In the twentieth century, social work services became increasingly incorporated into the state, either carried out directly by the state, or by the voluntary sector on its behalf, and statutory agencies became responsible for regulating and controlling the voluntary sector, through funding and inspection arrangements. As social work became progressively a more legally defined, narrowly proscribed activity, so the social reform agenda within social work became marginalized.

How did this change come about? We have already seen in the previous centuries a growing acceptance of the idea that the state should intervene to provide services and set conditions (to a limited extent) on behaviour. The twentieth century took this to a totally new level. Liberal reforms at the beginning of the twentieth century were followed during and after the Second World War by a massive programme of social legislation which promised to tackle outright the five giants of 'Want, Disease, Ignorance, Squalor and Idleness' (HMSO, 1942) and remove all trace of the stigma attached to the Poor Law. The principal systems of provision included social security and pensions, the National Health Service, education, family allowances, housing and planning, childcare and national assistance. The aim was to end social inequality for all; the task of social work was to pick up the small number of people who fell through the welfare net and rehabilitate them so that they could again play their part as full citizens. Three separate local authority departments were set up in 1948 to meet social work needs: children's departments targeted children deprived of a 'normal' family life; welfare departments were set up to work with older, physically handicapped and homeless people; and local health departments were created to provide services for mentally ill and handicapped people. According to this new standard, the voluntary sector was complementary and supplementary to the state, filling in gaps and experimenting with new forms of help.

It would be wrong, however, to assume that arguments against the increasing role of the state had been defeated for all time. The tide of social democratic optimism and new confidence in central planning measures that followed the Second World War may have muted the voices against state encroachment, but they did not disappear (Stewart, 1999). The limited funding made available to the new social work departments in the post-war period demonstrates that they were never expected to be a central arm of the welfare state in the way that health and education services were. A key aspect of social work practice – child protection services – remained in the hands of voluntary agencies, which also provided the bulk of

residential childcare services. It was not until after the passing of the Social Work (Scotland) Act 1968 and the Local Authorities Social Services Act (England and Wales) 1970 that statutory social services were on a level that seriously undermined voluntary ones. New generic Social Work and Social Service Departments brought together the previously disparate services under one roof, offering universal personal social services for all; 'through one door on which to knock' (Seebohm Committee, 1968). The voluntary sector's task was confirmed as being 'to supplement local authority work' and 'a stimulus to further progress', in the words of the Social Work (Scotland) Act. These developments have been described as the 'high tide' of social work (Langan, 1993).

There is a paradox in the expansion of the state's responsibilities. While voluntary agencies in the nineteenth century had, at least in part, seen their role as one of restraining state interference in the lives of citizens, voluntary agencies in the twentieth century became increasingly supportive of a greater role for the state. Those who campaigned for the passing of the Children Act in 1948 included representatives from powerful voluntary organizations that worked with children. The same was true of the later 1968 and 1970 Acts. In practice, voluntary social work agencies did unprecedentedly well out of the expansion of statutory social work, as local authorities, strapped for cash and resources, turned to the voluntary sector to meet requirements of the new legislation.

The driving force behind the developments that took place in both statutory and voluntary social work can be found in the intersection between the needs of the growing welfare state and the demands of social workers themselves. The state needed professional workers to staff its new departments. At the same time, the 'would-be professions' benefited from the occupational and organizational base provided by the state (Clarke, 1993, p. 15). The 'bureau professionalism' that became the pattern in local authority social work departments (and in many of the larger voluntary agencies) guaranteed social work its service-user base and its continuing legitimacy. But it also restricted the kind of activity that social work could be involved in, and the autonomy and discretion that social workers could exercise. Commentators have been critical of the self-serving nature of professions and the social work profession in particular. It is argued that professionalization encouraged social workers to give up their claims to change society (Hugman, 1991), led to a diminishing of the authority of women's voices in social work (Dominelli, 1997), and an abandonment of social work's traditional commitment to the poor (Jones, 1997).

Whichever is the case, the old arguments against the growing dominance of the state did not vanish. In the 1970s and 1980s in the United Kingdom, the welfare state in general, and social work in particular, came under increasing attack from both the right and the left. Challenges came from a number of distinct, and at times overlapping, areas:

- A decline in the United Kingdom's economic competitiveness and a reorientation of fiscal and monetary regimes led to the welfare state becoming a target for radical change (Clark and Cree, 2001).
- Black and anti-racist groups drew attention to the deep-seated racism within social work ideology and practice (Dominelli, 2008).

- Child abuse tragedies from the early 1970s onwards highlighted statutory social work's powerlessness to prevent abuse from taking place, either at home or in the very institutions set up to protect vulnerable children (Hill and Aldgate, 1996).
- Feminists pointed out that state services, while claiming to support women, reinforced gender stereotypes and confirmed women's oppression (Langan and Day, 1992).
- Disabled people campaigned against the paternalism of state provision, and fought for a measure of control over how services were to be delivered (Campbell and Oliver, 1996).
- Key voluntary agencies pushed for an increased role for the voluntary sector in 'welfare pluralism' (Gladstone, 1979).
- Radical social workers drew attention to the structural causes of service users' problems and sought to form political alliances through trade unions (Langan, 1993).
- A New Right agenda was promoting the role of the family and voluntary provision in preference to the 'nanny state' (Pinkney, 1998).

The consequences of the disillusionment with the welfare state included a retrenchment of the state in terms of its provision of welfare services. The idea that the state could not – and should not – provide all social welfare began again to gain ascendency. But although the rhetoric of the 1980s may have been about reducing state involvement, the reality was the introduction of new and ever-more stringent mechanisms for regulating and controlling social services, in statutory, voluntary and private sectors. The result has been greater, not less power for the state.

International comparisons make it evident that there is no 'right answer' to the questions of who should provide social work services, and of what kind. In many European countries, social workers are state employees with wide responsibilities in relation to employment and social insurance. In contrast, social services in Australia rest firmly with the voluntary sector and in the United States, most qualified social workers are either self-employed or working for private agencies as counsellors and therapists. In Latin America, social workers attached to churches play a key role in working with groups to tackle poverty. Moreover, some of the largest non-governmental organizations (NGOs), for example, the Red Cross, Age Concern and Oxfam, play a major role in the organization of welfare services throughout the world during times of trauma such as wars and civil conflicts (Dominelli, 2000, p. 32).

## Social Work and 'Postmodern' Society

It is impossible to say when the 'modern' period in social work ended and the 'postmodern' began, supposing that it exists at all. Whatever we think about 'postmodernity', we can be certain that the world of the twenty-first century has changed and is continuing to change rapidly. The structure and organization of social work in the United Kingdom has been transformed; 'modern' assumptions about the role of social work are open to question; it is uncertain what form social work will take in the future.

As we have seen, the relationship between social work and society has been shaped by a number of different processes, historical, social, economic and political. Factors beyond our geographical boundaries are of even greater significance for social work and postmodern society. The impact of economic organization on an international scale (globalization) has been that individual countries can no longer function as closed societies, if this was ever truly possible. Writing in 1993, Smart argued that social life and social relations, identity and experience could no longer be limited in scope to 'society', particularly where society is envisaged in terms of the boundaries of the nation state. For many countries, globalization has been experienced as a kind of colonization of local cultures and customs; a 'Westernization' or even 'Americanization'. Yet globalization has also opened up so-called marginalized and 'peripheral' communities throughout the world, bringing the potential for greater awareness of diverse cultures that may challenge the hegemony of 'Western' ideas (Allahar, 1995).

Globalization has already begun to have a direct influence on social work in the United Kingdom. As the transnational nature of economic organization has undermined the power of nation states (Bauman, 1998), old defensive barriers between countries have broken down and new alliances formed. Agreements reached at European level (such as the European Convention on Human Rights) are today reshaping policy and practice in all the member countries in the European Union, just as international treaties (such as the UN Convention on the Rights of the Child) is impacting on adults and children across statutory, voluntary and private agencies. Whilst some systems of government have become larger, there has been a cross-Europe movement towards the devolution of responsibilities away from governments to smaller units of power. In the United Kingdom, the Scottish Parliament and the Welsh and Northern Irish Assemblies have brought increasing disparities in the relationship between social work and society across England and Wales, Scotland and Northern Ireland, as demonstrated in the different countries' approaches to the question of provision of social care for older people.

Globalization has been accompanied by attempts across advanced industrialized societies to cut public expenditure and introduce new ways of managing welfare. In most countries, this has meant an increase in social inequalities. In the United Kingdom, the mechanism of the market has been introduced throughout public sector agencies. Statutory social work agencies have seen the creation of a split between purchaser and provider roles, and the introduction of charges for services, the contracting out of services and the promotion of competition between the statutory, voluntary and private sectors. Clients have become 'customers', and social workers budget-holders, with little control over the resources which they must purchase in the 'market' of care. Social workers are experiencing high levels of anxiety and pressure, as they strive to maintain the social work role in the face of challenges from other care professionals, such as occupational therapists, district nurses and community psychiatric nurses.

Some commentators propose that the defining characteristic of the post-industrial society is information – it is information that produces and sustains contemporary society and makes globalization possible (Kumar, 2005). By bringing together ever faster and cleverer computers with worldwide telecommunications' systems, knowledge and information can be shared instantaneously, and people can

### 1 Useful web sites

www.gcu.ac.uk/heatherbank/ – the Heatherbank Museum of Social Work, founded in 1975, and based at Glasgow Caledonian University.
www.workhouses.org.uk/ – contains interesting materials about workhouses and poorhouses across the UK.
http://swhn.chester.ac.uk/papers.php – the UK's Social Work History Network papers can be accessed here.
http://www.naswdc.org/pressroom/features/general/history.asp – provides information on American social work history.
http://historyofsocialwork.org/eng/index.php – launched in 2010 with support from the Flemish ministry of welfare and the Dutch ministry of welfare.

build social networks and communities of support across societies and countries. This has clear advantages for social workers and service users. But critics have pointed out that information technology (IT) is only really available to certain groups in society, leading to an increase in social exclusion for those who have no access to it. Information technology has also brought with it the capacity for surveillance and control to a degree unthinkable in the past. Networked computer systems, DNA screening and electronic 'tagging' bring ever-more sophisticated ways in which the 'disciplinary society' can 'police' its members (Foucault, 1977).

Globalization and information are not the only reasons for the changes taking place in social work. Postmodern society is also a 'risk society' (Beck, 1992). Our lives are affected by global risks beyond our control; the speed at which change is taking place makes us feel insecure and vulnerable. Social work in the United Kingdom has sought to cope with (and manage) the idea of risk and uncertainty by introducing new systems for organizing professional practice and new mechanisms for predicting future risks and their potential negative outcomes. How far management of risk is ever truly achievable remains an open question, but Cree and Wallace (2009) argue that social workers must nevertheless seek to behave in a professional, ethical manner, working alongside service users and other professionals to share the responsibilities and challenges that real life brings.

## Conclusion

The relationship between social work and society is a dynamic and highly contested one. As society 'modernized', so social work shifted from the informal to the formal sphere, from voluntary to statutory agencies. Social work became a key mechanism of the new 'disciplinary society', positioned, as Donzelot (1980) and others have claimed, at a midway point between the individual and the state. In more recent years, disciplinary power has continued to grow, as the state has increased its regulatory and inspectorial role in a new 'mixed economy' of care.

But the story of the changing relationship between social work and society is not one of 'caring' voluntary agencies versus 'controlling' statutory services. On the contrary, the motivations of those involved in the nineteenth-century voluntary agencies were as much about controlling and re-educating the working classes as they were about humanitarian concern or social reform. They worked hand-in-hand with statutory (poor law) agencies to manage the social consequences of industrialization and urbanization. At the same time, the emergence of 'the social' provided a gateway for middle-class women to enter the public arena and the world of professional work.

Today the lines between voluntary and statutory agencies have become increasingly blurred. Most voluntary agencies rely heavily on local and central government funding for their activities, albeit now within the rubric of the 'big society' (see http://www.communities.gov.uk/communities/bigsociety/). At the same time, statutory agencies continue to depend on informal networks of caring to meet most social need. There is a general acceptance (again) that the state cannot provide all social welfare needs; that statutory social work must be a service of 'last resort', rationed by ever-more intricate tests of 'risk' and 'need'. The 'undeserving poor' of the past are today's 'socially excluded' or 'underclass'; they remain the principal users of statutory social work services.

So what of social work and society in the future? Realistically, social work will continue to be more about helping people to fit into society than about changing society; it will be concerned with maintenance rather than social revolution (Davies, 1994). But given its breadth of scope, its complexities and its diversities, social work can do more than this. Social work has privileged access to the lives of individuals and the workings of society. Through this, it holds the possibility of exerting a positive influence on both. If it is to achieve this, it will have to align itself more completely with those it sets out to mediate on behalf of – the poor, the socially excluded and the less powerful in society. And it will have to show courage to speak out about the structural causes of people's problems and the extraordinary resilience of their lives.

## Five Key Points

1. Social work is situated midway between the individual and society, between the powerful and the excluded, negotiating, and at times in conflict, with both.
2. Historical analyses demonstrate that social work has always been subject to competing claims of definition and practice – there is no essential social work task.
3. Modern social work emerged as a deliberate strategy to ameliorate the worst effects of rapid industrialization and urbanization.
4. The professionalization of social work in the United Kingdom meant that social work (statutory and voluntary) increasingly looked to the state to provide its 'clients' and regulate its activities.
5. The postmodern world brings new opportunities for creativity and diversities in social work, as well as dangers of increased surveillance and control of social work's subjects.

## Three Questions

1. How far is social work a class-specific activity today?
2. What does it mean to say that social work is a 'women's profession'?
3. What is the role of the voluntary sector in social work today?

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CHAPTER 1.2

# Social Work and Politics

*Mark Drakeford*

What is the rationale for a chapter on politics in a book which is all about social work? Surely, social welfare is one of those rare topics which closes rather than widens political differences? Who could be against the proposition that help should be offered to those who need it the most? Well, as this chapter aims to demonstrate, almost all the apparently straightforward ideas which these questions contain turn out, on closer examination, to be more complicated and more contested than a casual observer might have imagined. Far from it being ground upon which differences are merged, social welfare and social work have become policy and practice areas in which some of the most fundamentally different ways of thinking about society are fought out.

The social worker who claims to be above or beyond politics is one who has denied her or himself access to a set of conceptual tools which are directly necessary to a properly informed conduct in today's complex world of practice. The claim to be 'unpolitical' is itself a political stance which tells us much about the organizations or individuals who make such declarations.

This chapter takes a broad view of what is meant by 'politics'. At root, the material discussed here is about *ideology*. It is concerned with basic questions about the organization of society, the relationship between individuals and the state, the ways in which some behaviours are deemed lawful and others unlawful, the sorts of policy choices which governments make, the actual services which are provided, and so on. In the practical world of social workers, these ideological questions are rarely faced in such a basic form. Instead they emerge in more everyday clothing, lurking, for example, behind the rules which govern the treatment of young people before the courts, decisions about charging for community care services, or the powers to detain an individual on the grounds of mental illness.

*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

Moreover, all such day-by-day decisions are taken in particular organizational contexts. It may be difficult to generate much heat in a discussion about local government committee structures or drawing the boundary between health and social services, yet from the resolution of such political questions a whole range of direct consequences flow for social workers and service users.

The relationship between social work and politics is thus a complex one and one which operates at very many different levels. To begin with, social welfare services are shaped and delivered within directly political milieus. Policy is formed in the different political settings of the United Kingdom's devolved administrations – the governments at the National Assembly in Wales, the Scottish Parliament, the Northern Ireland Assembly, and the Houses of Parliament in London. Political decisions at such institutions bring different approaches which shape the policies that flow from them.

Secondly, statutory services continue to be delivered in most places in the political context of local councils. Decisions about the allocation of resources, the location of services, the organization of particular functions and so on, are arrived at as the result of the political preferences and composition of local authority councillors, operating within the strategic frameworks which have been laid down by central government in its different guises. This chapter argues that the day-to-day practice of on-the-ground social work is highly influenced by this local political context, and that the level and nature of services provided to individual users is similarly affected.

Thirdly, it will be suggested here that social work is an inherently political activity, concerned fundamentally with a series of power relationships and conducted according to competing sets of notions as to how such relationships ought best to be resolved. Social workers spend a good deal of time inside families where power relations – such as those between parents and children – are fundamental to the issues which have produced a call upon social services in the first instance. The same individuals are likely to be engaged in a series of other relationships with the outside world, all of which have a formative power dimension. The social-worker-as-broker spends huge amounts of time in mediating between the individual and the school, or the doctor, or the housing department. In all those encounters, the social worker is anything but power-neutral. Statutory social workers in child welfare or mental health, for example, exercise direct and substantial powers on behalf of the state. Such powers reflect a view of social relations which is fundamentally political in its determination.

## Ideology and Central Government

One of the most consistent dangers which face contemporary actors in social welfare – policy-makers and practitioners alike – is that *novelty*, in the sense of immediate change, always appears more pressing and important than *continuity*, in the sense of longer-term trends and ideas which are more slow-moving or submerged. For the purposes of the discussion here, I want to suggest that the activities in which social workers are engaged take place at the intersection of a number of interlinked and long-term ideological disputes in which the boundary between one

side and another moves backwards and forwards, like some never-ending contest between two evenly matched tug-of-war teams. These disputes include:

- *Government: help or hindrance?* For more than 150 years – and some would argue for a lot longer – social policy in Britain and Ireland has been fundamentally contested between those who believe that the state is essentially benign and ought to work actively to assist the lives of its citizens, and those who believe that the state is essentially malign, more likely to do harm than good and whose tendency ever to encroach upon the lives of private individuals ought vigorously to be resisted. In modern times, the welfare state of the post-1945 period most clearly demonstrates the first approach, while the ambitions of the Thatcher governments of the 1980s to 'roll back the frontiers of the state' belong to the second tradition. The coalition government at Westminster which came into being in May 2010 is similarly aligned to 'small state' thinking, while administrations in Scotland and Wales continue to regard collective action as part of the solution to common problems, rather than part of the problem itself.
- *Private or public welfare?* A linked ideological divide emerges between those who believe that the best social welfare is privately provided and those who believe that public provision has greater advantages. Believers in private welfare emphasize the role of the family, the locality and charity. They remind us that most 'care' provided in our society is the result of families, neighbours and friends looking after one another. Where needs cannot be met in that way, such thinkers argue, individuals ought to have as much choice as possible in identifying and obtaining the sort of services which they would prefer. In this sort of analysis, the market emerges as the only place where such choice can effectively be delivered, as a plethora of private providers compete to attract purchasers on the basis of price and customer care.

  On the other side are those who believe that reliance on private welfare simply replicates and reinforces existing inequalities in society. The ability to choose private childcare, for example, will depend wholly upon having the money to pay for such services. Those who have stable families and access to financial resources will be able to use such private advantages to their own benefit. Those without either will find their disadvantages exaggerated still further. In these circumstances, such analysts suggest, public provision is much to be preferred because such services can be made genuinely available to all in a way which can guarantee access and quality.

These fundamentally different ways of thinking about government and services mean that the impact of politics, in the sense of ideology, has been directly felt in social work throughout its history. At different periods the practical effect has been sharper or less apparent, as ideological tides ebb and flow. The community care arrangements of the last 55 years provide a direct example of the way in which underlying political philosophies can come to the surface, impacting upon the services which social workers provide and the daily activities in which they are engaged.

Community care is a policy which, at the outset, received a good deal of bipartisan support in the political arena. The phrase 'community care' was first used by Conservative health ministers, in drawing up the 1959 Mental Health Act. During

the 1960s, a series of scandals in mental health hospitals produced an added impetus to the policy of transferring care from an institutional to a community base. The Ely Hospital Inquiry of 1969 was chaired by an up-and-coming Conservative lawyer, Geoffrey Howe, and reported to the Labour Secretary of State, Richard Crossman. Crossman's response laid the foundations for the 1972 White Paper, *Better Services for the Mentally Handicapped*, introduced by his Tory successor, Sir Keith Joseph. In 1976, with Labour back in power again, the follow-up White Paper, *Better Services for the Mentally Ill*, was published by Barbara Castle.

The plans of the 1960s and 1970s, by both parties, were written essentially from within the model of the 1945 welfare state in which governments were thought able to plan, over a considerable time horizon, and to set out policies and programmes which others – in this case primarily health and social services – would be charged to implement. As Parton (1994, p. 97) suggests, such a view rested upon a belief that, 'the interests of the social worker, and hence the state were similar to, if not the same as, the people they were trying to help'.

Much of this ideological quiescence was to change during the 1980s. The Thatcher governments of that decade embraced a very different notion of the proper role and capacity of the state itself and of its agents. A new emphasis was placed upon the role of the family, and of voluntary and informal networks, in the provision of care. Local authority departments were to be reorganized to reflect this new arrangement. Councils were to be essentially *purchasers* of services *provided* by others. The nature of that provision was to be determined in a new *market*, in which voluntary and private sector organizations would compete for contracts with the local authorities in order to carry out the work. For social workers, it is important to understand the implications of this change, for at its root lay a distrust of both their profession and their professionalism. The New Right distrusted the public servants and public services in general, but in welfare matters the political edge of this ideological position was particularly acute, dealing as it does with individuals and families who are, very often, economically inactive and net consumers of, rather than contributors to, the public purse.

Under New Labour, the politics of welfare moved away from the neo-liberal certainties of the Thatcher and Major years. Instead, the 1997 government made a positive virtue of what it claimed to be an absence of ideological dogma in its approach to social policy matters generally and the social services in particular. Rather than privileging one ideological position above others, the Blair Government preferred a pragmatic 'what works' approach to policy-making. As Iatridis (2000) suggests, however, the claimed retreat from politics and ideology is itself an ideology. The apparent neutrality which a 'what works' approach provides, however, allows politicians an elegant means of dealing with some difficult moral or financial questions – by passing such problems on to 'experts' for solution. As Harrison (1998, p. 21) describes this in the field of health: 'Not only does evidence-based medicine offer a solution, but a solution which diffuses the responsibility for potentially unpopular decisions by their delegation to doctors. This is important for the political acceptability of rationing.'

In social work, the 'what works' movement has also gathered considerable pace. Here, the ideological side-step involved is less concerned with rationing than with ethics. If a solution 'works' then arguments over issues such as freedom and indi-

vidual rights can be portrayed as minor or peripheral. The then-Home Secretary, Jack Straw, for example, in announcing the extension of electronic tagging to children as young as ten years of age, justified this course of action by reference to the 'successful trials' of such methods which had already been conducted and fended off criticism not by any reference to the ethical and ideological questions posed, but by citing an 'evaluation report of the trials' which the Home Office itself had conducted (Hansard House of Commons Written Answers, 20 Nov 2000 : Column: 100W).

As the New Labour years moved on, however, the Westminster model for social work generally located it either as a simple handmaiden to its health policy (absorbing social workers into Primary Care Trusts, for example) or as a tool in the authoritarian axis of its social policy-making. If Blairism involved dividing the population into those who play by the rules and those who do not (Blair, 1997), then social workers spend their time amongst the latter: neighbours who cause difficulties to others; parents who cannot look after their own children; young people who fall foul of the law, and so on.

This approach was taken even further in the aftermath of the 'riots' which broke out in English cities during the summer of 2011 (see Roberts, Lewis and Newburn, 2011). Alongside draconian sentencing, the Prime Minister, David Cameron, outlined a plan for social workers to provide a concentrated form of 'tough love' for the 120,000 'most' deprived and deviant families.

Such a cast of mind is not confined to ministers. There are social workers, as well as governments, who profess to regard their activities as somehow untouched by politics. The view of social work as a set of techniques, validated by 'evidence' has gathered substantial ground in recent years. As Kilty and Meenaghan (1995, p. 446) point out, however, the technocratic and managerial view can have the effect of disguising the essential point that social work activity is activity with a *purpose*, and that purpose involves the promotion of change. As they suggest, the direction of change is an expression of the values which social work espouses and 'it is also influenced by the political context in which it operates'. The preference for social work as a radical, emancipatory and transformative activity is not one based on the efficiency of one set of techniques over another. It is an *ideological* stance, and one which positions social work as a political rather than simply a practical activity (see Butler and Drakeford, 2001, 2005 for a fuller exploration of these issues).

The next section turns to consider the connection between politics, administrative context and social work practice by looking at the impact of devolution on social services and the place where most social work in Britain and Ireland still takes place – within the framework of local government.

## Administration, Devolution and Local Government

Devolution in the post-1997 United Kingdom has been the most radical departure in constitutional politics since the completion of universal suffrage in the twentieth century. It means that policies and practices in social work increasingly vary between the four nations of the United Kingdom. With the Conservatives and Liberal Democrats in power in London, Labour in government in Wales and the SNP in charge

in Scotland, the 'living laboratory' of devolution is in full production as each nation applies its own solutions to suit local circumstances, social work included.

One of the most important ways in which devolved administrations shape the politics of social services lies in the changes which they can bring about in the structure of *local* government. Central authorities, in all the UK nations, are policy-makers. No such authority delivers meals-on-wheels, plays with vulnerable children in a nursery or works with a mentally-ill person on survival skills. The *delivery* of services rests with local government; but the *terms* of that delivery and the *capacity* to do so are shaped by actions of central administrations. In that delivery, the political character of local authorities has a real impact upon the design and delivery of social services in each area. Indeed, as Parton (1994, p. 107) suggests, the connection between changes in social services and wider political change needs to be understood far more broadly than in simply organizational terms. The thrust of the 1980s and 1990s towards a reduced role for directly provided services, and a greater emphasis upon the market, paralleled 'a general shift away from corporatist centralism towards a more decentralised and fragmented minimal state'. Yet, the degree to which pluralism has been embraced in practice has varied between authorities, as has the level of investment provided. Both these variations, in form and funding, reflect political decisions which produce a very direct impact on street-level social work.

## Social Services

So far, this chapter has considered social welfare in relation to the directly political contexts of ideology, government and administration in which social work services are designed and directed. What, however, about the *delivery* of services? In what sense can on-the-ground social work be described and understood as a political activity? See Box 2 for a practical example of the sort of dilemmas that emerge in practice.

In the argument developed here, the different purposes to which social work might be directed have always been highly ideological and, as a consequence, highly contested. The denial of ideology, on the basis of an appeal to some 'scientific neutrality', has always been consistent with an attempt to bypass the inherent tensions of social welfare provision, by defining them out of debate. Yet if, in the American context, social workers take part in the allocation of children for adoption by monetary auction (as described by Sandel, 2012) then, as Mills (1996, p. 395) argues, social workers are not simply technocrats caught in an ideological field, they are *players* on that field, whose actions either support or resist the prevailing orthodoxies.

In the context of Britain and Ireland, Harris (1997, p. 28) makes the same point when he notes that 'social work entails applying social and political theory to a multitude of complex and sometimes insoluble problems', and speaks of social work as 'the child of contemporary politics'. Two contemporary examples of this linear relationship must suffice to illustrate the wider picture.

The first and most basic example lies in the perennial tension which exists in social work between its duty to individuals and its duty to society. Simplifying radically, it could be said that social workers might be divided between those who see

## 2 A case example

Politics and social work remain intrinsically linked at the front line of service delivery as much as in wider debates. Look at this case example and consider it in the light of the issues discussed in this chapter. How do you make sense of the link between ideology and action in social work practice?

A potential user comes to a social work office, complaining that her children keep falling ill because her home suffers badly from damp. As a result, they have missed a good deal of school and are falling behind others in education and other sorts of development. She has received letters from the local education authority, threatening her with prosecution. The house has central heating but, your client explains, she cannot afford to use it. Do you:

- put her in touch with a campaigning group in her local area which is lobbying the local council for new investment in structural improvement;
- make a series of appointments in which you will offer advice on better budgeting;
- make a referral to the local welfare rights team, to ensure that your client is receiving all the income to which she is entitled;
- contact the education office to make sure that all the information about the family is pooled and coordinated action can be taken;
- advise her that, in your view, the children may be at risk and that a fuller examination of her ability to look after them properly will have to be undertaken?

Think about the basis upon which you came to your chosen course of action. Did your decision emerge from a view of social work which is about changing the individual to fit society, or society to fit the individual? Was your understanding of social work one which regards the profession as one dedicated to keeping families together, or one which starts from a belief that children sometimes need protecting from their parents? The point of these questions is to bring to the surface those political and ideological roots, which lie behind the resolution of the most everyday social work encounters.

their primary task as changing the individual to meet the needs of society and those who see themselves as changing society to meet the needs of the individual. The reality, as in so much practical social welfare, lies more in the messy middle of these polar opposites, but, even if caricatured, the division does describe a basic fault-line around which different forms of practice can be distinguished. In the immediate post-war period, with a belief that, with the advent of the welfare state, the problems of poverty and of access to basic services had been solved, social work appeared to be dominated by an approach which looked for ways in which 'sad, bad or mad' people might be better 'adjusted' to an essentially beneficent society. During the 1960s, with the 'rediscovery' of poverty, and rising trends towards radicalism in

politics and liberalism in personal morality, the dominant outlook in social work changed too. 'Radical social work', essentially Marxist in persuasion, suggested that alliances could be formed between workers and clients in social welfare which would allow for vested interests to be challenged and authority to be redistributed from the powerful to the powerless. Even in less *avant-garde* circles, the nature of social work was moved from the margins of the maladjusted to the mainstream. The Seebohm Committee of 1968 proposed a 'universal' social work service which ordinary citizens would use as normally as a visit to the doctor or the school. The spirit of the times emphasized the rights of individuals to a service which was to mobilize resources on their behalf, rather than simply aid their accommodation to their circumstances.

The Seebohm reforms of the early 1970s represent what is arguably the high-water mark of social services in the second half of the twentieth century. A second example of the linear relationship between politics and social work took place in just that period. In 1973 one of those landmark events, which colour the long-term public perception of an issue or a profession, occurred in social work, when the death of Maria Colwell led to a public inquiry in which blame for the child's fate was laid firmly at the door of the profession. The view which was taken from the inquiry was of a social work service which, it concluded, had alternated between incompetence on the one hand, and a doctrinaire adherence to a particular theoretical model on the other. Its verdict has echoed down the years in successive scandals including, most recently, those of Victoria Climbié and 'Baby P' (see Butler and Drakeford, 2010 for an account of the shaping impact of these events on social work practice).

While the handling of the Colwell inquiry was not 'political' in the party sense, it was highly so in relation to the contest which ensued for understanding what had taken place. Sir Keith Joseph, the then-Secretary of State for Social Services was a Conservative and an adherent of the 'transmission' theory of intergenerational deprivation. According to this perspective, which emerged again under New Labour and very strongly in the post-2010 period, the explanation for the enduring nature of much disadvantage and inequality in society was not found in large scale forces – such as economic inequality, unemployment, poor housing – but in the child-rearing practices of certain social classes which passed, from generation to generation, the faults and inadequacies of one to the next. The purpose of social work, according to this view, was to focus upon individuals, rather than structures, helping – or obliging – them to mend their ways, or risk losing the care of their own children.

Much of this has emerged, sometimes surrounded in more benign terminology, in the 'Big Society' ambitions for social work in England. Garrett (forthcoming) argues that the Conservative Party, in opposition, had made a concerted attempt 'to re-enchant social work', a process which it continued in government through the Munro review (Munro, 2011; Department for Education, 2011). Yet, the Munro prescriptions for greater professional freedom and 'liberation' from 'top down' bureaucracy have to be understood in the context of post-2008 austerity in which public service is replaced by commercialization and public funding by charitable donation. When the least well off in society (and those most likely to be in contact with social workers) are expected to carry the heaviest burden of spending cuts

(Browne, 2012; Joyce, 2012), then the contest between emancipatory and authoritarian traditions in social welfare is heavily weighted in favour of the latter. Even in the heady days of 'anti-discriminatory' and 'anti-oppressive practice', when social workers were enjoined to 'confront' prejudice – on the grounds of race, gender, sexuality, disability and so on – such actions were capable of a close alignment with the neo-liberal preoccupation of equality of *opportunity*, rather than the creation of a more equal society (see, for example, Wilkinson and Pickett (2010) for an account of the arguments in favour of greater equality).

From this chapter's perspective, the important point to emerge is just how closely the connection between politics and social work emerges across time, and between issues. At the heart of the post-war welfare state was an attempt to create common interests between dissimilar groups in society. The contract-based models of the post-1979 period represent a very different set of priorities, based on choice and individual autonomy. The prospects for social work are shaped, fundamentally, by these very different political ideologies.

## Conclusion

This chapter has focused on the political impact of external agencies upon the nature of the duties which social workers are called upon to perform and the ways in which such duties can be carried out. Of course, there is a different form of politics which also has an important impact upon practice, the internal politics of the profession itself. Social work is rightly characterized by debates and disputes amongst practitioners and academics about the nature of the job itself – whether social work is a 'profession' at all, or whether it can just be reduced to a set of mechanical 'competencies' through which the requirements of employing organizations can be implemented. Equally different views are debated as to the *techniques* of social work, those courses of actions which might best be followed in particular cases, and by arguments even about the nature of evidence itself.

The connecting thread between these internal debates and the concerns of the external world is that, while these discussions can appear to be arcane or learned, most are ideological in character, shaped by fundamental views about the nature of the society in which we live, and are, in that essential sense, *political*. Moreover, the outcome of such discussions is political in the sense that they represent changes in power distribution, between workers and employers, between different service providers or between service providers and users. In all the activities in which social work is engaged, in other words, political considerations shape both the context and the results. Establishing the critical need for an understanding of that formative process, its direct impact upon the sort of social work we wish to pursue and the sort of social workers we wish to be, has been the central purpose of this chapter.

## Five Key Points

1. Social work stands upon some of the most ideologically contested terrain of contemporary politics, negotiated in increasingly different ways in the four nations of a devolved United Kingdom.
2. Claims that social welfare is 'above' or 'beyond' politics, by governments, organizations or individuals disguises a set of assumptions which are themselves ideological.
3. Organizational forms, as well as policy decisions, have political consequences which translate directly into decisions made at individual-user level.
4. Face-to-face social work always involves power relationships which have an impact upon even the most apparently mundane encounters.
5. Social work is characterized by internal political debates about the nature of professionalism and the purpose of action which are linked to wider political forces, by considerations of both ideology and power.

## Three Questions

1. How does the basic ideological divide between state-as-force-for-good and state-as-source-of-harm have an impact upon social work?
2. The framework for social work is set by national and devolved governments, but social work is mainly delivered through local government. How do these political relationships make a difference to services on the ground?
3. In what ways can the power differences between providers and users of social work services be described as *political*?

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CHAPTER 1.3

# Gendering the Social Work Agenda

*Audrey Mullender*

It is not possible to understand the personal or social world without taking a gendered perspective. We cannot intervene appropriately in people's lives unless we see how women remain disadvantaged in contemporary society, and how both men and women are still often expected to play over-rigid and falsely dichotomized roles. At the same time, it is important both to recognize diversity (bearing in mind the charge that early feminism focused on the interests of middle-class, middle-aged, white, able-bodied, heterosexual women) and to see women as social actors in their own lives, not as passive victims.

Despite major advances, underpinned by sex discrimination and other legislation, women in Britain still lack equal access to social influence – and women who are black, lesbian, disabled, poor or older find their choices doubly or multiply constrained. Women suffer discrimination in relation to education, employment, income, domestic responsibilities, support for caring, and social attitudes and expectations throughout all stages of life. Women are also frequently in danger both in public spaces and in the privacy of their own homes from sexual violence. These are realities that social work must encompass.

Social work itself is far from free of gender discrimination. The majority of service users, informal carers, and staff in the lower grades are female, while the majority of senior managers are men. Social work agencies, like society, are run within operational systems that favour the interests, lifestyles and coping strategies of men. Practitioners, given the chance, can look beyond the pressures of day-to-day work to identify underpinning gender issues that their employing organizations typically ignore (White, 2006).

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## Childcare

Social work perceives women predominantly in terms of child rearing and yet leaves mothers poorly supported. The majority of lone parents are women and women disproportionately live in poverty, which in turn causes health problems. At least one in four women experiences domestic violence in her lifetime (http://www.womensaid.org.uk). Lesbian mothers and disabled women, especially those with learning difficulties, may still have to fight to prove themselves as competent parents. Social work intervention can add to the problems, rather than providing much-needed practical and emotional assistance or routes to safety.

In some respects, women's position is worsening. Prevailing political attitudes condemn teenage mothers, especially those who lack money and a partner. Increased concern about children living with domestic violence has not been consistently accompanied by social work help to make women safer and there is still a presumption that contact with absent fathers is good for children, even where there is a grave danger from post-separation violence (Humphreys and Stanley, 2006).

The recognition that most sexual violence is perpetrated by men alerts us to the threat posed by some male practitioners. A gendered analysis suggests that male workers may be less appropriately able to work with survivors, that male-dominated authorities will be threatened by revelations of the scale of sexual abuse, and that investigative approaches are unlikely to name or tackle abuses of patriarchal power, whether in the family or in the child protection agencies themselves. The avoidance of challenge to male abuse can be seen in family dysfunction theories which deflect responsibility, in accusations that mothers 'fail to protect', and in expecting children to keep themselves safe. Meanwhile, therapeutic work with survivors remains under-resourced, and mothers of abused children are too often blamed rather than supported.

## Community Care

Women have particular needs in the adult care field, in every specialism from AIDS care to substance misuse. An overview of gender issues in the community care context is provided by Orme and Campling (2000).

### *Women as carers*

Considerations of gender in community care began with a focus on women as carers which remains real, even today. Although there are also substantial numbers of male carers, they are mainly husbands and mainly elderly. The person who gives up work, leisure or health to care for a dependant is far more likely to be a woman. Minority ethnic carers and lesbian and gay partners who care remain amongst the most neglected groups. The idea that informal carers should have attention paid to their own needs is only slowly influencing practice.

Carers in residential settings are almost all female. The assumption that their gender automatically makes them suitable for the work blocks access to training,

support and promotion. Many black women carry a double burden of caring, acting both as low-paid care or nursing staff and as key family and community supports.

### *Women and mental health*

Women use mental health services more than men, yet diagnostic practice frequently ignores gender issues – including ethnic context, treatments that can be inappropriate, and psychiatric hospitals that too often still lack childcare facilities. Amongst the largest groups of women patients are survivors of abuse, but too few psychiatrists show interest in histories of sexual violence.

Women have begun to reject traditional labels and inadequate responses and to name widespread sexual abuse by male therapists and male service users in mixed institutions. Women are setting their own standards and finding their own solutions to psychological distress both within and outside mainstream services. Workshops on eating disorders or depression, groups to develop creativity or empowerment, and alternative therapies all offer healing in a postmodern society where expertise is questioned and individuals seek to become experts about their own needs and health.

### *Disabled women*

Disabled women have particular needs as women, over and above those they have as disabled people. Double oppression can compound feelings of powerlessness, rejection and invisibility. Whereas women are generally stereotyped as wives and mothers, disabled women struggle to be regarded as sexual beings and as capable of parenting. Women with learning difficulties have traditionally been denied sexual knowledge, sexual choices and reproductive rights. Not recognized as being at risk of sexual violence, disabled women may actually be more vulnerable, both in their own homes, where partners and other carers may be abusive, and in care and educational settings where they may not be believed if they accuse a formal or informal carer of abuse (Thiara *et al.*, 2011). In one women's group on disability equality, every member had had experiences of abuse; one had regularly been indecently assaulted by the driver who transported her to school as he lifted her in and out of the taxi. Funding cuts have made it more difficult for disabled women to organize for change but the UK Disability Forum for European Affairs (UKDFfEA) Women's Committee and Beverly Lewis House in Islington, a specialist refuge for women with learning disabilities experiencing physical, sexual or emotional abuse, have nevertheless offered models to emulate.

### *Older women*

Older women, though growing in numbers, are doubly marginalized on grounds of age and gender. Our youth-orientated society considers their domestic, sexual and economic roles to be over, rendering them socially invisible. Poverty disproportionately results from gendered inequities in pay and pensions, while physical and mental frailty adds negative connotations of dependence for some. All social workers can help oppose such ageist attitudes. An exciting innovation would be to run

women-only groups in residential settings and day centres for older people, where women predominate. They might well have current issues of discrimination or abuse to share, as well as hugely interesting life stories of changing gender politics in family and society. Some could be helped not to approach the end of their lives still living with the frustration or guilt born of women's limited opportunities and constrained choices when they were younger.

## Criminal Justice

Male-dominated criminal justice services do little to challenge the conceptualizations of masculinity that are implicated in most crime, despite examples in the probation service of gender awareness and of agendas voiced by women staff. Women's offending is perceived as doubly deviant because it is statistically so much lower than men's and because it is measured in relation to norms of domestic and sexual roles and behaviour, rather than poverty or male coercion. This can have an impact on sentencing, which also pays too little attention to women's responsibilities as mothers. One area of real progress, though, is practice with male perpetrators of sexual violence, who are at last beginning to be held accountable for their behaviour.

## Methods and Settings of Intervention

Women are most easily empowered through women-only groups which focus on lived experiences of socially constructed inequalities and ways to challenge them (Cohen and Mullender, 2003). Such groups free women from taking responsibility for men's feelings and communication difficulties. Discussion starts from individual narratives and moves on to draw out broader institutional, cultural and social control and denial of choice. Women recognize, together, that abuse and exploitation are not their personal fault but are endemic in a society dominated by male agendas that devalue women and their contribution. This leads to decisions to take relevant action for change. Similar principles have been applied to modes of organizing women-only work settings and support for women at work. There are also individual approaches to intervention that recognize women as women (Milner, 2001) and all social work practice can be rooted in principles that strive not to oppress women as mothers, carers, service users or low-paid staff.

## Challenges to Men

It is not only women who need to change. The challenge to men is arguably greater as they have more status and power to lose. In social work education and practice, men can usefully come together in groups to work on the emotional barriers to the feminine in themselves – to feelings and vulnerabilities – which drive them towards aggressive competitiveness and, at the same time, keep women and gay men oppressed. Men need to consider how they can better support women colleagues – at every level from campaigning for crèches and sharing the care of dependants, to tackling sexual harassment and violence – and be part of a more appropriate service

for women and children and a more confrontational practice with abusive or exploitative men.

## Conclusion

We live in a society where there is no such thing as gender balance. Achieving equality in numbers – in organizations, on committees, between group members or facilitators – cannot of itself achieve equity since women carry less social influence, and often less organizationally ascribed authority than men. There is no form of social work intervention and no setting for social work practice where gender does not have a central relevance. Women-only organizations have led the way in helping women to feel more in control of their lives and more able to make choices. Women's agendas have posed a challenge to men, too, to stop being the problem and become part of the solution. Gendering the agenda in social work will improve both the employment context and the commissioning and delivery of every type of service.

### Five Key Points

1. Gender must be on the agenda in every aspect of the organization and practice of social work.
2. Women have traditionally been discriminated against by society and its institutions, including social work.
3. Women's needs and experiences of life are different from men's.
4. Groups and organizations established by women for women and run to women's agendas are the best means of empowering women.
5. Men, too, both as professionals and as service users, need to be challenged to rethink their traditional roles and assumptions.

### Three Questions

1. In relation to your social work practice or your reading about social work practice, ask yourself: What is the gender power analysis of what you are doing? Are there men or male-dominated institutions wielding personal, organizational or social power unfairly over women? How does this integrate with your understanding of other oppressions?
2. What difference does it make, to you and to them, that the person or people you are working with is/are male or female, and that you are male or female?
3. What can you do to empower women colleagues and service users to have greater safety, more choices and higher self-esteem, and to challenge men to take responsibility for their own actions and feelings and the impact these have on other people?

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CHAPTER 1.4

# Culture, Ethnicity and Identity

*Kwame Owusu-Bempah*

Due to Western nations' plundering and exploitation of the rest of the world, now euphemistically termed 'globalization', coupled with the United States' unrelenting quest for global dominance (Chomsky, 2004), modern migratory patterns have ensured that every culture, with its language, artefacts and practices, is represented in the United Kingdom, as elsewhere. Professional practice in today's multicultural, multi-ethnic and multi-faith world must, therefore, reflect this diversity. This chapter examines the influence of beliefs and assumptions about culture, ethnicity and identity on professional practice with black clients. The emphasis is on children and families.

## Culture and Ethnicity

A generally accepted definition of culture is that it is a composite structure of the real and the symbolic: beliefs, mythology, religion, ideas, sentiments, institutions and objects of a given group transmitted generationally and internalized in varying degrees by its members. It includes child-rearing practices, kinship patterns and the ethics governing interpersonal relationships. It includes also ideas about personhood: personal identity and group identity.

Although both *culture* and *ethnicity* are frequently used synonymously, there is a conceptual distinction between the two, as the following definitions of *ethnicity* illustrate:

> one of a number of [human] populations . . . which individually maintain their differences . . . by means of isolating mechanisms such as geographic and social

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> barriers . . . an ethnic group may be a nation, a people, a language or a [religion]. (Montagu, 1997, p. 186)
>
> a distinct category of the population in a larger society whose culture is usually different from its own . . . the members of such a group are, or feel themselves, or are thought to be bound together by common ties of race or nationality or culture. (Morris, 1968, p. 167)

These definitions indicate that there is no single criterion by which *ethnic group* can be defined. They show also that everyone has multiple ethnicities in terms of geographical region, religion, social class, and so forth. Notwithstanding, ethnicity and culture are frequently used by professionals, politicians, the mass media and even the academic community not only interchangeably, but also to connote, and often denote, 'race', 'immigrant' or 'otherness'.

## Self-Identity

We derive our self-concept from our culture. In Western European cultures, children are socialized to see themselves as autonomous, free from all external control. The child is taught not only to possess mastery of him/herself, but also of everyone and everything, including even time. This conception of the self is alien to most cultures outside the West. Other cultures emphasize interdependence, and so prepare their children for reciprocal relationships in adulthood with the social, physical and spiritual worlds (Wiredu, 1998).

Various researchers inform us that, within the context of world cultures, an actualized person is one who is most deeply connected to others and society as a whole. For example, there are Pacific Island groups who view themselves not as bounded, distinct entities, but as integral pieces of an eternal life scheme (Lesser, 1996); there are Indian cultures where the deep inner self, upon maturity, is not seen as achieving unbridled autonomy, but as merging with the social and spiritual worlds (Roland, 1988); there are African cultures where one is less than human without 'Us', or where the individual seeks the answer to the question 'Who am I?' not only in the question 'Who are we?' but also in the question 'Who were we?' (Owusu-Bempah and Howitt, 2000). In the extreme, there is the Innu (Eskimo) culture that does not even have a word for self-reference (Page and Berkow, 1991). Thus every culture is a different world with its own idiosyncrasies; or put differently, there are as many conceptions of the self as there are cultures. The implications of this for professional interventions which claim to enhance the self-esteem of ethnic minority children in British society, children of diverse and radically different cultural, ethnic and social backgrounds to the therapist's, are clear. It also renders such social work rhetoric as 'black culture' or 'black perspective' nonsensical.

## Culture, Ethnicity and Identity: An Interplay

Foster (1998) poses a number of questions to illustrate the fatuity of any attempt to generalize Western theoretical assumptions about culture, ethnicity, identity and psychotherapy. This is one such question:

> How do we figure out the deep self-experience of a Middle Eastern man from a religious sect, who feels that without the tribe he was trained to lead, his self-esteem is unformed, non-existent? Do we view this client through the American self-psychological terms of a narcissistically derailed self, through the Ego Psychology lens of a poorly differentiated self? Or rather, as a person centred in the ensembled self-experience of his Eastern culture, where bonding to family and group kinship renders individuals who throughout life are deeply identified with others? (Foster, 1998, pp. 259–260)

Trying to face the hard clinical or practice-related questions posed by such clients forces us to re-examine our assumptions, theory and practice. A good start will be an acknowledgement that we can understand people only by respecting and studying how they understand themselves. People of every nationality, culture or ethnicity seek to understand themselves – their own character, their ways and peculiarities that differentiate them from other peoples.

It is ironic that despite the emphasis on ethnic and cultural restitution as a solution to the structural difficulties facing ethnic minority children in Britain, what passes for and is recommended as culture might best be described as a pastiche of a culture. Perhaps this is unsurprising given the miscomprehension about the nature of culture and ethnicity amongst practitioners. The simple truth is that the culture which practitioners see as a lifeline for their black and ethnic minority children has little or nothing to do with any indigenous culture. These interventions implicitly assume a monolithic culture for ethnic minority groups in British society. This is far from the truth.

## Self-Identity and Practice with Ethnic Minority Children

Practitioners very often conflate personal, 'racial', cultural and ethnic identities. This is quite apparent in social work where the issue concerning these terms has been hotly contested in recent years. The literature in the area of fostering/adoption is replete with claims that black children in the public care system as well as those fostered or adopted by white families experience more psychosocial developmental problems than other children, including their white counterparts. These problems are routinely ascribed to the children's lack of awareness of their 'black culture' (e.g. Small, 1991). For obvious reasons, this explanation, rather than racism, is favoured by the Children Act.

Although institutional racism is a more plausible explanation for the children's psychosocial developmental difficulties, the accepted solution is to 'work on' the children's self-identity. Many casually accept this practice. Others even advocate it as a necessary anti-racist strategy for social work with black adults as well. Some social services departments have taken these damaging assumptions seriously and have established special clinics to 'repair the damaged self-identity' of black children in their care. Briefly, social work and educational establishments increasingly refer black children to therapists to improve their racial identity or self-concept. Coward and Dattani (1993) drew attention to how child protection case conferences and statutory childcare reviews routinely result in requests for professional involvement to improve black youngsters' self-image. Mullender (1991) also described a project designed to improve their self-confidence ostensibly because they are confused about

their 'racial identity' as a consequence of being adopted or fostered by white families. Such an approach ignores obvious alternative causal factors, for example separation and loss (Owusu-Bempah, 2006), and attributes the youngsters' difficulties to their colour.

Unsurprisingly, programmes used to achieve this are ethnicity- or culture-based. They include providing the children with information about their 'black cultural background', including information about black historical figures and/or counselling them to identify with 'the black community' and to take pride in their 'blackness' (e.g. Banks, 1992; Maximé, 1994). Such programmes are guilty of victim-blaming (Owusu-Bempah, 1994). Conventionally, biological factors have been evoked to justify the plight of black people. Today psychological (self-identity) and social anthropological factors (culture/ethnicity) provide the excuse. It is no comfort to the children whatever is adduced to justify their difficulties if it remains at the level of the individual (the child or the family) and fails to tackle the structural barriers facing them in the larger society; it matters not a hoot the skin colour of its proponents, or their intentions.

The programmes assume also that the children experience 'identity crises' because they have favourable attitudes to the white community. For example, Maximé (1991: 103) described a 10-year-old black girl as psychologically disturbed, simply because she preferred 'a white family placement as black ones were all too poor'. Describing this girl's choice as astute, based upon reality, would be more meaningful. However, because of its policy and resource implications, such an interpretation would not be welcome. It would also seriously implicate black practitioners; it would challenge them to work toward dismantling the structural barriers which preclude black communities from providing homes and support to their young members who need such help and support, instead of colluding with the system by rationing and administering palliative measures to these children, including psychotherapy. As such, one must be forgiven for suspecting an (unwitting) coalition of conspiracy or interests (Owusu-Bempah, 2003).

As the above case (Maximé, 1991) shows, the programmes also equate 'non-affiliation' with one's ethnic group with psychological damage warranting intervention. It may be rather helpful to regard such behaviour as an example of 'negative identification'. Erikson (1968) saw negative identification as neither always nor necessarily harmful; and so must not be interfered with unnecessarily. Furthermore, it suggests that the identity crises (personal, ethnic or cultural) which black children are presumed to experience may be caused by adults' (notably social workers' and therapists') preconceptions and overreaction to their exploration of aspects of different cultures to their own. This type of exploration or experimentation must be seen as a normal developmental process, given the variety of ways of life they are exposed to, as a result of growing up in a 'global village'.

Because 'race', culture and ethnicity are endemic in these programmes they confuse self-identity with ethnic/cultural identity. There is a distinction between the two concepts.

- Self-identity refers to an individual's sense of uniqueness, a unique personal property – what sets person A apart from person B; although a culture is shared

by all its members, each member experiences it in a unique way, resulting in individual personalities.
- Ethnic or cultural identity relates to group identity, a 'racial', ethnic, cultural or social reference group.

Owing to the confusion surrounding these concepts, ethnic minority groups are often presented as culturally homogenous, belonging to a single, monolithic culture shared by all ethnic minorities, regardless of their national or geographical origins. This illusory posture is likely to diminish the efficacy of programmes and practices in meeting clients' individual needs, or even harm them. Social workers' handling of Victoria Climbié's case is a crystalline example (Owusu-Bempah, 2003).

## Negating the Other's Self-Definition

The offspring of black and white unions are particularly singled out for pathologizing by helping professionals. The popular belief that identity crises are endemic to children of black and white unions is obviously no more than a racist assumption (Owusu-Bempah, 1994, 2005; Owusu-Bempah and Howitt, 1999). It is the ghost of the 'marginal man' evoked to haunt these children, to justify our unfair treatment of them. The notion of the 'marginal man' holds that they owe their marginal status in a racist society, and its concomitant social, economic and psychological disadvantages, to their inability to integrate their 'racial', ethnic and cultural identities. In modern British society, it is claimed that their psychological salvation lies only in identifying with the so-called black community (Maximé, 1994; Small, 1991). Is this not a reification of the 'one drop rule' (Owusu-Bempah, 2005)?

Systematic activities to deal with this putative psychological disturbance involve, explicitly or implicitly, denying their white side, a process which many of the children find emotionally painful, damaging and undesirable (Tizard and Phoenix, 1993/2002). The underlying assumption is equally paralogistical, as well as bizarre: if it is acceptable for these children to identify with their black side, what is problematic about their identification with their white side? Who should decide which aspects of their heritage should be significant to them, the children or those who want them to see themselves as 'black'? Briefly, which 'racial', ethnic or cultural side of their inheritance they feel comfortable with is largely determined by their own experiences and the subjective meanings of those experiences to them; denial of the 'black' label, or group rejection, is not necessarily symptomatic of a personality disturbance. Numerous empirical studies using a wide variety of procedures over the last several decades support this view (e.g. Cross, 1991; Wilson, 1987). It is an irony that those professionals who try to foreclose these children's identity at the same time claim to subscribe to human diversity, ethnic and cultural diversity.

Allen (1997) argues that identity, like 'race', ethnicity/culture, continues to loom large in the practitioner–ethnic minority client relationship, to the virtual exclusion of structural factors because:

> The [Western] concept of the self as a separate, atomistic, private, autonomous individual has been constituted by specific, complex, social, economic, historical, cultural

> and psychological relations . . . not only is [it] philosophically inadequate, but also serves neo-colonial and imperial goals of domination. (Allen, 1997, p. 9)

Bhavnani (1994) agrees with this view in describing the concept of intelligence as a psychological tool of subjugation, domination and control. In social work, as in other social institutions, 'race'/ethnicity has historically served this purpose. It is now unacceptable to espouse overt racist theories to justify the provision of second-class services to ethnic minority clients. Invoking 'black inferiority' under the guise of ethnicity, culture or identity serves this purpose safely. It does so more expediently and effectively because, as the literature reveals, it has the support and cooperation of ethnic minority professionals, particularly social workers, teachers and therapists.

## Black Culture, Black Perspectives

What social work model is needed to provide appropriate services to diverse populations? One common way of dealing with this is to highlight practitioners' poor knowledge and understanding of the cultures of ethnic minority clients. This offers the expedient solution of establishing units of ethnic minority 'experts' to service ethnic minority communities; black-on-black practice is an obvious example (Owusu-Bempah, 2003). Apart from holding ethnic minority workers responsible for solutions to the structural problems facing ethnic minority clients, it is deskilling. Owing to modern migratory patterns, the population of the United Kingdom (like that of any nation) comprises numerous ethnic and cultural groupings. The excessive demands (implicit in the Children Act) that would be placed on any practitioner wishing to be competent to know something of the cultures of all sectors of society can be illustrated, for example, by briefly examining language – one of the key elements of any culture. Knappert (1995) estimates that over a thousand different languages (discounting dialects) are spoken in Africa alone. No practitioner could be expected to understand even the beliefs and practices relating to health, illness and psychological functioning of so many different cultures. It is, therefore, not surprising that issues of race, culture and ethnicity often cause anxiety both in everyday social exchanges and in the activities of practitioners.

Is cultural or ethnic/colour match a solution to the difficulty? Although a practitioner may be knowledgeable about a particular culture or language, factors such as social class and status differential may also militate against professional effectiveness. The use of ethnic/cultural match does not automatically ensure effective outcomes. We saw the dire consequence of this in Victoria Climbé's case. The practitioners' professional background and training, based on Western values and assumptions, such as those regarding the 'normal' individual or 'healthy' family, may offset any gains from ethnic/colour match (see Owusu-Bempah, 2003). Furthermore, the sharing of ethnicity by professionals and their clients does not always exclude the intrusion of stereotypes. Hall (1997, p. 645) argues that 'not all the perpetrators of cultural errors are white'. Again, this reminds us of the cultural misjudgement by Climbié's key social worker.

Of course, there are training models designed to prepare practitioners for effective work with ethnic minority clients. Characteristically, however, such training has

been dominated by issues of 'race', ethnicity and culture (and 'political correctness'). It must be stressed that this can easily lead to feelings of insecurity amongst practitioners whose sense of a lack of competence in matters of ethnicity and culture can make them feel deskilled; it may also serve as an excuse for professional inertia. This emerged in the Victoria Climbié Inquiry (Laming, 2003). Additionally, training programmes and practices which overemphasize ethnic/cultural issues can be criticized for lacking a clear conceptual framework or for trying to use simplistic and formulaic methods to solve complex structural problems. Cacas (1984, p. 465) called such models and practices 'cultural *generalizations*, when the practitioner assumes that all presenting problems are related to the client's culture/ethnicity rather than to other factors'.

## Conclusion: Closing Gaps

The UN Convention on the Rights of the Child emphasizes that the goal of childcare practice should be to achieve equality for *all* children, whoever, whatever and wherever they may be; that it should aim at closing social, educational and economic gaps; an important goal of childcare practice must be to reduce social inequalities; the removal of discriminations, especially normative discriminations which are covertly institutionalized. Ascribing ethnic minority children and their families' difficulties to their colour, ethnicity, culture or psychological functioning, and dealing with them through psychological means is an admission of institutional racism, of 'racial' inequality in society.

The focus of social services departments has been on describing and explaining ethnic-minority-service-users' 'pathology'. Pollard (1989) has suggested an 'empowering' two-pronged approach to work with ethnic minority children and families, and other disadvantaged families. The approach distinguishes between 'alterable' and 'static' variables. 'Alterable variables' relate to factors in a person or the environment which can be manipulated somehow to enhance their functioning. 'Static variables' represent factors that are not easily changed, but only classify or label people; ethnicity, culture and self-identity are examples. In the case of children in care, for example, the 'alterable variables' approach seeks to:

- identify those children who seem to be thriving in the system and determine what factors are associated with their resilience;
- identify those factors within the system or environment which deleteriously affect, as well as those which enhance, their functioning.

This framework requires a positive attitude towards ethnic minority families, such as identifying, fostering and encouraging their strengths. It is similar to Wakefield's (1996) eco-systems approach to the social work assessment process. Both approaches are different from the problem-family/-client model which pathologizes even their strengths, such as the extended family structure, and adoption/fostering within the community.

While it is unlikely that many practitioners would assume a monocausality to problems in black childhood, for instance, their failure to identify clearly what

distinguishes a racial/ethnic or cultural identity problem from any other causes means that the boundaries are fuzzy and that culture, ethnicity or identity may be blamed unnecessarily. A preoccupation with skin tone, ethnicity/culture is likely to obscure the assessment process resulting in misinterpretations of ethnic minority clients' needs and the provision of inappropriate services to them.

## Five Key Points

1. Assumptions about 'race' culture, ethnicity and identity have a negative impact on service provision for ethnic minorities in British society.
2. British society is a complex web of cultures.
3. Conceptually as well as in practice, 'black culture' is a non-entity.
4. Providing effective services to diverse populations requires cultural competence more than cultural knowledge.
5. Helping professionals face a formidable task in a world in constant flux.

## Three Questions

1. There is no empirical foundation to own-race adoption and fostering policies and practices. Discuss.
2. What is the relationship between 'race', culture, ethnicity and self-identity?
3. An important goal of social work must be to reduce social inequalities. Discuss with reference to ethnic minority clients.

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CHAPTER 1.5

# Families

*Graham Allan*

Since the early days of industrialization, the decline of family life has regularly been lamented. Throughout this time, pleas to 'strengthen the family', to preserve 'family values' and to ensure that the next generation is properly socialized have been ever-present. Such moral and political rhetoric can undoubtedly be influential in shaping legislative action which directly affects the welfare of different families. For example, the state's actions in 'policing' and monitoring the behaviour of families through its various agencies, including social work, health visiting and other services, help to shape the boundaries of what constitutes acceptable family relationships. So too, regulations governing welfare benefits and tax advantages have a noticeable impact on family well-being. Yet claims made about the demise of family life have generally misrepresented the real character of the changes occurring. Not only has historical analysis demonstrated that contemporary family dilemmas – domestic violence, child abuse or family dissolution – are not new, but as importantly, families continue to be seen by those involved as arenas in which personal security and emotional satisfaction can be expected, if not always achieved (Charles, Davies and Harris, 2008).

Confusion often arises within popular discourses because change in family organization is frequently viewed as inherently negative. Romantic visions of the past are glorified, so that almost any change gets defined as damaging. Yet precisely because family relationships are both personally and socially significant, family organization cannot be expected to remain static. Any social institution which is central to the workings of a society is necessarily integrated with other key aspects of economic and social structure. Consequently, that institution must itself alter as these other aspects are modified under new social and economic conditions. In this regard, dominant family forms cannot remain constant and still be institutionally

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significant. They must change to reflect transformations in other spheres of social and economic activity. From a sociological angle, this is the key to understanding family life: family organization is inevitably patterned by the wider social and economic formation, even if ideologically the family is presented as being separate and apart – a cosy private domain located in an increasingly threatening public world.

## Changing Families and Households

In Britain, as elsewhere in the Western world, there have recently been radical changes in the demography of family life (Allan and Crow, 2001; Lewis, 2001; Chambers, 2012). While debate continues about whether these changes reflect a genuine reordering of family relationships – between parents and children, husbands and wives, and wider kin – three areas of change can be identified as particularly significant.

First, as indicated in Table 2, there have been major changes in patterns of coupledom and family formation. Aside from gay couples now being more accepted, the growth in heterosexual cohabitation has been particularly remarkable. According to the data available, until the 1980s cohabitation was quite rare for those who had not previously been married. The typical pattern then was one of youthful marriage following a formal engagement which often involved elements of a sexual relationship but stopped well short of living together. Now, cohabitation has not only become a dominant mode of engagement in that some 80 per cent of couples currently do cohabit prior to marriage, but, as importantly, increasing numbers of couples now cohabit whether or not they are planning to marry. From being a stigmatized form of coupledom, cohabitation has become a normal phase, receiving social approval rather than opprobrium. Moreover as cohabitation has increased,

**Table 2** *Selected family changes in England and Wales 1971–2011.*

| | *1971* | *1991* | *2009–2011* |
|---|---|---|---|
| Number of first marriages | 320,347 | 192,238 | 151,392[a] |
| Women's average age at first marriage | 21.4 | 24.6 | 28.9[a] |
| Number of second marriages | 84,390 | 114,518 | 81,051[a] |
| Rate of divorce per 1000 marriages | 5.9 | 13.5 | 11.1[b] |
| Children under 16 of divorcing parents | 82,304 | 160,684 | 104,364[b] |
| Number of lone-parent families | 570,000[d] | 1,300,000[d] | 1,958,000[c e] |
| % of all births to unmarried mothers[b] | 8.4 | 30.2 | 46.8[b] |
| % of teenage births to unmarried mothers | 26.1 | 82.9 | 95.9[b] |

[a] These figures are for 2009.
[b] These figures are for 2010.
[c] These figures are for 2011.
[d] These figures are for Great Britain.
[e] These figures are for the United Kingdom.
Sources: www.statistics.gov.uk/ (Birth Statistics Series FM1; Marriage, Divorce and Adoption Statistics Series FM2); Office for National Statistics (2011a); Office for National Statistics (2011b); Office for National Statistics (2012a); Office for National Statistics (2012b); Haskey (1998).

it is now becoming evident that there has been a concomitant decline in marriage. This is not just an issue of later marriage but also one of some people choosing not to marry at all. As an illustration of these changes, in the early 1980s only 15 per cent of women then aged between 30 and 34 had ever cohabited before they were 30, while 89 per cent had been married by that age. Between 2004 and 2007, 68 per cent of women aged 30 to 34 had cohabited by 30, while only 53 per cent of these women had married by that age (Beaujouan and Ni Bhrolcháin, 2011).

The second major change, also highlighted in Table 2, has been the growth in levels of partnership separation and divorce. While legislative change has clearly facilitated increased divorce, the root causes go far deeper, reflecting – and in turn encouraging – fundamental shifts in the ways people define a satisfactory and acceptable marriage. Over time, there has been considerable movement in what Cancian (1987) usefully terms 'marital blueprints'. These have developed to emphasize the expectation of intimacy and mutual fulfilment through the quality of the couple relationship itself. A failure in this regard within a relationship is increasingly recognized as grounds for reconsidering its future (Gillies, 2003). Recent projections suggest that some 45 per cent of those marrying this year are likely to divorce (Wilson and Smallwood, 2008). Moreover, each year in England and Wales some 100,000 children under the age of 16 now experience their parents' divorce. In addition of course, cohabitation tends to be less enduring than marriage, so significant numbers of children whose parents cohabit are also experiencing parental separation each year without this being formally recorded in the way it is for divorce. Panico *et al.* (2010), for example, estimate that around 19 per cent of children whose parents were cohabiting at the time of the child's birth experience parental separation before their fifth birthday compared to 9 per cent of children whose parents were married at the time of their birth. Debates continue about how children's interests can be best protected during the process of parental separation and divorce (Butler *et al.*, 2003; Mooney, Oliver and Smith, 2009. Also see Boylan and Allan, Chapter 3.1 in this volume).

Third, there have been major changes in patterns of childbearing. As well as women having children later, there is far less expectation that mothers should be married. As shown in Table 2, in 1971 only 8 per cent of all mothers, and 26 per cent of teenage mothers, were unmarried. By 2010, these figures had risen to 47 per cent and 96 per cent respectively (Office for National Statistics, 2011a). While some two-thirds of unmarried mothers are cohabiting with their child's father at the time of the birth, this is by any standards a mammoth demographic shift in little more than a generation. It reflects the changed social vision about the place of marriage (and divorce) within society and altered images of what individuals, and especially women, should be striving for in constructing their personal lives. Together with increased levels of partnership separation and divorce, it has contributed to major increases in the number of lone-parent families.

Because of these and other associated changes in family patterns – including increased numbers of remarriages, re-partnering and stepfamilies – new approaches to analysing family life have needed to be developed (Lewis, 2001; Smart, 2007; Morgan, 2011). In the past, social science discourses were often based around some notion of 'the normal family'. While the relationships, domestic roles and kinship responsibilities of these 'normal' families were not static, they were nonetheless

characterized by what now seems a curious sense of uniformity. This was best captured by the notion of the family or domestic cycle through which families typically passed: marriage, childbearing; child-rearing; the 'denuded' family once children had left home; and the death of one of the spouses. In the early part of the twenty-first century, such images of 'normal' families have become increasingly problematic. What has emerged is a higher degree of diversity in family patterns and a greater variation in the pathways different families follow. This has repercussions for how 'normal' families are defined (Allan and Crow, 2001; Chambers, 2012).

With increases in cohabitation, in childbirth outside marriage, in divorce and parental separation, and in remarriage and stepfamily formation, there can be no assumed or standard family pathway. Recognizing that these factors can affect people's experiences in both childhood and adulthood, it is evident that over the course of their lives different people follow quite distinct family pathways. So it is reasonable to talk of 'family course' or 'family pathway' but it is not sensible to think in terms of structured, patterned family careers that are common for the majority of people in the way that the notion of 'family cycle' implies. Yet in recognizing this, it is important to be aware that different pathways have implications for the family issues and problems which people face and which influence family decisions. There is no suggestion of randomness in this; family life may not follow a tidy schema, but earlier household and family structures still impact on later experiences.

Because 'the family' appears at nearly all times to be seen as under threat and in need of protection and strengthening, many of the issues which have rightly concerned social workers should be recognized as matters which indicate less a fall in public and private standards and more the emergence of new discourses and practices about the ways family relationships should be ordered (Morgan, 2011). In analysing the emergence of these 'problems', it becomes apparent that demographic change and family organization are only part of the process. What also matters is the interplay of moral, political and professional responses to the difficulties families of different forms face.

Many of the 'family problems' with which social workers have to grapple – child abuse, marital breakdown, domestic violence, family support for elderly people – are discussed elsewhere in this book, so will not be considered here. Instead the focus is on one particular 'issue': the growth of lone-parent families and the development of different understandings of these families. Examining the 'social construction' of lone-parent families illustrates some of the means by which aspects of family life become problematized within public discourses and highlights the dangers of too readily generalizing about the consequences of particular family and household structures.

## Lone-Parent Families

The numbers of lone-parent families have increased substantially – from 0.6 million in 1971 to nearly 2 million in 2011 (Office for National Statistics, 2012a). In 1971 there were approximately one million dependent children in lone-parent families, but by 2010 this had increased to 3.1 million (Beaumont, 2011). It is probable that

these trends will continue for some time. This represents more than a fifth of all households with dependent children living in them, compared to 8 per cent in 1972 (Office for National Statistics, 2012c, Table 3.6). Of course, these figures are 'snapshots': they represent the number of adults and children in lone-parent families at a given time. Others will have experienced living in lone-parent families, but now be independent or part of stepfamilies through cohabitation or (re)marriage.

Just as family life in general has become more diverse, so the experiences of lone-parent families are also varied (Rowlingson and McKay, 2002). Many factors influence the circumstances in which they operate. However the single most common characteristic of such families remains poverty, even though increases in lone-parent employment since 2005 have seen some reduction in the numbers of lone-parent families experiencing high levels of material deprivation (Department for Work and Pensions, 2011). Despite promises to eradicate child poverty by 2020, only a minority of lone-parent families has sufficient resources to manage comfortably. Female-headed lone-parent families, which now comprise 92 per cent of all such families (Office for National Statistics, 2012a), are especially likely to be experiencing financial hardship. Maplethorpe and her colleagues (2010, Table 6.2) report that in 2008, 41 per cent of lone-parent families had less than £300 per week to live on compared to only 10 per cent of couple families (i.e. families consisting of two adults and at least one dependent child). Conversely, 50 per cent of couple families had £600 or more per week to live on; only 4 per cent of lone-parent families had this level of income.

Maplethorpe *et al.* (2010, Table 6.5) also found that when allowance was made for the different family sizes involved, lone-parent families were three times as likely as couple families to be in the poorest 20 per cent of families with dependent children. A key difference lies in the significance of state benefits for lone-parent families: in 2008 42 per cent of lone parents were in receipt of housing benefit and 36 per cent received income support. The equivalent figures for couple families were 6 per cent and 3 per cent respectively (Maplethorpe *et al.*, 2010, Table 7.1). Using the most common definition of poverty – having an income less than 60 per cent of the national household average – the Department for Work and Pensions (2011, Table 4.14ts) estimates that once housing costs are controlled for, 46 per cent of children in lone-parent families were living in poverty in 2010. The equivalent figure for couple families was 24 per cent. In other words, nearly two out of five children in poverty in the United Kingdom lived in lone-parent families. (See also Bradshaw, 2002; Rowlingson and McKay, 2002.)

The reasons for this include the low level of women's earnings, especially for those women with few qualifications; the pattern of mothers in Britain re-entering the labour force in a part-time capacity; and the difficulties of securing adequate child-care provision, despite important policy initiatives since the late 1990s. Thus even though more than half of lone parents are in employment – 55 per cent in 2010 – this employment is often low paid and insecure. Moreover this still leaves 1.4 million children in 2010 living with lone parents who had no employment, the vast majority of whom were dependent on benefits (Department for Work and Pensions, 2011).

Lone-parent families also tend to be disadvantaged in terms of housing. A disproportionate number live in privately or socially rented housing – over 60 per cent

of lone-parent families compared to less than 20 per cent of couple families (Maplethorpe *et al.*, 2010). In turn, only a third live in owner-occupied housing compared to nearly four-fifths of couple families. Similarly, lone-parent families are more likely than couple families to be living in flats rather than houses and consequently to have more limited space as well as fewer household amenities. Furthermore many of those lone-parent families with least resources live in more run-down urban localities with poorer schooling, health care and other services (Rowlingson and McKay, 2005).

Social concern for lone-parent families has a long history, much of it less than progressive. The welfare of children in such families is a recurring theme, but so too is the burden of support which the state bears. In the mid-twentieth century, welfare measures aimed at increasing social participation and citizenship rights, including the development of health, education and income support services, covered lone-parent families just as much as any other family and household forms. However there was at this time a sense in which lone-parent families were seen as pathological and in need of extra support. A metaphorical red light flashed in the minds of social welfare professionals in their dealings with lone-parent families, warning them that special provision might be necessary.

As the number of lone-parent families increased, this potentially stigmatizing professional benevolence became less marked. The red light no longer flashed, certainly not as brightly. Instead there was greater acceptance of the 'normality' of lone-parent families and a recognition that many of their problems were caused by poverty rather than family disorganization or personality disorders. Yet concern with reducing state expenditure since the 1980s has led to the 'problem' of lone-parent families being redefined. The high dependence of lone mothers on state benefits and state housing, the increasing numbers of divorces and births to single mothers, and the apparent failure of non-married fathers to accept financial responsibility for their children resulted in the state seeking ways to limit its commitments. Policies have been developed, especially since the late 1990s, to encourage more lone mothers to find employment and greater pressure has been placed on non-residential parents – predominantly fathers – to make adequate financial contributions to their children's needs. In 2008, the Child Maintenance and Enforcement Commission was created to promote and enforce non-residential parents' financial responsibilities (http://www.childmaintenance.org/index.htm).

By the end of the twentieth century, continuing concerns over social exclusion and inadequate socialization had 'politicized' lone-parent family issues further. Notions like 'cycles of deprivation', 'cultures of poverty' and 'underclass' captured popular concerns about the interplay between individual pathology and social divisions. Although the underclass was not restricted to lone-parent families, some, in particular young unmarried mothers and those who had been dependent on state support long-term, were certainly seen as core to it. The use of such concepts in popular and political discourse highlighted the idea that children lacking the benefits of a 'normal' family environment come to be socialized into dysfunctional patterns of behaviour and hold sub-cultural values at odds with those of the mainstream. These discrepant values and behavioural patterns, instilled into the next generation and thereby supposedly perpetuating undesirable behaviour, are then seen as a principal cause of poverty. While such views – not least the idea of lone mothers

rejecting values associated with the material and other benefits of coupledom – have been heavily criticized in academic research, the main issue concerns the ways in which public visions of particular family forms and particular family problems are modified within a changing socio-political climate.

During the first years of the twenty-first century New Labour's emphasis on 'social exclusion' focused more on structural issues and rather less on personalized social disadvantage. Moreover, with the continuing demographic changes occurring in family life, lone-parent families came to be accepted culturally more as a *variant* rather than *deviant* family form. Yet a tension nonetheless remains, especially with regard to those lone-parent families headed by young mothers with fewest resources. These mothers are often still portrayed as feckless and irresponsible, and as playing a 'welfare state' game for the housing and other material benefits they can accrue. Yet it is evident that these families experience significant hardship, constantly struggling to manage on inadequate resources. This has clear consequences for the well-being of both the women and children involved. Not only are they effectively excluded from many of the activities defined as socially normative, they are also disadvantaged in a range of other ways which exacerbate their more immediate problems of coping with economic deprivation. For example, the correlation between poverty and poor health is firmly established, as is the link between educational underachievement and deprived material background. It is not surprising then that some of these families are likely to be defined as 'problem families' and to require disproportionate amounts of support from health and welfare agencies.

## Conclusion

As the social and economic basis of society alters so too does the structure and organization of domestic and reproductive relations. With the normative loosening of the relationship between sex, marriage and childbearing, the complexity of family relationships has undoubtedly increased. This in turn is reflected in popular imagery and language about family patterns. New ideas evolve about what is appropriate for families and what is problematic. However, not all the new complexities of family life attract the same public concern. While some lone-parent families have continued to be problematized, other family matters which generate equal levels of personal concern and potentially have an impact on children's development are left largely outside public action.

Consider particularly the increasing number of stepfamilies (Allan, Crow and Hawker, 2011). Research has pointed to the complex dynamics inherent in these families. Certainly for children the advent of a new 'parent' can raise all manner of emotional tensions, resentment and ambiguity. To develop successfully, these relationships require considerable investment and understanding. Yet the state apparently regards the formation of stepfamilies as unproblematic, if anything viewing them as 'solutions' to the problems of parental separation and lone-parenthood. Thus there are relatively few official services provided for people entering stepfamilies, even at the level of protecting the interests of children. These families are defined as 'normal' and as quite capable of meeting their own needs without additional support. In many respects the 'problem families' continue to be defined as

those in poverty who rely on state welfare benefits and public housing. Caught in a vortex of material disadvantage, there is an ever-present tendency to redefine their problems in terms of their own personal inadequacies, despite all that is known about the difficulties of sustaining family well-being with inadequate resources.

## Five Key Points

1. In recent years the diversity of family life has increased.
2. There have been radical shifts in patterns of family formation and dissolution.
3. Changes in family and domestic relationships need to be understood in the context of other social and economic changes.
4. Poverty continues to be a common experience for the increasing numbers of lone-parent families there are.
5. Economic and political factors influence the processes through which 'families with problems' become defined as 'problem families'.

## Three Questions

1. How can the processes of parental separation and stepfamily formation be best managed from the viewpoint of children?
2. What role does state action, including the activities of social welfare professionals, play in shaping domestic life?
3. What impact has the decline of marriage and other related demographic changes had on social work practice?

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CHAPTER 1.6

# Sexuality, Sexual Relationships and Social Work

*Siobhan Canavan and Seamus Prior*

Sexuality issues in social work practice are legion. We may quickly identify a wide range of areas of social work practice where sexuality issues arise:

- The loss of intimacy for an older person who loses a partner either because of bereavement or admission to residential care;
- The sexuality of vulnerable adults living in the community;
- The sexual abuse of vulnerable adults in residential settings;
- Experiencing disabled sexuality and implications for social work practice;
- Sexual behaviour between children and young people;
- Disinhibited sexual behaviour in some people with dementia;
- The sexuality of social workers and the impact of this on their practice;
- The exposure of children to parental sexual behaviour;
- The sexual abuse of children by trusted adults, including care workers;
- Experiences in the assessment of gay and lesbian prospective foster and adoptive parents;
- The housing of sex offenders in local communities;
- The placing of adults in mixed sex wards or care establishments at a time of psychological or physical vulnerability.

Sexuality presents one of the most complex and emotive areas in which social work professionals are required to make assessments and decisions. The general proliferation of sexual expressiveness in the media has not necessarily been matched by an increased capacity of individuals to reflect on and discuss sexual thoughts, feelings and behaviours. Although issues relating to sexuality are rarely the main reason for people coming into contact with social work agencies, they are often inherent and

*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

implicit in direct practice with service users. Thinking about sexuality and sexual relationships cuts across a number of themes – identity, ethnicity, age, body ability, faith beliefs, family care and relationships, difference and diversity, power, abuse and harm. Additionally, whilst we would contend that sexuality is not a specialist area of social work practice, sexuality issues can evoke taboos and provoke anxiety for social workers, especially in training. Service users require of their social workers the facility to engage in the contemplation and discussion of sexual issues both to support and promote a service user's healthy sexual development and to protect them and others from harm. Service users may look to their social workers to initiate conversations on sexuality, and workers need to develop the skills to engage in these issues without embarrassment, intrusiveness or causing unnecessary anxiety. There are four main areas in which social workers need to be aware of issues relating to sexuality and sexual relationships: firstly, they have a role in supporting service users in their sexual choices and preferences; secondly, they have a statutory role in protecting vulnerable people from sexual exploitation; thirdly, they need to be aware of not making assumptions regarding sexuality or sexual activity; and fourthly, they are required to demonstrate cultural sensitivity in this terrain.

Recent years have seen the construction of a more comprehensive body of knowledge on topics relating to sexuality and related aspects of social work practice. This may be a combined consequence of better training, the establishment of training requirements and national standards for social work training and practice, publicity relating to sexual exploitation and a more open society in which matters relating to sexuality are more widely debated. A worker's own sexuality is also significant, as is the organizational context in which social work practice is carried out and the changing sociocultural norms in relation to sexuality in which social workers and clients live. With a professional commitment to practice which addresses issues of power, difference and diversity and the requirement for a sound knowledge base for practice, the imperative for an individual worker to work effectively with issues relating to sexuality is considerable. Here, we offer an overview of some themes which might be considered when thinking about sexuality and social work practice, starting with a consideration of the complexities of defining and problematizing the issue of sexuality.

We would draw readers' attention to two significant books which explore and problematize sexuality, sexual identities and sexual relationships in social work from the perspectives of social work clients, practitioners and researchers. Bywater and Jones (2007) take a comprehensive and more traditional approach to the topics, exploring definitions and the heterosexual norm before proceeding to examine themes relating to social work and sexuality as it relates to young people, older people, disabled people, sexual violence and best practice in all of these areas. Each chapter of the book provides a research overview, theoretical framing and a series of activities for students to engage in their own learning and in class in relations to the themes of the book.

Dunk-West and Hafford-Letchfield (2011) take a critical social science perspective, arguing for reflexive methodologies and attention to wider organizational and policy arenas in contributions which cut across the themes presented in Bywater and Jones (2007). Research and critical reflection encourage readers to engage with different forms of knowledge, drawing on practice wisdom, research, personal

accounts and more conventional theoretical work in a stimulating way. Taken together, these two books offer social workers and social work students a comprehensive and challenging body of work on which to think about contemporary social work practice in relation to sexualities, sexual identities and sexual relationships.

## Defining the Territory

Sexuality is a significant part of our lives although we may want to debate the usefulness of assuming that there is a common set of ideas about sexuality when the concept is so differently expressed between cultures, from one person to another and at various points in history and in a person's life course. Dunk-West and Hafford-Letchfield (2011) emphasize the need for complex and nuanced understandings of sexuality and sexual identity and the disruption of dominant discourses to inform effective social work practice. They present the nature of intimacy and emotions, and the construction of identities and sexualities, as key areas for reflection and debate. The emergence of social movements concerned with sex and sexuality – the feminist, disability rights and gay movements in particular – have challenged ideas about sexual preference, identity and choice. Feminism as an area of academic study has exposed multiple forms of domination of women in the sexual arena, including sexual violence and harassment, the language of sexual denigration and abuse. Queer theory has developed thinking about the fluidity and expression of sexual identities and the problematizing of heterosexuality, and disability studies has opened up important debates relating to sexual expression, sexual choice and responsibility. A literature on sexuality and social work in the lives of older people is now emerging and in all of these arenas the narrative voice of service users and social workers themselves has a place which informs and challenges social work theory and practice. It has also posed questions about rights, responsibilities, sexual desire and pleasure. In all of this we are challenged to rethink the nature of our understanding about sexuality and the interconnectedness of influences and forces that shape emotions, needs, desires and relationships.

Irrespective of their sexual orientation, young people in their teenage years have common issues relating to being in relationships, making informed or uninformed choices about whether to become sexually active or not, and practising safer sex. Many young people feel coerced into sexual activity because of peer pressure and they need support if they make choices which are different from their peers. Others may go through a process of questioning their sexual orientation. For example, young people who have difficulty in acknowledging a sexual orientation other than straight may have behavioural problems which lead to them coming into contact with social work or coming into care. If the young person has experienced same-sex feelings or relationships they will need sensitive work and support. They may experience victimization by other children, compounding an already fragile sexual identity. If staff have not looked at the issue in training, they may believe that there is something wrong with being lesbian, gay or bisexual and pathologize the young person rather than offer them appropriate support. If a young person identifies as gay or lesbian, for example, they may need support if faced with family disapproval or rejection. They may also need help in developing a social network.

There are four different, but related themes which are helpful in locating sexuality and its relationship to sex and gender. First, there is its biological and physical base. It includes sexual arousal, the act of having sex, responding to sexual stimuli and fantasy and relating to other people. As such, the sexual response is physiological, located in the body's reactions. Secondly, there is the question of the function of sexual activity in any relationship, whether it is a casual encounter, a long-term partnership, consensual or not. Not only can it be a way of expressing intimacy, love and affection, it can also be used as a way of exerting power or inflicting pain. This takes us into the arena of sexual abuse and exploitation. Thirdly, there is the question of the way in which feelings are managed in sexual relationships. A knowledge of psychology and human relationships can help here, as can the knowledge about the effect of childhood experiences on adult sexual behaviour. Fourthly, there is a need for an understanding of the relationship between sexuality, power and gender.

## Self-Awareness, Sexuality and Gender

The confidence and competence with which social workers are able to address issues of sexuality are largely dependent on the extent to which they have worked on their own issues around sex, sexuality and sexual relationships. It is essential that they have an understanding of their own sexuality, no matter how confused or unsettled this feels. This means recognizing the extent to which their sexuality has been affected by their history and the personal significance of gender, class, faith beliefs, age, body ability and ethnicity. Understanding ourselves is vital to the process of understanding others and in the area of sexuality this has particular significance when social workers are called on by their clients to respond to a range of issues including sexual preference, sex education, sexual exploitation, sexual violence, sexual health and choosing whether or not to be sexually active. Dunk-West and Hafford-Letchfield (2011) offer deeply personal client and practitioner accounts of troubled and troublesome sexuality and sexual identities.

Sexuality issues cannot be understood or appreciated without reference to gender and power. The increasing public awareness of child sexual abuse perpetrated by male care workers, for example, may have had some effect in inhibiting male social workers from addressing sexual issues which arise in their practice. Men may be concerned that raising sexual matters with managers or colleagues will be judged inappropriate or indicative of a sexual motive on their part. In direct work with service users, men are rightly cautious that references to sexuality may be misinterpreted by service users, especially those with a history of sexual abuse. Anxiety in relation to sexuality may leave male workers feeling professionally deskilled and personally vulnerable, especially when their work involves providing intimate personal care. At the same time there is an unquestioned assumption that women are comfortable with providing personal care for men. A failure to grapple with, and find a way through, this discomfort and anxiety may result in traditional gender roles being reinforced, leaving women with the burden of personal care and the responsibility for addressing issues relating to sexuality or the body, further perpetuating the anxiety that men are not to be trusted in these areas.

Workers need to be clear about how their personal value base in relation to sexual issues may converge with or diverge from ethical and responsible practice. For example, when it comes to light that a 15-year-old boy in care is accessing Internet pornography, the worker's own attitude to pornography may affect what is regarded as an appropriate professional response. A male social worker who uses pornography unquestioningly in his private life may minimize the potential harm of this activity to the young person, advocating for the young man's rights to privacy, autonomy and freedom of expression, based on an unarticulated assumption that pornography is both ubiquitous and a normal part of male adolescent sexual development. This worker may not be able to undertake the assessment required in this situation to gauge the nature, content, frequency and circumstances of the young person's use of pornography and its consequential impact on his thinking, feelings, attitudes and behaviour.

Social workers with strong faith beliefs which condemn homosexuality need to address how they can promote the healthy sexual development of their lesbian, gay, bisexual or transgender (LGBT) service users. From another perspective, social workers who are personally very committed to LGBT equality issues need to be cautious that they do not inadvertently encourage service users who are questioning their sexual orientation to 'come out' when they are not ready to do so, when they may be exploring the possibility of same-sex attraction rather than identifying themselves as LGBT.

## Social Work, Sexuality and Vulnerable Adults

Whilst vulnerable adults with learning disabilities were previously cared for in institutions, with sexual behaviour prohibited, prevented or minimized through punishment and supervision, or covered up in an organizational culture of denial and silence, community care has now brought the sexuality of vulnerable adults into the public and professional spotlight. Social workers still face ethical and moral dilemmas in balancing an adult's right to freedom of sexual expression with their responsibility to protect vulnerable people from exploitation. These dilemmas are highlighted in the situation of a sexually active adult woman with a learning disability living in the community. While she may be content in what she regards as a fulfilling and consensual relationship, others may see her as being ruthlessly exploited for the sexual gratification of another. If this is a heterosexual relationship, there is the further complication of potential pregnancy, raising issues of the service user's right to parenthood, their parenting capacity and the protection of a child born into such a situation. These circumstances have led some social work departments to seek permission through the courts for sexually active women with learning disabilities to be forcibly sterilized. The rationale offered in defence of these actions is that it offers protection to the women from the trauma of pregnancy and the responsibilities of child-rearing and that it is an effective form of contraception. So here the granting of rights in two areas – integration into the community and the right to have intimate relationships – is paid for by the denial of rights to reproduce and to parent.

## Sexuality and Young People

One of the most sensitive areas for children and family social workers is the assessment of sexual behaviour between children. Research has shown that children and young people are as likely to be abused by other young people as by adults, calling into question the common assumption that sexual behaviour among young people may be regarded as playful or developmentally appropriate, a normal part of growing up (Cawson *et al.*, 2000). Social workers need to be able to distinguish between sexual behaviour which is mutually consenting, exploratory and age-appropriate and that which is coercive, exploitative and abusive. Key to such assessment is the capacity to discuss sexual behaviour and feelings with children, young people, their parents and carers, and to evaluate the subjective meanings which young people attribute to sexual incidents in which they are involved. Assessment and intervention need to balance the rights of the young person to privacy and freedom of sexual expression and the responsibility invested in social workers to protect children from harm. Young people also need to learn to be responsible in their sexual behaviour and to know that they have the right to choose not to be sexually active, when peer and media pressure make this difficult.

Sexual development in adolescence represents a significant period of transition in the family life cycle and for some families, who have been affected by sexual trauma or other sexuality-related issues, a young person's developing sexual expressiveness may be a source of significant anxiety for parents or carers. In our research on the impact of sexual abuse on the experience of parenting among female sexual abuse survivors (Canavan and Prior, 2012), we found that mothers were profoundly concerned with safeguarding their children and this could lead to significant tensions and conflicts as their children reached adolescence, with the root cause of the concern, the parent's own experience of sexual victimization, often undisclosed.

The complexity of this area of young people's sexuality is seen in the provision of residential care where young women who may be accommodated on account of their vulnerability to sexual exploitation are placed in settings with young men who may pose a significant risk to them. A natural tendency to regard young people in the care system as casualties of troubled family histories may result in professional reluctance to make a realistic assessment of the risks that they might pose to other vulnerable young people. Workers may be torn between the desire to protect young people from the further stigmatization that the label 'a potential risk to others' might impose and their duty to ensure that others are adequately protected. This dilemma, reflected in the ongoing care versus control debate, may be acute in relation to young people with learning disabilities who exhibit concerning sexual behaviours.

Social workers seeking care placements for children have to make careful judgements in relation to how much information about a young person is passed on to other professionals. They need to balance the young person's right to privacy in relation to sexual behaviour or abuse and the placement family's or residential unit's right to be fully informed of potential care needs and risks. These decisions are often made in the context of placement scarcity and the reluctance carers may have to accommodate children and young people with a history of sexual behaviour or abuse. The anxiety which is provoked in adults by children's sexuality is often

managed through silence and denial. Social workers, practising within a legal framework, need to be able to contemplate and discuss young people's sexual thoughts, feelings and behaviours, while teams and managers need to provide an environment where these taboo-laden subjects may be aired in order that appropriate assessments and decisions are made.

