Journey's end? From residual service to newer forms of pathology, risk aversion and abandonment in social work with older people

Keywords: Risk, Older people, Medical social work, Case management, Collaboration

Abstract:

Summary: This article details how social work with older people is disappearing whilst also being supplanted by seemingly more cost-effective forms of intervention in the UK. This has included the use of higher numbers of unqualified staff in roles once completed by qualified social workers, alongside highly rationed interventions that utilise fewer staff or associate welfare professionals, including those drawn from health care.

Findings: Such reforms represent important changes embedded within neo-liberal inspired professional discursive practices. These include the biomedicalization of ageing and associate narrow gaze interpretations of social care needs that privilege pathology and risk. For social work there has also occurred an ongoing retreat from older adults within communities: from care managed and personalised support to the extension of 'risk averse' safeguarding and promotion of personal autonomy and informal care. Rather than represent a break with the past such socially constructed and politically motivated reforms remain part of longer held societal and ideological trends. Importantly these include assumptions that older users remain a peripheral concern in contrast to other social groups or needs

Applications: The article concludes that the social work profession needs to articulate its distinct role with regard its capability to provide substantive support to an ageing population alongside it's capacity to look beyond a narrow and unsustainable focus on rationing or the endorsement of self-support, treating illness and controlling risk.

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Introduction

Social work for older people is gradually disappearing in the UK. Despite offering rhetoric to the contrary, the policy initiatives and reforms of the neo-liberal inspired New Labour (1997-2010) and Coalition governments (2010-present) in the UK Britain indicate a presumption that many core tasks and responsibilities fulfilled by social workers can be provided just as effectively by unqualified staff, or welfare professionals in allied sectors such as health care or education (Rogowski, 2010). Core policy initiatives such as "personalisation"[1] or *Sure Start* [2] have omitted a clearly defined or tangible role for qualified social workers (Lymbery, 2012); and activities once monopolised by professional social workers such as assessments of need or care planning are shared with associate professionals in other sectors, or are disseminated or franchised out to auxiliary or voluntary staff. Increased expectations upon informal care givers - predominately women and families - have also intensified. If social work retains a presence within 'post-Welfare' domains, this tends to coalesce around a narrow focus upon safeguarding, supply-side resource rationing, risk aversion, facilitating informal care and self-help or playing a limited and largely administrative role in larger arenas of welfare such as health care.

Such restructuring invariably links to wider political reforms and ideological agendas. For example, Deacon (2000) noted the eagerness of Global institutions such as the World Bank and the Organisation for Economic Co-operation and Development (OECD) to open up welfare states and programmes to private sector providers wherever possible; while state provision should subsequently narrow to focus on the provision of minimum support within health or education sectors (alongside greater emphasis being placed on self-help and volunteering). As Estes *et al*. (2003) note, health and education sectors offer greater opportunities to generate private revenue and profit than less fruitful fields such as social care for older people. Both the New Labour and Coalition governments have tended to be complicit in supporting this model.

Although a flurry of market-led reforms have restricted social work provision over the past three decades, the marginalisation of social work with older people has a much longer history. Phillipson (1982: 104), for example, highlighted how a number of studies of social work practice, 'appear to confirm a view of the elderly as a low-status group, whose demands for aids and meals on wheels can be consigned to the responsibility of unqualified staff and volunteers'. More recently Hall and Scragg (2012: 1) suggest that little has changed. For example, they noted that within many health and social care sectors 'regulators and some managers question the need for qualified social workers to work with older people, seeing it as an unnecessary and expensive use of qualified professionals'. Similar ageist views can also be implicit within some institutions that provide social work education (see Richards *et al*., 2013).

The discussion in this article reviews how professional social work with older people is steadily being withdrawn in the UK. The article begins by examining the residual role of older people, as part of generic social service provision, as well as identifying some expectations and identities of older adults and professional relations. It continues by examining the further retreat of social work with older people as part of care delivered through care management processes and personalised care, which has promoted rationing and limited support, risk aversion and unrealistic expectations upon informal carers and users themselves. Despite this, it is acknowledged that such systems, models and technologies of care have provided some benefits for older people in the UK.

The article then explores the increased influence of biomedical and health care discourses in defining what social workers with older people do, and the centrality of risk aversion in again narrowing and reducing the role of qualified social workers within an ageing industry. The conclusion includes a recommendation that the social work profession needs to articulate and be confident about its unique role and contribution to older people's tacit needs within communities, whilst resisting dominant ideological pressures to view ageing populations as a burden or as patients to treat.

