THE CARE MANAGERS: LIFE ON THE FRONT-LINE AFTER SOCIAL WORK

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ABSTRACT

The study investigates the impact of marketisation and New Managerialism upon current British social work, as well as the consequence of circumscribed resources or 'budgets' on increasing client need.

The research utilises ethnographic techniques of participant observation and interviews to explore in detail the day- to-day experiences of care managers and their respective front-line supervisors. Five teams were studied, including one in London, a hospital team and three based around a major city in the North of England. What emerges is at times a disturbing presentation of employee frustrations, despondency and anger in response to a job that appears to bear little resemblance to traditional social work, and its *apparent* attempts to provide regular contact, therapy and advocacy to vulnerable clients.

It is argued that a long-term crisis that has blighted social work is due for the most part to hostile governments; its weak standing in the labour market owing to a lack of support or understanding from the public for the occupation; as well as compliance from all quarters of social work to both policy and legislation. The thesis also considers the broader process of rationalisation and its impact on social work. Using the 'big bang' as an example it is argued that the interests of the client have been jettisoned in favour of a narrow set of compulsory procedures that the care manager must follow. Each repetitive and banal administrative task allows limited, if any, opportunity to provide assistance or support to people in need.

Finally it is argued that care managers now offer essential administrative support to an extensive (post-Fordist) social care industry, which is also a major British industry. In juxtaposition with their many bureaucratic interventions, care managers also on occasion respond to high-risk scenarios involving clients living in the community, and provide limited 'emergency' provision if any resources remain or services are available.

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CHAPTER 1

SOCIAL WORK, THE MARKET AND THE CARE MANAGER

High Ideals and the Bleak World of Practice

When I trained on the relatively new DipSW course at Cardiff University during the mid 1990s, it was apparent that there remained a sense of excitement and optimism running throughout the cohort of 54 fellow students. Graduates from a range of disciplines, including the natural sciences, talked about their desire to 'give something back' and perhaps even 'change people's lives'; the assumption being that such ambition could be facilitated through an 'altruistic' profession such as social work. In retrospect, such high ideals drew from a relative ignorance of social work's role in society, as well as a lack of understanding of the many changes that the occupation had, and was, continuing to experience. Nevertheless such high expectations endured, and indeed were openly encouraged in lectures that promised an impending opportunity to advocate for disadvantaged people, offer therapy and counselling to the distressed, proffer a source of stimulation and relief to the lonely, but most prominently (and grandiose) of all, empower the excluded and oppressed. Bold yet tangible ideals appeared to epitomise our time in training.

However once the two placements of the course had been completed it was soon clear that any such optimism had begun to recede. Fellow students returned from their placements and described, depending on their settings, a range of personal experiences that had displaced their initial confidence and excitement. They talked

about the long hours worked for relatively low wages, most notably in the voluntary sector. They also discussed the sense of cynicism, despondency and even regret that had been expressed by many veterans in the statutory sector about their decision to opt for a career in social work. Most notably however, many students were surprised at the volume of bureaucracy that was completed in local authority offices, and the lack of available finances in the budget to support clients' needs. Despite this, the eventually newly qualified social workers still felt that they could find a way through such obstacles and find a career route that would soon lead back to the initial optimism expressed at the beginning of the course. Perhaps the voluntary sector offered more opportunity for creative change, or could working for, or becoming, a provider allow more therapeutic client-centred work to prevail?

Five years later (May 2001) a reunion had been organised back in Cardiff; past students gathered together to discuss their first few years in their chosen career. During the afternoon my fellow students expressed their regret at not opting for another career. They each spoke about their 'boring' jobs and their need to try to find another career, preferably one that provided stimulation and, most important of all, *purpose*. It was apparent that my own experiences in London and Liverpool local authority teams had been little different: everyone felt disappointed about the nature of the work that they now engaged in each week in the statutory social services. We soon realised that we had each turned into the very people who had shocked us on placements five years before.