## Sexuality and Older People

Despite a significant increase in the elder population, and its heterogeneity, there is still a reluctance to consider older people as sexual beings, with specific sexual and intimacy needs. Here again definitions about what constitutes 'older' and how to take account of the range of elder voices are important determinants in how social work with older people is practised. The idea that sexuality is incompatible with and antithetical to older age persists, reinforced by two dominant discourses – asexuality in older life and 'the sexy oldie' (Jones, 2011). Themes of silence and invisibility have, until recently, dominated the literature on sexuality in older life and more recent literature quantifies (hetero-) sexual activity and commonly views issues of sexuality through a narrow, medicalized lens. Jones argues passionately for a research base in which the voices of older people are given parity of esteem with assessment pro formas and quantitative data collection, so that their needs and wishes can be articulated and monitored in a more humane and respectful way.

An additional assumption, that a transition into older age signals physical frailty, psychological vulnerability, loneliness and poverty does not necessarily mean that a person cannot express themselves sexually. Health issues may be linked to an increase in dependency, frailty and disability – issues which might be seen as incompatible with the sexualized ideal of youth, fitness and beauty. The importance of the person's adjustment to increased dependency, for example, will impact on their identity as a sexual being and the opportunities that they have for the expression of their sexuality. Bywater and Jones (2007) have identified needs which are relevant to older people in relation to their sexuality:

- the need to hold an inclusive view of sexuality in older people which is not measured within a 'norm' of heterosexual intercourse
- the importance of accurate information on changes relating to sexuality in the ageing process
- awareness in social workers of life events which might impact on sexual health issues such as the onset of physical illness, death of a partner, and the effects of medication on sexual desire and feelings.

Older people who come into residential care may have partners who are still living in the couple's home. In this situation both people are facing significant losses, which need to be taken on board as one person is admitted to care. The loss in separation, physical ability, independence, company, social networks and privacy are all present and can have implications for the way in which both people in the couple manage the transition. Residential care and nursing homes have few facilities for couples and even less for lesbian and gay couples, whether the relationship is part of a

person's life already or has developed within the care home. Admission to residential care also poses challenges for privacy in relation to personal care, the meeting of intimate sexual needs and control of private space. The personal and professional attitudes of care staff in relation to older people as sexual beings who are of a different generation with its own social mores further complicates this dynamic.

Working with people with dementia poses challenges as some people may begin to display sexually disinhibited behaviour in the community or towards staff and other residents in care settings. Not only does this cause distress in the living environment but also family members and friends will need support in witnessing these unexpected and often shocking interactions.

## Social Work with Sex Offenders

Social work with alleged and convicted sex offenders is a particularly challenging area of practice in which practitioners need to be highly aware of their motivations and the potential impact of the work on themselves. The persistent topicality of sex-offender-focused stories in the media, epitomized by 'naming and shaming' campaigns, highlights the extent to which the sex offender has become the predominant 'other' in the public mind. People quickly take up polarized positions in relation to the risks offenders may pose: for some, offenders should be given the benefit of the doubt, regarded as humans who had lapsed and should be forgiven, or are even seen as the victims of malicious false accusers; for others, all offenders pose ongoing extreme risks such that their rights and freedoms should be significantly curtailed. Social workers are required to work on a daily basis with the risks inherent in the assessment, care and rehabilitation of sex offenders. They have to relate in a meaningful and helpful way to a person who is entitled to respect and consideration, yet who has also committed (or allegedly committed) deeply disturbing acts against vulnerable others and may continue to be dangerous in this respect. Managing the anxieties associated with the risks, uncertainties and dual responsibilities in this situation, without resort to stereotyping, punitive thinking or emotional dissociation, is no mean feat.

## Sexuality in Social Work Training and Organizations

Within the social work training context, the learning environment needs to address both process and content – not only what is taught about sexuality, but how it is taught. Aymer and Patni (2011) give examples of challenges in this terrain. They explore the increasing visibilities of sexual identity and other difference in social work training and how to challenge oppression within an already oppressed or marginalized group. They examine the role of practice placements in offering a supportively challenging learning environment to follow through these issues in practice, especially for students who assert that the worker's personal issues can be held completely separate from their professional practice. The creation of a safe, boundaried yet challenging learning environment is crucial, so that both tutors and students can develop their self-awareness on this topic of significance for personal

identity and professional practice. Decisions which tutors and students make about how open they are about their sexual orientation, for example, raise important questions. Assumptions of heterosexuality are pervasive, as are assumptions of two-person sexual relationships as the ideal norm. To be open about one's difference, whether in relation to a minoritized sexual identity or an alternative sexual lifestyle choice, is both a personal decision and a political act. Some would argue that not to identify one's difference is colluding with the oppression which is being challenged through anti-oppressive practice. A counter-argument is that uncertainty caused by not revealing sexual preference, lifestyle or identity might be more effective in challenging expectations and assumptions.

Since December 2003 an individual is now protected from discrimination on the grounds of their sexual orientation under the Employment Equality (Sexual Orientation) Regulations 2003. Previous equality acts did not address this type of discrimination specifically. In recent years, as it has become more acceptable for LGBT social workers to be open about their sexual orientation in the workplace, an unspoken assumption has emerged in some teams that LGBT staff are more confident in dealing with sexual issues because of their personal development in coming to terms with their own sexuality. An unequal division of labour may occur where the service users for whom sexuality issues are more prominent are allocated to the lesbian and gay social workers who are seen to be, and may see themselves as, more comfortable dealing with sexual issues. The potential for ghettoization, discrimination and reinforcement of stereotypes is evident.

A healthy social work team in a practice setting or in the academic context is one where gender and sexuality issues can be addressed, not only in relation to the service users, but also in relation to the dynamics of the team itself, providing opportunities to address the unspoken assumptions and possible taboos which may underlie the team's day-to-day operation.

## Conclusion

Although not explicit in the professional standards and codes of practice, social workers have a personal and professional responsibility to work on their own issues around sex, sexual relationships and sexuality, if they are to practise in a responsible and ethical way. This demands a high level of self-awareness, being comfortable with the language of sexual expression and being able to talk explicitly about sex. This will inevitably mean that long-held views may be challenged but, equally importantly, it means that the social worker will be more open to others who are struggling to express doubt, distress and anxiety in relation to sexual matters. None of this is easy. It is likely to be fraught and messy at times. It will, however, go a long way towards ensuring that social work clients and social workers themselves are understood and supported in matters relating to their sexuality and sexual relationships.

## Five Key Points

1. Training on issues relating to sex, sexuality and sexual relationships is crucial for ethical and inclusive social work practice.
2. Social workers need to be able to consider sexuality, sexual identity and sexual relationship issues in different contexts and throughout the life course.
3. Sexuality and social work offer an important arena for discussion and exploration of issues of difference, diversity and power.
4. Sexually abusive behaviour occurs in a myriad of ways in social work organizations.
5. Social workers need to work through their personal issues in relation to sexual identity, behaviour and lifestyle to work effectively with others in these areas.

## Three Questions

1. What personal work are you aware you need to do in the area of sex, sexuality and sexual relationships throughout the life course in order to enable you to practise more effectively?
2. What are the main challenges you face in becoming a social worker who is competent to practise in the terrain of sex and sexuality?
3. What professional boundaries in relation to sexuality have you encountered in your practice? How have these been addressed by you and by the organization in which your work took place?

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# CHAPTER 1.7

# Psychology and Social Work

*Brigid Daniel*

Psychology is often defined as 'the scientific study of behaviour'. It is essentially a discipline or field of study that uses scientific methods to develop a body of knowledge about human behaviour. This knowledge is then applied by clinical, educational and occupational psychologists.

The spread of sub-disciplines and theoretical strands can be bewildering but what does characterize psychology is the emphasis upon an empirical approach that involves systematic, scientific and objective observations. Such observations may be obtained in many different ways that can be broadly classified into three types:

- Non-experimental methods that obtain correlational data to help find patterns of behaviour and include, for example, interviews, surveys and case studies.
- Experimental methods that look for causes of behaviour by varying one or more independent variable.
- Quasi-experimental methods that also explore causation by measuring variables that cannot be directly manipulated, for example by comparing younger and older people's memory skills.

Whatever the method, psychology aims to be rigorous. In this respect it has much to offer the current social work endeavour to move towards evidence-based practice.

Social workers are people who work with people. At the very heart of their work lies the ability to use interpersonal skills, based upon their knowledge of human functioning, to help, support, protect and empower people in distress. Therefore, psychology is fundamental, both as a tool for practice and for understanding the dynamics of practice. Consider the following:

*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

> A social worker visits a household after an anonymous referral alleging that the mother of the children is a drug addict and that the children are neglected. At the house three generations of the family are encountered: two children who appear undernourished, to have very limited language skills and to be out of parental control; the father, who is known to have a criminal record for violent behaviour, who looks deeply unhappy and says nothing; the mother who speaks to the social worker, but whose speech is very slurred; the father's mother who is very unkempt and appears confused.

From the first contact a number of questions might go through the social worker's mind:

- Are the children developmentally delayed?
- Has the mother a problem with drugs?
- Is the father depressed?
- Is the father's mother showing signs of senile dementia?
- What is the motivation of the anonymous caller?

Psychology can offer information about each of these issues. The broad academic subdivisions that offer most to social work include developmental psychology, social psychology and abnormal psychology. Most social workers will be uncomfortable with the term 'abnormal' psychology and may prefer to use the operational term 'clinical' psychology.

A different set of questions relate to the areas that would be most useful for the social worker to explore when making the assessment and deciding how to intervene:

- Is the mother physiologically addicted to drugs?
- Are there ways in which the parental environment maintains the children's difficult behaviour?
- Is the father's depression related to negative thoughts and beliefs?
- Could the mother's own childhood have affected her current behaviour?
- Would it be helpful to allow the grandmother space to describe her views about her situation?

Psychology has developed five main theoretical approaches to the study of behaviour: biological, behaviourist, cognitive, psychodynamic and humanist. All five of these theoretical approaches have influenced social work and all are associated with particular methods of intervention. The sub-disciplines already described have all, to a greater or lesser degree, been approached from each of these five theoretical directions. It is this complex interweaving of broad areas of study and different approaches to study that can make psychology a rather bewildering discipline from which to garner clear messages for practice. The situation is further complicated by the fact that a different theoretical approach can be used to guide intervention than was used to understand the reason for the problem.

A final set of questions is:

- What impact will the social worker's first impressions have upon future decisions and actions?

- Do the parents have any particular stereotype of, or prejudice against, social workers?
- How will the social worker and other professionals interact at any subsequent meetings?

Social psychology can help provide insight into these questions that relate to the underlying factors impinging upon the process of social work.

In summary, therefore, psychology underpins social work in three main ways:

1. It provides a wealth of information about human functioning, including development across the lifespan, social interactions and psychopathology.
2. It offers a number of theoretical strands that can be used both to guide assessment and to plan intervention.
3. It illuminates the kind of common psychological errors that can impinge upon, and undermine, effective practice.

## The Biological Approach

The biological approach is based upon materialism, that is, the view that the mind and body cannot be split. The assumption is that all behaviour has a physiological basis and that the key to understanding human behaviour lies in studying human biology. Physiological psychologists study all aspects of human biology, but the primary focus has been upon the study of the central nervous system and related systems.

Different areas of the brain that relate to particular functions have been mapped. The effects of head injuries that damage specific areas of the brain provide further evidence of the links between brain activity and behaviour. The effects of different drugs on mood and behaviour help with the understanding of chemical processes in the brain. It may seem that such information is relevant only to the medical profession, but for example, it can help the social worker in the above scenario to know that the grandparent's confusion may have a physiological basis so that appropriate referral for further assessment can be made. Similarly, an understanding of the physiological effects of addiction to and withdrawal from drugs can guide the provision of appropriate support.

The effects of the mind on the body can be illustrated by the work on the physiological impact of stressful life events. There is a significant link between the number of life events a person experiences and the likelihood of developing some form of physical illness. The current view is that a range of social and environmental factors impact upon the body's immune functions in a way that increases vulnerability to illness.

People with a history of childhood abuse have a higher risk of developing post-traumatic stress disorder in response to trauma in adulthood, perhaps due to the physiological effects of childhood trauma. Social workers are not in a position to diagnose or treat physiological effects but the knowledge that these processes occur can help the planning of prompt intervention to reduce trauma in childhood and in the recognition of the potential need for support for adult survivors of childhood

trauma. The social worker in the case scenario can be helped by the knowledge that severe childhood neglect can lead to developmental abnormalities in the neuronal pathways in the brain.

Much clinical psychology is underpinned by advances in drug treatments for mental disorders such as depression and schizophrenia. The efficacy of such drug treatments attests to the biological underpinnings of some mental disorders although the details of the physiological aspects are not fully understood.

The 'nature–nurture' debate about the relative impact of inherited characteristics and of environmental influences has a long history. A range of methods have been used to study genetic influences including twin studies that allow comparisons of variations in characteristics between identical and non-identical twins; and the comparison of characteristics between twins reared together and reared apart.

This area of study has been associated with vigorous and, at times, acrimonious debate because of the ways that genetic arguments have been (and, in some cases, continue to be) used to justify classist, sexist and racist views. There is now a general consensus amongst psychologists with the interactionist view that both genetic and environmental factors affect behaviour.

The notion that behaviour such as criminal behaviour has a genetic component is a highly influential one. Eysenck (1977), for example, believed that much of personality is due to variations along two innate personality dimensions, neuroticism and extraversion, and that people who score highly on both are most likely to become involved in criminal activity because they are impulsive and do not respond well to reward and punishment. The belief that criminal behaviour has a strong genetic component leads to the view that the best response is containment but it is a theoretical approach that is not drawn upon heavily within criminal justice social work.

## The Behaviourist Approach

The behaviourist approach is based upon the assumption that behaviour is learnt and shaped as a result of environmental circumstances. This approach attempts to explain behaviour by studying observable responses rather than by looking for internal processes. Those practitioners who work from behaviourist beliefs apply the principles of learning when trying to change behaviour patterns. Two main strands of empirical work have contributed to the current state of knowledge about learning. One springs from Pavlov's work on classical conditioning and the other from Skinner's work on operant conditioning.

Pavlov's ground-breaking work began in the early 1900s. He was initially studying digestive processes in dogs and showed that salivation was a reflex response to the arrival of food. He then tried ringing a bell every time the food was presented. In subsequent tests the dog would salivate at the sound of the bell, without the presence of food. In behavioural terms, the dog normally shows an unconditioned response (salivation) to an unconditioned stimulus (food), in the presence of a neutral stimulus. Subsequently, after the process of classical conditioning the dog shows a conditioned response (salivation) to the conditioned stimulus (bell ringing). From this very simple paradigm have sprung a myriad of variations and an explanation for the development of phobias. Wolpe (1973) developed a treatment for

phobias that is still widely used. Based on the fact that two reflexes cannot coexist, systematic desensitization aims to replace the fear reflex (conditioned response) to the feared object with a relaxation reflex.

Operant conditioning describes the way in which voluntary behaviour (as opposed to reflex behaviour) changes as a result of environmental consequences. On the basis of his experiments on cats Skinner (1958) proposed that the probability of a voluntary response increasing depends upon it being reinforced by some type of reinforcer. This is now known as the ABC approach, in which Antecedents cue the start of Behaviour that has a Consequence that reinforces it. Skinner believed that all behaviour could be understood by looking in detail at the contingency of reinforcement, that is, the way in which behaviour depends on the reinforcer. The system of reinforcers is quite complex and is frequently misunderstood or simplified. The simplest types are a reward to increase behaviour (positive reinforcer) or a punishment to decrease behaviour (negative reinforcer).

Operant conditioning techniques have been applied in many ways in social work. Behaviour that appears bizarre can often be understood when a careful analysis of the consequences is carried out. For example, the children in the scenario may be receiving positive reinforcement for demanding behaviour in the form of additional attention from the parents. The most effective intervention is not to remove attention, but to increase the amount of attention during times when behaviour is more desirable.

## The Cognitive Approach

The cognitive approach seeks to describe the processes that mediate between external stimuli and behaviour. It grew from a sense that behaviourism could not fully explain phenomena such as insight. It is a disparate theoretical approach that includes the study of memory, perception, language, problem-solving, social cognitions and so on.

The study of memory has distinguished between the processes of recognition of previously seen information and recall of previously stored information. Memory is currently understood to consist of three stages, sensory memory, that is an initial buffer; short-term memory, which only has a short retention span; and long-term memory. Such concepts are used in clinical psychology to help identify the type of memory loss in brain damage or dementia. Such knowledge will also be helpful for the social worker planning care for a client with memory problems.

Memory recall occurs by a combination of retrieval and reconstruction. The study of such processes and the ways that context and suggestion can affect them are useful for social workers. For example, there is a considerable body of work on the reliability of child witness testimony that is crucial for child abuse cases. Such evidence suggests that in some circumstances children's memories may be better than adults' for information that is very familiar or distinctive to them. Younger children tend to provide less detail and less information about events, but as they get older their accounts become similar to adult levels of free-recall. Children rarely report something that has not happened but younger, especially pre-school children, can be more susceptible to suggestion.

It is suggested by cognitive theorists that language development is based on an innate language acquisition device (Chomsky, 1972). The study of language development shows children actively working out the rules of grammar. Clinical and educational psychologists are skilled in assessing language skills; however, it would be helpful for the social worker in the scenario to have an overview of the stages of language development.

One of the most well-known cognitive theories in developmental psychology is Piaget's stage theory of cognitive development. He proposed that two processes drive development with the aim of achieving equilibrium between the world and mental representations. These are assimilation, by which new information is integrated, and accommodation, where existing representations are changed to incorporate new information. Piaget (1952) described four stages of cognitive development that culminate in the ability to think abstractly. Despite challenges to details of the theory, it remains conceptually helpful.

Kohlberg (1969) also used the cognitive approach to help with the understanding of moral reasoning. His six-stage theory proposes that children move from morality based upon obedience to those in authority towards reasoning based upon the recognition of the role of intention and of laws. Some people move towards reasoning based upon values that transcend laws. There is evidence that some young people who become involved in delinquency and aggression show immature types of moral reasoning.

Social psychology has also benefited from the cognitive approach. With a series of experiments on aggression Bandura (1973) set out to explain the role of modelling in learning. He hypothesized that imitation influenced behaviour and tested this by creating situations where children observed an adult acting either aggressively or non-aggressively towards a large doll. When the children were subsequently frustrated by removal of some toys, those who had observed the aggressive behaviour were more likely to behave aggressively themselves. He therefore suggested that learning can be influenced by modelling. People are more likely to imitate people they like, respect and see as successful.

Modelling is seen as one of the key factors in the development of prosocial behaviour; children whose parents act kindly are more likely to be kind themselves. Social workers can make extensive use of the theory, both to understand how some behaviour has developed and for intervention. They can, at times, themselves act as models for appropriate behaviour (Howe, 1987).

The cognitive approach to the understanding of behaviour has led to cognitive behavioural theory, one that is becoming very significant for psychologists and social workers. Researchers such as Ellis (1962) hold that behaviour is influenced by the way people perceive and think about themselves and the world. He uses an ABC approach, where the Activating event triggers a faulty Belief, that in turn triggers an emotional Consequence and problems arise from faulty cognitions. He developed rational-emotive therapy in which faulty cognitions are replaced with rational ones. Intervention based upon these principles is used in clinical psychology, especially for the treatment of depression, and increasingly in social work. The approach is also helpful for understanding low self-esteem and self-efficacy in children who have been abused or neglected. If children are convinced by perpetrators that they are to blame for the abuse they are likely to develop

faulty cognitions about being bad and guilty. Intervention can focus on changing these cognitions.

## The Psychodynamic Approach

To many, psychology is equated with the psychodynamic approach, so powerful has its influence been (Freud, 1910). It was also the first psychological theory that social workers drew upon. Fundamental to Freud's approach was the attempt to explain the internal processes that motivate behaviour. Freud's belief was one of psychic determinism, that is, that all behaviour has a cause that is to be found in the mind. As a result of his work with patients with hysteria he postulated that the mind has a conscious aspect which contains all the thoughts and feelings that we are aware of; and a subconscious part that has two levels: the preconscious from which thoughts and feelings can be accessed by choice, and the unconscious that holds repressed thoughts and feelings. According to Freud, the personality consists of three parts. The id, largely in the subconscious, is the source of the basic drives of libido and aggression and is governed by the pleasure principle. The superego, most of which is conscious, holds the internalized views of authority figures and acts as the 'conscience' trying to inhibit the id's drives. The ego, largely conscious, mediates between the id, the superego and the outer world. In order to cope with the tensions resulting from competing demands of the id, superego and outer world, the ego deploys a range of defence mechanisms. Anna Freud developed the notion of defence mechanisms further (1958).

Freud located adult pathology within faulty psychosexual development. He delineated five stages in the development of the expression of sexual drive energy: the oral, anal, phallic, latency and genital. At each stage the child has to resolve conflicts between the id, ego, superego and outer world. The way that the parent responds to the child is crucial to the successful resolution of conflicts. Problems of development are the result of the maladaptive use of defence mechanisms.

The psychodynamic approach has influenced all disciplines of psychology. Developmental psychologists have used Freud's theories to explore the impact of early experiences upon the development of adult personality. The theory that aggression is an innate drive has been employed by social psychologists attempting to understand conflict. Clinical psychology has drawn upon the view that dysfunction is due to unhealthy defence mechanisms.

Two other main strands of psychodynamic theorizing have affected social work. One strand, known as ego psychology, is represented by Erikson. He incorporated cultural factors and devised eight psychosocial stages characterized by conflicts, beginning with the trust versus mistrust conflict in the first year. Many social workers find Erikson's (1959) stages helpful in guiding their practice. For example, the worker in the scenario might consider whether the grandparent has problems with the final conflict of integrity versus despair.

The other strand, known as object relations, focused on the early development of the ego in personal relationships with significant others. Bowlby's attachment theory is from this tradition and has been hugely influential in social work theory and practice (Bowlby, 1969, 1971). Although his initial emphasis upon the primacy

of the mother has since been challenged, the idea that children need a secure attachment for healthy development underpins much childcare and protection work. It is highly unlikely that the social worker in the scenario would not be beginning to assess the children's relationships with the parents.

Yelloly (1980) provides a detailed account of the influence of psychoanalysis upon social work. She asserts that psychoanalytical thinking led to a more compassionate approach to mental illness and criminal behaviour because it challenged the Victorian view of people as morally autonomous that was associated with a culture of blame and censure. It also underpinned the development of case work, a technique that is still used. Yelloly (1980, pp. 121–122) lists six ways in which the social work value system was affected:

1. the primacy given to affective (rather than cognitive) elements of behaviour;
2. the central role ascribed to unconscious psychological determinants of behaviour;
3. the greater emphasis given to inner psychological processes than to social factors in explaining behaviour;
4. the stress on infantile life and its importance for the development of a personality;
5. a heightened sensitivity to psychopathology;
6. a belief in rationality, and a reliance on insight as a major strategy of intervention in therapeutic change.

## The Humanist Approach

In contrast to Freud's theory, the humanist approach is optimistic. It is also phenomenological in that it states that to understand behaviour it is necessary to understand the person's individual subjective experience. Behaviour is not determined purely by biology or by past experiences; rather people have a sense of purpose, are free and act intentionally. The empirical evidence to support this approach is largely gathered from case studies.

Rogers (1951) and Maslow (1954) are two of the best known humanist psychologists. Rogers identified the actualizing tendency which is the human drive for growth and self-enhancement. Each individual has cognitive structures for the 'self' and for an 'ideal self' that represents what one aspires to be. When the self and the ideal self are similar the individual experiences a state of congruence, but when they are very different the experience is of incongruence. The development of congruence is supported by social factors:

- the need for positive regard;
- conditions of worth – self- or other-imposed conditions for the earning of positive regard;
- introjection of values – incorporation of conditions imposed by others into the ideal self.

The best conditions for growth are:

- unconditional positive regard;
- openness (or warmth);
- empathy.

These concepts are applied in clinical practice. Rogers developed client-centred practice (later person-centred) based on the premise that the client knows what is wrong and what needs to change. The helping process hinges upon developing a relationship of equals and by aiming to provide the conditions of worth.

The concept of respect for the person and understanding of the subjective experience is a helpful model for practice, for example with people with disabilities, because it is based on a partnership rather than paternalistic model. It is also a common model for play therapy with abused and neglected children.

Maslow's focus was upon healthy rather than pathological personality development. He suggested that people's behaviour is motivated by a hierarchy of needs. First, there are those that drive behaviour by their absence. These deficiency motives are:

- physiological;
- safety;
- love and belongingness;
- esteem.

Overlaid on these are meta-needs for growth that impel the individual on a path of *self-actualization*.

Within social psychology both Roger's and Maslow's theories propose that violent behaviour is neither an innate drive, nor a simple behavioural response, but is the result of making a choice to respond aggressively. Maslow's theory has been applied to the understanding of the role of unmet needs in both victim and perpetrator psychology in criminal justice (Ainsworth, 2000).

Table 3 maps out the interactions between the different theoretical approaches and the different disciplines, with some practice examples.

## Process of Social Work

Precisely because social workers are people working with people, their own psychological make-up affects the process of social work. The cognitive approach to social psychology has shown that in any human interaction people make cognitive short cuts. Whilst helpful in allowing quicker information processing, such short cuts undermine objectivity. They include:

- selective attention;
- group polarization;
- stereotyping.

Another is the fundamental attributional error: the tendency to underestimate the influence of situational factors when interpreting other people's behaviour and to overestimate the importance of internal factors.

**Table 3** *Theoretical approaches and disciplines.*

| *Approach* | *Causes of behaviour* | *Treatment* | *Examples* | | |
|---|---|---|---|---|---|
| | | | *Developmental* | *Social* | *Clinical* |
| Biological | Physiological | Treat physiological causes | Appreciate physiological effects of childhood trauma | Contain criminals | Refer those with mental health problems for drug treatment |
| Behaviourist | Environmental reinforcement | Create an environment where reinforcers support required behaviour | Use behaviour management for conduct disorder in children | Use positive reinforcement to encourage pro-social behaviour | Behaviour modification for phobias |
| Cognitive | Cognitive processes | Replace negative automatic thoughts with rational reasoning | Change thoughts and beliefs underlying low self-esteem in abused children | Guard against attribution errors of assessment | Help a person with depression to overcome negative thoughts |
| Psychodynamic | Unhealthy defence mechanisms due to problems of psychosexual development | Develop insight into causes of behaviour | Ensure that a child has the opportunity to develop at least one secure attachment | Help a violent criminal to sublimate aggressive drive through art | Help an anxious person to gain insight into the impact of childhood trauma |
| Humanist | Incongruence between what people feel they are and what they feel they should be; unmet needs | Provide conditions for growth; ensuring needs are met | Provide non-directive therapy for a traumatized child | Help a criminal to find appropriate ways to meet needs | Help a person with low self-esteem to become self-confident |

In a study of the reports of enquiries into child deaths, Munro (1999) found a number of common psychological errors of evaluation that can have potentially fatal consequences:

- being resistant to changing one's mind, and failing to revise risk assessments;
- paying greater attention to evidence that supports one's own beliefs;
- looking for evidence to support one's beliefs;
- being less critical of supporting evidence than of challenging evidence.

Thus, social work can benefit from psychological insights into the ways that human functioning can impact upon professional functioning.

## Pitfalls of Drawing Exclusively upon Psychology

Although it is clear that psychology has much to offer social work, the wholesale adoption of psychological theory is not without potential problems. For example, there is a tendency to individualize problems and locate them within the person, whilst not paying sufficient attention to wider factors. This tendency has been described by Rose (1985) as the 'psy complex'. So, a further set of questions that the social worker could ask about the family in the scenario is:

- Is the family's income adequate to clothe and feed two children?
- Is the accommodation suitable for their needs?
- What access do the parents have to formal and informal support services?
- Do the family members feel integrated into the community?

Because psychology is based heavily upon the construction of norms, there is a danger that people who deviate from the norm are considered to be 'abnormal', even though a norm is only an average of the spread of possibilities. When the norm becomes that which is desired and normative there is a danger of labelling people as deviant, even when they represent part of the natural diversity of human beings.

This has particularly been the case when it comes to the understanding of the psychology of black people (Robinson, 1995). The flourishing of a black perspective in psychology is one attempt to address this problem, and the challenge for social workers is to ensure that they draw upon this material and avoid perpetuating institutional racism.

## Potential

Psychology does, clearly, offer a huge amount to social work, but the potential is probably not fully realized. Training in social work covers some psychology, but it is such a vast subject that only some of the basic principles of psychology and some areas such as human development can be addressed. However, it can be guaranteed that for every human problem the social worker encounters there will be a body of relevant psychological research.

## Five Key Points

1. Psychology is the scientific study of behaviour and is characterized by empirical research.
2. Social work can make use of three main disciplines of developmental, social and cognitive psychology.
3. Psychology underpins social work in three ways: by providing evidence-based knowledge, by offering theoretical approaches and by helping with the understanding of the process of practice.
4. The five main theoretical approaches are biological, behaviourist, cognitive, psychodynamic and humanist.
5. The use of a psychological approach must be balanced by knowledge from sociology.

## Three Questions

1. What arguments are there to support and refute Nicolson and Bayne's (2006) statement that 'social work is a branch of applied psychology'?
2. How can social workers ensure that their use of psychological theory does not lead them to individualize problems to the exclusion of consideration of wider ecological influences?
3. There is no doubt about the lessons that social work can learn from psychology, but in what ways could social work influence the direction of psychological research?

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# BOOK 2

# The Human Life Cycle



*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

# CHAPTER 2.1

# Infancy

*Gillian Harris*

The period of infancy is usually defined by developmental psychologists as being the first two years of life. There are many focal points of study in this field, but perhaps one of the most interesting questions we can ask about infants is: How and when do they become social beings? When do they begin to recognize others? And when does the first relationship form between the infant and caregiver?

One of the main problems with studying infants is that it is difficult to measure their skills and preferences. We cannot rely on verbal response or even upon controlled motor movements in the early months. Research carried out on early developmental preferences has, therefore, to rely upon certain assumptions. These are: that the infant will turn or orient towards pleasing or familiar stimuli; that the infant will preferentially look at pleasing or familiar stimuli; that the infant will modify its sucking response to experience pleasant or familiar stimuli; and that when the infant is bored with (or has habituated to) a known stimulus, it will preferentially respond to a novel stimulus. Most studies of newborn infants rely upon these assumptions.

## Early Development

The infant is born with certain innate preferences which are usually for salient stimuli within the environment that have survival value. The most salient stimuli are those that are linked with other humans, in that infants are relatively helpless for many years and must attract another to care for them. Newborn infants have specific perceptual preferences for speech-type sounds and for visual stimuli which, if grouped together, comprise face-type configurations. Newborns will track

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face-type stimuli right from birth. They will even imitate some human facial expressions very soon after birth.They also show a very marked preference for facial features such as the eyes. So newborns are programmed to search out and look at the human face, and to try and elicit a response from a human caregiver. Newborn infants also prefer sweet-tasting solutions. This means that the neonate prefers stimuli associated with the caregiver: human speech, the human face and, of course, breast milk – which is sweet.

Following birth and even in some cases, prior to birth, there is a period of very rapid learning in which the infant learns to identify known tastes, smells, sounds and faces. The newborn infant shows a preference for the mother's voice, the mother's face, and the smell of the mother's milk. This does not mean that the infant recognizes the mother, but that the infant prefers things that are familiar. Innate neonatal preferences can also be modified very rapidly by learning if this modification has survival value. If an infant is given bitter-tasting milk from birth, then because the bitter taste is associated with a positive calorie intake, the infant will learn to like it, even though infants usually find bitter tastes aversive.

Although the infant seems to prefer the known properties of the mother, this does not mean that a relationship has formed. There is no evidence to support the idea of early 'bonding' between infant and mother, despite the findings by Klaus *et al.* (1972) which seemed to support the 'bonding' hypothesis. More recent studies do not support the idea that early contact between infant and mother has a beneficial effect upon mothering behaviour in the long term (Svejda, Campos and Emde, 1980), but touch involving skin-to-skin contact in the early weeks has been shown to have advantages for premature infants in promoting growth.

Given the dangers of the birth process it would give the infant no advantage to become attached to the biological mother at or immediately after birth. In fact, the newborn infant does not appear to show any signs of specific pleasure in the mother's presence or distress at separation from her. This absence of early attachment means that the first relationship does not have to be with the biological mother; it does not even have to be with a female adult. Research has shown that men can and do react to and interact with infants in the same manner as women, especially where they have had experience in caregiving (Field, 1978). Infants can form an attachment to their fathers even if they do not form an attachment to their mothers. In extended families, infants might form an attachment to family members other than the main care provider. The early preference shown by the infant for the caregiver seems to give the appearance of social intent and makes the caregiver feel that the infant recognizes them. As a result, the caregiver is more likely to feel attached to the infant, and to provide care.

## Social Cognition and Attachment Formation

In order to decide whether or not an attachment has formed between infant and caregiver we must observe and measure infant behaviours; but which behaviours are likely to indicate that an attachment has formed?

One affiliative behaviour, smiling, is present from birth. The neonate will smile in response to various internal and external stimuli that are found pleasing. The

smile gradually becomes more discriminatory until it is only observed as a response to social stimuli – that is other people. Eventually, the smile is reserved only for familiar people. This only tells us, however, that the infant can discriminate between those who are known and those not known.

A better indicator of attachment is thought to be distress at separation, a behaviour not observed until about six months, when the infant will cry if left by the primary caregiver. Similarly, discriminatory responses, which are fear responses directed towards a stranger, are not usually observed until around ten months. This 'fear of strangers' response is less marked if the 'stranger' looks familiar to known caregivers, behaves in a positive manner to the infant or if the caregiver behaves in a positive manner towards the 'stranger'. This is possibly because the infant is able, at this age, to match internal representations of known adults with the external representation of the stranger, and find a mismatch. We could say that, at this age, the infant is able not only to recognize but to recall images of absent caregivers. In effect the infant has achieved *person permanence*: the child is aware that the caregiver continues to exist when out of the sight of the infant, and has an existence separate from that of the infant.

We would expect that the concept of person permanence would be attained at about the same age as *object permanence* – the understanding that objects continue to exist when out of sight of the infant. It was thought by Piaget (1952) that infants did not attain object permanence until the age of 18 months. But the task that infants were asked to do in his studies was quite complex and mapped onto other abilities that possibly do not develop until the second year. If we look at research studies carried out on purely perceptual tasks (Baillargeon, Spelke and Wasserman, 1985) then the infant seems to be able to understand that objects continue to exist even though they can no longer be seen, and that the objects have certain immutable properties in that one cannot pass through another. In a far simpler task (Hood and Willets, 1986), six-month-old infants were observed to reach out for objects in the dark that they had observed in the light. Infants do then seem to develop concepts of object and person permanence at around the same time. We might also say that to be able to form an attachment to someone it is necessary to be able to sustain a memory of them in their absence. Research studies certainly suggest that infants retain some memory for events which are experienced as early as 10 months (Fivush, 1994).

Infants of 10 months are able not only to recognize familiar caregivers (including siblings) but to remember sustained patterns of interaction specific to each caregiver. Infants can play elaborate social games with familiar others: games of 'give and take', games of 'hide and look'. During these games, the infant is able to predict the partner's behaviour, to attempt to elicit such behaviour and to respond to it appropriately. Caregivers usually also respond in quite a specific way to infants. Not only do they engage in specific 'games', but all adults and 'experienced' children use a unique form of speech and behavioural mannerism when interacting with infants and young children. The speech style, sometimes termed 'motherese', uses lots of exaggerations of pitch and speed, with questions, imitations, repetitions and extensions of the infant's own utterances. This speech style acts mainly as an attentional marker for the infant. When someone uses such a speech style the infant is more likely to react to them and interact with them. The behaviours which

accompany this speech style, such as exaggerated facial expression and extensive eye contact, also serve to engage and maintain the infant's attention within the dyadic interaction. In this way the infant learns, not how to talk for that ability is innate, but how to structure social interactions with others and what to expect from others. When strange adults use this familiar style of interaction infants are less wary of them; if strangers address them or behave towards them in the usual 'adult' style of interaction then the infant will be more wary. The infant is also able, from the age of 10 months, to use the caregiver as a source of information – they can engage in social referencing (Feinman and Lewis, 1983). And although we might say that an infant of this age is not fully aware of another's mind state, infants are able to interpret the adult's emotional expression. If an adult smiles at, or behaves positively towards, a stranger then the infant will be less wary of that stranger.

## Attachment Classifications

Infants of 10 months or so show separation distress, are more discriminatory in affect, smile more at the people with whom they are familiar and are more wary of strangers; and these are all behaviours which we would expect to observe between adults where an emotional bond has formed. It is assumed, therefore, that by this age infants are likely to have formed attachments, and that attachment behaviour between infant and caregiver can be measured. There is one standardized measure of infant-adult attachment that is most frequently used in research studies; the procedure is called the 'strange situation', and was first devised by Mary Ainsworth (Ainsworth, Blehar and Waters, 1978). It is usually carried out when the infant is mobile, at about 14 months, and entails monitoring the infant's behaviour during a series of manoeuvres in which the mother (or father) and a 'stranger' alternately leave the room and return. The infant is left at one point with the stranger, and at a second point, entirely alone. Separation, reunion and exploratory behaviours are specifically noted. The infant's behaviour in this situation tends to fall into one of three categories; two of which are deemed insecurely attached, one of which is deemed securely attached. Further sub-categories are sometimes used which discriminate between typical caregiver–infant interactions and atypical or abusive interactions.

The securely attached infants explore the strange environment with some confidence, and there is a difference between the ways in which they respond to the parent and to the stranger. The secure infant shows some distress on separation, and shows pleasure at reunion with the parent; but not so with the stranger. Insecure avoidant infants tend to ignore the parent. Insecure anxious infants, however, tend to be very clingy towards the parent in the strange situation and do not explore the environment. They also become extremely distressed at separation from the parent and rather ambivalent and angry upon reunion.

In the original studies approximately 66 per cent of a sample of children were observed to be securely attached, 20 per cent avoidantly attached, and 12 per cent ambivalently attached, when observed with the mother.

It has been suggested that this behaviour, shown by the infant, merely reflects differences in infant temperament. However, an infant can display insecure behav-

iour with one parent but secure behaviour with the other. This is not to say that infant temperament does not play any part in determining the relationship between infant and caregiver, but it does not explain all the behavioural differences observed in the 'strange situation'. Cultural differences have, however, been observed in the percentages of infants who fall into the three categories. Therefore, differences in child-rearing methods or expectations about the achievement of autonomy will affect the mode of interaction in the infant-parent dyad and hence the attachment category attributed to that relationship.

We can gain some insight into how and when this first attachment relationship is formed, by observing the behaviour of the parents towards infants who are given different attachment classifications. Observations carried out in the home showed that a mother's behaviour towards her infant could explain the infant's responses to her. Mothers of infants that were rated as securely attached behaved in a consistent and sensitively responsive manner towards their infants. Mothers of insecurely attached children behaved in either a rejecting or an inconsistent fashion towards their infants. It could be said then, that infants respond to the mothers' behaviour towards them. Those infants who are treated consistently and responsively become securely attached. Those infants whose mothers reject them show avoidant behaviour (an absence of overt attachment behaviours). Those mothers who are inconsistent in their behaviour to their infants have anxiously attached children, children who cannot predict the attachment figure's likely behaviour towards them.

Attachment formation, infant to caregiver, would seem to depend upon consistent and reciprocal interactions which occur across time. The process does not seem to start before the age of three months, and is possibly complete by the end of the first year. It has been suggested, most notably by Bowlby (1953), that an attachment to a primary caregiver must form within the first two years of life for the subsequent optimal mental health of the child. However, in single case studies of children deprived of the opportunity to form attachments in the first six years of life (Clarke and Clarke, 1976), subsequent attachments have been observed to foster parents. If there is a critical period for attachment formation then it would appear to be a long one. In normal family life, infants usually form a hierarchy of attachments to available family members or caregivers; and this hierarchy seems to serve a protective function for the infant. The availability of multiple caregivers also means that the likelihood of forming a secure attachment with at least one available caregiver is increased.

We might conclude then, that infants do not become truly social beings until the end of the first year of life, and that the ability to form attachments is based upon the acquisition of specific stages in cognitive development, and upon the availability of a consistent reciprocal interaction with another.

## Five Key Points

1. Following birth, there is a period of very rapid learning.
2. There is no evidence to support the idea of early 'bonding' between infant and mother.
3. A 'fear of strangers' response is not usually observed before about 10 months. At the same age the child can remember sustained patterns of interaction specific to each caregiver.
4. Infants of 10 months show separation distress, are more discriminatory in affect, smile more at the people with whom they are familiar and are more wary of strangers. They are social beings.
5. Attachment formation, infant to caregiver, is dependent on consistent and reciprocal interactions occurring across time – usually between 3 and 12 months.

## Three Questions

1. How and when do attachments form?
2. What methods have developmental psychologists used to observe infant behaviour?
3. How do patterns of attachment appear to affect infant behaviour?

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CHAPTER 2.2

# Childhood

*Gillian Schofield*

When social workers think about childhood from infancy to adolescence, they need to be aware of the specific features of the period which tend to mark certain stages. But they also need to be aware of the continuous tasks, such as building self-esteem or defining an identity, which flow from birth through infancy, childhood, adolescence and continue to evolve in adult life. Although social workers must be familiar with all kinds of evidence of healthy development, it is often the relationship-based areas of development which social workers are best placed to observe and assess because of their perspective on the child in her social context – the family, the playgroup, the school and the community.

## Dependency and Autonomy in Pre-School Children

The early attachment relationships which are established during infancy form the basis of development during the toddler and pre-school years. In the first year of life the available and sensitive parent needs to do whatever will build the child's *trust*. Understanding this process is helpful in thinking about how the development of a secure attachment leads to the child's experience of the attachment figure as a secure base for exploration (Bowlby, 1969). During the second year, in the context of the child's experience of security, the parent needs to respond in whatever way will make the child feel more *capable* (Fahlberg, 2012). The task of this period is to begin the move from the *dependency* of infancy to a gradual sense of *autonomy*. This development is a challenge to both the child and the parent. The toddler often goes through a phase of assertive or oppositional behaviour as she learns the power of saying 'mine' and 'no'. Assertiveness can be associated with pleasure and also

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with anxiety. As the sense of a *psychological* separation from the parent develops, the child can become anxious and apprehensive about *physical* separation. Behaviour at this stage is neither consistent nor apparently rational. The child who one day is demanding the freedom to put on her own shoes and gaining obvious pleasure from her new-found abilities, the next day may be refusing to walk and be demanding to be spoon-fed. The lesson to be learned most vividly from toddlers, but which is relevant throughout childhood, is that although children's development may be seen as broadly following in stages, a child's anxiety and uncertainty about the implications of progress are likely to mean frequent regressions before the drive to move forward reasserts itself. The challenge for parents in this period is to allow the child some flexibility and regression while giving appropriate encouragement to the child to enjoy and develop new skills.

Parents who get into difficulties at this stage have often been unable to cope with the challenge to their authority which a toddler or pre-schooler may represent. Dunn's research (1988) showed that the majority of two- to three-year-olds persisted in demands or did what they had just been told not to do. What is more, although many children were simply angry and defiant, a good number would be actually smiling at the parent and teasing them as they defied them. For most parents, such behaviour is immediately recognizable as part of a common and temporary phase, but some children may be at risk because of what parents attribute to the child and to the behaviour. The impact of parental attributions may mean that defiant behaviour is seen as confirmation that a child is responsible for parenting failure and is *constitutionally* a bad or difficult child. In this context, normal developmental processes of assertiveness are seen as *persecutory* and as beyond the influence or control of the parent. If the behaviour is perhaps further linked, for example, with an absent parent whom the child is felt to resemble, then the *meaning* of the child's behaviour will contribute to a further distortion in the parental response.

Although defiant behaviour is usually an important expression of the child's growing ability to see themselves as a separate person, there is evidence that serious behaviour problems, or *conduct disorders*, in pre-school children may persist into middle childhood. Behaviour, therefore, needs to be examined in the light of the other important processes of this period in order to distinguish between normal development, of which there is a wide range, and the problems which need to be recognized and helped.

## Development of Social Understanding

From birth, the child is learning lessons about how the world works. Early connections are made which help the child feel safe and allow her to postpone satisfaction. Even young babies are able to learn after a while that they can stop crying as soon as they hear the parent's footsteps on the stairs, because they can predict that a cuddle or a bottle or both is going to happen next. Looking for patterns in relationships and social behaviour, starting to learn the rules, is a critical part of the early experiences of children. The sound of the footstep starts to represent in a symbolic sense the beginning of the feed. This predictability, the reciprocity between parent and child and the development of trust in symbols are important elements in devel-

oping language. The likelihood that events follow each other also starts the child on the way to understanding that two and two always make four, that life has patterns which can be relied on. Predictability in the young child's world enables her to develop that feeling of competence which emerges from a capacity to produce an impact on her world. But predictability also brings mastery of her feelings. Secure attachment leads to a capacity to reflect and to regulate feelings.

A key part of what we think of as the secure base effect of attachment (Bowlby, 1969) is the way in which the child is freed to *think*, to explore and to find out about her environment. In everyday life, the child who is preoccupied about getting emotional needs met and fears separation will find it hard to be interested in the leaf which floats by or the sound of the rain. The child has a natural awareness of stimuli from birth which, if needs are met in a way which can be described as 'good enough' to use Winnicott's expression (Winnicott, 1965), will continue through childhood and will lead to learning. To a large extent the environment merely has

## 3 Attachment patterns

In their efforts to adapt defensively to their caregiving relationship, children develop one of four basic internal working models which give rise to distinct attachment patterns.

1. *Secure* attachment patterns: children experience their caregiver as available and themselves as lovable and effective.
2. *Ambivalent* patterns: children experience their caregiver as inconsistently responsive and themselves as dependent and poorly valued.
3. *Avoidant* patterns: children experience their caregivers as consistently rejecting and themselves as insecure but compulsively self-reliant.
4. *Disorganized* patterns (often associated with children who have suffered severe maltreatment): children experience their caregivers as either frightening or frightened and themselves as either helpless or angry and controlling.

Each pattern is associated with a characteristic strategy for managing anxiety and relationships:

1. *Secure*: approach, confident in the availability of others and worth of the self.
2. *Ambivalent*: maximize attachment behaviour, rely on emotion.
3. *Avoidant*: minimize attachment behaviour and shows of emotion; rely on reason.
4. *Disorganized*: incoherent, mix of avoidance and approach, helpless in infancy, controlling in older children.

Source: Adapted from Howe (2000), p. 27. See also Howe (2011).

to facilitate that process. This facilitative environment depends on the nature of the available relationships more than it does on the nature of the available toys. When children learn to role play the parent who feeds the baby or gets cross, she safely explores social situations which give pleasure or cause anxiety and develops her ability to see the world through the eyes of others.

Learning about the social world initially requires the child to learn from the patterns of relationships which she, herself, experiences; the impact others have on her and the impact she has on them. But a sophisticated operator within the social world needs also to learn about *how other people feel and how other people think*. Young children's capacity to comprehend the subtleties of 'other minds' has emerged as far more sophisticated than had been thought. This sophistication has important survival value for the child since communication of needs, practical and emotional, relies on some degree of understanding of how certain kinds of communications will be received and an ability to predict reactions. These lessons are learned with parents, grandparents, brothers and sisters. Increasingly, children start to become skilled observers of relationships *between* other family members and to learn lessons from them. The child is then likely to move into relationships with other children. Within the peer group, the child learns a whole new set of rules and the skills needed to establish relationships and negotiate within them.

Judy Dunn found that within what she called 'the drama of their everyday world', young children are highly motivated and emotionally involved, and therefore much more skilled in negotiating and learning about how the world works than had been thought by writers like Piaget who emphasized the 'egocentrism' of young children. In her research, Dunn found that by the age of three, children were demonstrating an *understanding of other's feelings*, 'the causes of pain, distress, anger, pleasure and displeasure, comfort and fear in others as well as in themselves. They joke, play with, and tell stories about these feeling states in self and other' (1988, p. 170). Out of this early responsiveness, she suggests, comes 'the foundations for the *moral* virtues of caring, considerateness and kindness'.

Children of this age are also demonstrating an *understanding of others' goals and intentions*. Dunn suggests that an understanding of feelings and intentions leads to 'an interest in transgressions of acceptable or expected behaviour and an understanding of social rules and family relationships'. Children's use of humour, jokes and teasing can be seen in this context as important evidence of the child's growing ability to use their understanding of adults and other children to anticipate and have an impact on other people in their lives.

Dunn and other researchers have made a case for rejecting Piaget's suggestion that young children are egocentric, in that by three years of age children are quite sophisticated in their ability to understand the feelings and goals of others. However, it is the case that children, and particularly children facing stressful situations, are often egocentric in the sense of holding themselves responsible for much of what happens to them. *Magical thinking*, as it is often called, or a sense of omnipotence can be particularly striking in children between the ages of four and seven or eight, who are still trying to make sense of their world. Social workers need to be constantly alert to the ways in which children blame themselves for the separation of parents, for parental illness and, most commonly, for the abuse which they have experienced.

## Developing and Refining a Sense of Self

Much of the process of social learning derives from and contributes to the child's developing sense of self. The emotional significance of secure attachment to parents and the tension which follows between dependence and autonomy in a world of more powerful and more competent others motivate the child to find a place for herself in the social world. The child's sense of 'self-efficacy' (Dunn, 1988) develops as the child finds the skills to operate within relationships. The child learns to oppose others where necessary, negotiate where necessary and cooperate where necessary. The *self-esteem* which is derived from early secure attachments should evolve during this phase through increasing competence, both socially and in playing with objects, toys and games.

For children whose experience of early relationships has not included developing a sense of trust and attachment which provides a secure base, self-esteem may be fragile. Children who live in families where there are frequent changes either in the physical environment or in the relationships and the emotional climate, do not experience the reassuring and predictable patterns which encourage them to go on to the next stage and develop a sense of self-efficacy. Maltreated children are particularly vulnerable. This becomes important when we consider what is needed for the child to make a successful transition to school.

The primary-school years from 5 to 11 have often been seen as a relatively quiet phase developmentally compared with the dramatic changes from birth to 5 and during adolescence. This is also reflected in Freud's labelling of this period as 'latency' within his psychosexual model of development. More recently, it has come to be seen as a period of *consolidation* but also further development of much of the learning about *self* and *relationships* which we know has been initiated in the pre-school years.

The emphasis on developing a sense of self has important implications for much of social work practice with the middle-childhood age group. We know, for example, from research on the psychology of adoption, that adopted children are particularly curious about their origins around the age of eight or nine. Children in foster care also need to make sense of where they fit and can feel very unsettled by change of home and change in school. Children in middle childhood are often well able to talk about their situation and they need to have their feelings about their situation listened to carefully if their hopes, fears and anxieties are to be recognized. But insecure fostered and adopted children who have had to construct defensive strategies to manage stresses and fear in their birth families communicate in rather different ways – for example, shutting down on their feelings or displaying feelings but in ways that miscue caregivers and social workers (Schofield and Beek, 2006).

In middle childhood, the impact of the school environment, the increasing distance from parental control of day-to-day life and the intensity of peer group relationships create a significant shift in the child's development. Specifically, they require the child to move even further towards understanding what is required and expected by the wider society. What is more, they place the emphasis on the child understanding the standards of others and then establishing her own. The exact nature of these standards and expectations will inevitably be very culturally specific.

Some societies, for example, encourage individualism, expect children to express their individual needs and are inclined to favour children who are assertive. In others, the most important lesson for children to learn is that where there is a conflict, what is in the best interests of the family or the village or the community must take priority over the child's individual wishes. What is important is for a child to learn the rules which are appropriate to their particular culture. Of course, children are regularly exposed to conflicting cultures, most obviously children from ethnic-minority families or minority religions. For many of these children, the challenge will be the need to understand both social worlds, learn to operate in both and to that extent incorporate both identities. Although adolescence is regularly seen as the stage of establishing identity, it is during the period from 7 to 12 that children are developing an understanding of the psychosocial meaning of their racial identity.

Sense of self during this period will also include significant areas such as the development of gender identity. We know that by the age of two, children are choosing stereotypical toys and are already associating certain tasks with men and women. Given the child's need to register patterns in the social world, this is not perhaps so surprising (Daniel *et al.*, 2010). Cross-cultural research has found that stereotyping by gender on certain characteristics, such as aggression, strength and cruelty for men and weakness, gentleness and appreciativeness for women, is almost universal and that for many children these stereotypes become more fixed between the ages of five and eight.

When we think of the psychosocial skills required to enable a child to make friends, the ability to be appropriately assertive while also being appropriately concerned for the other child's feelings, the ability to negotiate and cooperate, it is not hard to see the complex interconnections between cognitive skills, emotional qualities and the child's behaviour. Within the child's close relationships it is also possible to think in terms of increased complexity of family and peer group as children develop a more varied hierarchy of attachments that may include figures outside the family (Kearns and Richardson, 2005).

## Conclusion

This account of childhood has focused on some of the key processes of emotional, social and cognitive development, knowledge of which enables the social worker to go beyond the description of a child's behaviour and to acquire an understanding of the meanings behind it. Working sensitively with children in order to understand their needs and take into account their wishes and feelings would not be possible without developing an ability to see the world through the child's eyes.

## Five Key Points

1. Pre-school children need to gradually move from the dependency of infancy to a sense of autonomy and self-efficacy.
2. By the age of three, secure children have a sophisticated understanding of others' feelings and are already learning about the social world but insecure children are less reflective about their own or other minds.
3. By the time children start school, they need to have many social as well as cognitive skills.
4. Between the ages of 5 and 11, children refine their sense of self, expand their knowledge of the social world and develop standards of behaviour.
5. Cognitive, emotional, behavioural and social development proceed together and affect each other. Problem behaviour in one area of development must be put in the context of all areas of development if the behaviour is to be understood.

## Three Questions 

1. What might be the impact of abuse and neglect in early childhood on a child's secure base, self-esteem and identity?
2. What is the importance of peer group relationships for healthy development in childhood?
3. What are the factors which might enable the child to be resilient and to make good developmental progress at home and at school in spite of adversity?

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# CHAPTER 2.3

# Adolescence

*John Coleman*

Adolescence is a stage of life that is a challenge for many. For parents the teenage years bring with them a host of uncertainties and difficulties, whilst for professionals there is much that is troubling and troublesome when working with adolescents. It is important, however, not to overemphasize the negatives. In many respects the teenage years can be a positive life stage, during which even those suffering adversity can demonstrate strengths and resources to a surprising extent.

There are many different ways to define adolescence, but for the purposes of this chapter it will be taken to mean the second decade of life. Broadly speaking this fits with the period of secondary education. Having said this, however, there are many caveats to note. First, there are a variety of different indicators of maturity used by various agencies concerned with young people. The age of criminal responsibility is 10 in Britain, compared with the age of consent to sexual behaviour which is set at 16. An individual can get married at 16, join the army at 17, and cast the vote at 18. In addition, originating in the field of health, there is the concept of 'Gillick competence' (developed in more detail in the Fraser guidelines), which refers to the young person's maturity in being able to consent to medical treatment. This approach avoids specifying chronological age whilst emphasizing the intellectual and social development of the individual young person.

A further complication arises from the fact that the boundaries of adolescence are changing. In some respects adolescence can be seen to be starting earlier and ending later than was the case for previous generations. Puberty for some girls starts before the age of 10. At the other end of the scale, and as a result of the changing labour market and scarcity of jobs for young people, many individuals in late adolescence or early adulthood remain dependent on their parents. Thus no definition

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of adolescence is entirely straightforward, and many of these uncertainties will become apparent during the course of the chapter.

## Lifespan Theory as an Aid to Understanding Adolescence

The easiest way to understand adolescence as a psychological process is to see it as a transition from childhood to adulthood. By looking at it as a transition many of the puzzling aspects of behaviour become less of a mystery. It is worth remembering that all transitions have characteristics in common. These include:

- An eager anticipation of the future;
- A sense of regret for the stage that has been lost;
- A feeling of anxiety in relation to the future;
- A major psychological readjustment;
- A degree of uncertainty about the individual's status during the transition.

As will be readily apparent, all these characteristics apply in important ways to the adolescent stage of development. In addition to the emphasis on understanding transitions, lifespan theory has some key elements which are helpful in making sense of the adolescent period:

- First, there is *continuity*. By this is meant that adolescence does not arrive out of the blue. The adolescent is very much the product of his or her childhood experiences, and the process of development involves a gradual change and movement towards adulthood rather than an abrupt shift from one stage to the next.
- Another element of lifespan theory has to do with *context*. It is argued that we cannot understand the individual unless we take into account the historical time and the environment in which development is occurring.
- A third element of the theory concerns the *timing* of major life events. This is especially significant for adolescents, and refers to the fact that the number of life events occurring at the same time influences the degree of stress experienced. The more life events there are that occur simultaneously, the more stress there will be.
- Finally, lifespan theory emphasizes the notion of *agency*, an idea which is closely linked to the search for autonomy and independence so central to adolescent development. The notion of agency refers to the fact that the adolescent will be playing an active role in shaping the context in which he or she develops. This concept has important implications for interventions, and it is one to which we will return at the end of the chapter.

## Social Change

Adolescence is very much affected by social change. The experiences of young people growing up today are not the same as those of previous generations. This is a point that is central to lifespan theory, and one that has already been noted in the sug-

gestion that the boundaries of adolescence have altered. This has occurred both because of biological change and as a result of shifting social circumstances. There are many different ways in which social change impacts on adolescence. The main areas of note include the changing family, the nature of education and the labour market, alterations in concerns about health matters, globalization, diversity in culture and ethnicity, and the impact of the digital world. There is only space here to make a few brief points on this topic.

Of all aspects of social change, it is probably *the changing family* that has the greatest influence on the way individuals experience the adolescent stage of life. The increase in the numbers of children and young people growing up in families headed by a lone parent is one obvious change that has affected societies in the Western world. Other shifts include an increase in stepfamilies and what are known as blended families, the changing role of the father, and an increased role for grandparents as older people live more active lives.

While not wishing to underplay the other aspects of social change, it is clearly very important to point out the effect that alterations in *education and the labour market* have on young people. As has been noted, there are many ways in which maturity is defined in our society, but it is probably the achievement of financial independence that is the most salient. The fact that this has been gradually shifting further and further into young adulthood is of central significance for our understanding of the adolescent stage of life. The postponement of financial independence leads to alterations in such fundamental things as self-concept, autonomy, and relationships within the family.

## The Importance of the Family

This idea leads on to a consideration of the role of the family for adolescent development. Three topics will be covered here: parenting styles, the impact of divorce and family breakdown for adolescents, and recent work on support for parents of teenagers. Looking first at parenting styles, there has been a great deal of research on this subject over recent years. Broadly speaking, studies show that the authoritative style of parenting leads to the best outcomes for young people. This style is contrasted with the authoritarian, indulgent and indifferent styles of parenting. It is agreed that the authoritative parenting style includes warmth, the provision of structure, and the encouragement of age-appropriate autonomy.

As far as divorce and family breakdown are concerned, it is evident that adolescents can be just as affected by these experiences as younger children. What is clear, however, is that it is not the divorce itself that is most significant, but what has happened before in the family, and what happens afterwards in terms of family relationships. The most damaging experience for teenagers is to be 'caught in the middle' where there is continuing parental conflict following divorce. By contrast, adolescents can do very well if they are able to maintain good relationships with the non-residential parent, and if their own needs are recognized.

There has been much work done in the last decade or so on parenting programmes for parents of this age group. This has come about in Britain partly due to government policy relating to the use of parenting orders, and the objective of

supporting parents of young people in the youth justice system. However practitioners have also been keen to participate in the development of new programmes for use with a wider group of parents. Much has been learnt about how best to deliver these programmes, and there is no doubt that this is a field which will continue to develop in the future.

To conclude this section it is important to note that the parents of teenagers matter. They matter just as much as the parents of younger children, but they matter in different ways. Research shows that the involvement of parents during the adolescent years can make a major difference to outcomes, whether these are to do with educational achievement, health behaviours, the development of values or future employment. It is not uncommon for parents to believe the opposite, since their sons and daughters may be sending the message that at this stage their friends are more important than their parents. Practitioners can and should take every opportunity to address this false belief. Parents, and carers, have a central role to play during these years. The more this can be disseminated, the better it will be for adolescent development.

## Risk and Vulnerability

There are, of course, a multitude of risks that may affect the development of an adolescent. These may include poverty, racism, living in a deprived neighbourhood, war, natural disasters, family dysfunction and parental illness, abuse, neglect and so on. Early studies tended to look at each of these individually, but it became clear that risk factors often co-occur, so that it is the accumulation of risks that leads to the greatest adversity for a young person. Many writers have opted to consider risks in terms of whether they fall into the categories of individual, family or social factors. These can be defined as follows:

- *Individual factors*: anxious or irritable temperament, low intelligence, poor health, hyperactivity, low frustration tolerance;
- *Family factors*: parental ill health, chronic conflict or domestic violence, involvement in crime, harsh or erratic punishment, death of a parent;
- *Community factors*: poverty, poor housing, ethnic conflict, dysfunctional schooling, crime rate, lack of role models, low community cohesion.

Obviously not everyone is affected by risk factors to the same extent, and this leads on to a consideration of what are known as protective factors. These are often classified in the same way as risk factors: i.e. they are divided into individual, family and community factors. As an example, it may be considered that good schools, strong social cohesion, high-profile role models in the community, and adequate housing may all be community protective factors. In attempting to understand the impact of adversity on the individual young person it is necessary to take into account the balance of risks and protective factors. Many commentators have emphasized that the two processes interact, and that it is only by considering both that we can come to any conclusions about the vulnerability of any one individual.

Some conclusions that can be drawn from the literature on risk in adolescence are as follows:

- The major risk factors for young people tend to be those that are chronic rather than acute;
- The more serious the risk, or the greater number of risk factors, the stronger the protective factors will need to be to overcome adversity;
- The circumstances that tend to lead to the greatest vulnerability are those where there is an accumulation of risk, rather than those where there is only one risk factor present.

## Antisocial Behaviour

There are many different spheres of risk that could be selected to illustrate in more detail how young people's lives can be affected by adverse circumstances. Sexual exploitation or abuse, placement in care or custody, having poor mental health, being excluded from school, and so on are all examples of situations posing a threat to the health and welfare of this age group. Given limitations on space, involvement in antisocial behaviour will be chosen here as one topic through which to illustrate some more general conclusions.

The first point to note is that there are many types of antisocial behaviour, as is the case with other types of risk. One key conclusion from the longitudinal studies of antisocial behaviour has been that there are different trajectories of involvement in criminal activity. In particular, it is important to make a distinction between antisocial behaviour that is life-course persistent and that which is adolescence-limited. Research shows that there is a small group who show clear signs of difficulty in early childhood. These are the life-course persistent group, and in adolescence they account for a larger proportion of the criminal behaviour in the population than would be warranted by their numbers. They are also less likely to desist from crime in early adulthood than those who follow other trajectories.

Young men are significantly more likely to engage in criminal behaviour than are young women, yet rates of male youth crime have fallen since the mid-1990s, whilst this is not true for female youth crime. Factors associated with antisocial behaviour include having a family member involved in crime, as well as parental neglect, harsh or erratic discipline, poverty, and living in neighbourhoods with high levels of community risk factors.

Much has been learnt about the possible interventions available for those involved in antisocial behaviour. These include the development of the young person's social and cognitive skills, the enhancement of parenting strategies, the modification of disadvantaged environments, and the support of positive peer groups. Studies of interventions show that opportunities for employment are possibly the most powerful of all options, but that, in addition, those interventions which are multimodal are more likely to be successful than those that concentrate on one modality at a time.

## The Promotion of Resilience

It is only too easy in the world of practice to concentrate on the problems and difficulties faced by young people in disadvantaged circumstances. Indeed a portion of this chapter has been devoted to risk and vulnerability. Nonetheless there has in recent years been a welcome move within social work and other disciplines to develop an approach which has more of a focus on the positive capabilities of the individual. This is sometimes known as a strengths-based approach, or the use of an asset model. This is linked with an increasing interest in young people's participation, and a growing recognition that adolescents can have a role to play in the development of policy and service planning.

These trends are closely associated with work on the promotion of resilience. Such work identifies the protective factors that may be available for any individual young person, and attempts to reinforce these or harness them in the service of adolescent development. One aspect of this work relates to the notion of agency mentioned at the beginning of the chapter. The theory here is that, while adults believe that it is their influence which determines events, in reality it is the young person who is shaping and constructing their own environment. This is a central concept for any intervention. If professional adults are able to work collaboratively with the adolescent there is a much greater chance of success than if they assume that it is the adult who is in control of events.

At first sight it may seem a tall order to find ways of promoting resilience in young people facing serious adversities in their lives. Yet a number of commentators have suggested ways in which it is possible to do this. Sometimes this requires a different way of thinking about young people, involving a focus on the strengths rather than the weaknesses. At other times it demands an approach which concentrates on how to limit risk and promote any protective factors that are available. Here are some suggestions:

- Reduce the young person's exposure to risk. This may involve changing the environment, finding safe spaces for the young person to work or study, or offering more contact with positive role models.
- Interrupt the chain reaction that occurs after negative events. Key events such as bereavement, trauma, coming into contact with the police, or change in living circumstances may all lead to a downward spiral. Intervention at these times can make a significant difference.
- Offer the young person positive experiences that play to their strengths, or enhance whatever protective factors are available.
- Remember the notion of agency. The young person will be hard at work constructing a life for themselves, even in adversity. The choices they make may not be positive ones, but the goal should be to help them make better choices, rather than impose someone else's choices on them.

## Five Key Points

1. Many factors affect the definition and understanding of adolescence, including concepts of puberty, social change, and differing legislative and policy criteria for identifying the age of maturity.
2. Lifespan theory is a helpful way to look at adolescent development. Concepts of transition, continuity, context, the timing of events, and agency all contribute to a better understanding of this stage of life.
3. Parents of adolescents matter. They matter just as much as parents of younger children, but they matter in a different way. Parents and carers have a key role to play in providing support and engaging with young people's lives.
4. Some adolescents suffer more adversity than others. It is therefore important to consider the risk factors that may affect young people's lives, and these are often categorized as being either individual, family or community risks. It is the accumulation of risk that creates the greatest adversity.
5. In understanding outcomes for young people it is necessary to consider the combination of risk and protective factors. It is possible to promote resilience by enhancing protective factors, or by taking a strengths-based approach as part of any intervention.

## Three Questions 

1. The family is changing. How have the changes in the family which have occurred over the past 20 years affected adolescent development?
2. Young people face many risks during the adolescent years. To what extent are these an inevitable part of growing up in our society?
3. It will be easier to promote resilience in some adolescents than in others. Discuss the factors that may facilitate or hinder the promotion of resilience.

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CHAPTER 2.4

# Partnership and Parenting

*Janet Walker*

*At night returning, every labour sped,*
*He sits him down the monarch of a shed;*
*Smiles by his chearful fire, and round surveys*
*His childrens looks, that brighten at the blaze:*
*While his lov'd partner, boastful of her hoard,*
*Displays her cleanly platter on the board . . .*
The Traveller, *Oliver Goldsmith, 1728–1774*

Writing in the eighteenth century, Goldsmith captured a vision of partnership and parenting in which paternal and maternal roles were complementary, clearly defined and delineated, within an economic union which created a supportive adult alliance and kinship networks. It portrayed a powerful image of stability and permanence, but it is a deceptively simple view of complex intimate bonds between adults and between parents and their children. It is doubtful whether this idealized construction of warmth, well-being and contentment has ever realistically reflected family life in Britain, yet parents are often judged against it. Marriage, parenting and family have traditionally been regarded as 'a package deal' (Struening, 2002), but a review of the historical evidence (Thane, 2010) shows that references to a golden age of family life conveniently ignore the realities of extramarital sex and conception, domestic abuse, lone motherhood and stepfamily life, all of which have existed for centuries.

Rapidly changing patterns of partnership and parenting since the mid-twentieth century have provoked concerns about the demise of the family, and fears that families are now fundamentally unstable and family values are being rejected,

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leading to increases in juvenile crime, antisocial behaviour, drug use, and behavioural disorders in children. As a consequence, the policy agenda since the millennium has been dominated by a plethora of initiatives and legislative reforms spanning child and family services, child protection, criminal justice, social welfare and family law, designed to ensure that children at risk are identified as early as possible, parents are required to take responsibility for providing appropriate care for their children, and families are supported in fulfilling their responsibilities. Particular emphasis has been placed on involving fathers more in their children's education and upbringing, and on finding the right balance between working and caring.

More recently, the focus has broadened to highlight the importance of strong, stable couple relationships, whether they are same or opposite sex and whether parents are married or not. The evidence indicates that 'the qualities of our relationships have profound implications from our earliest years, for the emotional, cognitive, and physical development of our children, to our latest years – in old age, affecting the likelihood of hospitalisation, the rate of progression of disease in dementia, and even mortality rates' (Balfour, Morgan and Vincent, 2012, p. xxix).

Let us consider four questions:

1. What demographic, social and economic changes have impacted on family life?
2. What are the realities of modern partnerships?
3. How do these influence patterns of parenting and the obligations it implies?
4. What are the concerns and how are they relevant to social work practice?

Unparalleled social changes since the 1970s have resulted in greater ethnic and cultural diversity and huge variations in family living arrangements resulting from a declining fertility rate and increases in cohabitation, parental separation and divorce, single parenthood, same-sex partnerships, stepfamilies, people living alone, and the employment of women. Generally, people are living longer, are healthier, although health improvements are not evenly distributed across classes and cultures, and spend longer periods of their lives outside the conventional family unit (Roseneil and Budgeon, 2004).

Family life in the twenty-first century is fluid and diverse: although most young people expect to marry at some time in their lives and 7 in 10 families are headed by a married couple (ONS, 2007), marriage rates have declined and cohabitation has become commonplace, not only as a precursor to marriage, but also as a relationship of choice. Half of all births in the United Kingdom are registered to unmarried parents, although, in most cases, the parents are living together. Having children is frequently delayed and family size has decreased as couples are able to choose whether and when to have children (ONS, 2009).

While married couples still represent the main type of adult couple partnership, the age at which people marry has continued to rise. Most couples enter marriage having experienced earlier sexual relationships: an upward trend which has been evident for over 100 years. Despite a liberal attitude towards sexual behaviour outside marriage, facilitated by vastly improved methods of birth control, paradoxically, marriage today appears to demand a far greater commitment to sexual exclusivity and fidelity than was evident in more traditional marital partnerships. As a consequence, deep tensions emerge: sexual freedom prior to marriage is not

only tolerated but frequently encouraged, while monogamy is emphasized as the distinguishing feature of the marital relationship. Expectations of marriage are substantially greater than in the past and adulterous relationships are more likely to threaten its stability and durability, since tolerance of such behaviour has substantially diminished. Marriage today embodies a basic conundrum: mutual dependence, intimacy and sexual exclusivity have to be balanced within a culture which emphasizes personal growth and getting ahead – the 'we'/'me' dilemma. There is renewed emphasis on privacy, increased expectation of emotional companionship and equality, and a positive focus on sexuality beyond its function in procreation.

Until the industrial revolution, although the connection between romantic love and lifelong partnership through the institution of marriage was acknowledged, love and companionship were secondary considerations. The 'traditional' marriage has been described as 'differentiated' and 'complementary'. Modern partnerships, by contrast, are described as 'symmetrical' or 'companionate': a strong emotional bond from which personal emotional benefits are derived is no longer viewed as a bonus, but as a key aspiration. The emphasis in the 1980s and 1990s on achieving personal fulfilment changed the ways in which young adults view and form partnerships and approach parenthood. By the late 1980s, 40 per cent of marriages were preceded by cohabitation, and by 1996 this had increased to 77 per cent of first marriages and almost all second marriages. As these trends continue, it will be increasingly common for children to be born to never-marrying couples (Haskey, 2001). Of course, cohabitation itself is not new. Before divorce was an option people left unhappy marriages and lived with new partners, but cohabitation, either as a prelude or as a chosen alternative to marriage, is new. At the turn of the twenty-first century, a British Social Attitudes Survey (Barlow, 2004) found little support for the view that 'married couples make better parents than unmarried ones', and young people were considerably less likely to believe that 'people who want children ought to get married'. Although the quality of personal relationships is undoubtedly more important than their legal status, parenting and caring are still central elements in modern family life and there is no loss of commitment in modern partnerships: people seek to sustain the relationships they value (Walker *et al.*, 2010).

It is clear that the sexual and gender order that has underpinned family life is weakening (Roseneil, 2005), thereby stretching the conventional boundaries of partnership and parenting and rendering them infinitely flexible and permeable (McKie, Cunningham-Burley and McKendrick, 2005). Gay men and lesbians are able to adopt children and same-sex couples in the United Kingdom can register a civil partnership, according them rights and responsibilities similar to those of married couples. These newly acknowledged intimacies have required policy-makers and practitioners to move beyond traditional heteronormative conceptualizations of family life and parenting practices. In 2012, the UK coalition government took steps to permit gay marriage, a controversial but significant step in promoting gender equality in both partnership and parenting.

Postmodern living arrangements 'are diverse, fluid and unresolved, constantly chosen and rechosen' (Roseneil, 2005, p. 247). Koschorke (2004) argued that modern partnership demands a high degree of personal maturity, communication and negotiation skills, and described it as a difficult art. Couples have increasingly recast relationships into new confluent associations in which men and women are

seen as equals. Starting a family, however, appears to present a particularly important challenge to notions of equality in companionate partnerships. Although men and women can contract an equal partnership in cohabitation or marriage while they have only themselves to consider, when there are children the situation alters radically and the allocation of parenting tasks tends to be far from equal. While psychological literature has moved away from a belief in the exclusivity of the mother–child relationship, accepting that children can and do form multiple attachments, responsibilities for childcare fall primarily on mothers, even though the majority go out to work.

Fathers spend less time than mothers with their children and are less likely to take responsibility for their children's care (Clarke and O'Brien, 2004). The resulting parental role strain can have a detrimental impact on family relationships as increased freedoms in conjugal arrangements often conflict with the constraints inherent in parenthood. Whereas having a baby inevitably disrupts mothers' working patterns, few men can or do shift their work routines to accommodate children or take paternity leave. Most parents, and fathers in particular, view providing an income for the family as the central aspect of fathering. The enormous changes that life after having a baby entails are associated by many couples with a period of very high stress and parents' lives may begin to diverge (Walker *et al.*, 2010).

The increase in the number of families experiencing parental separation and divorce is almost certainly the single most important change in family life, and the one that has caused the most concern. Divorce rates increased substantially in most Western countries between the 1960s and 1980s, with other countries experiencing a more recent rise. Between 1958 and 1969 the number of divorces in Great Britain doubled, and it doubled again by 1971. The number increased until 1993, fell slightly, increased again between 2000 and 2004, and has remained fairly stable since then. Although more marriages survive than end in divorce, around 40 per cent of children experience parental divorce by their sixteenth birthday and others experience the breakdown of a cohabiting relationship. Around half of all divorces occur within the first 10 years of marriage (ONS, 2008a) – the period in which couples are most likely to become parents. Since many parents remarry quite quickly, and second marriages are even more likely to end in divorce, increasing numbers of children face repeated disruptions and the loss of several parental figures from the household. Such children are especially vulnerable and the most adversely affected by family transitions.

Until the mid-twentieth century, divorce was not a feature of daily life although there were probably just as many unhappy marriages. Economic, social and emotional constraints locked couples into intensely unsatisfactory and often violent relationships, with death the only release. Nevertheless, in the nineteenth century, two in every five children lost their father by age 15, and almost the same proportion their mother. Some 25 per cent lost both. Step-parents were as much a feature of Victorian life as they are today, as was living in a lone-parent household. The loss of a parent was absolute, however, and the complexities of post-divorce parenting arrangements unknown. Divorce, by contrast, has profound effects on parenting, and stepfamily formation following parental separation is one of the fastest-growing family forms in the United Kingdom: 40 per cent of all marriages are remarriages for one or both partners (ONS, 2008b).

In assessing the consequences of parental separation for children, the following factors demand consideration:

- the way in which children are prepared for parental separation and divorce (most are not);
- arrangements for continued contact with each parent and day-to-day living arrangements;
- the transition from a two-parent to a lone-parent (or step-parent) household;
- the number of disruptions;
- the quality of the relationship between parents and between parents and their children.

It is impossible and unwise to generalize about the effects, but the most distressed children are those caught up in their parents' battles. While most children experience short-term distress at the time of separation, only a minority suffer long-term adverse outcomes which can extend into adulthood (Pryor and Rodgers, 2001; Amato and Cheadle, 2005; Coleman and Glenn, 2009). Disentangling the emotional ties associated with the marital relationship while reformulating parental ties represents a hugely demanding and difficult transition for parents, making the ongoing obligations of parental responsibility particularly fraught (Ahrons, 2004; Walker *et al.*, 2004). Many non-resident fathers struggle to remain involved in their children's lives and some lose contact with their children over time, particularly when conflict between parents is unresolved.

The impacts of family change are keenly felt by adults and children. Research has highlighted the potentially detrimental impacts of divorce on children and on their parents (Mooney, Oliver and Smith, 2009), and the substantial associations between relationship breakdown and adults' physical and psychological ill health (Murphy, 2007). Parental separation and divorce can seriously compromise parents' ability to provide stable and consistent care for their children. Three consequences of family breakdown tend to arouse the most concern: the increase in child poverty, enduring parental conflict and father absence. Not all children experience these, but the risk factors for all children are increased, particularly in respect of poor educational attainment, behavioural problems, substance misuse, and crime and antisocial behaviour. The younger children are when they first experience family breakdown, the greater the likelihood that they will face multiple disruptions, simply because of their age. In the 2001 census, 38 per cent of cohabiting couples with dependent children were stepfamilies. An analysis of calls to Parentline Plus (2005) demonstrated the complexities and stressful aspects of stepfamily life: divided loyalties, feelings of rejection, anxieties about favouritism, resentment and anger are common. Since post-divorce family relationships are dynamic and subject to change, new parental relationships have to integrate with new forms of old relationships. The absence of clear cultural norms defining appropriate step-parent (particularly stepfather) responsibilities contributes to the difficulties families experience. Fathers and mothers have to renegotiate and redefine parental roles when parenting does not go hand in hand with conjugal partnerships, and their roles are open to a complex set of influences.

While parenthood requires no particular form of relationship or family structure, parenting denotes expectations about behaviours, tasks and commitments, and is a

challenging task. The meaning of parenthood has been transformed alongside the reconstruction of marital relationships: what has emerged is parenting based less on authority, gender division and marital status, and more on the quality of relationships between adults and between parents and children. The obligations of parenthood are not related to marriage but to the fact of being a parent. Children appear to have an accepting, inclusive view of what counts as family: their definitions and expectations do not centre on biological relatedness, and many children show considerable resilience and manage to overcome stress and disruption in their lives. Nevertheless, children from single-parent families tend to do less well than those living with both parents, although many do not have impaired outcomes. Lone mothers experience higher rates of depression and greater psychological distress than other women (Loxton, Mooney and Young, 2006) and often live in more disadvantaged neighbourhoods with a lack of social support.

Although the twenty-first century has seen greater acceptance of diverse family forms, anxieties continue about the stability of family life and the well-being of children. A variety of initiatives have been undertaken to redress the perceived deficit in parenting, but policies have stopped short of promoting marriage as the preferred family form. Nevertheless, there is clear evidence that children thrive best in families characterized by predictable and consistent care, and that such care is closely associated with stable and harmonious relationships between parents/adults carers, whether these adults are biologically or otherwise related to the children they are raising.

Data from the Millennium Cohort Study (Kiernan, 2004) suggest that the child-raising environment provided by cohabiting mothers may be less good for children that that provided by married mothers: mothers in cohabiting relationships are more likely to have had an unplanned pregnancy, live in a disadvantaged neighbourhood, have lower incomes and smoke heavily. Cohabiting fathers are just as involved in childcare as married fathers, however, and both cohabiting and married mothers score higher on all health and social indices than mothers who live alone. Recent studies (Hewitt and DeVaus, 2009; Reinhold, 2010; Svarer, 2004) show that cohabitation before marriage no longer increases the risk of divorce and, indeed, in countries in which cohabitation is firmly embedded, people in cohabiting relationships tend to be happier than married couples – both marriage and cohabitation appear to increase well-being (Musick and Bumpass, 2012).

Poor-quality couple relationships act as a risk factor which can contribute to worsening health, and two aspects of couple relationships are particularly important: the interaction between the partners, and the way in which partners work as a parental team. If both are positive, parents and children do well; if one or both is negative, the risk factors are significantly increased. Over 1,000 studies of child and adolescent adjustment indicate that the better the quality of the parent–child relationship and the better the quality of the relationship between the parents, and the better the economic and social resources available to the parents, the better the child's adjustment (Bornstein and Lamb, 2011). The task for policy-makers and welfare practitioners is to ensure that risk factors are minimized and protective factors increased, whatever models of partnership and parenting children experience.

The coalition government elected in 2010 reaffirmed the commitment to support families and promote the best outcomes for children, and provided increased

financial support for services that strengthen couple relationships. The Family Justice Review (Norgrove, 2011) pointed to the need for radical reform in both public and private family law, and widespread reforms in family law processes when parents separate, scheduled for 2013, emphasize that:

- both parents have a responsibility to ensure their child has constructive contact with each parent (shared parenting);
- help, advice and support for parents and children should be readily available;
- collaborative agreements between parents are likely to work better than those imposed by courts;
- children and young people should be given every opportunity to have their voices heard.

Reforms in youth justice have given courts powers to refer parents to parenting programmes, to make parenting and child safety orders, and to imprison parents for failing to ensure that a child goes to school or for breaching a parenting order. Poor parenting and lack of care and supervision are important influences on youth offending and antisocial behaviour, and parental obligations to bring up children as competent, responsible citizens are both encouraged and enforced.

The evidence suggests that parenting programmes can improve parent–child interaction and child behaviour (Quinton, 2004): universal services seek to support families at the key stages of vulnerability and change in a child's life, while targeted services aim to meet specific needs, for example during the breakup of parental relationships, when children get into trouble or through periods of mental or physical ill health. To be effective, 'parenting programmes need to ensure that they do not stigmatize or create dependency and last long enough for changes to be sustained rather than for false hopes and negative reactions to be evoked' (Barrett, 2003, p. 204). Increasingly, parents are expected to attend parenting information and parenting education programmes at the time of separation and divorce to help them understand the consequences for them and their children if they are unable to parent cooperatively. It is usually mothers who participate in these despite the widespread acceptance that fathers have a crucial role to play in their children's upbringing (Goldman, 2005). Should both parents be required to attend? Contemporary fathers are a diverse group and fathering has multiple dimensions within a diversity of styles and relationships (O'Brien, 2004). Fathering normally involves interaction with mothers, but when parents live apart that interaction can be damaged, disrupted or non-existent, thereby changing the ways in which fathering can take place. In order to promote a positive change in fathering practices, there is a need to:

- challenge traditional gender roles associated with childcare;
- encourage more flexible social attitudes to masculinity and fatherhood;
- facilitate more widespread family-friendly employment practices;
- encourage fathers' involvement in parenting activities and programmes.

As patterns of partnership change so do patterns of parenting. Practitioners face a considerable challenge in supporting parents across a variety of family forms, particularly those in which men have a weak investment. The modern family is faced

with a paradox: on the one hand, partnership formation and couple relationships are increasingly private and diversity is acknowledged; on the other, parents are expected to meet high expectations and their functioning is increasingly regulated. Social workers have to work at the interface between family autonomy and the obligations the state places on parents.

Today's families perform a variety of functions, including meeting daily material needs, caring for and raising children, caring for dependent adults, and meeting the intimacy needs of partners. The voluntary nature of modern adult partnerships makes them both fragile and strong: fragile because feelings are notoriously changeable, but strong because freely chosen relationships have an integrity and dignity which those based on economic dependence or coercion do not (Struening, 2002). Struening advocated that the welfare of fragile families must be a state interest because it is difficult for parents to do well unless they receive support.

Parents in the twenty-first century face a harder task than ever before. They are usually committed to their relationships and struggle to do what is right, and, in particular, to sustaining loving relationships with their children. Despite social flux, there are strong emotional and caring bonds within today's families, most of which provide children with an upbringing that is conducive to good physical and mental health, education, life opportunities, fulfilment and enjoyment (Williams, 2004). There is general agreement that social workers, health visitors, doctors and other professionals working with families should encourage couples to seek help and support at all stages of relationship formation and dissolution, recognize the detrimental impact poor relationships have on partnerships and parenting, strive to include fathers as well as mothers in parenting interventions and support programmes, and help couples manage the stresses which occur in all kinds of partnerships. It is important to confront overly romantic notions of partnership and parenting, and the taboos which prevent people from talking about relationships and relationship problems. Relatively few people take steps to prepare themselves for a committed partnership or for the demands associated with parenting.

## Five Key Points

1. Marriage, parenting and family have been regarded as 'a package deal', but the reality is different: modern partnerships put a strong focus on companionship and strong emotional bonds.
2. The boundaries of partnership and parenting are infinitely flexible, permeable and diverse, and parenting today is demanding, societal expectations are high, and partners have to adapt to new roles and responsibilities.
3. Parental separation and divorce have a profound impact on parenting, with potentially detrimental consequences for children.
4. Fathers play an important role in children's lives: traditional gender roles therefore need to be challenged and more flexible attitudes towards fatherhood encouraged.
5. Professionals working with families need to understand the importance of strong, sustainable family relationships and encourage people to seek help before relationships break down completely.

## Three Questions 

1. How does your own experience of childhood, partnership and parenting measure up?
2. Should all parents have to attend parenting classes, (a) when they have children and (b) if they split up?
3. How can fathers be encouraged to play a central role in their children's upbringing?

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# CHAPTER 2.5

# Late Life Ageing

*Ian Philp*

Late life ageing is shaped by the accumulation of life events and the proximity of death.

Although it is tempting to consider late life ageing as that which occurs towards the end of life, it is becoming increasingly recognized that late life ageing is profoundly influenced by earlier life experience. For example, a substantial body of research from the Medical Research Council Epidemiology Unit in Southampton suggests that early life nutritional experience, including as an embryo, affects health status in late life (Barker, 1992). Therefore, late life ageing needs to be considered as part of the complete life course.

Rembrandt's self-portraits in late life reflect this. His method of building up the foreground from the background until a clear and unique portrait emerges is one reason why his paintings of old age resonate. His method is analogous to late life ageing; the production of a complex and unique individual emerging from layer upon layer of background experience.

As long life increases exposure to life events, there is a tendency for late life ageing to be characterized by increasing diversity amongst individuals in relation to their health, functioning, relationships, standards of living, attitudes and perceived quality of life.

Although death is the ultimate leveller, late life ageing is not. We need, therefore, to avoid the temptation to make general assumptions which are too simplistic to explain late life ageing.

Furthermore, the world is changing at an accelerating pace, so the 80-year-olds of 20 years from now will have lived in very different times from the 80-year-olds of today, or 20 years ago, whose lives were dominated by the cataclysmic events of the Second World War. One of the most obvious changes is the greying

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of the population which is occurring in both the developed and developing worlds. However, the expectations of older people for improved material and health status may have as much impact on late life as the proportionate increase in the number of older people in the population.

Societies are also becoming more heterogeneous with widening differences (sometimes referred to as inequalities) in health and income which persist into later life.

To a large extent, then, late life ageing reflects the life-long influence of many external events on the individual. This process is described as extrinsic ageing.

Intrinsic ageing, on the other hand, refers to the ageing processes which are independent of external events and which, to a large extent, are programmed by genetic control. The genetic basis of ageing is illustrated by the 'disposable soma' theory (Kirkwood, 1995). This states that the human body is simply a vehicle for the transmission of genetic material. Ultimately, the human body is disposable, having served its role in the transmission of genetic material. In late life, it is of greater evolutionary advantage for the human to support 25 per cent of his or her gene pool in his or her grandchild, than 50 per cent in his or her child. Much human attitude and behaviour can, therefore, be explained from this perspective, including differing societal attitudes to old age which range from idealized views of old people in grandparenting roles to discrimination against old people in relation to life-saving interventions (Giallombardo and Homer, 1994).

An important determinant of intrinsic ageing is the limitation of the number of times different cells of the body can replicate. This is referred to as the 'Hayflick Limit', although the theory can be traced back to the nineteenth century (Weismann, 1891). Replication is necessary to repair worn out cells. In theory, it may be possible to alter the mechanisms which limit cell division, creating immortal cells, and extending life expectancy. However, interference with intrinsic ageing may extend life of poor quality if other ageing changes persist. Put simply, we could live for 700 years, but the last 600 might be spent in a state of advanced dementia.

In fact, advances in medical science are increasing our ability to modify extrinsic rather than intrinsic ageing, but there remains the prospect of molecular and genetic treatments becoming available which would fundamentally alter late life ageing.

The overall impact of recent health and social care systems on late life ageing is debated. Some have argued that the net effect has been the 'survival of the unfittest' (Isaacs, 1972), whereby people who would otherwise have died are saved for a life of disability. Others argue that the net effect has been to extend healthy active life which could lead to the compression of the period of disability into the last few years of life, prior to natural death from old age (Fries, 1980).

The balance of epidemiological evidence suggests that modern health and social care systems are helping to extend both healthy active life and disability-associated life prior to death. The combined effect, therefore, extends overall life expectancy.

Perhaps because extrinsic factors are dominant in the ageing process, we have yet to see life expectancy increase to the extent that compression of morbidity can occur as we get close to the limit of human life. Life expectancy for humans limited by intrinsic ageing is reckoned to be about 120 years.

A common misperception about ageing is that ill health and disability in later life are an inevitable feature of growing old. Although some features, such as deafness, poor vision, arthritis, a decline in fitness, failing memory and loss of teeth are

common, they are not inevitable in old age. The phenomenon of 'successful' ageing has been described, based on studies of cohorts of middle-aged people who have been followed over time into later life (Rowe and Kahn, 1987). Most of these people experience 'usual' ageing, characterized by a decline in a number of body functions, but some experience very little age-associated decline. Others experience greater than usual decline, described as 'pathological' ageing.

The importance of these studies is that they point to the challenge for disease prevention which could modify usual ageing towards successful ageing for future cohorts of elderly people. These studies also show that usual ageing changes are less dramatic than popular conceptions of ageing, which, for example, equate ageing with dementia. Only about 20 per cent of people aged 85 plus experience dementia, an example of pathological ageing, although most experience mild memory loss (usual ageing) and a small proportion experience no memory loss (successful ageing). These clinical findings are corroborated by autopsy examination of the brains of older people where a minority have extensive numbers of neurofibrillary tangles and plaques (the hallmark of Alzheimer's disease); most have a few, and a minority have none.

Public health goals may be directed towards promoting successful ageing, but health and social care practitioners will continue to work with older people whose ageing process is usual or pathological. A preoccupation with successful ageing could lead to discrimination against older people with disease and disability.

Disease in late life often comes to attention in non-specific ways including falls, confusion, immobility and failure to thrive. These presentations can be precipitated by a wide range of events, from a urinary infection to a change of environment, but there is usually a background of longer-term problems and a complex interplay of physical, psychological and social factors. Treatment strategies themselves may add to the problem. The term 'iatrogenesis' is used to describe illness induced by treatment and is fairly common in older people. The physiological reserve of the older person may be small, so that he or she may function adequately most of the time, but with a minimal threat a critical threshold may be breached causing dysfunction. A chain-reaction may be set up where dysfunction in one area leads to multiple failures of organs, systems, overall functioning and perhaps death.

For these reasons, rapid response to crises in older people may be rewarded by restoration of the older person to a state of acceptable health and functioning. However, repeated crises will reduce physiological reserve further and create a vicious cycle of increasing frequency of crisis and further decline in physiological reserve.