Peripheral service, changing user identities and professionalism

Social work with older people has long been considered a low priority. Marshall (1989: 109) observed that the role represents a 'peripheral activity practiced well by a small and silent

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band of converts'. In a similar vein to medicine or law, Phillipson (1982:104) added that deciding to work with older people is often regarded as representing 'professional or political suicide', ultimately low status work that is risky as a career choice in the UK.

Common assumptions prevail that organising routine auxiliary support and other low level practical tasks - which demand little foresight or training - is all that is required; largely limited roles that are best left to unqualified staff or volunteers (Phillipson, 1982; Dustin, 2007). Some students or professionals may also be keen to avoid contact with older adults: due to presumed difficulties with communication or stubbornness, or because of possible guilt felt owing to client loneliness, poor health or not being able to offer appropriate support due to inadequate resources (Phillipson, 1982). There may also be anxiety about intense bureaucracy, deskilling or work intensification attached to care management roles prevalent since the 1990s (see Dustin, 2007). However, Twigg (2006: 51) has commented that additional cultural and political anxieties provide an explanation for possible prejudices. For example, a "Fourth Age" of later old age which precedes death is routinely identified as embodying decay and deterioration in western societies. Here 'existential problems' may flourish with regard an apparent fear of death stimulated upon regular contact with older people. Despite such prejudice Estes (1979) has highlighted the proliferation of an 'ageing enterprise', which generates professional careers and business interests in growth areas such as residential care, medicine, psychology, pharmaceuticals, social work and research. Yet this enterprise or eclectic industry of care often restricts or bypasses the perspectives or needs of older people themselves.

Parsloe's (1981) extensive interviews with practitioners in thirty-three Social Service Departments in the UK discovered that older clients were often quickly passed to unqualified social workers or administrate staff, whilst childcare related casework was interpreted as "real social work" by most practitioners. Hall and Scragg (2012: 1) added that the traditional low priority given to older people within health and social care has since grown disproportionally following the community care reforms of the 1990s in the UK: especially due to a strong emphasis being placed 'on rationing services and providing routine responses to need'.

Tanner and Harris (2008: 11) argued that older people's needs within social work – and welfare more generally – have been regularly assumed to be uniform and predictable, whilst

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Phillipson (1998: 110) proposed that older people are often categorised within professional welfare discourses according to a simple binary built around 'harsh' or 'softer' types of dependency. Pinker (1971) added that subjectivities within market economies are classified according to one's capacity to gain economic and personal independence, with retired older people unlikely to be held in high regard.

The interviews with older adults conducted by Manthorpe et al. (2008) suggested some confusion about what it is that social workers actually do, and also that the social care system can be confusing and unnecessarily bureaucratic. Person-centred approaches were most appreciated, yet with high numbers of users experiencing poverty, the provision of tangible support and advocacy appears crucial. As the authors noted, however, social workers 'roles in rationing support and means testing' does not seem to promote such models. Professionals who prioritise their agencies agendas were also viewed with scepticism by the sample. Phillipson (1998; 2007) nevertheless identified increased choices available to some older people, such as through consumerism and longer periods spent in retirement. Yet such change sits uncomfortably beside greater risks posed due to the fragmentation of communities, social atomisation and retrenched welfare provision.

Many older people's identities now encompass a tension between fluidity through choice and social change pitted against personal needs for stability in later life. A paradox may also emerge for welfare users stood between active ageing subjectivities and increased reliance upon professional, institutional or market-led controls. In support Bauman (2000) has stressed the 'drifting identities' apparent among people within ever more fragmented societies whilst Fraser (1998) stipulated that identities no longer guarantee a platform upon which collective resistance may emerge as in the past: including for the right to decent housing, employment or greater equality. More likely they appear to represent *individual* strategies to gain recognition, sometimes including through collective identities. Furedi (2011: 90) again questioned the atomising and superficial nature of modern identity politics: in which through professional and legal governance 'the self is not so much affirmed or realised but institutionally processed and given the bureaucratic equivalent of a [polite] smiley face'.