Indeed it had soon become evident after qualification that social work had been transformed over a relatively short period of time, and its supposed altruistic ideals

had literally become squeezed out in the process. My fellow social workers talked of the 'mess' that they abandoned each Friday evening in order to enjoy a weekend. For the people who worked in hospitals sympathy had been expressed for patients, who were regularly discharged into the community with either no support or only a skeleton care package to accommodate their recently acquired, and often challenging, disability. Care managers in the community talked about the lack of finance available to fund any type of regular support for extremely vulnerable people living in high-risk situations each day. I was informed that services available to clients were generally poor, much like the working conditions and role we each fulfilled: essentially the job of care manager, as well as social worker with children, was awful. People talked about their 'relentless bureaucratic tasks'; budget obsessed and compliant managers; strenuous workloads; and the low esteem and lack of faith held by the public and fellow professions towards social work. Most startling of all was the general consensus held that in general we failed to actually assist or support the people who were lucky enough to gain brief access to our formal attention in our role as professionals. Essentially, as statutory employees, we helped to provide a 'mirage service' for the public; one that gave an impression of the provision of assistance and care, but failed in the long run to provide any tangible support to people in need.

My ethnography was originally intended as a study of care managers' attitudes to some key changes identified over the past ten years, notably the impact of the process of deskilling and marketisation (Jones, 2001; Dominelli and Hoogvelt, 1997) upon social work. I had noticed on placement the considerable gap that existed between the academic rhetoric, which concerned itself with a positive interpretation of 'good practice' and 'empowerment', and the day-to-day activities and experiences of front

line social workers and care managers. To be frank, most publications concerned with statutory social work appeared completely out of touch with the experiences of practitioners, and the policies that we each 'breathed life into'. For example, I could find no evidence of group work, counselling, advocacy, therapy and empowerment techniques down at the local authority office, despite regularly reading about their prevalence in academic texts. Further, whilst on placement veteran social workers would continue to remind me that their job was now 'nothing to do with social work!' With such sentiments echoed by the experiences of my fellow students, I decided to pursue a long-term study into the changed world of the care manager.

The thesis then is primarily concerned with an exploration of social work's new care management role since the implementation of the National Health Service and Community Care Act 1990 (NHS+CC Act). The watershed act was distinct in its ambitions to support people 'in need' in the community, and away from long-term placements in hospitals and other institutions. Social Service Departments (SSDs) would eventually be given important and specific duties in implementing such an Act, most notably regarding their role in assessments of need (for services), and the provision of community services provided in response. Such services were provided alongside encouraged independent (private and charitable sectors) providers (DOH, 1990), which have since gone on to provide a predominant part of the formal care service provision (Harris, 2002).

This thesis draws from a four-year ethnographic study of four local authority teams and one hospital based team, each dealing specifically with adults and working

predominately under the initiatives (explored later in more detail) of the NHS+CC Act 1990. One team was based in London (older people) and the other four on Merseyside (Older People and Learning Disability). The methodology is discussed in detail in chapter 2.

This chapter is intended as an introduction to some of the key themes and issues that are explored throughout the thesis. The chapter is in response to the data that I have collected and since analysed, and attempts to provide an epistemological foundation that supports and helps explain my findings; which are presented and discussed over chapters three to seven. Key themes throughout this chapter (and much of the thesis) include the historical context of a social work discourse, notably in relation to the recurrent influence of philanthropic values and the use of surveillance and control techniques by social workers upon clients. Also important within this chapter remains the still relatively more recent influence of a neo-liberal discourse in the British political economy, and its impact upon welfare services such as health, education and the personal social services. For social work particularly this includes the impact of both the NHS+CC Act and Children Act (1989), or 'big bang'; the gradual deskilling of the social work role (Carey, 2003); the impact of new managerialism (Clarke and Newman, 1997); and the formation of quasi-markets of social care (Le Grand et al, 1992; Le Grand, 1993; Means et al, 2003). Also important in consequence remains the sharp increases in poverty in Britain over the past twenty five years (Jones and Novak, 1999); and the impact of increasingly scarce resources upon the possibilities offered by social work interventions (Dominelli and Hoogvelt, 1996).

Despite the impact of such economic and political forces upon social work practice however, it will also be argued that social work as an occupation (with professional ambitions) has itself offered little resistance to such events, and indeed it will be proposed that it has also in part encouraged them. Indeed later within the radical right thesis, an attempt will be made to consider the paradoxical yet symbiotic dynamics that often remain between agency and structure within the canopy of political, economic and social relations. That is, it will be argued that the social worker as agent, and the social work occupation in general, is responsible for encouraging change that *supports* pieces of legislation and policy that they ultimately help breath life into.