Much of health and social care practice is, therefore, concerned with caring for this type of frail older person, living close to the edge of incapacity. Fragmentation of health and social care systems, and exclusion of older people from access to acute care services undermines our ability to respond to the dynamic needs of older people, and leads to an increased reliance on long-term care services or family care to support an increasingly disabled population of older people.

A medical model of ageing which embraces the concepts of disability and disease inevitably reinforces the perception of ageing as a process of decline. A perception of decline in late life extends to the psychological and social as well as physical features of late life ageing, characterized by loss of health, autonomy, financial status

and the comfort of family, friendship and marital relations. Yet the experience of late life ageing for many people is not dominated by decline, but by accomplishment and satisfaction with life.

A theoretical basis for a positive view of late life ageing is provided by the work of Eric Erikson on psychological ageing.

Each stage of life, from infancy to old age is characterized by a psychological battle between successful and unsuccessful ageing. In old age, the battle is between integrity and despair. Integrity is characterized by a sense that life was worthwhile, life's mission is complete, and death, while not welcome, is not feared. Despair is accompanied by a fear of death, or death may be desired because life is seen as worthless.

With increasing longevity, there may be a stage beyond integrity, given that years of life may follow the milestone when life's mission is perceived to have been accomplished (Erikson et al., 1986). In spite of the many losses which accompany late life ageing, many, perhaps most, older people achieve a sense of integrity. Perhaps the fundamental task of social work with old people should be to promote this goal.

There is much still to be studied about late life ageing, and how it is changing with time, and amongst individuals and cultures of great diversity. New horizons from genetics to psychology are appearing, which could change the course of late life ageing. We can be sure of very little, except that the challenge to better understand late life ageing will remain a fascinating and worthwhile endeavour.

## Five Key Points

1. Late life ageing is shaped by the accumulation of life events and the proximity of death.
2. Old people vary in health, functioning, relationships, standards of living, attitudes and their perceived quality of life.
3. Advances in medical science are increasing our ability to modify extrinsic rather than intrinsic ageing.
4. Life expectancy for humans limited by intrinsic ageing is reckoned to be about 120 years.
5. Despite the many losses which accompany late life ageing, many older people achieve a sense of integrity.

## Three Questions

1. What ethical concerns are raised by the potential of genetic therapy to intervene in the ageing process?
2. If the goals of public health are to reduce disability-associated life prior to death, should resources be withdrawn from disabled older people?
3. How will social work for older people change when the 'me' generation reach old age?

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# BOOK 3

# When Social Work is Needed



*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

CHAPTER 3.1

# Family Disruption and Relationship Breakdown

*Jane Boylan and Graham Allan*

People are now choosing to construct their family and relational lives in far more varied and flexible ways than was common for much of the twentieth century (see Chapter 1.5, this volume). Major demographic shifts have occurred in, for example, marriage, cohabitation, same-sex relationships, divorce, births to single women and stepfamilies. This chapter is largely concerned with one aspect of these changes: the consequences for children of parental separation and the implications of this for social work practice. It is worth noting that, in line with changing patterns of partnership and birth trends, we are using the term 'separation' to refer to the ending of both marriage and cohabitation. On the occasions when we use the term 'divorce', we will be explicitly referring to the ending of marriage. In addition, we use the terms 'child' and 'children' in this chapter to refer to all dependent children and young people.

Social work has long been concerned with problems in family relationships and behaviour. However, which particular family problems are considered to be relevant to social work practice varies in line with shifting normative understandings of how family relationships should be patterned. New policy initiatives and altered legislation also change the ways that different agencies come to prioritize their work. Consequently family problems which gave rise to social work concern in earlier times may later come to be defined as personal matters over which there is little real need for social work involvement. Consider cohabitation and divorce, both of which were relatively uncommon in the mid-twentieth century. Both were also highly stigmatized, each being thought to reveal much about the moral standing of those involved. Social workers, health visitors and other welfare professionals often considered any children in such families as potentially at risk, and so warranting a degree of professional vigilance.

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Over the last 40 years, our ideas about motherhood and marriage have clearly altered. In particular, being part of a lone-parent or unmarried family is no longer seen as socially deviant or morally suspect. Some of these families may at particular times need family support or other social work interventions under the Children Act 1989, but the great majority do not. The fact that they live in family and household contexts which do not conform to traditional standardized nuclear family models is no longer understood socially or professionally as symptomatic of other problems.

## Children and Parental Separation

Some children cope well in coming to terms with their parents' separation (Hill, 2001). Nonetheless, parental separation is typically experienced as traumatic, with children often finding the familial and emotional disruption caused difficult to comprehend or accept. How they respond to the experience has been researched extensively and been shown to be influenced by many factors, some obvious, some more subtle. Social work and other practitioners should be aware of the impact on and the needs of children in the process and aftermath of parental separation. Not only do children usually experience an enormous sense of loss, they also share their parents' concerns about where they are going to be living, if there will be sufficient money coming into the household and what the future holds. In addition there are increased risks of adverse health, educational and behavioural outcomes in comparison to children from similar backgrounds whose parents do not separate (Mooney, Oliver and Smith, 2009).

However, it is also important to recognize that there is a great deal of diversity in the impact that parental separation has on children's lives. To begin with, the children involved are themselves diverse. That is, children of different ages, genders, class backgrounds, with different family histories, support networks, and the like, will have different resources and different means of coping with parental separation. As importantly, the short- and long-term management of the separation by the parents will vary, with consequences for the experiences of the children involved. How material circumstances – income provision, housing and the like – are handled is of consequence here, but so too are the continuing levels of cooperation and conflict between the parents. Research has routinely shown how emotionally disruptive higher levels of conflict can be for children whose parents separate (Bream and Buchanan, 2003; Butler *et al.*, 2003; Mooney, Oliver and Smith, 2009).

As indicated earlier, the changes that children experience with separation are not just changes in parental involvement and household composition. As well as developing a different relationship with the non-residential parent (in the great majority of cases, the father), children's social and economic circumstances are also liable to change. There is likely to be less money in households following separation than there was previously and female-headed lone-parent families are particularly likely to experience poverty (Bradshaw, 2002; Maplethorpe *et al.*, 2010). In addition, for some children, parental separation can result in moving home, neighbourhood and school, with implications for their friendships and other

support networks. So too, partly depending on the character of their relationship with their non-residential parent, their relationships with that parent's family, especially the children's grandparents, may also alter. Moreover, the separation may be the first of a number of linked family changes the child experiences, particularly if one or both parents re-partners to form a stepfamily – changes which are now recognized as having a greater cumulative consequence than the parental separation alone (Cheesbrough, 2003; Flowerdew and Neale, 2003; Panico *et al.*, 2010). These various changes that can follow separation may have a continuing impact on children's lifestyles, over and above any immediate issues of parental disruption, conflict and loss.

Increasingly in Britain and elsewhere in the Western world, policy initiatives are now recognizing that it is generally in children's best interests to maintain positive relationships with both their parents, with separation signifying the end of a partnership but not the end of parenting. While few children spend equal time living with both parents, the older perspective that children's interests are served best by a 'clean break' with the non-residential parent is now discredited. Yet while sustaining positive parental relationships is in children's interests – as mentioned earlier, continuing high levels of conflict following separation has been shown to be particularly damaging to children's adjustment – it is not always easy for the parents to facilitate this in the aftermath of separation. The need for parents to cooperate with each other over contact and residence arrangements can readily become problematic when other aspects of their relationship, including post-separation financial arrangements, are conflictual and adversarial. But it is clear that this is what children want; many children have a real concern that following separation and divorce they may lose contact with their non-residential parent. Indeed a significant minority of children – more than a fifth – do lose effective contact with their (non-residential) fathers following separation, especially as time passes (Blackwell and Dawe, 2012; Ermisch, 2008).

A key issue for understanding children's experiences of parental separation is that separation is always a process. In the past there was a tendency for divorce especially to be seen as a specific event, signifying a clear-cut change of status. In legal terms of course it was just this; a consequence of an unambiguous court action. But while divorce is legally and symbolically important, in terms of understanding children's responses to the ending of their parents' partnership it is the diverse and varied *process* of separation that matters. How this process pans out, how it is managed, what happens over time to the children, these are the issues that count. In the short term nearly all children experience a degree of trauma when their parents separate. But this does not mean they all continue to experience psychological or social difficulties as they grow older, especially as the nexus of relationships with and between their parents develop new stabilities. Some children do continue to have negative experiences, in some cases into adulthood. And many will experience further changes in domestic and familial structure, change which itself may be experienced positively or negatively. The important point though is that children's experiences are never static; nor are they uniform. Parental separation needs to be understood as part of a process, with a history, a present and a future, all of which can influence the impact that the separation has on children's longer-term well-being.

## Giving Children a Voice

One issue that has been prominent in recent research on the impact on children of parental separation concerns the information that children are given, both about the reasons for the separation and the consequences it will have for their lives. Often children are left in a void, not being told enough to allow them to understand what is happening. The adults involved are themselves struggling to cope, unsure of the future and seeking to 'shield' their children from the continuing disputes and uncertainties of the situation. Children are consequently often left in a state of 'unknowing', not able to make sense of their experiences and having little idea about what the future might hold. Increasingly, however, it is being recognized in both academic and policy contexts that not only do children need to be given better information but they also need to have their voices 'heard'.

Within academic research, new conceptions of childhood have emerged in which the view of children as 'incomplete' adults or 'human becomings' has been rightly challenged. Instead children are recognized as active human agents who shape and inform the world around them, including the private domain of the family (Lee, 2001; Smart, Neale and Wade, 2001). This has led to an increased awareness by parents and professionals working with children of the importance of seeking children's views and involving children in the process of decision-making (Boylan and Dalrymple, 2009). Similarly, developments in legal and policy frameworks have emphasized the importance of consulting with and listening to what children have to say. Notably, Article 12 (1) of the United Nations Convention on the Rights of the Child 1989, and Article 8 of the European Convention on Human Rights and Fundamental Freedoms (incorporated into UK law by the Human Rights Act 1998), support children's rights as participants in decision-making. The Children Act 1989 and the Adoption and Children Act 2002 also reflect these concerns.

In line with this, there is now increased recognition of the importance of listening and responding to children's accounts of parental separation. Historically, children's perspectives on these issues have either been ignored, or adult proxies used to identify the issues they – the adults – feel are important for children, rather than listening directly to the accounts of children themselves. Yet children need a chance to understand post-separation arrangements and to have some input into decision-making processes, particularly though not only over issues to do with contact arrangements. Given the impact the separation has on their lives, children also need an appropriate understanding of why the separation occurred, though often they are presented with conflicting or incomplete accounts by parents who are themselves still working out their own versions or 'moral tales' (Ribbens McCarthy, Edwards and Gillies, 2003) of their separation.

Recent research which has drawn on children's narratives of parental separation is illuminating here. For example, Butler *et al.*'s (2003) research provides a detailed and sensitive account of children's experiences of their parents' divorce. Among other issues, it examines how children were told about their parents' separation, the unhappiness children encountered, the questions they wanted to ask, and who children turned to for information and support. (See also Wade and Smart, 2002; Douglas, 2005.) Butler *et al.* (2003) argue forcefully for an inclusive approach that

embraces children's participation, not as 'bystanders' but rather as key players who are trying to make sense of and come to terms with changes in their family lives.

## Interventions and Support

As parental separation has become more common – with about a third of all children now experiencing this in Britain (Maclean, 2004) – numerous programmes and interventions have been developed to help children cope with its consequences. Many, though not all, of these are provided by voluntary organizations of one form or another. Importantly, the role of social work professionals in ensuring that children's best interests are protected is generally quite limited. Resources do not permit a social work service to be provided to all, even if it were wished or considered beneficial. It is really only in those relatively infrequent cases when disputes over childcare arrangements go to court for legal resolution – usually as part of contentious divorce proceedings – that professional social work involvement comes to have a part to play.

Under current law, Family Court Welfare Services are provided under the auspices of the Children and Family Court Advisory and Support Service (CAFCASS). Where there is dispute between parents over contact and residence that involves court proceedings, the court may draw on the services of CAFCASS to appoint a Family Court Advisor – a qualified social worker working exclusively in family courts – to report to the court on matters pertaining to the child's needs and welfare. Though this person is not specifically the child's representative, they typically attempt to find an acceptable resolution to the conflicts that protect the interests of the child and satisfy the court's requirements. Where resolution in this way is unsuccessful, their reports are drawn on by the courts in making the necessary decisions. An important element within CAFCASS working is the effort made to reach parental agreement through conciliation and mediation rather than contested court procedures, in line with the evidence discussed earlier about the emotional harm continuing conflict between parents can generate for children.

With the increased recognition of children's rights to be allowed a voice over matters that concern them, there has also been a growing awareness of the need for some children to have access to separate representation in order for their views and opinions to be heard in court. Under Family Proceedings Rule 9.5, it became possible for a child to be made a party to the proceedings and a *guardian ad litem* appointed, but this was only invoked in exceptional cases. In the light of the Human Rights Act of 1998, the Adoption and Children Act 2002 amended the Children Act 1989 so that a Children's Guardian could be appointed to represent the child's views where parents are in dispute about arrangements for their children, especially where there is an apparent conflict between the child's wishes and those of his or her parents. However, while the involvement of a Children's Guardian goes some way to promote the voice of the child in court, it has to be recognized that the Guardian's involvement is highly circumscribed and premised on a paternalistic and protectionist paradigm. In this way we can see tensions between professional constructions of childhood, and how this impacts on perceptions of childhood and notions of children's autonomy, competence and voice. Consequently, children are

often positioned as either having rights or as vulnerable and needing to be rescued. Children's protective and participatory rights must be upheld to ensure their voices are heard in a meaningful way.

Over time there has been a considerable growth in the number of less formal programmes created to help those involved come to terms with their experiences of separation. Some of these services aim to help parents reach more amicable agreements about childcare arrangements post-separation; others focus more directly on the children and aim to provide means for helping them understand and adjust to their new family circumstances. For example, various initiatives have been developed that encourage solicitors to facilitate conciliatory practices to resolve marital/partnership disputes rather than the more confrontational court procedures traditionally used. For example, in 2003 the Legal Services Commission developed the Family Advice and Information Service (FAInS) which sought to use solicitors as initial ports of call who, as appropriate, could refer their clients for mediation, conciliation, and other equivalent services (Douglas, 2005; Walker *et al.*, 2007).

The number of programmes developed to offer children more direct support when their parents are separating has also been increasing. Hawthorne and her colleagues (2003) provided an extensive review of many of these initiatives up to that date in the United Kingdom. Their review offers a valuable guide to the range of different approaches available. These included telephone helplines and email services, school-based projects, leaflets and booklets, and, perhaps now most importantly, web sites designed for children, focusing on their issues. The services developed have generally been quite small scale and often not particularly well funded. Moreover, as Hawthorne *et al.* (2003) note, the impact of many of these projects in helping children cope with parental separation has rarely been evaluated systematically.

Clearly which services are found most useful depends, among other things, on the children's age and their ability to read and navigate through different sources of information. Schools generally provide material about family change within personal, social health and economic education (PSHE), though some also offer more direct support services for children whose families are undergoing change (Wilson *et al.*, 2003). As Wade and Smart (2002) point out though, not all children want to discuss home matters in school. For older children especially, it seems likely that web sites will often be a starting point for finding out information about the changes they are experiencing, though as might be expected friends and wider family, especially grandparents, also provide many children with informal support and information (Maclean, 2004).

## Conclusion

A significant minority of children in the United Kingdom and other Western countries now experience parental separation. However, the majority of these children will have no need for contact with social work services as a result of doing so. Nonetheless, many social workers will have some level of professional involvement with children and families who are experiencing difficulties consequent upon separation. As part of the day-to-day business of social work, in particular assessing need

and providing appropriate family support, social workers will have to respond to many children (as well as parents) who each have their own stories to tell about the impact of parental separation on their lives. Importantly, these stories will not be uniform; each story will have its own history and its own dynamic. It is therefore imperative that social work practitioners understand the ways in which separation impacts on children and are able to listen to, hear and respond to their specific needs.

## Five Key Points

1. The impact of parental separation and divorce for children varies widely, depending in part on their post-separation experiences.
2. Children typically want to maintain a relationship with both their parents after parental separation.
3. Children need to be given as accurate information as possible about the reasons for their parents' separation and about the consequences it will have on their lives.
4. Children's voices need to be heard in post-parental separation matters, as in other areas.
5. The main pieces of legislation relevant to social work input with children following divorce are the Children Act 1989, the Family Law Act 1996, the Human Rights Act 1998 and the Adoption and Children Act 2002.

## Three Questions 

1. Under what circumstances should social work agencies be concerned with separation and divorce?
2. What factors contribute to parental disagreement over post-separation arrangements for children?
3. How as practitioners can you develop an approach that promotes children's participation and provides a 'space' for their accounts?

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# CHAPTER 3.2

# Child Abuse

*John Devaney*

Even before they are born, children have a need for parents who will provide for their physical, social and emotional needs through the expression of love, a sense of security and the provision of care. Children, especially when they are younger, depend on parents and family to provide the stability and security required to form meaningful attachments, and to grow and develop in ways which are positive. However, we also know that not all parents provide this sense of stability and safety, either because they are unable or unwilling to do so.

Over the past 150 years children have moved from the periphery to the centre in relation to the state and its obligations, to the point where there are now a myriad of projects dedicated to keeping children safe from physical, sexual and moral danger, and to ensure their appropriate development. It is relatively recently that welfare provision has become a state responsibility. This is not because of any significant change in the pattern of adult behaviour towards children but because of changing patterns of personal, political and moral control in social life which have, in turn, affected our vision of what childhood is and what it should be.

Over the past 20 years there has been a much sharper focus on how to support families before a crisis arises and how to intervene when a child is in need of protection. There is a fine judgement to be made in ensuring that a child's right to be kept safe is balanced with the right of parents to bring up their child without undue interference by the state (Munro, 2011). When the public and politicians believe that that balance has been misjudged, there is an outpouring of opprobrium through the media, which can create further difficulties for professionals in responding to children's needs. This has resulted in a series of high-profile inquiries and government reports into the child protection systems across the United Kingdom, such as Eileen Munro's in England in 2011. However, there is clear evidence that the systems

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for supporting families and keeping children safe are working, with a very clear and significant decrease in the numbers of children dying from abuse and neglect over the 40 years since the current child protection systems were established in the United Kingdom (Pritchard and Williams, 2010; Sidebotham, Atkins, and Hutton, 2012).

## What is Child Abuse?

Defining child abuse is complex – it involves an interpretation of what acts or behaviours towards a child are inappropriate, and an estimation of the amount of harm suffered by a child. There are specific criminal laws which provide a clear benchmark of what is inappropriate behaviour, such as the rape of a child. But in other instances the civil law focuses on whether the child has suffered harm as a consequence of parental behaviour (or inaction), and whether the harm is significant or not, such as when concerns exist about parental substance misuse.

Children may be at risk of experiencing harm from a range of people: parents, siblings, extended family members, family friends, peers, adults in positions of trust and strangers. Contrary to many of the media representations, children are at most risk from those who are known to them; but there is a very small group of individuals who pose a significant risk to any child they may have contact with, and recent improvements in the criminal-justice-led arrangements for monitoring and managing adults who pose a risk to children are an essential element in the child protection system.

Professionals have grouped child abuse into four main categories:

- *Physical abuse*, such as hitting, poisoning or scalding a child (although in the UK parents still have the right to smack their child providing the degree to which this is done is 'reasonable').
- *Sexual abuse*, which includes forcing or enticing a child to take part in sexual activities, even if there is no actual contact (such as in watching sexual activity or appearing in sexual images).
- *Emotional abuse*, which can be defined as the persistent neglect of a child's emotional needs (such as a lack of love and emotional warmth), or the severe emotional abuse of the child (such as exposing the child to fear or bullying).
- *Neglect*, the regular failure to meet a child's basic need for physical and psychological care, including the provision of adequate food or clothing, protection from physical harm, or attention to educational or health needs.

Additionally, research has highlighted how children may be at risk through their use of technologies such as computers and mobile phones, and from peers as well as adults.

Recently there has been a growing awareness of the impact on children of parental behaviours, such as domestic violence, substance misuse, poor mental health and learning disability (Cleaver, Unell and Aldgate, 2011). These issues compromise an adult's ability to provide for a child's needs, and professionals must look to what other supports might be available to the child to compensate, and how the child will be kept safe.

Within each of the four UK countries the respective governments have set out policies (such as 'Working Together to Safeguard Children' in England, http://www.workingtogetheronline.co.uk/index.html) to aid practitioners in defining which behaviours towards children should cause concern, and what action should be taken. The common features underpinning such policies and procedures are the importance of professionals with different disciplinary expertise and knowledge of the family working together to share and analyse information to better inform the decisions and actions which need to be taken.

## How Common is Child Abuse?

It is difficult to estimate the incidence and prevalence of a phenomenon such as child abuse. This is partly due to the difficulty in defining 'child abuse', but it is also related to the hidden nature of the different forms which child abuse can take. Our understanding of the nature of child abuse comes from a range of sources, including statistics gathered by professionals in the course of their work, personal accounts provided by survivors of abuse and neglect, and research studies.

The most comprehensive figures on the prevalence of child abuse in the United Kingdom were collected by the NSPCC in their 2009 study of child maltreatment (Radford *et al.*, 2011). This study was undertaken with a random probability sample of parents, young people and young adults from across the United Kingdom who were interviewed about their experiences of child abuse and neglect. The sample consisted of 2,160 parents or guardians of children aged under 11 years; 2,275 young people aged 11–17 years with additional information from their parents or guardians; and, 1,761 young adults aged 18–24 years. One in four of the young adults in this study reported having experienced severe maltreatment in childhood, defined as severe physical and emotional abuse by any adult, severe neglect by parents or guardians and/or contact sexual abuse by any adult or peer (Table 4).

Between 2006 and 2011, in the United Kingdom, there was a substantial increase in the numbers of children assessed by professionals as being at risk of experiencing harm through abuse and neglect (Table 5). This does not mean that more children are necessarily suffering abuse and neglect. Rather it is more likely that children at risk of experiencing harm are being identified and responded to by professionals.

While some people have attributed this increase to high-profile child deaths, there is also a sense of a rebalancing within the child protection system as professionals have started to acknowledge that support in itself is not enough to meet the needs of some children living with adversity. Professionals are now recognizing the value of a child protection plan in providing children with the safety they require alongside services aimed at improving their parents' ability to provide for their needs.

## What Causes Child Abuse?

There is no simple explanation for why certain children are abused or neglected. While any child may experience abuse or neglect, research indicates that certain children are more vulnerable due to a number of factors, some of which are to

**Table 4** *Rates of severe maltreatment.*

| *Maltreatment type* | *Under 11 years old* | | | *11–17 years old* | | | *18–24 years old* | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Male* | *Female* | *Total* | *Male* | *Female* | *Total* | *Male* | *Female* | *Total* |
| **Severe physical (%)** | 1.3 | 1.0 | 1.2 | 6.7 | 7.1 | 6.9 | 10.2 | 12.9 | 11.5 |
| | (18)[a] | (13) | (30) | (59) | (60) | (119) | (98) | (120) | (218) |
| **Contact sexual abuse (%)** | 0.2 | 0.8 | 0.5 | 2.6 | 7.0 | 4.8 | 5.1 | 17.8 | 11.3 |
| | (3) | (10) | (13) | (23) | (59) | (82) | (50) | (165) | (215) |
| **Severe maltreatment by a parent or guardian (%)** | 4.9 | 5.1 | 5.0 | 13.5 | 13.3 | 13.4 | 11.6 | 17.5 | 14.5 |
| | (64) | (64) | (128) | (119) | (112) | (231) | (112) | (163) | (275) |
| **All severe maltreatment (%)** | 5.8 | 6.1 | 5.9 | 18.2 | 19.0 | 18.6 | 20.3 | 30.6 | 25.3 |
| | (77) | (76) | (153) | (161) | (159) | (320) | (196) | (284) | (480) |

[a]The bracketed figures are weighted frequencies (i.e. the number of children in the survey who reported this experience adjusted to take into account the UK child population numbers). The weighted frequency counts are rounded to the nearest whole number so do not always add up to the total frequency.
Source: Radford *et al.* (2011), p. 8, Table 1.

**Table 5** *Numbers of children identified by professionals as needing a child protection plan.*

| | *Children subject to a child protection plan. Figures March 2006* | *Children subject to a child protection plan. Figures March 2011* | *Percentage increase* |
|---|---|---|---|
| **England** | 26,400 | 42,330 | 60 |
| **Northern Ireland** | 1,639 | 2,401 | 46 |
| **Scotland** | 2,157 | 2,571 | 19 |
| **Wales** | 2,165 | 2,880 | 33 |

Source: Table compiled by the author from statistics gathered from Department for Children, Schools and Families (2008), Department for Education (2011), Department of Health, Social Services and Public Safety (2011), Scottish Executive (2006), Scottish Executive (2012), Welsh Assembly Government web site (http://www.statswales.wales.gov.uk/).

do with their situation, some are related to the characteristics of the child and their family, and others which are related to specific incidents that the child experiences.

At a structural level, we live in an unequal society in the United Kingdom. There are clear links between age of death and affluence (Wilkinson and Pickett, 2010), and between parents' own educational success and that of their children (Feinstein, Duckworth and Sabates, 2008). There is also an association between experiences of child abuse and social deprivation (with the notable exception of child sexual abuse). This is not the same as saying that poverty causes abuse – most children from socially deprived backgrounds have very happy and loving childhoods. However, we know that living in poverty increases parental stress (Ghate and Hazel, 2002), and that parental stress is associated with poor mental health, substance misuse and domestic violence. Similarly, we know that some parents who are suffering from poor mental health or dealing with substance misuse are more likely to live in the most socially deprived areas through lack of employment opportunities and a lack of choice as to where to live. Families living in poverty often do not have the financial resources to cope with life's up and downs, such as a broken washing machine or the need to pay for extra tuition for a child who might be struggling with aspects of their education. While some socially deprived communities have a strong sense of solidarity and high levels of social capital to help families in such situations, this is often not the case (Merritt, 2009).

Beckett (2007) discusses the literature in relation to *horizontal stressors, vertical stressors* and *system levels*. *Horizontal stressors* refer to challenging events that occur as we move through life, some of which are predictable, but some of which are not. Examples could include an accident, redundancy or the birth of a child. *Vertical stressors* are areas of difficulty that we carry from the past, such as growing up living with a parent with poor mental health, or having experienced trauma arising from sexual abuse. In this theory, life becomes more difficult when horizontal and vertical stressors intersect. *System levels* refer to the different levels at which these stressors operate. As Beckett puts it, 'each individual encounters her own unique challenges and carries her own unique legacy from the past, but so does each family, community, or even nation' (2007, p. 116). At a systems (or

family level) there is strong evidence that some families are able to cope with the challenges of life, whilst for other families there are an accumulation of stressors that have an adverse impact on children's development. For example, Sabates and Dex (2012) have identified from the Millennium Cohort Study (http://www.esds.ac.uk/longitudinal/access/mcs/l33359.asp) 10 factors (including parental depression, overcrowding, maternal smoking during pregnancy, excessive alcohol consumption and teen parenthood) that increase the probability of children experiencing compromised cognitive and behavioural developments by their fifth birthday. They describe 'proximal family processes' which impact on parent–child interactions, such as a parent's mental health, physical disability or smoking during pregnancy, and 'distal family variables' which relate to parental attributes which impact on the parent–child relationship, such as parental alcohol misuse. Finally, there are contextual factors, such as overcrowding, which compromise both proximal and distal factors.

There are also various psychological theories that aim to inform our understanding of why some parents do not provide their child with the standard of care expected and required. For example, various models have been espoused about why adults may have a sexual interest in children even when society has given a clear message about what is appropriate and when the sanctions on those deemed to have transgressed are significant. In some cases, adults who abuse children are seen as being victims of their own troubled childhood and therefore in need of understanding and support, whereas in other instances they are seen as deviant and in need of sanction and containment (Harrison, 2010).

What is clear is that most parents want the best for their children but that some struggle to provide this. This can in part be explained by a lack of understanding of what a child's needs are, and in other instances is related to parents struggling to cope with their own adult difficulties. However, for a small number of adults, whether the child's parent or not, there is a deliberate desire to harm or take advantage of a child and his or her vulnerability due to age, understanding or circumstances.

## What are the Consequences for a Child of Abuse and Neglect?

While child deaths from abuse and neglect are sometimes used as a proxy for the effectiveness of the child protection system, the numbers of children who die in the United Kingdom as a consequence of abuse and neglect are low and falling (Pritchard and Williams, 2010; Sidebotham, Atkins and Hutton, 2012). However, there is a very strong literature informing our understanding of how children's experiences of abuse and neglect can have significant negative consequences in both the immediate and longer term for the much larger group of children who do not die. There are many different aspects of this research to be considered, such as the relative impact of different types of abuse and neglect, the importance of the level, extent and duration, and factors such as the relationship of the child to their abuser (Davison, Devaney and Spratt, 2010).

It has been recognized by researchers that the experience of adversity and, in particular, *multiple* adversities in childhood has implications for the ability of

individuals to resist the negative impact upon their lives. Accumulations appear to have higher predictive power than singular experiences of adversity, even though the trauma associated with, for example, child sexual abuse, may in some cases have severe and long lasting consequences for the individual. When predicting poor outcomes for an individual it is the multiples which matter (Spratt, 2012).

It is important to note that exposure to adversity is not deterministic in terms of cause and effect. In other words, it is not inevitable that individuals experiencing high numbers of adversities go on to experience poor outcomes, either later in childhood or as an adult. Some children deal with the abuse or neglect they have experienced, through their own resilience, supplemented by the support of family members and significant others, and the impact of professional interventions. However, there is strong evidence of a graded increase in the probability of experiencing poor outcomes associated with the number of adversities experienced in childhood.

In reflecting on why some young people appear to cope better with adversity than others Coleman and Hagell (2007, p. 14) have noted that:

- There is strong evidence from longitudinal studies that, where protective factors are present, most children and young people do recover from short-term adversity. In this sense we can say that the majority of children and young people have the capacity for resilience so long as the risk factors are limited, and protective factors are in place.
- Where risk factors are continuous and severe, only a minority manage to cope. The more serious the adversity, the stronger the protective factors need to be. Thus, under conditions of major risk, resilience is only apparent among a minority who can draw on the strengths gained from protective factors.
- The major risk factors for children tend to lie within chronic and transitional events, rather than in acute risks. Therefore children show greater resilience when faced with acute adversities such as bereavement, or short-term illness, and less resilience when exposed to chronic risks such as continuing family conflict, long-term poverty, and multiple changes of home and school. The research confirms that it is the multiplicity of chronic adversities which are the most dangerous for children and young people.
- Resilience can only develop through exposure to risk or to stress. Resilience develops through gradual exposure to difficulties at a manageable level of intensity, and at points in the life cycle where protective factors can operate. This requires the support of others, typically family and peers. However, for some young people it may be that family and peers are the source of their stress.

## How Should We Respond to Child Abuse?

The modern system for protecting children from abuse and neglect has five interlocking objectives (Devaney, 2009):

- reducing the prevalence and incidence of child abuse and neglect through preventative approaches;

- reducing the child mortality rate as a consequence of having a system for identifying and protecting children at risk of significant harm;
- preventing children identified as being in need of protection from experiencing repeated harm;
- addressing the effects of the harm experienced by children on their development, and promoting their welfare resulting in improved psychological and social functioning and improved educational attainment;
- addressing the needs of other family members so that they are in a better position to provide for the care and future protection of the child.

There is a need to develop services which aim to reduce the likelihood of a child being abused or neglected in the first instance, alongside a system for responding robustly and effectively when a child is assessed as being at risk.

Through initiatives sure as Sure Start and the Family Nurse Partnership, governments have sought to target communities and families that may experience problems in bringing up their children. Such services aim to provide a preventative psychoeducational intervention, whereby carers are provided with parenting advice, alongside instruction as to how best to meet their developing child's needs.

There has been a growing interest in intervening early when parents request help or professionals identify children who may be experiencing less than acceptable standards of care (Allen and Duncan Smith, 2010). This is clearly to be welcomed, although earlier intervention does not always mean that the underlying problems can be remedied quickly, and that some professional interventions may need to be sustained over a lengthy period of time.

Whenever a child has suffered abuse or neglect, or is at increased risk of doing so, the child protection systems in the United Kingdom are based on:

- professionals sharing information in order to provide a fuller understanding of a parent's ability to meet their child's needs;
- the necessity for additional measures to keep a child safe; and
- the provision of services to address the issues of concern.

This may mean the need for a child protection plan, or legal proceedings to secure arrangements for the child's supervision and care.

Ferguson (2011) has written about the importance of spending time with children and their families, in the places they live, to gain a more in-depth and therefore better-informed understanding of the day-to-day reality of children's experiences. Winter (2010) has researched how social workers talk to children, and the techniques which can be used to gain a greater understanding of their experiences and points of view, even when children are quite young. Without this first-hand direct contact with children it is difficult to make sense of children's experiences, and to understand the likely significance of information provided by other professionals.

A balance must be maintained between providing services to parents to address the adult difficulties they are experiencing and which interfere with their ability to parent, and providing services for children. There can be a tendency to assume that children do not require interventions in their own right if the environment within

which they live and the standard of parenting they receive is improving. However, there is increasing evidence of the need for and efficacy of providing children and young people with the opportunity to discuss their experiences, using interventions with a proven evidence base (Wethington *et al.*, 2008).

## Five Key Points

1. Earlier, sustained and coordinated professional intervention leads to better outcomes for children and their families.
2. Effective child protection flows from professionals having a clear understanding of their own role and the role of other professionals.
3. Children's needs must be seen in the context of their parent's needs, but the child's needs must always take priority.
4. Spending time with the child, in their environment, is essential to understanding the child's point of view and their experiences.
5. Children need interventions in their own right to redress the emotional and psychological impact of the adversities they have experienced.

## Three Questions 

1. How can we define what constitutes 'good enough parenting', and what factors might influence this?
2. What are the outcomes we want to achieve for children when we intervene in respect of concerns about abuse and neglect?
3. What are the challenges for a social worker in seeking to support families whilst also ensuring the protection of children at risk of abuse or neglect?

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# CHAPTER 3.3

# Domestic Violence

*Cathy Humphreys*

Most social workers work with women, children and men affected by domestic violence, though relatively few are employed in specialist refuge, outreach services or perpetrator programmes. Intervention to support domestic violence survivors or to challenge domestic violence offenders may only be picked up as a secondary issue when addressing other agency priorities such as: mental health, family law, substance abuse, child protection, youth services, criminal justice, homelessness, older people. Each service brings its own specialism, of which an understanding of domestic violence intervention is but one element. It is everywhere and too often nowhere on the radar of the workers involved. It is not the main 'business' of any of these services, yet when women, children and some men are living in fear, traumatized by violence and abuse, then their worlds, their decision-making and their ability to change their lives will be severely constrained.

Increased attention has been given to both multi-agency working and to safeguarding of children over the past decade. While this represents significant progress, there remains a strong tendency towards fragmentation particularly in relation to ensuring safety and well-being for both women and children.

## The Extent of the Problem

Problems arise in estimating the scale of domestic violence as it usually happens behind closed doors. Definitions and terminology are always contested. Many jurisdictions now prefer 'domestic abuse', 'intimate partner violence' or 'family violence'. The term 'domestic violence' has both strengths and limitations.

A standard definition is provided by Women's Aid, England:

*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

> Domestic violence is physical, sexual, psychological or financial violence that takes place within an intimate or family-type relationship and that forms a pattern of coercive and controlling behaviour. This can include forced marriage and so-called 'honour crimes'. Domestic violence may include a range of abusive behaviours, not all of which are in themselves inherently 'violent'. (Women's Aid Federation, England, 2012)

It has also been important to include the issues in relation to children:

> it must be recognised that children are witness to and subjected to much of this [domestic] abuse and there is a significant correlation between domestic abuse and the mental, physical and sexual abuse of children. (Scottish Executive, 2000, p. 5)

Surveys show large numbers of women affected by domestic violence, usually citing one in four women affected over a lifetime. The British Crime Surveys are the most comprehensive in the United Kingdom and show that while many men report some form of abuse, women are overwhelmingly the most chronically abused and the most seriously injured. It is therefore a gendered issue evidenced by 81 per cent of incidents being attacks on women (Walby and Allen, 2004).

At its most serious, women die. More than half of female homicides are committed by a partner or ex-partner compared with only 5 per cent of male homicides in 2009–2010 in England and Wales.

## The Effects on Children

The link between child abuse and domestic violence is now well established (Holt, Buckley, and Whelan, 2008). Children's experiences of living with domestic violence are compounded by their increased vulnerability to many forms of abuse as evidenced by the research by Finkelhor, Ormrod and Turner (2009) which suggests that there is a group of vulnerable children who live in environments in which polyvictimization is prevalent. This literature shows a linear relationship between the number of childhood adversities (domestic violence, peer bullying, property crime, child physical and sexual abuse) and the level of adverse outcomes for children. Domestic violence leads to the largest increase in lifetime victimization scores for children under 18, though issues such as child sexual abuse are weighted more heavily in terms of their impact on the child's future emotional well-being.

Particular concerns have been raised about the level of direct physical abuse which children experience in the context of domestic violence. A meta-analysis of high-quality studies showed that rates varied widely from 30–66 per cent of child abuse cases (Edleson, 1999). Much depends on whether sensitive questions are asked about domestic violence, a factor that can easily double the rate of domestic violence which comes to light (Hester, 2006). Similar issues arise in the exploration of child sexual abuse, an area which Holt, Buckley, and Whelan (2008) point out has been less researched. Clear evidence is emerging that between 40–70 per cent of child sexual abuse occurs against a backdrop of fear created through domestic abuse (Kellogg and Menard, 2003).

The tactics of abuse often represent an attack on the mother-child relationship by the perpetrator, undermining not only his fathering role, but also the mother's

parenting abilities (Radford and Hester, 2006). Studies consistently show that children living with chronic domestic violence have two to three times the rates of cognitive and behavioural problems compared to children from non-violent families (Kitzmann *et al*., 2003). Problems for children can compound over time as developmental stages are disrupted. At its most serious, children also die. Child death inquiries, including those associated with deaths during child contact frequently show men who were violent to both the child and the child's mother.

However, children live in different environments of protective factors and vulnerability. In any study of children living with domestic violence, at least a third will be functioning as well or better than other children in the community. Children who have been most recently exposed to serious and chronic violence at a young age tend to show the most marked problems. Those who have moved on and are no longer living with violence may be much less disturbed, both emotionally and behaviourally: a finding that has implications for ensuring that child contact arrangements are safe and non-abusive.

In summary, children's responses to living with domestic violence cannot be predicted. Individualized risk and safety assessments of children and their circumstances need to be undertaken to ascertain the needs and the services which are required.

## The Impact on Women

Social workers in mental health teams, disability teams, teams for older people and social workers in the substance use and health sector will all be in touch with women who are affected by domestic violence.

Studies of women and mental health illustrate the seriousness of the impact. Amongst abused women, depression, post-traumatic stress, suicide and self-harm are so prevalent that they can be referred to as 'symptoms of abuse' (Humphreys and Thiara, 2003). Cross-national studies are consistently showing significant rates of mental health problems associated with domestic violence, with the problem of suicide attempts and other mental health issues for black and Asian women being particularly grave (Thiara and Gill, 2010). The serious health issues for women are also of concern. A major Australian population study found that domestic violence was the highest risk factor in determining the physical health of women under 45 years of age and that the health burden contributed by domestic violence was significantly greater than any other risk factor including smoking and obesity (VicHealth, 2004, p. 25).

The level of problematic substance use (while not a cause of violence) is an issue for a significant number of perpetrators of violence, as it is for some of their victims, though the patterns of use are different. Men are more likely to drink prior to and during an incident and women following an incident often as a means of coping with the emotional and physical pain of abuse (Galvani, 2010).

Other work has highlighted the issues faced by disabled women. It is now recognized that disabled women have an increased risk of suffering domestic violence relative to non-disabled women and that the range of abuse tactics which can be used against them is myriad and often troublingly punitive (Thiara *et al*., 2011), requiring a new range of standards and practice considerations to be developed (Healey, *et al*., 2013).

## Social Work Responses to Domestic Violence

While there has been increased attention given to domestic violence as a major social problem, social workers, particularly those employed in statutory childcare, remain with problems associated with:

- ignoring violence towards the child's mother unless the child is directly harmed;
- placing too much emphasis on separation without necessarily providing the support for this risky and often dangerous action;
- focusing on the mother's 'failure to protect' or other problems rather than on the man's violence;
- withdrawing too early to provide effective, ongoing action ('stop-start intervention');
- paying inadequate attention to strengthening the mother-child relationship which has been under attack through the domestic violence.

It is certainly far too easy to blame front-line social work staff for insensitive responses. Hester (2011) has drawn attention to the different intervention responses which women and children receive depending upon whether they engage through family law, child protection or the criminal justice system. Hester refers to this as intervention on 'three planets' and points to the need for the changes to supervision culture, training and resources required to ensure more comprehensive attention to a holistic notion of safety and well-being across agencies.

Significant organizational problems need to be overcome to develop more effective and safer intervention from social workers where domestic violence is present. Given that there are often both child and adult victim/survivors, policies involving adult and children's services should ensure that there is not an inappropriate focus on one at the expense of the other.

The impediments to women's help seeking need to be recognized. Women are often threatened by abusers with the loss of their children or construed as 'mad', bad or unbelievable. These issues are heightened for women whose social location in relation to ethnicity, poverty, disability and other social divisions create further barriers to services. Proactive work therefore needs to be undertaken by social workers to overcome discriminatory practices and to be alert to the danger of colluding with the abuser's definition of family problems which invariably invite minimization of the contribution of his violence and maximize the focus on the woman and her shortcomings.

Like in many other areas of social work, inter-agency collaboration is essential. Guidance across safeguarding and domestic violence constantly emphasizes its importance, and heightened attention has been given to attending to high-risk situations through multi-agency risk assessment conferences (MARACs) and domestic violence advisors (Howarth *et al*., 2009). The evaluation of these latter strategies point to the increased effectiveness which can arise from tight multi-agency working, which appears to contrast with the access to safety offered through the more standard child protection referral. The case-tracking study of 251 police domestic violence referrals to child protection services by Stanley *et al*. (2011) showed that the

### 4 Strengthening the mother–child relationship

It is now firmly established that domestic violence has a profoundly negative impact on adult survivors as well as their children. An aspect which is the subject of growing attention is the processes through which domestic violence also represents an attack on the mother–child relationship through:

- Disabling the mother physically through violence so she is unavailable to her children.
- Disabling the mother mentally through trauma and depression so she is emotionally unavailable.
- Actively undermining the mother's parenting.
- Interfering in quality time between mothers and children.
- Criticizing and insulting the mother in front of the children which undermines their respect for her.
- Sexually assaulting and humiliating the mother in front of her children.

Social work assessment needs to explore the ways in which domestic violence has affected relationships between mothers and their children. Planning intervention to strengthen these relationships in the aftermath of abuse should be an important aspect of support and healing (Humphreys, Thiara and Skamballis, 2010).

overwhelmed statutory service provided only 5 per cent of newly referred children with an initial assessment. Interestingly, the community-based domestic violence adviser services showed that, through providing multi-agency support and ensuring the mother's safety, the risks to children were substantially diminished between Time 1 and Time 2: conflict around child contact improved by 45 per cent; victim 'afraid of harm to children' improved by 76 per cent; and perpetrators threats to kill the children changed by 44 per cent. In essence, multi-agency collaborations can provide opportunities for social workers to provide a more responsive and safer service for women and children affected by violence.

It is not only the safety of women and children that needs to be considered. Workers are also at risk, particularly if they shift to a more challenging practice which does not collude with or ignore the perpetrator's violence. Organizations will need both policies and training to implement safety planning into practices of social workers in more self-conscious ways, if work in this area is to make progress.

## Future Directions

While there are significant barriers that constrain effective intervention, the increased awareness of domestic violence has led to greater attention being paid to the development of legislation, policy and practice.

A more effective legislative framework was put in place with the passing of the Domestic Violence, Crime and Victims Act 2004 and more recently attention has been given to strengthening legislation to exclude the perpetrator from the home. A further development in the United Kingdom has been the amendment to the definition of harm in the Children and Adoption Act 2002, which includes 'impairment suffered from seeing or hearing the ill treatment of another'.

Police have been issued with a clearer mandate for action. This includes the development and running of the MARACs to attend to high risk. Their work has been further enhanced by the development of specialist domestic violence courts which show an increase in convictions. Concerns are now growing about the number of domestic violence incidents which involve young people attacking their parents. The area of child contact where there has been domestic violence remains problematic. Contradictions can develop between social workers urging women to leave to protect their children, on the one hand, and family courts ordering contact which is often unsupervised, on the other.

Good practice will ensure that social workers are conscious of careful recording and enhanced evidence-gathering in cases of domestic violence. This will mean:

- screening for domestic violence at all stages of referral, investigation and assessment;
- recording in detail any information on domestic violence; and
- case advocacy to ensure that other agencies also document evidence.

The development of family support provision (section 17, Children Act 1989) and early intervention are under threat with funding cuts to Children's Centres, Sure Start, early years services, and children's workers in refuges. These services, along with funds for children's groups, women's groups, and children without recourse to public funds provide important community support.

An important new policy direction has been provided by the extension of domestic violence strategies to include a more holistic approach to violence against women and girls. In this process the issues of sexual violence, violence against young women in dating relationships, trafficking, female genital mutilation and 'honour crimes' can be attended to. The broader framing, while less focused, creates fewer silos in understanding the widespread problems of violence against women and girls (Home Office, 2011).

New directions are also developing for domestic violence intervention which takes into account other complexities such as substance use and mental health problems and also includes renewed pressure for adult services to direct their attention to the children whose parents are attending services: family sensitive practice. This shift in direction could provide more opportunities for more responsive, safer intervention which places domestic violence firmly on the mainstream social work agenda.

## Five Key Points

1. Domestic violence is a problem relevant to all areas of social work practice, though frequently the issue is invisible or marginalized as other service priorities take precedence.
2. Children's vulnerability to other forms of child abuse is increased by the presence of domestic violence.
3. The two key principles for effective work in this area are: accountability and consequences for the perpetrator (usually the man) and his abuse; and attending to the safety and well-being of domestic violence survivors (usually women and children) through providing for their separate as well as linked needs.
4. Screening for domestic violence by asking sensitive questions will significantly increase awareness of the numbers of individuals using the agency who are affected by domestic violence.
5. Domestic violence intervention requires effective collaboration in and between adult and children's services, as well as a wide range of other agencies including police, housing departments and the courts.

## Three Questions

1. What issues affect women's decisions to stay in or return to a situation of domestic violence?
2. What issues could be covered in risk assessment and safety planning with (i) women and (ii) children affected by domestic violence?
3. What local services should be available to create more effective domestic violence intervention?

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# CHAPTER 3.4

# Ill Health

*Eileen McLeod and Paul Bywaters*

'Recipients of social care services are likely to be among the most socially disadvantaged and most will have a long-term debilitating illness or disability' (Marmot, 2010, p. 159). Evidence of this double jeopardy has been reported for looked-after children and care leavers, mental health survivors, older people and people with learning disabilities. Service users are also over-represented in groups liable to receive inferior treatment or care when ill. However, the association between service users' ill health, poor access to treatment and adverse social circumstances remains neglected as a focus for social work. It should constitute a key reason for practice because it represents a situation of social injustice lived out in individual pain and suffering, a breach of human rights. 'Social workers in all settings are engaged in health work whether in creating the conditions for improved health chances or working alongside people to manage the impact of poor health on themselves or those close to them' (International Federation of Social Workers (IFSW), 2008).

## Lifetime Damage

There is powerful evidence that social disadvantage is associated with increased chances of profound ill health, reflected in the incidence of illness and reduced life expectancy. 'Those on the higher rungs of the socio-economic ladder are more likely to survive in good health; those on lower rungs are more likely to succumb to disease and premature death' (Graham, 2000, p. 2). This creates a gradient in health outcomes running right across society, not just a gap between 'haves' and 'have nots'.

Relative poverty is deeply implicated in these processes. In the United Kingdom, male life expectancy between 1998 and 2002 in the three most disadvantaged postcode areas in Glasgow was under 60 years while in several most advantaged areas

*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

baby boys could expect to live for over 80 years (Hanlon, Walsh and Whyte, 2006). Such socio-economic differences in the risk of ill health persist throughout the life course. Government figures on reported limiting long-standing illness show that men and women living in the most deprived areas in England spend twice as many years of their lives in ill health than those living in the most affluent areas – 26 years compared to 12 years for women, and 22 years compared to 11 years for men (Office for National Statistics, 2005).

Other interacting dimensions of structural inequalities such as racism also influence health outcomes. For example, Karlsen and Nazroo (2000) found that members of the Pakistani and Bangladeshi populations in the United Kingdom, four-fifths living in poverty, were on average 44 per cent more likely to report only fair or poor health than the majority white population.

Similarly, the complex interaction of gender and poverty with physical well-being is reflected in damage to health through violence and suicide, as well as illness. Men in social class V are four times more likely to commit suicide than men in class I, with men three times more likely to commit suicide than women (Department of Health, 2002c). Almost a third of women will experience domestic violence at some point in their lives, which is not only associated with serious physical injury, but increased risk of self-harm and suicide (Humphreys and Thiara, 2003).

## Service Users: At Risk

Most service users face particular obstacles in obtaining the basic resources for health: good economic, social, environmental and political conditions (Commission on the Social Determinants of Health (CSDH), 2008). Yet service users' material circumstances have remained largely undeveloped as a direct focus of social work action in the United Kingdom.

There is clear evidence that the low income which characterizes service users' lives will have health consequences. Care leavers identify safe, affordable accommodation as their major housing problem (Allard, Fry and Sufian, 2004). Mothers parenting in poverty have commonly been found to go short of food themselves to feed other family members (Seeley and Lobstein, 2004). Being unable to afford to heat their homes adequately remains a significant threat to older people, increasing both the risk of ill health and death (Marmot Team, 2011).

Discriminatory attitudes and behaviour also undermine the supportive social relations which are essential to maintaining health. A joint Mencap and Guardian (2012) newspaper inquiry into 74 deaths of learning disabled patients in NHS care found evidence of enduring institutional discrimination, despite a programme of improvements since their earlier report, 'Death by Indifference' (Mencap 2007), with inappropriate attitudes leading to mistakes and failures in treatment. There is also evidence that homophobia increases the risk of violence against lesbian, gay and bisexual (LGB) people. For example, in a study of school age LGB people, 78 per cent reported verbal abuse from and 23 per cent had been attacked by other pupils (Ellis and High, 2004).

Health screening programmes can be an important element in reducing service users' chances of ill health but structural discrimination is also associated with

generally lower rates of screening (and subsequent service provision). Lesbian and bisexual women are up to 10 times less likely than women in general to have had a cervical smear test in the past three years, while a survey of UK cancer services reported in 2008 found only 1 project in 77 which included an explicit focus on sexual orientation and cancer (Fish, 2009a).

## Ill Health: Unequal Treatment

Service users' unequal chances of ill health and premature death are compounded by a further injustice: harsher social conditions in which to manage ill health, and unequal access to good quality treatment and recovery. Socially constructed barriers may prevent people from getting to healthcare settings or accessing diagnosis and treatment. Internalized ageist assumptions about the inevitability of ill health in old age can result in older people being disinclined to 'trouble the doctor' despite worrying symptoms. Members of minority ethnic groups are less likely (than the majority population) to get an appointment on the day they want and more likely to feel that the GP does not answer their questions (Office for National Statistics, 2004).

The physical state of being ill, involving pain, malaise and debility, is also marked by social inequality, exacerbating the suffering involved. It is well recognized that effective assessment and management of pain in non-English-speaking patients and patients from minority ethnic groups is undermined by failure to address linguistic requirements, and assumptions about cultural norms (Green, 2003).

As well as aggravating the rigours of being ill, social disadvantage can make recovery harder, creating heavier demands on personal resources. Expenses are likely to rise with the need for extra heating, a particular diet or as a result of being unable to shop for yourself. Extra domestic help may need to be organized and paid for or additional phone calls made. This is much more difficult to negotiate if you are unsupported, living on a limited income and perhaps have a pre-existing physical impairment. Unfortunately there is evidence that large numbers of older patients are still having to cope on their own with recovery after hospitalization with inadequate material and social resources (Age UK, 2012).

## Inequity when Dying

The pernicious health effects of social inequality persist even when people are dying; as a result they experience needless, intensified suffering. The serious and widespread consequences mean this should be the concern of social workers generally, not simply those practising in palliative care settings; and once more, the imprint of poverty is discernible in many ways. Population studies have found that where people are both terminally ill and poor, they are:

- often desperately worried about how they can provide for their dependants;
- more likely to be living in accommodation which is problematic for their care;
- less likely to be able to keep their home adequately heated or to be able to find the money for necessities;

- less likely to be referred for specialist home care which is associated with longer periods of survival;
- less likely to have what is most people's choice: the possibility of dying at home (McLeod and Bywaters, 2000).

Ageist discrimination also meshes with relative poverty in the course of terminal illness. The majority of older people will be dying in relative poverty, particularly older women in advanced old age, living alone. However, people aged over 85 are less likely to be admitted to hospice care, despite the adverse social conditions they are likely to be experiencing, together with a higher degree of physical impairment. Pain relief in nursing homes has been found to be inferior to that available not only in hospices, but also in hospitals, and with little specialist back-up palliative care available (McLeod and Bywaters, 2000).

## Social Work: Making it Worse?

A key role for social work and social care services in tackling inequalities in health emerged in UK government policy in the late 1990s and was reinforced in the Marmot review (2010). This primarily took the form of requiring that Social Services collaborate with other agencies such as Housing and Health Authorities to address deprivation on a locality basis. In addition, the government recognized the importance of social work's contribution in its own right (Bywaters and McLeod, 2001).

However, social work's record on health shows that current practice, increasingly constrained by declining public sector budgets, can contribute to the problems people face. For example, as we have discussed, relative poverty is a crucial factor in prejudicing service users' health, but directly addressing poverty remains marginalized in practice. Personalized budgets and reablement approaches promote individualized rather than population-wide interventions and obscure the possibility of primary prevention. Social Services have frequently failed to protect and promote the health of children in the care system (Broad, 2005).

Social work's inattention to the health dimensions of practice has been exacerbated by successive governments' under-funding of social services and the increasing policy emphasis on narrowly targeted, means-tested, provision. The result is that 'hundreds of thousands' of people are deemed ineligible for social care services even though they need help with basic tasks like getting dressed or going to the toilet (Age UK, 2012). Informal carers continue to run an increased risk of long-term health problems, through inadequate levels of financial and direct home care assistance (Carers UK, 2004).

## Social Work: Making Things Better

There are powerful reasons for social work to recognize and address ill health as a location of socially created inequality. Service users suffer from widespread, unjust suffering in the form – and course – of poor health, and social work itself is

## 5 Working with Kerry

As a social worker in an outreach project working with homeless young people, you are in contact with Kerry who is living rough around the city centre. Kerry is 17, white European, and left care a year ago. Since then she has had a number of addresses including the lodgings she was first placed in, periods with a boyfriend who was living off her earnings as a prostitute and short-term stays with friends. She has also been quite a frequent attender at casualty as a result of asthma attacks and two occasions when she cut her arms. She weighs about 6 stone and smokes. Kerry attended special school and is described in her file as having 'mild learning difficulties'; she was rejected by her mother and father and taken into care when she became pregnant at 14. The baby was adopted. She is very reluctant to enter hostel accommodation.

In relation to this situation, consider:

1. How are unequal social conditions implicated in Kerry's current experience and future risk of ill health?
2. How can social work contribute to tackling the health problems she may face?

implicated in some of the processes involved. However, in incremental ways not confined to healthcare settings, social work can contribute to greater equity in the chances and experience of ill health (see Box 5).

The evidence base for social work's capacity to reduce health inequity by positively influencing the impact of the social determinants of health on people's lives is not well developed (Coren *et al.*, 2010). For social work – and the wider range of social care – services to maximize their effectiveness in this respect, a comprehensive, multilevel strategic approach needs to be adopted. This strategy would include a focus on the impact of social care agencies on the structural determinants of health:

- as employers of close to two million workers in the United Kingdom, making choices about pay, terms and conditions, health and safety, job security and retirement prospects
- affecting the environment through buildings, energy, transport and other policies
- as purchasers and providers of a range of goods and services
- as opinion leaders, data gatherers, regulators and inspectors of services.

Crucially, it would permeate the priorities, policies, guidance, training, research and management of front-line practice as well as practice itself. Some evidence has emerged about key features of such action (IFSW, 2008).

Social work practice which addresses health inequalities operates in all settings, not just in healthcare settings. It also addresses multifaceted aspects of service users' lives. For example, work with young people in the care system and leaving care involves tackling health inequalities when young people's immediate health needs are met through ensuring good access to dental and health services and through action on smoking and other substances abuse, sexual health and risk-taking, through maximizing educational and work opportunities and ensuring good quality housing and supportive social relationships (Broad, 2005).

Social work practice which addresses health inequalities recognizes the importance of interventions designed to improve not only current, but longer-term health chances, and prioritizes accordingly. For example, flexible, multi-agency early intervention and preventive services, such as Sure Start Children's Centres and Partnership for Older People Projects (Personal Social Services Research Unit, 2009) can – if focused on reducing inequalities – have long- as well as short-term benefits.

Social work practice is tackling health inequalities when interlocking aspects of disadvantage are a focus of attention; for example, adult care services which explicitly address the requirements of lesbian, gay, bisexual and trans people and recognize that some LGBT people will also be learning disabled people or members of an ethnic minority (Fish, 2009b).

## Conclusion

Physical ill health as a site of social inequality needs to be a major issue in social work. Threats to health and the experience of ill health characterize the lives of service users because of disadvantaged social conditions and interlocking dimensions to discrimination. As social workers we also need to be aware that our practice can exacerbate this situation. Nevertheless, the ultimate reason for this aspect of social injustice being a focus of practice is that social work can contribute to tackling service users' unequal chances and experience of ill health.

## Five Key Points

1. Ill health is a site of social injustice: social inequalities create unequal chances and experience of ill health causing profound, widespread, needless suffering.
2. Relative poverty cross-cut by further dimensions to social inequality is centrally implicated in unequal chances and experience of ill health.
3. Because of the disadvantaged circumstances in which most service users live, they experience high rates of ill health and often face inferior treatment and care.
4. Social work policy and practice can compound inequalities in health to the detriment of service users' well-being.
5. Across all settings, social work which explicitly targets inequality in ill health and addresses unequal social conditions can contribute to tackling service users' unequal chances and experience of ill health.

## Three Questions 

1. Why is health a central issue for social workers in all settings?
2. How is social inequality reflected in service users' chances and experience of ill health?
3. How can social work contribute to more equal health outcomes for service users?

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CHAPTER 3.5

# Physical Disability

*Deborah Marks*

When we think of physical disability, we tend to think of an impaired person using a particular technological aid, such as a young blind woman using a white stick or a young man with a spinal cord injury in his wheelchair. I have deliberately given a gender and age to these examples since they represent archetypal images of disability within contemporary Western culture. Images of disability within literature, charity advertising and movies are replete with visual (gendered, racialized and ageist) stereotypes. Many impairments are used as short-hand signifiers of negative characteristics, portraying disabled people as malevolent (as in facially disfigured baddies in James Bond films), as objects of curiosity, or vulnerable and helpless (as in so much charity advertising).

Whilst these representations are pervasive, they are not an accurate portrayal of the extent and nature of physical impairments in contemporary society. In order to go beyond visual stereotypes of physical disability, it is important to recognize that the meaning of disability is highly contested. Each definition of physical disability rests upon a set of theories about the body, society and the psyche. The kinds of theories we bring to bear have important consequences for the way in which we think and act in social work practice. This chapter explores medical, psychological and social models of disability. Then it attempts to show how each of these models may offer an important dimension to our understanding. Drawing upon these models, the chapter identifies some key concerns when working with physically disabled service users.

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## Theoretical Frameworks

### *Medical model*

For a medical practitioner, a physical disability is a dysfunction or abnormality located within an individual person's body. Within medicine, there are different ways of categorizing disability; in terms of a specific medical diagnosis (e.g. asthma), the bodily system affected (nervous, visual, auditory, musculoskeletal) or the functional loss (paraplegia) (Olkin, 1999). Each of these forms of categorization provides different kinds of information. What unites these different classificatory systems is their focus on *pathology*. When we make even a cursory examination of the nature and variability of impairments, the distorting simplicity of our popular images of disability becomes clear:

- The most common disabling conditions such as heart disease, back problems and arthritis are not identifiable by simply looking at a person.
- The degree or experience of physical impairment cannot necessarily be predicted from gaining access to their medical diagnosis. The physical consequences of particular impairments will vary for different people. The age at which an impairment is acquired may shape the way it is cognitively, emotionally and physically experienced. The consequences of congenital blindness, for example, will be markedly different from losing sight in old age.
- The experience of an impairment may also vary within the same person. Physical states are rarely fixed and conditions may be progressive, relapsing, or otherwise changeable.

### *The problem of categorization*

As well as impairments being highly variable both across populations and within an individual person, there are many boundary disputes regarding *who* comes to be identified as disabled. The process of rationing disability benefits and services is complex. Official definitions of disability may not coincide with a specific person's self-image. Someone who, for example, has an official disabled parking permit may see themselves as having difficulties walking far, but may not identify as a disabled person. By contrast, people who see themselves as physically disabled (for example, with a facial disfigurement) may not need or be entitled to benefits or services. Furthermore, there is great controversy regarding whether people who are ill should be categorized as disabled. For years, activists in the disabled people's movement have attempted to challenge the jurisdiction of medicine, which is concerned primarily with illness, over disability, which may affect healthy people (Thomas, 2007). Thus the question of who is physically disabled is not a straightforward one, and for these reasons, learning about an abstract range of 'conditions' may offer only limited help in understanding the nature of physical disability. Even within what has come to be termed the medical model, states of impairment cannot be understood in isolation from getting to know about a specific *whole person* within a *particular context*.

### *Psychological models*

Many, though by no means all, psychological approaches to disability share with the medical model a focus on the individual. The problem psychologists have traditionally concerned themselves with has been in helping a disabled person 'adjust' to their impairment. They may suffer from *learned helplessness*, which may compound the impairment. Therapeutic work (particularly if it is from a behavioural or cognitive perspective) may focus on improving *coping strategies*. Psychoanalytic approaches may use a *bereavement model* focusing on the importance of mourning the 'loss' of function, in order to come to terms with a new disabled self. The focus of such approaches is on the *individual* person's mental response to impairments.

### *Social model*

In contrast to the medical and psychological models, the social model (Oliver, 2009) locates disability within society: in the *built environment* and the *values* and *social practices* that *discriminate* against people with certain differences. A distinction is made between impairment and disability. Although no one is completely free of any 'impairments', only some kinds of impairment become disabling. For example, a wheelchair user in a fully accessible and inclusive environment, would, according to the social model, cease to be disabled, although they would still have an impairment. Thus, what is seen as 'disabling' changes in different cultures. In pre-Revolutionary China, the practice of foot-binding involved creating a functional impairment (breaking bones often caused infections and made walking difficult) but was not seen as 'disabling'. The converse was the case, since unbound feet could be constituted as an 'aesthetic impairment'. It is important to keep different cultural values and practices in mind when thinking about what kinds of physical differences come to be seen as disabling.

Social model theorists have been primarily concerned with challenging the discrimination and social exclusion suffered by disabled people. One of the key aims of this struggle has been to challenge the segregation of disabled people into 'special' institutions such as schools, residential homes and day centres and their exclusion from paid employment (Oliver, 2009). Disabled people should be treated as citizens with rights and responsibilities, rather than as recipients of care (Barnes, 1997).

## 6 The three models of disability

- The *medical model* views a physical disability as a dysfunction or abnormality located within an individual person's body.
- The *psychological models* (behavioural, cognitive or psychoanalytic) focus on the individual person's mental response to impairments.
- The *social model* locates disability within society: in the built environment and the values and practices which discriminate against people with certain differences.

## *Integrating dimensions of disability*

It may be that the medical, psychological and social models of physical disability each contain valuable insights. Having the ability to learn from service users about the physical consequences of an impairment, having the capacity to empathize with cognitive and emotional experiences, and finally having an understanding of the social policies and institutional contexts are *all* important aspects of social work practice. Here are some examples of experiences that have bodily, social and psychological dimensions:

- Having a physical disability or receiving hospital treatment may be physically painful and exhausting, may involve emotionally traumatic separations from loved ones (for example, for hospital treatments) and involve stigmatization and loss of social status.
- Whole families can be affected by the social barriers faced by an individual disabled member. It can also create anxiety and distress, in the form, for example, of guilt from parents who feel responsible, or rivalry from a non-disabled sibling who feels her sibling is getting more attention. The pressures of intimate physical care between, for example, a husband and wife can undermine their sexual relationship. When such care is given by a parent to a young person, developmental moves towards privacy and separation can become confused. These are just some of the potential difficulties that can have not just an emotional toll on a family, but also make members more prone to stress-related illnesses.

Having an integrative approach to our understanding of disability may help us to remain in touch with these different dimensions.

## *Integrative theories of physical disability*

There are different ways theorists have tried to integrate understandings of disability. Patterson and Hughes (1997), taking a *phenomenological perspective*, have shown how social exclusion can be produced and reproduced at a *bodily* level. For example, conventional 'scripts' for communication may exclude people with impairments that affect their speech (such as people with cerebral palsy) because ordinary rules of interaction offer only a limited time for each speech 'turn'.

Another way of integrating social and emotional levels of understanding physical disability is through a *psychosocial* approach. Such an approach will bring together social factors, such as professional interests, class, gender and culture with an examination of unconscious investments (Marks, 1999). For example, we might ask why it is that certain professions involved in working with and caring for disabled people (such as nursing and social work) are so dominated by women?

To summarize, when we think about physical disability we are always thinking about *relationships* between people with different life experiences and social positions. An integrative approach may well be the most relevant one for social work practice, where work involves thinking about the whole of clients' lives, rather than just their body, psyche or social environment. The next section therefore examines some ways in which social workers may maximize the independence and enhance the lifestyle of their physically disabled clients.

## Practical Steps in Working with Physically Disabled Clients

Checklists can be a useful way of fostering best practice. They can help workers identify common pitfalls that lead to the unintentional objectification and disempowerment of physically disabled service users. There are three key areas which need to be addressed to ensure good practice. These involve considering the *social*, *psychological* and *inter-professional* issues raised in working with physically disabled people. Within all three areas, the checklist emphasizes critical *self*-reflection, because it is important to get one's own professional and personal house in order before addressing the difficulties faced by others.

### *Addressing social barriers*

It is important to think not just about the needs of disabled service users, but also about the needs of disabled social workers. Disabled people are more likely to face barriers in obtaining professional qualifications and in accessing the environments within which social work takes place. As a consequence, they are under-represented within social work. Also, physically disabled people tend to be socially constituted as *recipients* rather than *providers* of care. This has meant that social work departments have few staff members with direct experience of some of the barriers faced by their clients.

As with other socially disadvantaged service users, physically disabled clients may need to be informed of their rights or assisted in gaining access to and controlling their own benefits and services. Having an up-to-date understanding of disability legislation and social policies is therefore important.

Where clients suffer from low self-esteem, have learning difficulties or lack access to relevant gatekeepers, social workers may need to become involved in undertaking advocacy work.

Disability equality training, ideally provided by physically disabled people, is important so that the culture of a social work service is one which treats physically disabled people – as employees or clients – with respect.

### *Addressing psychological factors*

We all lie somewhere along an ability/disability continuum. For those who see themselves as able-bodied, they are only contingently so, since most of us will experience increasing impairment and disability as we enter old age. Furthermore, many of those drawn to work within areas which bring them into contact with a large number of physically disabled people will have personal experiences of physical disability, perhaps from a family member. For this reason, it will be important for all workers to examine their own thoughts and feelings about disability and to reflect on how this may shape relationships with clients (Obholzer and Roberts, 1994). A social worker who spends a lot of time trying to address the suffering of others may, for example, carry an unconscious sense of guilt or an unconscious identification with someone whom society sees as damaged. Attending to other people's 'dependency needs' may be a way of vicariously dealing with one's own unconscious needs. This

carries the risk that a worker's response to a service user may be based on assumptions which are more relevant to that person's own personal history than to the real life concerns of the disabled person they are working with. Social workers might develop a self-reflective practice through going into personal counselling or therapy.

Sometimes professional groups may mirror and even act out some of the difficulties faced by their clients. Reflective practice may help professionals appreciate the psychosocial context not just of their clients, but also of their own practice. This can be achieved at an institutional level, through the provision of regular supervision which has a supportive/listening aspect as well as a task-focused, educational and regulatory function. Having an experience of being heard is likely to help practitioners to develop sufficient mental space to be able to offer their clients a similar experience.

It is important for all social workers to have good listening and counselling skills. Many physically disabled people, unsurprisingly, suffer from low self-esteem, or what Mason (1992) calls 'internalized oppression'. The offer of a non-judgemental, empathic outsider, such as a social worker, may help families with a disabled member to manage some of the stresses of living in a disablist society.

## *Liaison work*

It is important that social workers foster effective and genuine collaboration between themselves and service users (Beresford and Campbell, 1994). This may mean working alongside independent living groups and disability rights activists, who will be in a good position to represent the concerns of disabled people and therefore help support effective practice.

It is also important that social workers look at their collaboration with other professionals, such as healthcare workers and teachers. The management of case conferences is one key element in ensuring interdisciplinary work. All too often, inter-professional rivalries, hierarchies or different professional languages may prevent working together, to the detriment of service users (Marks *et al*., 1995).

## *Extra-curricular activities*

Social work practice with physically disabled people may be enriched if workers learn about disability culture outside the client–professional relationship. This may involve:

- Developing some familiarity with the burgeoning disability arts, literature and comedy. Listening to what disabled people say about professionals may offer an important mirror with which to view the profession. Narrative accounts by disabled people (e.g. Hockenberry, 1996) offer rich insights into the complexity, pain, amusement and frustration of living with a physical impairment.
- Becoming an ally within the disabled people's movement is another way in which social workers may increase their sensitivity to the concerns of physically disabled people.

These suggestions aim to bring a new dimension to understanding a range of experiences of physical disability.

## Conclusion

Social workers are themselves often subject to disabling social barriers. They have only limited means to transform the wider educational, economic, political and cultural context of a disabling society. However, being aware of and willing to challenge social barriers, being sensitive to physical and emotional experiences and being willing to listen to disabled people rather than occupy a position of the expert can all play a key role in enhancing the lives of physically disabled service users.

### Five Key Points

1. Despite popular characterizations that treat physical disability as a metaphor for internal states, many impairments which come to be disabling in contemporary society are invisible.
2. Categorizing disability is in many ways an arbitrary process, dependent on policies, institutions, culture and values within a society. What is disabling changes in different contexts.
3. Disability contains bodily, social and psychological dimensions. Attempting to draw upon and integrate these different levels can give a more holistic understanding of the lives of specific physically disabled clients.
4. Listening to and respecting clients must form a starting point from which to work with physically disabled people.
5. Work with physically disabled people requires attention to one's own personal and professional experiences of and investments in disability.

### Three Questions 

1. Where is disability located:
   - in the built environment, institutional policies and practices;
   - in the body of a person with a serious impairment; or
   - in the ability of that person to come to terms with and manage their difference?

   To what extent is it possible to integrate these models of disability?
2. How might a social worker most effectively empower and enhance their disabled clients' quality of life?
3. What issues might social workers take up both as individuals and as a profession to make their practice more inclusive for disabled people?

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# CHAPTER 3.6

# The Challenge of Later Life

*Chris Phillipson*

Older people present both a significant challenge and an opportunity for social work. As a group, they have moved from being a marginal concern to one of central importance to the profession in the twenty-first century. A combination of forces associated with demography, social attitudes and legislative change have assisted this development. On the first of these, the percentage of the UK population aged 65 and over increased from 15 per cent in 1985 to 17 per cent in 2010, an increase of 1.7 million people. Over the same period, the percentage of the population aged 16 and under decreased from 21 per cent to 19 per cent. By 2035, approaching one in four of the population (23 per cent) will be aged 65 and over compared to 18 per cent aged below 16.

This ageing of the population reflects the convergence of two main factors: first, the downward trend in the birth rate, so that the proportion of older people is increasingly larger than the proportion of children in the population; second, improvements in life expectancy. For social workers, the absolute rise in the numbers of older people is probably less important than the growth in particular groups such as those in late old age. The United Kingdom has seen a doubling in the population aged 85 and over in the 25 years from 1985: from 690,000 to 1.4 million people, with a projected increase to 3.6 million (5 per cent of the total population) by 2035. While the UK population grew by 4.2 per cent between 2002 and 2009, the numbers of people aged 85 and over grew by 21.5 per cent (Office for National Statistics, 2011).

The growth in the population entering late old age has important implications for social work. On the positive side, this is a group where there are significant numbers of people without major health and social problems: even amongst those aged 85 and over, around one-third of men and women do not have a long-standing illness or disability. On the negative side, the impact of ill health does become a significant

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issue for a majority of older people at some point in later life. Three out of five people aged 65 and over will have a limiting long-standing illness such as osteoporosis or arthritis. Among people aged 70 and over, 72 per cent have some kind of hearing loss; visual impairment is also increasingly common in the later stages of old age (Victor, 2010). The complex issues facing those diagnosed with some form of dementia is also raising a major challenge for social work practice. In the United Kingdom, the number of people suffering from dementia is projected to rise to over one million by 2021, including one in two of those aged 85 and older. Ray and Phillips (2012) highlight the significant role for social work in supporting people living with dementia, in particular through ensuring accurate assessment, securing appropriate help and coping with the various challenges associated with the condition.

In terms of social relationships, it is the loss of close friends and relations which is a striking feature of later life (for women especially). Unlike earlier generations, death is now clustered towards the end of the life course. Invariably, also, people often experience the death of someone close to them when their own personal resources of health and income may be diminished. Social work with older people, in these circumstances, is often inseparable from help in the context of bereavement and assisting people through the process of rebuilding their lives and social networks. This should be seen, though, in the context of older people in the twenty-first century having more complex social ties than in previous times, this reflecting the rise in divorce and remarriage (especially important for the baby-boom generation entering later life). On the one side this may lead to the loss of ties for some groups in middle and early old age; on the other side such changes bring the potential of links with a large network of stepchildren and grandchildren (Chambers et al., 2009).

Social work inevitably engages with older people during periods of crisis and loss. But it is also important to highlight the continued involvement of older people within their community, as well as the need for social work to assist wherever possible. Older people play a vital role in providing help within the family to adult offspring and grandchildren and to other family members needing care. They also provide essential citizenship roles as members and officers of organizations within their localities as well as performing numerous roles within the voluntary sector (Ray and Phillips, 2012). Maintaining citizenship roles is crucial to quality of life, and supporting these is important to maintaining agency and individuality in later life.

## Family Support

Despite significant changes, the social world of older people is still closely associated with their immediate family. Clare Wenger's (1984, 1992) research showed that among those older people with children, residential proximity tended to increase with age, with widowhood resulting in a move closer to children. More than half of the parents in her study saw a child at least once a week, and this rose to three-quarters in the case of parents over 80. Surveys in Britain based on nationally representative samples have confirmed the existence of high levels of contact between older people and relatives and friends (Chambers *et al.*, 2009). A survey published in 2004 reported that three-quarters of the sample of older people (77 per cent) saw relatives at least weekly; with just around 1 in 10 seeing relatives less than once a year (Bond, Victor and Scambler, 2009).

Research has highlighted the range of physical, social and financial costs associated with the types of care provided by partners, relatives and friends. The physical stresses associated with care may include the daily pressures associated with dealing with incontinence, lifting someone in and out of bed, managing a wheelchair; all of this carried out with limited help and alongside a range of other domestic and non-domestic tasks. Again, these activities have to be seen within the context of many of those involved in care themselves being in their 60s and 70s or older, with the likelihood that they might also have a chronic illness or disability. The social costs attached to caring may include the isolation and possible loneliness associated with intensive care work, loss of friends and limited opportunities for holidays and regular breaks. The financial pressures on those involved in care in the home may be considerable. A survey by Carers UK (2010) found that around 6 out of 10 carers had given up paid employment to provide care. Caring can thus be associated with considerable financial penalties (especially for women), with the loss of pension rights and income security in retirement.

Levin, Sinclair and Gorbach's (1989) study of carers of older people with dementia identified a range of social costs arising from this kind of care. For example, only two-fifths of the supporters had taken holidays in the previous year and over half the others had gone without them for at least five years. Supporters who did most for their relatives, those who coped with incontinence and other major problems, were no more likely to have had a holiday in the previous year. Similarly, many experienced difficulties in getting to see friends on a regular basis and felt less free to initiate meetings with friends and relatives.

There is growing evidence that some of the stresses associated with informal care may lead to the abuse and/or neglect of the older person. A national prevalence survey in the United Kingdom (O'Keefe, Hills and Doyle, 2007) suggested a figure of 4 per cent (including mistreatment by neighbours and acquaintances), which translates into just under 350,000 older people being abused each year (this figure excludes those living in residential or nursing homes). Neglect followed by financial and then psychological abuse appeared to be the most common forms of mistreatment, with spouses/partners or a member of the family being those most likely to be involved in abuse.

The significance of the 'informal sector of care' indicates the importance of recognizing the kind of social networks within which older people are located. These may vary considerably in terms of the kind of help provided and their ability to respond to particular crises in old age (Phillipson *et al.*, 2000). Moreover, there is also the issue of effective coordination between formal and informal sources of care, with the need for effective advocacy where appropriate both for the older person and the carer. Both these issues suggest an important role for the social worker, one which is likely to become of increased importance given pressure to achieve closer coordination between health and social care.

## Divisions in Later Life

So far this chapter has discussed old age without reference to some of the key social, cultural and economic distinctions affecting older people. Social class, for example, may be a much stronger predictor of lifestyle than age, with older people sharing

more in common with younger people of their own class than with older people from other classes. The importance of social class as a factor influencing opportunities in old age is likely to increase, as the sources of income in old age become more dependent upon benefits linked with private and occupational pensions (Vincent, Phillipson and Downs, 2006).

Gender is a second major social division. The gender imbalances of later life are now well established. Because women outlive men by an average of six years, there are 50 per cent more women than men amongst those 65 and over. The gender imbalance is even more marked in late old age: amongst those aged 85 and over, women outnumber men by three to one. 'The fact that over half of older women are widowed, whereas three-quarters of older men are married, has consequences for gender, identity, relationships and roles in later life' (Arber and Ginn, 1995, p. 11).

Race and ethnicity represent another important dimension. In the early part of the twenty-first century there will be a significant ageing of the black community as the cohorts of migrants of the late 1950s and 1960s reach retirement age. Research suggests a significant role for social work in relation to older people from minority ethnic groups. Some key factors here are: first, the increased susceptibility to physical ill health of this group because of past experiences such as heavy manual work and poor housing; second, greater vulnerability to mental health problems, a product of racism and cultural pressures over the life course; third, low uptake of health and social services; fourth, acute financial problems, with evidence of elderly Asians (especially those from Bangladesh and Pakistan) being at a particular disadvantage. The problems faced by ethnic elders have been defined as representing a form of 'triple jeopardy' (Norman, 1985). This refers to the fact that ethnic elders not only face discrimination because they are old; in addition, many of them live in disadvantaged physical and economic circumstances; and they are likely to face discrimination because of their culture, language, skin colour or religious affiliation. All this suggests a key role for social work over the next 20 years, as the size of this group is substantially increased (Victor, Martin and Zubair, 2012).

## 7 The concept of old age

*Old age* is a concept that:

- legitimates age bars in the implementation of policy regulations and practice procedures;
- underpins a conceptualization of 'elderly people' which alienates *them* from *us*, often segregating them involuntarily in specially designated places (such as sheltered housing and day centres);
- sustains ageist perspectives on the life course which cause us all to fear our futures.

Source: Bytheway (2000), pp. 236–237.

## Reasons for Social Work with Older People

The context of ageing provides a number of suggestions about the purpose of social work with older people, and especially those in late old age.

First, social work has a major contribution to make in the area of 'anti-ageist practice' (Bytheway, 1995). Ageism may be defined as discrimination against older people merely by virtue of their age. Ageism affects many institutions in society and has a number of dimensions – job discrimination, loss of status, stereotyping and dehumanization. Ageism is about assuming that all older people are the same, despite different life histories, needs and expectations. Ageism not only affects the lives of older people, but like ageing itself, it affects every individual from birth onwards, putting limits and constraints on experiences, expectations, relationships and opportunities. These points underscore the importance of social work adopting a clear anti-ageist framework, recognizing principles such as the following:

- ageing as a period of normal development;
- the positive social and economic functions performed by older people;
- the importance of using the term 'older people', not 'the elderly';
- the importance of talking about the rights and responsibilities of older people;
- the importance of listening to what older people have to say about their experiences and emotions; and
- the necessity of standing alongside older people in cases where there is conflict with those providing care in whatever setting.

Social work has a significant part to play in fostering greater awareness of the impact of ageism in society (and on the professions working with and for older people). The goal of working towards a society free of ageism should be as important as that of achieving a society devoid of racism and sexism.

A second important reason for social work relates to the provision and management of different kinds of social support to elderly people (Ray and Phillips, 2012). This reflects the vulnerability of the old not just to losses which are inevitable (such as the death of a partner or friend), but also to events which reflect particular types of tensions and divisions in society (such as domestic violence or racist attacks). Elderly people experience problems which would be distressing at any point of the life course (and of course problems such as poor health or poverty affect the young as well as the old). But elderly people experience these changes when their own resources are invariably depleted. The resources social work has to offer may, therefore, be crucial in terms of helping people forward to the next phase in their lives.

Third, within this process of support, recognition of the strengths of older people is vital. It is relatively easy to highlight the problems of the old; and, indeed, this is important in terms of constructing different forms of social work intervention. Equally, though, social work has a major role in reaffirming the resilience and power of older people. Of course, elderly people have achieved this themselves through their writings and their political organizations (Curtis, 1993). Social work interventions can, however, be used positively (through forms of practice such as personal biography work and life review therapy), to enhance the process of individuals rediscovering a sense of purpose and identity in later life (Bornat, 1994).

Fourth, social work in the twenty-first century is closely concerned with advocacy for groups such as older people. The case for this reflects both social changes and the impact of social legislation. Dunning (1995) observes that changes in family structures, living arrangements and patterns of employment, mean that some older people might not have a partner or close relative who can provide support or speak out on their behalf. For others, family relationships may be poor and conflicts of interest are likely to arise. At the same time, greater emphasis is being given to the idea of consumer choice and user empowerment in the provision of services.

More specifically, social work and advocacy is important because of the likelihood of older people entering situations where their frailties may be exposed or enhanced. This may happen as people move into residential care, or are discharged from hospital, or embark on long-term domiciliary support. As events, these may lead to greater independence for an older person; equally, though, the elderly person may feel their autonomy undermined by professional carers taking key decisions on their behalf. This possibility underlines the importance of advocacy as a central social role in work with older people.

## Conclusion

This chapter has noted, first, the increased importance of older people for the practice of social work; second, the pressures which they face through the loss of key relationships, this coming at a time when their own resources may be reduced; third, the possibility of frailty being enhanced within the context of developments such as a move into residential or nursing home care.

Social work with older people needs to recognize both the actual and potential disabilities of later life and the possibilities for further growth and development even in very late old age. This points to the importance of the social worker adopting a clear anti-ageist framework, using this to guide the complex decisions which have to be made in the 'triangle' of user, carer and service provider. In the twenty-first century, social work with older people is fundamental to the profession and a central reason for wanting to assume the identity and practice of being a social worker.

## Five Key Points

1. Demography, changing social attitudes and legislation have all made older people a target group of critical significance for social work.
2. Social work with older people often involves helping them to rebuild their lives following bereavement.
3. Work with carers – many of whom are themselves no longer young – is a major task for social work.
4. Social class, gender and ethnicity are all factors which need to be taken into account when considering the nature of social work with old people.
5. Social work with older people must be anti-ageist; it must be supportive; it must recognize client strengths; and it must use advocacy.

## Three Questions

1. How might an anti-ageist practice be developed in work with older people?
2. What sorts of conflicts are likely to arise in the relationship between older people and informal carers?
3. What are the issues that might be faced by particular minority ethnic groups as increased numbers move into late old age?

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# CHAPTER 3.7

# Mental Illness

*Peter Huxley*

Client groups may be defined by age or by contact with the criminal justice system, but the mental illness client group knows no such boundaries. Psychiatric patients are defined by contact with psychiatric services, but most mental disorder never reaches the psychiatrist. Mental ill health is a major worldwide public health problem. The WHO (2011) reported that mental illnesses are the leading causes of disability adjusted life years (DALYs) worldwide, accounting for 37 per cent of healthy years lost from non-communicable diseases (NCDs). Depression alone accounts for one-third of this disability. The WHO report estimates the global cost of mental illness at nearly $2.5 trillion (two-thirds in indirect costs) in 2010, with a projected increase to over $6 trillion by 2030.

Every organization in Britain is affected by mental distress and ill health in the workforce. The total cost to employers of mental health problems among their staff is estimated at nearly £26 billion each year. The business costs of mental ill health consist of £8.4 billion a year in sickness absence. This adds up to 70 million lost working days a year, including one in seven directly caused by a person's work or working conditions; £15.1 billion a year in reduced productivity at work; and £2.4 billion a year in replacing staff who leave their jobs because of mental ill health (Sainsbury Centre for Mental Health, 2007).

Almost one in five days of certificated work incapacity are due to mental illness alone, and 40 per cent of reports of adverse health effects at work are attributed to emotional problems. Mental illnesses are common, disabling and expensive.

In the United Kingdom, it has been estimated that GPs assign a psychiatric diagnosis to six million people each year (1.2 million are over 65, and 300,000 are under 15), compared to cancer which affects two million people and AIDS about 2,000.

*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

Mental illness kills more than four times as many people as die in road accidents, and suicide is the second most common cause of death in young men. However, it is not simply the ubiquitous nature of mental illness which makes it an important reason for social work. Social factors play a crucial role in the causation of mental illness, in the course of the illnesses, in the outcome of treatment and care and in recovery.

In 1976, the first study of mental illness in social workers' caseloads was conducted in London. It examined the physical and mental health of clients referred to social workers in an outer-London borough. The research team rated physical and mental health from case notes and found that 45 per cent exhibited minor or major mental illness. Subsequent studies conducted using screening questionnaires revealed that an even higher proportion of people receiving social work help experienced mental health problems, and these results were confirmed using standardized psychiatric assessments, which showed that the proportion of mental health problems ranged from 53 to 66 per cent (Corney, 1984; Huxley et al., 1988, 1989). One-third of the disorders were severe psychotic illnesses, and another 30 per cent were anxiety and depression.

Social workers, like GPs, do not identify all the instances of mental health problems presented to them by service users. Huxley et al. (1989) found that recognition varied by diagnosis; social workers recognized all of the people with a manic illness, but only half of those suffering from schizophrenia and less than half of those suffering from severe or psychotic depression.

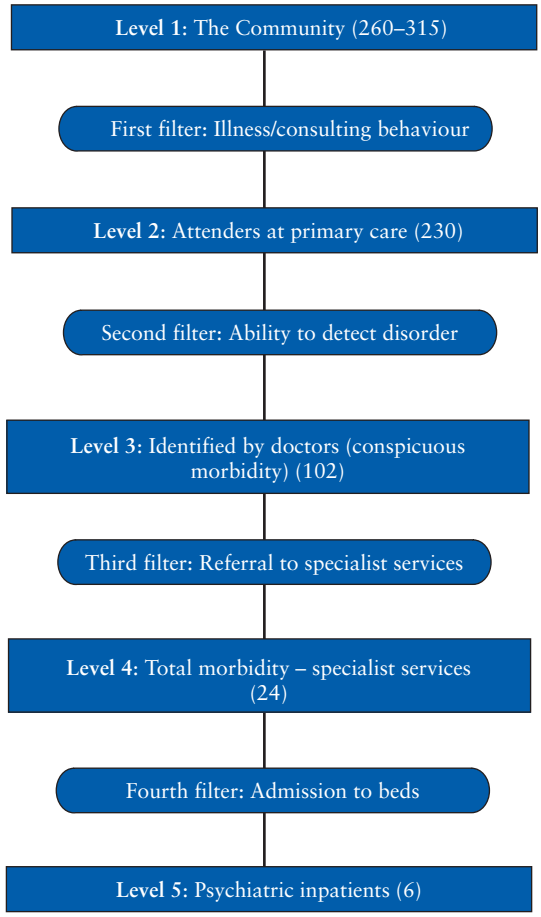
One study (Isaac et al., 1986) suggests that the overlap between childcare problems and mental health problems is very high. While none of the children entering care in this study sample had parental mental illness as an official reason, 84 per cent of the parents had received psychiatric care at some time. At the other end of the age spectrum a number of studies have shown that rates of mild and severe dementia and depression are between 30 and 40 per cent in the residents of local authority homes for people over 65. Subsequent work has shown a strong relationship between problems in childhood and later mental health difficulties.

Knowledge about mental illnesses has undergone a major upheaval in the past 30 years. Diagnostic classifications based upon the treated population of patients are no longer regarded as adequate to describe the totality of mental health problems. Research has shown that the diagnostic systems themselves are not very reliable, except in the most crude sense, and diagnostic classifications are poor predictors of outcome and also of the costs of providing services. The discovery of the frequent coexistence of symptoms of anxiety and depression reduces the need to have categorical classifications of disorder for less severe conditions. Epidemiological research shows that the prevalence of mental illness is considerable, and that most people with symptoms consult their family doctor, and the family doctor sees and treats most mental illness. In two books (Goldberg and Huxley, 1980, 1992) we outlined the pathway to specialist psychiatric care in the United Kingdom. Subsequent research has confirmed important aspects of this model; and even in societies where the filtering mechanisms are dissimilar, the model acts as a useful template against which to examine rates of mental health problems in local populations.

The model consists of five levels, each one corresponding to a stage on the pathway to psychiatric care. The first level is the prevalence of disorder in the community (the data come from community surveys). The first filter is consultation

behaviour or illness behaviour. Most people experiencing symptoms will present them to their family doctor, but the presentation is often of a somatic rather than a psychological complaint. Partly as a result, doctors vary in their ability to detect disorder and the factors which contribute to this variation are described in detail in the first book (Goldberg and Huxley, 1980); their ability to recognize psychiatric problems is the second filter. For cases which are detected, the family doctor decides to treat many of them and to refer the others for specialist psychiatric attention; the referral decision is the third filter. When the patient reaches the psychiatrist (level 4) they are treated as an outpatient, or admitted (filter 4) to hospital (level 5) (Figure 1 contains the rates at each level expressed per thousand population per year).

The mental illnesses encountered in community surveys are less severe than those admitted to psychiatric hospitals. Social dysfunction and clinical severity increase at progressively higher levels of the model.




Figures in parentheses are rates per 1000 population per annum.

**Figure 1** The Goldberg–Huxley pathway model.

## Social and Demographic Factors

A number of social and demographic factors influence the rates of disorder which come to the attention of social workers and other professionals.

### *Gender*

Female rates of mental health problems generally exceed male rates, although it should be noted that by including drug dependency and antisocial personality – where male rates greatly exceed female rates – greater parity is found. Jenkins (1985) has shown that if samples of male and female subjects are chosen who are closely comparable from the standpoint of social adjustment, the difference in rates disappears. Women with children are a particularly high-risk group for mental health problems.

### *Social class*

Most studies show greater rates for common mental disorders in lower social classes. There is a growing interest in social psychological factors, social capital, social exclusion and personal identity as mediators in health inequalities (Office of the Deputy Prime Minister, 2004). The strength of the relationship between social class and mental illness and the consistency of the social class gradient in depression and anxiety appears to be greater than in physical illnesses. The social class gradient in mental ill health may be influenced by specific social psychological and biological factors, experience of family disadvantage in childhood, and general vulnerability acquired through exposure to adversity of many types.