In the face of welfare retrenchment and community fragmentation Estes *et al*. (2003:36) have added that older people are now increasingly expected against great odds to generate identities from their own resources or attributes. Canvin and colleagues (2007: 984) also drew

from interviews with adults living on welfare benefits in socially deprived parts of England to highlight the ambivalence typically felt towards welfare professions by claimants. Users articulated an embedded distrust or even fear of the welfare professional: especially regarding their capacity to judge them unfairly, misunderstand their points of view or potentially remove benefits and services. Indeed, approaching welfare professionals was interpreted as representing a gamble that carried risks alongside a small chance of receiving a support service, helpful advice or benefits. Howe (1998) reminded us that social work in the state sector in the UK is still bound by tight legal responsibilities and regulations, and that inevitably these limit the autonomy and choices that are available to practitioners.

Means *et al*. (2003: 36) highlighted a 'history of neglect' in respect of social work with older people in which the choice has tended to be between anxiety, risk and limited provision in the community, or discomfort and stigma within institutions. Estes *et al*. (1996: 99) have identified three themes that prevail within the political economy of ageing: that ageing is reduced to biological and physiological decline; that some elders are recognised as deserving whilst others not; and that ageing is a social problem embedded with crisis and as representing a burden upon carers and taxpayers. Powell (2006) emphasised the theme of professional control apparent in social work with older people: measured political processes and tacit procedures such as assessments of need which probe, measure, evaluate, monitor, instruct and regulate or move the ageing body. Such responses or interventions it seems may be exacerbated by policy makers' keen above all else to limit the cost of an ageing population. Professionals, however, tend to have degrees of choice to resist such discursive cultures and hegemonic roles.

Care management and personalised care

The promotion of quasi-markets and care management throughout the 1990s has led to intense changes for social work with older people. Such reforms have garnered extensive criticism, especially regards the impact of local resource constraints, cumulative privatisation and the subsequent fragmentation of service provisions and roles; alongside a more intense administrative function for social workers newly ordained as 'care managers'. Core tasks such as assessing needs, purchasing care from competing providers and reviewing multiple provisions led to many questioning whether this role was really 'social work' (Postle, 2001). Dustin (2007) distinguished between the traditional roles of generic social workers - which

included interpersonal communication, negotiation, mediation and organisational skills - with a raft of additional skills required by care managers. These include risk assessment, accounting and budgetary skills, familiarity with information and communication technology and an understanding of management and information systems. Yet, Irving and Gertig (1999) and Lymbery and Postle (2010) have challenged this distinction and add that care management links to (and indeed extends) many traditional social work skills.

Additional concerns were expressed by critics' regards highly rationed local authority provisions and the key yet onerous role that care managers played as impersonal gatekeepers who rationed support through assessment technologies. Assessments quickly became resource rather than needs led – intent upon restricting rather than providing support - and invariably altered and undermined the relationship between social workers and older clients and carers. Care managers were severely limited in their powers of intervention and restricted to providing a bare minimum of practical, institutional or risk-averse care. The need for stability in older age - such as with regard the provision of coherent and reliable support - has been further undermined by ever more fragmented services that include frequent changes in staff and proprietors in core social care sectors such as residential and domiciliary care. Disparities also persist between rhetorically driven policy mandates which claim choice and flexibility and the limited support for vulnerable adults often living alone in precarious community settings (Morris, 1993; Dustin, 2007). However, these themes tended to merely support and intensify longer running historical trends (Means *et al*., 2003). Hall and Scragg (2012: 1) contend that a now long term tendency to ignore the unmet needs of many older users has intensified as part of an on-going period of welfare austerity and cuts: despite growing demographic and social care needs for conditions such as dementia, poor housing, loneliness and poverty that retirement commonly brings. Webb (2006) added that the ideologically embedded community care reforms in the UK fit with a wider political discourse that seeks as its maxim the management of finances and human risk. Older people have subsequently discovered that their choices and control remain extremely limited within social care despite the proliferation of ever more service providers. Limited information may also be provided regards their rights or available services. Indeed many older people are now placed at risk due to the expansion of low paid, over worked or transient staff who often spend brief periods of time with users in their home and receive limited training from their employers (Kings Fund, 2005; Baines and Cunningham, 2011). These trends suggest that human rights violations are not uncommon for some older people within strained social care systems: whether

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precariously placed in institutional care or living along with limited or no support. Some elders also remain at significant risk from their own family members or paid carers.