The Origins and Development of Social Work

The practice of social work is generally recognised as beginning in the nineteenth century during a period of rapid economic and social change in Britain. Most notably it is seen as a consequence of industrialisation and urbanisation (Dowling, 1999). Among other consequences industrialisation generated a strong demand for labour, particularly in fast growing urban areas (Marx and Engels, 1970: 72-75). As a consequence people unable, or deemed unsuitable, to gain employment often became economically marginalized or relegated to the fringes of society. The continued growth of capitalism also led to some of its characteristic traits soon developing, and becoming a conspicuous part of the social fabric. Most prominent remained the rise in poverty for a significant section of the urban population, one consequence of an individual's status in the, at times, precarious labour market (Novak, 1988). The problem of low waged employment also remained as a consequence of the drive for

profits on behalf of employers, and cyclical and seasonal unemployment were also common occurrences for urban labour in particular (Worswick, 1991). The expansion of cities and towns also helped lead to the persistent problem of poor housing, insanitary living conditions and the regular occurrence of ill health, most prominently through infections (Clarke, 1993).

Beginning in the eighteenth century, and developing throughout the nineteen century, a complex web of institutions and organisations developed in an attempt to monitor the growing population. According to Foucault (1975) the prison, school, borstal, workhouse and asylum all emerged in an attempt to contain and influence members of the population. But such institutions, and the various professions that they spawned, were also interested in establishing a moral code based around encouraging thrift, sobriety, discipline and family life (Allan, 1985). One possible motive was due to fear felt on behalf of the middle classes about the deprived populations who lived in poverty, and who offered a potential threat to the burgeoning capitalist classes (Scott, 1993). With charities struggling to cope with increased need, a complex system of disciplinary regimes offered a means of maintaining and controlling problem populations. Foucault (1975) articulates in detail the development of disciplinary institutions during the eighteenth and nineteenth centuries, emanating from a growing body of knowledge at the time:

> It would not be true to say that the prison was born with the new codes. The prison form antedates its systemic use in the penal system. It had already been constituted outside the legal apparatus when, throughout the social body, procedures were being elaborated for distributing individuals, fixing them in

space, classifying them, extracting from them the maximum in time and forces, training their bodies, coding their continuous behaviour, maintaining them in perfect visibility, forming around them an apparatus of observation, registration and recording, constituting on them a body of knowledge that is accumulated and centralized.

(ibid: 231)

Accordingly a 'juridico-economic' and 'technico-disciplinary' form of social surveillance developed, which permeated society. The assessment and study of populations, or demographics, became crucial at a period when the activities of people became essential to 'progress', power and profit. Further, knowledges of surveillance developed as people were adeptly studied, through discourses such as medicine, eugenics, biology, psychology, and sociology (Barrett, 1991). Social maintenance and control became an elaborate science, and through the development of society developed ever more rigorous and elaborate forms of discipline and monitoring, new professions emerged whose role of surveillance and normalisation were important themes that offered such occupations new powers:

> ...the growth of the disciplinary networks, the multiplication of their exchanges with the penal apparatus, the ever more important powers that are given them, the ever more massive transference to them of judicial functions; now as medicine, psychology, education, public assistance, 'social work' assume an ever greater share of the powers of supervision and assessment...these mechanisms of normalisation [become] ever more rigorous in their application (Foucault, 1975: 306)

As regards charity provision, for which there inevitably was excess demand, personal contact soon developed between the administrators and receivers of charity (Jones, 1983). It was from this point that casework developed, and here the imposition of middle class conservative values became apparent for clients to digest, a process that for some still persists today (Symonds, 1998c). Social workers held the capacity to administer selective rations of care to clients judged appropriate, worthy or 'deserving': again one of the many original schemes and techniques of social work practice that still persists today. More importantly they had the power and influence to impose a moral discipline upon clients, such as regarding the most appropriate way to rear children or avoid debt (Bosanquet, 1895). Indeed their moral discourse usually ignored structural issues and consequences such as power, class, and poverty, and instead centred upon an acute pathological judgement of an individual's worth or deficiency. For some such ambivalence towards clients has always persisted:

> Social work has, since its origins in the 'charitable' efforts of the Charitable Organisation Society during the last quarter of the nineteenth century, been deeply ambivalent about the poor. Throughout this history social work itself has not merely reflected dominant attitudes but has also been a crucial agency in the shaping and legitimising of those beliefs. Primary amongst these has been the view that poverty and inequality are not the most significant factors in the reproduction of the client population or of the multiple difficulties many of them encounter. Rather, this view has persisted in maintaining that the poverty and disadvantage of clients is not a result of social factors and systems

but a symptom of the clients' inadequacy of character and morality (Jones and Novak, 1999: 80)

Within casework social workers also helped to maintain and reproduce structural inequality and disadvantage, by targeting their attention on individual anomalies and failing to acknowledge or confront any structural factors related to disadvantage and exclusion (Thompson, 1993). Recent studies again suggest the continued beat of such a historical pulse in current forms of social work practice (see Davis and Wainwright, 1996; Morris, 2000; Harris, 2002).