### *Unemployment*

Unemployment has a substantial effect on self-reported physical health, anxiety and depression, and causes a decline in marital support (the number of weeks unemployed is related to the decrease in the quality of the marital relationship). Unemployment causes great financial strain which leaves people more vulnerable to the impact of otherwise unrelated life events. The effect of unemployment may be worse for those who have had little social contact outside the work setting. In the Office of Population Censuses and Surveys' (OPCS) community survey, unemployment was the factor most strongly associated with the rate of mental ill health (Jenkins *et al.*, 2003).

### *Ethnicity*

While black and minority ethnic groups are over-represented among involuntary hospital admissions and may use more emergency and inpatient services, the treatments given in hospital, compliance with depot injection clinics, and the prevalence of disorders in the community all appear to be unrelated to ethnicity. Hirschfeld and Cross (1982) found that differences between black and white rates of depression disappeared when social class was controlled. There continues to be an ongoing debate about the role of ethnicity in the onset, course and treatment of mental health problems.

## Life Events

A variety of factors make an individual more susceptible to develop symptoms under stress, including: genetically determined emotional reactivity; personality; parental loss and early abuse; and social adversity such as poor housing and unemployment. These factors may act to increase the rate at which adverse life events occur as well as their impact. Good experience of early parenting and a good marital relationship act as protective factors against the rate (and impact) of life events. Goldberg and Huxley (1992) call the process of beginning to experience symptoms 'destabilization', and the process of losing symptoms 'restitution'. It appears to be the case that 'loss' events lead to depression, and 'threat' events lead to the development of anxiety, and combinations of the two to types of mixed anxiety-depression. Major life events are not all negative experiences, and some of the most stressful events are culturally accepted as positive experiences, the two most stressful being marriage and moving into a new home. In community surveys, restitution appears to be related to: a decrease in the rate of life events; positive or 'fresh start' events; the presence of social support which is perceived positively and an absence of physical illness. In treated samples, restitution is associated with: better material circumstances; higher income; low expressed emotion relationships; an absence of negative self-concepts and satisfaction with levels of social support.

Though intimate close relationships are not universally positive in terms of mental health outcome, there is some evidence to indicate that social integration leads to better mental health. As the work of Brown and Harris (1978) shows, the existence of positive intimate relationships can be protective against depression. A substantial amount of research has also pointed to the importance of social ties in providing emotional and practical support (e.g. Harris, Brown and Robinson, 1999).

Not all problems presented to the social worker are new episodes of common disorder; many are of long-standing psychotic illnesses which are reoccurring for the second or third time. The OPCS survey (Jenkins *et al.*, 2003) found a prevalence rate of four per thousand of functional psychosis in the community. Schizophrenia is the major severe mental illness and it affects 1 per cent of the population. The onset is rapid or insidious (about half each), the course is episodic or continuous (also about half each) and outcome over the long term (more than 30 years) can be moderate or severe disability or full recovery (also about half each). Outcome tends to be better in Third World countries, which is said to be due to better community integration and more rapid return to a useful role. The recognition that serious illnesses can have very good outcomes in the long term, and some in the short term, is an important factor in the development of the 'recovery' model (Roberts and Wolfson, 2004).

The rates of admission of severely mentally ill people to psychiatric hospital are higher in areas of high social deprivation. One of the major contributory factors to relapse of the illness is the level of expressed emotion in the family home; high-stress homes invariably producing relapse, and low-stress homes only doing so if independent stressful events occur. People suffering from schizophrenia show heightened levels of arousal which reduce in the presence of non-stressful relatives. A non-stressful social worker may have the same calming influence on the sufferer, and this may help them to maintain the client in the community.

People who develop long-term severe disorders are now cared for in the community where delivering the necessary coordinated health and social care is much more complicated than in a mental hospital. In the United Kingdom a legislative framework has been provided within which care can be focused on severely mentally ill people, and it appears that compared to 10 years previously the clientele of community teams, on average, do indeed have more complex problems (Huxley *et al.*, 2006). Highly publicized tragedies, such as the murder of innocent victims by severely disturbed patients, suggest that in the mid-1990s the policy was failing many of those it was designed to help. More recently, however, prominence is being given to the fact that the number of homicides committed by people with mental health problems has actually been declining. Goldberg and Gater (1991) estimate that in a population of 100,000, there will be 2,600 people who will require planned, prolonged health and social care.

Case management was devised in the United States to provide this continuity of care (Ziguras and Stuart, 2000). When case management was adopted in the United Kingdom and transformed into care management, an inappropriate administrative rather than a clinical or assertive model was used. All models include similar components: assessment, case finding, care planning, and monitoring and review, but in the assertive and clinical case management models direct face-to-face work is undertaken by the case manager. Research evidence (Ziguras and Stuart, 2000) suggests that assertive case management is successful with the most severely disabled people and that the administrative model is both unsuccessful and unpopular. A major reason is the need for a close personal working relationship (of a low expressed emotion variety) in order to sustain community living. This long-term clinical case management is also applicable to other client groups such as the older mentally ill person, and emotionally disturbed children and adolescents.

A welcome development in mental health services across the world is the focus upon the outcome of service provision and on 'recovery' models. The fundamental question arises, if people are no longer cared for in large institutions, or in psychiatric units in general hospitals, how can we be sure that community services provide them with a better quality of life and greater recovery opportunities? It is no longer good enough to assert that treatment in the community must be better; there is a need (arising from public accountability of services) to answer this question based upon sound and systematically gathered evidence. Quality of life (QOL) assessment gives social workers a systematic way of assessing the outcome in life domains which have meaning to service users, are consistent with recovery models and put user views at the centre of service provision and planning (Priebe *et al.*, 1999). Results of the application of QOL measures to community services show that community treatment is more popular and can improve mental health and social relationships.

A variety of models have been offered to explain the way QOL is determined. One of the most useful is that originally produced by Campbell, Converse and Rogers (1976) – a revision of which is reproduced here as Figure 2 (Huxley and Evans, 2000).

Whatever the ultimate conclusions of the debate, there is little doubt that QOL assessment offers one opportunity to put the social dimensions that are crucial to recovery at the forefront of work on the outcome of care and treatment in the community.

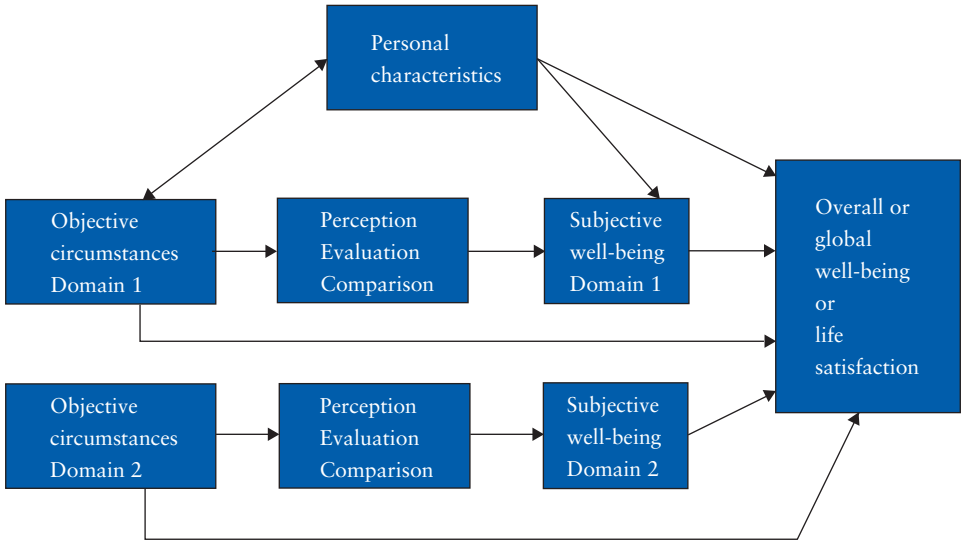



**Figure 2** The Huxley–Evans model of quality of life.

## Five Key Points

1. Fifty per cent or more of social work clients are suffering from mental disorder.
2. Common disorders can be distinguished from severe disorders and the former more often fail to reach psychiatric care.
3. Rates of mental illness in the community vary according to socio-demographic characteristics and social factors such as life events.
4. In order for people with severe illness to survive in the community effective after-care and continuity of care must be provided and recovery emphasized.
5. Quality of life measures reflect the social dimensions of severe mental illness, and can be used to assess recovery outcomes.

## Three Questions

1. What are the main factors which contribute to the variation in the rates of mental disorder in the community?
2. What are the main factors which contribute to more severe illnesses progressing to inpatient psychiatric care?
3. How can systematic quality of life assessment of mentally ill people become part of the operational practice of social workers?

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CHAPTER 3.8

# Learning Disabilities in Adults

*Kirsten Stalker and Carol Robinson*

This chapter begins by identifying the dominant theories and values informing social work with people with learning disabilities. It discusses numbers of people with learning disabilities in the United Kingdom, outlines relevant legal and policy frameworks, and considers rights, needs, wants and services as well as good practice principles in this important area of social work.

'Learning disability' is an umbrella term denoting a significant lifelong condition affecting an individual's development. It is applied to people with widely varying abilities, although most will need some level of support to understand information, learn skills and live independently. The everyday implications of living with learning disabilities vary according to social and cultural context. People First self-advocacy groups have expressed a preference for the term 'learning difficulties' and we apologize for any offence caused.

## Theoretical Frameworks and Value Base

Social workers engaging with people with learning disabilities need to draw on the same range of theories and models that apply to other areas of practice, tailored to individual circumstances. In particular, social workers are likely to use ideas derived from normalization (Nirje, 1980; Wolfensberger, 1972, 1983), inclusion (O'Brien, 1987; Ramcharan and Richardson, 2010) and/or social models of disability (Oliver, 1990; Thomas, 2007; Barnes, 2012). Normalization and inclusion emphasize the importance of people with learning disabilities leading 'an ordinary life', having opportunities to exercise choice and control, and be meaningfully included in their

*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

communities through a network of valued roles and relationships. Recent thinking focuses on person-centred approaches and community capacity building (Lord and Hutchison, 2003). The social model of disability identifies and challenges the material, social and economic barriers which disable people with impairments. More recent work in disability studies acknowledges the impact of living with impairments and the role of 'psycho-emotional disablism', meaning 'the intended or "unintended" words and social actions of non-disabled people (parents, professionals, complete strangers, others) in interpersonal engagement with people with impairments' (Thomas, 2007, p. 72). Although little research has been done on this in relation to people with learning disabilities, psycho-emotional disablism is likely to have a profound effect on many people's self-esteem and well-being.

### *The numbers of people with learning disabilities*

There is a shortage of reliable data about the numbers of people with learning disabilities in the United Kingdom. However, work by Emerson *et al.* (2010) provided an estimate of 900,000 in England aged 18 and above, of whom 191,000 (21 per cent) are known to learning disabilities services.

In 2010, an estimated 27,391 people with learning disabilities were known to Scottish local authorities (Scottish Consortium for Learning Disability, 2010) and 14,800 in Wales (Welsh Assembly Government, 2010). In Northern Ireland, 9,173 people with learning disabilities had contact with Health and Social Care Trusts between 1 April 2010 and 31 March 2011 (DHSSPS, 2012). There are more men than women within the learning disability population. In addition, there is an increased likelihood of mental health problems, affecting an estimated 25-40 per cent of people with learning disabilities (Foundation for People with Learning Disabilities, 2011: http://www.mentalhealth.org.uk/our-news/blog/1102-06-23/; accessed 10 October, 2012). We also know that many adults with (primarily mild) learning disabilities do not use specialist learning disability services possibly because they do not need services, wish to avoid any stigma associated with them or are not eligible for them, especially in the light of cuts in services and more restrictive eligibility criteria.

## Legal and Policy Frameworks

Disabled people have a right to social care services under a range of legislation. The National Assistance Act 1948, section 29, permits local authorities to make arrangements for promoting welfare for disabled people while the Chronically Sick and Disabled Persons Act 1970 requires authorities to provide disabled people with information on relevant services in their area, to provide equipment and make provision for home adaptations. The Disabled Persons (Services, Consultation and Representation) Act 1986 places a duty on authorities to assess a person's need for services under the 1970 Act and to consider whether a carer can continue to give a substantial amount of regular care. Under this law, councils should be informed of disabled young people leaving special education in order to facilitate long-term planning and to assist young people in their transition to adulthood.

The NHS and Community Care Act 1990 placed greater emphasis on people being enabled to live as independently as possible in the community. It strengthens the idea of empowerment and the participation of disabled people in planning for their futures. Section 47 requires local authorities to assess people who appear to be in need of community care services to determine whether they are eligible for services, including those available under the Chronically Sick and Disabled Persons Act. Local authorities must keep service users at the centre of assessment, listening to their wishes, preferences and feelings, and the care plan must address all eligible risks facing the person.

Since 2004, local authorities in England and Wales have had to apply Fair Access to Care Services criteria, whereby an individual is assessed as being in 'critical' 'substantial', 'moderate' or 'low' need of services in order to preserve their independence (Department of Health, 2003).

Wide-ranging anti-discrimination legislation is now in place throughout the United Kingdom. Social workers working with people with learning disabilities need to be aware of the provisions of the Human Rights Act 1998 and the Equality Act 2010 which replaced the existing anti-discrimination laws with a single Act.

## Strategic Frameworks

Following the establishment of the Scottish Parliament, the Welsh Assembly and the Northern Ireland Assembly, each jurisdiction within the United Kingdom has separate strategic frameworks relating to people with learning disabilities.

### *England*

The White Paper, *Valuing People* (Department of Health, 2001), was the first government policy document to be produced in accessible formats in England and to involve service users and family carers in its development. The strategy had, at its heart, the four key principles of civil rights, independence, choice and social inclusion. It aimed to bring about improvements in all aspects of people's lives by providing new opportunities and better access to education, social services, health, employment, housing and support. Emphasis was placed on partnership working across a range of agencies, many of which previously had few dealings with people with learning disabilities. Learning Disability Partnership Boards, with representation from people with learning disabilities and family carers, were set up to promote this aim and to ensure equal access to mainstream services such as leisure centres, health screening programmes and community housing. In 2008, a three-year extension *Valuing People Now* was launched to prioritize areas of least progress such as employment, health and housing. The strategy has not been replaced since its end in 2011 and there is widespread concern that some of the progress made in this field will be lost.

In England, the Mental Capacity Act 2005 (MCA) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make decisions for themselves. The same rules apply whether the decisions are life-changing events or everyday matters. The underlying philosophy of the

MCA is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made, or action taken, on their behalf is in their best interests. Social workers should be familiar with the five key principles of the Act and understand when a 'best interest meeting' is required. There is plenty of guidance about the way the Act should be interpreted and what good practice would look like. This can be obtained through the Ministry of Justice website: http://www.justice.gov.uk/guidance/protecting-the-vulnerable/mental-capacity-act/index.htm (accessed 10 October, 2012).

## *Wales*

Whilst *Valuing People* was the first learning disabilities strategy document in 30 years in England, several policy documents have been published in a similar period of time in Wales. In 1983, the Welsh Mental Handicap Strategy (Welsh Office, 1983) articulated three principles relating to people with learning disabilities:

- The right to an ordinary pattern of life in the community;
- The right to be treated as an individual;
- The right to additional help and support in developing their maximum potential.

In 2007, the Welsh Assembly government issued a new 'Statement on Policy and Practice for Adults with a Learning Disability', which replaced previous strategy guidance and confirmed the following statement of principles: 'All people with a learning disability are full citizens with equal status and value to other citizens of the same age. They have the same rights to:

- live healthy, productive and independent lives and to have support to reach their maximum potential;
- be individuals and decide everyday issues and life-defining matters for themselves;
- live within their community, maintaining their social and family ties and connections;
- have the support of the communities of which they are a part and access to general and specialist services that are responsive to their individual needs, circumstances and preferences.'

See http://wales.gov.uk/docs/dhss/publications/100126policyen.pdf (accessed 10 October, 2012).

## *Scotland*

*The Same as You?* (SAY) (Scottish Executive, 2000) is the key policy document for people with learning disabilities, with particular emphasis being given to person-centred support. The Scottish Consortium for Learning Disabilities, funded by government, is charged with providing information and training to the statutory and voluntary sectors to implement SAY's 29 recommendations. These include the introduction of local area coordination, originally developed in Australia to support

families living in remote areas. Advocating for the family, developing informal support networks and building community capacity are key features of the role. Although updated guidance was issued in 2008 (Scottish Government, 2008), in April 2012 there were still only 82 local area coordinators across Scotland.

In 2010, the Scottish government published a 10-year strategy for self-directed support, intended to become the 'mainstream approach' to providing social care and support for all service user groups. Since 2004 there has been a raft of policy initiatives around the transition to adult services and adult life for young people generally, although those with learning disabilities are often highlighted (see http://www.scotland.gov.uk/Topics/Education/edandtrainingforyoungple; accessed 10 October, 2012). The Scottish equivalent of the Mental Capacity Act 2005 is the Adults with Incapacity (Scotland) Act 2000 (Scottish Parliament, 2000), intended to 'help safeguard the welfare and finances of people who lack capacity'. An important principle is that any intervention must be the 'least restrictive option'.

### *Northern Ireland*

In September 2005, the Department of Health, Social Services and Public Safety published *Equal Lives: A Review of Policy and Services for People with a Learning Disability in Northern Ireland* (Department of Health, Social Services and Public Safety, 2005). This strategy, which sets out a vision for developing services over 15–20 years, contained 74 recommendations. It proposed a 'new service model' designed to move people out of congregated, segregated services and promote integration, community participation and access to the full range of mainstream opportunities. However, a review of health and social care in Northern Ireland (DHSSPS, 2011) found that progress was frustratingly slow. It called for further reform of day centres, more flexible and age-appropriate short breaks, more information and support for individuals and their families around direct payments, more easily accessible information about service options and better availability of independent advocacy. Finally, it set a target for the complete closure of long stay hospitals by 2015.

## Personalized Funding

Across the United Kingdom, legislation exists to permit the use of direct payments by disabled adults, young people aged 16 and 17 years and families caring for a disabled son or daughter. To date, take-up among people with learning disabilities has been low, but local authorities must offer direct payments or self-directed support as an alternative to services for people eligible for support. The personalization agenda has not changed despite a change of government in 2010; the coalition administration indicated its desire to see personal budgets for children in education, health and social care.

### *Rights, wants, needs and services*

As successive studies and consultation exercises have shown, people with learning disabilities want to be treated with respect, have opportunities to make choices, be included in local communities, exercise their civil rights, develop meaningful

## 8 Principles of good social work practice

- Information-giving in a way that enables people to make informed choices. This will require workers to have good knowledge about available options and be willing to research areas about which they have limited knowledge.
- Access to advocacy – workers will need to be aware of the ways in which individuals can get support to express themselves and be prepared to listen and act upon those views.
- Partnership working is required not only with the person with learning disabilities but also with family members and across a wide range of agencies to ensure that plans, both individual and strategic, reflect a wide range of views and can be achieved through joint ownership.
- An inclusive approach that promotes equality of access to local provision.
- A focus on achieving positive outcomes for people is essential.
- Keep an open mind – think about how things can change and try to anticipate new developments or ways of working.
- Act as an enabler, not a 'gatekeeper'. If resources are hard to find, seek out alternative ways of helping people and 'sign post' them appropriately.

relationships (which for some will include having partners and children), have interesting and useful occupation, a reasonable income and, in some cases, their own tenancy or home. However, for inclusion to be successful, mainstream facilities must accommodate difference in a positive way by providing the right kind of support tailored to individual need: social workers can play an important role in promoting this. Other principles of good practice are set out in Box 8.

The paucity of accessible information about services and entitlements is a recurring finding of research, especially but not exclusively in relation to families from Black and ethnic minorities. Parents often talk about having to 'fight' for services. Families with learning disabled members value social workers who arrange practical help, provide information, act as a link to other support, take time to listen and allow users to remain in control (Stalker *et al.*, 1999). It is important that social workers involve people with learning disabilities in making decisions affecting their lives, as far as possible using the individual's accustomed form of communication. Where individuals have little or no language, time can be spent observing their responses to different settings and services and garnering the views of relatives and staff who know the person well. This can lead to tension or conflict, where people have different opinions about what 'is best' for the individual, and these ideas may also differ from the person's own feelings. In these circumstances, it may be advisable to bring in an independent advocate to speak up for the person with learning disabilities or ensure they are supported to speak up for themselves. The social worker's overall aim, however, will be to work in partnership with all family members and colleagues from their own and other agencies.

Social workers have legal duties to intervene or support people in certain circumstances, for example, planning transition to adulthood, conducting community care assessments, arranging direct payments or determining capacity. They may assist in setting up regular support, such as social and leisure activities, or they may intervene at times of family difficulty, such as bereavement or carer stress. The higher than average incidence of mental health difficulties among this population often calls for sensitive and skilled social work support.

One form of support that social workers often arrange for adults with learning disabilities is short breaks. These can take many forms, ranging from inclusive activities on a one-to-one basis or with a small peer group in mainstream settings, overnight stays in ordinary family homes to institutional settings. Good short breaks offer a positive experience for the individual as well as a break for carers.

Although social workers aim to promote inclusion by encouraging people with learning disabilities to use mainstream services, many individuals still rely on segregated services for much of their support. Residential provision, run by statutory, voluntary or private providers, ranges from so-called village communities to supported living options where individuals own their own homes and have visiting or continuous support as required. The amount of time people spend in day centres has been reduced, as a wider range of work opportunities becomes available. Many people with learning disabilities, United Kingdom wide, will be affected by the government's welfare reforms, particularly the cessation of Incapacity Benefit and Disability Living Allowance. For some, the greater emphasis on people with learning disabilities getting a paid job will be welcome but social workers must ensure that people receive expert welfare benefits advice and support to maximize their income whether they are in paid work or not.

People with learning disabilities are subject to high levels of 'hate crime' ranging from name-calling and bullying, exploitation and misuse of their property, to serious physical and sexual violence (EHRC, 2010). The term 'mate crime' refers to situations where perpetrators pose as 'friends' to people with learning disabilities. In some cases, despite victims being known to social services and other agencies, abuse has persisted for years. Quarmby (2011) argues that social workers have a vital role in tackling these crimes, alongside other agencies including the police.

The perceived vulnerability of people with learning disabilities means that families and paid carers may wish to protect a relative or client from relatively minor and/or unlikely risks, leading to unnecessary restrictions on an individual's activities. Social workers often face the difficult task of balancing their duty of care, ensuring adequate protection is available, on the one hand, while encouraging an appropriate degree of self-determination on the other. Sellars (2011) sets out good practice guidelines for assessing and managing risk with people with learning disabilities, including those with complex needs and/or 'behavioural difficulties' who will need additional care and support.

## Five Key Points

1. People with learning disabilities are not a homogenous group: they have the same range of needs, feelings and aspirations as anyone else.
2. A person-centred approach that gives individuals an opportunity to express their wishes, needs and preferences is important.
3. People with learning disabilities have repeatedly said they want more opportunities to work, have relationships and live where and with whom they choose.
4. Risk-aversive practice can result in unnecessary restrictions on individual lives. Some risk-taking is part of everyday life: wherever possible, it should be assessed and supported.
5. Social workers must be familiar with the legal and policy frameworks which form an essential backdrop to practice.

## Three Questions

1. How can social workers promote inclusion for people with learning disabilities?
2. What are the implications of user empowerment for social work practice?
3. In what, if any, circumstances should the right of people with learning disabilities to self-determination be curtailed?

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CHAPTER 3.9

# Alcohol or Other Drug Problems

*Sarah Galvani*

For centuries people have sought to alter their physical or mental state. Humans of all ages have found natural and manufactured ways of changing the way they are feeling. Consider the children in the school playground who hold hands and spin round and round until they fall over. This is fun because it makes them feel dizzy and wobbly. Or the adults who subject themselves to potentially high-risk leisure activities such as abseiling, parachuting or scary amusement park rides, because of the physical and mental buzz they get from doing so. People are creative in finding ways to alter their physical, emotional or mental state.

Using alcohol or other drugs (hereafter 'substances') is another way of achieving this. Most people who use substances never develop problems. Some will use them occasionally at levels that do not create problems for them. However, like the activities just described, substance use is not without its risks. For some people, substance use becomes problematic in a number of ways: they may experience problems in their intimate relationships, friendships and family lives, problems with their work or studies, problems with their finances, problems with their mental and physical health, and problems with the law.

Social workers meet these people in their routine practice and can offer a way of working with them that operates from a social model of care – a perspective that takes a holistic approach to a person's life, rather than focusing on one problem alone.

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**Table 6** *Frequency and levels of alcohol consumption.*

| *Alcohol consumption in the previous week* | *Men (%)* | *Women (%)* |
|---|---|---|
| Drinking on at least five days | 17 | 10 |
| Drinking above recommended weekly limits (21 for men, 14 for women) | 26 | 17 |
| Heavy drinking: more than 50 units a week for men, 35 for women | 6 | 3 |

Source: Office for National Statistics, 2012.

## Prevalence

### *Alcohol*

In the United Kingdom, a key source of data on alcohol consumption among the general population is the General Lifestyle Survey. In the 2012 survey, 67 per cent of men and 53 per cent of women had drunk alcohol in the previous week (Office for National Statistics, 2012). The gender differences remain for frequency and level of consumption, but overall the data highlight a notable percentage of the adult population drinking frequently and above recommended limits (see Table 6).

Even among heavy drinkers, the figures do not mean they automatically have problems with alcohol; people experience problems at lower and higher levels of alcohol consumption depending on a number of individual factors, including pre-existing health or financial problems.

Of people receiving treatment for their substance use in 2009, data show that more than 111,000 people cited alcohol as their main substance problem with a further 31,000 disclosing that it was one of the drugs they had problems with (Department of Health/National Treatment Agency, 2011). However, this figure only represents the number of people that seek formal help from a substance use service. Other people with alcohol problems seek informal help, may not want help, or may be successful in reducing, or stopping, their alcohol problem by themselves.

### *Drugs*

Estimates of the number of people in the general population who use illicit drugs are based on surveys of a sample of the population. Millard (2011) found that more than one-third (36.3%) of people aged between 16 and 59 had used illicit drugs in their lifetime, and 8.8 per cent had used in the last 12 months.

Simply using illicit drugs does not mean somebody will develop a drug problem, although they may get into problems with the law. Many people will try one or more drugs once or twice, or may use them more often during a particular period of their lives. Most will not develop a problem with drugs and will decide either to continue using at a controlled level or to stop using altogether. Some will continue to use drugs, increasing the amount they use and the frequency, and this can lead to problems.

The number of people with drug problems is difficult to estimate because its illegality means that many people's drug use will remain hidden until they seek help

or are deemed to be putting themselves or other people at risk. The National Drug Treatment Monitoring Systems (NDTMS) records the number of people receiving formal interventions for their drug problem. In 2010–2011, 204,473 people were registered on the database as receiving structured treatment (Department of Health, National Treatment Agency, Office for National Statistics, 2011). As with alcohol, this is likely to be only a small proportion of the people who are experiencing problems.

## Drug and Alcohol Use

The effects of drugs and alcohol will differ from person to person. People feel the effects because of the impact they have on the body's central nervous system (CNS). However, there is no 'one size fits all' effect as it depends on a number of factors including a person's mood, what other substances have been taken, beliefs about the substance and how used to taking it they are.

Substances are often grouped by the biological impact they have on the CNS. These groups are:

- Drugs that *depress* the CNS, e.g. alcohol, tranquilizers, solvents and gases.
- Drugs that *stimulate* the CNS, e.g. speed, cocaine, crack cocaine, ecstasy, caffeine, tobacco.
- Drugs that *alter perceptual function* (hallucinogens), e.g. LSD/Acid, magic mushrooms, cannabis.
- Drugs that *reduce pain*, e.g. heroin, opium, methadone, codeine.

The way that people use the substance determines how quickly and intensely the effects are felt: injecting a drug into the bloodstream will have a more immediate effect than smoking the same drug.

There are many useful web sites that provide details of drugs, alcohol and their effects, including:

- Alcohol Concern – www.alcoholconcern.org.uk
- Drugscope – www.drugscope.org.uk
- Social work, alcohol and drugs – www.swalcdrugs.com

### *Why people use*

One person's motivation to use alcohol or drugs is likely to be different from the next person's. What is the same for everyone is that *nobody starts using alcohol or drugs expecting to, or intending to, develop a problem*. Some of the reasons people will start, or continue using substances include:

- to experience something new;
- to take a risk;
- to feel better;
- to escape emotional or psychological pain or stress, including memories of abuse;

- to rebel, fit in, or to forget work/home problems;
- for medical purposes;
- to celebrate or commiserate;
- to conform with cultural norms;
- . . . and to have fun.

For people who have been using alcohol or drugs frequently and at high levels, one of the reasons to continue using or drinking is to avoid the uncomfortable, and potentially painful, physical and psychiatric symptoms that can accompany withdrawal. The withdrawal process needs to be medically supervised and the person may need prescribed medication to help them deal with the symptoms.

People tend to cut down or stop their alcohol or drug use when the problems associated with it outweigh the benefits. This may be when a relationship is in jeopardy, when they lose their job or business, or when their physical or mental health deteriorates. It may also be when statutory agencies become involved: for example, if there is trouble with the police, or social services become concerned about the care of children. Whatever the motivation for reducing or stopping substance use, it is important for the person to have adequate support in place to help them reach and maintain their desired goal. Social workers' holistic approach means that they are well placed to help put this support in place.

## The Importance of Social Work Involvement

All social workers work with people who *use* alcohol and drugs, some of whom have alcohol and drug *problems*. For some social workers alcohol and drugs work will be their chosen area of specialist practice. For others, working with people with alcohol and drug problems will be just one aspect of their specialist focus. For example, work with people experiencing mental ill health will include working with people who have both mental health and alcohol or drug problems, or working with children and families will include families where there are child protection concerns based on parental substance problems.

There are few estimates of the number of people with drug and alcohol problems receiving social work interventions. Most estimates are based on research with a selection of social work teams working with children and families. Research suggests that approximately 25 per cent of children on child protection registers involve parental alcohol or drug use (Advisory Council on the Misuse of Drugs (ACMD), 2003) while higher estimates have been found among parents involved with children and families services more broadly. Hayden (2004), in a review of this research, found estimates ranging from 20 to 78 per cent. Kearney, Levin and Rosen (2000) report that social workers estimated that 50–90 per cent of parents on their caseloads had drug, alcohol or mental health problems. On a general population level it is estimated the 6 per cent of children under 16 have a parent who is 'dependent' on alcohol, with 2.8 per cent dependent on other drugs (Manning *et al.*, 2009).

Research data shows the extent of the use of alcohol and drugs by people that social workers often work with:

- Between 16 and 51 per cent of people attending mental health services use substances with many using a range of substance and combining them with prescribed medication (Needham, 2007).
- Among *older people*, 20 per cent of men and 11 per cent of women (over 65) reported drinking above the recommended limits on one day in the previous week (Robinson and Harris, 2011). They are also the age group that has the highest proportion of daily drinkers (Robinson and Harris, 2011).
- Boreham *et al.*, (2007), in the first nationally representative survey of arrestees, found 52 per cent of offenders had taken drugs in the last month. The main drug of choice was cannabis, although offending rates were higher among those using heroin or crack cocaine regularly. In terms of alcohol, the study found that 57 per cent of the offenders were 'dependent' on alcohol.
- Among *young people aged 11–15*, research shows that 45 per cent had drunk alcohol at some point in their lifetimes and 13 per cent reported drinking once a week (Fuller, 2011). Similarly young people have higher levels of illicit drug use than their adult counterparts: 18 per cent of 11–15 year olds had used in the last 12 months (Fuller, 2011).
- The NHS Information Centre (2011) reports that lifetime drug use among younger people (16–24 year olds) was 40.1 per cent and last year use was 20.4 per cent. Among children aged 11–15 years, it reports lifetime prevalence as 18 per cent with 12 per cent reporting drug use in the previous year.
- There are no prevalence data in the United Kingdom on alcohol or drug use among people with *learning disabilities*. Substance use among this group of people is generally considered to be a lot lower than among peers without learning disabilities although reports from practitioners and some studies of people with mild learning difficulties or 'borderline intelligence' suggest otherwise (Hassiotis *et al.*, 2008; McGillivray and Moore, 2001).
- There is limited data on the prevalence of illicit drug use among people with *physical disabilities* in England and Wales. According to the British Crime Survey, drug use among people with 'longstanding illness or disability' which 'limits activities' is far higher than among those without disabilities (Hoare and Moon, 2010). US data supports this with some research claiming rates of substance use up to twice the rate of those without physical disabilities (Krahn *et al.*, 2006).
- There is a huge overlap between *domestic abuse* and substance use. Among women with substance problems estimates consistently suggest that approximately two-thirds of women have suffered domestic abuse in their lifetimes (see Galvani, 2010).

People who have problems with alcohol and drugs often have a *negative impact on other people in the family*, including partners, parents, siblings and children. Family members are at risk of psychological and physical harm but are often overlooked by alcohol or drug services which tend to focus on the individual alone. Family- and network-based interventions are beginning to be offered by some substance use services but it is important that social workers identify and assess the needs of family members and offer them support in their own right as their needs are likely to go beyond the impact of their loved one's substance use. Research has

shown that this helps to reduce their physical and psychological suffering and has a positive impact on the substance use of the person with the drug or alcohol problem (Copello *et al.*, 2000, 2006; UKATT Research Team, 2005).

### *A social work perspective*

Social workers work primarily with the social harms relating to alcohol and drug problems, although often these will overlap with health concerns. Social harms include the impact that alcohol and drug problems can have on a parent's ability to take care of the children, a young person's offending behaviour or a person with mental health problems whose substance use is putting themselves, or others, at risk of harm.

The social work approach looks at more than just the person's substance problem. It recognizes that the person exists within a wider social context (see Box 9) and may have a number of problems. Social workers are prepared to work with those too. A social work perspective should not view the person solely as an 'alcoholic' or 'addict'. Such terms are labelling and stigmatizing. They identify the person by a problem rather than as a person who has a number of identities – parent, colleague or friend. This distinction is important both for the person's sense of self-efficacy and their self-esteem. Using labels implies that addressing the substance use will solve all the person's problems. This is not the reality, as people with substance problems usually have other problems that predate their substance use and may have exacerbated it in the first place.

## 9 The impact of social context

Consider the difference between two people trying to reduce or stop their drug use:

- Trevor is a homeowner in a middle-class neighbourhood, with a supportive partner, family and friends, no immediate financial crisis, and an employer who is giving him time off work to 'get himself sorted'.
- Roz is a single unemployed parent. She has been re-housed on an estate after escaping an abusive and violent partner. Both the domestic abuse and her drug use have left her isolated from her family and friends. The housing conditions are poor, there is a high crime rate and few local amenities. The children have nowhere to play because the playground is unsafe and repeatedly vandalized. Her only support is her drug-using friends. She is in trouble with the police and social services have become involved after a neighbour became concerned about the children being left alone in the flat.

While both people face the same challenge of overcoming their drug problem, it is easy to see how the person's environment and social context is likely to help or hinder them during this process.

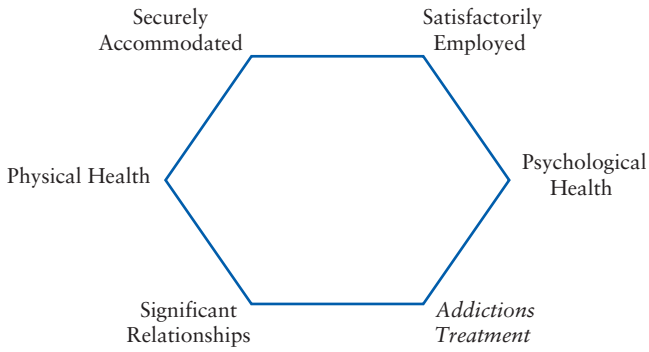


**Figure 3** The Six-Cornered Addiction Rescue System (SCARS).

The importance of a supportive environment in helping someone overcome their alcohol or drug problem is portrayed by McCarthy's SCARS model (see Figure 3) (McCarthy and Galvani, 2004). It helps workers to analyse quickly what support a person has in place and where they may need help to plug the gaps. SCARS (or the Six-Cornered Addiction Rescue System) uses a 'safety net' image to show that when a person has only one corner of the net supported, for example alcohol or drug treatment, the safety net is unlikely to support them. The more areas of a person's life that are stable or supported, the more likely it is that the safety net will hold them and help them to successfully reach their desired goal in relation to their alcohol or drug use.

The SCARS model operates from a perspective that problems are interlinked and, by meeting peoples' needs in a number of areas, their chances of successfully overcoming their problems will be maximized.

## Value Base

A great deal of shame and stigma are attached to having alcohol or drug problems. This is often exacerbated by media-enhanced stereotypes of the 'junkie' or 'alcy' that portray people as being weak-willed, liars and undeserving. The values and principles of social work reject such stereotypes and place emphasis on treating people with respect regardless of their circumstances.

People with substance problems are used to being avoided and treated with suspicion. Anti-oppressive practice rejects such discriminatory behaviours; instead it respects people by working with them and understanding that each individual is the expert in their own lives and problems. It listens in a non-judgemental way and recognizes that the person's social, cultural and environmental context may need to be discussed in relation to what type of intervention or support they need.

People suffering substance problems often report feeling out of control, not knowing who to ask for help or how to change their behaviour and the way they feel. Social workers are in a strong position to support someone in this situation due to the profession's commitment to working in an empowering way, helping the

user regain a sense of power and control over problematic parts of their life, and so obtain increased confidence to make positive and healthy choices.

## Challenges and Opportunities

Working with people with alcohol and drug problems provides both challenges and opportunities for social workers. One of the challenges is dealing with the frustration that the work involves. Social workers report a sense of frustration about how to intervene and work well with alcohol and drug problems. This is not helped by the lack of training they receive about alcohol and drugs on social work qualifying programmes. Nor does it reflect the prevalence of people with alcohol and drug problems in contact with social work services. The other frustration, which stems partly from this lack of knowledge, is that of seeing people with alcohol or drug problems repeatedly in and out of the 'revolving door' of services. Changing a long-term pattern of drinking or drug use is hard, particularly if people do not know what to replace it with. They can make many attempts to change their substance use before being able to do so. It is frustrating for the social worker to see the emotional, physical and psychological roller coaster that the individual and family go through during this difficult change process.

One of the important roles a social worker can play is helping them fill the void that reducing or stopping their substance use leaves behind. This is why a supportive environment is so important. Most people, however motivated they are, feel ambivalent about changing their substance use.

The social worker does, however, have duties and powers to intervene to protect vulnerable adults and children from harm. This protective and controlling role has to be balanced with the needs and wishes of the individual and the needs and wishes of those at risk of being harmed. This is a difficult task and one that needs to be made after consultation with service users and professional colleagues.

These conflicting demands are often mirrored in working relationships with alcohol and drug specialists. Historically, there has been a lack of mutual understanding between social workers and specialist alcohol and drugs staff, based on ignorance of each others' roles, priorities and referral and intervention procedures. In order to work well with other specialists it is important to understand the agencies' priorities as well as ask what they can and cannot disclose about their work with the person. It is also important to communicate what information or advice the social worker would like and why. Arranging joint interventions with the service user, social worker and specialist alcohol or drugs worker, as well as any individual meetings, is likely to be a more supportive and effective way of working with the individual and, where appropriate, their family.

A key challenge arises in working with someone who is denying their alcohol or drug problem or is unable to see the problems or harms related to it. It is unsurprising that people will not easily disclose their substance problems to a social worker because of the illegality of drug use, and the shame and stigma attached to problematic alcohol or drug use. Where the person has children, they may fear that they will be removed following disclosure of substance use. Overcoming this hurdle requires skilled communication and intervention on the part of the social worker.

People are unlikely to disclose sensitive information if they feel threatened and defensive. The social worker needs to show understanding of the person's situation by listening to them, acknowledging and highlighting the person's strengths, and discussing the benefits the person gets from continuing their alcohol or drug use. The social worker is then in a better position to discuss openly and honestly their concerns, their statutory duties, and negotiate a way forward.

In spite of the challenges of working with people with alcohol and drug problems there are also huge personal and professional rewards. The nature of the work is never dull; every person and every situation is different. It involves working with and for a group of people who are often viewed as undeserving of help by professionals and public alike. At times, it involves protecting people from themselves and protecting others from the harm they may cause. Importantly, it is about supporting people who have a serious challenge ahead in terms of changing their problematic substance use. This means establishing what support they need to maximize their chances of success. It also involves an educative role that may be related to their alcohol or drug use, or may be about its impact on their children or their physical or mental health.

Social workers see people's lives turned around by working on their drug and alcohol problem and supporting them through the change process. Problematic substance use can affect every aspect of a person's life. Stopping or reducing their problematic use can have a hugely positive impact on their physical health and appearance, their psychological well-being and their social and family lives.

## Conclusion

Social workers are ideally placed to work with people with alcohol and other drug problems. Social work training and the principles which underpin the profession commit it to a holistic approach – working with the whole person rather than one aspect alone. A social work approach emphasizes the importance of a supportive environment to a person's ability to overcome their problems. Social workers recognize and build on a person's strengths.

The challenges and frustrations of working with people with alcohol and drug problems are outweighed by the rewards of seeing people regain self-esteem and personal control as they begin the difficult journey of changing their problematic substance use. Important, too, are the benefits this reaps for their children, family and friendships.

## Five Key Points

1. Don't be judgemental: nobody starts using drugs or alcohol intending to develop a problem.
2. A social work model works with the whole person, not just the person's alcohol or drug problem.
3. Alcohol or drugs can be a way of coping with problems as well as potentially creating them.
4. Helping people to develop a supportive social environment will help them overcome their alcohol or drug problem.
5. Families and partners of people with alcohol or drug problems need support in their own right too.

## Three Questions

1. What are some of the reasons that people develop problems with alcohol or drugs?
2. What are the key elements of a social work approach to working with people with alcohol or drug problems?
3. To what extent can someone's environment or social context help or hinder their attempts to overcome their alcohol or drug problem?

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CHAPTER 3.10

# Modern Migration and the Creation of the Refugee

*Debra Hayes*

The movement of people, migration, is a normal part of human existence. In order to survive, individuals, families, tribes and groups of people have moved across global spaces to hunt, to trade, to harvest, to work. For most of human history the boundaries people crossed did not involve border control; borders as we now understand them are part of the development of modern capitalism. The construction, fencing and policing of territory came with the modern nation state. In that development newcomers were often seen as essential, vital for growth and expansion, an indicator of increasing power and accumulation. So how have we reached the point in the richer parts of the globe, those parts which have gained most from migration, that incomers are considered a problem, a threat, a burden, to be controlled, detained and removed? This chapter attempts to track that story, to contextualize the current preoccupation with immigration and asylum, and to explore how social work as an activity is now unavoidably impacted upon by the modern movement of people and is increasingly enmeshed in systems designed to control it.

> Capitalism has made use of both free and unfree workers in every phase of its development. (Castles and Miller, 2009, p. 79)

European expansion from the sixteenth century took migration to new levels, resulting in somewhere between 10 and 20 million people being taken by force out of Africa (Harris, 2002). The lucrative plantation system in North and South America was fuelled by that enslavement. After its demise from the mid-nineteenth century millions more Indian and Chinese workers built railways and farmed and mined in Asia and Africa, creating massive profits for their European masters. At the same time, some 70 million Europeans moved to Africa, the Americas and Australasia.

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These mass movements sat alongside smaller flows of workers moving from rural to urban settings to satisfy industrial growth in the rapidly developing economies of the West. It has been these economic developments which have shuffled populations around the globe.

Running parallel to the process of migration was the necessary construction of clearly defined territory and a set of ideas, nationalism, which would bind together those disparate groups 'under one roof'. Laws, education, religion and government became ways of reinforcing those who belonged and those who did not. Despite this, the movement of people between territories remained largely uncontrolled until the twentieth century. There were reactions and expulsions – for example, Jews from Russia and Poland in the late nineteenth century – but no formal barriers 'as the economic need for workers took precedence over any political aim to impose a social uniformity on the population' (Harris, 2002, p. 12).

The period after the Second World War saw many rich nations actively recruiting labour, firstly from ex-colonies and then beyond, to manage reconstruction and expansion into new markets. Significantly, from the 1950s we began to see the flow of migration globally shift from South to North: 'around 35 million people from the Third World, including 6 million "illegal immigrants" came to settle in industrialised countries between 1960 and 1990' (Hayter, 2000, p. 10). In this period, growing inequalities between the North and South of the globe have meant increasing numbers of people seeking refuge outside their countries of origin. By 2007 it was estimated that around 200 million people or around 3 per cent of the world's population were international migrants (UN figures cited in Castles and Miller, 2009, p. 5). War, civil war, persecution, 'natural' disasters like tsunamis, floods and earthquakes are responsible for many, but additionally the pace of economic development displaces millions. As Mike Davis comments in his wonderful exposé on the growth of the modern city, 'rural people no longer have to migrate to the city: it migrates to them' (Davis, 2006, p. 9). It is worth remembering here that the bulk of the world's displaced people are accommodated in regions close to home, not in the rich West. Around 26 million people are thought to be displaced in their own countries of origin (Castles and Miller, 2009, p. 7). Many of these millions who move for physical or economic survival and manage to reach the West will work in both the legal and the undocumented economy providing very cheap labour for international capital. There is also increasing awareness of the feminization of migration as women leave the Third World to provide essential functions in the affluent parts of the globe (see Ehrenreich and Hochschild, 2002).

This period since the Second World War is marked by attempts by countries, particularly in the richer part of the globe, to control their borders, to respond to this acceleration in international movement by deciding who can enter and to place tighter controls on those who do.

> In an era of globalisation of trade, investment, culture and communications, which undermines the powers of the nation state in many areas, immigration policy remains primarily determined at national level. Indeed the ability to control national borders has a powerful ideological significance at a time of declining national power. Immigration policy, in determining who may belong to the nation state, is central to constructions of national identity. (Sales, 2007, p. 3)

Consequently, alongside reinforced frontiers are systems which ensure that many residents of rich nations remain disenfranchised and unequal. Immigration controls therefore exist externally at borders but significantly work internally as well through the policing of differential rights and entitlements. It is these increasingly sophisticated internal mechanisms, relying heavily on parts of the local and national state rather than the obvious immigration systems, that are of concern to us in social work.

## The UK Context

As an empire nation, Britain has always gained significantly from both emigration and immigration. The wealth extracted from stolen foreign lands remains the foundation upon which modern Britain rests. The labour required to build industrial Britain came initially from rural areas, then from places like Ireland, and then from the former colonies in Africa, the Indian subcontinent and the Caribbean. The control of this movement, though, is a relatively new phenomenon, only beginning early in the twentieth century when Jews were targeted as they fled from persecution in Eastern Europe (Hayes, 2002). After the Second World War immigrants from the Commonwealth were welcomed as a valuable source of labour, particularly in transport, hotels, catering and the newly formed National Health Service. Britain's post-war immigration policy then became concerned with gradually separating the rights of different categories of British citizen. The 1962 Commonwealth Immigrants Act ended free entry for colonial subjects and citizens of the Commonwealth; in short, this brought about an erosion of the automatic rights of entry for those from the New (predominantly black) Commonwealth, establishing 'race' as a key feature of immigration control (Sales, 2007). Successive Immigration Acts in the 1960s and 1970s brought tighter restrictions, initially provoking a significant period of increased black and Asian immigration as people rushed to beat the ban and as many who were settled in the United Kingdom and had intended to return home did not do so for fear of being unable to re-enter. 'Race' and immigration became key features of general elections in this period as those who had been *inside* empire became reconstructed as *outsiders* until primary immigration for settlement from the New Commonwealth had all but ended by the 1980s (Spencer, 2011).

Within Europe, Britain was not the only country to reconstruct its relationship with former colonies. The development of the European Union changed definitions of those deemed *insiders*. Free movement for those citizens within the EU came with stronger controls around external borders. Just like Britain, Europe as a whole continues to require labour; what has changed has been the ability to choose who to let in and the conditions under which people reside if allowed entry.

The economic benefits of migration will not go away in advanced capitalism, but policies are increasingly about selecting the terms of entry and determining the rights afforded to those who enter. This means that the millions now resident outside their countries of origin may be perfectly legal, but they live with temporary residence rights and restrictions on their rights of long-term settlement and their right of access to provisions like welfare. Understanding this process – the shifting goalposts in

rights of entry and access to citizenship rights upon entry – is crucial in understanding the shift to asylum which has taken place particularly since the 1990s in Britain and other rich nations.

Migration for personal betterment, unless of course you are from a rich nation, is now considered negatively. The idea that you may wish to move to rich industrialized countries from poorer ones to improve your lot is constructed as unfair, shameful, and even criminal. Work permits may be possible for the minority who have desired skills but, for the bulk of the world's displaced, the door is firmly shut. Restrictive immigration controls have now made claims for refuge the only avenue of entry. Those seeking refuge are at odds with the economic impetus of immigration controls and are now constructed solely in terms of being a problem to be managed.

The United Kingdom has an obligation under the 1951 UN Convention on the Status of Refugees to grant refuge to those with a 'well founded fear of persecution'. The focus of immigration discourse in the United Kingdom in the last two decades has been on those seeking asylum. Running through this is a powerful ideology that most of these applicants are bogus, not genuinely escaping persecution but intent on securing access to economic privileges which are not rightfully theirs. Even a cursory look at the countries of origin of those seeking asylum tells a different story, reflecting terrible global catastrophes like war, civil war, natural disasters and relentless development which crushes all in its path. In 2009 the main countries of origin of applications for entry into the United Kingdom were Afghanistan, Zimbabwe, China, Iran, Sri Lanka, Pakistan, India, Eritrea, Sudan and Nigeria (Refugee Council web site). Further analysis illustrates the point made earlier concerning the cutting of old colonial ties: the majority of these countries were British territories in the not too distant past, but those fleeing their shores are now consigned to the status of asylum seeker having had any previous rights of entry to the United Kingdom removed. The question of who is considered a genuine refugee is now being interpreted more and more narrowly with around 70 per cent of those seeking asylum being refused annually. These are not large numbers of people to accommodate – only around 18,000 people in 2010, 27 per cent down on 2009 – but their very presence is constructed in entirely negative terms. Seldom are they lauded as valuable members of our communities; instead, they experience continued and sustained hostility and are seen as a burden, an unwelcome and expensive addition, particularly in times of austerity.

## Asylum, Immigration and Welfare

Immigration controls don't simply operate at borders but work *internally* enforcing restrictions on those legally resident but without full citizenship rights. What is of most interest here is the relationship between immigration control and the delivery of welfare. Since controls began, right at their heart have been mechanisms which ensure that those non-citizens are unable to access welfare. The first UK control, the 1905 Aliens Act, did just that by allowing in only those who had the *means* to support themselves and their families, and by providing for the deportation of those who illegally claimed parochial relief (Hayes, 2002). The modern-day 'no recourse

to public funds' rule continues to do the same, ensuring that non-citizen families are excluded from state welfare. The welfare state from its outset has had a strong nationalist ideology: welfare is fundamentally about improving the health and well-being of the nation and is not there for those outside of the nation. Over the last 100 years or so this has been played out many times with those delivering welfare being drawn into mechanisms to ensure that justice is done, from passport requirements for social security in the 1970s to gatekeeping in the NHS to obstruct the 'health tourist'.

What has escalated this more recently has been the establishing of a completely separate and inferior welfare system for asylum seekers. The 1999 Immigration and Asylum Act removed any remaining entitlement to normal welfare for those seeking asylum, setting up regional zones into which they would be dispersed. A no-choice, one-offer of accommodation would work alongside subsistence level welfare at around 70 per cent of normal benefit rates. Initially this was planned as a non-cash system with vouchers to be exchanged for designated food and essentials (Sales, 2007). A sustained campaign against the degrading voucher system brought its demise, but, sitting alongside the removal of the right to work, this system has since 1999 reinforced the separation of asylum communities. Dispersal has established new asylum communities in towns and cities around the United Kingdom, changing the landscape for social work and bringing new service user groups into our localities. The responses have been mixed; at worst a hostile and intransigent statutory sector, and at best a vibrant, creative third sector of faith groups, voluntary agencies, user-led projects and community groups. Chapter 4.10 in this volume explores the detail of these challenges for social work but mention must be made here about destitution. Those asylum seekers who fail in their claim for safety (some 70 per cent) may find themselves outside of all support. We now therefore face increasing numbers in our communities who are completely destitute. By removing wholesale asylum seekers from normal benefit systems, the safety net of national assistance is also removed. That last refuge as envisaged by the architects of the welfare state – that no longer would anyone ever again be completely destitute – does not apply to those at the sharp end of the asylum process, thus posing further challenges for social work.

In addition to the demands created by the needs of these vulnerable communities, social work now finds itself enmeshed in the *internal* control of asylum populations. Statutory services, through the process of gatekeeping the state's resources, make decisions about eligibility and provide a direct line of communication to the UK Border Agency; social workers are involved in age assessing unaccompanied young people in the asylum system to decide upon entitlement, and social work may be required to manage children where families are made destitute by harsh immigration decisions. The ethical tensions here open up debate, not simply about this particular service user group, but significantly about the kind of profession we want in the twenty-first century.

## Five Key Points

1. The movement of people is normal, but the numbers of people displaced globally have escalated.
2. Immigration and asylum policies are attempts to control and select at borders but also to control *internally.*
3. Welfare delivery is a key dimension of internal immigration control.
4. Asylum seekers are an excluded and marginalized group living in a purposefully inferior and hostile 'welfare' system.
5. Health and welfare professionals have been drawn into the internal control of immigration.

## Three Questions

1. How far does current asylum policy represent continuity with the past?
2. What are some of the dilemmas for professionals in health and welfare?
3. How can those professionals resist the oppressive drift in role and work in more liberating ways?

## Further Reading

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# BOOK 4

# Social Work in Practice



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CHAPTER 4.1

# Social Work Practice and Relationship Breakdown

*Simon Ward*

Many of the skills that define good social work practice are tied up with relationship building: that can include the social worker's interactions with colleagues and other professionals as well as with service users. Effective relationship building has become underrated in social work; and if Munro's argument that bureaucracy in childcare work should be reduced is followed through, a challenge for many social workers will be to become re-skilled in that area (Munro, 2011).

## Imogen

Imogen, aged nine, has been accommodated in a foster home for the past three weeks. This followed an incident at Christmas when she opened everyone's presents before the occasion and subsequently set fire to the Christmas decorations.

Imogen was born three months prematurely and was in an incubator for a time after her birth. Her mother, Angela, experienced post-natal depression following the birth. Angela was 17 at the time and Imogen was conceived as a result of a 'date rape' experience with Justin, a boy in a year above her at her sixth form college whom she had previously idolized. This experience led to a period when Angela avoided close relationships with men.

Angela has since married and has two younger daughters, aged six and three. She is now six months pregnant and she and her family have all

*Continued*

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envisaged that the baby 'will be a boy'. Imogen is seen as 'bad' by her family – even by some extended family members such as Angela's sister, who refers to Imogen as 'evil' when describing her behaviour. Imogen is also the apparent source of tension between Angela and her husband, Eric. Eric says that he has tried to 'build bridges' with Imogen, but recently he has left the family home on a couple of occasions saying that he 'cannot cope'.

The issues of how, when and whether Imogen should return home are at the moment unresolved. Her half-sisters, Katie and Natasha, constantly ask the social worker about her; on the surface, Imogen appears relatively unmoved by recent events.

A well-planned social work intervention with Imogen will depend on a thorough assessment of her development, her relationships within the family and how the family is situated in the community.

Social work intervention relating to family breakdown might take place in various ways and at different stages:

- with the family, including Imogen and her half-sisters, prior to the care episode;
- between Angela and Eric, Imogen's mother and stepfather;
- with Imogen following her placement in foster care: the involvement of the foster carers in that will be crucial;
- with the whole family in an attempt to assess what changes need to take place if Imogen is to return;
- with all participants if Imogen is unable to return to her family and a 'permanence' plan is made which reflects that decision; the plan would include contact arrangements between Imogen and family members.

The skills required by a social worker in this process will include:

- communicating with the family and Imogen;
- facilitating family members' communication;
- helping them to reflect upon what has happened and agreeing together an action plan in terms of what needs to change;
- making and retaining a working relationship with family members while at the same time intervening effectively.

Given the way that Imogen appears to have been scapegoated and is seen in a negative way by family members, there appears to be an element of emotional abuse. That means that the requirement to work 'in partnership' with the family will be tempered by the duty to protect Imogen from 'significant harm' and the social worker will need to be conscientious in seeking her wishes and feelings.

The social worker's first consideration will be to see whether Imogen can be returned to her family in a way that is safe and satisfactory for her. If that proves to be impossible, the task will be to work with her in order to find emotional

'permanence' in another family setting. For social workers to be effective in this area, they require interpersonal skills, skills in the use of a range of theories and an ability to reflect purposefully on what they are doing. In addition, they need knowledge of law and resources, and an ability to negotiate with organizational bureaucracies.

## The Social Worker's Use of 'Self'

The childcare social worker will need to be aware of how their personal impressions and values might influence the ways in which they interact with all the parties involved and how they might affect the assessments and decisions that have to be made. With this in mind, reflective social workers should consider asking themselves the following questions:

- What is their own experience of relationship breakdown? How does the task of working with situations such as these make them feel? Some awareness of psychodynamic concepts, particularly defence mechanisms, may be useful.
- What is good empathetic work in this case? It is important for the worker to listen carefully to participants' points of view while not themselves becoming overwhelmed by feelings of grief or anger. They must maintain their protection responsibilities. There is a requirement for the effective social worker to be both 'involved' and 'separate'.

## What Theoretical Perspectives May Help the Social Worker?

### *Attachment*

The social worker's assessment should throw light on the nature of Imogen's principal attachments. However, given the way in which she is viewed by family members, and given her behaviour, it is unlikely that her attachments will be anything other than insecure. Her relationships with her parents will not provide her with a secure base and her conceptualization of relationships, her internal working model, is likely to be distrustful in relation to the reliability and intent of others.

That is not to say that Imogen's relationship with her mother is insignificant. There is a difference between a secure and a significant attachment; what is seen as 'strong' in a parent–child relationship may be insecure and unhelpful to Imogen's emotional development. If Imogen is to be more successfully parented by her mother in future, Angela's care for her child's needs will have to undergo a considerable transformation in terms of consistency and the provision of unconditional affection: that will require Angela to spend constructive time with Imogen, sharing activities and offering security to her daughter however much Imogen may seem to reject it.

If successful social work is to be carried out with significant family members, there will need to be some investment in explaining Imogen's attachments to them, as well as suggesting how they might be modified.

## *Grief and loss*

Bowlby (1971) saw the experience of loss as being closely related to the quality of attachments. He outlined a sequence of three stages that a child goes through when they experience their main caregiver(s) as being unavailable:

- initial protest – separation anxiety;
- despair, related to grief and mourning;
- denial or detachment, related to psychological defence mechanisms such as repression of the sense of grief.

It is possible that Imogen may, emotionally, have already reached Bowlby's third stage, and that will contribute to her attachment behaviour.

It would also be useful to consider whether Angela experienced feelings of loss and trauma relating to the circumstances in which Imogen was conceived and whether they continue to affect her relationship with her eldest child. Reder and Lucey (1995) have written about the significance that a child may have for a parent in terms of that parent's relationship with and feelings for the other partner. In this case, Angela's disappointment and disillusionment with Justin for the way in which he treated her could be said to represent a loss experience and those negative feelings might be being projected upon her daughter. Exploring such feelings should be seen as part of the assessment of why Imogen's relationship with her mother has broken down.

There are signs that Imogen's half-sisters are bewildered by Imogen's absence and are missing her. Section 17(3) of the 1989 Children Act allows their welfare to be considered and provided for; it is also the social worker's responsibility to assess whether their situations, too, may be potentially abusive.

## *Family systems theory*

Consideration of the support systems around both Angela and Imogen will be important in the task of assessment and intervention. One of the main premises of family systems theory is that concentrating upon mending individual relationships within a family unit is often insufficient (Carr, 2006). Tolstoy wrote in *Anna Karenina* that 'all happy families resemble one another, but each unhappy family is unhappy in its own way'. That includes particular beliefs that family members may have about the world and about each other, which may lead to them taking on roles or scripts that are in some respect necessary for the family to continue to exist as a unit. Consequently, the message to Imogen that she is 'bad' or 'evil' and the expectation that her behaviour will reflect that may be self-fulfilling. A child's difficult behaviour may mirror tensions in the relationship between their parents. In this case, Imogen's stepfather, Eric, appears to be resistant to Imogen being stereotyped in that way, and this may explain the tensions in his relationship with Angela and his apparent urge to escape from the family system – if only temporarily. Skilled application of a family systems perspective should ensure that Katie's and Natasha's views of the situation are sought and respected.

Social workers are not family therapists, but there is much in the family therapy literature that can be helpful in exploring with the family how Imogen's situation might be improved. Family systems literature places emphasis on the importance of asking family members how they view relationships within the family, rather than of imposing professional interpretations (Carr, 2006). Family group conferences are part of the official court strategy designed to avoid care proceedings. They rely on getting family members together in an attempt to find solutions. They are not the same as family therapy sessions, being much more task-based, but they do have some similarities.

A wider systems perspective would suggest that the social worker should be looking beyond the nuclear family unit to other support systems, a view that family group conferences endorse. A family systems approach has value, but the worker will need to ensure that group opinion is not allowed to fossilize into further scapegoating of Imogen. That is where the attempt to 'mend' family relationships should be balanced against Imogen's right to be protected under the 1989 Children Act.

## The Need for Caution

Prior and Glaser (2006) suggest that attachment theory may be better at offering insights in understanding a relationship than at indicating what steps should be taken to change it.

Currently the emphasis in therapeutic writings and in public policy is on acknowledging the user's perspective on their situation and not simply imposing externally designed solutions. That approach should include helping users to understand, whenever possible, the fundamental tenets of the approaches that social workers wish to use. Of course, there may always be tensions both between the different users' interests (for example, between Imogen's perspective, her mother's and her stepfather's) and between each of those and the social worker's perspective – which includes, at least in part, a responsibility to ensure child protection.

Social workers are particularly concerned to avoid simplistic or inflexible approaches. For example, there is every reason to be worried about the quality of Imogen's attachments with her main carers, but that does not justify a rigidly negative approach: research suggests that at least 30 per cent of us have insecure attachments (Prior and Glaser, 2006), so their existence does not in itself justify separating children from their parents. Of course, there is much to be learnt from attachment theory but concerns have been expressed that it has become too dominant a discourse amongst childcare social workers (Barth *et al.*, 2005).

## Five Key Points

1. It is important for social workers not to neglect the skills required to work effectively when relationships break down.
2. They need to be reflective about their own experiences in this area and how they might affect their practice.
3. A range of life-course theories can be used when working in this area, including ones relating to attachments, grief and loss and family systems.
4. As far as possible the social worker needs to be able to put those theories 'on the table' when working with users, to explain the ideas behind them and their relevance to the situation.
5. Another skill required by the social worker is communicating and gaining trust with family members (not forgetting the children), while keeping sight of their child protection responsibilities.

## Three Questions

1. As a social worker, are you comfortable about working with the emotions expressed when relationships break down?
2. How up to date is your knowledge of related theories and how they can be applied?
3. What do you know about findings from research relating to returning children to their parents?

## Further Reading

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CHAPTER 4.2

# Social Work Practice and Child Abuse

*Jess McCormack*

In March 2012, over 50,000 children in the United Kingdom were known to be at risk of abuse (Department for Education, 2011; Scottish Government, 2012; Waugh and Fitzpatrick, 2012; Welsh Assembly Government, 2011). This statistic was calculated using the number of children on child protection registers or subject to child protection plans and therefore only includes the children known to professional services and receiving support. This is not the same as the number of UK children who have been, or are being abused, which may be much greater.

Child abuse is one of the most passionately debated topics in society. This is most likely because children are so vulnerable and their parents are tasked with their care and protection, but also because at a societal level we too take responsibility for investing in our children and enabling them to achieve their potential. So when things go wrong and children are abused, we can all feel a sense of responsibility to fix the damage done and to stop any more children from being harmed.

The ability to intervene in situations of child abuse is given by law to local authority social workers. There is often a sense that social workers are 'damned if they do and damned if they don't', in that leaving a child in a potentially harmful situation is an unacceptable risk, but removing them from their parents' care is abusive in itself. One of the biggest challenges for social workers is achieving this delicate balance between protecting children from harm and supporting their right to life with their families.

This chapter illustrates the struggle for such a balance. It outlines a real case (with all identifying details changed to protect the confidentiality of the family), explored from the social worker's perspective through a series of case recordings.

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After each case note are practice considerations which encompass a number of questions to promote reflection on the information presented and its application to the child's circumstances.

Although this case is presented within a Scottish context in terms of legislation and child protection policies and procedures, the process of defining, identifying, explaining and responding to child abuse can be generalized to families living across the United Kingdom.

## Defining and Identifying Child Abuse

### Week 1

***Thursday 10.15 a.m.*** – Telephone call from Ms Crumlish, head teacher at Whitemonks Primary School, with concerns about Nia Harper (age 7). Ms Crumlish reported that during a PE lesson this morning, Nia's teacher noticed a large bruise on her lower back. The teacher asked how she got the bruise and Nia stated that her mum's boyfriend caused the bruise by pushing her out of the way of his computer game.

Ms Crumlish also noted a number of other concerns about Nia:

- Her attendance is low and she is often late to school.
- She is struggling academically and has only just attained a 5-year-old reading level.
- Nia's mother, Christina, does not attend school meetings and does not appear to be supporting Nia's learning outside of school.
- Nia has had persistent head lice. School policy is to send children home when lice is detected, but the school have often been unable to reach Christina and Nia has consequently had to spend the day in school, isolated from her peers.
- Nia's physical presentation is often poor – Ms Crumlish described her as 'unkempt and dirty'.
- Nia struggles with peer relationships and does not seem to have any close friends.

Discussed the above with social work team leader and agreed the following action:

- Further information to be gathered under child protection procedures – initial enquiries.
- Background check of social work records for Nia and family members.
- Contact GP for health information.
- Team leader to contact police to request background check and to determine whether there needs to be a joint investigation. Also check Child Protection Register – child not named.

*Practice considerations*

Is the child in imminent danger? Nia should currently be safe in school, but an assessment needs to be done of whether it is safe for her to return home this evening – are emergency legal protection measures required?

Has a crime been committed requiring a joint investigation with the police, or can social work respond as a single agency?

Are there any cultural or religious factors that need to be taken into account?

Is it a breach of Nia's right to confidentiality to share information about her with other agencies? In cases of suspected child abuse, should the safety of the child always take precedence over the need to maintain professional confidentiality?

***Thursday 11:30 a.m.*** – Records show that Nia was referred to social work shortly after her birth due to Christina being identified by her midwife as a vulnerable parent. Nia is described in the records as of white, Scottish origin and of Christian faith. Christina was placed in a number of residential facilities as an adolescent following allegations that she was sexually abused by her stepbrother. These allegations were never proven in court. Christina may have a learning difficulty, although she has never received a diagnosis. Nia's case was closed to social work when she was a year old, as it was felt that Christina was providing a good enough standard of parenting and support would continue from the allocated health visitor.

Telephone call to GP: no concerns noted. Nia has rarely been seen at the practice and there are no records of any presentations at A and E. Records from previous health visitor note that Christina was often unavailable for home visits. Almost all of Nia's immunizations were delayed due to non-attendance at clinic appointments.

Update from contact with the police: child protection inquiries can be led by social work as a single agency. Criminal records check revealed Christina has been convicted of three counts of shoplifting, but has not spent any time in custody.

Discussed the above with team leader and agreed there is a need to interview Nia in school to gather more information about her injury. Attempts made to gain parental consent for the interview using telephone number provided by the school.

***Practice considerations***

How can the background information be used to inform the investigation, but not lead to bias in the social work response?

Should Nia's case have been closed to social work when she was a baby?

It is important to gather information directly from Nia – should consent be sought from her mother first, or could this compromise the investigation? If consent is not sought, how might this impact on the working relationship with the parent?

***Thursday, 12:30 p.m.*** – Visit to Whitemonks School by the worker and colleague to interview Nia. Several attempts made to contact Christina by telephone to seek consent, but she was consistently unavailable. Team leader decided to proceed with interview without parental consent.

Nia engaged readily with workers. She seemed very keen for adult attention and was overly familiar with workers, given she had never met them before. Nia accepted the explanation about workers' roles and responsibilities and this did not seem to impact on her willingness to share information. She demonstrated an understanding of the truth and the importance of being honest.

Nia spoke generally about her life at home on the 22nd floor of a high-rise block of flats. She said the flat was 'always cold' because there was 'no money for the

meter'. Nia spoke about playing outside in the park at the flats, but described crossing the road to school as 'scary'. Nia indicated that she travels alone to school because her mum is still sleeping.

When asked about her mum's boyfriend, Walter, Nia became noticeably withdrawn and reluctant to talk. She said that he didn't live with them, but was often there to play on his computer games. Nia said she didn't like it when Walter shouted and 'banged the walls'. When asked specifically about the bruise on her back, Nia said that Walter 'pushed' her out of the way when he was playing his computer game and she banged into the edge of the open living room door. Nia demonstrated the force of the 'push' and indicated this wasn't very hard, but did cause her to lose her balance and fall against the door. She clearly stated that Walter had never pushed her before. Christina was reportedly sleeping when this happened, but woke and responded to Nia crying by telling her to go to her room. Nia stated her mum is 'always sleeping'.

Nia's physical presentation was poor. Her hair did not appear to have been brushed and her school uniform was poorly fitting and unwashed.

*Practice considerations*

The age and stage of child – chronological age may not reflect developmental capabilities. How do you measure the child's understanding of the investigative process and the role of social work?

Should consideration be given to the impact of the child sharing information on their family relationships?

All children have the right for their views to be heard (Scottish Executive, 2004), but what if this compromises their safety? Or if their wishes can't be upheld due to risk?

How do you decide if child abuse has occurred? What are the thresholds?

The importance of differentiating between fact and opinion – only facts can be used to legally secure a place for a child outside of the home.

What more do you need to know at this stage? Why might Christina always be sleeping? Who are her sources of support? Why is there no money to heat the home?

***Thursday, 2 p.m.*** – Case discussion with team leader confirmed the following:

- From Nia's interview, there is inconclusive evidence of physical abuse, but there are indications that Nia may have been subject to neglect.
- Nia is in need of protection, but emergency measures will not be sought at this time as long as there is agreement from Christina that Nia will have no contact with Walter until further assessments have been completed, as he is still considered to be a significant risk factor.
- Further information is needed about Nia's home circumstances, as well as Christina's willingness to engage with social work.
- A medical examination of Nia is to be arranged as a matter of urgency.
- Social worker to return to the school to meet with Christina when she arrives to collect Nia.
- Initial Child Protection Case Conference to be convened next week.

*Practice considerations*

How to identify and evidence neglect, defined as 'the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development' (Scottish Government, 2010, p. 14)?

How to engage effectively with Christina given the importance of a positive working relationship?

How can differing thresholds (both in individual workers and organizationally) impact on decision-making processes and consequently on action taken to protect children?

***Thursday, 4 p.m.*** – Meeting with Christina at Whitemonks School: Christina initially expressed hostility towards social work and appeared angry that Nia had been spoken to without her knowledge.

Christina said that she has been in a relationship with Walter for 'about a year'. She acknowledged he sometimes 'gets angry and shouts' but was adamant that he would never harm Nia.

Christina reluctantly consented to Nia having a medical examination this evening. She also agreed to a home visit from social work tomorrow. Christina agreed to ensure Walter would not be in the family home nor have any contact with Nia until further assessments have been carried out. She appeared to understand that a breach of this agreement would result in emergency measures being sought and that Nia could be placed in foster care. Monitoring check to be carried out this evening.

*Practice considerations*

Does domestic abuse need to include physical violence for a child to be harmed?

What are some of the potential difficulties of asking a mother to prevent a violent partner from seeing a child?

***Friday, 9 a.m.*** – Report received from paediatrician noting that the injury to Nia's back was consistent with her explanation of losing her balance and falling against an open door. Paediatrician advised that Nia is now stating she tripped and fell into the door. She is denying any involvement from Walter. Christina is now stating that she witnessed Nia fall and that Walter was not present. There are no other indicators of physical injury. There is therefore no forensic evidence of physical abuse.

Paediatrician also notes that Nia is underweight and requires dental treatment due to significant tooth decay. She also recommends an ophthalmology assessment to assess a noticeable convergent squint in Nia's right eye.

*Practice considerations*

How does the additional health information support the assessment that Nia has been subject to neglect?

Why might Nia's story have changed? How should social work respond to this?

If she were still stating that Walter had pushed her, would Nia be considered to be a reliable witness if the case went to court?

What might the impact of a child abuse case going to court be on Nia and her family?

## Explaining Child Abuse

***Friday, 11 a.m.*** – Visit to Christina at home. Nia was at school. The family home was poorly maintained and sparsely furnished. Nia's room contained only a bed, no bedding and a few damaged toys that were more suitable for a younger child. Christina advised that Nia usually sleeps in her bed, as it's warmer. The kitchen cupboards contained only two tins of spaghetti.

The living room was untidy and there were two large holes in the wall, which Christina advised were caused by Walter during an argument. She denied that Walter has ever been violent towards her or Nia. Christina does not appear to understand the potential impact of Walter's verbal aggression on Nia's well-being.

Christina's presentation was markedly different from yesterday at the school. She appeared very sleepy and her speech was slow and slurred. When asked directly about substance use, Christina admitted to taking 'two valium' to help her sleep last night, as she was 'so stressed' by what had happened. The tablets were not prescribed, but were bought from a 'friend'. When asked about the frequency of her drug use, Christina said 'not every day'.

Christina admitted to struggling financially. She is dependent on income support and has never had paid employment. Christina described her main sources of support as being Walter and her family. When asked if this included her stepbrother, Colin, Christina said 'yes' and that the sexual abuse he perpetrated against her was 'a long time ago'. When asked specifically if Nia had any contact with Colin, Christina stated that she did because 'he's family' but indicated that they were never left unsupervised.

When asked about Nia's behaviour, Christina said she was 'no bother' and that she was 'out playing' most of the time. Christina said she watches Nia playing from the kitchen window. When challenged about how she would respond from the 22nd floor if Nia needed her help, Christina dismissed this as a possibility, stating, 'she's fine'.

Advised Christina a Child Protection Case Conference will be held next week. She agreed to continue to ensure that Walter has no contact with Nia.

*Practice considerations*

How might Christina's self-medicating use of benzodiazepines impact on her care of Nia in terms of meeting both her physical and emotional needs?

How might the conditions within the home impact on Nia's safety and well-being?

How does the information about Nia's contact with her uncle Colin contribute to the assessment of Christina's ability to protect her from harm?

How should social work respond, if at all, to Christina's possible learning difficulty – does this affect the assessment of her ability to care for and protect Nia?

What are the concerns/vulnerability factors for Nia?

What are the protective factors?

Do the protective factors outweigh the vulnerability factors?

Can child abuse ever really be explained?

## Responding to Child Abuse

### Week 2

***Thursday, 11 a.m.*** – Initial Child Protection Case Conference, at which three decisions were made:

1. There is sufficient information from the child protection investigation to suggest that Nia is likely to suffer significant harm due to the risks posed by parental neglect and substance misuse; domestic abuse perpetrated by Walter McIntyre and the risk of sexual abuse by Colin Harper. Her name has therefore been placed on the Child Protection Register.
2. Emergency measures are not required at this time, but a referral will be made to the Reporter to the Children's Hearing System to consider the need for compulsory measures of care.
3. The child protection plan will include multi-agency work with Christina to assist her understanding of Nia's physical and emotional needs and the risks to her welfare.

*Practice considerations*

Should children be directly involved in case conferences? Nia is able to verbalize her views, but would attending the meeting be a traumatic experience?

Should Walter be included in case conferences? What about Colin Harper?

How will Christina's engagement with the child protection plan be measured?

How will progress for Nia be measured?

### Week 13

***Thursday, 11 a.m.*** – Child protection review case conference.

Over the past three months, a high level of support has been offered to Christina with the aim of improving her parenting capacity. She attended most appointments, but has struggled to apply the information provided to her parenting of Nia, who is still offered too high a level of independence.

Christina has continued to use illicit benzodiazepines, which has an ongoing impact on her ability to be both physically and emotionally available to Nia, particularly in terms of a stable and consistent morning routine.

Nia's attendance at school improved initially, but her late arrivals have continued to be a concern. Her educational attainment is still poor and her physical presentation is described as 'variable'.

Nia has still not attended the ophthalmology clinic. Two appointments have been offered.

Christina has consistently stated that she is no longer in a relationship with Walter, but there is evidence that he has continued to be present in the family home against professional advice. Christina has not acknowledged that Walter poses any risk to Nia.

Colin Harper is now on remand in custody on a burglary charge.

Legal grounds have been established and Nia is now subject to compulsory measures of care.

Two decisions were made:

1. Nia's name to remain on the Child Protection Register.
2. Given the lack of progress with the child protection plan and the absence of any sustained improvement in Christina's ability to care for and protect Nia, a further Children's Hearing will be requested and a recommendation made that Nia is removed from her mother's care and placed in foster care.

*Practice considerations*

Is three months long enough for Christina to demonstrate sustained change?

Is it acceptable to make Nia wait for things to get better?

Is turning up to appointments enough?

If Nia becomes looked after and accommodated could this 'do more harm than good'?

How could being placed in foster care impact on her cultural identity?

How might she respond to such significant, multilayered loss?

How do you measure a successful outcome for a child?

## Conclusion

Although initially referred to social work on the suspicion of physical abuse, a detailed assessment revealed Nia had been subject to emotional and physical neglect and was also at risk of sexual abuse. Christina's own needs had impacted on her ability to provide a good enough standard of care and as a result Nia was exposed to multiple risk factors. Attempts were made to support Nia in the family home, but Christina's failure to accept responsibility for and acknowledge the risks to Nia's welfare led social work to ultimately seek alternative care arrangements.

Attempts to achieve a balance between support and protection in Nia's case proved difficult. Keeping Nia's needs and her right to safe care at the centre of the assessment and intervention allowed for clear evidence to be gathered in support of the decision to remove her from her mother's care. This decision hopefully eliminated the potential for her to be subject to any form of child abuse in the future, as well as allowing her to safely achieve her potential.

## Five Key Points

1. Always strive to maintain the focus on the child, keeping them at the centre of assessments and interventions, in spite of competing demands from parents' often-complex needs. This can be achieved by always asking 'What is the impact on the child?'
2. It is important to include the child's views at each stage, whenever possible. To do so effectively involves spending time alone with the child, building a relationship and finding creative ways to explore and gather their views. Even pre-verbal children can express a view – take time to get to know them and to observe and listen to them.
3. Effective working relationships with parents are crucial to successfully intervening in a child's life. There can be many barriers to achieving a positive relationship with parents due to the imbalance in power. However, maintaining an open, honest and respectful approach is a helpful foundation.
4. Evidence-based practice is the key to developing realistic, measurable recommendations about the welfare of a child. This involves using models of assessment and intervention that have been demonstrated to be effective. The integration of theory into practice can also take different forms, including critically reflecting on practice.
5. Do not underestimate the importance of multi-agency working in gaining a balanced, holistic view of a child. Integrating chronologies of significant events from different agencies can provide a much richer, clearer picture of the child's needs and the risks to their welfare.

## Three Questions 

1. A child protection investigation requires gathering a large amount of information from different sources. What are some of the challenges to gathering this information, both practically and ethically?
2. How did the social worker in this case keep Nia at the centre of the investigation and intervention? What more could have been done to ensure Nia's views were heard and understood?
3. What are the risks to Nia's welfare and development? What are the protective factors? How do these contribute to the decisions made in this case?

## Further Reading

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CHAPTER 4.3

# Social Work Practice and Domestic Violence

*James Evans*

The words 'violence', 'abuse', 'threats', 'mutilation' and 'coercion' are frequently used in social work practice and may lose their significance because of this. Practitioners must give these words their true significance. Violence is associated with a human being experiencing fear, panic, pain, desperation and thoughts of potential death.

## The Reality of Domestic Violence

Home Office statistics indicate that at least two people a week are killed by their current or previous partners in England and Wales (Smith *et al.*, 2011). Perpetrators of domestic violence are predominantly adults. Most victims are women. British Crime Survey figures are seen as the most reliable estimates of the extent of domestic violence because they come from a household survey and not from official police figures. Not all crimes are reported to the police or recorded by them (Strickland, 2012). In the 2010–2011 survey 30 per cent of women (4.8 million) and 17 per cent of men (2.8 million) reported that they had experienced domestic abuse by a partner or a family member since the age of 16. Women were more likely to be sexually abused and repeatedly victimized and to suffer enduring effects. Victims can be male, female, transgendered, lesbian, gay or be partners or family members. Domestic violence occurs in all class and income brackets, in heterosexual and same-sex relationships and in all ethnic and cultural groups (Brayne and Carr, 2010). There is a risk of death to unborn children. 'Violence towards women increases in severity and frequency during pregnancy, and often involves punches or kicks directed at the women's abdomen' (HM Government, 2010, p. 264). Smith

*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

*et al*. (2011) indicate that 94 women and 21 men were killed by their current or former partner in 2009–2010. Domestic homicide reviews have been set up under section 9 of the Domestic Violence, Crime and Victims Act (2004); these work as part of the government's action plan to end violence against women and girls.

Children who witness domestic violence feel helplessness, terror, despair and anxiety. Because it is recognized that witnessing or hearing domestic violence has a significant impact on a child or young person's welfare, the definition of abuse has been extended under the Adoption and Children Act 2002 so that children who witness or hear domestic violence are considered to be suffering from significant harm and should therefore be subject to child protection procedures.

An Ofsted (2011) review of 50 serious case reviews between April 2007 and March 2008 highlighted the failure of professionals to see the child's perspective. They followed this up with a report in April 2011, based on an analysis of 67 serious case reviews, that has one single theme: hearing the voices of children. For practice with children and families it is important to remember that the child's welfare should remain the paramount consideration. Munro (2011) is clear that systems must be more fully focused on the needs of individual children. One can imagine the intense anxiety a child or young person may feel if an incidence of violence has taken place that they could only hear. Has the perpetrator of the violence killed the victim? Will the perpetrator kill them? These acute feelings of fear, desperation and anxiety may cease as each incidence of violence ends, but research indicates that domestic violence can escalate in frequency and intensity (Home Office, 2011). This means that children must face intense acute fear as well as long-term emotional anxiety if violence is repeated over a long period. This is striking when you consider Laming's (2009) estimate that 1.8 per cent of children in England live in households where there is a known risk of domestic violence.

## Practice example

A social worker on a children and families team is called by a community psychiatric nurse (CPN) to help with a situation involving a family with three children of 2, 4 and 8 years old. The children are subject to child protection plans and a number of services have been involved with the family. The mother has ongoing mental health problems related to severe depression, and the father is prone to violence and alcohol abuse.

The social worker arrives at the family home to find that the mother has been beaten by the father and is on the floor screaming hysterically and refusing treatment from paramedics. The CPN and two police officers are present. An ambulance is outside. The CPN and the paramedics are trying to comfort and calm the mother, and the police are monitoring the behaviour of the father who is bare-chested, pacing the ground floor rooms and shouting, swearing and threatening more violence to his wife. The older children are running in between the adults and the two-year-old is in a baby seat.

The professionals quickly agree that the children must be removed to a place of safety; neither parent will be able to provide suitable care at present, as the mother must go to hospital and the father will be detained by the police. The social worker talks to the older children and tells them that they need to come with him. He picks up the two-year-old who is very quiet, with a fixed stare and who seems 'floppy'. The social worker takes the children to a local Family Support Unit and subsequently begins to try to identify a suitable placement for them.

What are your thoughts about each member of this family?

- What do you feel about the father's behaviour? Is there a link between alcohol misuse and domestic violence? What about drug use? What else might explain the violent and abusive behaviour of this man?
- Is there a link between the mother's mental health problems and being a victim of domestic violence? What impact does domestic violence have on the victim? What about its impact on the mother's capacity to parent?
- What about the children in this home? What are the immediate and long-term effects of them witnessing and hearing domestic violence? What has happened to produce the 'vacant expression' on the two-year-old's face? Why does she seem physically 'floppy' when she is picked up?

Your answers to these questions will be likely to influence your practice in this situation.

## A Proactive Inter-Agency Collaborative Approach

Working Together to Safeguard Children (HM Government, 2010, p. 311) suggests three central imperatives for working with domestic violence. Interventions should:

- protect children, including unborn children;
- empower the mother to protect herself and her children;
- identify, hold accountable and provide opportunities for change to the abusive partner.

The social worker's first task is to carry out an assessment of the family situation. This will allow her to gain an insight into the family's functioning in the context of its surrounding environment. During the assessment, the practitioner will need an understanding of child development and attachment theory, should engage collaboratively with health and other professionals, and work anti-oppressively in partnership with family members. Partnership is a long-term goal, given that the immediacy of a violent situation makes it impossible to establish true partnership in the short term. Judgements on parenting capacity and on family and environmental factors should be

balanced and non-judgemental. Will the parents engage in interventions and change? Can this engagement and change be sustained?

The social worker must work effectively with other professionals when dealing with domestic violence. There is a statutory duty on relevant agencies to cooperate in the safeguarding of children; for example, multi-agency risk assessment conferences (MARACs) are meetings which have the safety of high-risk victims of domestic violence as their focus. In our practice example, protection plans would have to be prepared for each child; input would be provided by professionals from adult mental health, the police, social work and education. Poor inter-agency cooperation has been pinpointed as a weakness in numerous child abuse inquiries going as far back as 1945 and the Monckton Inquiry into the death of Dennis O'Neill. Both Laming (2009) and Munro (2011) re-emphasize the need for better collaborative working to safeguard children.

## Identifying Domestic Violence and Prosecuting the Offenders

All professionals 'should be alert to the frequent interrelationship between domestic violence and the abuse and neglect of children' (HM Government, 2010, p. 255) and to the crucial importance of identifying and being sensitive to the receipt of disclosures about domestic violence. Being proactive in asking direct questions about violence is good practice in safeguarding assessments.

Statutory social work involvement in domestic violence cases will be driven by the presence of children and by their need for support and protection. Domestic violence is not a specific statutory offence but it can lead to serious crimes ranging from murder to false imprisonment. The legal remedies available can be grouped into four broad areas:

1. Non-molestation orders, which prohibit either a particular behaviour or general molestation.
2. Occupation orders, which can define or regulate rights of occupation to the home.
3. The Protection from Harassment Act 1997 created two criminal offences: 'harassment' and 'putting people in fear of violence'. The Act also provides for restraining orders.
4. Domestic violence protection orders (DVPOs). A pilot exercise involving these orders began in 2011 in three police areas. Domestic violence protection notices can be issued by the police to secure immediate protection for a victim from future violence or threats of violence. The DVPN will trigger an application for a DVPO which will last between 14 and 28 days.

Urgent action may be required in situations involving domestic violence. Re-housing may be necessary and access to welfare benefits could be a priority. The practitioner should have relevant and up-to-date information on refuges, police support, and advice and counselling services. Women and children often have to leave the family home with nothing but the clothes they stand up in, so practical support is a priority. Knowledge of the legislation and guidance related to homelessness will be useful

to the practitioner in situations of crisis. It is important to be able to reassure victims and their children that they will be classed as homeless if they have to leave and to explain to them what the legal options are if they wish to stay at home safely. Victims of domestic violence should be considered to be in priority need of re-housing if they cannot remain at home due to the threat of violence.

## Supporting Victims

Support for victims and children involved in domestic violence situations needs to be sensitive and person-centred. The social worker should be aiming to develop a working alliance with the service user; this acknowledges the importance of the services user's input and emphasizes their potential for growth and development once they become engaged. The working relationship will need rules and boundaries, and the social worker should be clear about what their service offers, how frequently they will see the service user and what powers they have in terms of statutory intervention.

Three attributes from the person-centred approach may help to enhance the practitioner's listening and communication skills: congruence, empathy and unconditional positive regard (Rogers, 1957). The fear and distress felt by victims and children will be intense, and immediate communication in situations of crisis may be difficult. The practitioner should focus on building positive relationships and creating an environment that will enable positive outcomes.

Intervention in our practice example involved:

- The provision of immediate medical attention focusing on the mother's extensive physical injuries and on an assessment of her mental health so that appropriate treatment and therapies could be offered.
- The provision of practical support to meet the immediate needs of the family. A task-centred approach was adopted to identify target problems, tasks and time limits so that housing, finance and other practical issues could be dealt with.

The aim was to empower the mother to move forward and deal with the ongoing problems of life in a focused manner. Rather than solely managing the emotional and psychological impact of the violence, much of the work was practical and concentrated on day-to-day needs. An emphasis on partnership with the service user meant that the victim of the violence could regain a sense of control over her own life.

Task-centred practice is not focused on social change in a broader context. Feminist approaches are more helpful here. Feminist approaches to working with the female victims of domestic violence promote the idea that the safety of women and children should be the priority and that support for families should be aligned with this. Feminist approaches suggest that men's violence towards women has its roots in the patriarchal structures of society. Because of this, eradicating the problem of domestic violence should begin by working towards structural change in organizations and institutions across society. The mother in the practice example was suffering from mental health problems and low self-esteem. Her capacity to parent

was diminished and her ability to care for herself was reduced; these are common features in women who have suffered domestic violence. The abuse she suffered led to broken limbs, particularly her wrists, and this seriously impacted on her ability to perform day-to-day tasks and to provide care for her children. Continuous fear together with emotional and psychological abuse led to erratic sleep patterns, low self-esteem and poor personal care. She had few friends and felt very isolated. From a feminist perspective, group work and therapy with female victims might present the most appropriate ways of helping her to deal with the emotional impact of the violence she has suffered. An emphasis on her as an individual could reinforce the idea that domestic violence is somehow the woman's fault and could make her feel responsible for the perpetrator's behaviour.

The voices of the children have become lost, according to some serious case reviews. Using approaches where the service user narrative is central will allow the victim and child to tell their story. This in turn will allow for better planning and intervention. The service users' stories will reveal their strengths, weaknesses and the resources and hazards that surround them. Practitioners can work with service users to build and work on these. Parton and O'Byrne (2000) propose that their concept of 'constructive social work' builds on the positives of people's lives which are recognized in their stories or narratives. Doyle (2006) suggests that workers cannot get a full appreciation of a child's experience of abuse unless they listen to their voices.

The practitioner should remember that children can speak to them in a number of ways using verbal communication, non-verbal communication, behavioural signs and physical appearance. In our practice example it became apparent that the two-year-old child's vacant stare and 'floppy' physical presentation were mainly a result of poor stimulation and interaction. The father took no interest in the child and the mother's deteriorating mental health meant that her capacity to provide stimulation through learning and play was diminished. In their day-to-day work with children, practitioners should be aware of the core components of a child-centred approach. Practitioners should keep environments child-friendly and consider play, refreshments and rituals when they are assessing children and arranging and facilitating contact. Social workers should clearly understand children's needs and rights and their developmental level. This will allow for effective communication and help to give children a voice.

## Five Key Points

1. Do not diminish the reality of domestic violence and its impact on the human beings involved.
2. Take a person-centred approach when you are dealing with victims and children.
3. Listen to the voices of the victims of domestic violence and the children involved; their narratives are the key to informed interventions.
4. Be alert to the correlation between domestic violence and the abuse and neglect of children.
5. Work hard to promote a proactive inter-agency response.

## Three Questions

1. What should be your immediate concern in managing the aftermath of any incidence of domestic violence?
2. How can you ensure that service users express their own narrative during assessment?
3. What skills will allow for proactive inter-agency approaches?