Some elements of quasi-market reforms nevertheless benefit older users. For example, older people were initially served by specialist social work teams, many of which targeted their specific attention on elders alone, and carried their own funding to support community-based services for adults (Means et al, 2003; Dustin, 2007). Second, the role of care managers became more focused, better structured and less uncertain than earlier generic teams. Whilst assessment of needs quickly became bureaucratic and driven by financial agendas, such care management technologies and processes did at least offer a clear framework through which to identify, recognise, quantify and respond in part to the complex needs of older people. Third, quasi-markets offered some choices for users regard provisions, and allowed newer and perhaps more innovative providers to enter an increasing yet fragmented landscape of social care.

One significant consequence of the rapid development of social care markets and care management remained that qualified social workers became extremely vulnerable to being replaced by unqualified staff or associate welfare professionals. As substantive care manager roles constituted largely simple bureaucratic tasks and procedures to follow as part of a standardised labour process, many such tasks could be fulfilled by associate staff, including unqualified or other professionals. Subsequently, due to financial and political pressures, the care management role for older people has gradually been replaced by numerous unqualified and health care staff working alongside an ever dwindling proportion of qualified social workers. Similar patterns have emerged in mental health, disability and child-care services: each of which again follow the process driven task-centred principles of care management. Indeed, Langan (1993: 164) argued that any claims about social work 'to professional expertise lie in ruins' following the initiation of quasi-market reforms during the early 1990s. Whilst the title of "social worker" has survived in principle, many adult roles were quickly being devolved 'to poorly trained (and poorly paid) care workers, or to the voluntary or informal sectors'. In essence, one of the few initial benefits of care managed support for older people - that of a greater likelihood of receiving attention from a qualified social worker - proved to be short lived. There clearly remain questions however of whether unqualified staff or professionals from other fields are able to adequately understand, articulate and respond to the social needs of older people, or be fully aware of their legal, civil or human rights.

A related set of reforms held within a care management and quasi-market discursive framework falls under the banner of "personalisation". Spicker (2012) suggested that there are three models of personalisation within social care, these are: including support services tailored to individual need following a professional assessment; choices and preferences made by service users including via self-assessment; and users becoming more involved in how services are designed in consultation with professionals. The notion of personalisation suggests a very different concept of citizenship to that which has previously operated under the welfare state in the UK. In the latter, an ethical concept of justice inculcating entitlements was emphasised (Rawls 1996), whereas the notion of personalisation can be understood as support that is concerned with promoting capabilities for autonomy and self-support. Foucault, in particular, has highlighted the role of welfare professionals in enhancing autonomy, self-governance and hegemony in motion or action of the reflexive 'self on self' (Foucault, 1986; Dean, 2010). One means to achieve such aims are to enhance a person's choice and control over the care they receive: leading to autonomy, wellbeing and mild forms of social inclusion. As Lymbery (2010) adds, seemingly altruistic aims such as inclusion and empowerment remain difficult to challenge.

Gilbert and Powell (2012: 266), nevertheless, have argued that personalisation builds upon and extends the neoliberal principle of self-governance for older citizens. Such governance is held within a rhetorical policy and practice-led prompting of greater 'independence, choice, freedom, responsibility, quality, empowerment, active citizenship [and] partnership'; articulated through the enabling state, co-production and community action. Concerns persist that personalisation seeks to manage 'risk' and crisis at a low cost, and that privileged and better educated users or carers benefit more from the policy: especially since they are perhaps more able to engage with core activities such as self-assessment and the purchasing and managing of formal care. Many older people also experience anxiety and stress 'brought on by the burden of organising their own care' (Gilbert and Powell, 2012: 267-268). Glasby (2012) has detailed greater risks to users following the further fragmentation of public services following personalisation and, crucially, the lack of resources and professional support attached to the policy.

Spicker (2012: 14) has questioned the efficacy of personalisation and highlights the 'wildly exaggerated claims that are made for it'. He added that matching users to resources and

multiple services is time consuming and dependent upon numerous practical or personal contingencies (as with care management).As Spicker concludes:

> "If as the largest evaluation suggests, services for older people and people with learning disabilities are not actually improved by personalisation, and the gains for younger people with physical disabilities are marginal, then many of the people who are supposed to benefit from personalisation gain little from it. Crucially personalisation has maintained no clear role for adult social workers who are largely resigned to providing advice or brokerage; although such roles may again be provided by unqualified staff, volunteers or other professionals." (Spicker, 2012: 14)

Ferguson (2007) has argued that the personalisation agenda neglects issues of poverty and inequality, misunderstands the complex needs of users and may also stigmatise vulnerable adults: it represents the privatisation and 'export of risk from the state to the individual' page number. With no extra resources provided to support services - and any support dependent upon means tested eligibility criteria - personalisation can be viewed as extending core market-led ideological traits embedded within care management, and as representing another form of abandonment for many older people, especially those with moderate needs or who live alone.