During the inter war years of the twentieth century the welfare activities of local and national government expanded. This was particularly due to the discovery of the poor health of the population during the Boer and First world war, when many soldiers were found to be unfit for duty (Hall, 1985). The British Federation of Social Work was established in 1936 in an attempt to establish some sense of unity amongst the disparate types of social work practised. Notably, a concern with work that encouraged the establishment of 'normal' family structures and relationships soon became a priority. With the development of the post 1945 welfare state, social work continued to develop apace as a profession, but now one that was increasingly entwined and involved with the interests of the state. By the 1960s social work was becoming an increasingly important part of the social democratic welfare state. It was distinct however in its regular, and at times close, working relationship with its traditional client group, the working class poor. That is, social work is distinct from other parts of state welfare such as health and education in the fact that it is predominately *class-specific,* and targets its now increasingly authoritarian methods

and interventions almost exclusively upon the working class (Jones, 1983), or more recently the working class poor (Jones and Novak, 1999). This inevitably has led to a hostility being felt towards many in the occupation by understandably beleaguered people within such a specifically targeted social class:

> The view of social work from below has been largely negative. There is a widespread sensibility in many working-class neighbourhoods that social workers are to be avoided because of their powers to remove children or commit people to mental hospitals (Jones and Novak, 1999: 84-85)

Social work as an important part of the state welfare system eventually led to the publication of the Seebohm Report in 1968 (Alcock, 1989). The report was an attempt to bring together 'the fragmented state of social work services, which had been the focus of increasing criticism' (Pierson and Thomas, 2002: 423). Many areas of "social work", such as in relation to work with people with mental health problems and learning difficulties, were performed through the health service. It was hoped that such fractions could be brought under the attention of "generic" social service departments in England and Wales. This ambitious Report, perhaps romantically, envisaged social work as also being capable of encouraging greater equality and social solidarity, as well as being able to encourage individuals to contribute to the stability and well being of communities (Jones, 1983). Langan (1993) also acknowledges the Report's recognition of social inequality and its attempts to encourage social work away from the stigmatising practices often inherent in the culture of charity work. However, in hindsight, it is now evident that the Report held an overly optimistic view of social problems and underestimated the extent of

Beveridges' five giants within British society: poverty, poor housing, disease, ignorance and unemployment. The Report particularly failed to acknowledge the number of people living in poverty, and still managed to preoccupy itself with 'problem families' and 'difficult personalities'. Langan (ibid) implies that the Report still encouraged the historic distinction between the deserving and undeserving poor. Nevertheless the initial optimism of the Seebohm Report was short lived, as the 1970s brought with it a sterling crisis and economic recession, which eventually led to budget cuts in welfare expenditure and added pressure upon recently formed local authority social service departments.

Reform and perpetual flux would continue to become an essential part of statutory social work in its relatively brief history. Despite this, cultural values established during the inception of the profession during the nineteenth century remained (Jones, 1983; Dowling 1999). First, social work retained its "casework" approach, and with it continued to collect and process information about "clients". Surveillance has thus always remained a pivotal part of social work culture. Second, a simplistic distinction has often been drawn between clients defined as deserving or undeserving, worthy or worthless. Third, despite some resistance during the 1970s from 'radical social workers' (Ife, 1997; Powell, 2001), social work in practice has continued to prefer individual, and often pathological, gazes into clients' habits, personalities and lifestyles, whilst regularly ignoring the profound influence of structural deprivation and circumscribed life chances. Such an approach has led to regular accusations of racism, sexism and disableism (Dominelli, 1988; Dominelli and McLeod, 1989; Barnes, 1991; Thompson, 1993), amongst many other forms of discrimination and oppression, by social workers in their practice (Galper, 1980). Finally, social work has

regularly utilised disciplinary techniques in its practice in order to control and manipulate its clients. This is regularly the case when a client's behaviour or mental health is considered to be anomalous, or removed from a narrow definition of what is apparently normal. This is particularly the case in its work with children and families (Goldson, 1999), but social work's history also suggests a rigid and strict dislike of idiosyncratic behaviours regarding age, gender, ability, sexuality, and health (Oliver, 1990).