## Further Reading

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CHAPTER 4.4

# Social Work Practice in Healthcare

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Traditionally a number of models of social work practice have been employed within healthcare settings. These have generally been focused on two service user groups:

- People in need of secondary (hospital-based) healthcare for either acute illnesses or sudden exacerbations of existing health conditions and who require assistance and support in relation to returning home. Many of these are older individuals, who in general terms make up the largest proportion of hospital patients; this role is often referred to as 'discharge planning'. The social worker has a key role in liaising with local, district-based community services, because developing and accessing care packages enables patients to return home quickly and safely.
- People who have long-term and complex health conditions and disabilities. It has long been established that inequalities in health impact on the well-being of individuals and that social workers have a key role to play in such situations (Bywaters, 2009). Most individuals affected by long-term health conditions now live in the community rather than in institutions, but there is a need for many of them to have regular social work contact in order to provide assistance and support – either in relation to contact via primary, community-based healthcare or via secondary hospital care, if the individual is admitted to hospital for treatment.

## The Primary Care Led National Health Service

In the autumn of 1995, a debate was launched by the secretary of state for health about the future of primary healthcare. A number of changes had already taken place following the introduction of new technologies, different ways of working

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(including the development of GP fund-holding) and developments in patterns of care. Following a consultation exercise (National Health Service Executive, 1996), the five core principles for primary healthcare were that it should:

- be fully comprehensive;
- provide continuity of care;
- be properly coordinated so that it is effectively delivered;
- be the gatekeeper to secondary (hospital) care; and
- address the health needs of local communities as well as those of individuals.

It is evident that offering care close to a person's home has to be reconciled with the requirements of clinical effectiveness. The setting for primary care is often the GP practice, although the focus is generally on the primary healthcare team rather than solely on the doctor (Fort Cowles, 2000). Social services departments were perceived by the Department of Health as having an important part to play in the provision of primary care (National Health Service Executive, 1996). The development enshrined in the Health and Social Care Act 2012 of a shift away from commissioning of primary care services by Primary Care Trusts at local level to the intended development of GP-led consortia for commissioning of services can be viewed as the most recent relevant occurrence.

## Health-Related Social Work Provision

Traditionally, there have been a number of models of social work provision to GP practices including attachment and liaison services (see for example, Rushton and Davies (1984) for some early examples of these). Generally, these have worked to the benefit of clients, health and social services staff. Social work liaison schemes, where the social worker is not based in a health centre (as is the case in attachment schemes) but works from a social services office, have been the more common approach in the United Kingdom. There is an impression that such schemes have decreased in number since 1993 because of the increase in other demands on the time of district-based social workers in adult care.

### *Jennifer: social work in a GP liaison scheme*

Jennifer was six years old when her GP referred her to social services for an assessment of need. The referral was made through the GP liaison service that was in operation with local district social services, with a social worker visiting the health centre every week.

Jennifer had a rare (and untreatable) genetic disorder which resulted in multiple and complex disabilities. Although she had been born with the condition, her parents had previously been reluctant to accept assistance, but had recently moved to live in the area and were described as struggling to manage with the care of their daughter as they now lived at a distance from family members who had previously helped with Jennifer's care and with the provision of support to her parents. In addition, Jennifer's mother had become pregnant (unexpectedly) and was finding

the complex care that her daughter required much more difficult to provide as her pregnancy progressed; she was understandably concerned about the possibility that the new child would also be born with complex needs.

The assessment therefore focused on Jennifer's needs for care, together with a realistic assessment of the family's capacity to provide this care on an ongoing basis, and the level of support required to help them do so. Close liaison with the specialist school that Jennifer attended and with primary care health services was necessary. Assessment and ongoing review of the situation, including the likely need for continuing support (beyond the time of pregnancy and birth) were closely considered and formed contributions to the support package that the social worker developed with the family.

### *Joan: social work in a GP attachment scheme*

Joan was in her mid-80s when a GP-referral was made to the social worker who was based in the health centre. Joan lived with her husband and unmarried son and had severe visual and mobility problems – blindness, arthritis and osteoporosis. She was dependent on her husband, Alfred, for assistance with most tasks. Alfred had been taken seriously ill and admitted to hospital as an emergency. Joan was in need of urgent assistance as her son was out at work from 6.30 in the morning till 7.30 in the evening.

Joan was provided with day care at a local residential care home during the week. Home care assistance was arranged in the mornings to make sure she was up and could go to day care, and in the evenings on her return from day care but before her son arrived home from work. Unfortunately, Alfred died in hospital, so the temporary care arrangements became more permanent. In addition, Joan was provided with short-term (respite) care at the home on a regular basis, in part to provide relief for her son from caring for his mother in the evenings and at weekends.

After several months, during a review of the situation with the social worker, Joan's son indicated that he was finding the care of his mother increasingly difficult as her health problems were worsening. The health-centre based social worker had continued her involvement with the family and was well placed to undertake the review (rather than use a reviewing officer from the principal social services office for the wider district).

During the course of the review, Joan's son talked of a number of occasions when he had locked his mother in her bedroom and in the house on weekends while he went shopping for food. He was concerned about these situations and did not want them to continue or to escalate, but was not sure what else to do in order to keep her safe whilst he was out of the house. Discussion with Joan determined that she too was unhappy with what was happening and did not wish the evident pressures on her son to continue. Both Joan and her son were aware that Joan's health was deteriorating and that she was eventually likely to require more support than the son could provide for her at home, even with additional support.

The review concluded that admission to residential care for Joan on a permanent basis would be sought. This was achieved within several months; Joan wanted to go to the residential home she was familiar with, so there was a wait for a vacancy at that particular home. Both Joan and her son were agreeable to this course of

action; indeed it was Joan's suggestion during the review that this should happen. Joan settled well in the home and at a review of Joan's placement some months later the relationship with her son was reported as improved and the placement was confirmed as permanent. At this point the social worker's continuing involvement ceased although the social worker remained potentially available for reassessment or review purposes.

Joan remained in the home until her death several years later.

## Hospital Social Work Provision

The provision of social work services to hospital patients is based on a long historical tradition and 1995 saw the centenary of health-related social work in the United Kingdom.

Hospital social work services have not been subject to review at national level for many years, although some attention was paid in the late 1990s to the issue of discharge from hospital (Department of Health, 1995, 1998). The focus on discharge appears to have resulted from a perceived increase in the use of social workers in discharge planning following the implementation of the NHS and Community Care Act, 1990. However, other aspects of hospital social work provision remain relatively uncharted.

Much has been written about the problems surrounding discharge from hospital and the transfer of care across the health and social care divide (Fields, 1990; Fort Cowles, 2000). Recent changes in inpatient care (especially in acute care settings) and the resulting reductions in the length of hospital stay for individuals have led to people being discharged 'quicker and sicker' with higher levels of dependency and disability than before (Victor, 1992). The following case studies illustrate the use of social work within discharge planning in two situations – one relating to admission to residential care, the other a return to living at home in the community.

### *Diana: social work in discharge planning: admission to residential care*

Diana was 76 when she was admitted to hospital. She had severely ulcerated legs, was confused and dehydrated on admission, with some signs of malnutrition. Her physical health was generally poor and she had a progressively deteriorating heart condition due to heart disease. Diana recovered slowly in hospital, and was visited irregularly by her son, with whom she lived. Diana's husband had died 10 years previously. Her son, Ivan, was 47 and had always lived at home. He had two jobs and spent little time in the house. Diana was referred to the hospital social worker for assessment during a regular multidisciplinary ward meeting; it was to be focused on her needs to enable her to return home once her physical health had recovered sufficiently to allow for this.

A home visit with Diana, by the hospital social worker and the occupational therapist, as part of the discharge planning process, revealed that the house was old and in poor condition. There was very little furniture in the house and only one small electric heater to provide warmth. Diana slept on the settee in the living room where the heater was; she was confined to the ground floor of the house as she no

longer had sufficient mobility to get upstairs; this had been the case for at least six months before her admission to hospital. There was very little food in the house, and Diana reported that Ivan tended to bring in food on a meal-by-meal basis. Although there was no formal arrangement in place, Ivan controlled Diana's finances and the home and apparently had done so for some years.

During the assessment process, Diana said that she did not really want to return home and wished she could be somewhere where she could be looked after. From the hospital she went to a small residential home, close to where she lived, for a period of short-term care, ostensibly to regain her physical health. Whilst staying in the home she decided that she would like to stay there. Fortunately, a vacancy arose in the home towards the end of her period of respite, and Ivan was agreeable that she should stay there. Diana settled into the home very well and lived there until her death several years later. The hospital social worker was involved as key worker/care manager throughout the case and was involved in undertaking the review and confirmation of Diana's placement in the care home as permanent.

### *Emily: social work in discharge planning: return to the community*

Emily was 96 when she was admitted to hospital with a severe chest infection/possible pneumonia. She lived alone in sheltered accommodation, was registered blind and had rheumatoid arthritis which severely limited her mobility. Prior to her admission, however, she had received no support from either health or social services, although she employed a private cleaner on a weekly basis. The hospital social worker attached to the general medical ward where Emily was located received a referral from ward staff to provide an assessment concerning Emily's likely needs on discharge from the hospital, but on visiting the ward for the purposes of the assessment it appeared that additional problems had developed as Emily was reported as extremely confused and disorientated. At that point the ward staff were of the opinion that Emily needed to be moved to another ward for a full psychogeriatric assessment, as they considered that the general ward was not really suitable for her needs.

In discussion with Emily it became apparent that her disorientation was largely due to the fact that she had been placed in a bed that was located very close to an area used by nursing staff as an 'ad hoc' nursing station. Although she was not certain where she was and thought that she might be in some sort of factory setting, Emily talked quite clearly about the noises that she heard 'at all times of day and night', including a radio playing loudly and people laughing and talking. With acute aural senses, it seemed that Emily was picking up on the environmental factors of the staff's working conditions (for example, at night a radio was kept on to provide some entertainment for the staff on night shifts) and had been trying to make sense of these. Unfortunately, due to her illness and disturbed sleep, over a period of days Emily's condition began to worsen rather than improve and in a lucid moment she asked the social worker if she could return home, as she feared that she would die if she stayed where she was.

From discussion within the weekly multi-agency case conference of the clinical team on the ward, including the consultant geriatrician, a decision was taken that although it was somewhat risky, discharging Emily home was an appropriate route

to follow. This was achieved with the provision of initial high levels of support and assistance, including the provision of a 'Hospital at Home' scheme and district nursing support, as well as social care support in relation to meals and personal care to support her recovery from her acute illness, as she was still really quite unwell at the time that she went home. Ongoing support from the primary healthcare team and local, district-level social services was also provided for a further period following this initial period of intensive care provision in order to ensure that Emily's recovery was maintained and to determine whether she had any additional needs for health or social care support. Transfer of Emily's care to community-based services took place at the time of her discharge home. In relation to provision of social work assistance, once it was apparent that Emily was not likely to be immediately readmitted to hospital, it was appropriate to transfer responsibility for her support to the local district social services office for the involvement of a community-based social worker. At a final review meeting held after three months it appeared that Emily was fully recovered from her illness and was no longer in need of additional support over and above that which she normally received from her friends and neighbours in the housing scheme she lived in and her private home help, who agreed to provide some increased care support to help maintain Emily to live at home.

## Healthcare Social Work with a Different Focus

Hospital social workers are generally quite deeply involved in those sections of hospital-related care having a high number of older patients who are largely in need of assistance in relation to discharge planning to enable a safe and early discharge home. Other patients with different kinds of complex needs – for example, in neurology, HIV/AIDS, respiratory diseases, intensive care, oncology, and A and E – are also covered by hospital social workers. Specialist workers are also actively employed within hospice and palliative care settings (Allison, Gripton and Rodway, 1990). The provision of social work in some specialist areas is sometimes provided through joint financing agreements with charities like the Macmillan Fund (which assists with cancer-related diseases). This is because a more traditional hospital social work service (including the provision of counselling) is likely to be required rather than a focus on discharge planning. The final case study in this chapter focuses on the provision of social work assistance in a short-term emergency situation. It offers a useful illustration of the variety of situations that hospital-based social workers may work with and the potentially intensive nature of the work.

### *Angela: social work as crisis intervention*

Angela was in her mid-30s when she was referred to the hospital social work service by the ward specializing in respiratory illnesses. She had been admitted late one night at the weekend following a major and severe asthma attack. There was sufficient concern about the severity of her health condition and its potentially life-threatening nature that the ward staff had strongly advised against Angela taking her own discharge. The referral to the social work team had resulted from negotiation with Angela about remaining in hospital to receive treatment for her

worsening respiratory illness and the very real and serious risks to her physical condition.

Angela had two young children under five living at home and was separated from the children's father. Although he had been contacted at the time of her admission to hospital and had agreed to care for the children temporarily, Angela was concerned at the idea that he should care for the children for more than 24 hours and the ex-partner himself had indicated that he would not be able to care for the children during the week as he could not afford to take time off work to do so. He had confirmed this information to the 'Out of Hours' social work team who had been contacted by ward staff and had visited to check that the children were indeed being cared for.

Such was Angela's concern about the situation that on Monday morning the ward staff made a referral to the hospital social work team for further assessment and support for Angela. The social worker who took the referral visited her on the ward and then made contact with the local Children and Families Intake team to refer for a further, community-based assessment of the children's needs. The hospital-based social worker remained involved with Angela whilst she was in hospital and assisted in the development of a support package, including domiciliary care provision for Angela for the first two weeks following her return home from hospital before the case was transferred to district social services for a temporary (time-limited) period of ongoing support for Angela and her family from the local Child and Family Services team.

## Competing Objectives

Within healthcare systems, particularly perhaps within hospital settings, there is an apparent tension between the need:

- to make the best use of resources and be both effective and efficient within the constraints of the market; and
- to promote user-centredness and individual choice for service users and patients.

It is debatable whether these competing objectives can ever be resolved: to allow for user involvement and choice takes time, but it is clear that time is an expensive commodity in the health service, particularly within the acute sector. It is not likely to be easy to design and implement systems which can incorporate both objectives, particularly when the language used in the health and social work sectors is so different and culturally distinct. We need to deal with these tensions creatively and social workers in healthcare settings can make a constructive contribution to this.

Ways have to be found of ensuring that people participate fully within healthcare systems for their own health and well-being – but these must be ways that do not patronize or otherwise demean them and which are wholly sensitive to their needs. Recent developments concerning personalization extending to individual personal health budgets look encouraging in this respect (Carr, 2010). Additionally, and crucially, professionals need to work together and to collaborate fully: multidisciplinary team working is the best way of achieving this. Social workers within

healthcare settings have a key role, and look set to continue to make a distinctive contribution. But the most critical challenge lies in finding ways of empowering individuals and of involving them more centrally in the decisions about their treatment, care and support.

## Five Key Points

1. Social workers make an effective contribution in a number of healthcare settings.
2. Multidisciplinary team working is an essential element of collaborative working.
3. Health-related social work is increasingly important with the development of primary care.
4. Developing partnership working with service users involves moving beyond the 'team knows best' approach in order to really empower individuals.
5. Discharge planning has been a key element of hospital-based social work since the implementation of the NHS and Community Care Act, 1990.

## Three Questions

1. Will social workers continue to be based in acute hospital settings, and if so what will be their role?
2. Should social workers linked with primary care settings be members of an integrated, multidisciplinary health and social care team?
3. What should be the principal focus for the social worker within personalized health provision?

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CHAPTER 4.5

# Social Work Practice and People with Physical and Sensory Impairments

*Pam Thomas*

Social work with disabled people has changed considerably over recent decades. In the past the priority was to provide alternatives to the hostilities of a disabling world, but this led to segregation. Disabled people themselves demanded choice and control over their own lives and this led to the priority being independent living. Today disabled people usually live in their own homes with their own families and many work full time.

## Adele and Laurence's story (1): introduction

Adele and Laurence have been married for eight years and own an accessible bungalow. They have two sons: one aged 7 and another 10 months old. They run their own business and both work as freelance disability equality consultants and trainers. Adele is currently studying for an MA in Social Work. Laurence also has a career as a stand-up comedian; he has worked in the United Kingdom, Australia, United States and the Middle East. They are both disabled people with significant physical impairments and receive social care support from the local authority.

Disabled people's definition of independent living does not mean doing everything for oneself, but rather to have choice and control over one's everyday life and future plans. Some people may choose not to take direct responsibility, preferring to let someone else make decisions for them. Even with that option, they are exercising varying levels of choice and control.

*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

### Adele and Laurence's story (2): choice and control

Adele: 'Having choice and control over the support I need and how that support is provided means that I am an active member of my community. As well as being a wife, a mother, holding down a job and studying for an MA, I am also a governor at my son's primary school and have an active social life. Not having choice and control over my support would mean that many of these things would not be possible. Instead I would be expected to be a passive receiver of care and decisions about how I should be supported would be made for me and not with me.'

Laurence: 'Nobody truly lives their life independent of all other people. We all rely to a greater or lesser extent on partners, family and friends for support. However, we also all want choice and control over how we are supported. For example, you may fancy fish and chips for dinner and may get annoyed when you come home to find your partner has already made the decision and cooked lasagne. Support for disabled people is no different. We feel disempowered when we don't have choice and control over how we are supported.'

## The Social Work Task

Social workers need to be adaptable to each individual case, but their tasks will include helping disabled people to:

- overcome the problems of disability;
- negotiate the transition to adulthood and achieve independent living;
- access direct payments, individual budgets and other funding; and
- secure personal assistance, equipment and employment adjustments. (General Social Care Council, 2008, p. 16)

Social workers are also part of a system that distributes scarce resources and this means they also have to help to 'ensure that public resources are allocated and any charges applied fairly, and inform commissioners of any evidence that the type, scale or quality of services is not matching needs' (General Social Care Council, 2008, p. 16).

In order to carry out social work tasks social workers need to have knowledge, and skills in applying that knowledge. This knowledge needs to include a clear understanding of what it is that disables people who have physical and sensory impairments. Physical and sensory impairments bring individual functional limitations to varying degrees – including limited mobility, not being able to see or not being able to hear. These individual limitations will inevitably bring personal restrictions which individuals can learn to manage.

Cultures and societies vary and the way in which they are organized can either exclude or include people with impairments. Where people with impairments are

included as a normal part of diversity they can function to the best of their ability. However, where they are considered to be not normal, their needs somehow become 'special' and the culture and society created does not take them into account and so produces disabling barriers. These barriers may be attitudinal, physical or systemic. This matters to social workers because they can either look for disabling factors within the individual or within the environment and culture within which they live.

## Supporting the Task

Current thinking in social work is that theory should be practice-based, but this is problematic where social workers are practising in a way that removes disabled people from mainstream life, marginalizes them and takes away choice and control. Social work has the potential to enforce dependency; as Priestley notes:

> Thus, care assessments all too frequently consolidate the social segregation of disabled people in their own homes, rather than challenging their enforced dependency. (Priestley, 2004, p. 259)

Thinking about disability as something that is imposed on top of personal functional limitation is unlikely to come from traditional practice. This way of understanding disability has come from the practical experience of disabled people rather than social work practice and has become known as the social model of disability (Oliver, 1983). Through working with disabled people social workers will find the best way of using the social model of disability in their work.

Assessment and reviews start with desired outcomes (Department of Health, 2010, ch. 3, p. 11); then needs are assessed; on the basis of this, the type of support required is decided. So although the assessment starts by deciding on desired outcomes, it soon reverts to being needs-led. In practice, assessments have to fit in with the policy and guidance of *the eligibility framework* first described in *Fair Access to Care Services* (Department of Health, 2003) and referred to again in *Prioritising Need in the Context of Putting People First* (Department of Health, 2010, p. 21). People who may be considered for social care will fall into one of four categories: critical, substantial, moderate or low. Few if any local authorities provide funding for moderate or low needs, some now only fund critical needs. Although social workers and disabled people may work in partnership, it is local authority social workers who decide how needs are met, and cost plays a large part in that decision.

### Adele and Laurence's story (3): self-assessment

'We believe that everyone is an expert on their own lives. Because of this, the person themselves will always be best placed to say what their needs are, as they will have the most insight into the barriers they themselves encounter and the best ways to overcome these barriers.'

Most disabled people with physical and sensory impairments are capable of managing their own support and the social worker's role is quite different from when people need help with this. Social workers will need to keep more of a distance but still provide casework when people first start to manage their own support, and the need to review the situation in partnership with disabled people remains.

## Managing Direct Payments

Direct payments are cash payment in lieu of community care services. They are vital in allowing disabled people the chance to have choice and control over their everyday lives. With direct payments disabled people can recruit and employ their own personal assistants. The role of a personal assistant is very different to that of a carer, and the relationship with the disabled person is also very different.

Direct payments fit in well with personalization, but they are not one and the same thing. Personalization means having a personalized care or support package, and it can be partly or entirely made up of directly provided services or direct payments. It can mean the disabled person managing it themselves, or they can ask the social worker to arrange a care manager for them.

### Adele and Laurence's story (4): managing personal assistants

Laurence: 'I have managed my own personal assistants (PAs) for the past 20 years. I am clear that I am the employer and my PA is a member of staff; therefore I am their manager.

The main points of their job description include:

- Drive my car to and from work;
- Support me to go to the toilet whilst at work;
- Make drinks and support me to get and eat meals;
- Support with admin tasks such as filing and record keeping;
- Support me with taking notes during meetings;
- Assist with dropping off and picking up my son at school.'

Adele: 'I have managed my own PAs for seven years. Recruiting PAs who understand disability issues from a social model or barrier removal approach can be difficult. At recruitment level many people think of disability from a medical perspective. Through my own personal and professional experience I am able to demonstrate to prospective staff that it is not my physical impairment which restricts or excludes me from accessing the same opportunities as my non-disabled peers; it is society and the physical, attitudinal and systemic barriers it creates which disables me.

Therefore, I would expect my PAs to assist me with tasks such as:

- Driving me to work and/or university;
- Accompanying me on trips out with my young sons, especially to places such as the park and soft play areas where there are many physical obstacles;
- Assisting me to drop my sons off at nursery and school;
- Assisting me to keep on top of household tasks such as shopping, laundry, ironing and mopping floors.'

## Working with Disabled People and Their Families

Impairment and disability have an impact on family life. Managing impairment is one part of this, but disabling factors caused by physical, attitudinal or systemic barriers also need to be taken into consideration. Families themselves can be disabling by being overprotective or in some cases there can be financial, emotional, physical or sexual abuse. Social workers need to be alert to these possibilities. Sometimes disabled people are trapped in a family situation, perhaps because lack of support or money means that they are unable to live elsewhere; some may opt for institutional life as the only viable option to get away from family.

However, many disabled people do live independently away from their families and go on to have families of their own. Social workers need to ensure that the requirements of the family as a whole are taken into account and that disabled parents are supported in their parenting role. Taking account of an individual's impairments requires the social worker to make sure that the right support and practical assistance or equipment are in place.

### Adele and Laurence's story (5): family life/future expectations

Laurence: 'We have a very busy family life. As well as both of us working, we do all the usual things around school, having friends of our children round to play, etc. Having a new baby is a joy and of course there are the sleepless nights and endless washing of clothes. We would not be able to keep working and still look after our children and maintain our home were it not for the support we get from our personal assistants.'

'Having PAs around all the time means we have other people around the home which can sometimes be invasive; however, we cannot do without them. But as more and more cuts affect social care provision, we are fearful of how much longer we will receive adequate support to live independently.'

*Continued*

Adele: 'I am proud to be a mum and I feel society needs to respect disabled people's right to be parents. Through both my personal and professional experience I recognize the barriers disabled people encounter around parenthood, such as the common assumption that disabled people are asexual, the lack of understanding within sexual health services about the needs of disabled people and the notion that we cannot adequately care for our children because of our impairments. I want my sons to grow up with confidence and to know that my impairment has not been a barrier to me raising them. To them I am just 'Mum' and I want them to have the same life chances as their peers, such as a good education, a good job and the chance to mix in a wide social circle.'

In looking at the family as a whole social workers need to be mindful that disabled people and their families deal with the same issues as the rest of the population across the whole life course, including those in faith and black and ethnic minority communities, and in the lesbian and gay communities. Disabling issues arising from societal systems and cultural expectations and pressures are additional.

## Five Key Points

In order to support disabled people to reach their potential, social workers need to:

1. Think beyond issues which arise purely from physical or sensory impairments.
2. Be sensitive to other characteristics such as race, gender, faith and sexuality.
3. Be alert to the many societal and cultural influences which cause disabling barriers and are imposed on top of the effects of impairment.
4. Recognize that some disabled people are institutionalized – either literally through a life in residential or day care or through covert controls in family life or societal pressures.
5. Understand that disabled people have the same aspirations of family life as other people.

## Three Questions

1. What are the advantages and disadvantages of social workers assessing disabled people against the advantages and disadvantages of disabled people assessing themselves?
2. How can social workers best help disabled people keep choice and control over their support?
3. How can social workers best help disabled parents in their parenting role?

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CHAPTER 4.6

# Social Work Practice and the Challenge of Later Life

*Sandy Sieminski*

Many of the social workers working with older people will have a care management role, planning support with service users to enable them to continue to live safely within their communities. This chapter considers key aspects of social work practice concerned with person-centred approaches to the assessment of need and to the planning of support for older people; social workers operate within the general current health and social care policy context emphasizing choice and independence. A case study approach is used to illustrate a range of skills and knowledge relevant for this work.

According to Leadbeater, Bartlett and Gallagher (2008, p. 61), in implementing the personalization agenda social workers need to act as:

- Advisers: helping clients to self-assess their needs and plan for their future care;
- Navigators: helping clients find their way to the service they want;
- Brokers: helping clients assemble the right ingredients for their care package from a variety of sources;
- Service providers: deploying therapeutic and counselling skills directly with clients;
- Risk assessors and auditors: especially in complex cases and with vulnerable people deemed to be a risk to themselves or other people;
- Designers of social care systems as a whole: to help draw together formal, informal, voluntary and private sector providers.

Social work with older people often involves supporting those who are experiencing crises arising either through loss and change such as bereavement or changes in physical and mental health. The Scottish Executive (2005, p. 3) states that:

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> Effective social work with older people draws on distinctive aspects of the social work role – sensitive communication, moving at the individual's pace, starting where the client is, supporting the person through crisis, challenging poor practice, engaging with the individual's biography and promoting strengths and resilience.

Although the majority of older people up to the age of 85 have no long-term health problems, there are certain conditions associated with age which lead to sensory and physical impairment and which can make carrying out daily living activities difficult.

A single or unified assessment framework is commonly used to obtain a holistic assessment of needs. Assessment provides an opportunity for incorporating the perspectives of service users, professionals working with the service user, family members and informal support networks. Collaborative working, especially with health service colleagues, is an important feature of work with older people. The aim of inter-professional work is to provide a holistic approach to the assessment of need and to support planning. Lymbery (2006) has argued that the unique mix of skills and knowledge that social workers possess enables them to make a specific contribution to collaborative working. Social workers possess expertise in working with complexity, uncertainty and risk, and have an appreciation of family and community contexts. Furthermore, adherence to the social work value base, which incorporates a professional commitment to anti-oppressive practice and empowerment, equips social workers well to adopt the principles of person-centred practice essential for good care management.

## Practice Example: Joyce

### *The starting point*

Joyce has Parkinson's disease and was hospitalized following a fall when she fractured her hip and arm. The medical team are confident that Joyce's fractures have mended well but have recommended the use of a walking frame to increase her stability. Joyce is now ready to be discharged from hospital with a package of intermediate care to support her rehabilitation.

Joyce lives in supported accommodation where she has a self-contained flat. The occupational therapist has assessed the risks within Joyce's home environment and has identified strategies and equipment to support Joyce's safety. Her son, Bob, is anxious about his mother's ability to manage at home as he has seen a decline in her mental health following the death of his father six months ago. He feels that the time has come for her to move into residential accommodation where she can be 'properly' looked after. However, Joyce wants to preserve her independence and says she would 'hate to go into a home'. The social worker, Sheldon, arranges to visit Joyce and Bob at the hospital to assess her needs and to consider options for the provision of support.

### *The importance of good communication*

When he meets Joyce, Sheldon begins by describing his role in the assessment process and by explaining how he can contribute to this with his knowledge of

community resources and his experience of supporting people to find ways of managing their complex situations. Sheldon needs to establish a rapport with Joyce and he uses his communication skills to do this.

When communicating with service users, it is important to move at their pace and to use language that they are familiar with. In communication, consideration needs to be given to implications of health and disability; for example, if a service user's speech is restricted, the social worker will need to consider ways of ascertaining the service user's views. Strategies that might be considered include the use of sign language, pictorial representation or the inclusion of a carer who knows the service user well and is able to interpret their responses.

Research findings (Tanner, 2009) suggest that during assessments some social workers have limited the areas of exploration by using 'needs-talk' that focuses on resources, abilities and disabilities; this is very different from the focus adopted by older people who use 'self-talk' when speaking of themselves, their relationships or their feelings. For person-centred assessment to be a reality there needs to be a broad exploration of the issues involved in the service user's situation. This can be supported with the use of an 'exchange' model of questioning and the use of non-verbal communication to demonstrate attention and to encourage service user participation in the process. The social worker will need to check the accuracy of their understanding of the service user's views, and this can be best achieved by paraphrasing some of their words and idiom.

### *Risk assessment and management*

During Joyce's assessment process, Bob raises concerns about the risks that his mother will face if she goes home. Sheldon acknowledges Bob's concern and assures him that a risk assessment has taken place. Risk assessment is an integral part of this process and involves making a judgement about the likelihood of an event occurring and about its possible consequences. Risks identified through assessment require a *risk-management strategy*. The practitioners involved in Joyce's assessment commented on the following risk factors:

- moderate or high risk of falls;
- medical instability due to Parkinson's disease;
- social isolation and low mood.

These risks are recorded in the support plan and will need to be monitored.

Sheldon attempts to alleviate Bob's concerns about his mother by suggesting that some risk-taking may be necessary if quality of life is to be maintained and that Joyce is the person who needs to make a judgement about this. He makes it clear that Joyce is an expert in terms of her own situation; because of this, it is important to listen to her views. Sheldon knows that the needs and wishes of family and carers are not always compatible with those of the person being cared for. Negotiating compromises may be a delicate role that the social worker undertakes when working with both parties. To address Joyce's needs and minimize risk factors a package of support is established which includes daily carer support, some mobile meals, use of a pendant alarm, a place in a day centre and lunch club. Bob has

volunteered to help Joyce with shopping and to take her out of her home for Sunday lunch. Her health needs will be addressed through physiotherapy sessions; and arrangements are made to monitor her Parkinson's condition effectively.

## *Empowerment*

Throughout the assessment process Sheldon has tried to facilitate Joyce's empowerment by working in partnership with her and by ensuring that her voice is heard. Lymbery (2005) reminds us that empowerment is a contested concept, not least because it is associated with a consumerist vision within community care which fails to recognize the ways in which service users' choices, including their ability to exit from services, are constrained by factors such as their health, marginalized social position, and social class. Older people may have experienced multiple forms of oppression – including ageism – which may impact on the way they engage with services. Social workers need to recognize that service users may find it difficult to voice their needs because they have internalized oppressive ageist assumptions that have had an undermining effect on notions of self-determination. Thompson and Thompson (2001) suggest that empowerment can be achieved if the social worker firstly works in partnership with service users in identifying needs and evaluating services and secondly adopts a rights perspective that holds that older people have the right to as 'normal' a life as possible.

Recurring themes have been identified when older people with high-support needs express their views about the factors that contribute to their quality of life (Tanner, 2009; Katz *et al*., 2011). These factors can be grouped in terms of social, physical and psychological aspects of well-being:

- Social well-being includes having meaningful personal relationships, opportunities for social interaction and good relations with carers. In addition, older people value being engaged in activities and feeling that they are able to make a contribution.
- Physical well-being includes feeling safe and secure in one's neighbourhood and having the opportunity to get about.
- Psychological well-being is maintained by having a sense of self-determination over where and how they live and who supports them.

## *Reviewing the support plan*

Joyce's intermediate support package is coming to an end. Sheldon explains to Joyce that her continuing care will be funded through direct payments in line with the personalization agenda. The availability of direct payments can be empowering for service users as it gives them greater choice and more control over their care. Sheldon and Joyce need to review her support plan: they will consider the extent to which the support plan has helped Joyce to achieve outcomes that were prioritized in the initial assessment; and they will discuss whether adjustments are needed. The intended outcomes that were initially listed were to:

- Promote independence;
- Increase mobility;

- Stabilize the symptoms arising from Parkinson's disease;
- Strengthen Joyce's personal support network;
- Support her in maintaining positive family networks;
- Enhance Joyce's self-esteem.

Although Joyce's fractures have mended, her Parkinson's symptoms still place her at risk of falls and she continues to require support with personal care tasks. Sheldon notices that Joyce has a low mood and asks her about this. Joyce is still grieving the loss of her husband who she described as her companion and best friend. Joyce explains that they were very close and that they went out a lot together and enjoyed dancing. Although she sees her son and attends a day centre, she has very little contact with people that she shares a common interest with. She spends a great deal of every day alone, reading and listening to music. When Sheldon asks Joyce about her relationship with her carers, she says she does not feel comfortable with the two women who currently support her with her personal care. They hardly communicate with her and perform their tasks in a competent but mechanistic way; sometimes they put her to bed earlier than she would like. She does not want to be a nuisance and complain, or be a burden on her son as he has his own life to lead. Joyce feels helpless to change her situation for the better.

### *Working together to improve outcomes*

Sheldon's appreciation of theories of loss helps him to empathize with Joyce and, because he adopts a biographical approach with her that acknowledges the importance of her life experiences, he is able to appreciate her subjectively defined needs and wishes and her individual personality. Sheldon explores with Joyce ways in which she might be able to strengthen her social networks. Together they look at the local authority web site, which lists local activities. They see that there is a local book club which meets every two weeks at the library. The posting mentions that volunteers can provide transport. They also notice that there is a tea dance every Wednesday afternoon at the Town Hall. Joyce thinks she would enjoy these activities; even if she can no longer dance for any length of time, she will enjoy watching others on floor and chatting to people over tea. She agrees to telephone group organizers.

Joyce will now have direct payments, and Sheldon explains that she will be able select her own carers and can be involved in interviewing them. Sheldon says he can help with this. Joyce likes this idea but feels overwhelmed by the thought of managing her own budget. Sheldon explains that her son could take on this role if she wished and if he were willing; alternatively he could put Joyce in touch with organizations that can support her with this, such as the Disabled Living Foundation.

Sheldon and Joyce agree that the objectives of the support plan should remain the same but that more is needed to achieve the objective of promoting independence and strengthening her support networks. Increased participation in community activities, combined with Joyce having greater control over carer support, should help to counter her low mood and enhance her confidence and self-esteem. There is an element of task-centred work involved in this intervention with Joyce. Tasks are identified, and responsibility for taking things forward is shared between Joyce

and Sheldon. He is keen to ensure that Joyce does as much as she can to change her circumstances for the better.

### *Securing the necessary resources*

Sheldon must now make a well-evidenced case to his manager for the level of funding required for the support plan. Resource issues inevitably have an impact on the implementation of personalization in practice. Securing adequate funding for service users is, of course, dependent on the assessment of need meeting eligibility criteria. In recent years, eligibility criteria for care services have been tightened, so that funding is targeted at those with substantial or critical needs. This limits the amount of preventive work that social workers can engage in.

Older people's lives are complex and varied and there are a number of social work theories and approaches that are helpful in work with them. Theories relating to loss and transitions provide insight into psychological distress and recovery. Systems-based theory (Bilson and Ross, 1999) enables the service user to be understood within the family and social context. An ecological approach (Jack, 2000) can assist with identifying network support and highlighting areas that could be strengthened. Crisis intervention theory focuses on helping to enhance the individual's capacity to respond productively to stressful situations by identifying and drawing on their strengths.

## Five Key Points

1. Social workers need to understand the negative impact that ageism can have on service users' lives.
2. All assessments of needs should take into account the life experiences, strengths and preferences of service users.
3. Working in partnership with service users can help to combat disadvantage and pave the way for empowerment.
4. Inter-professional working enables support planning to incorporate a holistic approach to meeting needs.
5. Proposals for support planning need to be justified by reference to information obtained through sound assessment processes.

## Three Questions

1. What are the advantages and disadvantages of self-directed support for older people?
2. How can social workers ensure that they adopt a person-centred approach in their work with older people?
3. How do different social work theories and approaches relate to the varied situations that challenge people in later life?

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CHAPTER 4.7

# Social Work Practice and Mental Illness

*Barbara Hatfield*

In our society the scale of mental health need and demand for services is high: a recent survey identified that almost one in four adults in England experienced some form of current mental health problem (McManus et al., 2009) whilst economic and social costs in 2009–2010 have been estimated at £105.2 billion (Centre for Mental Health, 2010). Specialist mental health resources and services tend to be concentrated on people presenting with high levels of need and risk, acute crisis, more severe illnesses, and greater complexity – for example where there is criminal justice involvement, drug misuse, or there are safeguarding issues.

Mental health social workers (MHSWs) generally work within community mental health teams alongside other mental health professionals from a range of health disciplines; they may act as 'care coordinators', assess people referred with mental health needs, and organize the delivery of services and interventions within the framework of the care programme approach (CPA). Some MHSWs may work within specialist crisis teams, providing a response to individuals in acute mental health crisis; others may work within more specialized therapeutic services. Mental health services are now generally organized and managed within health trusts, with major implications for mental health social workers (Nathan and Webber, 2010). A smaller number of mental health social workers may work in services within the independent sector.

Services at primary care level and wider access to psychological therapies have increasingly been developed in recent years for those with more common mental health needs – generally anxiety or depression (Clark, 2011).

Most mental health social workers within statutory services undertake the role of approved mental health professional (AMHP) under the Mental Health Act 2007, which involves statutory assessment with a view to compulsory admission to hospital. They may also have a statutory role with individuals subject to community treatment orders (CTOs), and those involved in assessments of capacity (Mental Capacity Act 2005).

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## Community Mental Health Teams and the Provision of Services

Whilst some individuals with serious mental illness experience complete or partial recovery from their symptoms, others will experience a continuous and debilitating impact that is both distressing and that impairs their ability to continue to function on a daily basis. Others will experience repeated episodes of illness. Care coordinators (including MHSWs) in community mental health teams are responding predominantly to those with longer-term impairments and needs (Hatfield, Sharma and Ryan, 2007) and these individuals tend to be more vulnerable to a range of other disadvantages, including lack of employment, living in inappropriate accommodation and social isolation. Additionally problems of motivation and drive may accompany the illness itself, or be a side effect of medications prescribed.

Mental health services have recently embraced the philosophical base of 'recovery' and social inclusion (Repper and Perkins, 2003; Gould, 2010), within which services aim to support mental health service users in developing their own goals and aspirations, and work to harness mainstream opportunities and activities as far as is possible. The service user may remain impaired to some degree, but can still be supported in achieving a maximum quality of life. The case of Lukasz illustrates aspects of this approach.

### Lukasz

Lukasz is a 24-year-old chemistry graduate from Poland. He hoped for a better future in England but found learning the language harder than he expected, and he could only do manual work packing vegetables. He found it hard to make social relationships even with other young people from Eastern Europe, and became isolated and depressed. He was admitted to hospital following an overdose of aspirin, but on discharge said that he wished to remain in England. He again became depressed, and was found wandering in very few clothes in the middle of the night. He told police that his body was 'filling with contaminated waste'. He was admitted to hospital where he remained for several weeks, and on discharge, was referred for care coordinator support. The diagnosis was 'depression with psychotic features'.

When contacted by his care coordinator, Lukasz appeared withdrawn and embarrassed by contact with mental health services. He did not want to discuss his mental health, and also resisted any discussion of his family in Poland, but he did acknowledge that he had been 'stressed'. Engagement was impeded by the lack of a common language; the care coordinator introduced an interpreter but this seemed to inhibit communication even further. Lukasz affirmed that his primary goal was to live and work in England, and to improve his English. He also said that his bed-sit accommodation was a source of stress. He agreed to the care-coordinator's offer of help in these areas. Fortunately he was able to return to his job.

The care coordinator identified an English class predominantly used by young Eastern Europeans which Lukasz was keen to attend. Although there were no other Polish people in the class, he met three Lithuanian girls who were looking for a housemate, and they agreed for him to move in. The care coordinator remained in contact for three months, during which time Lukasz's English began to improve. Although he remained 'edgy' and withdrawn, the household worked well as he was tidy and paid the rent promptly.

On case closure, the care coordinator felt that he had achieved a degree of engagement that may enable Lucasz to return for help if needed. Working with the 'recovery' model enabled him to help Lucasz in his own chosen goals. However, the care coordinator felt that Lucasz was still 'like a volcano waiting to erupt'. He also sensed that there were significant family issues that had not been disclosed.

Commonly mental health social work intervention can only address part of the service user's problems. In this case, professional concerns remained about the service user's ongoing vulnerability, and the need for a longer period of therapeutic support, but the short-term intervention had helped him to improve his social situation. Longer-term support could not be offered within the priorities of the service.

In other cases, social workers in community mental health teams help to organize services for individuals who have severe mental health issues and complex long-term needs.

## Eddie

Eddie, 58 years old, was diagnosed with schizophrenia in his early 20s and has had numerous hospital admissions. He is very disabled by his mental illness, is preoccupied with hallucinations, and is unable to deal with domestic tasks or self-care. He has diabetes which needs regular monitoring, and is a heavy drinker of cider.

Although Eddie has lived all his life in the locality, he has no family contact or support. He is very dependent on services to survive and has no external social relationships. He lives in a residential unit, and attends a day facility run by the voluntary sector. Eddie enjoys football and supports the local team by putting posters in his room. Students at the Unit occasionally accompany him to the park with other residents for a kick-about. The care coordinator organized his care services, but is concerned about Eddie's general apathy and passivity. She talks to the unit staff about increasing the amount of activity and stimulation in Eddie's life, including working with Eddie to do his own washing and cooking simple meals. She also discusses Eddie's level of medication and its side effects with his psychiatrist. Eddie states that he is happy with his situation and does not want any changes.

In the case of Eddie the mental health social worker has coordinated a range of other service providers to put in place the best possible 'package of care' for a service user with long-term vulnerability. The intervention reflects the aims of the care programme approach and the influence of a recovery approach in identifying individual choices.

## Crisis Intervention Services

In most localities, serious mental health crises can be responded to by specialist teams that provide intensive support in the normal home environment, and may prevent emergency hospital admission (Johnson, Totman and Hobbs, 2011). Teams are staffed by mental health social workers and nurses, with ready access to psychiatric assessment. Home support services with support staff can also be a component of response. Social workers are uniquely equipped to evaluate and intervene in the social context of the individual, which is often central in the crisis. The case of Dionne is an example of the approach.

### Dionne

Dionne is 32 and has been known to mental health services for about eight years, with regular intermittent contact. She has been admitted to a psychiatric unit on a number of occasions with deliberate self-harm, and threats to kill herself. She has a diagnosis of borderline personality disorder (BPD), and also misuses drugs. Dionne was sexually abused as a child.

Dionne has periods of relative stability and works periodically in bars or cafes. However, she has a pattern of highly turbulent relationships which end in rejection, despair and self-harm. Dionne has two children aged 2 and 9. During periods of stress they have been left alone without food for periods of days, and also left with a known abuser. Child protection services are continuously involved in monitoring a range of risks to the children.

Dionne presents at A and E saying she has taken a bottle of aspirins. After treatment, she is referred to the crisis service, where her background is known. Dionne is in despair following a relationship breakdown. She is without electricity as she cannot afford to pay the bill, and says she cannot care for the children. The children are placed in foster care. Dionne's mother agrees to stay for a couple of nights, although she says she has 'had enough'. The social worker spends time talking to Dionne and allowing her to express her feelings of despair and abandonment. She tries to help Dionne contain her feelings, and plan for small practicalities. A support worker is allocated for a few hours daily and supports Dionne in household tasks, with washing herself and eating, and a routine begins to return.

Child protection services are now considering the permanent removal of the children as Dionne has proved unable to provide consistent care. Dionne is devastated. She becomes hostile and abusive to the children's social worker. Emergency orders are put in place preventing her from taking the children back. Dionne self-harms once again. The mental health social worker continues to work with Dionne and, once the immediate crisis abates, Dionne is referred to the community mental health team for longer-term involvement. An intervention based upon 'emotional regulation' is planned.

A person with a diagnosis of borderline personality disorder is likely to present complex challenges to mental health services, and, whilst crisis services can support during an acute period, a repeating pattern of impulsive and sometimes risky behaviour can be expected. Dionne cannot cope with relationships in which rejection and abandonment occur, and at these points she fails to meet the needs of her young children. The mental health social worker's primary task is to support and plan for Dionne, but positive co-working with child care services is also essential in the delicate process of balancing needs (Karban, 2011). Dionne cannot be expected to make substantial changes in response to short-term intervention, but ideally needs a longer-term therapeutic commitment. However, the crisis response does seem able to prevent repeated hospital admissions.

## Assessing Risk and Working with Statutory Frameworks

Whilst most mental health intervention involves collaborative work with service users to improve their circumstances, in a minority of cases mental health social workers are involved in the assessment and management of serious risks, either to the person themselves or to other people. In the cases of Dionne and Lukasz, risks of self-harm were evident, and there were clearly risks to Dionne's children.

Mental health social workers who are also approved mental health professionals are empowered to make application for compulsory detention in a psychiatric hospital, based upon specific grounds and thresholds of risk. This enables psychiatric treatment to be provided for the person's mental disorder, as in the case of Brendan.

### Brendan

Brendan is 47 and lives with his 72-year-old mother in her terraced house. He spent many years as a regular soldier with active deployments. In the past few years he has worked intermittently as a security guard. Brendan's mother is physically well and has a 'no nonsense' attitude to life.

*Continued*

Brendan has few interests other than exploring the Internet. He has no social relationships outside of the home, although his mother has a number of friends. In recent years he has become preoccupied with what he sees as the 'terrorist threat' which he researches for hours on end. He is convinced that he is the subject of a plot to assassinate him, and he has reported local Asian families to the police, saying there is evidence of terrorist involvement. On two occasions he has been arrested for threatening local Asian teenagers. Brendan refuses offers of mental health support, and accuses a social worker of 'acting under their influence'. Brendan's mother dismisses his preoccupation as 'silly ideas' and seems to have no problems with him in the house.

Brendan's mother contacts the police saying that she has found a gun in his room, and that he is unusually tense and anxious. The police are contacted.

Brendan tells the police that he has obtained a gun through the Internet, in order to protect himself. He says he has identified the 'centre of operations' at a nearby house, and he knows that the area is soon to be 'taken'. He says he is prepared to kill if necessary. The police remove the gun and take Brendan to the police station where a psychiatric assessment under the Mental Health Act is arranged. Together, the approved mental health professional, Brendan's doctor and the psychiatrist agree that he needs to be admitted to fully assess his mental state and to contain the risks to other people. Brendan's mother agrees that this is necessary. Brendan is admitted to hospital on a compulsory basis. The AMHP coordinates the assessment, makes formal application for admission, and arranges the admission.

Brendan is diagnosed with paranoid schizophrenia. His delusions respond to some degree to medication, but Brendan will only accept medication if he has to. On discharge, he is made the subject of a community treatment order (Mental Health Act 2007) with a requirement to accept medical treatment. The social worker acts as the supervisor in the community, and maintains close involvement to monitor treatment and risk, and to provide support to both Brendan and his mother.

In the case of Brendan, the AMHP has to act against the stated wishes of the service user, because of the level of risk to other people, and works within a statutory framework both for admission to hospital, and for treatment in the community. However, the social worker will also try and build a relationship with the service user and the family that enables helpful intervention and support.

## Conclusion

Mental health social workers practise in a wide range of situations and in close collaboration with other mental health professionals. Their unique contribution lies in the social science perspective that underpins social work knowledge. As the cases

in this chapter illustrate, MHSWs will always consider such factors as relationships and/or social isolation; issues in relation to the community and wider society; social stressors such as poverty and unemployment; and stigma and discrimination. Wherever possible, the service user's own choices will guide the direction of intervention.

## Five Key Points

1. There is a close association between mental health vulnerability and social stress and disadvantage. Mental health social workers are uniquely equipped to address mental health problems in their social and relationship contexts.
2. Mental health social work is essentially *teamwork* across a range of disciplines and organizations, and MHSWs are centrally involved in co-working and the organization of different services into 'care packages'.
3. The building of relationships with mental health service users is fundamental to being able to provide interventions and services that are useful and positive in their lives. Sometimes these relationships are difficult to forge.
4. The level of intervention that MHSWs are able to provide will be limited by organizational priorities and restricted resources. Often this means that not all of a service user's specific situation can be addressed, or that the amount of contact is less than ideal. Situations of high need, or risk, are prioritized.
5. Most MHSWs will also be approved under the Mental Health Act to assess and apply for compulsory hospital admission, and to act as supervisors within a community treatment order. Working within a framework of compulsion presents ethical and relationship challenges to all mental health professionals, but services aimed at improving quality of life will also be offered to those experiencing compulsion. Social workers acting as approved mental health professionals will only implement compulsory measures if all other avenues have been exhausted.

## Three Questions 

1. In the case of Lukasz the social worker senses undisclosed family issues, and feels that the mental health issues remain unresolved. Should he do anything more to work with these areas?
2. In the case of Eddie, the mental health issues appear to have stabilized but with a lot of remaining impairment. Could he be supported in a return to independent accommodation? What would be the risks?
3. What strategies should the social worker try in attempting to create positive engagement with Brendan?

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CHAPTER 4.8

# Social Work Practice and Learning Disabilities

*Ian Buchanan*

This chapter's focus is on two major issues for practice: person-centred planning (PCP) in the context of the personalization of services, and adult safeguarding. The case studies used are drawn from personal experiences and those of colleagues. They are presented out of any identifiable context and have all been bowdlerized to protect individuals' identities.

## Influences on Practice

Practice in learning disability social work and social care is shaped by general developments in the care system and particular developments associated with late twentieth-century de-institutionalization. The former are characterized by the pursuit of equal treatment for individuals and have come about under the umbrella of the 1990 NHS and Community Care Act (NHSCC Act). Important among these have been the development of Fair Access to Care Services (FACS) resource rationing criteria, and the coming to greater prominence of adult safeguarding. The latter influenced the *Valuing People* white paper (Department of Health, 2001) and its policy counterparts in Scotland and Northern Ireland which adopted aspirations developed beyond the professionally determined social goals of normalization theory to embrace choice and control in everyday life within a human rights framework through PCP.

However, the responsibilities associated with statutory social work have tended to distance social workers from many people with learning disabilities. The social worker as care manager has, perhaps unfairly, come to be associated with service

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review and possible service reduction, rather than with improving lives. These changes are a cause of concern for some service users:

> In the question and answer session at the end of a service user consultation during a review of services Gerry, who is middle aged, asked why he didn't have a social worker any more. The chair who had run a very open and supportive meeting discussed what support he had and how he got it before (re) assuring him that his care manager was a social worker. Had he had time to find out he would have realized that Gerry wasn't asking about a qualification or title but about a role. (2002 service review)

## Person-Centred Planning

PCP is a continuous supportive planning process with the individual at the centre of a circle of support. It recognizes that learning disability is lifelong and accompanied by persistent stigma produced by socially constructed incapacity. The purpose of the circle of support is to reinforce the individual, listen, learn and get things done together. The end product should be a holistic mobilization of resources (not just services) in line with the individual's plan (Brewster and Ramcharan, 2010). It is a value-driven process in pursuit of the individual's own aspirations.

It is important to make a distinction between the general policy of personalization and PCP in learning disabilities:

- Personalization is an extension of the NHSCC Act community care reforms. It is a restatement of policy advocating the mechanism of personal or individual budgets to reach the Act's original goal of providing services that people choose rather than fitting people to services.
- PCP is concerned with how people with learning disabilities learn and how they can make difficult decisions for themselves. Individual budgets are a help in reaching desired outcomes but the process is not based on supply and demand economics.

We can understand PCP better through a circle of support that got off to a poor start:

> At an initial person-centred planning meeting facilitated by his learning disability nurse, supported by his care manager, Steve, who is 40 and lives in his own place, left the room with a friend of his choice to talk about the thing he would most like to do while others from his circle of support thought about things he had done and things he might go on to do. On his return Steve said that he would like to get married and have children. His mother, sister, advocate, care manager, support worker and friends did not know how to deal with the idea. The facilitator quickly switched the meeting back to a health and leisure agenda.

Steve had taken at face value the meeting's purpose to support him to do things in his life that he wanted to. No one anticipated his choice but those who knew him best understood it. However, the circle didn't listen to his first aspiration and it failed to take the opportunity to learn more about him. He didn't mention wanting to be a parent again at a PCP meeting and his place as the focus of the meeting was contested by professionals' concerns and his family's fears and anxieties. PCP in this particular case reverted to a form of professionally led individual planning.

When PCP works well it takes time but can work in a cohesive way as Zoe's case shows:

> Zoe used to eat large meat pies that she bought because they were good value for money. When she first began talking about her weight, her circle of support listened to her and spent time talking to her about food, things she enjoys and about her life and things she would like to do. Getting Zoe to talk about her life took a long time and she often said contradictory things. Zoe eventually decided that it would be good to be thinner and made a plan that involved her support worker, Jayne, and her best friend, Joyce. She has lost a great deal of weight. Her support worker helped her most along with her friend Joyce. Everyone in her circle of support and other people encouraged her. It took months and Zoe is very pleased with herself and everyone says how good she looks.

The circle of support acted as a supportive unit with Zoe at the centre. Once Zoe began to trust everyone she became interested in what different people said because they all wanted to help her. The facilitator encouraged Zoe to make a plan and to help make things happen but he only got involved when Zoe wanted. He left the support to Jayne and Joyce.

Evidence of what makes for good PCP and successful outcomes from plans is scarce. The best research on PCP processes indicates that committed facilitators are very important in completing a plan from a PCP process and in obtaining positive changes from working with a completed plan. This appears to be a result of their commitment to people rather than organizational obligations. It is also worth noting that, contrary to earlier evidence from research in supported housing, successful outcomes were not linked to measures of the person's ability (Robertson *et al.*, 2007).

## Safeguarding

Since the publication of *No Secrets* (Departmetn of Health, 2000), high-profile learning disability cases, including the murder of Steven Hoskin in St Austell in 2006 (Flynn, 2007) and the relentless physical abuse of patients at Winterbourne View Hospital (DoH, 2011) have given impetus to the desire to protect vulnerable adults along the same lines as safeguarding children. Procedures constructed on a welfare bureaucratic model using the evidence of inquiries and serious case reviews (Flynn and Brown, 2010) have implications for adult practice. Their effectiveness

in protection is not always as clear as their effectiveness in organizational accountability. Moreover, adults, unlike children, must be assumed to have both agency and capacity which makes the judgement of abuse difficult for less skilled practitioners. There is some potential for conflict between supporting choice and independence on the one hand and safeguarding on the other. This is particularly acute in relation to adults with learning disabilities because of their stereotyping as perpetual children. This is not to deny the importance of addressing the problem of abuse. However, the challenge in working with adults with learning disabilities is illustrated in the following straightforward cases:

Jenny is an active and widely known member of her self-advocacy group. She chose to help the group out when it was struggling financially by storing documents and some office equipment in her spare room until it could find new accommodation. Her housing support person filed a safeguarding referral, citing this as abuse.

Ahmed was found on the floor of his parents' house by a driver who called to collect him to take him to a service that he uses. Ahmed was not injured and said that he fell. This was the first reported instance of Ahmed falling at home. The driver filed a safeguarding referral.

The outcomes for Jenny and Ahmed differed. Jenny was interviewed twice in person and subsequently on the telephone by a care manager. The care manager did not know her. Everyone who did know her was amazed that the issue had been raised. She was angry because she knows her own mind and also because she could not get direct support from any of her peers at her self-advocacy group. The referral went no further. Ahmed, despite being clear that his fall was an accident, ended up at a case review with his parents and attended by five others – his care manager, support worker, nurse, day facility worker and a chair person. The only outcome was in response to a problem raised by his parents about the day service.

Jenny's and, to a greater extent, Ahmed's cases are examples of over-bureaucratic responses. It is important to manage safeguarding referrals effectively in a system where there are large numbers of referrals of this type. This in turn implies a challenge to find ways for safeguarding to coexist with work in a strengths-based framework.

## Towards Good Practice

Since Gerry asked his question about why he 'didn't have a social worker any more' in 2002, it has become more important. The general question might be rephrased as: 'Where should social workers exercise their skills to contribute to the lives of people with learning disabilities?' It is right that social workers employed directly by local authorities should take responsibility for safeguarding and the assessment

of risk and needs that will be met through scarce resources. They possess the skills and are trained to take on such responsibility. On the other hand, social work's values and its strengths-based approach along with narrative and solution-focused therapies parallel person-centred planning in learning disability (Bigby and Frawley, 2010, ch. 4), but social workers have decreasing opportunities to exercise them in practice. Even before the economic crisis of 2008, some local authorities responded to the adoption of time-consuming person-centred approaches by replacing social work staff with care staff. Health has also taken on greater policy importance for adults with learning disabilities (Improving Health and Lives, no date), and self-assessment within the personalization agenda is reducing the scope of the local authority care manager.

It is possible to imagine a world where social workers enter the lives of people with learning disabilities only to assess them under 'Fair Access to Care Services' or when there is a safeguarding issue. In such a world the opportunities for using a strengths-based approach is limited and rights enacted as equal treatment through FACS fall well short of what is required to combat the routine violation of rights and exclusion of people with learning disabilities. Social and economic exclusion continues despite successive generations of policy initiatives (Race, 2007; Redley, 2009; Johnson and Walmsley, 2010).

The distinction between PCP and the personalization agenda has been made to draw attention to the particular requirements of working with people with learning disabilities. Having choice and control requires lifelong positive support that for most people needs to rely on a wider range of resources than those available in the service system. In reviewing care management in the context of personalization Paul Cambridge makes a case for diversifying social work by leaving the task of carrying out FACS assessments within local authorities and revising and moving care management out into social enterprises so that it can contribute to individually tailored and targeted PCP. This proposal is based on person-centred case management that would free social workers to advocate and take a part in creative processes (Cambridge, 2008). Failing that or similar changes, social workers who are aware of the importance and implications of person-centred work and working from a positive optimistic stance can still engage. If they can't get the time to work in a sufficiently person-centred way, it will enhance the effectiveness of their practice if they recognize and work with those who can.

Note: The term 'learning disability' is used here because it has common currency within the legal structure for adult social work and care in the United Kingdom. The internationally recognized term is 'intellectual disability' and service users prefer to be described as having a learning difficulty or in some cases in terms of the social model of disability as being learning disabled (by society).

## Five Key Points

1. Practice in learning disability is now shaped by supporting choice and control in everyday life in a human rights framework.
2. Social and economic exclusion persists despite successive generations of policy initiatives.
3. Person-centred planning (PCP) and the policy of personalization are different.
4. The responsibilities associated with statutory social work have tended to distance social workers from many people with learning disabilities.
5. There is potential conflict between supporting choice and independence and safeguarding.

## Three Questions

1. Where should social workers exercise their skills to contribute to the lives of people with learning disabilities?
2. How should adults with learning disabilities' lifelong learning needs influence social work practice?
3. Should social workers focus only on risk and safeguarding adults with learning disabilities?

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CHAPTER 4.9

# Social Work Practice, Alcohol and Other Drug Problems

*Wulf Livingston*

Social work operates in a society where alcohol and other drug use is the norm and there are particularly high rates of prevalence among the social work service user population. As a consequence of this, social workers in their everyday roles of protection and support are especially well suited to respond to this area of practice. This chapter, through an evolving case study, will explore some of the considerations faced by social workers and will outline the intervention responses that can enhance effective practice.

## Assessment

Following an anonymous tip-off, Angie, aged 11 and Bobby, aged 5, have been found left alone at home by the local police. Charlie, their mother, was subsequently found to have been drinking with a neighbour, having only 'just popped round to borrow some food'.

*What should the social worker do?* The task is to identify where consumption of alcohol or drugs is creating a risk or a problem: therefore, the social worker must talk to Charlie about her drinking.

Imagine that you are a duty and assessment social worker, having to respond to the police report about Charlie. While the immediate focus may be on non-substance use concerns – in this instance, child protection –, such cases also leave the worker with a range of alcohol questions. Sometimes these may be asked as part of a general assessment, but often they need to be explored within wider conversations. Is Charlie's drinking a problem? How is it impacting on her ability to parent?

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Identifying the nature of alcohol and drug use can be done through observation and direct questioning. Frequently social workers say that they find the task of asking about alcohol and drug use intrusive to working relationships. Yet, as in this case, where we have to ask Charlie about her parenting, social workers already successfully explore intimate aspects of people's lives, and substance use should just be one among many. Service users will often talk as openly about this aspect of their lives as about any other if the approach is supported by good quality communication and engagement skills.

There are a range of specialist tools that social workers may find helpful in complementing their existing assessment skills (Rastrick, Heather and Godfrey, 2006). The most common of these are tools that look at accurately identifying levels of consumption and levels of concern. AUDIT ('Alcohol Use Disorders Identification Test') is one such tool (Babor *et al.*, 2001). It asks questions like 'How often during the last year have you failed to do what was normally expected of you because of drinking?' These tools help to explore alcohol or drug use in context, and to look at the functions and consequences of use. This allows the worker to understand whether the alcohol or drug use is a symptomatic response to other issues or whether it is in itself problematic. Frequently, the answer is 'both'. So Charlie may well be drinking to cope with the pressures of parenthood and her past relationships, but it may also be leading her to neglect Angie and Bobby and put them at risk of potential harm.

- *Dilemma 1* – The first dilemma facing the social worker is this: How do I explore and respond to the reasons for alcohol and drug use at the same time as dealing with the risks it may present?

## Intervention

Charlie is now working with her social worker on an ongoing child safety plan. The assessment process has identified that she sometimes drinks heavily as a means of coping with a frequently absent partner (Dave), caring for her grandmother (Emily) and responding to her own underlying childhood traumas. 'Sometimes I just need to drink to get away, have time to myself', she says. She is occasionally prescribed tranquilizers by her general practitioner, and 'in my early years I did heroin'. Angie and Bobby 'are doing well at school': there are no concerns of risk of harm or physical neglect, but Bobby 'is overly clingy and quiet'.

*What should the social worker do?* The task is to work with Charlie and her alcohol and drug use – thus using the social work role to give support and facilitate change.

As the story unfolds, we typically begin to see that our understanding of alcohol and drug use in the case changes; as this happens, it may suggest a diversity of potential interventions. Social workers are frequently best placed to be the providers of a range of direct interventions with service users. These may be brief and focused conversations utilizing generic communication skills and designed to offer advice

about harm reduction or to encourage motivation to change. The interventions can sometimes be longer, given that many social workers have specific skills such as in counselling or group work.

Social workers often find themselves faced with the need to play different roles – in this case, encouraging Charlie to address her emotional needs by means other than through a bottle, whilst ensuring that her current consumption does not cause Angie and Bobby any harm. Despite their effective generic skills for such situations, social workers often respond by choosing to concentrate on statutory functions like safeguarding and seeing the role of working with Charlie on her drinking as one for another specialist. Sometimes this will undoubtedly be appropriate, and social workers will collaborate with multi-agency partnerships in their work with drink and drugs. The social worker may wish to liaise with the general practitioner, or, had Charlie's drinking been significant enough to induce withdrawals, then co-working with a specialist alcohol service would be required.

It is important, however, to note that it can be easy to create a false dichotomy between social work and substance use work. Social work requires a professional qualification that enables individuals to work in a range of organizations and with a wide diversity of service users. Whilst we have, so far, explored the case study from the perspective of a statutory sector child protection social worker, it is perfectly possible in this scenario for the specialist worker to be also a qualified social worker.

- *Dilemma 2* – To what extent do I have confidence in my own skills? And when is it right to seek the involvement of a specialist agency?

> Three months on, there is a further police call-out. Dave had arrived at the house. Charlie says he was 'hanging drunk, screaming and punching as usual'. He was remanded in custody. Charlie informs the social worker that Dave has mental health problems because 'he can't stay off the speed'.

*What should the social worker do?* The need now is to recognize that Dave's drink and drug use is particularly problematic – in other words, to respond to acute risk and need.

The new information provides us with further contextual understanding for Charlie's alcohol use: she is subject to peer, or partner, pressure and feels the need to numb the experience of violence. Social workers often have to explore and work with the complex interrelated issues of substance use and domestic violence, through familial, court and multi-agency contexts. Domestic violence is an example of the common situation in which social workers have to handle the tensions surrounding the problems and risks exacerbated by substance use while at the same time providing support to enable the user to deal with the underlying causes of consumption. This can be described as the dilemma of care and control (Keene, 2010).

Working with Dave and his mental health needs is a further example of this. Alcohol and drug use can spiral to such an extent that the priority intervention in Dave's case is likely to be focused on the protection of others and on the need to enable him to achieve control over his use. Patterns of entrenched and dependent

use will probably need support through alternative prescription medication, inpatient or community detoxification, treatment therapies like cognitive behavioural approaches, and possibly longer-term intensive rehabilitation programmes. In such instances, the likelihood of the social and substance use concerns being successfully addressed without attention being paid to both elements of 'care and control' is particularly slim. Social workers need to be aware of working with two broadly very different outcomes in such situations. Thus, it might be that Dave can only achieve control over his use and mental health problems through the ongoing provision of prescription medication and services; or the outcome might be found in an alcohol- and drug-free refreshed lifestyle beyond service provision.

- *Dilemma 3* – How do you achieve a prioritized balance between care and control?

Emily, Charlie's grandmother, is admitted to hospital following a fall. She is showing a range of symptoms consistent with an older person experiencing increased levels of physical immobility and some mental disorientation. However Charlie informs you that she has 'been at the gin again'. Emily informs you that she is in acute pain and prefers 'a little drink to the [doctors'] pills'.

*What should the social worker do?* The need now is to work with the whole family's experience of drink and drug use.

The realization that Emily may be developing a drink problem highlights the fact that alcohol and drug use is a factor across all ages and in a wide range of service user groups. Problems associated with consumption of alcohol and drugs amongst older people is on the increase (Wadd *et al.*, 2011). Where service users like older people or those with physical or learning disabilities choose to consume alcohol and drugs, this potentially aggravates any possible vulnerability; as a result, social workers face difficult challenges in how to balance their support of the rights of self-determination and positive risk-taking against their need to ensure that individuals are safe. So for Emily, as for many other older people, 'medicinal' use of alcohol may be an appropriate lifestyle choice. Alternatively, an awareness of increasing levels of consumption by Emily may prompt a need for the social worker to work with primary health care staff to reassess her physical pain and support needs and to consider the likelihood of her causing herself further injury. Such, though, is the nature of alcohol and drug use that the increase in Emily's consumption may be related to new and growing levels of psychological or emotional insecurity.

Emily's hospital admission illustrates how the variations of alcohol and drug use can weave their way into the everyday process of social work. It is possible that the pressures of caring for her grandmother is a further factor influencing Charlie's current drinking pattern. Social workers are in the front line of community care provision, and should thus expect to have to explore and work with alcohol and drug use in the majority of situations they encounter.

- *Dilemma 4* – To what extent should the social worker support people's right to drink compared with the risk it might cause?

## Outcomes

In responding to these situations, it is worth noting that usually the service user and the social worker are interested in achieving the same substance- and non-substance-related outcomes. For both parties the solution may include (but is not always about) a reduction in consumption, and will include other behavioural or lifestyle changes. Thus Charlie is looking for a less demanding and less abusive environment that in turn might lead to a reduction in her need for and consumption of alcohol and drugs. For Dave, the future might involve more (prescribed) drug use goals in a quest for relief from his mental pressures. Emily might choose a future where she can ease her aches and pains through safely consuming gin.

Whatever the outcomes sought, the achievement of long-term sustained change will enable the avoidance of continually working with the immediate safeguarding concerns of harm reduction. The cycle which involves drinking to escape social, physical, psychological and environmental problems and the fact that this in turn creates more of the very same problems is only likely to be permanently broken by successfully addressing the whole situation. In some instances the need to focus on safeguarding makes this approach difficult to sustain. But social work, nonetheless, is particularly well suited for such a holistic approach. In mental health social work, there is a growing emphasis on the concept of 'recovery'. In the field covered by this chapter, the notion of 'recovery' involves working with people on issues beyond alcohol and drug use together with the development of communities of peer groups supporting each other to maintain healthier alcohol- and drug-free lifestyles.

## Conclusion

Working with alcohol and drug issues in a complex case scenario presents a range of ethical and practice considerations. In this area of practice, social workers have frequently been seen to experience a lack of confidence about their role and its legitimacy; their ability to respond appropriately has been questioned; and they have been shown to not always receive adequate support when they do respond to such issues (Galvani and Hughes, 2010; Richardson, 2008).

Yet we have seen in the case of Charlie, Dave and Emily that they are well placed to intervene, especially if following key practice principles (see Box 10). There have been calls for the provision of more education for social workers about alcohol and other drugs; whilst this can only be a good thing given the prevalence of alcohol and drug use in the social work case load, it is sometimes seen as difficult to deliver given all the competing demands on the social work education curriculum. Social workers, in addition to their invaluable core skills, will have lots of personal and experiential knowledge of alcohol and, possibly, drugs (Livingston, unpublished), and therefore in responding to these scenarios without such training, they need to be provided with and to develop their own effective use of supervisory and supportive environments to understand what patterns of consumption they are seeing, what are the causes and problems of such use and what might be the most appropriate responses.

## 10 Five practice principles

- *DON'T be afraid to ask*. Social work is all about dealing with sensitive personal issues, and if you don't understand what users say about alcohol or drugs, you should always ask them to explain.
- *MAKE SURE you ask about the reasons for alcohol and drug use*. Nobody starts out drinking or using drugs intending to develop a problem.
- *DO remember:* Research shows that brief interventions from front-line workers can help people change.
- *DO explain the social work role:* What you can and can't do; what the limits of confidentiality are; what the role of other agencies is.
- *DO keep alcohol and drug use in perspective:* Is it making any problems worse or is it helping to reduce them?

## Five Key Points

1. The social worker's assessment should go beyond the level of consumption, and should focus on the context, functions, positives and negatives of any use.
2. The social worker should be mindful to ensure that any intervention does not increase the pressures to consume.
3. Effective alcohol and drug interventions in social work are built on the quality of the relationship established with service users and carers.
4. Interventions always need to be personalized to the individual and familial circumstances.
5. Service users and carers usually want the same outcome as the social worker; for both parties, these are not necessarily about alcohol or drug use, but more about changes in some other aspects of their lifestyle.

## Three Questions

1. What is the range of knowledge, skills and values you already have that enable you to be well placed to work with those using alcohol and other drugs?
2. Can you distinguish between alcohol or drug use as a presenting problem and a complicating factor?
3. What are the interventions and support mechanisms that enable effective social work practice with alcohol and other drugs?

## Further Reading

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CHAPTER 4.10

# Social Work Practice, Asylum Seekers and Refugees

*Benedict Fell*

Social work with asylum-seeking and refugee individuals and families tends to be viewed as 'niche' and to fall to certain members of agencies. The greater part of service provision for asylum seekers and refugees has come from the voluntary and independent sector (Centre for Social Justice, 2008, p. 5). Many such agencies, including charities and faith-based organizations, employ qualified and registered social workers. Of course, statutory local authorities have also played a part; for example, local authority asylum teams were set up following the Asylum and Immigration Act 1999 but their involvement was mainly related to the management and provision of housing for people seeking asylum. This Act also introduced the policy of 'no choice' dispersal of people seeking asylum to different parts of the United Kingdom and the introduction of a separate system of welfare for asylum seekers, the National Asylum Support Service (NASS) – now known as Asylum Support.

Adults seeking asylum do not trigger any particular statutory requirement for local authority social services involvement. The opposite is the case where an unaccompanied asylum-seeking child has been identified – in such cases, duties under sections 17 and 20 of the Children Act 1989 and 2004 are engaged (where it is assessed that the child is indeed a child) to provide for the needs of such a child.

In 2008, the GSCC, in concert with other key stakeholders drew up a statement about social work roles and tasks. *Social Work at Its Best: A Statement of Social Work Roles and Tasks for the 21st Century* (2008) asserts a role for social work with people claiming, and being granted, asylum in the United Kingdom:

> Social work at its best helps to ensure the wellbeing and human rights of migrant, refugee and asylum-seeking children, adults and families, and seeks to improve understanding between migrant and host communities. (GSCC, 2008, p. 8)

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Weaver and Burns also note that:

> the historic mission of the social work profession, to assist disenfranchised and vulnerable people, should lead more social workers to serve this population. (2001, p. 151)

Social work with asylum seekers and refugees has formed an increasing focus within social work literature in recent years (for example Hayes and Humphries, 2004; Humphries, 2004, 2006; Fell and Hayes, 2007; Kohli, 2006, 2007). Some of this literature has depicted social work involvement as representing a collusion with oppressive immigration controls and inadvertently supporting the systems that view asylum seekers as 'bogus'. However, such a view risks obscuring the good work that social workers and agencies are doing every day in the United Kingdom with asylum seekers and refugees (see for example, Fell, 2004). Gradually, work with people seeking asylum and refugees has found its way into social work training curricula, although the nature and form of this is not uniform.

## Switching Discourses

The term 'social work with asylum seekers and refugees' can imply that interventions with this group may differ from that offered to other groups who require social work services. Practitioners should always be aware that people seeking asylum, and who then eventually claim refugee status, are first and foremost human beings (Crawley, 2006). Despite the differing cultural backgrounds, including possible traumatic experiences, they share the same essential needs for shelter, warmth, fulfilment and well-being as anyone in the community. However, they also occupy an ambiguous and unsettling position of residing in an unfamiliar country following the decision to flee their homeland. They are then faced, particularly in the United Kingdom, with a frequently hostile public response (Buchanan, Grillo and Threadgold, 2003; Greenslade, 2005) and the task of navigating a complex and suspicious system whereby the onus is on them to prove that they meet the definition of a 'refugee' as contained within the United Nations Convention on Refugees (1951) as having:

> a well-founded fear of persecution on the grounds of race, religion, political belief or membership of a particular social group.

There is, however, a tendency to slip into a position where all asylum seekers and refugees are viewed as vulnerable victims; some commentators have pointed to a 'victim discourse' having emerged in respect of this group (Watters, 2001, 2008; SCIE, 2010). This is to deny migrants' resilience and determination to improve their lives and to neglect the positive contribution that many can bring to the countries where they seek and are granted asylum (SCIE, 2010).

## Social Work Responses

Despite the terms 'asylum seeker' and 'refugee' being used interchangeably, there is a crucial distinction which has a large bearing on entitlements to services. If a person seeking asylum is granted indefinite leave to remain in the UK, they become eligible

for mainstream benefits and are free to seek employment (Fell and Hayes, 2007). In contrast to health-related literature, there has been a relative dearth in social care literature relating to provision for asylum seekers and refugees (SCIE, 2010). There will undoubtedly be differing social work practice responses to adult asylum seekers and refugees compared with unaccompanied children seeking asylum. This merely reflects the same differing needs and practice approaches to adults and children generally.

The aim of this chapter is to provide a flavour of good practice when working with people seeking asylum. What the asylum seeker desires most – leave to remain in the country – is not within the power of the individual social worker or agency to grant. It can also often be assumed that, once leave to remain has been granted and the former asylum seeker has become a refugee, this brings to an end the problems for the person concerned. On the contrary, granting of refugee status can signal a new range of perplexing processes associated with settlement, ranging from a complicated benefits system to participation in further/higher education and finding suitable employment. Hostility and racism from established populations can persist, given that the UK public is not well versed in the difference between an asylum seeker and a refugee. Once asylum seekers have been recognized as refugees they are, theoretically, entitled to receive the same services as UK citizens, including those that local authorities provide under legislation such as mental health and community care services. Here, they will be subject to the same eligibility thresholds and decisions about risk as British citizens are, and these will determine whether they are eligible for the provision of appropriate services. However, there can still be confusion over 'status', and it will generally be severe and acute cases, which bring to the fore issues of risk and public safety, which will secure a statutory response.

## Good Practice

The SCIE (2010, p. xi) good practice guide perhaps offers the best review of social care responses to this client group. It synthesizes features from research that it recommends should underpin social care for asylum seekers and refugees:

- A humane, person-centred, rights-based and solution-focused approach to the needs of asylum seekers and refugees;
- Respect for cultural experiences and migration;
- Non-discrimination and promotion of equality;
- Decision-making that is timely and transparent and involves people, or their advocates, as fully as possible in the process;
- Promotion of social inclusion and independence;
- A holistic approach to meeting needs dependent on cross-organizational collaboration.

However, these recommendations represent generic good practice with *any* client group. There is a clear focus on the importance of multi-organizational working in securing positive outcomes for asylum-seeking adults, children and families. This is particularly important when there is uncertainty about who is 'responsible' for providing services to people with uncertain immigration status. A practice example illustrates how multi-agency working can make a difference.

## Practice example: Akhbar

Akhbar is a 45-year-old male asylum seeker. He was an Islamic scholar in his home country. He fled after his wife was shot in front of him when she tried to protect him from militia who wanted to arrest him for making what they considered seditious sermons. Akhbar was smuggled to the United Kingdom where his claim for asylum was refused, as were all his subsequent appeals, and he was informed by letter that his support during his claim would now come to an end and he must take steps to return to his country of origin. After receiving this letter, Akhbar tried to hang himself in his flat. His flatmate fortunately found him in time, called an ambulance and he was admitted to Accident and Emergency. Here, staff became concerned about his mental distress.

Barry, a local authority social worker based at the hospital and an approved mental health practitioner (AMHP) agreed that Akhbar should be detained under the Mental Health Act 1983 (2007 amended). Barry contacted a local voluntary agency providing advocacy and support to asylum seekers and refugees. The agency, 'FUTURES' had a small staff team, managed by a qualified social worker, Audrey. Barry asked Audrey about the possibilities for Akhbar being accommodated if he was to be discharged from hospital. Barry was also concerned that Akhbar seemed obsessed with his asylum claim. Barry had already arranged a meeting with a lawyer and Akhbar, but Akhbar had been hostile towards the lawyer, saying that he was conspiring with the Home Office to keep him in hospital.

Audrey and a student social worker went to visit Akhbar in hospital. They explained that they would try to find another lawyer to take a fresh look at his case and make representations to the Home Office that it would be against Akhbar's human rights to attempt to remove him in his current mental state. A lawyer was found and she applied for a grant of humanitarian protection for a period of three years. This claim was successful.

Having now got limited leave to remain in the United Kingdom, Akhbar was entitled to mainstream benefits and housing support. He received aftercare to meet his mental health needs under Section 117 of the Mental Health Act 2007 and support from both a psychiatric nurse from a community mental health team and continuing input from Barry from the local authority team.

Akhbar, to begin with, was a 'refused' or 'failed' asylum seeker. Refused asylum seekers can face a particularly difficult situation. Those with dependent children can still receive some form of support but, for single adults, all financial support and accommodation is effectively stopped and the person is labelled as having 'no recourse to public funds' (NRPF), meaning they are not entitled to any state-funded support . For those unwilling or unable to return to their country of origin, there is no choice but to face destitution and somehow eke out an existence while trying to evade the authorities.

There is evidence that asylum seekers and refugees can exhibit poorer mental health than members of the citizen population (for example, Blackwell, 2005; Fazel, Wheeler and Danesh, 2005; Watters, 2001; Weaver and Burns, 2001; Maffia, 2008). Psychological distress experienced by asylum seekers and refugees can be attributed to four broad domains:

- Adverse 'push' experiences in home countries which cause a person to flee – for example, persecution as a member of a certain religious group, war, conflict, threats to life and/or attempts on one's life.
- The journey to the place where sanctuary is sought – journeys which may involve travelling thousands of miles in cramped and difficult conditions with strangers and smugglers who may exploit the dependency of their 'passengers'.
- Distress experienced in an alien and hostile country, which can include a culture of suspicion and racist reactions from local host communities, coupled with ongoing uncertainty of their immigration status as their claim for asylum is processed.
- Following rejection of a claim, as in Akhbar's case, the likely destitution that arises and the fear of being returned to face the persecution that was fled. This stage can also entail a fear of detention and of being forcibly removed.

It is important not to make assumptions either about the homogeneity of asylum seekers and refugees or that adverse experiences will *always* result in psychological distress. Many people exposed to traumatic events do not go on to develop post-traumatic stress disorder (Kasiram and Khosa, 2008). But in the case of Akhbar, it was clear that his mental distress was contributing to his suspicion that the lawyer was conspiring to keep him in hospital. However, social workers are not immune to being on the receiving end of this suspicion. In many countries producing asylum seekers, a professional activity that we call 'social work' may not exist. Thus 'social workers' may appear indistinguishable from UK Border Agency (UKBA) staff or any other person 'in authority'. A social work assessment interview may be experienced by the asylum-seeking client as similar to the interviews (interrogations?) undertaken by UKBA staff. The role of interpreters can be crucial in mitigating such potential perceptions. Accurate interpretation can also help with gaining insight into the nature of the distress experienced. Erroneous assumptions can be made about behaviour which, when seen in a cultural context, takes on a different meaning (Dein, 1997).

## A Social Work Process with Asylum Seekers and Refugees

Referring to refused asylum seekers, a former Conservative Party leader (Iain Duncan-Smith) notes in the report *Asylum Matters* (Centre for Social Justice, 2008, p. 5):

> It is left to the voluntary sector to pick up the pieces of these shattered lives. With little support from the Government or the general public, these groups, on very limited budgets, do an heroic job stabilising asylum seekers' lives, helping them through the

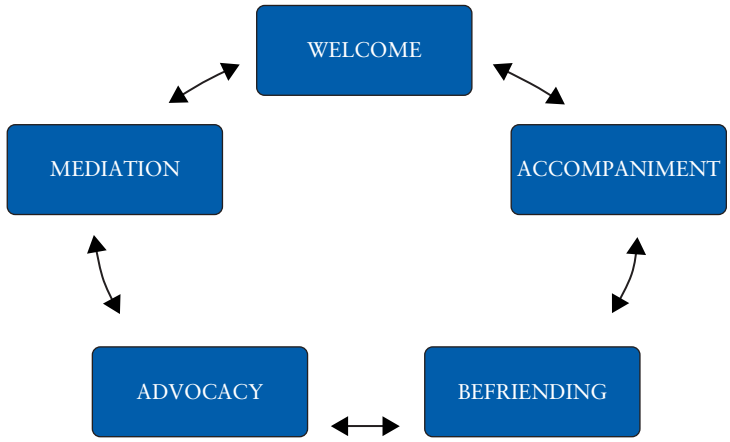


**Figure 4** WAMBA.

asylum process and assisting them to return home or integrate into the UK if they gain refugee status.

The terms 'stabilising', 'helping', 'assisting' and 'integrating' could all indeed be said to convey a flavour of the type of interventions that social workers might be best placed to deliver to this marginalized group. I have some experience of shadowing workers at one voluntary agency supporting asylum seekers and refugees in the North of England which had a staff of qualified social workers and social workers in training. Over a number of years, a process of social work support emerged that was refined and developed as case work with asylum seekers and refugees progressed. This non-linear process consists of five elements, as shown in Figure 4: Welcome, Accompaniment, Mediation, Befriending, Advocacy (WAMBA) (Fell and Fell, forthcoming).

*Welcome* – The asylum-seeking/refugee client should be made to feel welcomed and the assessment should not be experienced as an interrogation. Offices should be welcoming and comfortable and communication warm and clear, with the use of trained interpreters so that the ecological setting of encounters with clients promotes and signals the opposite of the barrier mentality and culture of immigration controls.
*Accompaniment* – This reflects the notion derived from the person-centred counselling tradition of 'being with' a client. This should be offered and not imposed. Accompaniment does not mean 24-hour availability: it is a fostering of the awareness amongst clients that a particular kind of care and expertise is available. It may foster assurance that moments of crisis (for example, rejection of an asylum claim) can be negotiated together.
*Mediation* – Asylum-seeking clients may find themselves enmeshed between government agencies and complex welfare and legal systems. Social workers may see their role as mediatory because they can find themselves, literally, 'standing between' the client and the state represented by the Home Office which assesses asylum claims;

between the client with no claim on public funds and welfare providers; between the client and a suspicious public. We should be subtle in our work in order not to engender false hopes in clients.

*Befriending* – The 'befriending' relationship is different from 'friendship'. Aldridge (1994, p. 726) highlights the possible confusions that social workers may feel between 'befriending, being friendly, and being a friend . . . friendship is socially constructed as "natural", spontaneous, within the capacity of every normal person'. *Be*friending, on the other hand, implies that there is an element of difference and, more precisely, a differential of power and possibility in the relationship: I befriend you because I perceive that I may offer you something which may enhance your existence but which at the moment you are not able to obtain because of your circumstances. Befriending is obviously another side to the relationship of accompaniment. The political reality within which asylum seekers find themselves is distinctly *un*friendly – tightly controlled, suspicious and hostile. However, when we befriend clients in our professional role, we do not become 'best friends'. We must keep our boundaries and seek our nourishing personal friendships elsewhere.

*Advocacy* – Advocacy with asylum seekers who have not yet been granted refugee status, with its virtual guarantee of access to services and eventual full citizenship, will be different in nature from advocacy with other groups of people who, although they may be excluded in other ways, at least have certain rights as citizens. They may also benefit from rights-based legislation directed towards them rather than immigration controls which restrict their inclusion as such. We need to recognize that working with asylum seekers whose claim has not been recognized or has been refused places social worker advocates in a position where they may not be able to assist their clients entirely through their own efforts. The granting of asylum is *not* in the power of the individual social work advocate.

## Conclusion

Asylum seekers and refugees are and will always remain a part of UK communities. It is clear that social workers in different settings will meet them in their work. Indeed, some will seek out this area of employment upon qualification. 'Asylum seekers' and 'refugees' are not a homogenous group. Yet what they do share is being subject to a separate welfare system from the majority of the citizen population coupled with uncertainty as they wait for a decision on their claim. A negative decision can signal a possible return to the persecution and threats that caused them to flee, and marks a withdrawal of the support available from the government while the claim is ongoing.

Social work is a profession that seeks to meet the needs of vulnerable and oppressed people in society and we cannot ignore the presence of asylum-seeking and refugee communities. We have a positive contribution to make, but it will always take place against a state system that seems ever-more determined to deter people from arriving to seek sanctuary on its shores.

## Five Key Points

1. It is likely that social workers will meet asylum seekers and refugees in the course of their work. Most work with this group of people will not differ significantly from that which social workers are used to engaging in with UK citizens.
2. Asylum seekers are people subject to a separate system of welfare whilst their asylum claim is being considered in the United Kingdom. This often involves 'no choice' dispersal and accommodation. Knowledge of this system can assist social workers working with this client group.
3. It should not be assumed that *all* asylum seekers and refugees are vulnerable and needy. Many have demonstrated great resilience in their determination to escape persecution and are keen to integrate and make a contribution to the countries in which they seek protection.
4. The notion of the profession of social work, as it exists in the United Kingdom, is likely to be unfamiliar to many asylum seekers fleeing countries where such professional help may not exist. This can mean that social workers may be viewed with suspicion at first, making trust and clear explanations essential – interpreters will be a valuable tool here.
5. There has been a tendency in some previous social work literature to depict social work as colluding with inherently racist and exclusionary immigration controls. This view can obscure the great potential of social work(ers) to make a positive difference to the lives of asylum seekers and refugees.

## Three Questions

1. What difficulties could arise for a social worker and their clients when assessing a client's needs and explaining their rights through an interpreter?
2. How would you seek to explain the role of a 'social worker' and what 'social work' is to an unaccompanied asylum-seeking child coming from a country with no similar service?
3. How much can social workers reasonably want or expect to know about their asylum-seeking clients' lives prior to their involvement and how can we avoid our interviews with clients feeling like interrogations?

## Further Reading

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# BOOK 5

# Social Work's Core Components



*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

CHAPTER 5.1

# Assessment, Intervention and Review

*Jonathan Parker*

The dynamic and complex arena of human need has been heightened, on a global scale, by the fiscal crisis starting in 2007, which, concomitantly, exerts a tremendous impact on the social welfare systems of many developed nations (Farnsworth and Irving, 2011). Working with people made vulnerable for a range of reasons demands the deployment of flexible, creative and negotiated responses from social work and social care services. At times, the mutable and constantly evolving nature of social life and interactions has militated against the development of sound scientific and systematized approaches to practice that build on evidence, however that contentious concept is defined. It has, therefore, been difficult to provide a framework for social work practice which enables service users and their carers to engage in a clear process which assists practitioners in implementing structured and knowledge-based work with people. This is clearly untenable for a profession seeking to make a difference in the lives of people who are often vulnerable, marginalized and excluded. It is imperative that social work demonstrates the 'hows' and the 'whys' of its importance to contemporary society: in other words, showing its evidence base in a transparent way that also allows challenge and development to take place.

This chapter will introduce a systematic model for understanding some of the key processes involved in social work practice in a range of contemporary practice settings, namely assessment, intervention and review. Account will be taken of the complexities and challenges raised by working in human situations which are necessarily fluid, and the need for artistry and flexibility in applying the model and developing a clear evidence base will be stressed (Sheldon and Macdonald, 2009).

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## Social Work: Its Roles, Tasks and Purposes

To a large extent the development of social work has been associated with the fragmentation of communities, a decline in the influence of traditional regulatory frameworks (whether political, social, familial or religious), and the anomie associated with social transition from agrarian to industrial economies. Its development, in modern forms, began in the West and has become embedded within the social and political landscapes associated with social regulation as much as it has with social change. This tension permeates social work thought and practice and provides the context for examining a systematic approach. The questions concerning the care and control functions and tasks of social work relate in part to questions of individual values, but also to the purposes for which agencies have been set up (their mandate), and to the legislative base which underpins the work. These aspects are built on wider social constructions that have been developed and generally concern social care and appropriate treatment of individuals, groups and communities. Social work practises within this context but has a broader professional perspective that enjoins with and promotes the principles of social justice.

Social work is a discipline that has unapologetically 'borrowed' many key concepts and theories on which it bases its practice. However, these are employed in particular situations with people at the margins of society with a view to assisting people to function, engage and challenge the structures that have led to their exclusion from society. In their work, social workers have developed and internalized a wisdom that is tacit and intuitive, built upon experiences and nuances within the social work relationship which cannot always be easily categorized and labelled. However, this 'artistic' approach to social work practice is not the whole story, and social workers need to develop the evidence base for their intuitions, for the practices they have developed, borrowed and repackaged if they are to convince their political masters and the general public who fund social services that they are valuable, if they are to justify their work to their agencies and teams, if they are to develop as practitioners and, most crucially of all, if they are to provide the best possible service to the people with whom they work. Some of the theories underpinning the processes of assessment, intervention and review within this chapter are taken from other disciplines but they have been modified in the context of social work practice. They are used in flexible and artistic ways drawing on practice wisdom but also grounded in established evidence-based practice that can be demonstrated as fit for the purpose for which they are deployed or to effect change.

## A Systematic Model for Practice

There are different elements within the models that have been developed to describe social work practice (Healy, 2012). Thompson (2005) suggests there are five stages to the process – assessment, intervention, review, ending and evaluation. Elsewhere, I have suggested four stages to the process (Parker and Bradley, 2010) including planning as a separate stage, but in this chapter I simplify the model to three elements, merging planning with assessment whilst combining review and evaluation.

In truth, the model is not linear and the component parts and stages merge into one another, and oscillate. Whilst assessment, intervention and review will be introduced and examined, a caveat needs to be introduced to indicate that the stages are not always so easily separated in practice and a degree of flexibility and interlinkage between them is important. Negotiation around these fluid pathways demands intelligence, critical thinking and analysis, and an ability to change in the light of reflections and 'evidence' from those people with whom social workers practise.