The limits of health and social care integration

A further tendency prevalent within social work with older people remains the ongoing escalation of a health care (or more specifically biomedical) focus set within a wider health and social care ideological framework. This tendency persists within a relentless government induced inter-professional narrative which has in the recent past repeatedly advanced idiomatic claims of enhancing 'partnerships' and promoting 'joined up working' at a local-level, despite many policy mandates being didactically driven from a nucleus of centralised government power (Clark, 2002). In noting the prevalence of 'implementation deficits' and 'modernisation muddles', Means *et al*. (2003: 213-214) question the extent to which such reforms have been successful within health or social care welfare agencies at a local level. For example, as with earlier quasi-market reforms problems have emerged due to the speed, volatility and extent of restructuring and reorganisation. As the authors add 'relatively small failures of co-operation between different organisations can easily multiply to create a major implementation deficit' (ibid: 213-214). Numerous structural, cultural and resource related

difficulties have also been faced by complex bureaucratic organisations and practitioners when attempting to achieve multi-agency commitments around collaboration and joined up working.

Closer professional ties between health and social care sectors carry a raft of potential benefits for patients, users and carers. This is especially with regard to adequately supporting complex multifaceted needs in relation to conditions such as dementia, arthritis or in relation to end of life care (Tanner and Harris, 2008). Despite this the unique defining features of social work praxis and role have shifted, become diluted and indeed withered in crucial fields such as the care of older people as part of integration policies and reforms. Medical or health care professionals, discourses or techniques of care may be less likely to prioritise the significant impact of poverty or poor housing upon a core of social work clients within an increasingly bio-medicalised ageing industry.

Student social workers, and often equally perplexed practitioners, are encouraged to embrace an evidence-based paradigm, processes, technologies of care and provisions which, as many such as Webb (2001) have highlighted, tend to be ideologically spiked with realist and behavioural principles that invariably decontextualize and over simplify complex social needs and interventions. Evidence based policies and practices can also be used to achieve other political objectives: such as limiting or refusing provisions and rationing services or discrediting alternative yet effective practices that seemingly lack a clear evidence base through measurable outcomes. For many older people, this may lead to the demise of core services such as day or respite care because tangible short-term evidence of effectiveness may be difficult to achieve. It is also questionable where the fit remains between social work and a (political) methodology so embedded in health and clinical care: and which lacks capacity to consider unique personal or historical themes, human emotions or ethics, as well as mitigating 'real world' dynamics such as neglect, poverty, discrimination, abuse, and much else.

With a biomedical spin, great emphasis is increasingly placed upon inculcating social work into fulfilling science-led and health care orientated objectives and interventions. For example, ever more social care concerns are geared towards being part of treating pathologies (such as dementia, strokes or falls); whilst also fulfilling largely auxiliary roles in medically orientated service provisions with regard to rehabilitation, nursing care, residential,

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intermediate and end of life support, or fulfil a largely remedial role in tasks such as reducing bed-blocking of the oldest old in hospitals. Whilst concentrating on the experience of almoners[3], Bywaters (1986) has highlighted the long history of prejudice held against social workers by health care staff in hospital settings. In particular, the author stressed the implicit assumption which often prevails that core social work activities require only limited training, knowledge or skills and constitute practical and low skill activities. In addition, significant power differences prevail within rigid discursive arenas such as the hospital, surgery or clinic where medics maintain almost complete control.