Community Care

Although social work has tended to prioritise its work with children, its scope of practice has also included regular work with adults. Traditional client groups have therefore included older people, the physically disabled, people experiencing mental health problems and clients with learning difficulties. Such 'community work', which also includes social work practice in hospitals, stood as an important part of generic social work. Despite this, critics of the generic system, as well as clients' and advocacy groups, believed that social work with adults had become secondary in contrast to social work's at times obsessive concern with children (Oliver, 1990). The implementation of the Children Act (1989) and NHS +CC Act (1990) eventually led to the establishment of specialist teams, each dedicated to work with a specific client group. Thus, work with children was separated from adults, and such a divide was further sub-divided into further specialisms (Harris, 2002). Most local authorities now tend to divide teams into specialisms based around children and families; mental health; older people; learning difficulties and physical difficulties.

Community care has a long history; many even believing its origins can be traced back to the nineteenth century (Symonds, 1998a). Parrot (1999: 75) argues that the Mental Health Act (1959), which attempted but failed to reduce the numbers of disabled people living in institutions and hospitals, began the push for increased formal support services in the community. Salvage (1998) however argues that it is difficult to trace the exact origins of community care, but instead suggests that as a policy the early 1960s stand out. Of influence remained the publication of Goffman's 'Asylums' in 1961; in which the at times brutal consequences of institutionalisation were articulated. Although perhaps more motivated by economic motives, Enoch Powell (then a Conservative health minister) in 1962 proposed to replace institutional care with 'care in the community', a proposal that was however never responded to at the time (Lewis and Glennerster, 1998). More recently however, but particularly since the implementation of the NHS +CC Act (1990), community care refers to support or care provided in the community for people with mental health problems, the disabled, older people and people with learning difficulties. The NHS+CC Act is distinct from any other attempt to propose such a policy due to the encouraged expansion of independent (private sector and charity) providers of formal care services, and the eventual "selling off" of many local authority owned services such as residential and nursing homes (Sharkey, 2000). As is further addressed later in the chapter, the 1990 Act encouraged the development of a 'quasi-market' of care services to be formed, whereby the prior monopoly of local authority care service provision would be eventually overhauled by the introduction of other competing "providers" of care (Harris, 2002).

Two distinct camps typically provide care in the community; formal support provided by professional or unqualified support staff and care assistants, and informal support provided by family members, friends or neighbours, notably unpaid women (Finch and Groves, 1983; Finch, 1984). Research has tended to suggest that informal care provides by far the greatest contribution to support in the community, saving the government an estimated 57.4 billion pounds per year (Birmingham Carers, 2003). Formal support provided through SSDs cost just over 12 billion pounds in 1999 (DOH, 2000).

The 1990s also saw an emergent priority in community care policy given to primary care provision in health care (Sharkey, 2000). Primary care developed and is provided predominantly by GPs, community and psychiatric nurses, occupational and physiotherapists, and social workers. Market ideas were again encouraged alongside the push for primary care provision, and led to GPs controlling their own budgets and recruiting their own staff, and independent trusts within the NHS developing (Ham, 1996). The development of primary health care also lead to tensions developing with local authority social service departments, particularly regarding what constituted 'health' and 'social' care in the community, and over which agency had responsibility for service provision (Nocon, 1994).

Community care is a vast area, in which a complex web of relations is drawn between many disparate professionals, as well as formal and informal care providers (Parrot, 1999). The dynamics of support are deeply political, and draw from a range of power dynamics and points of conflict related to risk, need, class, gender and status. Feminist studies (such as by Finch, 1984) have tended to stress the historic

expectation by the state on women to provide informal care at no cost and little recognition (Morris, 1991). It has been argued that such expectations have tended to increase substantially with the implementation of community care policy since the 1990 Act (Walmsley, 1998; Sharkey, 2000). This has led to the generally accepted proposal that during the 1990s care in the community transformed into care *by* the community, due to a lack of formal support services available following the closing down of many institutions and long-stay hospitals (Parrot, 1999). Further it has been argued that former patients have not been de-institutionalised but *re-institutionalised* within community settings such as children, residential and nursing homes (Sharkey, 2000); as well as day centres and supported living accommodation, or the simple fact that they are "trapped" in their homes owing to a disability and a lack of available resources for support services (Carey, 2003).