## What is Assessment?

Assessment is seen as the keystone of ethical and effective practice (Milner and O'Byrne, 2009) as it provides insight into the situation which is of concern or having an impact on the service user, or the person or agency making the referral. Assessment is multifaceted, not lending itself to easy definition it demands the application of knowledge, quick thinking and analysis and an ability to change as further information illuminates the complex and often fraught situations in which assessment takes place. Elsewhere, I suggest that '(a) balanced approach would suggest that social work assessment is both an art and a science since it involves wisdom, skills, appreciation of diversity and systematically applied knowledge' (Parker and Bradley, 2010, p. 4).

Assessment in the abstract is a neutral activity. However, it is important to note that in practice it always has political and value connotations depending on the reasons for assessment, the mode of assessment, the involvement of service users and others, and the attention given to questions of power. Smale, Tuson and Statham (2000) provide a useful model for assessment that describes the use of expertise without acknowledging the same in others, or the unquestioning following of procedures which characterizes some elements of social work practice, emphasizing that social workers must strive to engage with service users and seek a relationship based on exchange of information: a joint activity that guides the process. It may be asked whether a true exchange relationship can be achieved in the world of state social work and whether it should be attempted. However, whilst it is true that social workers necessarily follow given procedures and frameworks, the underlying spirit of assessment concerns engagement and exchange (Parker and Bradley, 2010). The potential for exchange relationships is under constant attack, however, from the risk-averse bureaucracy and assessment culture emanating from the managerialist and actuarial approaches developed within neo-liberalist society (Rogowski, 2010).

## What is Involved in Assessment?

Whilst there are a number of different models and types of assessment, they all follow a fairly similar pattern and include at least a variation of the following elements:

- Preparation, planning and engagement using the rapport and relationship building skills to work with people to introduce the need for assessment and decide how it should be carried out.

- Data collection and creating a perspective on a given situation using a range of means depending on age, understanding, abilities and the purposes of the assessment.
- Preliminary analysis and interpretation of data – testing out your thoughts and hunches with service users and carers.
- Deeper analysis after testing data – preparing an interpretation (which should be negotiated and shared).
- Construction of an action plan – together with service users.

Assessments may represent a perspective from a certain point in time and from particular points of view. It may be constructed for a given purpose such as a report to court or for a case conference or discussion. Whilst these represent important tasks in which social workers must develop high-level skills, assessment is limited if seen purely as a means to an end. As part of the systematic process of social work it can be viewed as ongoing and continuous, informing the working relationship and its evaluation throughout. In this the exchange becomes meaningful as specifically directed towards issues of concern and importance and reviewing where people are and what they have achieved.

## How Do You Do it?

Social work skills in relationship building are as central to the assessment as they are to the systematic social work process. It is important to engage the person or people at the centre of the assessment, providing information about the reasons for the assessment, the uses to which it will be put, their role and involvement and the rights of those involved. However, alongside the interpersonal or people skills, and clear social work values, social workers need to be administratively competent in order to produce assessments that are meaningful, understandable and transferable.

One way of building the relationship and putting people at their ease within the assessment is to use drawing and charting techniques, producing genograms that will provide information about family networks, ecomaps that will show the strength of connections between people and places, and flow diagrams of life road maps that indicate important events in people's histories. Benefits of using these techniques include the fact that the physical act of doing them helps to provide a focus on a third object that can reduce anxieties; they also allow social workers and service users to explore issues in depth, to hold off or to correct mistaken impressions; and they provide information that can inform any tangible report that needs to be constructed (see Parker and Bradley, 2010).

A further way of assisting the process is to start from a wide perspective, gathering a broad social history that gives context and allows service users to construct ecological narratives before beginning to focus on more personal and individual issues and concerns. The pace of the assessment will determine the quality of the information provided. Service users may respond to service-focused questions and set protocols but this is unlikely to get the rich detail of their lives which are central to effective planning, interventive work and the evaluation of change.

A good assessment allows the social worker to plan openly with service users what comes next, is likely to be a product or snapshot of a person's or family's life at a particular time and also a continuing process of narrative development. If the assessment is a negotiated process which is based on the relationship between the social worker who has a deep knowledge base about what works in what settings, with whom and how, and the service user and/or carer who is expert on their own situation, life and experiences, the power differentials can be mitigated. This acknowledges the importance of the social worker's knowledge and the importance of true exchange. The plan leads to the development of the intervention, the ways in which social worker and service user will work to meet goals and objectives agreed within the assessment and plan.

## Intervention

Intervention is a contested term, raising for some the idea of 'doing to others' or imposing a level of expertise that is exclusive rather than inclusive. It need not be so, and can be understood as 'working together with people' in a systematic and planned way in an identified situation to make a difference. If social workers are to be effective in working with people and achieving identified goals – whether they be change or maintenance oriented – they will need to identify the evidence base from which they work. This is important in justifying the methods of practice employed or suggested to commissioners of social work, managers and supervisors and all importantly to service users themselves who are entitled to the best possible and most effective service. To be effective, social work practice should achieve what it claims it will. However, this does not in itself make it ethical or acceptable and the processes involved must be transparent as must the evidence base if service users are going to make informed choices about how to work together with practitioners. Of course, it might be argued that the knowledge base of social workers means they know best, and that the imperatives of practice – a child protection investigation, a mental health crisis, a discharge from hospital and so on – may lead some social workers to act rather than explain and take people with them. Social workers should have a command of the knowledge and theories underpinning the models they use if they are to be effective. However, the models used should fit the person and his/her lifestyle and choices if they are to work best. Intervention works best if it is engaged with by service users.

## Types, Models and Theories

There are many different types of model and theory that can be employed in social work (Healy, 2012). Sometimes social workers develop expertise in some areas as a result of personal preference, sometimes they elect to use an eclectic mix of theories and models. However, the driver for the model should always be the evidence base plus the active engagement, from a position of being fully informed, of the service user. Models for practice include individually focused work such as psychodynamic, cognitive-behavioural, crisis intervention and task-centred models; social approaches

based on systems thinking, social psychology and social and community development; and socio-political frameworks including critical theories, feminist theories, anti-discriminatory and anti-oppressive practice. These approaches cover the wide variety of areas and settings in which social workers practise. Interventive models can be analysed and classified in various ways as coming from identifiable philosophical and political perspectives, and it is important that practitioners take a critical and analytic approach examining why they are using a particular model and the impact this may have on those with whom they are working. The analytic framework proposed by Payne (2005) acknowledges that no theory can be defined by one category alone, but it is helpful in delineating the theoretical orientation and philosophical position of theories:

- reflexive-therapeutic;
- socialist-collectivist;
- individualist-reformist.

The importance of this analysis lies in its promotion of the purposes of social work as intrapsychic help, individualized and interpersonal assistance or social change. In practice all aspects interweave with one another as the individual constructs and is constructed by the social world, but such heuristic devices are important to our conceptualization of social work. Lymbery (2005) develops this understanding for work with older people.

## How Do Social Workers Choose What to Use?

In order to make choices service users need to know what will work in what circumstances; they are entitled to the evidence and social workers have a duty to keep up to date with research and, indeed, to engage in their own practice research and development. The ways in which social workers themselves decide on which approach to suggest will be determined by a variety of factors. It cannot be divorced from the belief systems and value-bases of individual social workers but is likely to be guided more by the purpose of the agency and its underlying philosophy and the legislation and social policies underpinning it. As social services become more evidence-based in their practices and as social workers develop their duty to provide the best possible services to the people with whom they work, whether or not an interventive method achieves the outcomes it claims will be a fundamental influence on individual social workers' choices. Many choices, however, take second place to a procedural-bureaucratic approach that has taken precedence as a risk-averse means of mitigating public fears and outcry over tragic, well-known but rare cases. This has stagnated approaches that offer more than a routinized herding and categorizing of people. Methods of intervention, although increasingly out of vogue, offer a variety of means for assisting people to take or maintain their position in society, to change and develop.

Many social workers choose to merge a variety of models, often resulting from a developing wisdom in practice gained from experience: an eclectic approach. Where it is subject to reflection and the tacit knowledge becomes framed as a model

for working it can be seen as developing an evidence base which, although not always theorized consistently, can begin to be justified. However, eclecticism may betray a lack of deep knowledge of models and their impacts on people. It may also represent a lack of theoretical conceptualization which is, potentially, a powerful indictment of education. If the latter is not addressed in continuing professional development programmes, which it may not be given the emphasis on the technical instrumentalism of contemporary social work, it is likely to detract from social work's rich potential for working with individuals in society.

On the other hand, it may reflect a lack of time or opportunity to use models of intervention resulting from agency pressures and directives which indicates a need for review of the purposes and aims of the organization and team.

We noted earlier that Smale, Tuson and Statham (2000) constructed a threefold model including expert, procedural and exchange approaches to understand assessment. This analysis can also be applied to ways in which intervention is approached by social workers. For instance, a social worker may develop a contingency management programme with a young person refusing to attend school based on expert knowledge of social learning theory and applied according to up-to-date research but ignoring the discrete situation in which this young person found him/herself. It may be, on the other hand, that the social worker's agency prescribes this particular method of working and a perfunctory approach to it is adopted. However, the exchange approach would seek to explain and share knowledge of the approach with the young person involved and seek to engage him/her actively in developing, implementing and evaluating that programme.

## Review and Evaluation

The importance of review and evaluation can be neglected within social work but they are central to the furtherance of evidence-based approaches and key to developing transparent and open approaches to working with people. The two terms have some similarities but also a number of differences that need clarification.

*Reviews* can be informal in the sense of referring to a summation of work or discussion prior to continuing or ending a session. In a more formal sense, however, review relates to the statutory and procedural obligations social workers have to monitoring their work and preventing drift. For instance, there is a statutory requirement to review a care plan for a young person looked after by the local authority, for care plans developed for adults and so on. Reviewing the success of work undertaken, how a placement or care plan has proceeded and what needs to be done now may be considered wearisome by some but it is crucial to effective and ethical practice. Being involved in or responsible for reviewing social work practice demands a clear knowledge of legislation, models and theories for practice, and the individual care plan and people involved in the case. Social workers will also need to develop their interpersonal and communication skills to coordinate and chair reviews, and their administrative skills in keeping to timescales, ensuring good communication channels and keeping accurate records of the process.

*Evaluation* is more closely allied to research-mindedness and the inculcation of evidence-based practice, the two of which may be understood together. The models

chosen for evaluation of practice will depend on and link with the methods of intervention chosen, which themselves will link to the assessment that was completed initially. The evaluation checks what has happened, whether plans have been achieved and provides evidence to demonstrate the achievement of agreed aims and objectives.

There are personal, professional, organizational and statutory drivers for conducting review and evaluation of social work practice (Parker and Bradley, 2010). It is important that social work demonstrates to the government and to its employing agencies that it is doing what it is expected and created to do. However, the development of the profession alongside other disciplinary groups and the centrality of social workers' individual duty to provide best practice based on research demands the continued development and progression of practice by evaluating its success or otherwise. In this way it is much akin to reflective practice in which social workers consider what has occurred in a deep and critical manner looking at processes as well as surface issues and make hypotheses as to why and how practice has had the impact it has. This allows social workers to develop further their practice and maintain a critical edge whilst providing evidence that it is working.

## Summary

The separation of assessment, intervention and review assists in developing a systematic approach to social work practice. However, the process is not a linear one and the stages merge with one another, or the relationship moves from assessment, intervention, review and further work at one or other stage. In a constantly changing and fluid world the model offers a way of guiding and conceptualizing social work that need not be constraining but facilitative of working together with service users.

## Five Key Points

1. Systematic approaches to social work require both evidence-based practice and person-centred artistry.
2. Social work practice is concerned with the regulation of social life as well as promoting social change.
3. Assessment, intervention and review are elements of systematic practice but do not necessarily follow a linear pattern.
4. Assessment, intervention and review are politicized activities depending on the context of the work and agency and mediated by the values of the social worker.
5. Engaging openly and honestly with service users assists in making assessment, intervention and review more effective.

## Three Questions 

1. How can social work practice be considered both an art and a science?
2. The 'exchange' relationship is based on the social worker's appreciation of the service user as expert by experience. Describe how this model might be applied to assessment, intervention and review in social work practice.
3. Explain why and how social workers might choose their models for practice and explore some of the possible implications arising from these choices.

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CHAPTER 5.2

# Care Management

*Aisha Hutchinson*

Care management was widely introduced in the United Kingdom as a process which would tailor services in response to individual need (DOH, 1991a), as well as controlling spending on residential care through standardized gatekeeping and targeting functions (Payne, 1995; Lymbery, 2005). Care management is therefore both a system of organizing services and a practice or type of intervention (O'Connor, 1988; Orme and Glastonbury, 1993). It is an approach which is largely used by local authorities (LAs) to structure work with groups for whom they have powers and duties to fund residential care, day services or home-based care – or for whom they have a duty to undertake a statutory assessment. Other duties, such as safeguarding and prevention work, tend to run in parallel or within an integrated care management process. Care management has largely been adopted in relation to adult social care, although principles of care management have also been integrated into some areas of social work with children and families (Horder, 2007).

## Care Management and Community Care

The introduction of care management is intrinsically linked to the advent of 'community care' which was launched in the 1990s as the main framework for responding to adult health and social care needs (Payne, 1995). Throughout the 1980s there was increasing recognition of the limitations associated with a social care system that lacked structure and accountability. Adult social care was underpinned by a whole range of legislation and policy guidance dating back to the National Assistance Act 1948 and lacked a coordinated approach to the identification and meeting of needs (Mandelstam, 2005). Residential care was accessed through the benefit

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system without any systematic assessment or care planning guiding the process or other options for care in the community being seriously considered (Crawford and Walker, 2004). This resulted in a high and, seemingly, ever increasing social security bill, with very few checks and balances in place to monitor levels of needs and suitability of placements (Griffiths, 1988). Social care provision was considered paternalistic and top-down by the growing service user movement who advocated for more provision within the community, choice and independence.

Positive American experiences of case management led to a series of research projects in the United Kingdom commissioned by the Department of Health on how this model could be used effectively in the United Kingdom (Challis *et al*., 1998). A series of studies showed that intensive care management for people with complex needs could be very effective in terms of reducing costs for local authorities alongside increased user satisfaction and improved quality of service. Using the model across different client groups established how better outcomes for some service users could be achieved (Davies and Challis, 1986). Research confirmed the value of targeting scarce resources to people considered most vulnerable by means of a 'production of welfare' approach, balancing the costs of inputs (providing care) against outputs (meeting needs) through the process of assessment, planning and review. Community care was finally introduced through the NHS and Community Care Act in 1990. Its main aims were to establish a fair allocation of resources through systematic and rigorous assessment (Thompson, 2002), reducing costs by bringing care into the community rather than paying huge residential bills (Lymbery, 2005; Ray, Bernard and Phillips, 2009). Community care is predominantly provided through a mixed economy of care, separating the roles of local authorities as service purchasers and private agencies as service providers. This became known as the 'purchaser–provider' split in contrast to previous service arrangement where LAs were largely direct providers. This sought to stimulate competition in the care market, bring down prices and increase choice for service users (Crawford and Walker, 2004).

Community care is also founded on principles of multi-agency working to ensure integrated and coordinated services between different agencies providing health and social care (DOH, 1989; DOH, 1991b). It brought with it a whole new system of charges which distinguished social care from health care, with the latter being provided free at the point of access through the NHS. Devolved responsibilities for social care budgets, financial ceilings on residential care or 'packages of care' and Fair Access to Care Services (DOH, 2002) legislation have all contributed to the resource management strategy embedded in the reforms. Community care practice is essentially about the effective use of limited resources, targeting those most in need, which is usually the province of management and politics (Payne, 1995) and is associated with an increase in managerialism within the social care sector (Lymbery and Postle, 2010).

## The Process of Care Management

In many ways care management is an administrative approach to social care, enshrined in legislation, which mobilizes available resources to meet identified need. With particular emphasis on liaison and coordination, it embodies neither a

therapeutic nor a collectivist approach (Lymbery, 2005), although it potentially bridges the gap between them (Payne, 1995). A number of models of care management were potentially available to the UK government seeking to integrate this process in community care practice (Pilling, 1992), but the one most common in the United Kingdom has been that of 'social entrepreneurship' (Payne, 1995). This is the process by which a 'care manager' completes an assessment to determine a person's health and social care needs and risks, as shown by the case study described in Box 11. The care manager subsequently contracts services on behalf of the individual to meet their identified needs. While service users should be fully involved in this process, direct control and final choice of service provision ultimately remains with the care manager (McDonald, 2010). The 1989 White Paper which preceded the 1990 NHS and Community Care Act stressed that a primary objective of the community care reforms was 'to make proper assessment of need and good case management the corner stone of high quality care' (DOH, 1989, p. 5). Care management, as a process of establishing need, developing care plans and accessing services, therefore operationalizes community care policy and legislation. The Department of Health 1990 guidance outlines seven stages of care management which have come to shape the structure of services provided by adult social care directorates and the practice of individual care managers (DOH, 1990):

1. Publishing information
2. Determining the level of assessment
3. Assessing need
4. Care planning
5. Implementing the care plan
6. Monitoring
7. Review

When the guidance was first published it was unclear who would have the responsibility to complete each of these stages and whether the whole process could be completed by one care manager (Orme and Glastonbury, 1993). Care managers act as a single point of contact for service users and as a 'manager' or coordinator of the care provided. However, over time, different local authorities have structured their adult social care in ways which have tended to separate or consolidate the seven stages. For example, many social care directorates have a single point of access which provides information and processes referrals, determining the need for assessment and eligibility, before passing onto a care management team for initial and full assessments. Some care managers will then follow the whole process through until review, or pass this responsibility on to a separate team or worker. Hospital care management teams, for example, may be active in all of the initial stages including the provision of information, but they will transfer the monitoring and reviewing roles (which take place after hospital discharge) to community teams. Assessment and care planning are cyclical processes extending over time for as long as a service is provided or a need is recognized, and may well therefore be repeated by different care managers over time (Coulshed and Orme, 2006; Horder, 2007).

## 11 Case study

Jean is an 89-year-old woman who lives alone in her two bedroomed ground floor apartment. She was admitted to hospital with a broken hip after a fall. Following surgery, a referral was made to adult social care to complete an assessment regarding her care needs on discharge. A care manager visits the ward to speak with Jean and arranges a joint meeting with Jean and her daughter, the nursing staff, physiotherapist and occupational therapist assigned to her care. Through this meeting it is established that Jean will need ongoing physiotherapy in the community and will need some adaptations made to her home before she is discharged. Jean agrees to the instillation of a care line which can be used to call for help if she were to fall again, and Jean's daughter said that a family member would be able to visit once a day for the next six weeks as well as do a weekly shop. It was agreed that Jean would need some temporary support with her personal care and meals for at least six weeks, and some help with the housework. The care manager arranges for a temporary package of care to support with these tasks and to provide 're-enablement' support, helping Jean to regain her independence and rebuild confidence. It is anticipated that support will be short term, and information is given about a weekly bathing service and meals on wheels in case Jean wants to make use of these in the future. At the meeting concerns were also raised regarding Jean's alcohol consumption which may have contributed to the fall, as well as some short-term memory loss, and disputes with her neighbours. The hospital care manager sets up the care needed to ensure Jean's physical needs are met when she returns home, and makes a referral to the community team to follow up concerns regarding alcohol consumption, memory loss and conflictual relationships because it was not felt appropriate to tackle these in the hospital context.

## Values System Underpinning Care Management

While the emphasis of care management is different and heavily influenced by neoliberal individualism, it has also been argued that many of the values (and skills) sustaining care management are not incompatible with 'traditional social work' (Renshaw, 1988; Payne, 1995; Gorman, 2003; Dustin, 2006). Underpinning care management practice are values of equality of access to assessment and services along with a fair distribution of resources, giving priority to those in most need (Orme and Glastonbury, 1993; Ray, Bernard and Phillips, 2009). Principles of participation and partnership with service users are also fundamental, embedded in an individualized response to need, especially during the assessment process and care planning stages (Coulshed and Orme, 2006). Service users are valued as consumers and purchasers of services, and the process of care management is ideally service user centred, with care plans being based on individual need rather than available

services. The process of assessment and care planning has introduced some form of equity to the provision of expensive services, with standardized assessments and processes.

One of the goals of care management includes the empowerment of service users through the promotion of choice and independence (DOH, 2006). The mixed economy of care and market forces promises to give service users or 'consumers' choice and increased control over how their social care needs are met. 'Direct payments' which further aimed to increase independence and control were enshrined in legislation (Community Care (Direct Payments) Act 1996), paving the way for the personalization agenda. Interpersonal skills and the importance of relationships with service users remain central, although the therapeutic emphasis is replaced with an emphasis on skills in assessment and care planning (Gorman, 2003). Care management aims to help clients clarify their needs and make effective use of their own personal and community resources in meeting those needs (Payne, 1995).

As a system, the care management process is underpinned by values of equality, transparency and rights of redress. This has been supported by legislation such as the Data Protection Act (1998) and the Freedom of Information Act (2000) which give service users a right to see, control and limit the information held about themselves. While community care was introduced largely as a resource management system, moving from a residential- to a community-focused system was also underpinned by values of empowerment, social integration, choice and independence. Care management is not exclusive and can coexist with other methods for delivering care such as the care programme approach (CPA) or person-centred planning (PCP), as well as alongside other approaches such as task-centred social work, solution-focused social work and crisis intervention (Coulshed and Orme, 2006).

Unfortunately, while the values underpinning care management speak of equality, choice, empowerment and individual responsiveness, these have not always been operationalized well in the context of community care policy (Gorman and Postle, 2003; Lymbery, 2005).

## Strengths of the Care Management Approach

One of the main strengths of the care management approach is the centrality of needs-led assessment from which all other plans and action are negotiated (Crawford and Walker, 2004). Care managers are expected to assess needs before considering what services are available, which, while causing tensions due to limited resources, gives an independent value to the assessment process. Assessment is at the heart of what social workers do (Coulshed and Orme, 2006; Lymbery and Postle, 2010) and is seen as a valuable service in itself, enshrined in legislation (Crawford and Walker, 2004). An exchange model of assessment based on partnership, which includes service users and carers as experts of their own needs, is preferred to a questioning or procedural model (Smale *et al.*, 1993). While the provision of services may be constrained by limited resources, many groups have a statutory right to a full and comprehensive assessment, including carers. Assessment is more than just a gateway for accessing services; it is a way for people's needs,

wishes and preferences to be articulated, a channel for empowering practice which seeks to identify strengths and build resilience (Coulshed and Orme, 2006; Kelly and Gates, 2010; Lymbery and Postle, 2010). Assessment has been the core of good practice under care management in a community care context, although it has also often been explicitly used for gatekeeping purposes because funding agreements for care are based on assessments completed (Lymbery and Postle, 2010).

Advocates of the care management approach argue that with the introduction of market forces and a 'private' sector in the provision of social care, the stigma of public assistance is slowly being eroded and the boundaries between public and private services are blurred (Horder, 2007). The care management process seeks to build opportunities for innovative and flexible care provision that is responsive to individual needs and that values service users as consumers of private services (Orme and Glastonbury, 1993). The growth of the private care market, and investment made in ensuring that information about services is available (stage one of the care management process) has increased opportunities for some service users to purchase their care needs independently with little involvement from adult social care. Schemes such as Direct Payments have also extended this opportunity to those who are eligible for funding from statutory agencies, but wish to remain in control of their 'budget' and 'package of care' (Ray, Bernard and Phillips, 2009). These schemes have been championed, developed and very often run by the service user movement which has grown substantially following the introduction of care management (Bornat, 2006).

Care management has been implemented in the context of strong governmental promotion of partnership with the private sector, inter-agency and multidisciplinary work (DOH, 1989; DOH, 1991b; Lymbery, 2005). Multidisciplinary and joint working is considered crucial when attempting to work holistically, providing a seamless service where communication between professionals is improved and knowledge is shared – as is seen in the development of community mental health teams and community disability teams which consist of workers from different disciplines or professions, working together to provide a holistic approach to the needs of service users (Petch, 2002). Single assessment, pooled budgets and other multidisciplinary approaches have arisen in which social workers and care managers play different roles.

While the shift from residential to community provision is associated with a reduction of costs, there is no doubt that it has increased community resources which enable people to stay at home for longer (Ray, Bernard and Phillips, 2009). Ideologically, the provision of care in the community and in people's homes is seen as preferable to residential and institutional contexts, promoting independence, self-determination and choice for service users. Debates rage around the boundaries of care provided *by* the community and care provided *in* the community, with a huge burden of care being taken up by informal carers and voluntary agencies. The care management process has been an essential part of making care in the community possible, ensuring that care needs are properly established and that service provision reduces risks and increases levels of independence. Monitoring and review is crucial for ensuring service provision is responsive to needs as they change. With the growth of care providers, and an increased focus on providing care in the community, many more people are able to stay home, with their care 'managed' to ensure needs are

met and risks reduced. However, this process is always affected by resource constraints, and spending cuts impact on how far community packages are allowed to go before residential care is considered the cheaper option.

## Weaknesses and Critiques of the Care Management Approach

Much of the critique levied at the care management approach in the United Kingdom has been related to the role care management has played in the wider context of community care. For example, the contradiction between a needs-led assessment process and a resource-limited system has transformed the role of care managers into gatekeepers (Ray, Bernard and Phillips, 2009). This has created tensions for practitioners who seek to balance this gatekeeping role while trying to meet needs, advocate for and support service users and engage in helpful and empowering interpersonal relationships (Postle, 2002). Funding is always insufficient and uncertain, resulting in additional time needed to advocate for clients by providing extensive evidence of needs and risks, writing up lengthy assessment documents and funding applications, and being creative with resources. Gatekeeping has also meant that definitions of need and risk have been professionally constructed rather than service user led (Horder, 2007). Unfortunately this has led to critique that assessments have become reductionist and procedural in care management under community care (Smale, Tuson and Statham, 2000).

While assessments often need to be completed as a matter of statutory duty, lack of resources can be used as a reason to refuse services and this has resulted in ever-tightening eligibility criteria, reducing the ability to engage in prevention work (Gorman and Postle, 2003; Lymbery, 2005; Lymbery and Postle, 2010). Fair Access to Care Services legislation allowed social services to set eligibility criteria for services based on balancing resources against needs (DOH, 2002). This can make it difficult for practitioners, especially when they have spent a lot of time on a complex assessment in partnership with service users (McDonald, Postle and Dawson, 2008). While care management was hailed as a process which would facilitate empowerment through an increase in people's choice of services, in reality, choice is frequently constrained by lack of resources in many LAs (Means and Smith, 1998; Crawford and Walker, 2004; Vallely *et al.*, 2006).

McDonald, Postle and Dawson (2008) and others argue that the development of community care policy and practice has taken place at the same time as the growth of managerialism, which has had a significant and negative impact on service provision and professional practice (Lymbery, 2001; Postle and Beresford, 2007; Ray, Bernard and Phillips, 2009). A managerialist approach is the proceduralized control of working practices (Clarke, Gerwirtz and McLaughlin, 2000; Harris, 2003), prioritizing concrete outcomes over meaning and process (Lymbery, 2005). Management principles of efficiency, effectiveness and accountability have been pervasive, often reducing professional practice to a series of tasks and stages, deskilling the workforce in terms of professional knowledge and judgement (Lymbery and Postle, 2010). Supervision has tended to discuss workload management rather than professional issues and dilemmas, and at a practice level practitioners can rely on procedures to shape work rather than engage proactively and creatively with

complex cases (McDonald, Postle and Dawson, 2008). Under these influences, policies prescribing practice have flourished. As McDonald comments, 'Professional discretion has to a large extent been replaced by formulaic approaches to assessment and service eligibility' (2010, p. 28). These concerns have taken centre stage through the Munro Review which relates specifically to child protection, but recognizes the impact of managerialism on social care systems and the loss of confidence in professional knowledge and expertise (Munro, 2011).

A further unfortunate feature has been the intense bureaucratic processes involving multiple form-filling, report writing, means-testing and hierarchical structures for authorizing expenditure. While there have been some important developments in case recording, concerns have been raised that the levels of form-filling and recording have reduced the amount of time practitioners can spend with service users (Challis *et al.*, 2007; Lymbery and Postle, 2010). The ability practitioners have to establish productive working relationships has been something that service users say they value (Beresford, 2007), yet for those working with older people there has been a trend towards heavy workloads, characterized by high-volume, low-intensity practice (Lymbery, 2005). McDonald, Postle and Dawson (2008) argue that with the influence of managerialism, relationships between social workers and clients have changed to 'prescriptive encounters' (Ruch, 2002, p. 205) and 'risk averse decisions' (Ruch, 2002, p. 207). They state relationships have changed in character from interpersonal to economic, from therapeutic to transactional, and from nurturing and supportive to contractual and service-orientated.

The care management approach is an individualistic approach, despite the need for LAs to foster service provision which reflects the wider needs of the communities in their area. The current care management process takes one individual assessment and 'case' at a time, which can make it difficult for practitioners to see the impact of structural inequalities on the lives of many individuals (for example, impact of ageism, poverty or marginalization due to disability), and respond accordingly.

Individualized assessments risk pathologizing individuals rather than society or the welfare system. While the social context may be taken into consideration, the care management process works to promote individual change rather than societal change; it neglects structural, economic and political dimensions of needs and risks, and collective action as a response (Horder, 2007; Harris, 2008; Lymbery and Postle, 2010). An important example of this in adult social care is the long failure to address the lasting implications of health inequalities (McLeod and Bywaters, 1999).

Historically, adult social care had been operationalized largely through unqualified staff, and through the introduction of care management it was hoped that the professionalization of social care and social work would be strengthened. However, because care management can be carried out by a range of practitioners with various qualifications, many believe that it denies the unique professional contribution of qualified social workers (Ellis, Davis and Rummery, 1999; Coulshed and Orme, 2006). From its implementation there has been a growing concern that the care management approach has harmed the profession because it created a new form of professional identity rather than strengthening social work as a 'caring' profession (Postle, 2001). In some places the term 'care manager' has been used instead of

'social worker' and can refer to professionals who are not social work qualified. Debates have raged regarding whether care management is synonymous with social work, and what skills, values and knowledge are needed in this role (Orme and Glastonbury, 1993). Through the procedurized care management process in the context of managerialism many social work practitioners appear to have experienced a loss of professional skill and identity (Ray, Bernard and Phillips, 2009).

## Concluding Discussion

There is widespread agreement that the social work role, in adult social care particularly, has been transformed by the implementation of care management and community care (Postle, 2002; Gorman and Postle, 2003; Carey, 2003). It seems the nub of the change is more about the purpose of social work intervention (gatekeeping rather than direct work) than a change in skills (Lewis and Glennerster, 1996). Dustin (2006) argues that 'traditional' social work skills of interpersonal communication, negotiation, mediation and appreciation of organizations and procedures, are still essential for care management. However, additional skills required to practise under community care also include risk assessment, ability to construct a case, understanding management information systems, use of information and communication technology, managing contributions of groups of service providers to meet service users' needs, accounting and budget skills, and the ability to manage tension between traditional casework and care management.

It is important to remember that the care management approach in the United Kingdom is one which has been highly shaped by policy and legislation as well as ideology. It was developed through a top-down process rather than being built from grassroots social work practice, with management as part of the central agenda (Payne, 1995). Care management is informed by social work values and has the capacity to hold in tension therapeutic social work and social care planning (Payne, 1995) through a systematic and service-user-centred approach to care provision. However, it has been heavily politicized and heavily critiqued because of the context of community care and the way care management has been shaped to meet the needs of government rather than professionals or service users. The care management process has a lot to offer those who have the desire and ability to proactively engage in the identification and meeting of needs, especially when therapeutic skills are not required to engage with complex underlying issues such as safeguarding or emotional distress. It is especially helpful in response to less complex cases and for systematically planning and coordinating responses to need. However, in response to complex cases the procedural nature of care management can reduce engagement with service users to a conveyer-belt-like relationship, marginalizing professional knowledge and expertise. While care management could be well used in response to some contexts in adult social care, unfortunately this model has not lived up to its potential in the context of scarce resources, gatekeeping, managerialism and a market economy (Gorman and Postle, 2003; Lymbery, 2005). With the shift towards personalization it is not entirely clear how the care management approach will be adapted in this ever-changing policy context of single or self-assessment, pooled budgets and brokerage (Lymbery and Postle, 2010). It could be that one day care

management will be an approach which is conceptualized as 'traditional' as we move forward into new territory.

## Five Key Points

1. Care management in the United Kingdom is synonymous with the introduction of the NHS and Community Care Act 1990, and has therefore been shaped by top-down legislative and political influences as well as ideology.
2. Care management is both a system of organizing services and a practice or type of intervention.
3. Care management is a process which tailors service provision to individual need through assessment, care planning and review, and is therefore not conducive for tackling collective needs.
4. Good assessment is at the heart of the care management process, although this has often resulted in bureaucratic procedures which minimize the use of professional knowledge, creativity and skills in partnership with service users.
5. While the care management approach is underpinned by values of quality, empowerment, service user self-determination and choice, the model of care management has not lived up to its potential in the context of scarce resources, gatekeeping, managerialism and a market economy.

## Three Questions

1. Is care management social work?
2. Care management is both a system of organizing services and a practice or type of intervention. What complexities does this cause for LAs and practitioners engaging with this approach?
3. What can 'care managers' do in response to the tension between managing limited resources and responding to needs in partnership with service users?

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CHAPTER 5.3

# Risk Assessment and Risk Management

*Hazel Kemshall*

Risk assessment and management are key issues in social work, social care and probation. Responding to the risks posed by others, assessing and limiting risks to vulnerable clients, and managing risks to oneself as a worker are common place. Risk is often central to decisions to allocate resources, to intervene in the lives and choices of others, or to limit the liberties and activities of clients. However, there are different views on the nature of risk, how it should be assessed and managed, and the extent to which risk can be effectively managed and reduced.

## What is Risk?

Risk has traditionally been understood as an uncertain prediction about a future behaviour or event. For some, this means a 'chance' or 'likelihood' that something may happen, and where statistical calculations of likelihood are made (for example, in life insurance) the word 'probability' is often used. Whilst in gambling risk can be associated with 'good risks' (for example, winning a bet at 25 to 1), in some aspects of contemporary use risk is often associated with unwelcome, harmful and negative events or behaviours: for example, the probability of death from particular diseases, of car accidents, of prisoners reoffending after release from prison, or of child abuse in child protection work. In social work, social care and probation, risk assessment is usually of 'bad risks', harmful events and behaviours to be limited or avoided.

The idea of the probability of future harm is central to risk assessment, but what harmful event or behaviour is of concern? It is usually framed by the type of agency

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the practitioner works in. For the social worker in child protection, the concern is with the risk of sexual or physical abuse to children. For the probation officer, the concern is with the risk of reoffending posed by an offender on community supervision. In residential work, practitioners may be concerned with the risks of violence between residents, or of violence by residents on workers. The risk concerns of the nuclear industry are not the same as those of the Department of Transport, and neither are they the same as those presented to local authority social workers working in community care.

One way of analysing risks in social work is to separate them into two categories:

- those risks which people *pose to others*;
- those risks to which *people are exposed*; these are perhaps best understood as referring to people who are *vulnerable to risk*.

## *People who pose risks to others*

The most common area in which risk is approached in this way is the risk assessment of offenders in probation work. The concern here is to identify and accurately assess the risks posed by offenders of reoffending either following release from custody or during the period of a community sentence. The assessment of reoffending has been paralleled by an increased concern with the assessment of likely dangerousness (Kemshall, 2001). Sex offenders, for example – especially paedophiles – have attracted increased regulation, risk assessment and management (Kemshall *et al.*, 2005). Mentally disordered offenders and those with severe personality disorder have also been subject to increasingly formalized and rigorous risk assessment and community management (Home Office, 1999). The common features of such an approach are:

- the person assessed is seen as a poser of risk to others;
- risk is defined as harmful behaviour, with the harm directed at others;
- the desired outcome of risk assessment is accurate identification of risky persons and their likely behaviours;
- the desired outcome of risk management is the reduction or avoidance of risk to others;
- the rights, and to some extent the liberty, of posers of risk can be limited in the interests of protecting others and preventing future risks.

## *Vulnerability*

Assessing exposure to risks – or a person's vulnerability – is central to assessment in social care and social work fields such as community care and work with older persons. Pritchard (1996) has argued that risk-taking is an important feature of all our lives, and that the wish and need to take risks is no less important for older persons. However, a key issue for workers, families and carers is often the risks to which the older person is exposed – whether in the home environment or in residential care. The key features of this approach to risk are:

- Identification and assessment of the risks to which the client is exposed. What risks are they likely to encounter and with what result?
- Determining whether such risks are acceptable or not. Should the risks be run?
- Balancing the desirability of reducing risk against the likely reduction of choice and the likely impact upon quality of life; for example, the reduction of risk to an older person through admission to a residential care home has to be balanced against their consequent loss of independence.
- Risk management strategies are generally informed by the desire to balance risk reduction with autonomy, quality of life and rights.

### *Is it that clear-cut?*

In some cases, a person will both pose risks to others and also present as vulnerable: an example is of the mentally disordered person who, when acutely ill, offends harmfully against others. An individual's vulnerability may itself harbour the seeds of risk to others; for example, mentally ill persons who fail to comply with medication regimes are more likely to commit homicide and suicide than those who do (Boyd Report, 1994), and failures in community care provision to mentally ill persons have been associated with subsequent risk management failures (Blom-Cooper, Hally and Murphy, 1995).

In such cases, risk assessment and risk management require a delicate balance between meeting the expressed needs of such individuals, respecting their autonomy and rights, and protecting the public and potential victims. Distinguishing between vulnerability and risk to others may assist practitioners in achieving clarity about this delicate balance of potentially conflicting objectives in risk assessment.

## Risk Assessment: Key Components

Risk assessment can be understood as a calculation about the possible occurrence of a negative event or behaviour in the future. This usually involves a calculation of both likelihood, most often expressed in terms of *probability*, and the likely *impact* of the event or behaviour should it occur. Risk assessors are usually required to identify the consequences of any impact (for example, the likely extent of injury to a child), and who might be at risk should the risk occur. Risk assessments are usually made in order to inform decision-making on interventions, or *risk management strategies*. For example, the risks posed by a paedophile upon relocation into the community will inform the type and location of accommodation provided and the intensity of supervision carried out by the police and probation services. Risk assessment and management are inextricably linked.

Risk assessment in social care, social work and probation has the following key features:

- identification of the *risk of what*? – the behaviour or event of concern;
- calculation of its likelihood or probability;
- the conditions, situation(s) or circumstances in which the risk might occur;
- the likely impact of the risk;

- the consequences of the risk and who might be exposed to and harmed by the risk.

There are two basic assessment techniques used to assess risk: clinical assessment and actuarial assessment.

## *Clinical assessment*

Clinical assessment is an individualized assessment method carried out by practitioners on a case-by-case basis and essentially a diagnostic technique derived from mental health and medical fields. It is an individualistic assessment of the personal and social factors deemed to be relevant to the risky event or behaviour, based upon case-based knowledge, personal contact and interviewing of the client and relevant others, and consideration of the individual circumstances of the client. The assessor uses this information to make a judgement of the risk that the individual poses or is exposed to. The process is highly dependent on assessor and client interaction and on interview and observation techniques designed to collect information on social, environmental and personality factors. As the clinical judgement of risk is individualized it is often not generalizable to other individuals. Whilst such assessments are often couched in the language of likelihood, they are not probability calculations.

Clinical risk assessment, particularly in the areas of offending, violent behaviour and child abuse, has a poor record of accuracy (Crighton and Towl, 2005). The method is plagued by various sources of bias and error and is highly dependent upon the subjective processes of interviewing, observation, and the self-report of the client whose risk is being assessed. The subjective bias of the assessor, particularly in cross-cultural situations, has resulted in high levels of inaccuracy (Milner and Campbell, 1995). Two types of inaccuracies can result: false positives and false negatives.

- *False positive predictions* are those which predict that a risky behaviour or event will occur (for example, a violent offence) and it subsequently does not. This can result in people being detained in prison beyond their earliest release date, detentions under mental health legislation, removal of children in child protection cases, and over-intrusive responses in community care cases.
- *False negative predictions* are those which predict that a risky event or behaviour will not occur (for example, a child will not be abused by a parent) and it subsequently does. This can result in extensive harm to victims and public and loss of credibility for practitioners and agencies.

Naturally practitioners and their agencies wish to avoid both types of errors.

Whilst limited, clinical assessment can make an important contribution to risk assessment. Such risk assessments often have a low predictive accuracy, but can be useful in explaining behaviour, assessing motivation to change in risky persons, and in providing highly detailed information about specific situations and circumstances. Such assessments often aid practitioner understanding of risk and inform risk management strategies rather than predict with certainty probabilities of risk.

### *Actuarial assessment*

Actuarial risk assessment has its roots in the insurance industry and is based upon statistical calculations of risk. Risk probabilities are usually expressed in numerical terms (for example, a 60 per cent probability of reconviction if released from prison, or a 1-in-3 chance of suicide under specified conditions). Such predictions are based upon aggregated statistical analyses of similar patterns of behaviour in similar circumstances. For example, car insurance for young male drivers is derived from statistical knowledge of the accident rates for that group of drivers. This method has been applied to the risk assessment of offenders, particularly in assessing the likely risk of reoffending if released from prison on parole.

Attempts have been made to apply the method to other social work risks such as child protection, but with limited success (Corby, 1996). Whilst more accurate than clinical assessment, the method is limited by the difficulty of transferring knowledge derived from groups to an individual. Statistical probability is flawed by the 'ecological fallacy' – that is, the use of knowledge about past behaviours relating to a particular group or type of behaviour and the presumption that this is knowledge of real events rather than an oversimplification of likely events:

> To put the matter bluntly, you will either die horribly in a road accident, or . . . you will not. After your eventual death, we can see retrospectively that the odds on this particular adverse event were 'really' either 1 or 0. (Heyman, 1998, p. 10)

A 60 per cent prediction of reconviction upon release from prison when applied to a particular prisoner means that the chances of being correct are 6 out of 10, little better than tossing a coin. Even in cases of high predictive accuracy, for example 90 per cent prediction, this still means that 1 in 10 predictions will be incorrect. Where life and liberty might be at stake this may be too high a false positive rate. Actuarial prediction is further limited by the difficulty in stating with any certainty which group an individual might belong to. Is an individual prisoner likely to be one of the 60 per cent who reoffend or one of the 40 per cent who do not?

The reliable application of statistical data is more difficult to obtain for infrequent behaviours in the population – such as child abuse or paedophilia. Even for those behaviours which occur more frequently (for example reoffending), the application of statistical aggregates to individual prediction is *inherently* limited. This problem is particularly acute around the probability range 40–60 per cent where most people will cluster and where chances are almost even.

In essence, the actuarial method is useful for the assessment and prediction of frequently occurring behaviours or events such as accident rates amongst young male drivers or the likelihood of death from heart disease, but the more infrequent the risk the less accurate the prediction will be.

Neither the clinical nor the actuarial method of assessment can guarantee 100 per cent accuracy, and, for this reason, the use of risk assessment to predict, particularly where liberty and civil rights are at stake, has been heavily resisted (Wood, 1988). The moral and ethical issues involved in such predictions are seen as substantial (Walker, 1996), and, for some commentators and practitioners, they militate against the desirability of risk assessment in social work (Caddick and Watson,

1999). Psychiatrists have long eschewed the role of prediction, particularly in the court arena, not least because the accuracy of predictions is seen as unlikely to withstand either ethical or legal challenge (Monahan, 1993).

### *Holistic risk assessment: the 'second generation'*

However, risk assessment is now a central feature of much social care, social work and probation practice, and this has fuelled research and practice responses to the dilemmas it presents.

Approaches to risk assessment which combine the best features of clinical assessment with actuarial prediction are now recommended (Kemshall, 2003). These combined methods are often referred to as 'second generation' tools (Monahan and Steadman, 1994). They combine the ability of clinical assessment to offer detailed explanations of risky behaviours and the circumstances pertinent to risky events in individual cases with the predictive accuracy of actuarially based risk factors. This has resulted in the development of methods utilizing aggregated and statistical data to establish base lines of risk; for example, previous offending is the best predictor of future offending, combined with detailed professional knowledge of individuals and their circumstances.

Such approaches are also seen as essential to the case planning and case management process, as combined methods highlight areas for significant intervention and change.

## Risk Management

Risk management cannot guarantee to prevent risk. It can only attempt to reduce the likelihood that risky behaviours or events will occur, or reduce the impact of those behaviours and events should they happen. Minimization rather than reduction is the key, whether this be of self-harm or harm to others. The key objectives of risk management are:

- the reduction of the risk a person presents to others;
- the reduction of vulnerability or exposure to risk of an individual.

In both areas of risk work, practitioners are tasked with:

- identifying the factors which may lead to a risky behaviour or event (sometimes known as precipitating factors);
- working to remove or reduce them;
- reducing the impact of risky behaviours or events by improving the client's coping and/or choice mechanisms;
- reducing the impact of risky behaviours or events by implementing or strengthening the client's protective factors;
- providing and enhancing support networks to prevent situations and behaviours deteriorating;
- implementing strategies to protect potential victims and vulnerable persons 'at risk'.

Two case studies are presented in Boxes 12 and 13 which illustrate the differences between posing a risk and being 'at risk', including key issues in risk management, and pose some key reflective questions for readers.

Risk management strategies are likely to become the subject of extensive scrutiny in those situations where 'things go wrong' and clients are either harmed or harm others – for example, child deaths in child protection work. Carson (1996) has argued that such situations are always subject to 'hindsight bias', or investigation of what went wrong with the benefit of hindsight. One implication of such bias, either in internal or external inquiries, is that workers and their agencies must make 'defensible decisions'.

### *Defensible decisions*

Carson argues that risk decisions are highly complex, based upon uncertain and incomplete knowledge and tools which cannot guarantee 100 per cent accuracy. In such situations 'errors' are bound to occur, and workers and their agencies may find themselves exposed to public scrutiny, if not litigation, for their decisions and actions. In effect, workers do not have to be 100 per cent accurate, but they do have to show that their decisions were the best that could have been made on the day, and are in line with the best current practice on risk assessment and management. This can be translated into minimum standards for risk decisions:

- Practitioners must work within and be trained in appropriate knowledge and skills for risk work, including clinical, actuarial and legal knowledge.
- Practitioners must base their risk decisions on appropriate information, including the questioning of significant others, and detailed investigative interviewing of the person either posing or 'at risk'.

### 12 Case study 1: posing a risk

Marcia is a single mother with two children, a girl aged 3 and a boy aged 5. She has recently met Michael and has formed a relationship with him. Michael has just moved in with her.

Michael is a registered sex offender and has previous convictions for child sexual abuse, and police notify social services of his change of address and new relationship. Police and social services meet to discuss the risks in this case.

- What risks do you think they should consider in respect of Marcia and her children?
- What risks are posed by Michael and to whom?
- What should police and social services tell Marcia and why?
- What are the child protection issues in this case?
- What risk management strategies are required to protect Marcia and her children?

### 13 Case study 2: vulnerability to risk

Freda is a 77-year-old white woman living alone in council accommodation. Her family has noticed that she is becoming increasingly forgetful, and that the household tasks she previously managed are increasingly difficult for her. Her son recently visited and found a gas ring on, and a saucepan boiled dry. Neighbours have complained about the smell of gas. Freda has always been fiercely independent, and resents any reliance upon family or 'interfering social workers'. However, her family remains worried and after monitoring the situation for some weeks feel they must refer her to the local social services department.

- What factors do you think Freda's family and the social worker should consider?
- What risks do you think Freda is exposed to?
- What risk management strategies should her family and the social worker consider and how can these be balanced with Freda's own wishes and her right to independence?
- What protective factors can be put in place and how can Freda's support network be strengthened?
- What do you think will be the crucial issues in a defensible decision in this case?

- Practitioners must assess the likelihood and impact of the risk, based upon the evidence, and actively pursue relevant evidence and facts.
- Risk management plans should be well matched to the risks identified, appropriately resourced and delivered with integrity (adapted from Kemshall, 1998).

## Conclusion

Risk is central to modern life. We are exposed to risks every day: food risks, crime risks, health risks, and lifestyle risks. Many of us are risk-takers, engaging in risky eating habits, smoking despite health promotion campaigns, or driving too fast despite speed restrictions and accident warnings. Social care, social work and probation are professions increasingly involved in risk assessment and management – either risks people pose to others, or risks people are exposed to. This requires highly skilled and complex decision-making in a climate where public and legal scrutiny of 'failed decisions' is likely to take place. Dealing with risk is itself a risky business, hence the trend towards combined and holistic methods and defensible decision-making.

## Five Key Points

1. Risk concerns are framed by the type of work and the agency the practitioner works in.
2. The range of risks facing workers can be divided into two key categories: clients who pose a risk, and clients who are vulnerable to risk.
3. Combining clinical and actuarial risk assessment into second-generation holistic tools provides the most accuracy.
4. Risk decisions must be defensible.
5. Risk management is about risk reduction and harm minimization, and not the elimination of risk.

## Three Questions

1. What do you understand by the term *risk*? What do you think are the key features of its assessment?
2. Think about the last time you assessed risk either in your personal or professional life. What factors did you consider and why?
3. Is your approach to risk assessment clinical, actuarial or holistic?

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CHAPTER 5.4

# Welfare Rights Practice

*Neil Bateman*

Social care and social work are concerned with the protection and empowerment of people who have less power within society. And in a society which has great economic inequalities, a high potential for vulnerability and disempowerment inevitably accompanies life on a very low income. Welfare rights practice is one way of empowering and protecting people living in poverty. It is the area of social care activity which involves the worker taking on the role of adviser and advocate on social security, debt and/or housing rights issues on behalf of service users. It involves social care workers acting in a different but complementary way compared to their other roles. In addition, specialist welfare rights caseworkers may be employed to undertake welfare rights work.

Many welfare rights specialists may not have a social work background though they may be employed within social care organizations as well as by advice agencies, social landlords and the voluntary sector. They will have a specific role to act either as front-line advisers or as second-tier advisers providing training, consultancy and advocacy in complex cases as well as running initiatives to improve take-up of benefits by groups of people on low incomes. Such specialists may also have expertise in other areas of social welfare law – for example, housing, employment, immigration or community care.

The welfare rights movement's history can be traced back through the history of formal welfare systems and there are examples of advocacy on behalf of paupers under the old English Poor Law. It was also a feature of the work of the Unemployed Workers Movement in the 1920s and 1930s and was a major part of the US Civil Rights Movement because of the blatant misuse of welfare rules by officials in the southern states of the United States against the predominantly African-American

*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

black impoverished populace. Indeed, the name 'Welfare Rights' was developed in the United States during this era, the word 'welfare' referring to the patchwork of state administered, discretionary, means-tested income maintenance for the poorest people which still exists in the United States.

In the United Kingdom, there was a growth in welfare rights activities during the late 1960s and 1970s in which social workers and allied professionals played a key role. This development reflected the growing awareness of poverty. The 1980s saw a significant growth in welfare rights services, frequently located alongside social care services and was a response to the huge changes in inequality and joblessness of that era – unemployment rose from 1.07 million in May 1979 to over 3 million in May 1985 remaining above 2 million until November 1996 (sourced at www.nomis.co.uk, accessed 12 October, 2012). At the same time there were successive reductions in the real value of social security benefits, so welfare rights activity became not only a practical social care response to the growth of poverty but a way of challenging restrictions on entitlement and of highlighting the consequences of government policy.

Since 1997, there has been a decline in the number of welfare rights services – the combined effect of political antipathy towards welfare rights values and successive cuts in resourcing.

Throughout history, a major driver behind welfare rights activity has been the experience of people on benefit and of those working on their behalf that welfare officials either deliberately or negligently apply the rules and deny access to legally guaranteed benefits. This is still often the perception today and provides a strong rationale for the existence of welfare rights advocacy. Welfare rights advice and advocacy also acts as an important safeguard of constitutional rights for some of the most socially excluded members of a modern society who may not have ready access to formal channels of legal assistance to enforce such rights.

## Social Work, Poverty and Welfare Rights

Most people who use the social care services are poor and there is clear evidence that poverty either causes or contributes to the issues handled by social care workers; for example, there are clear links between poverty and ill health (see www.poverty.org.uk); poor people experience a higher rate of family breakdown (see Yeandle *et al*., 2003); and there are a disproportionate number of children from the poorest households in public care (see Becker, 1997). A more detailed discussion is contained in Bateman (2005). Changes to the benefits system are predicted to significantly increase poverty, particularly among people with disability and families with children. Work does not provide a guaranteed route out of poverty in the United Kingdom. Almost two-thirds (62 per cent) of children growing up in poverty live in a household where at least one member works (www.cpag.org.uk/poverty-facts/index.htm, accessed 21 October, 2012).

And yet the relationship between social work and welfare rights practice has not always been an easy one and this is despite the nineteenth-century roots of British social work in the Charity Organisation Society which reflected a concern for the effects of poverty on people and a desire to respond to it.

Two things have restricted the development of welfare rights practice in social work settings:

- the adversarialism implied in the role of an advocate may not rest comfortably with many social care organizations' expectations of their staff;
- the view that social work is about things other than money and that there is neither the time nor the skill to do welfare rights work.

This is despite the strong practical arguments for social care staff to be engaged in welfare rights practice and the urgings of much practice guidance – for example, in the Mental Health Act 1983 Code of Guidance, the *Framework for Assessment of Children in Need* (Department of Health, 2000), the *Fairer Charging Policies for Home Care Practice Guidance* (Department of Health, 2002) and the *National Service Framework for Children and Young People* (Department of Health, 2005).

In trying to understand the ambiguous relationship between social work, welfare rights work and poverty, writers have drawn similar conclusions. Becker (1997), for example, stated that

> many social workers have distanced themselves traditionally from the material and cash problems of their clients, which if they are acknowledged at all, are seen as the proper responsibility of other agencies, particularly the social security bureaucracies, or other specialists such as welfare rights advisers. While many social work users are claimants of social security, and many are also poor, this does not translate itself into prescriptions for social services policy or social work practice. (1997, p. 93)

Becker further considers the focus of much social work practice:

> social services and social workers have largely managed poor families with children by defining them as dysfunctional families requiring individual or family treatment, rather than confronting and engaging with poverty as a structural and political issue. The social work 'mission' has centred on helping individuals to function more effectively in their social environment. (1997, p. 103)

In her study of social workers' attitudes, Dowling (1999) found that, although they appeared to be aware of poverty in theory and acknowledged it as an indisputable part of service users' lives, in practice they found it difficult to translate that awareness into action. And Green (2000), when discussing the importance of poverty for social work practice, says that 'at the individual level, social workers appear to be suffering from collective amnesia as to why most of us came into the social work profession in the first place'.

The role of the social care worker as welfare rights adviser and advocate has been shaped by the international history of social work. In the United States, for example, state employed social workers are frequently engaged in aspects of income maintenance and the policing of welfare expenditure. Consequently much of the welfare rights activity in the United States has developed among voluntary organizations and among private attorneys funded through contingency fees. Social work practice in Sweden and some other European countries is often linked to income

maintenance and generous income maintenance to behavioural expectations. This can compromise the social care worker's role as advocate on social security issues – even though effective operational protocols can reduce such conflict.

In the United Kingdom the drift towards social care organizations becoming income maintenance bodies because of gaps in the social security system or deliberate policy changes nationally has implications for the role of social care workers as welfare rights advocates. For example, the active involvement of social care services in providing income maintenance to care leavers and young people looked after under the Children Act, to people cut off from the benefits system because of their immigration status and the localization of the Social Fund as a result of the Welfare Reform Act 2012 all have major implications for both the nature of care services and welfare rights practice.

## Social Work and Advocacy

No work to empower disempowered people can be taken seriously unless its proponents are prepared to be advocates. Advocacy has a long history in the affections of social work, but there are signs that managerialism and the workers' feelings of being under siege have encouraged people to avoid welfare rights work and the associated role of advocate. The use of eligibility criteria and the extension of charges for care services both act to marginalize the welfare rights and advocacy perspective. Indeed, social care practitioners are now themselves increasingly likely to be on the receiving end of advocacy – particularly given the development of litigation about local authority duties to provide community care and child care services.

The General Social Care Council's Code of Practice for Social Care Workers requires care professionals to 'protect the rights and promote the interests of service users and carers . . . promote the independence of service users and carers . . . respect the rights of service users' (General Social Care Council, 2010, p. 5). This requirement implicitly places advocacy at the heart of the social care worker's ethical obligations. The advocacy role can extend to that of whistle-blower and has been given some statutory protection by employment legislation.

In a classic social work textbook, Davies (1994) states that 'strategies of change in social work might sometimes need to be directed, not at the client, but at dysfunctional elements in the client's environment' (p. 90). He goes on to describe two forms of advocacy in social work: personal advocacy and structural advocacy. Personal advocacy, he says, focuses on the individual's need and structural advocacy on a community or group. 'In either case, the assumption is that the social worker has skills and qualities or access to resources that are likely to tip the balance in the favour of those whose interests would otherwise be overlooked or over-ridden' (p. 90).

The most common and successful form of advocacy in social work will be welfare rights work where the effects of a lack of an adequate income, often as a result of official error or interpretation, become pressing concerns in the lives of social work consumers.

### 14 The ethics of advocacy

Because advocacy is always concerned with securing the best outcome for the service user, it involves a strong ethical emphasis on principles for practice. The advocate must always:

- act in the service user's best interests;
- act in accordance with their wishes and instructions;
- keep them properly informed;
- carry out instructions with diligence and competence (recognizing the limits of their knowledge and competence);
- act impartially and offer frank, independent advice; and
- maintain client confidentiality.

## Welfare Reform

One of the stated aims of successive pieces of legislation has been to reduce the number of people eligible for benefits. Ostensibly, this is partly to make it easier for people to enter paid employment. The problem with this is that the United Kingdom has high levels of structural unemployment caused by economic changes in the 1980s and 1990s – essentially the loss of millions of unskilled jobs which have not been replaced by similar jobs. These changes have led to an increased demand for skilled labour and in areas where unemployment has generally been lower. The United Kingdom's Welfare Reform strategy has been predicted on 'supply side' economic models (i.e. increasing the supply of low-wage and casual labour), rather than 'demand side' measures (for example, active job creation).

The Welfare Reform Act 2012 significantly intensifies conditionality for people to receive benefits and this is reinforced by an arsenal of sanctions and penalties which benefit officials can use to police and punish benefit claimants. These measures create significant hardship and the resulting financial stress can necessitate social work intervention. Social work professionals are thus having to challenge excesses and misuses of the sanctions and penalties.

Public antipathy towards perceived benefit 'scroungers' and the 'work-shy' has increased, encouraged by all the main political parties and by repeated negative and misleading media coverage emanating from the Department for Work and Pensions' Press Office. This has made it more difficult for social work professionals to secure funding from local authorities for welfare rights services.

## The Importance of Welfare Rights Work

Many arguments can be made for the case that social care workers should be engaged in welfare rights work:

- It is a practical response to the poverty of service users who will have money problems which need resolving so that they can survive in society or engage with interventions to change their lives or behaviour.
- It eases the hardship which poverty causes and the consequent damage which creates a need for social work intervention.
- The additional income helps service users to lead more independent lives.
- The long-standing problems of poor levels of benefit take-up, poor standards of decision-making on benefit entitlement and the lack of widespread independent advice on benefits produces a clear need.
- It builds a rapport with service users who will not be interested in nor respectful of the view that welfare rights are not a part of the social care worker's role. Indeed, there is some empirical evidence to show that providing practical support with benefits and housing is viewed as being a key social work quality by service users (Beresford, 2012).
- The problem solving inherent in welfare rights work can be incorporated into task-centred casework methods.
- The alarmingly high error rate by the Department for Work and Pensions and other welfare bureaucracies means that one can neither rely on them as a source of consistent help and advice for consumers nor assume that people have been paid the correct amount of benefit.
- The need to sort out an external agency problem inherent in welfare rights work can put practitioner and service user on an equal footing – which complements empowering approaches to social work practice.
- The emphasis on rights to welfare reduces the potential for value-based or discriminatory practice which may spread beyond financial problems, thus improving practice standards.
- An increase in income from benefits advice has proven positive effects on health and well-being, and higher levels of means-tested benefits increase babies' birth weights.
- Disability-related benefits are likely to be used by service users to buy in additional care. For example, it has been estimated that the care component of disability living allowance to people on low incomes adds the equivalent of more than 25 per cent to community care budgets (Noble *et al.*, 1997).
- The almost universal existence of charges for community care services means that service users whose income has been maximized are not only more likely to pay such charges, but the charge formulae frequently create additional revenue for social care services when service users receive particular benefits.
- It reduces unnecessary expenditure – for example, the creative use of the benefits system to subsidize supported housing, as an alternative to payments under the Children Act to destitute families, or to supplement payments to foster parents.
- An improved income reduces family stress.
- It increases the supply of money within low-income communities, thus aiding their social and economic regeneration.
- If properly supported and resourced, many social care workers find this an enjoyable area of work which contrasts with their other roles as social controllers and gatekeepers of services.

- Social care workers work with some very marginalized people, who may be unable to access or sustain contact with mainstream welfare rights advice services.

An important summary of the need for and effectiveness of welfare rights practice can be found in Wiggan and Talbot (2006).

Welfare rights work ranges from simple form-filling through to complex legal argument and litigation. It is an ever-changing subject with numerous amendments to social security legislation each year. For example, the National Audit Office (2005) has observed that between 2000 and 2004 there were six Acts of Parliament and 364 Statutory Instruments affecting social security law. The period since has been little different.

A frequent response to such problems is to declare that the social work task does not extend to welfare rights work, but this response is not sustainable: because most social work customers are poor, they will require welfare rights help in some form, and unresolved money problems exacerbate and create other problems. Furthermore, an approach based on expecting external agencies to undertake welfare rights work (especially front-line advice services) frequently fails to meet the needs of the most marginalized and socially excluded people – the very people who are more likely to be the consumers of social work services.

It is possible to identify an appropriate level of competence in welfare rights practice for busy social care workers undertaking emotionally demanding work and which ensures that more complex issues are passed onto experts – indeed, one needs a reasonable level of knowledge in order to be able to identify when skilled help is necessary and a frequent complaint by welfare rights advisers is that all too often, even simple welfare rights problems which are having a detrimental effect on service users are not identified by social care workers and/or not referred on. All too often they only reach the specialist when they have become even more complex and time-consuming to resolve.

The nature of social care assessment lends itself to incorporating a welfare rights check. During an assessment, one is working at the service user's pace to build an all-round picture of social care needs. The process often involves gathering detailed information and evidence about material circumstances, ill health or disability. It is easy to translate such information into a check on benefit entitlement – indeed, a typical community care assessment essentially collects much of the same evidence as is needed for a disability-related benefit claim.

The key to empowering social care workers to act confidently as welfare rights advisers and advocates is ready access to high-quality training, back-up and support. The back-up must be available *within* the organization, and many social care agencies have developed in-house welfare rights services to do this; some specialist provision is essential (see Levy and Payne, 2006).

It is essential for there to be consistent messages from senior managers about the importance of welfare rights work and a commitment from them that social work includes advocacy. In this way the apparent complexity and time-consuming nature of welfare rights practice is made manageable.

The specialist back-up service should provide training and consultancy support and a protocol for taking on the more complex cases; access to standard welfare

rights textbooks and other written guidance is essential. Social care workers can then integrate welfare rights work with their practice, advise competently on benefit entitlement for service users, assist with the claiming process, deal with problems arising out of it and challenge wrongful and dubious refusals of benefit in the more straightforward cases.

## Some Examples of Welfare Rights Practice

Welfare rights practice can involve work on behalf of both groups and individuals. At its best, it involves a strategic response to the issues raised in individual cases. A suitable level of competence for social care practitioners would be:

- Identifying benefit entitlement in common situations.
- Helping people through the claims process, providing supporting evidence and resolving common problems which can arise.
- Acting as an advocate to resolve common problems and successfully challenging straightforward benefit refusals.
- Helping to challenge benefit sanctions, particularly where benefit officials have not taken account of mental-health-, family- or learning-related issues.
- Protecting clients from burdensome or inappropriate questioning or investigation by benefit officials.
- Attempting to modify negative or stereotyped attitudes among benefit officials that they deal with.
- Supporting vulnerable service users through appeals, with representation being done by a welfare rights specialist. (Bateman, 2005, p. 61)

Here are some examples to illustrate the competences:

- Completing an *attendance allowance* application form for an older person, gathering supporting evidence for the claim and writing a supporting letter highlighting areas of strong entitlement. When the benefit is awarded, ensuring that the higher levels of means-tested benefits payable to people on attendance allowance were put into payment and backdated.
- Advising a parent with a child who has severe behavioural problems that they would be entitled to a *disability living allowance* and assisting with completing the claim form and providing a letter illustrating the child's need for additional supervision; chasing up the Department for Work and Pensions if the claim is delayed; drafting a letter seeking a review if it is refused; and referring to the in-house welfare rights service to represent at appeal tribunal if this was not successful.
- Preparing a financial statement to persuade *creditors* that a service user is unable to pay unsecured debts and to obtain repayment of secured debts at an affordable rate. Seeking help if this is not successful.
- Advocating on behalf of a service user with a *learning disability* that they did not need someone to be an appointee who would therefore control their benefits.

- Challenging a housing official who did not take a *homelessness* application from a homeless person but instead offered advice about where to look for accommodation.
- Drafting a letter of appeal about a *benefit overpayment, sanction or refusal* with help from a welfare rights adviser over the phone.
- With support from a welfare rights service, undertaking a trawl of pupils in a *special school* to maximize benefit take-up by their parents.

An example of the knowledge and skills needed for welfare rights practice, including those appropriate for the type of welfare rights work undertaken by social care workers, has been published by the Scottish Executive as part of the suggested competences for Type I advisers in the *Scottish National Standards for Information and Advice Services*. It is available from www.communitiesscotland.gov.uk.

## Knowledge and Skills for Advocacy and Welfare Rights Practice

A range of specific skills is needed for effective welfare rights work (Bateman, 2000 and 2005), including many which are used elsewhere in social work practice. They can be summarized as:

- Interviewing skills – especially in gathering relevant facts and evidence to support a case.
- Recording and report writing – especially important for any advocacy involving correspondence or in putting together a comprehensive and coherent argument in support of the service user.
- Skills in persuasion and assertiveness.
- Skills in negotiation – especially relevant where the law does not strongly support a service user's case.
- The range of skills associated with self-management and the effective use of one's time.
- Legal research skills and the ability to get a good grasp of the relevant and most favourable legal points in the service user's favour.
- Having a sufficient knowledge of social security law for the type of work being undertaken.
- Skills in litigation – in other words the ability to represent somebody at a hearing.

Central to being able to undertake welfare rights work as a social care worker is a good grasp of the relevant legal framework of social security. As the level of expertise in welfare rights work is a continuum, there clearly has to be a cut-off point for the degree of knowledge required, but practice shows that it is not an impossible task to equip social care workers with the correct level of knowledge and skill in order to meet an appropriate level of competency – particularly if there is easy access to an in-house welfare rights support service.

## Conclusion

Welfare rights practice is a combination of skills and knowledge which social care workers should include in their tool kit. It is a practical and empowering response to poverty which itself has major implications for social work and care practice. Welfare rights practice involves advocacy skills but it can be effectively carried out by busy practitioners provided the level of competence required of them is clear and if satisfactory support systems are in place.

For more information on welfare rights, visit:

- www.neilbateman.co.uk
- www.rightsnet.org.uk
- www.cpag.org.uk
- www.ageuk.org.uk
- www.disabilityrightsuk.org
- www.thesite.org/homelawandmoney/money/benefitsandtax
- www.carersuk.org.uk

For online benefit claim forms and 'official version' information:

- www.gov.uk/browse/benefits

### Five Key Points

1. Poverty has a major negative effect on many aspects of peoples' lives and it both creates and exacerbates the need for social care services.
2. Welfare rights work is a practical and effective response to individual poverty.
3. Welfare rights practice is a valid part of social work.
4. Good back-up is essential to provide and support the knowledge base required by practitioners and to enable them to act as effective advocates.
5. Social care workers often have an ambivalent response to poverty and to welfare rights practice.

### Three Questions

1. What are the implications of poverty for social care practice and service users?
2. What is an appropriate level of competence in welfare rights for social care workers?
3. What can employing organizations do to empower their staff to become effective welfare rights advocates?

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CHAPTER 5.5

# Interviewing and Relationship Skills

*Janet Seden*

While practice environments for social work are continually subject to change (Dickens, 2011), it is not difficult to argue that the principal areas of theory and skills that social workers use are clearly identifiable, if developing (Trevithick, 2009; Lishman, 2010). Key themes persist even though they are constantly reworked in new political climates and in evolving social and cultural contexts (Dickens, 2011; Seden et al., 2011). This chapter considers the skills that are needed for the human processes of social work, namely communication, interviewing, relationship and counselling skills. Social work in the early twenty-first century has been affected by managerialism and bureaucratization. Business models have permeated the organization of the personal social services (Harris, 2007; Harris and White, 2009). Social work and care professionals are working in contexts where target cultures and the drive for efficiency, economy and effectiveness in the management of resources have profoundly affected their work. Middle managers have arguably been the most affected by these changes and have grappled with the requirements of New Public Management and passed them on to the workforce, across a range of care settings (Dent et al., 2004).

However, there have also been voices arguing for the prioritizing of relationships with service users. It can even be argued that 'in a time of financial crisis the social worker's only sure contribution to the well-being of others is the self, their personal qualities and their skills in relationship and advocacy' (Seden, 2011, p. 56). People who use services continue to report that they value supportive and caring delivery as well as ethical and informed practices. Prior, Lynch and Glaser (1999) studied the views and perceptions of children and carers involved in social work intervention in relation to sexual abuse. They found that the participants in their study,

*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

despite some concerns, perceived social workers as helpful. When this was explored further, the carers and children most valued social workers who provided emotional support, reassurance, information, explanation, well-coordinated services and also helped them to find counselling or therapy. When asked, service users consistently identify that the best services are delivered by social workers with high levels of personal skill. Middleton (1998) shows that parents of disabled children value social workers who are proactive in arranging services and offer supportive counselling, advice and listening. While this chapter is not the place to pursue the theme of the political contexts for social work, this discussion is included to outline how a tension between managerialist extremes and a desire to deliver a humane process is the interface where social work operates. Practitioners aiming to put people at the centre of their practice can find themselves contesting for the space and resources to do so.

Good skills in working with people are at the heart of best practice: this is the essential component underpinning all social work processes (Seden, 2005, 2011). Additionally, it is important to learn skills and to keep developing them from feedback and experience in practice, to develop self-awareness and to be able to make sure that skills are used relevantly in context. The impact of self on other and others on self is a critical component of sensitive practice (Howe, 2009). It is essential to be clear about power differentials between professionals and others and to take account of the impact of culture, gender and other socially constructed factors. A capacity for critical reflective practice (Fook, 2007; Cooper, 2011) enables the social worker to appraise which skills are potentially most useful in approaching any particular person(s) and/or task. As Cooper suggests:

> It is a critical and reflexive attitude that regards continuing professional development as an opportunity for lifelong challenge and growth . . . there is no argument that the nature of social work is such that communication and engagement, through relationships with individuals and their families in the uniqueness of their cultures and communities, is the means through which the work happens. (2011, p. 21)

Cooper also considers that this kind of process is now under threat from bureaucratically driven procedures and the reduction of time that practitioners spend with people (see also Trevithick, 2005, p. 137). However, in a climate where resources are short, the practitioner's use of self and their ability to sustain conscious and self-aware human processes becomes increasingly critical as the means of working towards the well-being of others.

## Communication

Human beings communicate through a variety of means: speech, tears, laughter, body language, art, writing, email, twitter, phone calls. Much of the time we may not give our means of communication too much thought. However, professional practice requires that communication is used in a way that is fit for the purpose. It is central to practice and is, as Thompson says, 'not just the simple mechanical matter of passing information from one person to one or more others, but rather

is a complex multilevel event' (2011, p. 13). Most social and care work, whatever the legal, political and organizational drivers, is made up of day-to-day exchanges with individuals and their families. It is through effective skills in these personal transactions, whether in a care home or someone's home or an office interview, that effective work is undertaken with marginalized, vulnerable or disadvantaged individuals and groups. There are also key organizational aspects to communication (Brody, 1993; Handy, 1999) which are not considered here as the focus is on intrapersonal skills and transactions.

Communication involves the transmission and reception of messages, but also conveys values and attitudes about the relationship(s) between the people concerned – the possibility of connection or disconnection, and subtle or unsubtle messages about power, role, perception. It is a process, where messages and multilayered meanings are exchanged. In many communications only some of what the communicator intended is received by the other and the possibility of miscommunication and misunderstanding is always present. In social work settings communication is not neutral; it has a defined professional purpose, and therefore practitioners cannot leave the means and content of communication to chance.

To communicate, in social work practice in an ethical and effective way, it is necessary to make flexible and appropriate use of communication and counselling skills such as:

- attention giving, active listening, non-critical acceptance;
- paraphrasing, reflecting back, summarizing, checking;
- the ability to use different kinds of questions, to minimally prompt and to find alternatives to questions for exploring areas of conversation;
- empathic understanding, immediacy and linking;
- challenging, confronting, work with defences;
- goal setting, problem solving, focusing techniques;
- understanding own and others' body language;
- avoidance of judging, patronizing or moralizing comments;
- boundary awareness, the ability to say difficult things constructively;
- the ability to offer feedback, techniques for defusing hostility and for avoiding hostility, assertiveness.

These kinds of skills and how to use them are explored in a range of literature on counselling and interviewing (Egan, 1990; Corey, 1997; Heron, 1997; Seden, 2005; McLeod, 2009). Additionally social workers need to be able to communicate effectively with people with learning disabilities and a range of physical impairments. They need the ability to communicate across the lifespan with children, young people and adults in all age ranges, including those with mental health issues, such as psychosis or dementia. They will encounter people with whom they don't share a common language and need interpreters. Each service user the practitioner meets may challenge them to refresh and refine their skills, to know when to ask for help from another practitioner who is more skilled, but not to opt out from doing their best through failing to recognize and minimize any barriers to communication. Positively responding to and interacting with a diversity of people is, for many practitioners, one of the most rewarding aspects of their job.

Social work is based on the 'minutiae of interactions between helper and helped' (Coulshed, 1991, p. 44). Poor communication has been cited as a problem in inquiries into the failures of practice. A critical example is found in the Laming report (2003) where miscommunication between agencies and repeated failures to engage with and understand Victoria Climbié's plight contributed to her death. Miscommunication and misunderstanding is the source of many difficulties. The mode of communication needs careful thought, especially where hostility or other strong feelings may affect what is transmitted and/or received. Really careful listening is critical to ascertain what the other is feeling and thinking. It is always useful to summarize in order to check out that you have understood. Text messages and phone calls may be enough for arranging informal meetings but formal meetings require confirmation in writing. Court dates and other important events need written communication and many items of a sensitive nature require carefully planned face-to-face interviews, especially where a vulnerable child or adult is a cause for concern. The practitioner is required to bear in mind the need for ethical sharing of information and the requirements of data protection legislation. Thus the practitioner has to weigh carefully the best means of communication for the particular piece of practice under consideration and achieve the best outcomes through the use of skilfully chosen communication and actions.

## Interviewing

Interviews in social work usually have a precise purpose (for example, to prepare a report for court or tribunal; assessments; discussion of personal issues). Such interviews need to be both planned and structured. Often the interview will be a combination of elements such as seeking and giving information, and supportive and/or therapeutic aspects where feelings and issues relating to the social work involvement with the person(s) can be explored. If much information is required and time is short, it is best to be honest about the need to ask questions and to maintain a clear focus in order to move on to provide a service – for example, benefits-related work. On the other hand, the skilled practitioner can design an interview and carry it out in such a way that it seems more like a 'conversation with a purpose', as described by Hugman (1997), who argues for acting naturally.

Interviewing is structured communication for a purpose, usually with an individual or sometimes with a family or group. The first important consideration is to decide where the meeting should take place; care needs to be taken that physical arrangements are suitable so that the interviewee is not disenfranchised and disempowered. Conversely, it can be difficult to interview in someone's home if distractions such as other family members, neighbours or television are present; often the office visit can provide welcome confidentiality and space for the service user. Consideration also has to be given to any need for another person's presence, for example an interpreter or signer. The first part of the interview is usually used to clarify the agenda and purpose of the meeting. It is helpful to consider issues of authority/power and the parameters of confidentiality at this stage so that the interviewee is able to judge the possible choices and outcomes that may arise. This enables them to be reassured about the confidentiality of the interview or to raise

questions if they are unhappy about where information might be shared (for example, with other professionals or family members).

Once these basic structures are in place, the interview can move on to the key issues, always leaving space for the interviewee to ask questions for clarification and for the interviewer to show their receptivity to the interviewee's opinions. It is important while maintaining a focus on the task in hand to listen for those times when it may be appropriate to change direction in response to what the interviewee is saying.

Egan (1986, 1990) suggests a model for interviewing:

- Stage one consists of relationship building and identifying mutual concerns.
- Stage two is concerned with exploration and identifying strengths and resources for problem solving.
- Stage three is concerned with looking at actions, costs and consequences of particular decisions and goal setting.

Egan's work has been very influential in interviewing in health and social care settings, but like any guidance provides a useful framework rather than a prescription.

Three other frameworks have proved particularly useful in social work. First, the strengths approach (de Jong and Kim Berg, 2008) shows how to interview in order to maximize the interviewee's own potential and problem-solving abilities. Second, motivational interviewing (Miller and Rollnick, 2002) has been found helpful in those agencies where behaviour change is high on the agenda, such as projects concerned with drug and alcohol misuse. Third, Heron (1997) provides detailed frameworks which can help with confrontation and change processes.

It is important to end interviews carefully, summarizing what has been discussed and checking that the interviewee shares your understanding of what will happen next. In social work it is useful to put a summary in writing afterwards or at the time. Interviews in social work are central to the process and the initial interview where a relationship with the agency is made for the first time can be critical. As Trevithick comments:

> The task of interviewing can be thought of as an intervention in its own right because of the opportunity it provides to gain a greater understanding of people and their situations . . . They help us to ensure that our work has a structure and a purpose, with clear objectives located within a meaningful value base. They are also useful when we encounter difficult or chaotic situations or complex and intractable problems. (2005, p. 188)

Interviews are also a means to building relationships.

## Relationships and Relationship-Based Work

The idea of the relationship as fundamental to social work stems from the earliest days of the profession (Perlman, 1957; Biestek, 1961; Hollis, 1964). Working

with the '*person in the situation*' was a predominant concept although, even then, there was a critique. Younghusband in the introduction to Biestek (1962), says, 'the task of social work as a precipitant and guide of social change is far more complex than the consideration of the individual alone would suggest' (Introduction). Subsequently other paradigms such as radical social work, empowerment and anti-oppressive practice have emphasized the necessity to combat the disadvantages in society such as poverty, racism or ageism which impact on the lives of the people who come into contact with social workers (Braye and Preston-Shoot, 1995). The notion of working mainly within the relationship between worker and client is something that has remained paramount in counselling (Jacobs, 1993), while social work has emphasized more political activity, concerned as much with societal as individual factors. Nonetheless, the oppressive impact of some bureaucratization and managerialist approaches and the rise of service-user-led movements have reminded social work of the need to keep the humanness of respectful relationships at the centre of practice. A holistic approach builds a working relationship while also recognizing the impact of discrimination and disadvantage.

Relationship-based work has been kept on the agenda by the counselling literature but also in social work writing (Howe, 2009; Ruch, Turney and Ward, 2010; Hennesey, 2011). Howe argues that, 'one of the major skills of social work is to recognize and understand what goes on when practitioner and service user meet' (2009, pp. 159–160). He suggests that social workers need to understand a therapeutic sequence where the social worker is committed:

(i) to be warm and friendly, accept and acknowledge, listen to understand, communicate and collaborate, be honest and reliable, and only then
(ii) to explore, reflect, analyze, assess, formulate, challenge, criticize, plan, prod, support, encourage, treat, seek meaning and find solutions. (Howe, 2009, p. 160)

Relationship is the context for work which may lead to change; a basis is laid down within which the service user can express their views and choices. The theory for relationship-based work is drawn mainly from psychodynamic and attachment theories and also from the person-centred humanistic approach (Rogers, 1951). Ruch, Turney and Ward explore the complexities of relationship-based work in practice, particularly examining psychodynamic systems and attachment issues. They present illustrative case studies and argue for the need to rework theories in current contexts. They suggest that 'without the interest in and ability to work with human relationships, the social work task is diminished' (2007, p. 245).

All work requires good communication and counselling skills, but often it is the maintenance of relationships over time which leads to complexity. Issues arise: for example, hostility, the risk of being drawn unhelpfully into family systems, losing objectivity through familiarity or failing to keep professional boundaries in a way which protects everyone. It becomes more necessary then to understand some of the complexities of relationship building and work using the self – such as handling psychological defence mechanisms, strong feelings such as love and hate and the possibility of both negative and positive transferences occurring. In long-term pieces of work – perhaps work with children in care and their carers, or mental health

supportive work – social workers find themselves taking on a more in-depth relationship and often more supportive counselling roles.

## Counselling and Social Work: Some Differences

The British Association for Counselling and Psychotherapy (BACP) has defined counselling as follows:

> It takes place when a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps their dissatisfaction with life, or loss of a sense of direction and purpose. It is always at the request of the client as no one can properly be 'sent' for counselling.
>
> By listening attentively and patiently the counsellor can begin to perceive the difficulties from the client's point of view and can help them to see things more clearly, possibly from a different perspective. Counselling is a way of enabling choice or change or reducing confusion. It does not involve giving advice or directing a client to take a particular course of action. Counsellors do not judge or exploit their clients in any way. (www.bacp.co.uk, accessed 16 September, 2008)

This applies to a range of different therapeutic counselling approaches, underpinned by diverse theorizing about the human personality and society (McLeod, 2009). The three most influential approaches have been person-centred counselling, psychodynamic counselling and cognitive behavioural counselling. Counselling has tended to be a private activity between client and counsellor, with confidentiality staying between the parties involved except in very exceptional circumstances. By contrast, social workers' professional activities are embedded in government policy guidelines to which they are accountable. Social workers do make judgements and they give advice; they set agendas for change and influence external environments to achieve social justice:

> Social work 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 the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work. (International Association of Schools of Social Work and the International Federation of Social Workers, 2004)

Social work is a public and political activity where information is often shared with other professionals and complete confidentiality between individual and worker cannot be guaranteed. Social workers cannot consider someone's personal and psychological goals in isolation; they are involved in social action. Counsellors can usually select their clients and decide if they are suitable for the kind of counselling on offer; social workers can seldom do this. Additionally, the people they see might not want a social worker and be ambivalent, reluctant or hostile to the idea of state intervention in their lives. Some actions social workers take – particularly in mental health, criminal justice, child care and asylum seeking – have profound implications

for people's lives and liberties. Social workers have less choice than counsellors about the methods they use and with whom they work. Even where counsellors and social workers can agree on their theories, methods and values, their roles give them different kinds of responsibilities. However, the issues that lead people to become users of social work services and the compulsory nature of some of the work means that social workers often meet people who might benefit from an in-depth counselling approach.

## Counselling and Social Work: Some Similarities

The first social workers were trained from a literature and a methodology very close to counselling training, emphasizing relationship and psychodynamic models. Over the years social work has drawn from other sources of knowledge, especially sociology and social policy, actively prioritizing advocacy, empowerment and combating disadvantage. The result is a body of knowledge directly applied to the aims of social work, as exemplified in this volume. There has been increasing preoccupation with the means to deliver services – for example, through markets, commissioners and providers. This has led social workers to a more bureaucratic and directive kind of work in contrast to the more personal kind of assistance given by counsellors. However, social workers have remained concerned to relate well to people. Many social workers are motivated by the wish to 'care', 'help people' and 'make a difference'. They work from an ethics which shares many of the same principles as counselling ethics, such as ideas about human rights, service user voice and autonomy. Many social workers find the person-centred values of Carl Rogers useful even if they have to step in to safeguard someone through a compulsory intervention. Social work values include anti-discriminatory and anti-oppressive practice and counsellors have also become more aware of the potential for oppression in some approaches (McLeod, 2009). Counselling practice has been re-evaluated for its relevance to disadvantaged, ethnic and minority groups. Counsellors have re-examined ideologies, attitudes and values (Davies and Neale, 1996; Lago and Thompson, 1996). Increasingly both social work and counselling have sought to practise in a culturally competent manner and to use a research-informed evidence base.

There remains a creative synergy between the two disciplines. Social workers, like counsellors, draw from person-centred, psychodynamic and cognitive behavioural theorizing to understand people and create methods for practice. In the varied activities of social work it is impossible to function without engaging in some level of relationship and drawing from psychological as well as social theories about how to understand people and their lives. Social workers become involved with people needing support, protection from self or others, help to deal with disadvantage or injustice, or in fact any combination of life-changing events depending on the particular circumstances. Developmental understandings of human growth and life course which are used to help people receiving counselling about a crisis, change, transition or loss are equally useful in social work to support people (Seden and Katz, 2003). There is a common base of communication and relationship skills.

## Counselling and Social Work: The Relationship

Some practitioners have both social work and counselling training and experience. Sometimes the same service user may require social work and counselling interventions. Social workers do take supportive counselling roles within their statutory duties. Trotter, Cox and Crawford describe a social worker using counselling to support the father of a young offender. The father says:

> Prior to the counselling I was at my wits end as to how to cope with the situation my son and I found myself in regard to his offending, its effects on those around him, the grief it was causing . . . clearly these sessions could not be a cure-all but they offered tools that could and did assist . . . I believe many families would value this kind of assistance. (2002, p. 126)

Counsellors and social workers often work within the same organizations in teams or in partnership arrangements. While such blending of roles is possible, social workers often also make referrals to counselling services.

Differences in practice are not always clear cut. Motivation is sometimes created by the necessity of compulsion or containment and counselees who leave therapy because it is uncomfortable can prematurely terminate useful work. Counsellors who are employed in similar agencies to social workers – such as large health and care organizations – may find themselves equally challenged by the demands of business models which include contracting arrangements where the provider has to implement the purchaser's decisions and work to their performance indicators. Commissioning arrangements between health, social services and counsellors may mean that private counsellors, who used to be very self-determining with their clients about the nature of the work, will be subject to the scrutiny and wishes of purchasers. Counsellors in some settings may find that their managers ration the number of sessions any client may have.

Social workers may themselves commission counselling services and be accountable for the outcome. They therefore need to understand the differences between the various counselling therapies when they look for counselling for a particular service user. Sometimes therapists, using integrative models, combine different theories to underpin the counselling they offer. It can be difficult for the service user, especially if they are feeling stressed by their situation, to assess the usefulness of what is being offered. They may feel pressure to accept what is recommended by a professional. Some of the more subtle differences make it difficult to know what any particular kind of therapeutic counselling involves. If someone contemplating counselling is to be truly empowered to make a realistic choice about what suits them, they may need advice about what is involved.

## An Overlapping Future

Brearley (1991) traces the historical interaction between counselling and social work and outlines how the two activities influence each other in terms of skills, knowledge and values, while at the same time having distinct identities and training pathways.

She writes: 'A logical categorization of the counselling dimensions of social work would therefore be as follows:

- counselling skills underpinning the whole range of social work;
- counselling as a significant component of the work, carried out in conjunction with other approaches;
- counselling as a major explicit part of the job description.' (Brearley, 1991, p. 30)

This remains relevant, but increasingly multi-professional and inter-professional approaches to delivering services are being developed with social workers and counsellors in the same team. This creates a different set of issues: some social workers, for example, find themselves marginalized from the counselling role, as independent counsellors are commissioned to undertake therapeutic work. Valios (2000) describes someone who retrained from social work to counselling because of 'frustration with the way social work was going, it was increasingly about costs, budgets, and performance narrowly defined by managers and organisations' (www.communitycare.co.uk, accessed 5 January, 2006). Managerialism and business methods have alienated some social workers from their jobs. However, there may be benefits to clients from having counselling provided by an experienced independent counsellor focusing on therapeutic needs. There may also be issues for the purchasing agency if those counsellors are unaware of the legal and practice issues for social workers. The commissioner has to be clear about the counsellor's brief, in particular whether the session is completely confidential and independent, or whether there are limits or even expectations of feedback to the social worker: for example, if a child or adult discloses problems about contact with a carer or other matters relevant to social work. Many independent counsellors would not agree to disclose anything from individual sessions, while purchasers might expect the counsellor to have some allegiance to the funding authority. Such issues need to be clarified in each situation for co-work between social workers and counsellors to succeed. These issues may be easier to resolve when counsellors are employed in social work teams.

Counselling can be integrated into mainstream services effectively. Long describes a counselling service for parents and children within a local authority family centre:

> The service is now approaching the end of its second year and the managers are committed to provide a therapeutic service which aims to intervene with vulnerable families who are having difficulties. The managers see it as cost effective and efficient as well as preventative. The counselling service has now become an integral part of the family centre. (2000, p. 60)

As the organizational framework for social work changes and social workers and counsellors work together in multidisciplinary and multi-agency structures, they will need to appreciate the boundaries of each other's roles and to understand each other's contributions to the well-being of people using services.

## Conclusion

People continue to appreciate practitioners who think relationships matter, as research into service user views on what makes a good social worker shows. Children have said that they value five main qualities in practitioners: reliability, practical help, support, time to listen and respond, and seeing children's lives in the round (Department of Health, 2001). Service users want social workers to be good at practical parts of the role, but also to listen and build a relationship. In other words, they want them to be competent at their mandated role and carry it out using counselling-type skills (Seden, 2005). Thus social workers and counsellors hold much in common, as they communicate, interview and build relationships with a view to supporting the people they work with to achieve greater well-being.

The challenge for social work and counselling is to work in partnership when needed, with clarity about each other's roles and responsibilities so that the service user benefits.

### Five Key Points

1. Communication, interviewing, relationship and counselling skills are the bedrock of best practice.
2. Service users value relationship skills and supportive counselling from practitioners.
3. Counsellors and social workers share history, skills, knowledge and values.
4. Social workers can understand the different counselling approaches to help people find the best therapeutic help.
5. Changing organizational arrangements for delivering services shape the relationships between social work and counselling.

### Three Questions

1. What are the main skills needed to communicate, interview and build relationships in social work?
2. What are the main differences between social work and counselling roles?
3. What kinds of attributes and skills do service users value from social workers?

## Further Reading

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# CHAPTER 5.6

# Groupwork

*Mark Doel*

Groupwork is one of the four pillars of social work: individual, family, group and community work. It was central to the origins of social work in the nineteenth-century Settlements, when people would more likely come to the Settlement houses with others rather than individually, and collective action was the norm. Groupwork developed as a milieu for working with people through adult education and the recreation movement, where activities were seen not just as leisure but as part of a social process.

By the 1930s, groupwork was aligning with the developing profession of social work, certainly in the United States. The 1950s and 1960s witnessed the development of theories of group development and models for understanding group practice such as the social goals, reciprocal and remedial models (Papell and Rothman, 1966). In the United Kingdom in the 1970s, newly formed social services departments brought the various social work services together and there was a burgeoning of groupwork, particularly with young people, family services and mental health work. In some probation departments groupwork became the default method of practice.

Recent decades have seen a retreat from practice methods in general and groupwork in particular, as we shall explore later in this chapter. First we will consider what social groupwork is, and how and why it is practised.

## Group Process

When Reneith (the group leader) notices that Carol (a group member) has been quiet for much of the time and asks her how she feels about what is being discussed,

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she is attending to group process. When Jerome addresses the whole group with a reflection about what it seems to him is happening in the group, he too is attending to process. Group process is the awareness of what is happening in a group at the level of each of individual *and* with the group as a whole. This knowledge is then used to improve communication in the group so that the group can achieve its purposes. This is sometimes also referred to as group dynamics, most notably conceptualized by Kurt Lewin (1947).