Whilst health-centred pursuits and wider policies may hold benefits for older users (or their carers) they invariably run the risk of drawing attention and further resources away from understanding and meeting a wider range of *social* rather than health-care related problems and needs. As many, such as Huntington (1986) and Kitchen and Brook (2005), have noted, social workers can be extremely effective in accessing valuable resources (finances, housing, access to networks of support or crucial services, and so on) for their community-based clients: a key role that associate staff or professionals may lack the time, inclination or skills and knowledge to accomplish. Foucault (1973) has detailed the ways by which the medical profession reinterprets illness and health: with the sick 'other' reconstituted within knowledge-rich 'circles of power' as a passive object made up largely of dysfunctional parts to be examined and modified through expert interventions. Estes and Binney (1989: 588) add that within biomedicine the understanding of ageing is recognised as a purely medical problem that embodies illness, decay, dependence and deterioration; whilst the impact of historical trends, economics, policy, poverty or forms of inequality and exclusion diminish or are ignored. There is also a heavy reliance upon new technologies as the body's *natural* process of ageing may quickly become bombarded with tests and treatments which aggressively pathologise the patient. Crucially such discursive procedures move beyond mere treatments and begin to impact upon policy, research and 'the way we think about ageing and even science, as it is defined and evaluated in terms of a biomedical structure of thought'.

Whilst itself prone to integrate reductive bureaucratic classification systems, engage in surveillance/regulation techniques and accommodate normalising binaries generated through casework and pedagogy (client/professional, deserving/undeserving poor, competent/deviant parent, humanist/managerial models and theories, and so on) - as well as utilise psychological, functionalist or business paradigms that again limit understanding of complex

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needs - social work as a discipline still draws from a more eclectic range of paradigms and practices, which includes recourse to constructivist, humanist and critical stances. Such eclectic paradigms permit a broader and more subtle understandings and interpretation of ageing.

Estes *et al*. (2003: 92-95; 109-110) have drawn from critical gerontology to argue that policy and practice initiatives for health care maintain regular links with business, enterprise and a search for profits; which often stands against the core interests or needs of older adults. Associate belief and value systems such as bio-ethics maintain again a strong influence within health-care slanted welfare sectors; with emphasis given to the universal principles of *autonomy* and *choice*. Practically, such values translate into increasing audit or service monitoring processes and offer patients choice from limited numbers of private sector dominated services within a free-market economy. Such principles look to also reduce direct state provision and extend private practices and supplies: while utilising professional expertise to provide a technical gatekeeping role within 'the symbolic space of a special one to one bond' whilst 'wider circumstances of policy and power relationships are not addressed'.

The incorporation of social work with older people into inequitable health and social care systems also overlooks that there are significant differences in the UK in core legislation, administrative processes, knowledge cultures, practices and rudimentary activities, tasks and roles which professionals in such different sectors engage with. Indeed so many of the most fundamental activities undertaken by social workers stand poles apart from their health colleagues, and links are likely to remain tenuous. As well as being based predominately in community settings and residential areas rather than controlled and contained spaces (clinics, hospitals, surgeries, etc.) social workers also confront many more unpredictable contingencies in such often precarious settings whilst subsequently confronting issues and needs (poverty, neglect, poor housing, etc.) that inevitably demand a different knowledge base, alongside different resources and skills. Lewis and Gennerster (1996), for example, have noted that such disparities between social work and health care remained one of the key reasons why social service departments were organised as independent from the NHS in England and Wales during the 1970s.

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Regards integration, Fitzpatrick (1999) has offered a polemical critique of attempts by New Labour to alter and widen the role of General Practitioners (GPs) in England to include tasks traditionally fulfilled by social workers. As well as lacking the relevant training, experience or time to act as advocates - or provide advice and guidance on lifestyles or parenting - Fitzpatrick adds that newer acts of 'moral engineering' performed by GPs run the risk of conflating their core responsibility to diagnose and treat. This may also generate confusion, distrust and hostility from patients. Such conflation of roles is likely to also intensify further the fragmentation of service provision within health and social care arenas, as well as lead to a reduction in the number of professionals as more and more responsibilities are shared.

Risk hegemony

The growth and promotion of risk-averse cultures within welfare, alongside the extension and priority given to safeguarding roles, have again stood to undermine the capacity of social workers to meaningfully assist older people. Many of these activities are resource intensive, reactionary and difficult to manage due to being associated with numerous complex causal factors including demographic and social trends alongside poverty and deprivation among client groups traditionally served by social work; unrealistic expectations placed on informal carers, a lack of formal support on offer or the significant growth and fragmentation of home care companies alongside the low pay and transient nature of care work (Biggs *et al*., 1993; Baines and Cunningham, 2001; Webb, 2006). Whilst these influences are only rarely acknowledged by policy makers the responses of social workers are not uncommonly reduced to a series of short-term investigatory, crisis management or surveillance related tasks. As with the *McDonaldised* and task-centred facets of care management such obligations are often brief, short-term and lacking any preventative dimension, especially provision of longer-term support or exploration of underlying causes. Conversely, last minute responses to personal crises prevail alongside intense questioning and bureaucratic and investigatory processes; all of which remain resource intensive and may be avoided with substantive early interventions, appropriate support and more funding alongside competent governance on behalf of policy makers including regards social care governance.

As part of a caustic critique Powell has argued that the 'discovery' of elder abuse masks very different policy agendas. This includes largely haphazard attempts to regulate informal care

alongside the maintenance of ever more professional assessments and bureaucratic processes which largely fail to prioritise need as priority:

> As with other forms of tacit control, the surveillance role left to a residual local state evokes a 'surface' of reality as constructed as 'depth', whereby generic methods of surveillance are presented as 'concern' models. This act of observation confers a uniformity that emphasises the 'protective' role of the professional rather than the substantive requirements of older people at the centre of inspection…assessment decisions seem to be taking place within an existing discourse on abuse rather than user need. (Powell, 2012: 4)

Again the limiting of state intervention and encouragement of outsourcing and privatisation to a constellation of different providers who all demand regulation remain part of these processes since the rise of safeguarding adults extends and builds upon the principles of the business model of social care promoted since the 1980s.

Tanner and Harris (2008: 190-191) highlight further paradoxes when working around risk and protection of older people. For example, tensions persist between the promotion of users' independence whilst seeking to protect through further monitoring and surveillance. Respecting clients and carers will also prove difficult if responses and interventions implicitly assume that their behaviours generate risks or undermine other people. There is also the possibility that safeguarding technologies of care such as risk assessments encourage anxious practitioners to cover their backs and protect their organisation above all else. This may also further increase overtly bureaucratic and authoritarian responses to complex needs. Greater involvement with the police and more punitive interventions may again further undermine social workers image and reputation in many working class communities: invariably building trust remains critical for fulfilling other core social work or welfare related activities. Such policies indicate that many 'social work' activities have now moved much closer to Althusser's (2003) understanding of a Repressive State Apparatus (alongside the army, police, and so on), and further away from Foucault's more subtle and nuanced interpretation of 'pastoral power' that inculcates benevolence, subtle regulatory support and implicit control (Dean, 2010).

Tanner and Harris (2008: 191-192) have drawn attention to the possible ageist assumptions embedded in risk-averse social work with older people. Here, subtle assumptions may prevail that older people should not be allowed to take risks as these remain the preserve of younger adults. The capacity to take a risk assumes choice and autonomy for active citizens whilst being at risk may quickly relegate (and objectify) subjects to a largely passive and dependant role as a vulnerable and meek 'other': remarkably similar to the ageist presumptions made in medical models of care within clinical gerontology and biomedical ethics that privilege the decisions made by the knowledge rich 'expert' professional. Some empirical evidence (for example, Ballinger and Payne, 2002) suggests that there is often friction between professional and older peoples' understanding of risk: such as priority being given to physical risk by professionals against many older people's feelings that it is their autonomy and independence which remain more of a priority.

Frank Furedi (2004) has argued that risk has now become an implicit part of all pervasive belief systems in modern Anglo-American societies. It appears as if almost everyone is at risk, whether from possible neglect, stress, discrimination, abuse, trauma, harassment and much else. Such often exaggerated risks may promote human powerlessness and passivity through which a 'diminished self' emerges alongside fragile identities. At the same time reliance upon therapeutic or welfare professionals increase whilst informal relations with those around us are undermined as people are increasingly suspicious of other people who pose apparent risks. The problems of everyday life it seems are also reframed through a prism of emotions which help to promote reflexivity alongside new forms of civic conformity. For social work with older people this may again limit and narrow previous possibilities and constructive roles, and encourage the further objectification of older clients as passive others whilst undermining autonomy, human potential, trust or solidarities.