In addition to the dynamics of communication and relationships in the group, process also refers to the phases and stages of groups. At its broadest, these are the beginnings, middles and endings, each of which have different characteristics, but some theorists detect other patterns and stages in groups, such as Tuckman's (1965) oft-quoted forming, storming, norming, performing and (added later) mourning. Group process is sometimes understood in terms of systems, such as the membership system and the leadership system. This can help explore group phenomena such as 'wheel and spoke', where one system (group members) communicates via another (the group leaders). If this communication pattern becomes entrenched, it limits the group's potential. A skilled groupworker actively changes group process by using methods that encourage member-to-member communication.

## Different Kinds of Group and Groupwork

There are many ways in which one group might differ from another. For instance, some groups are open-ended and others have an agreed time limit. Below are twelve dimensions which can be used to develop a profile of a particular group. Each group has its own position along each of the twelve continua (see Figure 5).

A group for survivors of child sexual abuse is likely to be small, closed and intimate. A group for older, confused people might be a little larger, open-ended and with an open membership. A group to campaign for open space and a play area near a big apartment block will aim for a broad, diverse membership and have an outward-looking focus.

Groups that are positioned towards different ends of these continua have a very different feel. For instance, a group that runs to a programme that has been tried and tested (such as *Parenting Plus* groups for parents experiencing difficulties with their children) sits at the *tight* end of line 11. These are sometimes referred to as manualized groups. A support group for homeless people with no fixed agenda or set routine sits at the *loose* end of this continuum, being largely non-directive. Members will experience each group quite differently. However, despite these variations, experienced groupworkers can work with very different groups because of their understanding of group process and their ability to use this understanding to help groups achieve their purposes, however different these purposes might be.

Another difference is the theoretical perspective or orientation that influences the choice of group methods. A psychodynamic groupworker might focus on intrapsychic forces, unconscious motivations and early conflicted childhood experiences, using group process to explore transference and counter-transference. A task-centred groupworker would lead the group through an exploration of problems to agreed goals, using group process to develop and rehearse tasks that help achieve

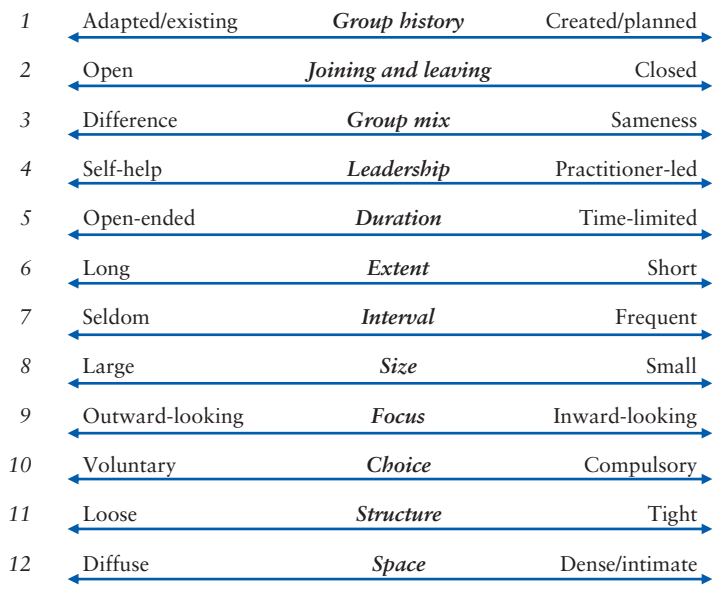


**Figure 5** Twelve dimensions to profile groups.
Source: Adapted from Doel and Sawdon (1999), pp. 73–74.

these goals and review progress. A self-help group might take a pragmatic, ad hoc approach, focusing on the group's emotional and practical support. All three groups would use group process to help achieve the group's purposes.

## Group Purpose, Function and Outcomes

Groups can have a wide range of purpose and function. One model considers seven types of function: consultative, educational, social action, social control, social support, task and therapeutic (Doel, 2006, pp. 23–24). These are not mutually exclusive, so that any one group might incorporate a number of these functions to a lesser or greater extent. The *Parenting Plus* group programme mentioned earlier has a primarily educational purpose, but could fulfil aspects of all the other functions.

Some groups have clearly expressed purposes with expected outcomes, others are organic, allowing purpose to clarify (or not) with the development of the group. The agencies that sponsor groups are less likely to tolerate those with organic purposes and there is often an assumption that groups must work to goals that are agreed before or at the start of the group, with disregard for the 'soft' outcomes that are frequently achieved. These are outcomes that are not identified in the planning and opening stages of the group but which emerge as a result of group process. Groupwork researchers and theorists should pay regard to this soft evidence, i.e. outcomes that were unintended and hard to measure, but are nevertheless beneficial (MacGowan, 2008; Preston-Shoot, 2004).

## Life Course of a Planned Group

### *Researching the need for a group*

Groups are created to respond to a need that is not otherwise being met. In some cases the need is self-evident and in others it might require some research. For instance, you become aware that there are a number of women with severe and enduring mental health problems in a particular neighbourhood: would they benefit from meeting together in a group and, if so, what kind of group?

### *Planning and offering the group (pre-group contact)*

Once a need has been established, detailed planning is required. What are the likely purposes of the group and what resources will be needed to meet these purposes? This includes groupworkers' time and practical issues such as venue, transport, equipment, refreshments and a possible budget for the group.

There is some evidence to suggest that offering the groupwork service to individuals prior to the planned first session is likely to increase the success of the group itself (Doel and Sawdon, 1999). It is a chance to share expectations and refine the group's purposes in the light of prospective members' ideas; it can give them the confidence to attend the first session of the group.

### *Leadership*

The nature, style and location of the group's leadership is critical. In some groups the social worker is the central person; in others internal leadership develops amongst group members; yet others are self-help, without any formal leadership. Leadership styles have classically been described as democratic, authoritarian and laissez-faire: since a central value of groupwork is strength through collective action, all leaders should be aiming to empower groups to become self-directing whenever this is possible (Mullender and Ward, 1991).

### *The first session*

The nature and purpose of the group should determine how structured each group session is. However, even in a loosely structured group, the first session benefits from careful planning. Tuning in to how group members are likely to be feeling as they turn up for the first meeting helps group leaders to plan an appropriate response (Shulman, 2009). Groupworkers should always be ready to change their plans and even discard them if the group process and purpose requires it. The aim is flexibility – not single-mindedness on the one hand, nor drift on the other.

Subgroups might be created (pairs, trios, etc.) to help build confidence amongst people who find it hard initially to contribute to the full group. In contrast, the leaders of a group for adolescents might focus on how best to avoid too severe subgrouping and harness the young people's energies to the group as a whole. There is no single template for the first session, only the need to plan carefully with the knowledge of the individuals who will be coming to the group.

## *What does the group do?*

The classic eight-strong group meets for an hour and a half for 8 to 12 weeks, sits in a circle or horseshoe, and relies on 'talk therapy'. But this is only one template amongst a huge variation of group shapes. Though discussion is still probably the most common medium used in groupwork, there is an enormous variety of activity in groupwork, sometimes called action techniques (Doel and Sawdon, 1999, p. 131):

*Spoken word* – such as discussion and role play

*Written word* – questionnaires, letters, etc.

*Graphic techniques* – flipchart drawings, artwork, dreams, spider diagrams and the like

*Hardware equipment* – using audio-vision, photography, computers

*Props* – any object or artefact can be used for group purpose, such as chairs, tokens, masks, even smells

*Physical* (sometimes referred to as kinesthetics) – such as dance, relaxation and numerous activities and games.

With such a range of activities to choose from, it is important to let group process and purpose guide the choice of activities and not vice versa. Group members should leave a group with feelings of belonging, acceptance and solidarity, not awed by the 'fireworks' let off by group leaders.

## *Documenting the group*

Agencies that regularly support groups might have their own pro formas for documenting the group; if not, groupworkers will need to develop their own recording materials and methods, perhaps in the shape of a group log that briefly captures group process and individuals' progress through the life of the group.

Group members should be involved as much as possible, so that the record belongs to the group, rather than deriving solely from the workers' observations of the group. There might be numerous documents, such as individual portfolios for each group member (a place where they keep their own work in the group and their reflections) and a group document, open to all, which contains things like flipchart sheets and artefacts used or made by the group as a whole.

## *Reviewing, ending and follow-up*

Groupworkers should make sure that the group has a regular opportunity to review both the process (how the group runs, what it feels like to be in this group) and outcome (what impact the group is having and what changes group members experience in their feelings, behaviours and beliefs). At the end of each session it is usual to have a 'round' (the French call it a *tour de table*) for immediate feedback. Some

groups might use a formal 'pre-test' and 'post-test' questionnaire to measure changes and the impact of the group.

Follow-up is frequently neglected. It is important that after an agreed time (perhaps six or so months), the group leaders contact group members (assuming they are no longer working with them) in order to find out whether the group has had a lasting effect. Most groups register immediate satisfaction (the so-called 'happy-clappy' effect), so it is important to establish whether this satisfaction is sustained and whether any changes have had a lasting impact.

## Life Course of Ongoing and Naturally Occurring Groups

In addition to groups that are created for a particular purpose and have a planned start and finish, there are many groups that are ongoing. These include most social, political and religious groups. Social workers might have some kind of involvement with ongoing groups such as pain management groups, Alzheimer's support groups and groups for young people who are in care ('accommodated') and leaving for independent living. Though their memberships are very different, all of these groups have the following characteristics in common.

### *Changing membership*

Ongoing groups experience changing membership. It is important, then, that these groups consider how new members are welcomed and included, and how the departures of existing members can be marked, depending on the nature of the exit.

### *Possible drift*

The initial purposes of an ongoing group might not suit the changing membership, so it is important that there are review points when the group can take stock and decide whether it wants to change direction – or perhaps it has inadvertently changed its direction.

### *Naturally occurring groups*

Groups are a natural part of human life and social workers engage with some of these kinds of group; for instance, street groups of children and young peoples' gangs (Lee, Lo and Wong, 1996). Social workers must find ways of gaining access to these existing groups, sometimes to try to dissolve them or re-divert them when they are destructive.

### *Self-help groups*

There are many examples of self-help groups, the most famous being Alcoholics Anonymous. Some created groups decide to continue beyond the departure of the professionals who created the group to become a self-help group.

### *Teams as groups*

A much-neglected topic is the team-as-a-group. If teams are conceptualized as ongoing groups it becomes possible to recognize the importance of group process in the team, leading to improvements in communication patterns and team function. Too often, problems in teams are the result of problems in the team dynamics and a failure to see the team as a group.

## Groupwork Now

Groups are central to human life, but formal groupwork is more unusual. The prevalence of social groupwork is hard to gauge but there is some evidence that groupwork is declining in mainstream social work practice (Ward, 2009) and that it has reduced in the social work education curriculum (Birnbaum and Auerbach, 1994; Simon and Kilbane, 2012). It seems that more groups are being facilitated by professionals other than social workers (for instance, occupational therapists) and there has been a tendency for 'casework in groups' (in which individuals are worked with in a group setting) rather than 'real' groupwork, in which group process is used actively with a focus on the group as a whole.

It is important to recognize group process in daily experiences, such as 'flash groups' that arise spontaneously (Doel and Kelly, in press). In this way, the connections can be made between everyday groupwork and professional groupwork.

### *New forms of groupwork*

The new technologies have had a striking impact on what it means to be *a group*. Video-conferencing and Skype allow groups to meet across great distances, and online discussion networks mean they can participate at different times. This challenges conventional views of what groupwork is. The implications of these new forms of groupwork are as yet unclear: can they truly replace the personal contact of people in the same room at the same time?

Whatever the prevalence or shape of contemporary groupwork, the power of groups is beyond dispute and the need for groupwork with social work service users is as strong as ever. The feeling of belonging and the collective strength of a group of people working and being together makes groupwork an ideal method and can turn the rhetoric of empowerment into a reality.

## Five Key Points

1. Groups are central to human experience. Social groupwork is just a specialized example of being together and acting collectively.
2. Groupwork is one of the four pillars of social work methods – individual casework, family work, groupwork and community work.
3. Groupwork is a broad term and can refer to the context of social work practice (in a group milieu) or to a conscious, skilled use of group process.
4. There are many different kinds of groupwork (cognitive behavioural, psychotherapeutic, etc.), and groups have many possible purposes. What makes this all 'groupwork' is the active use of group process and the group-as-a-whole.
5. The prevalence of groupwork is hard to determine, but it seems likely that it is not as widely used in social work as formerly. This reflects a general decline in the use of specific methods in social work practice.

## Three Questions

1. If you are not already using groups, would groupwork be a suitable method for the people that you work with and, if so, what would be the likely purposes of such a group?
2. Context is known to be significant to the success of groupwork, so how supportive of groupwork is the place where you work and how might you encourage the development of a groupwork service there?
3. Groupwork is a central part of human life, both at work and play. How can the group processes in everyday experiences, such as teamwork and inter-professional meetings, be recognized and used?

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CHAPTER 5.7

# Ethics

*Richard Hugman*

In recent years there has been a renewed and steadily growing interest in social work ethics (Congress, 1999; Clark, 2000; Reamer, 2001; Banks, 2006). Ethics is the branch of philosophy that considers the formation and operation of moral values. In other words, it is the explicit deliberation about what is good or bad and what is right or wrong. Social work attends to core aspects of our society, often focusing on people who are excluded, marginalized, disadvantaged or who lack access to the resources needed to resolve their own problems. Such people include children and their parents, people with disabilities, older people, people with mental health difficulties, people struggling with poverty and lack of access to social infrastructure such as reasonable housing, and so on. These are areas of our lives about which we all tend to hold strong and sometimes conflicting values. So how could ethics not always be at the forefront of our thinking about social work?

The main reason why interest in social work ethics can be said to have grown again is that in the 1950s and 1960s the influence of an individualist perspective on ethics tended to predominate. Indeed, I would argue that for a generation of social workers the writing of Biestek (1961) on the principles of casework was the main ethical point of reference. That Biestek's work is not primarily an ethical work as such, but is concerned with principles of a particular practice, is something that appears often to escape both his supporters and detractors. With the development in the 1970s of a greater awareness of the social structural, and hence political, roots of the problems which the service users of social work faced in their lives, questions of ethics (seen as the 'correct actions of individual practitioners') became supplanted by concerns with the politics of practice (for example, Bailey and Brake, 1975; Galper, 1975). The more recent 'return' to ethics as a focus of attention is coterminous with the rise of neo-liberalism in the political sphere that, among other

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things, has sought to delegitimize the overt political actions of professions. Social work, perhaps more than some other occupations, has responded by looking again at the ethical basis of its values, because ethics is something that cannot be said to be beyond the concern of professions.

A separation of ethics and politics would have made no sense to the early moral philosophers whose work continues to be foundational, either in the Western tradition of Socrates and Plato (around 400 BCE), or in the Eastern tradition of Confucius (around 500 BCE). For all these ancient thinkers ethics and politics were not separate but inherently bound together. Questions about the good person and the good society are two sides of the same coin. For example, we might imagine them asking how social workers who are unjust in their personal relationships can work effectively for social justice, or how just social workers cannot be concerned about social injustices around them. Thus ethics cannot be confined to questions of personal responsibility. Yet at the same time we must be concerned with personal responsibility – professionals exercise considerable power with respect to service users through their knowledge and skills and their access to resources. Failing to take account of this reality does not make it go away. Without a conscious engagement with ethics social workers are poorly equipped to deal with such responsibilities and to act accountably to service users or, indeed, to address issues of injustice, exclusion or disadvantage.

## Ethical Principles and Core Approaches

The ethics of social work is, in many ways, actually very similar to that of other caring professions. That is, whether or not social workers may consider themselves to have unique values, the formal statements of ethical principles of the profession are often either identical or very close to those of medicine, nursing, occupational therapy, physiotherapy, school teaching and so on (Hugman, 2005). This is because all such statements are derived from the same stock of concepts in moral philosophy and the wider values of the societies in which these professions have developed. Furthermore, although the formal ethical statements or codes of social workers in various countries differ from each other in detail (Banks, 2006), almost all of them share core characteristics. This is because the professionalization of social work globally has tended to follow a similar pattern, which reflects the emergence of contemporary professionalism as an aspect of modernized, industrialized, urbanized society.

There are two philosophical concepts in particular that underpin almost all social work ethics (and the ethics of other caring professions). The first of these is 'deontology'. This term is derived from the Greek word 'deon', meaning 'duty'. It refers to ways of understanding what is good and what is right by considering what duties each person has towards other people and the world around them. For example, it may be argued that all human beings should be treated with respect, simply because they are human beings and therefore are all moral entities. So in these terms 'telling a lie' is morally wrong because it treats another person as less than fully human, irrespective of the consequences of telling the truth. (The origins of deontology understood in this way is usually attributed to the work of Emmanuel Kant (1724–1804).)

In contrast to deontology, professional ethics in social work also embodies the principles of 'teleology'. This term also comes from a Greek word 'telos' meaning 'the end' and it is the approach that considers something to be good or right by looking at what follows from it. Thus some writers also refer to it as 'consequentialism'. So, for example, whether it is good or right to tell a lie will depend on what are the ends of doing so: the classic example is that of using a lie to protect someone from serious physical harm. Teleology often appears in social work ethics in the form of 'utilitarianism', which is a particular form of the approach. 'Utility' in this sense refers to the way in which something contributes to the greatest possible well-being for the greatest possible number of people. (The origins of utilitarianism are usually seen in the work of Jeremy Bentham (1748–1832) and J.S. Mill (1806–73).)

As these two approaches are inherently in conflict with each other, but both influence professional practice, they have tended to be moderated by taking core principles from them and combining these in a way that downplays their differences. This third approach is sometimes referred to as 'principlism' and is most highly developed in biomedical and health ethics (Beauchamp and Childress, 2001). The principles that appear in this approach are: respect for people; beneficence (seeking to do good); non-maleficence (seeking not to do harm); justice. As Beauchamp and Childress themselves, among others, have acknowledged, the bringing together of principles from different approaches still leaves it to professions and their individual members to make sense of how these ideas are constituted in practice and how to develop a shared sense of what is good and what is right.

## Ethics, Professionalism and Accountability

As I have already stated, the importance of ethics in a profession such as social work is that all professionals exercise power in relation to the users of their services. While the experience of a junior member of a profession may not always be experienced as 'powerful', the impact of all practice on service users can be said to be powerful in that it has the capacity to affect human lives in profound ways. Indeed, if it does not, we perhaps should ask what is the purpose of undertaking such work.

Power does not have to be overt or equated with force. It can take the form of influence or persuasion, for example. The power of a therapist or counsellor would often take such forms, as would the pronouncements of a community development worker. Because of the expertise that professionals are seen to have, their words 'carry weight' and this is often the most effective sort of power in contemporary society.

The sense of responsibility on which professional ethics is based comes from recognizing power while at the same time holding values that emphasize the moral (including the political) standing of service users as equal to that of professionals. The ethical documents of professions thus serve as guidance, which is sometimes quite firm, about the 'good' in practice. Moreover, they also constitute a declaration to the wider society, including service users, about what can be expected of the 'good' practitioner. On these two grounds, taken together, codes of ethics and similar statements can provide an explicit vehicle for accountability (Banks, 2004). In a society such as the United States the implications of a code of ethics may even

be seen as contractual, forming the basis by which service users can seek legal redress for actions that breach the terms of a code (Reamer, 2001). In many other countries codes of ethics provide a mechanism for redress that falls short of litigation but in which a professional body may hold practitioners to account for failures to conform to the terms of a code.

## Codes of Ethics

In the contemporary globalized world it is difficult to think of a profession that does not have a code of ethics. These are the formal statements that represent the values of the professional community. Some national associations, such as those in Australia and in the United Kingdom, state that the core values are: human dignity and worth; social justice; service to humanity; integrity; competence (Australian Association of Social Workers (AASW), 2002, p. 8; British Association of Social Workers (BASW), 2002, p. 2). To these, the national association in the United States adds 'the importance of human relationships' (National Association of Social Workers (NASW), 2008, p. 1).

In addition, codes usually – but not always – contain quite detailed guidance or instruction on how values and principles are to be interpreted in specific aspects of practice (Banks, 2006). For example, in the Australian Association of Social Workers *Code of Ethics (1999)*, each clause in the section on 'ethical practice' begins with or includes the phrase 'social workers will . . .' (AASW, 2002, pp. 11–21). Similar phrasing is used in the codes of the British Association of Social Workers (2002), the New Zealand/Aotearoa Association of Social Workers (1993) and the National Association of Social Workers (1999). Sometimes such statements are concrete, as in:

> 4.2.6 [. . .] (f) Social workers will protect clients' records, store them securely and, where applicable, retain them for any statutory period. (AASW, 2002, p. 17)

or:

> 1.04 [. . .] (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. (NASW, 1999, p. 4)

At other times the statements of codes can appear to be quite general or abstract:

> 4.1.6 [. . .] Social workers will: (a) Acknowledge the significance of culture in their practice, will recognise the diversity within and among cultures and will recognise the impact of their own ethnic and cultural identity. (BASW, 2002, p. 9)

or:

> 4.1.3 [. . .] (a) Social workers will provide a competent and humane service to clients, mindful of fulfilling their duty of care and observing the principles of natural justice. (AASW, 2002, p. 11)

Some codes, such as those of the AASW and NASW provide additional support for practitioners through discursive advice on the interpretation of the code in specific situations (AASW, 2002, pp. 22–24; NASW, 1999, pp. 1–2).

Furthermore, these instructions are given the force of requirements through their role in sanctions that can be exercised against individual practitioners. In some states of the United States and in some provinces of Canada someone who is held to have breached professional ethics may have their registration or licence removed. More recently registration has been introduced in the United Kingdom and in New Zealand giving ethics similar importance. In Australia, as yet, the sanction remains that of exclusion from the professional association.

The problem for individual practitioners is that many statements in codes of ethics may at times be open to interpretation, despite the guidance provided for individual application. Although an injunction to 'protect client's records' may be relatively easy to apply, a statement such as 'social workers will acknowledge the significance of culture in their practice' requires a greater degree of interpretation, while the injunction to 'provide a competent and humane service to clients, mindful of fulfilling their duty of care and observing the principles of natural justice' necessitates a sophisticated grasp of ethical concepts by a practitioner.

## The IFSW/IASSW Joint Statement on Ethical Principles

In 2004 the International Federation of Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW) approved a joint statement on ethical principles in social work that replaces previous ethical documents of the two bodies (IFSW/IASSW, 2004). As the global peak organizations for social work, this statement serves as the basis for national social work associations around the world in the formation of their codes or statements of ethics. The IFSW/IASSW document is not intended to form a blueprint, but rather to act as a guide and as a starting point.

Compared with the previous 'codes' of the two bodies, the 2004 *Statement of Principles* is simplified. It discusses in detail, but briefly, just two core values which are asserted as being core to professional social work: human rights and human dignity, and social justice. These values (which roughly map onto the twin approaches of deontology and teleology) are a reflection of the United Nations and related documents that are cited as the point of reference for social work internationally (such as the UN Declaration on Human Rights). This list is considerably shorter than those of the national associations cited earlier. Moreover, the implications of the values, and the broad principles that are derived from them, are spelled out succinctly. Human rights and dignity are seen in terms of self-determination, participation, treating each person as a whole and focusing on people's strengths. Social justice is considered to include challenging discrimination, recognizing diversity, seeking equity, challenging unjust policies and working in solidarity (IFSW/IASSW, 2004). Thus the international associations' document does not include the other principles to which national association documents may refer, such as service, inte¬grity or competence. It could be argued that these latter notions are themselves either explicable in relation to the foundational ideas of human rights and dignity or social justice, or else are to be understood as derived from a different approach

to ethics as a whole – integrity, for example, is perhaps more accurately seen as a virtue, which is an approach that has a very different dynamic to those of either deontology or utilitarianism.

The other point of interest about the IFSW/IASSW *Statement of Principles* is that the document is quite specifically not intended to be a 'code'. This task is left to national associations (who are required to have a code of ethics as part of the conditions of membership of IFSW, for example) (IFSW/IASSW, 2004). This approach recognizes that although there are some core values and principles in social work, such as human rights and social justice, it is appropriate that variations between countries are reflected in specific codes of ethics, for example embodying cultural differences. Nonetheless, the *Statement of Principles* does contain a brief list of short prescriptions of 'good social work', such as not using social work skills to support torture or terrorism, where these were seen to be helpful to defend the core values (personal communication). The point remains that this list is neither exhaustive nor is it enforceable at the local or individual levels of practice by either international organization.

## The Challenge of 'Different' Ethics in Diverse Societies

Although I have indicated that there are some similarities between the ancient ethical traditions of Eastern and Western societies, in the centuries since Confucius and Socrates a greater divergence has opened up. The dominant approaches in professional ethics that have been described, namely deontology, teleology and principlism, are Western. They reflect the impact of scientific thought and what is called 'modernization'. Thus the values expressed in the United Nations documents to which the IFSW/IASSW ethical statement refers, with their foundational principles of human rights and social justice, have been criticized as inherently Western in their outlook. In particular, the concept of 'rights' that exists in Eastern approaches to ethics is somewhat different to that of the West, especially in so far as Eastern ethics tends to prioritize the harmony of the family and the community over the interests of individuals (Wong, 2004). Similar observations may be made about the core values of indigenous societies, such as Aboriginal Australians or Native Americans, and about post-colonial communities such as traditional Muslim communities in Western countries. Thus some critics have argued that professional ethics as presented by the IFSW and IASSW are not international, but represent an imposition of values from one cultural perspective onto all others (Azmi, 1997).

It is also the case that the approaches of deontology, teleology and principlism do not represent all the possibilities in Western ethical thought. Recent ideas have included the 'ethics of care' (in which the nurturing of caring relationships is a primary value), ethics grounded in the intelligent use of emotions (in which 'compassion' is a primary value) or 'postmodern ethics' (in which, I would argue, an appeal to the Socratic idea of virtue is a very strong element) (Hugman, 2005). However, as Banks (2006) argues, although these approaches provide many useful ideas that can inform how principles may be operationalized in specific situations, they do not provide a firm foundation for the ethics of *a profession*. That is, where membership of an occupation is the one common factor between all social workers

(who may be from many different cultures, both men and women, with different identities and experiences) it is insufficient to rely on each individual person applying their own values. Service users should be able to expect something in common between practitioners, so that they can rely on knowing that social workers should protect the privacy of service users, should not exploit service users (for example, sexually or financially) and so on, rather than having to negotiate each of the aspects that are covered by a code of ethics.

Perhaps, then, the solution to diversity is to regard ethical statements, at both the national and international level, as living traditions in the manner of an ongoing conversation (Hugman, 2005). At any specific time there will be a written statement on ethics, probably in the form of a code, which applies to the professional community. But this is open to continual debate and reconsideration. The task for each social worker is to be prepared to take part in the conversation and to ensure that the ethical tradition of social work remains alive and continues to grow.

## Five Key Points

1. Ethics is the way we understand moral values, what is good and bad or right and wrong in our society.
2. Professional ethics is important because of the power that social workers can exercise in relation to service users.
3. The primary values of social work have been defined by the profession internationally as 'human rights and human dignity' and 'social justice'.
4. In many countries, social work associations have 'codes of ethics', which are often written as 'rules for good practice'.
5. Recognizing cultural diversity in beliefs and values creates a challenge for contemporary professional ethics.

## Three Questions

1. What do you consider to be the core values of social work?
2. Read your national social work code of ethics – how can you apply it in your everyday practice?
3. Can there be an effective, overarching code of professional ethics if all our values are grounded in different cultures and personal beliefs?

## Further Reading

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# CHAPTER 5.8

# The Law

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The body of law relevant to social work practice is constantly evolving, growing in size and complexity and can appear overwhelming. It provides powers and duties and a framework within which good social work practice is located. Although not always apparent, all social work activity has its roots in the law and law is inextricably bound to social work practice. Many of the chapters in this volume will, implicitly or explicitly, touch on the law relevant to the area of practice under discussion. The objective of this chapter is to consider the place of law in social work practice, why it is necessary to understand and locate law and how to apply law positively to practice. Elements of existing law applicable to practice with children and families and with adults illustrate the discussion.

Study of law has long been part of the qualifying framework for social workers. The precise formulation of the requirement to study law changed with the introduction of the Professional Capabilities Framework, (PCF) in 2012. The PCF has nine domains applicable to all roles and settings, effective throughout an individual's social work career. Knowledge, understanding and application of law feature significantly throughout the domains. For example, the 'Values and Ethics' domain (2) requires social workers to be knowledgeable about the value base of their profession, its ethical standards and relevant law; domain 4, 'Rights, Justice and Economic Wellbeing' requires social workers to recognize the fundamental principles of human rights and equality, and that these are protected in national and international law, and to understand the importance of using and contributing to case law and applying these rights in their own practice; law is included in domain 5 as an area of required knowledge; and perhaps of most importance, law is the key to domain 7, 'Intervention and Skills' as it provides the authority for social workers to use

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judgement and authority to intervene with individuals, families and communities to promote independence, provide support and prevent harm, neglect and abuse.

In order to understand law, but also to critique aspects of law, utilize and apply law, it is necessary to consider the role or roles of law. This will vary across different areas of law, and the legal landscape applicable to a particular area may accommodate a number of perspectives. Law can be described as having certain objectives, for example, punishment, protection, empowerment. It can authorize certain types of action, such as to provide support, and give a mandate for particular practice, such as a duty to investigate or assess. It is a powerful statement or reflection of society at a particular time, addressing social concerns and responding to particular events. Although the law tends to be reactive rather than proactive, it can also raise the profile of an area, promote and endorse particular types of behaviour and views, such as in relation to equality, and lay down the limits of acceptable behaviour, as, for example, through the incorporation of the European Convention on Human Rights into the Human Rights Act 1998.

The main focus is on law relevant to social workers employed in the statutory sector i.e. local authorities with social services responsibilities. It is recognized that many social workers are actually employed outwith that sector – for example in hospital, youth justice and the independent and voluntary sector – but will engage with the same individuals. Many of the areas of law discussed are also pertinent in those roles.

## What Law?

Acts of Parliament, e.g. The Children Act 1989 (CA), also referred to as legislation and as statute, form the primary source of law relating to social work practice. The volume of relevant legislation has grown rapidly over recent years and at times has resulted in duplication, inconsistency and complexity. That was a key finding of the Law Commission (2012) in its review of adult social care law, from 1948 to the present day; they recommended a single consolidated and accessible statute.

A range of features are typically found in the construction of social care legislation, including: definitions; principles; aids for decision-making; powers and duties; designation of key roles.

Some legal definitions appear straightforward: a child is defined as a person under the age of 18 (CA, s.105). In contrast the term 'vulnerable adults', itself disputed because of connotations around use of the word 'vulnerable', is defined differently in existing legislation including, the Care Standards Act 2000 (CSA), the Youth Justice and Criminal Evidence Act 1999, the Domestic Violence, Crime and Victims Act 2004, and the policy guidance, *No Secrets* (DH, 2000). Definitions may relate to a condition or state of affairs – e.g. s.1 Mental Health Act 1983 defines mental disorder; the role of carer is contained in the Carers (Recognition and Services) At 1995; s.31(9) Children Act 1989 defines harm as 'ill treatment or the impairment of health or development'. Provision of services or other intervention often depend on an individual's inclusion in the terms of a definition, such as services provided to children and their families where there is a 'child in need', defined in s.17(10) CA.

Laws can be directive and specific, but often there is an element of choice or discretion as to the particular legal pathway to be followed. In choosing when and how to invoke and apply the law, guiding principles can be a helpful steer for good social work practice. The Mental Capacity Act 2005 (MCA) is built around the guiding principle or presumption in s.1(2) that 'a person must be assumed to have capacity unless it is established that he lacks capacity'. Good practice is directed in the next principle, whereby, a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success (s.1(3)); a commitment to minimum intervention is evident in s.1(6), which stipulates that 'regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action'.

Principles can establish priority of interests as in the Children Act 1989 central principle, that 'the child's welfare shall be the court's paramount consideration' (S.1(b)), a clear indication to social workers that whilst partnership work with parents is important, the interests of parents and other adults are only relevant in so far as the welfare of the child is concerned.

Greater consistency of decision-making can be achieved where there is guidance as to relevant factors to be taken into account. The welfare checklist in the CA and the factors to be taken into account in assessing best interests under the MCA are examples of how this is built into statute.

Having established the objectives and scope of application of a statute, the next key area is the powers and duties that are bestowed, sometimes referred to within the phrase 'mandate to practice'. It is essential to distinguish between powers and duties in order to comply with the law. A *duty* is identified through use of words such as shall or must, suggesting an imperative to act if the relevant circumstances prevail e.g. the duty to carry out an assessment under s.47 National Health Service and Community Care Act 1990 is triggered by the appearance of need. A *power* suggests discretion and is often used where a decision has to be made about allocation of services. Such discretion is not unfettered and must be exercised in a rational way which allocates services appropriately and in line with guidance (R v Gloucestershire CC, ex p Barry [1997] 2 All ER 1, DH 2010).

Legislation may also specifically designate roles to certain individuals and may create certain posts. For example new and adapted roles were created in the form of the Independent Mental Capacity Advocate, and the Approved Mental Health Professional (AMHP). Indeed, the requirement to have adequate social workers to carry out social services functions has its origins in the Local Authority Social Services At 1970 (LASSA) (as amended).

The second major source of law is case law. Some areas of law are entirely based on case law decisions, known collectively as the common law e.g. the definition of murder. In relation to social work, most case law is closely linked to statute, providing clarification and explanation of terms, and additional detail as to practice. A good example is X Council v B (Emergency Protection Orders) [2004] EWHC 2015 (Fam). Munby J gave 14 points of guidance applicable to local authority without notice applications for emergency protection orders (EPOs), with emphasis on the need for a proportionate response in child protection cases. This judgement is commonly referred to as a checklist of good practice by justice's clerks at hearings for

EPOs. It is much easier to access case law now that it is available on the Internet and guidance is available on understanding the format and citation (Brammer, 2010).

Guidance is a further important source which informs and directs social work practice. Guidance which includes a statement that it is issued under LASSA 1970, s. 7(1), is formal policy guidance e.g. Working Together (DCSF, 2010), the status of which is explained in *R.* v. *Islington, ex parte Rixon* [1997] 1 ELR 477 HC:

> If this statutory guidance is to be departed from it must be with good reason, articulated in the course of some identifiable decision-making process . . . In the absence of any such considered decision, the deviation from statutory guidance is in my judgement a breach of law.

Guidance not issued under LASSA 1970, s. 7(1) can be regarded as general guidance (which should still be followed) but of a lower legal status, described as advice rather than directive. Guidance may also be issued in the form of Codes of Practice. Two important examples are the Codes accompanying the MCA and the Mental Health Act 2007 (MHA).

Elements drawn from a combination of the sources already mentioned are often translated into agency policy and procedure. This does not have a specific legal status and as a matter of good practice it is essential that the origin of elements of the policy are known e.g. as to whether it relates to a duty or power.

In addition to the sources outlined, law may be categorized in other ways e.g. public/private, civil/ criminal. Law relevant to social workers in the statutory sector is mainly civil law pertaining to responsibilities for children and families and adults. Knowledge of law beyond those areas is also important. Investigation and prosecution under the criminal law is the responsibility of the Police and Crown Prosecution Service. Social workers may have some involvement however, through joint investigations concerning child or adult abuse. Such may lead for example to a prosecution under S.44 MCA for ill treatment or wilful neglect of an adult lacking capacity, at which a social worker could be required to give evidence. Certain circumstances may lead to both civil and criminal action. For example child abuse may prompt a social services application for care proceedings. It may also lead to a prosecution of the alleged perpetrator under the criminal law. The invidious position has been noted that although the child is unlikely to give evidence in civil proceedings, he or she may have to give evidence at criminal court, albeit with support of special measures (Brammer and Cooper, 2011). A social worker may be required to offer support to the child throughout that process.

## Where Does Law Come From?

In order to have a complete understanding of different pieces of legislation it is necessary to understand the context in which it was introduced and the influences that shaped the legislation. Law may be driven by policy developments as in the introduction of direct payments legislation or may be overtly political, such as the introduction of the MHA reforms in response to anxiety expressed relating to

perceived dangerousness of mental health patients in the community (Gould and Martin, 2012). Pressure groups and organizations can be influential in shaping policy and law reform, an example being the inclusion of vulnerable adults in addition to children in the offence of causing or allowing death, resulting from the efforts of Action on Elder Abuse. Social morality may influence the shape of developing law as it responds to changes in society e.g. recognition of same-sex partnerships via the Civil Partnership Act 2004.

Some law can be traced to work of the Law Commission, an independent body which reviews existing law and through a consultation process makes recommendations for reform. Notably, the MCA derives from recommendations of this body. Child law in particular has developed in response to recommendations from inquiries and serious case reviews e.g. Colwell (Department of Health and Social Security, 1974), Cleveland (Butler-Sloss, 1988), Laming (2003) and the specially commissioned Munro report (2011).

From this discussion it is clear that the judiciary have a role in developing law and perspectives of particular judges can be discerned (George, 2011). On occasion the judiciary will also signal the need for law reform, as voiced in Re F (Adult: Court's Jurisdiction) (2000) 1 WLR, 1740, at 1752 B-C, an adult safeguarding case preceding introduction of the MCA.

> The assumption of jurisdiction by the High Court on a case by case basis does not, however, detract from the obvious need . . . for a well structured and clearly defined framework of protection of vulnerable mentally incapacitated adults, particularly since the whole essence of declarations under the inherent jurisdiction is to meet a recognised individual problem and not to provide general guidance for mentally incapacitated adults. Until parliament puts in place that defined framework, the High Court will still be required to help out where there is no other practicable alternative.

The High Court and above may also issue a declaration of incompatibility under the Human Rights Act 1998 (HRA) (we shall return to this), which acts as a trigger for law reform and has resulted in, for example, the Gender Recognition Act 2004.

## Defining Social Work and Setting Professional Standards

Law has a regulatory function in relation to various aspects of social care law, including, at its heart, the role and status of social workers, as a statutory profession.

The Care Standards Act 2000 (CSA) vested responsibility for training and regulation of social workers in the General Social Care Council (GSCC). Codes of practice were developed by the Council and there is a registration requirement for social workers (s. 56). This development puts social work on a par with other professions such as doctors and solicitors. It is an offence for a person to use the title 'social worker' or imply that he is a qualified social worker if he is not registered. Where there are concerns about conduct a person may be removed from the register. Examination of conduct hearings has found examples of misconduct such as inappropriate use of restraint and forming relationships with a service user (McLaughlin,

2010). The Health and Care Professions Council took over responsibility for regulation of social work from the GSCC in 2012 and holds the professional register.

The essential legal element of professionalism is the requirement to exercise a duty of care. This is a concept drawn from negligence and if complied with, generally provides protection from liability. Case law explains the standard of the duty with reference to a professional peer group. In ABB, BBB, CBB, DBB v Milton Keynes Council [2011] EWHC 2754 (QB) four individuals brought a claim against the local authority who were alleged to have failed to protect them from abuse as children. The case confirmed the principle established in JD and others v East Berkshire Community Health [2003] EWCA Civ 1151, that a duty of care is owed by social workers in local authority employment, stating further:

> A social worker's duty in common with other professionals is to exercise reasonable skill and care and the test in Bolam ... applies. Accordingly a social worker will not be negligent if she acts in accordance with practice accepted at the time as proper, by a responsible body of social work opinion, even though another social worker might adopt a different practice. (para 27)

## Equality and Human Rights

Good practice demands that social workers conduct themselves in an anti-discriminatory fashion and are aware of and willing to challenge the oppression and discrimination that service users may experience. Both elements find some support in the law.

Specific laws applying to social care may include provisions which support anti-discriminatory practice. For example, lack of capacity (which a social worker may assess) cannot be established merely by reference to a person's age or appearance, or condition, or aspect of behaviour, which might lead others to make unjustified assumptions about his capacity (s.2(3)MCA). Within children's law there are also references to the need to take into consideration religion, racial origin, cultural and linguistic background (Adoption and Children Act 2002, s.1(5)).

Beyond the range of social care legislation there is focused anti-discrimination legislation. Discrimination laws have developed piecemeal since the Equal Pay Act 1970 but are now contained in a single statute, the Equality Act 2010. The new Act offers protection from discrimination in respect of nine areas of protected characteristics: age; disability, gender reassignment, marriage and civil partnership; pregnancy and maternity; race (including ethnic or national origins, colour or nationality); religion or belief; sex; and sexual orientation. Extended forms of discrimination are recognized including direct discrimination; dual discrimination; discrimination by association; discrimination by perception; indirect discrimination; harassment; and victimization.

In addition to the opportunities for individuals with one or more protected characteristics to make a claim of having suffered discrimination, two specific duties are imposed on public bodies, which include social services authorities. Public bodies must have due regard to socio-economic inequalities when making decisions of a strategic nature about how to exercise their functions (s.1). Secondly, an equality

duty applies, meaning that local authorities must, in the exercise of their functions, have due regard to the need to eliminate discrimination, harassment and victimization and advance equality of opportunity in respect of each of the nine areas of protected characteristics (s.149). Challenges have been brought against local authorities for failure to comply with the equality duty. In R (W) v Birmingham City Council [2011] 1147 (Admin), the authority's decision to restrict the provision of support for people with disabilities to those whose needs were assessed to be critical was unlawful. By failing to assess the practical impact on those disabled persons whose needs were substantial, the local authority had not paid due regard to the equality duty.

## Human Rights

All law relating to social work practice must be viewed through the lens of the Human Rights Act 1998. Returning to the PCF, domain 4 calls for social workers to recognize fundamental principles of human rights and equality and to ensure these principles underpin their practice. The Act incorporates a range of rights and freedoms, set out in articles of the European Convention on Human Rights and Fundamental Freedoms, into UK law. Several are of obvious application to social work, including: article 2, the right to life; article 3, freedom from inhuman and degrading treatment; article 5, the right to liberty; article 6, the right to a fair trial; article 8, the right to respect for private and family life; article 10, freedom of expression; and article 14, the right to enjoy these rights and freedoms free from discrimination. The key to understanding how these rights should underpin practice is through inclusion of local authorities as public bodies under the Act (s.6). Public bodies must not act incompatibly with a Convention right. If they do so (or propose to), an individual affected may bring an action against the body (s.7). The effect of these sections is to oblige social workers within public bodies to act compatibly with the convention rights of service users, whether in conducting an assessment, providing a service or making an application to court. Whilst this provides an additional mechanism whereby individuals may challenge the actions of social services (alongside complaints procedures, judicial review and the work of the Local Government Ombudsman), it can be viewed as a vehicle to promote good practice and uphold rights of service users. On occasion social work intervention may legitimately infringe a service user's rights e.g. removal of a child is a clear violation of the right to respect for family life. In such cases the question is whether the action is lawful and for a legitimate purpose and a proportionate response in the circumstances.

Case law examples of violations have included: failing to provide community care support to a disabled woman violated article 8 (R (Bernard) v Enfield LBC [2002] EWHC 2282 (Admin)); failure to take protective child protection measures violated article 3 (Z v UK [2001] 34 EHRR 97, E v UK [2003] 1 FLR 348); depriving an individual of his liberty against his and his carer's wishes violated articles 5 and 8 (London Borough of Hillingdon v Steven Neary (by his litigation friend, the Official Solicitor) Mark Neary [2011] EWHC 1377 (COP)); and failing to properly explore potential carers because of limited court time in a contested contact case violated article 6 (Re Dhaliwal (A Child) [2005] EWCA Civ 743).

## Skills

Effective use of law requires a wide range of skills, including (but not limited to) the ability to explain law, accurate record keeping, court skills and updating knowledge.

Increasingly it is becoming necessary for social workers to have an understanding of law, not simply limited to that which provides specific powers and duties but also law that will impact on service users e.g. divorce, welfare benefits, housing, asylum, criminal justice. The social work role falls short of providing full legal advice, but there is a skill in knowing when to advise an individual to seek such advice. Some legal concepts are complex to the lay person, particularly at times of crisis and the social work role can legitimately extend to providing explanations of terminology e.g. parental responsibility, and insight into likely process of a case. Forecast reductions in legal aid are likely to result in diminishing advice networks within social welfare law, such as law centres and Citizens Advice Bureaus. Solicitors from legal aid practices are reducing in number and the growth in self-represented litigants may require social workers to act as 'McKenzie friend' more frequently.

Law provides scrutiny of the substance of social work decisions; it is also concerned with the process of decision-making. Accurate recording of decisions, including clear identification of relevant information taken into account in reaching a decision is essential to meet this requirement. Laming notes, 'the case file is the single most important tool available to social workers and their managers when making decisions as to how best to safeguard the welfare of children under their care' (Laming, 2003, 6.623). Authorities will have various conventions for record-keeping styles; however essential requirements are that records should be objective, unbiased accounts, written with precision (without waffle or colloquialisms), and distinguishing fact from opinion. Greater transparency of social work records is a consequence of requirements to share information with other professionals, may be the result of requests under the Data Protection Act 1998 and Freedom of Information Act 2000 or as evidence subject to the scrutiny of the court when it determines whether to make a particular order.

Once a matter reaches court, files and reports are open to scrutiny as is the oral evidence of a social worker. Here, the objective is to be a professional, credible and assertive witness. Court can be a daunting setting and some nerves are inevitable. Preparation is key, including an understanding of the conventions of the court. The benefits of a good working relationship with the local authority lawyer cannot be overestimated and the apparent tension that may exist between social worker and lawyer can be overcome if there is a clear appreciation of the delineation of roles (Dickens, 2005). The respective tasks are complementary, not synonymous. Various guides to court craft have been developed (Davies, 2007; Seymour and Seymour, 2011).

Students of social work will experience various styles and approaches to law teaching (Braye and Preston-Shoot, 2005). Beyond the academic stage, social workers are increasingly expected to commit to continuing professional development (CPD) to improve skills and keep up to date, supported as appropriate by practice educators and supervision. Evolving law and policy must clearly be included within that expectation.

## Conclusion

Social workers occupy positions of great responsibility at the interface between the state and some of the most vulnerable members of society in complex and challenging situations. Law provides a range of powers and duties which at their extreme have been described as 'draconian' in nature and may require intervention in family life. Often there is a wide degree of discretion as to how these legally driven tasks are exercised. That is inevitable in a world of limited resources and diverse situations. It would be impossible for law to anticipate each and every scenario, and as a consequence some areas of law are deliberately broad, e.g. the meaning of 'significant harm'. The existence of powers and duties presents the starting point for legal competence, but is meaningless without the understanding of values and principles that shape the application of law. Some of those principles may feature within the law; others are broader, as for example in the PCF. A further influence is the requirement to act within the context of an overriding framework relating to equality and human rights. Essential checks and balances to the exercise of legal powers are provided by law and may be described as an aspect of accountability which enhances good professional practice through provision of levels of scrutiny including the role of the courts and the professional body. Law is an essential component of social work and good social work practice embraces law actively and positively.

### Five Key Points

1. Social workers need to understand and apply law, the main sources of which are legislation and case law.
2. Law provides for regulation of the social work profession and imposes a duty of care.
3. Law can support anti-discriminatory and anti-oppressive practice through provisions in a range of statutes and importantly the equality duty in the Equality Act 2010.
4. The Human Rights Act underpins all social work practice through an obligation to act compatibly with the articles of the European Convention.
5. A commitment to keeping up to date with law will be necessary throughout a social work career.

### Three Questions 

1. Can law keep pace with developments in social work practice?
2. Does law provide certainty and direction?
3. What skills do you need to work effectively in court settings?

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# BOOK 6

# Social Work's Theory Base




*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

CHAPTER 6.1

# Relating Theory to Practice

*David Howe*

In their day-to-day practice, social workers face a busy and complex world of human behaviour in a social context. It is a world in which relationships break down, emotions run high, and personal needs go unmet, a world in which some people have problems and some people are problems.

If they are to find their way in this confused mix of psychological upset and social concern, practitioners must try to see some pattern and order behind the tumult and distress. They must try to understand and make sense of people and the situations in which they find themselves. Striving to make sense of experience is a fundamental characteristic of being human. If we are to cope with and be competent in social situations, we need to have ideas about what might be going on. This need becomes pressing in situations where need, stress and upset are present in large measure. Professionals who work in such situations develop more deliberate, systematic and formalized ways of making sense. It is these more self-conscious attempts to 'make sense' which we call 'theory'.

If social workers are to act clearly, competently and usefully in practical situations, they need to think theoretically. If we did not theorize, social life would remain a cauldron of unorganized experience and to all intents and purposes practical action would be impossible. The join between theory and practice is a seamless one. And, as has often been said, there is nothing so practical as a good theory.

If practice is to be compassionate as well as relevant, it is important that social workers retain a deep interest in people. The struggle to understand behaviour and relationships, actions and decisions, attitudes and motivations needs to be maintained at all times if practice is to be sensitive and effective. The more social workers think about, puzzle over and engage with people and the situations in which they find themselves, the more sense they will be able to make. The challenge is to remain curious about and thoroughly interested in people. The social

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worker needs constantly to ask herself the 'reason why' of things, to develop an active and enquiring mind. Why does this woman stay with her violent husband? Why is this 4-year-old child so subdued and withdrawn? Why does this daughter feel so hostile towards her increasingly dependent 81-year-old mother? So, although there is no consensus about which theories best explain particular situations, there is agreement that practitioners who develop and offer coherent understandings of what might be going on are those best able to keep their professional bearings and sustain personal commitment. Both abilities are highly prized by the users of social work services.

The argument is that by analysing practice and reflecting on people's needs and relationships, social workers become clearer about their theoretical assumptions. However, it is also possible to turn this process around. As well as induce theory from practice and observation, it is also possible to deduce from theory what to do and what to see. The social worker in possession of a clear theoretical outlook finds that it guides and influences her practice in five key areas:

1. Observation: it tells her what to see and what to look out for.
2. Description: it provides a conceptual vocabulary and framework within which observations can be arranged and organized.
3. Explanation: it suggests how different observations might be linked and connected; it offers possible causal relationships between one event and another.
4. Prediction: it indicates what might happen next.
5. Intervention: it suggests things to do to bring about change.

Different theories, of course, lead to different observations and explanations. For example, in the case of a difficult toddler, the behaviourist notes that the young mother reinforces her child's poor behaviour by only giving him attention when he is naughty; the feminist practitioner is struck by the mother's stress, low self-worth and lack of support from her oppressive partner; and the social worker using a developmental perspective observes that the mother, who was neglected herself as a child, grows anxious and agitated when her son becomes too demanding and dependent. This is not to argue that these three observations are mutually exclusive. However, in practice it is often the case that a practitioner with a strong theoretical preference is inclined to observe, describe, explain, predict and intervene in a style and a language that is noticeably different from a social worker holding a contrasting theoretical outlook.

## The Social Work Process

A simple but effective way of exploring the relationship between theory and practice is to ask a series of seemingly innocuous questions about a case or a piece of practice. By insisting on clear answers to these questions, the practitioner finds that she is able to reflect on matters at a surprisingly deep level. It is during this reflection process and the answer-giving stage that the relationship between theory and practice becomes explicit and available for discussion. Five questions can be asked of a case or piece of work:

1. *What is the matter?* This question helps the social worker define problems and identify needs. Supplementary questions might include: For whom is it a problem? Who benefits if the need is met? When answers are tentative or incomplete, further observations are made; more information is gathered.
2. *What is going on?* This is perhaps the most important question. It demands that the situation is assessed, analysed, diagnosed, interpreted or explained. The social worker makes sense of what is going on. She makes a formulation.
3. *What is to be done?* In the light of the assessment, goals are set, objectives identified, plans made and intentions declared.
4. *How is it to be done?* The methods, techniques, skills, services and resources needed to achieve the goals are chosen and deployed.
5. *Has it been done?* The outcome is reviewed and evaluated.

Different theories sponsor different answers to these five questions. But whatever the response, the answers and activities map out the basic features of *the social work process* with its five-stage sequence of: (1) the formulation of problems and the identification of needs, (2) the analysis of cases and the making of an assessment, (3) the setting of goals and objectives, (4) the design of methods of work and intervention, and (5) the review and evaluation of the involvement. This process describes a sequence and a structure to help social workers practise in a thoughtful and systematic way. It provides the basis of a disciplined and professional social work practice. It is also designed to overcome the tendency of social workers and their agencies to jump from problem to solution in one bound. Within the social work process, considerable importance is given to the stage of assessment. This is a time for reflection, enquiry and vigorous analysis. Assessments encourage practitioners to stop and think about what is going on. They provoke thought and liberate practice from the routine and humdrum.

## Theories for Social Work

Things might be relatively simple and straightforward if social work was underpinned by one or two generally agreed theories for practice. In any one case the five questions of the social work process would receive a limited range of acceptable answers. Unfortunately, the theoretical world underpinning social work practice is a far from stable place. Because social workers deal with people in social situations, most of their theories, albeit adapted to the social work context, derive ultimately from psychology and sociology.

However, these primary disciplines have not established a consensus about the true character of human nature, individual development and social interaction. Although they strive to 'make sense' of people and society, the range of theories and understandings on offer are numerous and diverse. Sociology and psychology provide intellectual arenas in which fierce debates rage about the individual and society, the personal and the political, order and conflict, biology and culture, free will and determinism, causal explanation and subjective understanding. To the extent that social work's theories are based on psychological and sociological theories, they, too, will reflect the range, diversity and disagreements present in the parent disciplines.

So long as these epistemological disputes exist, there can be no universally agreed criteria by which to judge social work's theories and practices. This is not to say that some theories will be preferred at certain times and in particular places. Political and cultural factors also come into play and influence what is thought and what is done in the name of good social work. The rise of evidence-based practice, for example, has been inspired, in part, by the successes of scientifically informed medicine and clinical psychology. Nevertheless, social work theory remains a highly varied and contested activity. If the argument holds good that in practice there is no escape from theory, the social worker needs to understand how and why different psychological and sociological theories vary as they do. Rather than bemoan the number and range of theories, the practitioner needs to acknowledge that the diversity reflects the subtlety and complexity of the human condition. Appreciation of the elegance and multidimensionality of these conceptual landscapes can be highly stimulating.

## Types of Theory

Many frameworks and taxonomies have been developed to help practitioners find their way around social work's theories. The attempts to classify the theories rely on recognizing a limited range of key conceptual dimensions, various combinations of which help to define particular sets of related theories. At root, most of the classifications draw on discussions about human nature, the relative importance of biology, culture and experience in human development, and the social movements and ideological climates that define and shape human society (see Turner, 1996; Howe, 1987; Payne, 2005; Healy, 2005). Mapping out social work's theoretical terrain helps practitioners locate themselves intellectually and invites them to explore new areas of thought and practice.

Although in some circles there is a coming together of psychology and sociology, these two disciplines still create one of the main divisions in social work theory between structural and psychological explanations of personal difficulty. Within the structural perspective, the focus is on the political, economic and material environment in which people find themselves. The approach includes anti-oppressive and anti-discriminatory perspectives. Poverty and inequality, the lack of opportunity and social injustice seriously disadvantage some people. The disadvantages induce stress, anxiety and 'poor social functioning'. Such problems bring them to the attention of society and its agents. However, structural theorists maintain that for these groups, the individual should not be seen as a problem for society; rather society should be seen as a problem for the individual. This outlook influences the way problems are defined, the type of assessment made, the goals planned and the social methods employed.

In practice, though, most social work theories remain heavily influenced by the more psychological approaches to human behaviour. There are many ways in which these psychological theories can be categorized. Most rely on making particular assumptions about human nature and the ways in which we learn, develop and respond. One simple division is to see whether a particular theory emphasizes either the client's emotional condition or his or her capacity for rational action.

Theories which pay most attention to the emotional side of people's lives and the quality of their relationships seek to understand present behaviour in terms of past

experiences. The character of our relationship history influences our personality and social competence. As most social work clients experience or express difficulty in one or more of their key relationships (with partners, parents or children), it seems appropriate to try and understand the quality of their social and interpersonal development and how it might be affecting current behaviour. Understanding, support, nurturing, the meeting of emotional and developmental needs, containment and insight are present in many of the practices associated with these theories. By understanding past events, the client and the worker might be able to contain or make sense of current experiences. Making sense allows people to gain control of the meaning of their own experience and move into the future with a more robust, mature, independent and strengthened personality. Such a personality is likely to be more socially competent, and socially competent people handle relationships more effectively. Altering the meaning of experience brings about changes in behaviour.

Theories of this persuasion include all those which take a developmental perspective. They are person-focused. They consider people from the psychological inside. Psychoanalytic theory, attachment theory, theories of loss and separation, many forms of feminist theory and elements of the person-centred approach can all be placed within this broad category of developmentally orientated and relationship-sensitive approaches to social work practice.

Theories which appeal to clients' rational capacities and cognitive strengths tend to adopt a problem-solving approach. These theories are based on the belief that people with problems can resolve them by the use of rational thought, cognitive understanding and behavioural advice. Practitioners work with clients in problem-solving partnerships. Typically, the approach involves:

- the identification, description and quantification of the problem;
- analysis of the factors, including the behaviour of other people, which maintain the problem;
- the selection of goals;
- the identification and implementation of those actions which will achieve the goals and resolve the problem.

Based on an analysis of present conditions, problem-solving approaches encourage clients to identify what steps they will need to take if they wish to move themselves into a problem-free future. Practice is often pragmatic, time limited and task-centred. People are viewed from the behavioural outside. The belief is that by changing behaviour, personal experience is improved.

Social work theories that fall into this category include task-centred approaches, cognitive-behavioural theories, many forms of family therapy, brief solution-focused therapy, strength-based perspectives, and some aspects of systems theory.

## Theory and Practice in Social Context

One further layer of analysis has to be added if we are to gain a full understanding of the relationship between social work theory and practice. Social work takes place and is formed within a social and political context. It occupies and is defined by the space between the personal and the political in which the state relates to the

individual and the individual relates to the state. So, although social work practices need the help of the psychological and sociological sciences if they are to make sense of people in social difficulty, the *purposes* of social work and its practices are defined by a different set of intellectual traditions.

In the broadest sense, the purposes of social work are determined by prevailing political values. These values influence welfare legislation, political policy, government guidelines, and the distribution and definition of resources. The politically defined purposes of social work also influence the psychological and sociological theories chosen by practitioners to help them 'make sense' and practise.

Political philosophies which emphasize collective responsibility and action also value harmony and cooperation, equality and interdependence, well-being and happiness. They support theories and practices which are more structural, developmental and therapeutic in their outlook. Psychologically healthy development occurs only if the individual is embedded in a good quality social environment. A sense of belonging and being wanted in a community of close personal relationships is essential if a secure and coherent personality is to form.

When the political pendulum shifts away from welfare collectivism towards neoliberal concepts of freedom, choice and personal responsibility in the context of a market economy, theories and practices tend towards the brief and the behavioural (Howe, 1996). The individual is seen as independent and free, disembedded from and unconstrained (and not limited) by his or her social environment. Such freedom and autonomy allows full scope for creative endeavour and the rational pursuit of what is in one's own best interests. Morally and psychologically, the individual must stand alone. Individuals are personally responsible for who they are and what they become, for what they do and how they do it. This represents a shift away from explaining people's psychological insides to measuring their behavioural outsides. The external performance, of both worker and client, becomes the unit of audit. *What* people do is more important than *why* they do it. Economic and political partnerships replace therapeutic relationships. The theories which come to the fore in this political climate are those which encourage brief, task-centred and behaviourally measurable practices in which the act rather than the actor becomes the focus of interest.

## Summary

Practice, as defined by the social work process, varies as practitioners make use of different theories. Theories vary as they appeal to different understandings of human nature, personal development and society. And different theories come in and out of fashion as political values and social philosophies change with the flow of large social movements through history. Just as theory relates to practice, so practice relates to theory. Only the faint-hearted despair at the inordinate subtlety of personal experience and social life. So long as social workers retain a passionate interest in and concern for the quality of human experience, and so long as they strive to 'make sense', the relationship between theory and practice will continue to invigorate, fascinate and professionally uplift.

## 15 Anna

Anna is aged 10. She lives with her mother and two younger brothers, aged 5 and 3 years. Anna's mother suffers from depression. The family live in a large apartment block in a very disadvantaged part of the city. The school authorities have expressed concern about Anna's increasingly poor school attendance record.

- Think of as many reasons as you can that might explain Anna's school attendance problem.
- What is the theoretical basis of each explanation?

## Five Key Points

1. Social work theories help practitioners make sense of complex and difficult human situations.
2. Different social work theories generate different understandings of human behaviour and social situations.
3. The social work process of 'defining problems and needs – making an assessment – setting goals – carrying out methods to achieve those goals', describes a sequence and a structure which helps social workers practise in a systematic way.
4. Social workers who use theory to inform their use of the social work process are more likely to practise in a thoughtful, professional and effective manner.
5. The purposes of social work and the theories which support them vary depending on the cultural context in which social work finds itself.

## Three Questions 

1. How might different social work theories explain or make sense of the same case or social situation?
2. What assumptions does a particular social work theory make about (a) human nature; (b) the influence of human biology, culture and social experience on personal development; and (c) appropriate political and personal values?
3. In particular cases and situations, how do different social work theories influence the content of the social work process?

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# CHAPTER 6.2

# Twenty-Four Theories for Social Work



*The Blackwell Companion to Social Work*, Fourth Edition. Edited by Martin Davies.

# 6.2.1

# Anger Management

*David Leadbetter*

We all experience anger, but a recent report suggests that society may be getting angrier. The Mental Health Foundation (2008) reports regular loss of temper at work (45%), aggression to computers (50%) and road rage (80%).

Anger ranges from mild irritation to intense fury. Traditionally it has been viewed as a negative force, a passion which grips, assails and possesses the individual, sitting in opposition to reason – a view which detracts from our understanding of the emotion, obscuring its socially constructed nature and the influence and durability of underlying cognitive structures.

Anger is defined by Novaco (1975) as 'an effective stress reaction to provocation events'. Anger can play a facilitative role in social interactions, counteracting feelings of helplessness, promoting self-assertion and energizing the victim. An individual's failure to develop effective self-regulatory threat response mechanisms and skill repertoires is a key factor in dysfunctional and abusive behaviour. Social workers support a diverse range of individuals for whom the inability to regulate anger may impair the quality of their lives and prejudice the well-being of others. Yet anger has no diagnostic classification and and has been subjected to only very limited scientific clarification.

Chronic anger is associated with a range of physical and mental problems including depression, increased risk-taking and substance abuse, with the estimated cost of domestic violence standing at £23 billion.

Various studies have identified information processing problems and attributional bias as key issues in understanding the nature of anger, illustrated by studies on violent prisoners (Shelley and Toch, 1968), adolescent males (Lochman, 1984) and children (Naseby, Hatyden and De Paulo, 1980). McGuire reports that anger-prone children

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> encode a narrower range of environmental cues; selectively attend to aggressive cues; attribute hostile intent to others, especially in ambiguous situations; more readily label internal states as anger; generate fewer alternative solutions to problems; select action orientated rather than reflective solutions; possess a more limited range of interactional skills; and manifest an 'egocentric' perspective in social problem solving. (McGuire, 1997, p. 73)

Research 'has demonstrated that the appraisal of events as provocation stimuli (direct or indirect threats or aversive stimuli) influences the magnitude of aggressive behaviour' (Feindler and Ecton, 1986, p. 3) and that this may lead to a thinking style, described by Howells (1982) as *aggressonogenic* with chronic states of *hyper-arousal* (anxiety) and *hyper-vigilance* (oversensitivity to threat).

Luria (1961) charted a process of self-regulation of internal impulses, in which the child's dependency shifts from external adult verbal cues and speech to their own overt speech, until finally behaviour is governed largely by internal speech between the ages of four-and-a-half and five-and-a-half. Parenting style is crucial. The anger response is recognizable as early as four months. Underlying cognitive distortions are highly influenced by the development of empathy and conscience (Palmer, 2003). This involves an attachment-driven transition through successive stages in which egocentricity diminishes in favour of empathy and perspective taking. The eventual development of mature moral reasoning (Gibbs, 2003) is associated with the use of inductive discipline, in which the child is offered explanations of behavioural transgressions (Palmer and Hollin, 1996, 1997), enhanced parental warmth, and low levels of perceived rejection (Janssens and Dekovic, 1997).

Advances in Magnetic Resonance Imaging (MRI) technology have offered increasing insights into the developmental and neurological damage inflicted by *active abuse* (sexual and physical) and *passive abuse* (neglect), indicating the required low-arousal, 'trauma informed' responses required from supporting services (Perry, 1997; Bloom, 1997).

Various theoretical formulations have informed clinical practice. Behaviourist approaches tend to focus on the reinforcers which maintain behaviour. The social skill teaching perspective employed by the 'constructional approach' views anger as a social skill deficit that leads to an inability to express emotion appropriately. 'Trauma theory' perspectives highlight the therapeutic milieu and outline the required changes in the approach of clinical services (Bloom, 1997).

However the most influential approach has emerged from the broad church of cognitive behaviourism in which human cognitions are assigned a central role. In his 'information processing model', Novaco (1975, 1976) proposes that anger consists of three principal and interrelated components:

- the *physiological* component – cardiovascular and endocrine activation and muscular tension;
- the *cognitive* component – antagonistic thought patterns, labelling, and destructive impulses; and
- the *behavioural* component.

His basic premise is that 'anger is fomented, maintained, and influenced by the self statements that are made in provocation situations' (1975, p. 17). 'External

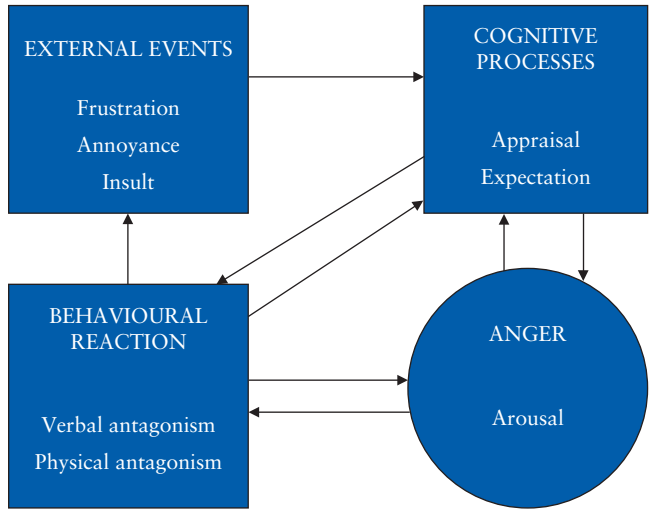


**Figure 6** The Novaco model.

circumstances provoke anger only as mediated by their meaning to the individual' (Novaco, 1975, p. 252). (See Figure 6.) The three interlinked components are addressed through a *stress inoculation* approach in which the individual is metaphorically helped to develop cognitive anti-bodies to aversive events involving three stages:

1. An *educational stage*, exploring the functions, patterns and triggers.
2. The *skill acquisition stage* which promotes cognitive restructuring skills, problem-solving and arousal-reduction strategies, assertiveness and communication skills.
3. The *application stage* in which skills are tested through gradual exposure to real-life aversive situations.

A diversity of generic and population-specific anger control programmes have been developed: for offenders (Schlichter and Horan, 1981); domestic violence (Moran and Wilson, 1997); learning disability (Gardner and Gray, 1982; Gardner and Cole, 1987); and child abusing parents (Bank, Patterson and Reid 1987; Bank *et al.*, 1991). Results appear generally positive.

Accurate assessment of underlying pathology, trauma history and motivation remain essential prerequisites of treatment. Multimodal approaches which combine anger management techniques with other approaches such as assertiveness and social skills training seem to offer the best prospect and widest potential application (Feindler and Ecton, 1986; Goldstein and Keller, 1987).

Many anger management programmes involve complex, systematic interventions requiring considerable clinical knowledge and support. Nevertheless, understanding anger as a problem of information processing and habitual thought patterns may help a broad range of practitioners to help service users understand and address chronic anger problems and correctly locate the responsibility for their anger.

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# 6.2.2

# Anti-Oppressive Practice

*Beverley Burke*

Anti-oppressive practice is located in the radical tradition of social work, and informed by a critical understanding of the concepts of power, oppression and social justice. It is a humanitarian and politically aware response to social situations that are morally untenable. An anti-oppressive perspective recognizes that social divisions such as those based on ethnicity, class, gender, disability, sexuality and age are constructed and legitimized within political, economic and cultural structures. It is against this background that individual and collective experiences of resilience and resistance, marginality and struggle need to be understood. Informed by this analysis, anti-oppressive practitioners engage in a range of practice interventions which attempt to disrupt unjust structural relations.

The concepts of 'power' and 'oppression' are central terms within anti-oppressive practice. However, they are contested, socially constructed, and value-laden. An anti-oppressive understanding of power explicitly draws our attention to the fact that as a social process it is contradictory and complex. A postmodern definition of power as ubiquitous, fluid and multidirectional contributes to our understanding of social relationships. However, an analysis of power should also account for structural inequity in the distribution of power within social relationships, where the 'interests' of some individuals and groups, supported by political, economic and cultural systems, are prioritized over others' interests and needs.

Oppression is not simply the absence of justice but the consistent denial of individuals' or social groups' humanity. It is reproduced and sustained by conscious and unconscious actions of individuals and groups through routine institutional practices, policies and procedures. The range and the complexity of people's experiences of oppression are due to the interconnections between various forms of social

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difference. Practitioners have unique personal and professional biographies, which may assist or obscure understanding of the complexity of human experiences. This understanding is enhanced through open and honest dialogue with people who have had their rights to selfhood denied, suppressed or violated. It is through the systematic analysis of the impact of social systems on individuals and communities and how they sustain and texture the social position and concerns of service users that effective ways of diminishing social inequalities can be developed.

Like all theoretical and practice methodologies anti-oppressive perspectives are subject to academic scrutiny. Anti-oppressive practice has attracted criticism for its purported focus on a structural analysis of social problems which, it is argued, has led to its failure to address the range of factors which shape people's lives. Anti-oppressive practice is also criticized for being politically and morally idealistic and for its appropriation by some to support practices and ideas which are questionable in relation to matters of social justice.

However, an anti-oppressive perspective does not simplistically posit a view that individuals and groups are determined only by macro-social and economic structures, but by the complex relationship which exists b*etween* individual action and the micro-, mezzo- *and* macro-structures of social life. An anti-oppressive analysis recognizes both the specificity of particular forms of oppression and how the interconnections between the various oppressions are played out in unique ways. For example, women within a patriarchal, capitalist society may well share some similar oppressive experiences of sexism. However, this commonality is mediated by ethnicity, age, poverty and social class, sexuality, physical and mental (dis)ability, religion, geographic location, and other factors related to national and international conditions. All of these give rise to a specific and complex form of sexism, with particular significance for the individual woman and the nature of relevant practice. People are much more than the sum of their oppressions; experiences of being stigmatized and oppressed contribute to, but do not totally shape, their identity and agency. Experiences of mutuality, care, success, resistance, and levels of personal, familial, and community support inform the rich tapestry of their lived experiences. Failure to work with this complexity contributes to practice which has lost its claim to be anti-oppressive.

A central tenet of an anti-oppressive perspective is the need for it to be critically reflective and reflexive, meaning that there is continuing dialogue about its own potential to be misinterpreted, or misused, undermining its radical impetus. Being anti-oppressive requires an openness to be challenged and to challenge. Utilizing an anti-oppressive framework for practice requires workers to critically analyse the political nature of oppression, to be aware of the web of power relationships in which they are embedded, drawing on theories of social intervention that contextualize practices within wider social systems, and are consistent with the ethical aim of challenging oppressive social relations. Anti-oppressive practitioners need to make holistic, needs-led, theoretically-informed ethical practice responses. In pursuit of these objectives, social workers need to be reflexively self-aware, politically astute, and prepared to engage in a range of practices: both caring, attentive to particular needs, but also justice orientated.

Adoption of an anti-oppressive approach to practice has implications for all concerned in the development of just welfare services. Social problems require the

engagement of diverse humanitarian and emancipatory micro-, mezzo- and macro-social interventions if they are to be resolved or minimized. Practitioners can individually and collectively use their relative power to intervene in organizational and political structures which express and consolidate oppressive relations. Opportunities for change are very often provided by contradictions and inconsistencies within political and social policies, legislation and practice guidance. Social action involves the development of both informal and formal strategies, from voicing concerns personally and collectively, working with service user and carer groups to making links with community and political activists concerned with the needs of different social groups. Facilitating the coming together of people to reframe personal concerns into wider collective issues necessitates action which moves beyond the boundaries of individual practice. Such action requires courage, preparedness to challenge as well as making creative and sustainable alliances with others.

Practitioners who work from an anti-oppressive standpoint reject taken-for-granted ideas about the nature of inequality, power and privilege. Through practices fostering conditions characterized by care, mutuality and equality they can, with others, contribute to the difficult process of changing systems which preserve inequality and social exclusion.

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# 6.2.3

# Attachment Theory

*David Howe*

The nature and importance of the parent–child relationship has long fascinated philosophers and politicians, novelists and social scientists. More recently, developmental scientists, including ethologists, psychologists, neuroscientists and geneticists have taken a particularly interest in the interactions between caregivers and their babies. It has been found that the quality of relationships in the early years affects gene expression, psychosocial development, and brain growth and organization.

A pioneer of this integrated scientific approach to understanding the developmental importance of mother–infant and family–child relationships was the British child and family psychiatrist, John Bowlby (1907–1990). His original enquiries were triggered by clinical work with children and their parents. With his social work colleague, James Robertson, he began to explore why the quality of the parent–child relationship was so critical for children's early psychological growth and development, and why so many behavioural and mental health problems met later on in life could be traced back to childhood experiences of abuse, neglect, trauma, rejection and loss.

Along with his friend and collaborator, Mary Ainsworth, Bowlby gradually fashioned what we now refer to as *attachment*. The basic theory, heavily influenced by the animal and evolutionary sciences, postulates that at birth nearly all infant mammals are highly vulnerable and dependent on their mothers and other family members for protection, survival and nourishment. The natural world is full of dangers. Without the care and protection of 'stronger and wiser' adults, babies simply would not survive. Observation recognizes that apparently helpless infants actually possess a number of 'programmed' behaviours that are activated whenever the infant feels distressed – danger threatens, fear is felt, hunger is aroused, illness occurs. The goal of these behaviours is to recover proximity with the source of

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safety and comfort, namely the parent or primary caregiver. In the case of human infants, such behaviours include crying and other distress signals (which get caregivers to come to the baby), clinging, eye contact and smiling (which keep caregivers engaged). The neuro-sensory system that triggers these behaviours is referred to as the *attachment* system. The behaviours whose goal is to recover proximity with the caregiver are described as *attachment behaviours*.

Although it takes time for attachment behaviours to become fully focused, by around seven months of age most babies have a very clear sense of who to turn to at times of need and distress. At this point, a baby's main carers can be described as that child's *attachment figures*. The affectional relationship that attachment figures have with their children is described as the *caregiving bond*. Children usually have several attachment figures, hierarchically organized. Attachment behaviours tend to be at their most intense and most frequent between the ages of seven months and two to three years, the time when children are most dependent and most vulnerable, although they remain present throughout the life course.

When distressed children recover proximity, the next task of caregivers is to deal with their children's arousal. The *regulation* of children's distressed states generally witnesses parents comforting their children physiologically (using all the senses), emotionally, conversationally, and cognitively. In order to do this well, 'good enough' parents must 'tune-into' their child's feelings and mental perspective. They need to be 'mind-minded' and see and feel the world from their child's point of view. Children who enjoy reasonably 'good enough' regulation over the years become able to understand and manage not only their own needs, arousal and distress but also those of other people. These abilities predict good self-esteem, self-control, social competence, and mental health. To be on the receiving end of empathy and understanding helps children to develop empathy and understanding. In any normal population around 65 per cent of children will enjoy such attuned parenting. Their attachments are described as *secure*.

However, some children will experience 'sub-optimal' caregiving in which children are not confident that at times of fear and distress their caregivers will be emotionally, psychologically, or indeed, physically, available. The caregivers lack mental attunement. In these relationships, and depending on the type of parental insensitivity exhibited, children develop a range of adaptations and behavioural strategies designed to maintain as much proximity as possible under the circumstances, although without necessarily experiencing the emotional regulation enjoyed by securely attached children. This means that these *insecurely* attached children miss out on some key psychological and relationship experiences that normally help promote healthy psychosocial development. In extreme cases, the cause of the children's fear and distress is the behaviour of caregivers themselves. Children who suffer abuse, neglect and relational trauma are therefore exposed to a number of developmentally damaging experiences. The cause of the children's fear is the hostile or helpless behaviour of the parents who not only cause their children's distress but also fail to 'tune-into', regulate, or do anything about it. This causes children's attachment systems to be intensely and chronically activated leaving their minds in highly dysregulated states. These adverse experiences prefigure later-life behavioural and mental health problems. Although many parents who suffered abuse and neglect as children do not maltreat their own children, of the parents who do maltreat,

most experienced unhappy childhoods of abuse and neglect leaving them poorly equipped to deal with stress and unable to self-regulate.

Attachment theory has been influential in helping social workers work with complex cases of child maltreatment. It also has relevance to fostering, adoption, and many branches of adult mental health social work. Attachment strategies, types and styles are not fixed or continuous. In the context of any close relationships, attachment patterns, whether those of children or adults, can change. Social workers who aim to improve the quality of people's understandings and behaviours in the context of close relationships can change attachments from insecure to secure, and behaviour from poorly regulated to well regulated.

There is growing evidence-based research supporting the effectiveness of attachment-based interventions with children, parents and poorly regulated adults in at-risk populations. Most interventions focus on helping clients improve their social cognition (that is to think about feeling in themselves and others) and ability to self-regulate. These improvements lead to increased sensitivity, emotional attunement, and relationship competence. Social workers should be cautious and sparing in their use of research-based attachment categories and the technical jargon associated with the theory. Attachment theory is at its best when it sensitizes social workers to the quality and importance of relationships and their impact on development, behaviour and mental health throughout the life course, and at its most unhelpful when practitioners use its language as a substitute for careful thought and proper analysis.

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# 6.2.4

# Behaviourism

*Robert Jordan*

We generally suppose that our behaviour is caused by our states of mind. Behaviourism claims that this is a misapprehension. It therefore represents a radical reappraisal of our common-sense intuitions about the causes of human behaviour and of what kind of intervention is required to change it. Behaviourists hold the view that the origins of our behaviour do not lie in the mind but in the environment.

The traditional idea that our minds govern our actions rather like the pilot steering a ship (the so-called 'myth of the ghost in the machine') is rejected (Ryle, 1963, p. 17 ff.). Instead it is proposed that our behavioural dispositions are determined by their environmental consequences. Behaviour which succeeds (or, to use the technical term, is *reinforced*) will increase in frequency and intensity; behaviour which doesn't, like a maladaptive species, will become extinct. By using this knowledge to deliberately reinforce desired behaviour we can therefore bring about reliable behavioural change, either in ourselves or in others.

Early pioneers in behaviourist methodology were Ivan Pavlov (1849–1936) and John Watson (1878–1958). However it was the Harvard psychologist B.F. Skinner (1904–1990) who developed behavioural theory most fully. Skinner was happy to bite the bullet and accept that human beings do not have free will. All of our behaviour, he claims, is the result of environmental conditioning. Even the most dysfunctional behaviour makes sense given the reinforcement history of a particular individual. Most importantly, from a social work perspective, reinforcement can be used therapeutically to bring about a more desirable pattern of behaviour. Behaviourism thus has powerful clinical implications.

While sophisticated behaviour modification programmes need to be supervised by a psychologist, social workers can employ behaviourist insights in their practice relatively easily. Indeed, it is important that they do. If behaviourism is right and

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all interactions with others or with the environment are reinforcing behaviour of some kind, then it is essential that we do not inadvertently reinforce the very behaviour we are trying to discourage. The classic example would be the parent who tries to subdue a toddler's tantrum by giving her sweets – thereby in fact increasing the likelihood of future tantrums by reinforcing (i.e. rewarding) them. Numerous examples could be sought from social work practice. Increasing the number of home visits to someone with agoraphobia, for example, may be reinforcing the dysfunctional pattern of behaviour, as would giving more rather than less attention and input when a service user exhibits challenging behaviour of any kind.

An important aspect of behaviourism is its close relationship with learning theory in general. Reinforcement assists learning, as the behaviour to be learned is strengthened by the positive consequences (or the removal of negative consequences) that follow it. This is to be distinguished from punishment, in which an aversive stimulus is used to deter or weaken a particular behaviour pattern. Behaviourists are clear that teaching and reinforcing desired behaviour is far more successful than punishing undesired behaviour. It seems plausible that individuals who cope well are those who have learned a variety of constructive life skills rather than merely having been punished for what they did wrong. There are clear implications here for criminal justice, which Skinner takes up in his later work (Skinner, 1972).

A purist approach to behaviour modification can be and has been used in some social care settings (Sheldon, 1982). This might involve a structured programme of positive reinforcement, probably under the supervision of a clinical psychologist, aimed at shaping constructive patterns of behaviour. A classic approach would be to try as much as possible to ignore (rather than punish) undesired behaviour and reinforce behaviour that has been identified as desirable. Reinforcers can be tangible (money or access to leisure facilities, for example) or social (praise or attention). However, as with many theoretical models, social workers can also employ a more pragmatic approach, drawing on behaviourist insights when they are useful without necessarily committing themselves to the model in any exclusive sense. A worker in a children and families setting, for example, might well enrol a parent in using positive reinforcement to better manage their child's challenging behaviour, especially if inconsistent behaviour management has been identified as a feature of the parenting in the past.

In the last few decades there has been increasing scepticism about classic behaviourism in both psychology and philosophy. In particular its neglect of the role of cognition has come under scrutiny. One of the outcomes of this has been the development of cognitive behavioural therapy, which incorporates many of the insights of classic behaviourism but which prioritizes work on cognition as a way of changing behaviour rather than attempting to shape behaviour directly. This is not necessarily a return, however, to the idea of a fully autonomous self in the traditional sense. To the behaviourist, thought is just another form of behaviour, shaped by environmental reinforcement (Skinner, 1974, p. 117).

Behaviourism may strike one as dissonant with social work values, even potentially oppressive. The use of behaviour modification techniques, especially with vulnerable service users, should clearly be informed by ethical considerations. This is especially the case if the service user is unable to fully understand the approach themselves. But if behaviourism is true and if all of our interactions with others are

reinforcing aspects of their behaviour anyway, then it is better that we avoid the accidental reinforcement of dysfunctional behaviour patterns. Otherwise intervention may do more harm than good. Furthermore, in its critique of punishment, behaviourism attempts to replace a pre-scientific image of the human being with a more enlightened and arguably more humane model. If we lack free will then we also lack moral responsibility, in the traditional sense, for our actions. Treatment rather than punishment should be the response to deviant behaviour. His defence of this revisionist account of the human condition earned Skinner notoriety (Toates, 2009), but his reply was that conventional accounts of freedom and responsibility had to be given up in the light of scientific discoveries.

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# 6.2.5

# Cognitive Behavioural Therapy (CBT)

*Barbra Teater*

Cognitive behavioural therapy (CBT) is a method that aims to reduce psychological distress and dysfunction by exploring and addressing how the integration of service users' thoughts, feelings and behaviours are contributing to the presenting problem. Three assumptions form the foundation of CBT:

1. Thinking (cognition) mediates emotions and behaviours.
2. Faulty cognitions lead to psychological distress and dysfunction.
3. Psychological distress and dysfunction is reduced or alleviated through modifications in the faulty cognitions and behaviours (Trower, Casey and Dryden, 1988; Vonk and Early, 2009).

Therefore, CBT seeks to modify and replace existing faulty or distorted thoughts, feelings and behaviours with more positive and acceptable ones that will lead to the alleviation of the presenting problem (Teater, 2010).

The implementation of CBT in practice involves three stages: assessment; intervention and evaluation (Teater, 2010). *Assessment* consists of exploring jointly with service users how their thoughts, feelings and behaviours are contributing to the presenting problem in terms of frequency, intensity and duration. The A-B-C model is often used at the assessment stage; it requires service users to explore (A) the activating event, (B) their belief system or attitude in relation to the event, and (C) the consequences as reflected in their behavioural or emotional reactions.

The assessment stage will inform the type of *intervention* to be selected, based on the thoughts, feelings or behaviours that are the focus of change. Such interventions could include cognitive restructuring (Frojan-Parga, Calero-Elvira and

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Montano-Fidalgo, 2009); relaxation techniques (Payne and Donaghy, 2010); social skills training (Sheldon, 1998); assertion training and problem-solving skills (O'Donohue, 2003); systematic desensitization (Sharf, 2012); and reinforcement, modelling and role-plays (Sutton and Barto, 1998).

The *evaluation* stage serves as an opportunity to identify any changes that have occurred in the intensity, frequency and duration of thoughts, feelings and behaviours and the extent to which the presenting problem has diminished from pre- to post-intervention.

## What are its Origins?

CBT is a combination of behavioural and cognitive therapies. Behavioural therapy, traced back to the 1950s through the works of Ivan Pavlov, John Watson, and B.F. Skinner, seeks to modify learnt behaviours that are problematic and undesirable and to replace them with more acceptable positive behaviours, particularly through the use of consequences and reinforcers (Sharf, 2012). Cognitive therapy, developed during the 1960s primarily through the works of Albert Ellis and Aaron Beck, is based on the notion that behavioural and emotive aspects are critical in addressing psychological distress and dysfunction. Ellis developed the A-B-C model in order to explore how activating events lead to behavioural or emotional consequences by being filtered through the service user's belief system (Teater, 2010).

Cognitive therapy places an emphasis on the importance that service users' established beliefs or schemas play in the thought process which sustains problematic situations. Cognitive behavioural therapy acknowledges that both behaviours and cognitions are critical in contributing to psychological distress and dysfunction and, therefore, that focus should be placed on the integration of thoughts, feelings, and behaviours.

## For Whom is it Designed?

CBT is designed for individuals:

- who are experiencing psychological distress and/or dysfunction; and
- who are able and willing to explore how their thoughts, feelings and behaviours are contributing to the problem; and
- who are able and willing to respond to interventions that aim to modify individuals' thoughts, feelings and behaviours.

Although CBT assumes that social workers will be prescriptive in their approach, research has shown that, in practice, modification may be necessary based on the needs of service users: for example, by incorporating more aspects of acceptance and reassurance with service users experiencing eating disorders (Bamford and Mountford, 2012); or by employing more therapeutic relationship aspects when working with children with Asperger's Syndrome (Donoghue, Stallard and Kucia, 2011). CBT can be applied to individual and group settings.

## What are its Limitations?

There are several limitations to the use of CBT:

- Firstly, its focus is primarily on the service user rather than on any social or political factors that may be contributing to the presenting problem – such as oppression, discrimination, cultural expectations or poverty (Sharf, 2012).
- Secondly, the approach requires that service users engage in the process, and this might be difficult when the social worker is working with mandated service users or those who do not accept that they are experiencing any problems.
- Thirdly, CBT is concerned with the here-and-now and fails to address any underlying difficulties that may be contributing to the presenting problem (Teater, 2010).
- Finally, the directive approach of CBT could be viewed as disempowering to service users.

## In What Situation/Circumstances Can it or Can it Not be Used?

CBT is a widely used method in different settings and populations with evidence that it works across cultural groups (Ross *et al*., 2008), but the approach may need to be adapted to fit individuals' culture and environment (Teater, 2010). CBT assumes that service users have the capacity to explore how their thoughts, feelings and behaviours are contributing to the presenting problem, and that they have the capacity to respond to consequences and/or reinforcers; because of this, CBT may not be appropriate in situations or circumstances where service users do not have this capacity or it may need to be adapted to fit service users' needs.

## What is the Research Evidence for it?

The CBT approach has been widely researched and has been shown to be effective when treating problems such as depression, anxiety and self-esteem (Ekers, Richards and Gilbody, 2008; Ishikawa *et al*., 2007; Morton *et al*., 2012), eating disorders (Bamford and Mountford, 2012; Sysko and Hildebrandt, 2009), obsessive compulsive disorder (Jonsson, Hougaard and Bennedsen, 2011), substance abuse and victims of abuse and trauma (Ruffolo and Fischer, 2009), children with externalizing and violent behaviours (Ozabaci, 2011; Squires and Caddick, 2012), post-traumatic stress disorder (Bohus *et al*., 2009; Nixon, Sterk and Pearce, 2012), and recurrent and chronic self-harm (Slee *et al*., 2008).

The National Institute for Health and Clinical Excellence (NICE) in the United Kingdom encourages the use of CBT when working with problems such as eating disorders (NICE, 2004a), obsessive compulsive disorder (NICE, 2005), anxiety (NICE, 2004b), attention deficit hyperactivity disorder (NICE, 2008), antisocial personality disorder (NICE, 2009), and depression (NICE, 2004c).

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# 6.2.6

# Crisis Theory

*Jackie Skinner*

Many service users who come into contact with social work agencies are experiencing trauma or loss. The classic conceptualization of a 'crisis' arose from Caplan's (1964) work in preventive psychiatry. According to him, individuals maintain a level of emotional homeostasis (or balance) and are normally able to use problem-solving abilities to deal with stress.

However, some situations may present such a challenge that those affected are unable to draw on their usual coping mechanisms with the result that a crisis reaction occurs. Importantly and of relevance to service development is the notion that a crisis is time-limited to four to six weeks, after which an individual experiences further psychiatric impairment or damage to emotional growth. Caplan viewed a crisis as a transition period with the potential for an individual to develop an improved self-concept based on the fact that the crisis had been overcome. Adjustment to the crisis is made possible by the individual's existing range of coping skills, the perception of the event and the availability of social support.

Caplan's work continues to be of relevance to social work, especially within the mental health field where workers are involved in assessing the service user's perception of a crisis, work with them on building coping strategies and can explore or mobilize available support networks. Specialized crisis teams limit their involvement to six to eight weeks.

## Seven Stages in the Process of Crisis Intervention

Roberts (2005, pp. 33–34) has usefully identified seven stages that a 'person typically experiences through crisis stabilisation, resolution and mastery. The stages are essential, sequential, and sometimes overlapping in the process of crisis intervention.'

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1. *Psychosocial and imminent danger assessment*. The practitioner needs to assess lethality, ascertaining if the service user has any suicidal ideation present. This assessment would include: asking about suicidal thoughts and feelings, assessing the service user's strength of psychological intent, enquiring into suicidal history and taking into consideration risk factors such as social isolation or bereavement. The service user throughout this assessment needs to feel that they have been heard and understood.

2. *Establishing rapport and building a collaborative relationship*. The practitioner needs to identify with the service user positive factors in their lives such as informal support networks, while also taking into account risk factors such as a significant loss, depression, social isolation or problems in meeting daily needs. As Roberts asserts, building rapport is facilitated by indicating respect for and acceptance of the service user. Trevithick (2005) says that communication is a vital tool. 'As practitioners, to achieve an understanding about what is being communicated means everything at our disposal in order to come alongside the experiences of the people with whom we work.'

3. *Identifying the major problem*. Roberts (2005) suggests prioritizing problems and deciding which to work on first – an approach referred to as 'looking for leverage' (Egan, 1997). This can include allowing the service user to explain how they are feeling about events that may have led to the current crisis. The practitioner should remind the service user of past coping mechanisms they have utilized when faced with previous crises.

4. *Encouraging the exploration of emotions*. The practitioner must allow the service user to express their feelings and be given time to explain their current situation. Listening skills should be employed throughout this process, such as paraphrasing and respectful probing (Egan, 1997). Gradually the practitioner must introduce challenging responses – such as giving the service user information about their current options – into the crisis intervention dialogue.