Unsustainable future and constructive social work with older people

Social work with older people is not at an end but what remains is shrinking and likely to wither further. Many local authorities in England as elsewhere continue to replace their qualified care managers or care coordinators with unqualified and often inexperienced staff. Yet it is not merely the total number of qualified staff which is contracting but also the diminishing roles and rationale of those who remain. A thin-line of qualified provision now fulfils adult safeguarding roles or attempts (largely in vain) to encourage self-help and expand

informal community care with limited or no additional provision provided. Invariably, reduced financial support and services continue to impact significantly upon users and family members: with 382,000 fewer adults receiving social care support from councils within England in 2012-13 compared to 2009-10 (Samuel, 2013).

Although at first these responses may seem surprising, especially given the rise in needs around conditions such as dementia, coupled with demographic changes that include an upsurge in the proportion of oldest old people and declining numbers of younger people. Recent findings that nearly a million older people are regularly malnourished in England (Care Quality Commission, 2012) offer some indication of the extent of unmet need. In some respects, however, such findings build upon the past in that they represent a continuation of the policies, practices and attitudes within the social work profession which have tended to consider the needs of older people to be of much less importance than other social groups.

Older people in effect represent the 'invisible clients' of social work, rarely able to generate the attention or interest of children, and falling behind other more "interesting" client categories such as with regard mental health, addictions or asylum related work. Richards *et al*. (2013), for example, noted the limited content relating to older people on a number of social work Master's programmes in English Universities, as well as the lack of opportunities to undertake related practice-based learning around ageing. Academic research regarding older people within social work again lacks the attention, kudos or research-funding established within areas such as child protection or foster care, and if it does then it's likely to focus on health care related needs. Such traditions and outcomes at different levels are complex yet remain profoundly ageist at heart. Davies (2012: 28) noted that the prevalence of ageism typically begins as 'a cognitive framework for evaluating groups of people', which then 'translates into behavioural discrimination within a culture, and then either informally or officially [becomes] enacted through regulations and statutes'. From a constructivist perspective, perceived 'realities' such as ageist values or beliefs can quickly become solidified and real, taken for granted assumptions which carry many consequences and proliferate into beliefs, actions and reactive policies in response (Berger and Luckmann, 1966).

For ageing populations such forms of socially-constructed prejudice have tended to be fortified by associate policies and symbiotic practices which have altered the types of

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intervention which older people and their carers receive. Just as with care management or personalisation - and their ideological privileging of eligibility, risk management and safeguarding, audit, user processing and client objectification; alongside the promotion of informal care, autonomy and self-governance - there has arisen an ageist focus and push towards reductive social care activities which sit within the pathological discursive domains of the biomedical, psychosocial and behavioural. Fears of demographic time bombs and exaggerated claims of dependent populations or financial collapse again add to this discourse. Such approaches have in fact been interpreted as representing the concerted abandonment of structurally disadvantaged people (see for example: Jones and Novak, 1999).

Little resistance has emerged regarding these extensive reforms: and no consistent attempt has been made to advocate the distinctly constructive role that social workers might play within ageing communities; especially beyond regulatory and standardised *McDonaldised* tasks and mundane knowledge bases that privilege competition, markets, superfluous assessments and carefully rationed care packages, alongside a push for autonomy, community based self-governance and biomedical care (Estes and Binney, 1989; Rose, 1993; Deacon, 2000; Webb, 2006; Dustin, 2007). Key social work roles such as advocacy, constructing and fortifying networks of support or navigating users' through complex social care and welfare systems is unlikely to be adequately met by any other professional group. Nevertheless since power is never complete or total, ideologically 'deviant' activities such as empathy, befriending, advocacy, group, pedagogical and community work - or daring to promote social networks, collective resistance and fairer access to essential resources and services such as decent housing, appropriate pensions, preventative support services and greater equality may sometimes remain possible. Ironically perhaps such responses are not merely more moral but also more sustainable and efficient for the support
of ageing populations.

Notes
1. In principle "Personalisation" seeks to enable individuals to live independently and retain choice regards which support services are available. This model contrasts with previous welfare provision which relied upon assessments of need from a social worker alongside organised services and care plans. Despite some evidence of autonomy and choice many social workers have expressed concerns that

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'personalisation' recipients are abandoned once a personal care budget is set up; and that limited resources mean that vulnerable adults often living alone are regularly left with not enough support to cope (see Lymbery; 2012).

2. Launched in 1998 *Sure Start* is similar in principle to the US Head Start programme and is intended in principle to provide support to families living in poverty, especially young children.

3. Almoners included hospital-based social workers who interviewed patients and offered advice, respite and after care among other services.

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