5. *Generating and exploring alternative strategies*. Service users in crisis tend to cling on to familiar ways of coping even when they are failing to work (de Jong and Berg, 2008). But if stage 4 has been effectively worked through, the service user in crisis ought to be able to re-establish some emotional balance. The practitioner and service user need to consider some of the options available, which may include: the provision of respite, alternative housing, referral to appropriate agencies, counteracting social isolation, reassessing benefit entitlement, GP assessment. Because the practitioner must be careful not to reduce the service user's self-esteem or to create dependency, care should be taken to empower the service user to generate and explore their own alternative coping mechanisms at this stage.

6. *Implementing an action plan*. The utilization of available services will be critical for restoring psychological balance, but, as Roberts (2005) indicates, the cognitive dimension is also essential. The process of recovering from a crisis requires the service user to ask questions about the crisis event. Why did it happen? What does it mean? This is essential if the service user is to be able to cope with similar situations in the future.

7. *Follow-up*. The practitioner must plan for an immediate follow-up contact with the service user. Attention could be focused on the service user's physical condition, overall functioning, any current stressors, and the need for possible

referrals. A further visit should be arranged about a month after the crisis intervention has been terminated. Treatment gains and potential problems should be discussed.

## Research

In a meta-analysis of research carried out into crisis intervention, Roberts and Everly (2006) conclude that there is a need for better planned and more rigorous experimental and quasi-experimental studies on the effectiveness of crisis theory to enable practitioners to base interventions on procedures that are known to work. They say that crisis intervention research has made important progress towards identifying best practices and that common factors in treatment success have been identified. Nathan (2004) predicts future growth and wide-ranging implementation of evidence-based treatments.

## A Cautionary Note

One danger with the technique of crisis intervention lies in its potential to be used in a disempowering manner or to lead towards disempowerment of the service user altogether. There is clearly a risk that the worker might move into a formal, 'authoritarian expert' mode, facing dilemmas concerning both rights and risks; Thompson (1991) argues that such a situation has the potential to place too much emphasis on 'internal' psychological coping resources, limiting the importance of social networks and supports and avoiding any consideration of the issue of oppression. Watson and West (2006) note that to address inequalities of power in relationships, an 'understanding of social disadvantages and discrimination is necessary in the daily work with people in crisis situations to make this method not just effective but ethical' (p. 118).

## Further Reading

A comprehensive outline of the model is provided in A. Roberts (2005) *Crisis Intervention Handbook: Assessment, Treatment, and Research*, 3rd edn. Oxford: Oxford University Press.

Research covering the model and its implementation in practice is given in a study of an analysis of 36 crisis intervention studies: A. Roberts and G. Everly (2006) A meta-analysis of 36 crisis intervention studies. *Oxford Journals*, 6 (1): 10–21.

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# 6.2.7

# Critical Perspectives

*Jan Fook*

Critical perspectives in social work are underpinned by critical social theories. There are different meanings of the term 'critical' as it is applied in social work: sometimes 'critical' simply means crucial or significant, but the perspectives outlined here are based on the word 'critical' as it is used in social theory. This is based on four key principles:

- The importance of challenging social oppressions that can take many forms – structural, interpersonal and personal. There are two main concepts involved: the concept of power and its operation; and the importance of understanding the links between personal and structural oppressions. Power is complex – it does not always simply operate in a 'top down' way. Individuals may sometimes create and manipulate power for different effects. Understanding that there are direct links between personal experience and the individual's social context is important in understanding how people can participate in their own oppression by unwittingly accepting ideas which can actively undermine their own power.
- The concept of 'false consciousness' is relevant to the idea of oppression. False consciousness refers to the presumption that individual people can hold beliefs (consciousness) which work against their own self-interests; a belief may be 'false' in that it is not necessarily true but is important because it has a political function; its power lies in the fact that it is believed, and that it acts to prevent people from doing things that they otherwise might have done and that would serve their own interests. An example of 'false consciousness' would be a belief about 'myself' that functions to ensure that I do not challenge the existing system of power relations. So, for instance, I may believe that because I am from a lower class background I will not be successful in obtaining senior

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management positions in professional circles. Therefore I do not try. It is crucial from a critical perspective that individuals understand how their own beliefs may therefore be derived from something about their social contexts, and may therefore be changed. This is an important aspect of empowerment for individual people.

- In understanding (researching) our social world, we need to appreciate that knowledge about it can be socially constructed. Our approach to research and knowledge creation should therefore include more than just assuming that 'facts' or ideas exist independently of the people and society who use them. It is important to recognize that we ourselves have a role in creating and selecting the knowledge we think should count. With this in mind, self-reflection, interaction and communication become important processes of creating knowledge. Understanding these ideas becomes a foundation for ensuring that people are able to transform themselves by participating in a process of creating new knowledge. Through reflection and dialogue, people can create new understandings of themselves and their own power which allows them to make changes.
- The possibility of social change (which can incorporate personal change) is crucial. In this sense, a critical perspective is not 'deterministic': it upholds and believes in the possibilities for change, and it encourages people to strive for change, rather than being stuck in structures, relations, or ways of behaving which are predetermined.

## Origins of the Approach

Critical perspectives in social work (that were labelled as such) date from 1997 with the publication of a classic book by Australian Jim Ife. Critical social work, however, has its earlier origins in the radical social work movement of the 1970s in the United Kingdom (Bailey and Brake, 1975; Corrigan and Leonard, 1978); and writings about empowerment in North America (Solomon, 1976). The perspective (and analysis) developed further with feminism in the 1980s (for example, Dominelli and MacLeod) and the structural approach in Canada (Mullaly, 1993). Later developments (from Australian authors) have included postmodernism (Pease and Fook, 1999; Healy, 2000; Fook, 2002, 2012). In the United Kingdom it is fair to say that 'anti-oppressive' (Dominelli, 2002) and 'anti-discriminatory' (Thompson, 2006) social work approaches have been more popular. Currently, in the United Kingdom, radical social work is experiencing a resurgence, based on neo-Marxist principles (Lavalette, 2011); in Australia, though, the term 'critical' is still preferred (Allan, Briskman and Pease, 2009).

## Advantages and Limitations

A critical perspective speaks particularly well to the social justice principles of social work. It provides a detailed and complex analysis of how personal experience intertwines with social and structural contexts, and of how this enables personal agency and power. The analysis therefore provides an excellent basis for transformation.

Technically, practice based on this type of analysis is relevant for any form of social work, and may be particularly helpful for empowering workers themselves. However, actually practising on the basis of the perspective can be limited if the links between the personal beliefs of workers (about their own power) and the possibilities for social changes are not fully understood. Critical analysis is not always so easy to apply, given that it often runs counter to our taken-for-granted assumptions about the world.

An error is often made in that many social workers believe that critical social work cannot be practised in repressive settings. In fact, it may be that critical social work (based on an appreciation of the sorts of self-defeating beliefs that workers internalize) can be better practised in settings where the sources of power (and disempowerment) are much more clearly defined. In this sense, practising critical social work is not just about achieving predetermined 'social justice' outcomes, but about developing a more critical approach to understanding one's place and power, and the ability to act on it in different ways and in different contexts. This sort of approach to practice is relevant regardless of situation.

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# 6.2.8

# Desistance

*Beth Weaver*

Interest in the subject of desistance from crime emerged in the 1970s and 1980s. Since then, research has moved beyond seeking descriptive explanations towards revealing how and why people give up crime.

There are inherent difficulties in judging when someone has desisted. Most criminologists associate desistance with *both* ceasing *and* refraining from offending. This is because desistance, like any other behavioural change, is not an abrupt event but a process characterized by lapse and relapse. Some scholars have identified distinguishable phases in this process, but perhaps the most widely recognized is Maruna and Farrall's (2004) differentiation between primary and secondary desistance:

- *primary desistance* refers to any lull or crime-free gap in the course of a criminal career;
- *secondary desistance* is defined as the movement from non-offending to the assumption of a role or identity as a non-offender or 'changed person'.

Theoretical explanations for desistance cohere around maturational reform, social bonds and narratives theories (Maruna, 2001).

## Maturational Reform

Maturational reform theories suggest that people naturally 'grow out of crime' as they mature (Rutherford, 1992). The oft-cited aggregate age-crime curve suggests that offending peaks in early adulthood and then drops off gradually before people reach 30 or 40 years of age (Piquero *et al.*, 2001). It is argued that physical, mental and developmental changes within the person explain this phenomenon. Critics of

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these theories converge in concluding that age indexes a range of different variables, including biological and physiological changes, but also reflecting changes in social contexts, in attitudes, beliefs and values, in life experiences and in the impact of social and institutional processes (Bushway *et al*., 2001). Advancing age is not, on its own, an explanation.

## Social Bonds

Other theories focus on the role of social bonds in triggering change. They suggest, for example, that gaining employment or acquiring significant relationships can support change by creating a stake in conformity and rendering offending incompatible with the change in lifestyle, associations and roles that these bring. However, gaining employment or a significant relationship does not itself produce desistance; what is important is:

- what these ties mean to an individual;
- the perceived strength, quality and interdependence of the ties;
- their impact in buttressing informal social controls, improving self-control, and reducing opportunities and motivations to offend.

## Narrative Theories

Narrative theories of desistance combine individual, relational and structural factors in their explanations of the desistance process. They emphasize the role of subjective changes in the offender and in their sense of self or identity. They are reflected in greater concern for others, in changing motivations, values and attitudes, and shifting relationships within their social frameworks.

## Messages for Practice

While research has revealed the diversity of pathways to desistance, some specific messages have emerged.

Motivation and hope are critical in the early stages of change. Hope can give people a sense of confidence that they can exercise choice and exert influence and control over their lives, and that they can overcome the challenges they face in trying to give up crime (Farrall and Calverley, 2006; Lloyd and Serin, 2011). With hope, a person may be more inclined to take advantage of positive social opportunities and feel more resilient when they encounter setbacks – though it is important that the problems they encounter are not perceived to be overwhelming (LeBel *et al*., 2008).

Positive factors that help to bring about change include:

- someone believing in the individual;
- increased distance from the label of ‘offender’;
- identification with and internalization of a more constructive, non-stigmatized identity or role, be that as an ex-offender, parent, or by virtue of their occupation.

In this vein, involvement in 'generative activities' (contributing to the well-being of others), such as mentoring, peer support and volunteering, can support the development of an alternative identity (see Maruna and LeBel, 2009; Weaver, 2012).

However, desistance is not just about the acquisition of a sense of agency or hope; nor is it only about the experience of shifts in one's personal and social identity. Desistance requires social capital – which is essentially the network of social or relational connections that exist between people, based on norms of reciprocity and mutual helping, through which we achieve participation in society (Fukuyama, 2001).

Dynamics in the process of desistance resonate with concepts of resilience with young people (Robertson *et al*., 2006), recovery from addiction (Best *et al*., 2010) and processes of recovery in mental health (Brown and Kandirikirira, 2007; NSW CAG, 2009).

Desistance research provides a wealth of knowledge for practice, but it does not provide a manual or method that can be universally applied. It does, however, indicate general principles that have relevance to social work fields beyond criminal justice.

1. The change process depends on more than the interventions of formal support systems; individuals and informal networks have particular contributions to make. Practice should focus on maintaining, protecting and developing the ties that matter to the individual. It should aim to enhance their capacities to sustain positive roles and relationships. It should support them in the process of building networks and contexts in which shifts in identities can be embedded and through which they can make useful contributions to families, groups or communities.
2. There is an emphasis across change-focused literatures on the centrality of narrative reframing work to support identity transformations. Stress is laid on the importance of strengths-based approaches in the development of people's personal, psychological and social resources and capacities.
3. Developing motivation, hope and agency are key tasks for practitioners (McNeill *et al*., 2012). Participatory and empowering approaches to practice might be one means of realizing this (Weaver, 2011; Weaver and Lightowler, 2012). Indeed, across the recovery and desistance literatures, placing people, not programmes, at the centre of change management processes is seen to be of crucial significance in people's accounts of how change has been achieved. The individual's active role and ownership of the change process must be fully respected.

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# 6.2.9

# Theories of Empowerment

*Jerry Tew*

The term 'empowerment' is used (and misused) widely within social work. It describes a value or orientation towards practice – one which seeks to enable individuals, families or groups to take power for themselves and, as far as possible, assume responsibility for making their own choices, managing their own affairs and participating fully within the life of their community. Instead of seeking to rescue or control people who are in vulnerable or risky situations, an empowerment approach explores how people may take charge of resolving these situations for themselves, building upon whatever strengths and resources they may already have (Saleebey, 2006). However, such processes of taking power may not be straightforward and take place within particular contexts of social power relations.

Within sociology and psychology there are very different theories of power. Many of these relate to the exercise of *power over* others (individually or collectively) – which is not the goal of empowerment as generally understood. However, for many of us, understanding and freeing ourselves from some of the ways in which others may exercise *power over* us may be the first step towards taking any significant power for ourselves. This may involve resisting the impact of wider structures of power, as in tackling racism, economic deprivation or homophobia (see sections 6.2.2 on anti-oppressive practice and 6.2.11 on feminism in this volume), or may involve dealing with more localized constructions of dominance and subordination, as in bullying or abuse – and may often involve both.

Empowerment theory is primarily about the productive deployment of power in order to open up opportunities that would not otherwise have been possible (Tew, 2002); it is about achieving *power to* and *power together* with others 'so that individuals, families, and communities can take action to improve their situations' (Gutierrez, 1995, p. 229). Crucially, it marks a shift away from a more traditional

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view of power as a competitive 'zero sum' game in which power is seen as a finite commodity and any individual's gain has to be at the expense of another's loss.

There is no single theory of empowerment. Processes of empowerment generally involve three interacting dimensions – each of which has its own frameworks for theoretical understanding:

1. *Personal efficacy.* From a foundation in social learning theory, Albert Bandura (1977) proposed that personal efficacy (our *power to*) involves both the confidence that we can exercise agency and influence, and the capabilities by which to do so. Both confidence and capability can be learned, but only in situations where there are real opportunities to exercise choices, make decisions and follow through actions – and where such intention and activity brings rewards. Here, social learning theory needs to be supplemented by a recognition of our personal histories. Experiences of discrimination, subordination or abuse may render us lacking in both confidence and capability – we may have come to fear using power for ourselves in case of retribution.

The motivation to act or take more control may arise through a growing awareness of injustice – helping us to understand our situation in ways that move us on from narratives of blame and victimization which render us powerless (see, for example, Freire, 1970). Unlearning such negative beliefs may only be effective if our initial tentative steps towards using *power to* are supported by social contexts that allow and encourage this – and negotiating this space with family and peers may be an important focus for intervention.

2. *Empowering relationships.* Challenging more competitive and individualized notions of power and 'will', Jean Baker Miller (1991) emphasized the importance of cooperative relationships of *power together* as a way for those in disadvantaged positions to open up opportunities for change and development that would not be available to them as atomistic individuals. What can be particularly empowering are relationships that offer us *recognition* for who we are and this may be seen to apply on both micro- and macro-scales. However, it should be noted that not all instances of *power together* are productive. *Power together* may also be collusive – forming an 'in-group' or solidarity can involve 'othering' those that are seen not to fit.

While it may be easier to establish mutuality and *power together* with others who are 'like us', this can lead to a rather limited and inward-looking mindset: it is often the challenge of developing mutual relationships with those we may have seen as 'other' that can be most empowering – as long as the implications of any underlying power differentials are acknowledged (Tew, 2006). For social workers, moving out of positions of *power over* and establishing a basis for mutuality and human connection may be a crucial foundation for enabling the empowerment of service users and families – as long as there is space to discuss issues such as the potential use of statutory authority.

3. *Enabling social contexts.* The capabilities approach of Amartya Sen (1993) may be useful in analysing what social and economic opportunities would be meaningful for us, and whether or not these are currently available – and hence identifying where interventions may be helpful in enhancing opportunities. Alongside this, social capital theory provides a framework for analysing our access to 'the actual and potential resources' that come from our membership of formal and

informal social networks (Bourdieu, 1986, p. 248). A fuller exposition of how this can be applied in social work can be found in Hawkins and Maurer (2011).

It can be helpful to distinguish between two forms of social capital. *Bonding social capital* describes the potential resources for mutual support and collective action that may derive from relationships with 'people-like-us'. *Bridging social capital* denotes connections of *power together* that cross boundaries which may be particularly important in opening up opportunities for members of disadvantaged social groups (Puttnam, 2000). Both forms of social capital may play a crucial role in empowerment. However, attempts to assist people in building their social capital may come up against 'conservation strategies' deployed by those in more privileged positions whereby to exclude those identified as 'other' (Bourdieu, 1986).

Empowerment has been particularly influential in fields such as mental health and disabilities where service users have been more forward in claiming power for themselves (Chamberlin, 1997; Barnes, 2007) – and underpins moves towards 'personalization' or self-directed support. However, it is equally applicable to other fields such as children and family services where initiatives such as Family Group Conferencing have been shown to provide effective alternatives to more paternalistic forms of practice (Barnsdale and Walker, 2007).

Where the application of empowerment theory is more complex is in situations where statutory authority is being used. However, it may still be very relevant if there can be a longer-term focus on how individuals and families can potentially reclaim power and responsibility for themselves.

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6.2.10

# Family Practices

*Christine Jones*

The concept 'family practices' first caught my attention as a researcher looking for an explanatory theory that adequately captured the experiences described to me by adoptive parents of building new family relationships following adoption (Jones and Hackett, 2011). 'Family practices' refers to the daily work undertaken by social actors to create and maintain a sense of family connectedness. The concept was developed by the sociologist, David Morgan (1996, 2011), and draws on the work of the social philosopher Pierre Bourdieu (1977, 1990). The term fits within a social constructionist perspective on families and has been influential in re-energizing the sociological imagination of academics working in this and related fields.

Morgan highlights some of the limitations of traditional sociological concerns with 'the family'. He suggests that the use of the term 'family' as a noun leads towards normative and, therefore, restrictive views of what constitutes a *proper* family. Often this is taken to mean the hetero-normative model of the heterosexual couple and biologically related children. Instead he suggests that the use of the term 'family' as an adjective creates possibilities for more inclusive and diverse definitions of family relationships that take account of subjective meanings and the socio-cultural context in which such meanings are created and expressed.

Morgan outlines six key aspects of the term 'family practices' that he wishes to convey when exploring its analytical potential:

1. 'Family practices' focuses on both the actor's and the observer's perspective. Morgan avoids normative prescriptions of what counts as a proper family. At the same time he is careful to incorporate but not privilege subjective accounts over researcher interpretations. This dual focus on both *perspectives* allows some exploration of differences.

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2. 'Family practices' focuses on *actions* – on what is done. This moves the analysis beyond the traditional focus on family and household structures and opens up possibilities for new understandings of family and family-like relationships to emerge.
3. 'Family practices' focuses on day-to-day experience and the taken-for-granted aspects of *daily life*. The significance of these seemingly mundane actions becomes apparent when understood within a wider social context.
4. 'Family practices' focuses on actions that are repeated – as opposed to one-off actions – and on actions that have a sense of *regularity* or rhythm. This represents a shift from family structures to family processes.
5. 'Family practices' moves away from fixed definitions of family to accommodate the possibility of *shifting* social realities.
6. 'Family practices' acknowledges the historical and biographical *context* within which family life is shaped and played out.

Morgan's writing takes account of the changing patterns of family relationships within contemporary Western societies. These changes have proved highly challenging to traditional conceptualizations of family relationships and have provided fertile ground for rethinking definitions. For example, the introduction of civil partnerships and the arguments in favour of gay marriage represent a major shift in the acknowledgement of the legitimacy of gay partnering. Empirical work has focused on family relationships following divorce (Smart and Neale, 1999), gay and lesbian relationships (Weeks, Heaphy and Donovan, 2001) and more recently child and family social work (Jones and Hackett, 2012).

The concept 'family practices' sits alongside developments in kinship theory within anthropology where there has been a move away from narrow definitions of 'the family' based on biological connection (the blood relative) and legally defined relationships (such as marriage and adoption) towards an emphasis on diverse forms of 'relatedness' (Carsten, 2004). New anthropological studies of kinship have put emphasis on the power of social agents to define family as family. For example, Weston's study of gay and lesbian relationships in the San Francisco Bay area in the 1980s was ground-breaking in its exploration of the 'family' quality of such relationships and its introduction of the term 'families of choice' (Weston, 1991).

Anthropologists have also turned to new reproductive technologies to re-examine kinship. For example, interesting questions have been raised around family identity as health technologies have been developed that allow gay men to father a child through a surrogate 'mother', or a woman to achieve a pregnancy using her dead husband's frozen sperm (Carsten, 2004; Inhorn and Birenbaum-Carmeli, 2008). Conclusions are drawn that neither biological nor legal definitions of family relationships alone can adequately capture people's lived experience.

For practising social workers, the concept 'family practices' has much to commend it. As a theoretical approach to understanding 'family', it prompts questions such as:

- 'What are family relationships?'
- 'How are they made and lost?'
- 'To what degree are these a private or a public matter?'
- 'How should the state be involved in such matters?'

A focus on 'family practices' demands a degree of questioning uncertainty around what counts and does not count as family or *proper* family. It does not deny the powerful cultural appeal of biological connections, but equally it does not privilege biological connections over other family-like relationships. This approach leaves room for much creativity on the part of social actors to forge family relationships and obligations in new and empowering ways. This fits well with social work's concern with challenging oppression and tackling discriminatory structures and behaviours. Potentially, the approach leaves room for the sense of 'family' created within, for example, foster families or residential care settings to be valued as highly as the sense of 'family' created in birth families and within kinship care arrangements. It does not deny the reality of legal categories of relationship and the consequences that flow from these, but it does acknowledge the power of social actors to define situations in diverse ways and to push against the boundaries of social and legal definitions. The analytical potential of the concept 'family practices' within social work theory, research, policy and practice remains under-explored but I believe it has much to offer.

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# 6.2.11

# Feminist Theory

*Bec Buss*

Feminism is an essential concept for all student social workers to grasp and to carry into their practice. At its core, feminism questions the way in which women are seen in and are treated by society. It argues that discrimination starts as women are seen *in relation to men* rather than by looking at women in their own right (Beasley, 1999). In most societies, men are responsible for defining what is 'important'. This leads to inequalities of power where men have the upper hand; it has an impact on all aspects of life – individual and group psychology, family make-up, gender roles, politics, social structures and economics.

Consider, for example, in the United Kingdom:

- How many women are in parliament? How many are in the cabinet? (www.parliament.uk)
- Who are more frequently called upon in the media as experts in the field of science, economics, mental health? (Cochrane, 2011)
- How are women, both service users and carers, seen in terms of social work? (Warner and Gabe, 2008)
- How many cases of sexual assault are successfully processed through the courts? (Wolf, 2012)

Debates within feminism have led to it being categorized into a number of different streams – Liberal, Radical, Black, Socialist, Marxist, Post-feminist and Materialist. Let us take a snapshot of some of these.

*Liberal Feminism* (Friedan, 2010) generally believes that women and men should be treated by their personal attributes rather than because of their gender. Education is seen as an important feature to bring about change. Mary Wollstonecraft, Betty Friedan, and Gloria Steinem are often cited as examples of liberal feminists. While this has led to advances such as legal attempts to ensure equal pay, other streams of feminism point to the fact that patriarchy still means that women are not seen as equal to men.

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*Radical Feminism* (Crow, 2000) originated around the 1960s and argues that, because inequality between men and women is due to patriarchy, a completely new system is needed to address this. A feature of this stream lies in the argument that male violence is perceived as a primary method of controlling women. Originally, radical feminists were described as 'man haters' by critics, but the radical discussion has moved beyond this point.

*Black Feminism* (Mirza, 1997) asserts that race, class, gender and other issues interplay and need to be addressed together (Hill Collins, 1990). It tends to argue that there needs to be both a change in individuals and a transformation in political and economic institutions. Only then will there be significant social change.

*Socialist Feminism* and *Marxist Feminism* (Zhongqiao, 2011) identify that women are exploited in two roles: in work, for example with lower wages; and in the home including through the unpaid labour of bringing up children and running the household. Socialist feminism sees the exploitation of women being perpetuated by ideologies such as 'women are more passive', or 'women are better with children'. This leads to both men and women being socialized into gender-based roles. Marxist feminists focus on social class rather than patriarchy and believe that gender equality will not be achieved under a capitalist system.

A cautionary note is that these categories are, of course, not necessarily distinct and many thinkers do not fit easily into a single box. At times, debate between those calling themselves feminists has become heated but could be better seen as a sign of diversity. Feminism should not be considered a Western theory but one which is expressed in its numerous forms worldwide (Wolf, 2012; also see SCIE web site). Feminist approaches should not be seen as being exclusively for women. They provide a broad understanding of how societies function and how this impacts on both men and women, though clearly the focus is on the way in which social structures disadvantage women.

The way in which society views women has an impact on both service users and social workers. For example, in my work as a children and families social worker, I have frequently seen young women who have been encouraged by professionals to embark on hair and beauty or childcare courses; indeed, these career routes are often suggested by young girls themselves. The view seems to be that these are the only professions available for girls, especially if they are from a working class background. As a social worker, it is helpful to use a (Marxist/Socialist) feminist perspective when considering this. For the social worker simply to suggest alternative career opportunities might seem to be a straightforward approach; but that is far from being so, given the unspoken – or spoken – expectations of family, peers, wider society and the internal thoughts of the girl herself (see Brückner, 2002 for more on this). As a critical thinking social worker, sensitive to feminist theory, you will be able to take a step back and consider how a theoretical understanding might help in assessing this situation. Hopefully this will lead you to some thoughtful anti-discriminatory practice on a number of levels – child, family, institutions, society.

Arguably, one of the areas where feminist theorists have had the most impact is in highlighting issues of domestic violence (Hester, 2009). While violence from women to men and within same-sex couples should not be ignored, Women's Aid points to male-on-female violence being common. From the early socialization of children through to power issues when a woman tries to leave a controlling partner,

feminists have considered social and psychological processes in regard to domestic violence. This has resulted in campaigns and discussions which in turn have raised public awareness, changed government policy, and promoted organizations which provide support. In one respect, however, feminist theory has been more limited in its influence: despite women being 'victims', they are still often viewed as being responsible for 'failing to protect' children, or are made to feel guilty for their relationship by professionals (Worrall, Boylan and Roberts, 2008).

Given that the majority of those who are at the end of social work involvement are women (Milner, 2001), it is not too much to expect social work practitioners to have an awareness of the place of women in today's society and of the discriminatory challenges they face in their everyday lives. Feminist theory helps the social worker to achieve a better understanding.

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6.2.12

# Maintenance Theory

*Martin Davies*

Maintenance theory states that the role of social work is twofold: to enable individuals to maintain their own role in society, and, by so doing, to maintain society in a state of social equilibrium.

A by-product of the structural/functional school of thinking in sociology (Merton, 1968), maintenance theory was proposed as a way of dealing with the paradox that, since the mid-twentieth century, social work has expanded rapidly in the United Kingdom and elsewhere despite frequent and widespread empirical demonstrations of its limited therapeutic effectiveness. Maintenance theory offers, not a guide to social work method, but an attempt to explain the role of social work in contemporary society.

It reflects an assumption that social work is a key publicly-funded profession serving the ends of the welfare state, and that its primary focus is on those who find themselves on the margins of society.

Maintenance theory had its origins in probation research that was faced with making sense of the cumulative evidence that suggested that social work intervention, whether focused on the individual or the environment, appeared to have only a limited effect on the lives or behaviour of those under supervision. In the criminal justice system, probation did, however, divert offenders from the experience of imprisonment – which research has shown to be often counterproductive and to lead to higher levels of criminality (the 'university of crime' argument); thus, probation could be said to offer individual offenders the chance to change course – not because of therapeutic intervention, but because it offered the individual an opportunity to desist.

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Social work in other spheres makes use of foster care, adoption, care management and the personalization agenda – all of which are designed to enable vulnerable people to be empowered and to move forward with appropriate support.

Maintenance theory asserts that the primary function of social work (and the reason why it is funded out of the public purse) is to maintain the community-based independence of adults, to protect the short- and long-term interests of children-at-risk (who represent constituent members of any future society), and to contribute towards the creation of a community climate in which citizens can maximize their potential for personal development.

Maintenance theory is not intended to guide social workers in their day-to-day practice. It does not offer any recipes for successful social work, but seeks to explain the place of social work in contemporary society. It is perfectly compatible with methods-related theories that are designed to contribute to improved opportunities for self-maintenance or personal development. That compatibility is limited only by the absolute principle that the social worker's efforts should contribute to the maintenance or improvement, not the deterioration of the individual service user's position. It has echoes of Florence Nightingale's classic clinical injunction that hospitals should 'do the sick no harm'. Social work should never, as a result of the worker's own actions, produce a worsening in the service user's position.

The theory is unusual in social work in that its core assertion is not drawn from the work of psychologists (as is the case with the cognitive behavioural approach or attachment theory), sociologists (as with systems theory) or political or moral ideologists (as in anti-discriminatory practice or feminist theory), but has emerged directly from empirical studies in social work: studies that sought answers to the question, 'In practice, what is it that social workers do?'

The theory postulates that the social workers' varied skills and the resources on which the social worker can draw represent a triumphal characteristic of our modern welfare state. Never before have people on the margins of society been able to draw so heavily on the skill, commitment and sensitivity of a state-funded professional service committed to help them maintain themselves in a state of equilibrium.

That is social work's agenda, as revealed in empirical research studies.

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# 6.2.13

# Motivational Interviewing (MI)

*Barbra Teater*

Motivational interviewing (MI) is a collaborative method that presumes behavioural change is achieved by utilizing the basic elements of Rogers' (1959) person-centred approach – empathy, unconditional positive regard and congruence – yet is goal-directive in identifying service users' intrinsic motivation to change, resolving the ambivalence towards change and moving through the stages of change (Miller and Rollnick, 2002).

Change can become difficult for service users when they are ambivalent about the extent to which the change will be beneficial. MI presumes service users will commit to change when they are motivated, or when they see the importance of making a change, have the confidence and are ready, and have connected the change to something of intrinsic value (Miller and Rollnick, 2002). Service users' *intrinsic value* and *ambivalence* to change comprise the critical working elements for the social worker. In exploring service users' intrinsic value and ambivalence, social workers should adhere to the following four basic principles:

1. express empathy – a genuine interest in service users' feelings, experiences and perspectives;
2. develop discrepancy – listening for discrepancies in current behaviour and present values or future goals;
3. roll with resistance – avoid arguing for change;
4. support self-efficacy – a genuine belief in service users' abilities to make a change (Miller and Rollnick, 2002).

Implementing MI in practice requires an understanding of the Stages of Change model (Prochaska, DiClemente and Norcross,1992), which consists of five stages:

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1. Precontemplation – individuals do not see that there is a problem and have no intention of changing;
2. Contemplation – individuals acknowledge a problem, but are not ready to make the change;
3. Preparation – individuals take the necessary steps to address the problem and make the change;
4. Action – individuals make the change;
5. Maintenance – individuals have maintained the change for six months.

Social workers are able to determine the appropriate interventions once they have assessed service users' stage of change.

Motivational Interviewing suggests the following techniques for assessing service users' motivation and to change:

- scaling – service users rate on a scale of 0–10 the importance, confidence and readiness to change;
- open-ended questions – asking 'How would you like things to be different?';
- decisional balance (Janis and Mann, 1977) – this involves asking service users to consider the pros and cons of changing and staying the same (Miller and Rollnick, 2002).

The development of a plan to make a change should include end goals, specific tasks to reach the goal, suggestions for maintaining the change and relapse prevention strategies (Miller and Rollnick, 2002).

## What are the Origins of MI?

MI was developed by two clinical psychologists, Dr William Miller and Dr Stephen Rollnick, and was based on theories from social psychology, such as cognitive dissonance and self-efficacy, Rogers' person-centred approach, and the Stages of Change model (Britt, Hudson and Blampied, 2004; Prochaska, DiClemente and Norcross, 1992; Rogers, 1959). Dr Miller initiated the MI approach after working with service users having problematic drinking behaviours who were not responding to interventions that challenged their behaviour and attempted to persuade them to change. Dr Miller believed that a more effective method should encompass an acknowledgement of the stages of change and a collaborative, client-centred approach to help service users identify their intrinsic motivation to change.

## For Whom is it Designed?

MI is designed for use with service users who need or desire to make a behavioural change in order to overcome problems or difficulties. MI is often used within drug and alcohol treatment or health care settings with individuals yet can also be used in group settings. MI is designed to be used with individuals at any stage of the change process.

## What are its Limitations?

There are several limitations to incorporating MI into practice. Firstly, MI assumes that service users will be able to make connections between their current behaviour and their values or future goals, yet not all service users are able to do so. Secondly, MI may be more difficult to use with mandated service users and those who do not believe they have a problem. Such individuals may change immediately, yet resort to normal behaviours after the work together has ended. Finally, some service users may want the social worker to be more directive in providing guidance than the ethos of MI suggests (Miller and Rollnick, 2002; Teater, 2010).

## In What Situation/Circumstances Can it or Can it Not be Used?

MI is designed to be used in situations or circumstances where service users need or desire to make a change and is often used in settings that address addictive or potentially harmful behaviours. MI presumes that service users are the experts in their situation and requires that they have the ability to link their current behaviours to their actions, intrinsic motivation and desired future goals. Therefore, MI may not be appropriate for use in situations or circumstances where service users are unable to make these links or where the problem has been identified by someone other than the service user.

## What is the Research Evidence for it?

The evidence base of MI has pointed to the effectiveness of the approach when working with alcohol problems, cigarette smoking, other drugs of abuse, psychiatric treatment adherence in dually diagnosed patients, treatment compliance, water purification, gambling, relationships, HIV risk behaviours, diet, exercise and other lifestyle changes and eating disorders (Heckman, Egleston and Hofmann, 2010; Lundahl *et al*., 2010). The use of MI with service users experiencing alcohol problems or drug addiction has led to good maintenance over time; treatment adherence and retention is more effective than no treatment and is effective as either a stand-alone treatment or as a prelude to other treatments (Hettema, Steele and Miller, 2005).

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# 6.2.14

# Narrative Therapy

*Stephen Madigan*

At the heart of social workers David Epston and Michael White's creative practice known as *narrative therapy* (Epston and White, 1990; Epston, 1988; White, 2004) is an unswerving commitment to a relational/contextual/anti-individualist therapeutic view of people and relationships. Turning away from 150 years of psychological thought, narrative therapy is founded on an ideology designed to *counter* the decontextualized, skin-bound, non-relational, individual self (Madigan, 1992, 1996, 2008).

The practice of narrative therapy is primarily concerned with questioning the politics of identity making and of who has the story-telling rights to the story being told in therapy. The practice has also brought forth the unique idea that the *person is not the problem – the problem is the problem*. This practice is known as externalizing the problem (White, 1989, 2002). It sets out to separate the person/client from the problem (and/or the restraints which maintain the dominant discourse about the problem).

By taking up a post-structural theoretical view of the self as relational, narrative therapy proposes that the complexity of life, and how lives are lived, are mediated through the expression of the stories we tell (Madigan and Epston, 1995; White, 1995). (Narrative therapy is under the influence of post-structural ideas put forth by the fields of post-colonial, Queer, post-feminist, critical disability studies, literary criticism, anthropology etc., which challenge isolated unitary descriptions of the self.) And these stories of our lives are fully shaped by the surrounding *dominant* cultural and discursive context. Narrative therapy believes in the idea that the stories we tell (and do not tell), are performed, live through us and have the ability to both restrain and liberate our lives.

A narrative therapy perspective brings forth a multi-sited and multi-storied idea of the individual, and disputes any universalized/totalized descriptions of who

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persons are stated or labelled to be by the expert of psychological and social work knowledge (Madigan, 1992, 1997). This therapeutic concept affords the narrative-based social worker a flexibility to view persons and problems *not* as fixed, fossilized or under any one unitary description, theory, or label. Where most psychological theory wants to pin a person's identity onto a category of behaviour (for example, attention deficit disorder), narrative therapy wants to open up the discussion to include multiple possibilities describing who the person may have been, might be and may become – outside the boundaries of the problem description. This allows both client and therapist the possibility to revise, recollect and remember a story from various and competing perspectives (Madigan and Epston, 1995; Madigan, 2007). It is among the many forms of relational re-authoring conversations that change is believed to take place in narrative therapy.

Re-authoring conversations are a crucial part of both the philosophical underpinnings of narrative therapy theory as well as the practice work itself. The purpose of constructing re-authoring conversations is a responsibility and accountability towards exploring the issue of *story-telling rights* and more specifically, *who has the story-telling rights to the 'problem' story being told?* From a narrative therapy perspective, it is the stories people tell and hold onto about their lives that shape and determine the meaning they give and how they express their lives. Therefore, it is what *we select out as meaningful* from the stories we tell that is given expression (Epston, 1988; Madigan, 2009, 2011).

Re-authoring conversations act to reinvigorate people's efforts to more fully inhabit their preferred lives and relationships (Madigan, 2008). For example – a narrative therapist might ask a group of men about what it means to be a man and pose the following questions:

- At what point in the history of men's development as men did these essential ideas about being dominant first emerge?
- In what specific ways do these ideas (practices) about being a man shape your life?
- If you were to decide to step further away from non-violent living what do you imagine this would require you to do to your life in the future?

Narrative therapy questions are central to the narrative practice of re-authoring lives and relationships (Epston, 2009). Questions act to open discursive space for new descriptions, exceptions, and information previously restrained by the problem. The intention of narrative questioning is to include news of information and difference that weakens the problems version of the client and their family. Questions are grammatically designed to unpack the politics of the problem and predict possible futures, moments of freedom, and victories across the temporal plain (past – present – future).

Re-authoring conversations provides conditions under which it becomes possible for people to step into the near future of the landscapes of action of their lives. Questions are introduced that: 1) encourage people to generate new proposals for action, 2) account for the circumstances likely to be favourable to these proposals for action, and 3) predict the outcome of these proposals (Madigan, 2009, 2011).

Narrative questions also act to contradict the problem-stories dominance in the person's life. Post-structural questions explore multiple discursive contexts that have

helped *train* the person into the problematic lifestyle. For example, when asking questions regarding a woman's relational struggle with anorexia (Madigan and Goldner, 1998) a narrative therapist may ask:

- What rules of anorexia did you have to break in order to come to therapy today?
- Given perfections' influence on women's lives and relationships, have there been any times when you have been able to rebel against it?
- By what methods do you think women get trained up into body surveillance?
- Have there ever been times that you have thought you might step away and out from under anorexia's death march?
- How is it that anorexia wants to kill some of the best minds of our generation?
- Is there any memory of you giving anorexia the slip to indulge yourself in an anti-anorexic conversation?
- Can you imagine a time in the future when you might defy the culture of anorexia and give yourself a break?
- Do you know any other women who have done this?

Narrative therapy questions asked (and not asked) are never conceived of as neutral since:

1. they state a particular political ideology and location;
2. they stand behind a particular psychological/theoretical position;
3. they are active and push towards preferred directions;
4. they are shaped through the trinity of power, knowledge and rhetoric;
5. they are not viewed as solitary structures but as historical texts;
6. they are influenced by communities of discourse;
7. they are culture-specific;
8. they do not solely belong to the questioner; and
9. all questions are interpretive and do not hold a truth status.

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6.2.15

# Person-Centred Practice

*Ali Gardner*

Person-centred practice (PCP) is about working with individuals to enable them to have more choice and control in designing, implementing and reviewing the support that they receive.

Traditionally, the delivery of social care services has been influenced by paternalistic values, whereby the *state* through the medium of the *expert professional*, identifies, quantifies and organizes support. Person-centred practice places the individual receiving support in the driving seat. 'Person centred thinking and planning is a way to connect fundamental beliefs about what people want with practical ways of making it happen for individuals' (Sanderson and Lewis, 2012, p. 20). The core principles underpinning PCP involve listening, sharing power, responsive action and connecting with citizenship.

Since the 1960s, disabled activists and people in the mental health survivor movement have campaigned for a shift in the relationship between the state and the service user. Concerned about the way the state controlled and dictated how welfare services were distributed, they sought to introduce notions of independent living based on a social model of disability (Swain *et al.*, 1993), whereby the focus was placed on the physical and attitudinal barriers excluding a person. Theories of normalization (Nirje, 1969) and the idea of social role valorization (Wolfensberger, 1972) argued that disabled people should have positions in life that were valued in the same way that was afforded to non-disabled people. This work influenced ideas around person-centred thinking, which John O'Brien brought to the United Kingdom, proposing that work with people with learning disabilities should be informed by five accomplishments: community presence; relationships; choice; competence; respect (O'Brien, in Brown and Benson, 1992).

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Formal recognition of person-centred practice came in the shape of the White Paper, 'Valuing People' (DH, 2001) that identified PCP as central to delivering the government's four principles: rights, independence, choice and inclusion. 'Valuing People' made the link between care management and PCP explicit, noting that 'care management will continue to be the formal mechanism for linking individuals with public services. Its systems must be responsive to PCP' (DH, 2001, p. 50). Since then, PCP, personalization and self-directed support have secured a central place in government policy relating to the delivery of adult social care.

The emergence of the personalization agenda has brought with it a growing sense that real change will require 'root and branch changes to policies, practice and culture' (Sanderson and Lewis, 2012, p. 15). Whilst personal budgets and direct payments are centrally important to the future of adult social care, a recognition that giving people real choice and control over their day-to-day support is the key ingredient to achieving change at an individual level. In this sense, PCP can be seen to be crucial for the delivery of personalization. Listening and focusing on what people want must become the key role of professionals and support workers. Duffy (2004) argues that a *professional gift* model of service delivery – one that assumes that needy individuals will be given what they need by the professional who understands those needs – must be challenged. In contrast, Duffy calls for the adoption of a *citizenship model*, whereby notions of rights and entitlements and of enabling individuals to contribute to society are central to achieving independence. PCP is one way this can be achieved. This shift in power has more recently been referred to as 'co-production', whereby individuals are viewed as 'assets who are equal and essential partners in their own support, treatment and recovery, as well as in designing and delivering services' (Sanderson and Lewis, 2012, p. 26). Co-production can take place at an individual level through PCP but also at a service level, whereby the individual engages with professionals and service providers to design and review social care services more generally.

Models of self-directed support have relied heavily on person-centred thinking to shift the power from professionals to individuals: for example, the development of self-assessment, whereby individuals are recognized as experts in identifying and quantifying their own needs. The skill required of the social worker is to 'help draw out that expertise so service users can confidently express their own needs' (Gardner, 2011 p. 40). In the support planning phase of self-directed support, PCP tools such as 'Good days, bad days', 'Top tips', 'Relationship Circles', 'Communication charts', 'Decision-making profiles' and 'Doughnuts' (Sanderson, 2000) can provide practical ways of enabling individuals to design their own support. Further detail on these tools can be found on the web site: www.helensandersonassociates.co.uk (accessed 17 October, 2012).

Person-centred tools have been used to ensure that the individual is central to the review process and that meetings focus on the outcomes as identified by the individual rather than the professional. Traditionally, reviews are process-driven and professionally-led so that paperwork can be completed. While recognizing that providing data for council performance management systems and information to inform commissioning decisions or satisfying safeguarding protocols are all important, these aspects should be drawn out of the review rather than be allowed to dominate it (Cambridge and Carnaby, 2005).

Personalization and PCP have secured support on either side of the political spectrum, and the introduction of policy has rarely been questioned. Implementation of personalization, however, has not always been so harmonious. Frustrated by inadequate resources, unrealistic targets and rigid process-driven systems, workers have sometimes struggled to achieve the more radical transformational outcomes they had hoped for. While many social workers have embraced the idea of using PCP to deliver personalization, recognizing the potential to do *real social work*, suspicion still remains for some social workers (Ahmed, 2008), who fear that personalization is being used to address severe resourcing issues and ultimately poses a threat for the future of the social work role.

Those who see disability as being *quintessentially collective* have expressed concern in relation to the level of emphasis placed on individual experience (French and Swain, 2006). They warn that this perpetuates 'medical model' thinking in that the problem is located with the person and the collective need remains hidden. Furthermore, Spandler (2004) claims that purposeful fragmentation can lead to a loss of the collective voice, thus easing the government's responsibility for the delivery of high-quality services to all vulnerable people.

Research findings are starting to emerge in relation to PCP and personalization, including the national evaluation of individual budgets carried out by the Department of Health (Glendinning *et al.*, 2008). From a health perspective, it has been found that the most effective spending plans tend to be the outcome of a person-centred planning process (Alakeson, 2007). A study of personal health budgets found that participants reported increased confidence and self-esteem as they felt their views had been listened to.

PCP is extending to different areas: carers, disabled children, prevention and well-being, long-term conditions, mental health recovery, reablement, support at home, residential care, end of life, and approaches to risk. The use of PCP to deliver personalization, in particular personal budgets, has more recently been adopted within health, probation, drug and alcohol services and education.

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6.2.16

# Psychodynamic Theory: The Essential Elements

*Jack Nathan*

Whilst differences exist between different psychoanalytic schools, clinicians working within the 'psychodynamic frame' share certain key elements.

The first key element is that the mind operates on a *conscious* and an *unconscious* level, and that there is a dynamic relationship between these two levels of consciousness that result in powerful *internal psychic conflicts*.

For example: Tom repeatedly misses key meetings with his worker regarding having his child back home. His *conscious explanations* include: he 'forgot', 'the traffic was bad', etc. These accounts mask *unconscious dynamics* which may include being fearful of the worker's persecuting authority ('I'm going to be attacked for being a bad father'), Tom's tendency to sabotage progress in their work together ('I destroy all my relationships, even with my child'), even that he does not want his child back ('I'm too much of a child myself to be a responsible parent') and so on.

Implicit in this form of practice is *hermeneutics*: 'the making of meaning' where the practitioner's task is to explore the client's behaviour. This is particularly the case when confronted by what appears, at a 'common sense' level, contradictory: viz. Tom consciously asserts that he wants his child home. The need to understand psychic conflict and how we 'make meaning' of highly destructive forms of behaviour is especially crystallized in clients who self-harm.

For example, Sarah tells her social worker that as well as regularly burning herself, when cutting her legs with a razor blade, she pours acid on the wounds. The client is both a 'victim' of the cutting, burning, etc., and also the 'perpetrator' of these self-damaging acts. Such behaviours, however destructive, do having meaning: as a way of managing overwhelming anxiety, and/or as an expression of rage against her hated 'weakness' and/or a protective act ensuring that she doesn't violently attack someone else.

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Such complexities are further compounded by the hugely powerful emotions aroused in us as practitioners. We can feel particularly perplexed, when confronted by the sheer violence of the self-harmer.

This touches on another key feature, namely that 'meaning making' fundamentally arises out of *the relationship with the worker*. This places the client–practitioner interaction at the heart of the work. This does not mean the outside world is ignored, as engaging and negotiating with external reality is essential to therapeutic progress. The relationship is a 'working laboratory' exploring how the client functions 'out there', by paying careful attention to what is happening in treatment.

For example, in a supervision group, Femi, a mental health social worker, presents a first meeting with Barbara, who accuses him of wanting to section her. A picture emerges of a woman who was abused by her father over many years. It then becomes clearer that Barbara comes to the meeting with a predetermined sense of an abusing male authority figure, mirroring her experience of her father.

Freud referred to this phenomenon as *the transference*, by which he meant that experiences 'belonging' to the past are inevitably experienced in the present. Barbara carries an historical burden that corrupts her relationships in her current life. It is through the seminal work by Bowlby (1971) on attachment that we have come to understand these processes in greater detail. What we now understand is that Barbara views the new worker through the prism of a pre-existing 'internal working model'.

To make sense of these dynamics requires an emotional strength and self-knowledge as powerful emotions are inevitably aroused in the practitioner. Freud called this the *counter-transference*, by which is meant the totality of the practitioner's emotional responses to their client. He suggested that our own personal issues can limit the work with our clients, hence the importance of personal therapy for therapists. However, the counter-transference can also tell the practitioner something that the client is not conscious of.

For example, when a client spoke in a flat, detached manner about not having seen his 3-year-old daughter for two years, I felt a tearful sadness and suggested that he was not letting me know just how upset he was feeling. He began to cry describing with a forlorn intensity the longing for his beloved daughter: an experience he had so penetratingly communicated non-verbally to me.

Such experiences reflect a further key feature, namely *the use of defences* – in this case, *projection*, a mechanism whereby the client 'pushes' feelings he does not want to experience onto me; I then have his sense of unacknowledged anguish about his daughter.

From today's vantage point it is difficult to appreciate just how revolutionary Freud's work really was. Unlike conventional practice at the time that was geared to making symptoms disappear through hypnosis, Freud encouraged his mostly female patients to 'free associate' i.e. to talk about whatever came to mind. Personal experiences, however strange or bizarre, were now being taken seriously as 'signals from the unconscious' with profound idiosyncratic meaning and not simply the hysterical rantings of the 'mad'.

Psychodynamic work is designed for use with any service user wishing to think about their part in what 'happens to them'. One client put it succinctly: 'After 10 years of failed relationships, I concluded that there was only one common

denominator: it was me.' She needed to find out what 'goes wrong' through engaging in a relationship with a therapist.

Because of the emphasis on *making the unconscious conscious*, the client has to have some capacity to take responsibility for these insights and therefore subsequent behaviours. In modified forms of psychodynamic work, the practitioner can support such change through the use of more cognitive and behavioural techniques.

Thus, other than the limitations imposed by clients who are actively abusing drugs or alcohol, there are no constraints on undertaking psychodynamic treatment.

Psychodynamic work has 120 years of scholarship behind it. There is a growing body of evidence in both short- and long-term work with depression and the range of personality disorders based on mentalization-based therapy and transference-focused psychotherapy.

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# 6.2.17

# Signs of Safety

*Joe Smeeton*

There is increased interest in the signs of safety approach in providing family-centred therapeutic services (Madsen, 2009), child protection services (Dalzell and Sawyer, 2007) and more specialized services (for example, Myers, 2005). The approach was developed by Turnell and Edwards in Western Australia in the 1990s, based on Solution-Focused Therapy (de Shazer, 1985) and has begun to spread throughout child protection services in the United States, Canada, United Kingdom, Sweden, Finland, Denmark, The Netherlands, New Zealand and Japan (Turnell, 2010). It is based on Turnell and Edwards' argument that families are likely to engage with professionals if they are not labelled as problematic but are acknowledged as having family resources that can increase safety (Horwath, 2010, p. 75).

Morrison (2010, p. 317) believes that the signs of safety approach contains elements of practice that can be used to assess motivation for change by:

- understanding the position of each family member in relation to the problem;
- searching for exceptions to the problem: this conveys the message that the practitioner believes there are occasions when the problem doesn't occur and therefore the parents have some skills to address it;
- asking about strengths;
- using scaling questions to gain opinions from the family and others who have concerns as to how bad things are and what needs to change. This can open up helpful discussions. Scaling questions can also be used to assess the family's willingness, confidence and capacity to change;
- focusing on positive futures and goals that parents have for their children.

When social workers are concerned about a child's welfare, an inadequate understanding of the parent whom they consider to be responsible for that child can often

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lead to skewed and oversimplistic conclusions. Clarity around the legal duty to protect the child leads practitioners to seek causal explanations and to seek to avoid becoming paralysed by uncertainty and 'woolly thinking'. However, this can often conflict with values about social justice and fairness. An emphasis on identifying weaknesses rather than strengths contributes to a family's defensiveness; when a string of professionals focus on their deficits, the family can lose any sense of their own capabilities, and this can further reinforce professional concern and contribute to the narrative of 'bad parenting'. The signs of safety approach seeks to redress this balance through a rigorous incorporation of family strengths while keeping the concerns very much in mind.

Turnell and Edwards (1999, pp. 30–32) list a number of practice principles that should guide the approach:

1. *Respect service recipients as people worth doing business with*.
2. *Cooperate with the person, not the abuse*.
3. *Recognize that cooperation is possible even where coercion is required*; this acknowledges that the power relationship between social workers and families is always uneven and that this should be used ethically and sensitively.
4. *Recognize that all families have signs of safety*. Avoid seeing them only within the 'problem label' without weighing this up with other aspects of their behaviour.
5. *Maintain a focus on safety* – framed by focusing on what should be done rather than what shouldn't be done. For example, 'It's important to be able to hear and see your baby at all times' rather than 'Don't leave your baby alone'.
6. *Learn what the service recipient wants*; work with their motivations.
7. *Always search for detail*. Get specific, balanced information from as many sources as possible inside and outside the family.
8. *Focus on creating small change*. Specific small changes give a sense of achievement rather than trying to achieve big dramatic changes all at once.
9. *Don't confuse case details with judgements*. Allow time for understanding why service users' behaviours might occur in the wider context, rather than using them to justify the judgement you've already reached. For example, the fact that a mother misses a morning appointment because she has had a restless night should not be taken on its own as an indication of failure to cooperate.
10. *Offer choices*. While the work may be statutory or contain an element of compulsion, enabling the family to have some control about how the work might proceed can help them to maintain their engagement and minimize the power differential.
11. *Treat the interview as a forum for change*: even child protection investigations can be therapeutic.
12. *Treat the practice principles as aspirations, not assumptions*; no one gets it right all the time.

An important tool is the assessment and planning form: it provides a straightforward way of expressing the concerns and strengths of the family on one side of paper; it spells out the goals and suggests what success would look like. Through this, the social worker can be clear about the reasons they are involved with the family and,

through 'scaling', can indicate the degrees of concern and safety within the family context. The family can also be clear about what needs to happen in order to reduce concerns and increase strengths to the degree that the agency can close the case.

There are some really strong tools for engaging children and young people in a meaningful way, such as the 'Three Houses Tool' which helps the young person to express their wishes and feelings through writing and drawing about their 'House of Worries', 'House of Good Things' and 'House of Dreams'.

The value of the signs of safety approach lies in the distinction that is made between strengths and protection, based on the working definition that 'safety is regarded as strengths demonstrated as protection over time'. It helps practitioners to maintain relationships with the family by focusing on specific, observable behaviours rather than by using judgement-loaded terms that are more likely to work against cooperation. The underlying assumption that assessment is a work in progress rather than a definitive set piece should be increasingly valued in child protection practice.

A number of evaluations now exist (Gardner, 2008; Wilder Research, 2010) and seem to offer some reassurance against a worry that focusing on strengths may lead practitioners to overlook concerns, but more research would seem to be appropriate in the UK practice context.

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6.2.18

# Social Behaviour and Network Therapy

*Joy Barlow*

Social behaviour and network therapy (SBNT) was developed by drawing on a number of strategies found to be effective in the field of alcohol treatment. Its authors and originators, Alex Copello, Jim Orford and Gillian Tober, became aware of the need to consider the effectiveness of socially rather than individually focused treatments for alcohol problems during the early stages of the design of their United Kingdom Alcohol Treatment Trial (UKATT Research Team, 2001). Socially orientated treatment approaches had already been illustrated in the findings of Project MATCH (Research Group, 1997); additionally relevant to the idea of SBNT was 'network therapy' that had originated from the work of Ross Speck and colleagues at the Hahnemann Medical College, Philadelphia, United States in 1969 and that had been developed as an approach in the treatment of people with schizophrenia. Copello and his colleagues also acknowledge that SBNT was influenced by Galanter (1993) in his work on cocaine dependence.

## The Essential Elements

Social behaviour and network therapy is based on the notion that, to give the best chance of a good outcome, people with serious drinking problems need to develop positive social network support for change. SBNT is a pragmatic approach based on the idea that the problem drinker can be supported by their social network to change their drinking behaviour. The task of the worker (the 'therapist') is to work towards this goal with problem drinkers and those members of their social network who are willing to support their efforts to change. Network members can include family members, friends and work colleagues. Work can take place with the

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individual in network settings or unilaterally with the person alone. It can continue with network members even if the person with the drinking problem has ceased attending sessions. SBNT can be used to pursue either the goal of abstinence or moderation. There are three underlying assumptions which inform the treatment:

- Social network support for change is relevant to everyone presenting for alcohol treatment.
- Family members and concerned others are central to the treatment process.
- Work conducted during the treatment aims to create the conditions for the future maintenance and support of change.

The therapist's care skills can be described in four ways:

- *The therapist must think 'network'.* This requires the ability to think about, understand or select any aspect of the intervention in a way that helps to bring about an increase in positive network support for the person at the centre.
- *The therapist must focus on the provision of positive support.* This involves keeping a clear focus on any opportunities to develop positive support and to minimize negative features in relationships within the support network.
- *The therapist is an active agent of change.* This may be in sharp contrast to other social work approaches – for example non-directive counselling – as the worker may actively communicate with network members or invite network members to a meeting.
- *The therapist is a task-orientated team leader.* In effect the 'team' is the subject's network and the therapist is the 'leader' of it for the purpose of therapeutic success (Galanter, 1993).

## The Structure of the SBNT Intervention

As used in UK Alcohol Treatment Trial, social behaviour and network therapy consists of eight sessions conducted over a period of 12 weeks.

*Phase 1* consists of the first session, in which the network is identified, a network diagram is constructed, and invitations are issued to network members. Contact is made by the therapist and invitations issued to take part in supporting the individual in her/his efforts to change.

*Phase 2* consists of sessions 2–7. The focus is on building, engaging and mobilizing the social network. Core topics include material on communication, coping, increasing social support and dealing with possible lapse or relapse.

*Phase 3* is the eighth session. Its aim is to consolidate the work that has been carried out in the previous sessions and to plan for the future.

## Benefits of the Intervention

From its origins in 2001, social behaviour and network therapy has developed into a treatment in its own right. First used when the person at the centre was a problem drinker, further developments have included its use with illicit drug problems. The

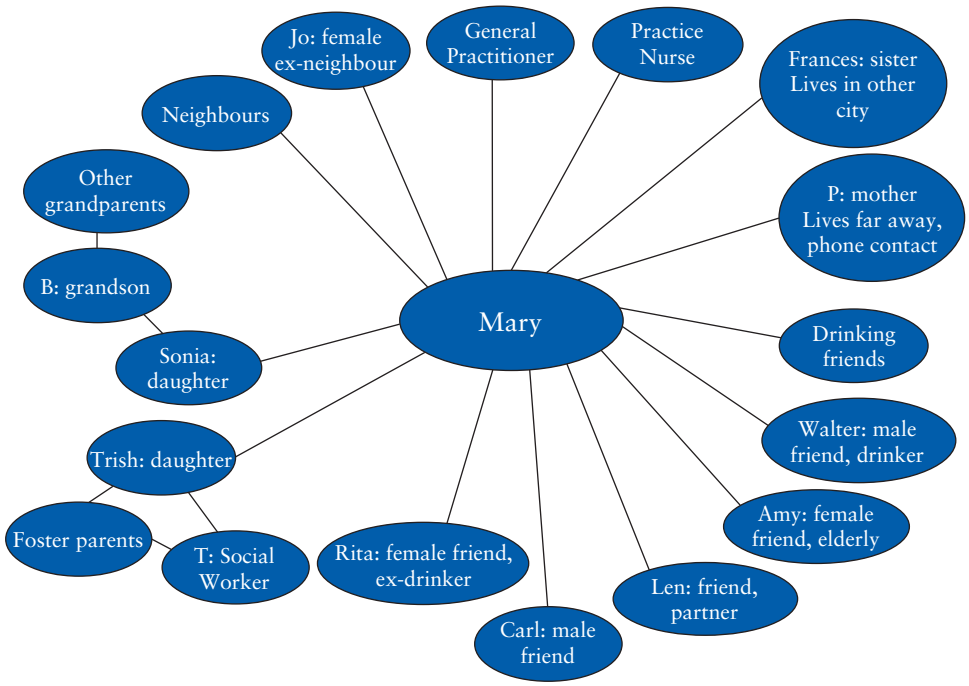


**Figure 7** Network map for Mary.
Source: Copello *et al.*, 2002.

approach has also been used to help support people who want to quit smoking. The emphasis on recovery and on the development of people's 'recovery capital' suggests its potential further use in a range of social work settings.

Research has concluded that SBNT is a feasible treatment for problem drinking and problem users of illicit drugs and their networks. Providing network members with information about drug use, facilitating more open communication about it and helping to reduce exposure to social influences that encourage problematic drug use may be features of SBNT that are more prominent when the problem is one of illicit drug use than when the problem is one of alcohol use.

Challenges for SBNT therapists regarding future development of the method are, in particular, the areas of communication, conflict, control and confidentiality. The key factor in achieving maximum efficacy in the approach is the choice of people to be included in the network, and criteria for recruitment follow the work of Galanter in this regard. The establishing of the network is an active collaboration of the patient (service user) and therapist. The therapist must think in a strategic fashion of the interactions which may take place among network members. For an example, see Figure 7.

Orford (2008) suggests that the field of psychological intervention should stop concentrating on named techniques and instead focus on change processes. These processes should be studied within the broader, longer-acting systems of which

treatment is part and then the field should be brought up to date by acknowledging the variety of sources of useful knowledge.

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6.2.19

# Social Constructionism

*Derek Jones*

Social constructionism has been (and continues to be) influential within social work research and practice (Witkin, 2011). As with all constructs that have their origins outwith a professional discipline there is a danger that those using it do so with a lack of precision or fail to keep up with developments and debates in the field of origin. The aim of this chapter is to provide you with *sufficient* knowledge to critically evaluate (or at least approach with caution) any materials you encounter that promote or claim to utilize a social constructionist approach.

## Social Constructionism: Origins and Essence

The focus here is on the sociological version of social constructionism as presented in the work of Peter Berger and Thomas Luckmann in their influential book *The Social Construction of Reality* (TSCR), first published in 1966 (Berger and Luckmann, 1991). It can be difficult to untangle and differentiate social constructionism from a range of other theories (for example, interpretavism, postmodernism, poststructuralism, and construct*ivism*) and theorists (for example, Max Weber, W.I. Thomas, Kenneth J. Gergen). What they share in common is a set of ideas that:

- question the notion that there exists an objective reality that is independent of our experience of it;
- propose that the way in which we understand the world and what we accept as reality emerges out of social interaction;
- emphasize that understanding is located within a particular cultural and historical context – what we believe now is different from what was believed in another time and place and may be different in the future.

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The stated aim of TSCR was to provide, 'a theoretical treatise in the sociology of knowledge' (p. 7); that is to say, it is concerned with how we come to know the things we know. At the heart of TSCR is the idea that, in order to make sense of our world and to communicate our subjective experience to others, we create or use objective signs (language). So for example, on observing a volcano erupting, ancient peoples may have sought to explain this event through the creation of some supernatural deity; that is to say, this explanation was socially constructed in collaboration with other members of the group (i.e. emerging out of the subjective experiences of the tribe). Over generations the fact that at some point in time someone came up with this explanation would disappear from memory. Thus an originally subjective experience would become internalized and acquire the status of objective fact (or 'reified' as the jargon would have it). So it is with any phenomenon which humans encounter; at some point a particular conceptualization of that 'thing' (idea, observation, or experience) becomes taken for granted.

## Application to Social Work

With this as our starting point for understanding the world, it follows that social work practitioners operate in an environment in which day-to-day 'common-sense' understandings shape and are shaped by dominant social beliefs and attitudes and the legislative frameworks within which they work. Social constructionism, when applied within the context of social work policy and practice, has highlighted that foci of intervention such as family or impairment or crime or childhood are merely language labels and associated sets of beliefs that have become attached to particular phenomena. In another time or place these labels may mean something different or make no sense at all.

## Problems and Issues

Speed (1991) highlighted how the idea that our experience of reality is socially constructed has led some to argue that there is no such thing as reality, only different explanations of it. This position has been extended beyond the social world to the physical and biological world: not only are our understandings of, for example, disability, gender roles or the family socially constructed but so too are the 'laws' of physics, biological processes or viruses. According to this extreme relativist or strong constructionist view, there are multiple versions of reality and all explanations of human experience are viewed as having equal value. So, illness can be constructed as a blockage in energy channels to be diagnosed by the laying on of hands; or resulting from the action of various pathogens detected by various blood tests. Neither is right nor wrong; they are simply alternative constructions.

This approach throws up a number of problems for applied disciplines such as social work (Peile and Mccouat, 1997), not least the inability to make any recommendations for practice when the evidence on which those recommendations is based comes from a position in which the knowledge produced is highly context-dependent on merely one version of reality. These problems do not, however, mean

that we need to abandon the idea that things are not necessarily as 'normal' or 'natural' as they appear to be. Regardless of whether we can say something is ultimately true or real, our constructions do take on an objective reality.

The limitations of social constructionism (as it has been applied) have led some (see Houston, 2001) to reject this perspective in favour of critical realism primarily associated with the work of the British philosopher Roy Bhaskar. Whereas the constructionist is interested in the processes by which subjective experience becomes objective fact (reified), the critical realist is interested in the way very real social structures impinge on individuals' experiences and life chances. So, for example, rather than simply exploring the ways in which 'disability' is socially constructed, a critical realist's perspective would be that it is a social fact (truth or reality that is out there) that if you have an impairment in most Western industrialized societies you will be amongst the most disadvantaged and excluded.

## Take Home Messages

Social constructionism has been a powerful force within social science and has filtered through to influence social work and related care professions. Whilst the concept holds great potential for application to the field of health and social care, it is open to being used carelessly. As the old adage goes: when the only tool you have is a hammer, everything looks nail-shaped.

If you are undertaking some sort of assessed work, the following prompts will help you to ask questions of your reading that can then be used to demonstrate evidence of critical evaluation. When reading you should ask yourself: are the author(s) consistent in their application of social constructionism or do they use it interchangeably with related terms such as constructivism or postmodernism? If they do scatter these terms about, do they provide a transparent justification by drawing on some of the common features of these schools of thought? If a research paper claims to be informed by social constructionism, do the authors maintain this position throughout their research questions, methodology and methods? Do the authors mean that they are intending to explore the way in which their participants construct some aspect of their world, in which case one would expect the findings to take the form of an exploration of that process of construction; or do they actually mean, 'I am attracted to the ideas of social constructionism but what I am actually going to do is simply give you a thematic summary of participants experiences'?

Furthermore, a paper that concludes it has uncovered some underlying 'truth' would be at odds with its underpinning assumption that knowledge is context-dependent.

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6.2.20

# Social Pedagogy

*Mark Smith*

Social pedagogy is the principal approach to direct work with people across much of Europe, particularly Northern Europe. It has attracted growing attention in the United Kingdom in recent years, largely as a result of work at The Thomas Coram Research Unit (TCRU) in London. This interest is evident in a number of government-sponsored pilot projects, other pilots initiated by individual social services agencies and in new degree programmes.

Because it has developed differently in different national contexts, there is no single definition of social pedagogy. It is most often described as 'education in its widest sense' or 'social education'. Its scope encompasses broad conceptions of upbringing, personal formation and social connectedness.

The underpinnings of progressive European educational ideals reach back to Enlightenment figures such as Rousseau and Pestalozzi. Their vision was to educate the whole child, requiring the active involvement of the learner in the learning process. It included three elements, head, heart and hands, emphasizing intellectual and emotional as well as practical dimensions to education.

The concept of *social* pedagogy, as a development of such understandings about the nature of education, has roots in German philosophical responses to industrialization and concerns about loss of community and in the democratic movements that emerged across Europe following the revolutions of 1848. It had a distinctly egalitarian and reformist ethos, its aim being to promote well-being through broadly based socio-educational strategies and to find educational solutions to social problems. A social pedagogical approach is concerned with the integration of the individual in society and with the promotion of social functioning, inclusion, participation, identity and competence as members of society with shared responsibilities to that society.

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The medium through which to bring about personal and social change is the relationship established between social pedagogues and those they work with. This calls for more sophisticated insights into the nature of relationships than is accommodated within dominant social work assumptions around the separation of the personal and professional. A notion of the 'professional heart' is central to social pedagogy, recognizing that the personal and professional are not readily kept apart.

Much social pedagogic practice is undertaken with groups. It happens in contexts where pedagogues and those they work with share a common life space. Such relationships are often forged through the purposeful use of activities, allowing them to develop in ways that are less hierarchical than within an expert-client model. The centrality of self in relationship requires particular qualities in social pedagogues; specifically, they need to be reflective and reflexive practitioners able to reach situated professional judgements informed by a broad range of theoretical insights, rather than merely following procedure. There is no one 'best practice' within a social pedagogical canon; what is right or wrong will depend upon the circumstances of a particular case or situation. Central to this location of decision-making with the individual pedagogue is the German notion of 'Haltung', which reflects a pedagogue's ethical stance and how this is brought to bear on their work.

The need for such a rounded professional orientation is reflected in degree-level education for social pedagogues across Europe, in contrast to the United Kingdom, where social work curricula have been increasingly prescriptive and instrumental and where vocational qualifications are considered sufficient for what are called social care jobs.

While social pedagogy is most often thought of in relation to residential childcare, its principles can be, and in many European countries increasingly are, extended to work with individuals and groups across the life course: early years, teaching support in schools, family support, drugs work, youth work, youth and criminal justice, learning disability and physical disability services and support for older people. Social pedagogues are generalists; while they are the main staff group in some services, such as nurseries and school-age childcare, they also work in a complementary role alongside other professions such as teachers, social workers, doctors and nurses. At a time when there is a major political drive for different services and professions to work more effectively together, social pedagogy might provide a conceptual framework to make it happen.

Comparative studies conducted at the Thomas Coram Research Unit indicate that outcomes for children are better in European countries than in the United Kingdom across a whole range of measures from educational attainments to lower levels of teenage pregnancy. It is perhaps this prospect of better outcomes that contributes to the burgeoning interest in social pedagogy in the United Kingdom.

There are, however, a number of caveats to be drawn. The first is that approaches cannot readily be transposed from one national context to another. Taking the example of residential childcare, for instance, poor outcomes in the United Kingdom cannot be divorced from the fact that residential childcare has become a residual service catering for scarcely more than 10 per cent of looked-after children, in contrast to many European countries where it is the option of choice. Moreover, it needs to be acknowledged that social pedagogy is a degree-level professional qualification; it cannot be properly introduced through short courses or, worse, through

attempts to shoehorn it into a vocational training rubric, which would be antithetical to its reflexive and value-based foundations.

Furthermore, social work in the United Kingdom has become focused on statutory requirements, especially in relation to concepts of protection. This is manifest in overly procedural, over-regulated and risk-averse practice cultures. A predominant focus on risk is reflected in individualized and deficit-based approaches to practice at the expense of broader social-educational approaches, which stress human maturation rather than individual pathology. The adoption of social pedagogical ways of working in the United Kingdom would require a substantial realignment of conceptualizations of social work or social care roles. Social pedagogy is not just another method or fad, not a quick fix to the problems facing childcare and education, but a different way of thinking.

It is a way of thinking that casts a light on the relationship of the individual and society and as such is an irredeemably political practice with the potential for conservative or emancipatory manifestations. In its latter form it is more likely to find a home in social democratic political cultures rather than neo-liberal ones. It is noteworthy that, just as interest in social pedagogy develops a head of steam in the United Kingdom, its existence is being questioned and threatened in its Danish and German heartlands, as political directions there veer rightwards. Whatever happens elsewhere, though, interest in social pedagogy in the United Kingdom continues to grow.

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## Web Resources

Children Webmag, www.childrenwebmag.com/t/social-pedagogy
http://www.infed.org/biblio/b-socped.htm
Socialpedagogyuk, www.socialpedagogyuk.com/

6.2.21

# Solution-Focused Brief Therapy (SFBT)

*Barbra Teater*

Solution-focused brief therapy (SFBT) aims to identify and build on service users' strengths, abilities and solutions to problems in order to achieve their preferred future (de Jong and Berg, 2008). SFBT involves social workers focusing more on when problems do not occur or on the exceptions to the problem, rather than on when problems do occur. SFBT holds a number of key assumptions when working with service users:

- Focus on solution-oriented talk rather than on problem-oriented talk.
- Exceptions to every problem can be identified by social workers and service users.
- Change is occurring all the time.
- Small change leads to larger change.
- Service users are always cooperating.
- People have all they need to solve their problems.
- Therapy is a goal- or solution-focused endeavour with service users as experts (Walter and Peller, 1992, pp. 10–28).

Implementing SFBT consists of five stages:

1. Service users briefly describe the problem while moving them towards solution-oriented talk.
2. Service users describe their preferred future in order to develop well-formulated goals.
3. Exploration of the problem by identifying times when service users are not experiencing the problem or when they are, to some extent, achieving their goals.

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4. Provision of end-of-session feedback by identifying what service users are already doing well and linking this to suggestions for out-of-session tasks.
5. Evaluation of service users' progress (de Jong and Berg, 2008, pp. 17–18).

Solution-focused brief therapy aims to alleviate problems by utilizing service users' existing strengths and abilities to reach their preferred goals. The use of positive language and questioning strategies are key elements in SFBT:

- *Goal questions* are used to help service users identify their goals. The 'miracle question' is commonly used in this process; it asks 'Suppose that one night there is a miracle, and, while you are sleeping, the problem that brought you into therapy is solved. How would you know? What would be different?' (de Shazer, 1988, p. 5).
- *Exception questions* ask service users to identify times when the problem has lessened or ceased.
- *Coping questions* ask service users to identify how they have managed to cope with problems; this enables service users to discover their past and present successes in addressing the problem and reaching their goals (de Jong and Miller, 1995).
- *Scaling questions* are used to determine the extent of the problem. Service users are asked to rate an aspect of their life on a scale of 0–10, where 0 = the problem is at its worst and 10 = there is no problem (de Jong and Miller, 1995).

## What are its Origins?

SFBT was developed by Steve de Shazer, Insoo Kim Berg and colleagues at the Brief Family Therapy Centre in Wisconsin. The approach was based, firstly, on work at the Mental Research Institute in California, which focused on the cyclical process of failed attempts to solve problems and the extent to which they required more creative approaches to solutions, and, secondly, on the philosophical work of Ludwig Wittgenstein, which demonstrated how language can impact on problems (Hoyt, 2002; de Shazer, 1997). de Shazer and colleagues realized that change occurred more frequently in families when the therapist focused on what was going right within the family rather than on the problems and on what was going wrong. This positive approach aims to encourage families to identify their strengths and abilities and to see that things are not always problematic.

## For Whom is it Designed?

SFBT is a short-term approach designed for service users who are experiencing a specific problem or difficulty where normal attempts to solve the problem have not been successful. It has been implemented with male domestic violence offenders, juvenile offenders, adolescents in crisis, psychiatric hospital patients, homeless mothers, persons with alcohol problems, mandated clients, cancer patients and their families, and persons in prison (Teater, 2010). SFBT can be used with individuals and in group settings.

## What are its Limitations?

There are several limitations to incorporating solution-focused brief therapy in practice. Firstly, SFBT focuses on solutions to problems rather than on the problems themselves; this might lead social workers to miss valuable information that could assist service users in reaching goals (Walsh, 2010). Secondly, some service users may wish to discuss their problems and believe that they would benefit from doing so. This might lead them to not fully engage with the SFBT approach. Thirdly, SFBT focuses primarily on individual and familial solutions to a problem, which means that it can fail to acknowledge societal or environmental barriers that are prohibiting service users from meeting their goals. Finally, SFBT assumes that service users have the capacity to identify solutions to their problems; this may not always be possible for all service users (Teater, 2010).

## In What Situation/Circumstances Can it or Can it Not be Used?

SFBT is designed for use with individuals or families and in group settings and is intended to be a short-term approach focusing on specific presenting problems or difficulties. It may not be appropriate for service users who could benefit from longer-term treatment designed to address underlying problems.

## What is the Research Evidence for it?

The evidence base for the effectiveness of SFBT is still in its infancy (Kim, 2008). The body of evidence is growing around:

- work with children and adolescents – for example, foster care placement stability (Koob and Love, 2010) and at-risk students in school settings (Kim and Franklin, 2009);
- work with adults who are receiving treatment for sexual disorders (Trepper *et al*., 2010);
- work with those who participate in deliberate self-harm (Tapolaa, Lappalainen and Wahlstrom, 2010).

A meta-analysis has examined the effectiveness of the therapeutic model of SFBT as reported in 22 published or unpublished papers. It found a small but positive treatment effect of SFBT in respect of treatment outcomes of externalizing and internalizing behavioural problems and in respect of family and relational problems (Kim, 2008). In particular, SFBT appears to be effective in treating depression, anxiety, self-concept and self-esteem, but is less effective in treating hyperactivity, conduct problems, or family and relationship problems (Kim, 2008, p. 114). There is, however, a need for more research evaluations of SFBT's effectiveness.

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# 6.2.22

# Strengths-Based/Resilience Theory

*Aisha Hutchinson*

Strengths-based and resilience perspectives in social work are founded on the recognition that individuals, families or communities can and do survive and overcome adversity. Theories of resilience are central to a strengths-based perspective (Fraser, Kirby and Smokowski, 2004), which can be understood as requiring the worker to identify a measure of someone's ability to adapt, or bounce back in response to risk, vulnerability and adversity (Norman, 2000). Strengths-focused social work is preoccupied with reinforcing the survival and growth capacity that clients already possess (Munford and Sanders, 2005), believing in the possibility of overcoming difficult and stressful situations while growing and developing through them (Saleebey, 2006). This can be achieved by seeking to harness and build upon environmental supports, resources, exceptions and possibilities that already exist (Kelly and Gates, 2010).

Saleebey (2006) identifies six underlying principles of the strengths perspective:

1. Every individual, group, family and community has strengths and the ability to alter, extend and reshape their behaviour, feeling and cognition.
2. Trauma and abuse, illness and struggle may be injurious but may also be sources of challenge and opportunity.
3. Assume that you do not know the upper limits of the capacity to grow and change and take individual, group, community aspirations seriously.
4. We best serve clients by collaborating with them.
5. Every environment is full of resources.
6. Caring, caretaking and context.

Norman (2000) argues that the concept of resilience is one which can be used to operationalize strengths perspectives and that resiliency enhancement, by drawing

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attention to protective factors and coping strategies, is one of the ways that social work can put a strengths perspective into practice.

## Origins of the Theory

The strengths-based perspective has grown in direct response to the disease model in social work practice, a dominant model which highlights injury, problems, stress, adversity, maladjustment, victimization and learned helplessness (Norman, 2000; Kelly and Gates, 2010). The strengths-based perspective led to a focus on strengths, hope, coping, opportunities, wellness and repair (Saleebey, 1996), embodying the concept of resilience within a social work context (Kelly and Gates, 2010). The concept of resilience, which underpins a strengths perspective has emerged from a variety of academic disciplines, and this is reflected in the diverse range of epistemological, ontological and methodological approaches associated with, and contributing to it (Ungar, 2008; Glantz and Sloboda, 1999). While examples of a strengths perspective can be seen throughout the history of social work, it was predominantly through Saleebey's work in the 1990s (Saleebey, 1996; 1997) and others, that led to it gaining influence and momentum, particularly in the United States (Norman, 2000; Rapp and Goscha, 2012). It is, though, still in its infancy and the task of putting this way of thinking into social work practice in different contexts around the world remains to be done (Rapp, Saleebey and Sullivan, 2005; Laird, 2008).

## For Whom is it Designed?

At the core of this perspective is the belief that there are always strengths to draw upon, no matter how difficult the situation is or how terrible the problem (Saleebey, 2006; Kelly and Gates, 2010). This theoretical framework was designed to underpin all social work intervention and can be infused into a range of approaches. Rapp, Saleebey and Sullivan (2005) draw attention to four strengths-based approaches which have been developed in recent years:

- strengths-based care management (Rapp, 1998);
- solution-focused therapy (Miller, Hobble and Duncan, 1996);
- individual placement and support model of supported employment (IPS) (Becker and Drake, 2003);
- the asset-building model of community development (Kretzmann and McKnight, 1993).

These approaches incorporate the six hallmarks of strengths-based practice and can be used widely across the different contexts of social work. Kelly and Gates (2010) also advocate for the strengths-based assessment interview which can be used as a foundation from which to gather information on environmental support, resources, exceptions and possibilities for further strengths-based intervention.

One of the limitations of a strengths-based approach is that the structural nature of some problems may not be properly acknowledged and individuals may be

encouraged to respond to structural inequalities with individual strength rather than by collective action/strength. Individuals can remain pathologized even while their strengths are recognized if the challenges associated with structural inequalities and power relationships do not inform a strengths and resilience perspective (Laird, 2008).

## What is the Research Evidence for it?

Over the years there has been a huge amount of research dedicated to identifying attributes shown to be protective or to enhance resilience, particularly in the area of social psychology (Norman, 2000). Empirically-derived inventories have shown the ways in which people cope with stressful events, such as death of a spouse, poor health, addiction and conflictual relationships (Folkman *et al*., 1986; Carver, Scheier and Weintraub, 1989; Frydenberg and Lewis, 1991). Knowledge of these protective factors and coping strategies – such as social networks, the creative use of social protection payments or the use of systems of reciprocity – have then been used to underpin intervention which reinforces capabilities and strengths, facilitating rather than constraining people's own mechanisms of resilience (Power *et al*., 1996; Beck and Nesmith, 2001; Saleebey, 2006).

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# 6.2.23

# Systems Approaches

*Joe Smeeton*

Pincus and Minahan (1973), working in the United States, were the main early proponents of a systems approach to social work, arguing that:

> Social work is concerned with the interactions between people and their social environment, which affect the ability of people to accomplish their life tasks, alleviate their distress and realize their aspirations and values. (p. 9)

The use of general systems theory declined in the United Kingdom as social work became more individualized and performance-oriented, but in the United States Pincus and Minahan's ideas continued to be developed. Newer systemic approaches are now beginning to re-colonize UK practice in a wide range of settings – for example, with children on the edge of care and in fields linked to crime and anti-social behaviour.

## General Orientation

Systems theory contends that it is difficult to understand individuals outside of the systems that they are part of, and that systems like families or peer groups have characteristics greater than the sum of their individual members. Moreover, the behaviour of individuals is, to a large degree, a result of their membership of systems, rather than simply a result of biology or psychology.

Systems thinking asks:

- Is this an *open* system or a *closed* system? That is to say: does the boundary of the system allow easy transfer between it and the wider environment?

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- What are the *inputs* to this system from the external environment? How are these *throughputs* used within the system? What are the *outputs* to the wider environment?
- What *feedback loops* exist and how are they used?

Imagine a family with very few boundaries or routines where the teenagers in the family are engaged in antisocial behaviour, encouraged and supported by other young people. We could think of this family as an *open* system in that it is using the *inputs* from others; it is likely to have a chaotic *throughput* in the daily lives of its members and poor *outputs* in the form of antisocial behaviour. Angry neighbours complaining might be the *feedback loop* that *inputs* back into the system with either positive or negative consequences.

Within the general orientation of systems theory, a practitioner may choose to use a number of other theoretical approaches in order to understand situations or to tackle particular issues.

## Family Systems Therapy

*Family systems therapy* Is often used within child and adolescent mental health services as a way of working therapeutically with the whole family, rather than giving individual therapy to one person who is seen to be 'the problem'. It focuses on the interactions between members of the family system and recognizes that individuals within it impact upon each other reciprocally.

Family systems therapy concerns itself with:

- *Family roles.* Family members tend to ascribe roles to each other: not just parent or child, but the clown of the family, the organizer, the grumpy one. Individuals tend to take on and play out the role allocated.
- *Family rules.* Rules are usually unwritten but are understood as to how that family works together. They cover areas such as how affection is shown and how decisions are made, as well as indicating boundaries and routines.
- *Patterns of interaction.* Roles and rules create complex patterns of interaction that can become predictable and even entrenched. This may provide stability in the family but if they constitute 'problem interactions', they can be difficult to change.
- *Homeostasis / equilibrium.* This represents the idea that systems have a tendency to reach a fixed state in which it is difficult to bring about change in one part of the system without the rest of the system adjusting to accommodate that change. For example, trying to change the behaviour of a challenging adolescent through individual therapy may be hard because the family will continue to expect him to behave as he always has; in order to change the individual member, the whole family will need to interact differently.
- *Differentiation.* How does the family adapt to changes within its make-up to get back to a state of equilibrium? For example, following the birth of a child, an elderly relative requiring care moving in, or a family member being imprisoned.
- *Circular causality* is a key concept in systems theory. It leads the practitioner away from a search for the answer to the question 'Who is to blame?', towards

a recognition that the behaviours of two or more individuals within a family are reciprocal.

## Ecological Systems Theory

Ecological systems theory is based on ideas about human development (Bronfenbrenner, 1979) and parenting (Belsky, 1984). Bronfenbrenner illustrates how children develop within a number of systems:

- *Micro-systems* – for example, home, school or peer groups – have a big impact on child development.
- *Meso-systems* are the interactions between the micro-systems. For example, how well do school and home communicate with each other?
- *Exo-systems* do not contain the child but are external conditions – for example, the parents' employment – that may have an impact on parenting.
- *Macro-systems* are the wider cultural and political conditions within which the child is developing.

## Multi-Systemic Therapy

Multi-systemic therapy uses ecological theory to underpin a practice intervention (Sawyer and Borduin, 2011). It is often used intensively with offenders or where families are at risk of breakdown. The therapist attempts to engage with all the systems at play in a young person's life, recognizing the bidirectional nature of the interactions. A young person who is at risk of exclusion from school due to problematic behaviour with peers is at higher risk of family breakdown; a therapist would therefore try to work with all three systems and the young person in order to bring about change.

## Complexity and Chaos Theories

Recent developments in systems theory lie with complexity and chaos theories that recognize the difficulty of trying to understand and work with humans within a social world that is uncertain and largely unpredictable. Nowhere is this more apparent than in areas of high risk such as child protection work (Stevens and Hassett, 2007). Eileen Munro's systems analysis and recommendations (Munro, 2010, 2011) are beginning to inform policy and practice in this area by steering social work away from single-cause linear understandings towards a recognition that each social work intervention can have multiple possible outputs and that systemic elements (such as resource availability, caseloads or performance measures) will exert pressure in a particular direction. We therefore see a move away from serious case reviews that attempt to discover who is to blame towards systemic reviews that try to understand all the elements of the system that are operating towards a particular outcome. Chaos theory suggests that small changes early in the progress of a case can have large consequences further down the line; this leads to an emphasis on the importance of ensuring early intervention.

Howe (2009) is somewhat dismissive of systems theories because, while 'fun and attractive', their roots are in biology, engineering and physics; he does not see any easy way of translating them into the social sciences and believes that claims of their relevance to social work are overstretched. He says that this explains why systems theory has never managed to fulfil its promise as a grand practice theory.

Systems theory fell out of use during the 1990s, coinciding with social work's embroilment with modernist searches for simple causation and the rise of managerialism. It may, though, be finding a new generation of practitioners who recognize that the main strength of systems approaches lies in their ability to put an eclectic range of understandings and interventions in the social worker's tool kit, while reminding them to embrace the connected complexities of people within their environments.

The blossoming of systems approaches within UK social work through wholescale systemic organizational change in order to support practice is embodied in the 'Reclaiming Social Work' projects (Goodman and Trowler, 2012).

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6.2.24

# Task-Centred Practice

*Peter Marsh*

Understanding social actions, events and causes is particularly challenging: a fact well known to social workers and to social scientists. Both need to be particularly good at not being 'misled by the evidence of everyday experience' (Gilovich, 1993, p. 193).

Social workers need to understand the nature and cause of problems, and they need to help provide solutions. Those solutions involve others changing their actions and probably their views, usually in difficult circumstances of some deprivation.

A social worker in the 1960s would have thought that everyday experience indicated that longer-term work brought more benefit than shorter work, but Bill Reid, a social work doctoral student, thought this should be tested, not assumed. His work then, and a canon of excellent studies since, provides the foundation for task-centred practice (Reid, 1963).

Social science, its methods and its results (Marsh, 2007) is the basis of task-centred social work. It has shown that it is efficient and effective, valued by service users, and practical in the real world of social work (where it was developed).

## The Task-Centred Model

A task-centred social worker helps service users move from problems to goals. Problems are areas of life that are going wrong; the goals are the solutions needed to make them better, usually providing partial, not total, solutions.

Both the problems and the goals are negotiated with service users. They are not imposed, unless there is some external mandate such as a legislative requirement. If

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there is an external mandate, then this needs to be accepted by the service user, however grudgingly, in order for task-centred work to proceed. If there is no agreement to the external mandate, then task-centred work cannot be done, and general support and surveillance, for example, will take its place. A task-centred worker will be regularly asking themselves 'what right do I have to be engaging in this person's life?'

Separating problems ('what is wrong?') from goals ('what is required?') and negotiating both on the basis of agreed mandates are fundamental to task-centred work. Once this is done priorities are given to both problems and goals to make sure there is maximum motivation for change. Working on what is most important to you is strongly linked to motivation. Priorities are worked out via discussion, with workers giving advice, based on experience ('I know that this problem has been really important to others in the past'), and knowledge of what works ('there is evidence that this sort of goal is a really good way of solving this sort of problem'). Ultimately, the decisions about priorities are to be taken by service users in the light of this discussion and advice. There will be opportunity for review as the work progresses.

A discussion about a time limit for the work is held at a relatively early point, based on views about the nature of activities needed to reach the goal and their effect on the time it will take. This time limit should provide a real target date for reaching the goal. It generates motivation in both user and worker and it provides a way of holding workers to account, making sure that they have a clear and testable professional commitment to service users. It will normally be a number of weeks, or a small number of months. As noted earlier, there are opportunities for reviewing progress as the work continues, using tasks to aid in that review; if there are substantial and good reasons, the time limit can be adjusted.

To emphasize the importance of the foundation of the work, an agreement of some form, with a clear statement of purpose in the user's own words (therefore jargon-free), should normally be recorded. The work can then move on to tasks.

## Tasks

At the heart of task-centred social work is the method of moving from problem to goal. This will involve a sequence of tasks, to be undertaken by user, or worker, or both. It is vital that the task-centred worker considers a task as a way of making progress on a journey.

PROBLEM → task → task → task → GOAL

Tasks are undertaken by the user, and by the worker, based on expertise, need, and sometimes an element of expediency. They are the engine of change for the work, and they are also diagnostic tools, both about whether they are the right task, and about the problems and goals (Marsh and Doel, 2005, pp. 121–128). If tasks regularly remain undone, or are done but seem to make little progress towards goals, it may be that the foundations are wrong, and problems and/or goals need to be reviewed. Tasks are also a key factor in motivation, providing an opportunity for

celebration, for reflection, and for encouraging each party to make sure appropriate priority is given to the work.

One of the early developments of the model was to test different ways of undertaking the development of tasks, resulting in a specific task-planning sequence (Reid, 1975). Tasks are usually undertaken between the meetings of workers and service users, but can also be used very successfully within sessions (Reid and Helmer, 1985).

## The Range and Applicability of the Model

The model has been tested within all areas of social work, and an interesting model of a task planner for different problems has been developed in the United States (Reid, 2000).

Task-centred practice has a particular advantage of being understandable by others, and is particularly good for inter-professional work where services are needed in combination. Although it is a time-limited model there is no reason why it cannot be used within long-term models of service, for example with children in the care system, by using the task-centred work as specific elements within the long-term approach. It can also be combined with other approaches, via use of tasks which are effectively 'contracted out' (for example the use of cognitive behavioural therapy as a task with another professional). It is applicable to individuals, to groups and to communities with necessary variations in the foundation stage to accommodate multiple users (Tolson, Reid and Garvin, 1994).

It is limited to areas where there is an agreed mandate (whether based on user views or imposed but accepted) and does not cover work where there is no agreement possible with the service user.

The failure to provide research in social work practice in the United Kingdom in the twenty-first century (Marsh and Fisher, 2008) is also imposing a limitation on the model, in so far as it is not developing its theoretical and practical base as fast as it should (as would be seen in an updated task planner, for example).

## Further Reading

A comprehensive outline of the model and of the methods of learning and developing it is provided in P. Marsh and M. Doel (2005), *The Task-Centred Book*. London, Routledge.

Research covering the model and its implementation in the United Kingdom is given in a study of partnership practice in action: C. Newton and P. Marsh (1993), *Training in Partnership – Translating Intentions into Practice in Social Services*. York: Joseph Rowntree Foundation.

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