The New Right and the 'Nuisance' of Dependence

The 1980s represented a period of profound change for social work. With the political and social climate significantly changed by the influence of the Thatcher administrations (Hall and Jacques, 1983), and the growing dominance of a New Right discourse in many spheres of civil life, social work quickly followed suit and experienced dramatic reform in a relatively short period of time. The New Right were distinct in their ideological desire for traditional moral values, as well as a penchant for an at times obsessive demand for authoritarian self-discipline on behalf of citizens (Hall and Jacques, 1983). Importantly however this was also fused with a celebration of the power of the market, and regularly led to policies that were identified as being economically neo-liberal in essence (Gamble, 1988). At a time when the existence of

welfare was accused of being at the heart of Britain's many economic and social problems, social work stood out for special attention by the conservatives owing to its firm base in the public sector and its supposed liberal image and reputation (Jones and Novak, 1999).

One of the most common accusations made by neo-liberals against social work at the time (and continuing today) was that it encouraged a 'dependency culture' amongst its traditional clients, which further drained the state of finite resources at a time of impending financial crisis (Oliver, 1990). During the 1960s and 1970s, public spending had risen sharply, and statutory social work departments were identified as one important cause of such high expenditure (Hudson, 2000). Throughout the 1980s dependency and excess welfare expenditure became a recurrent theme within New Right rhetoric. However, an exploration of the 'social construction of dependence' reveals that it is specific social groups who are typically demonised through the use of the idiom 'dependant'. Symonds (1998b) for example, argues that the term has referred more specifically to 'the poor' since the nineteenth century, such as in the arena of 'community care':

> Historically...the construction of physical dependency upon one or more of the other agencies of provision (the state, family, voluntary organisations) for specific groups of children, older people, those with mental or physical ill health or handicap has been based on their poverty. Orphaned children of the rich were not institutionalised, the wealthy 'mad' or disabled were either treated privately or cared for by servants, wealthy older people gained power

and influence through the dispensations of their money to relatives. (Ibid, 1998: 53)

In a political context dependence has a long history, and as a discourse its connotations are considerable. For government however, particularly during the 1980s, the label offered one of many opportunities to justify confronting welfare and reducing expenditure, a stance that soon became articulated in policy and legislation (Hudson, 2000). In 1979 the first public expenditure White Paper of the newly elected Conservative government ended the protected status for personal social service spending, as well as ending the monitoring of local authority provision in community services, and increasing a reliance upon non-statutory forms of social support (Walker, 1993). During 1981 in the White Paper 'Growing Older', it was argued that formal provision for older people in Britain should be 'supportive' rather than 'instrumental'. It was also argued that the role of the state, such as through local authority provision, should encourage informal family support, and was 'never to displace such support and care' (DHSS, 1981: 3). As noted earlier, the white paper continued a long historical trend of encouraging women in the home to provide support and care, usually without pay and recognition (Symonds, 1998c).

In 1982, a government funded study into the role and function of social work was published as the Barclay Report. The Report found that social services provided an important role in the community, but it needed to support informal networks of support rather than attempt to replace them:

> ...the majority of social care in England and Wales is provided, not by the statutory or voluntary social service agencies but by individual citizens who are often linked into informal caring networks (Barclay Report, 1982: 205)

The Report suggested that social workers had an important role to play as 'upholders' of such networks, and should work in 'partnership' with such groups rather than be a 'monopoly provider' of care (Bornat et al, 1993). Sharkey (2000: 93) notes the 'vague and ill defined' description of 'networks' in the report, but also acknowledges the surge in community social work throughout the 1980s following its publication. However the trajectory of the policy supported calls to reduce public provision and support informal provision in order to reduce cost.

The Audit Commission's 'Making a Reality of Community Care' (1986) was more precise in its criticism, placing blame with the benefits system and it's 'perverse incentives' to encourage formal care offered by nursing and residential homes. With costs continuing to escalate, it was argued that attempts needed to be made to encourage support for provision within a person's own home.

Along with the later publication of the Griffiths Report in 1988 a clear theme and stance had emerged regarding the view of government. First, the cost of formal support or care in the community was simply too high and continuing to rise. This was particularly the case for the cost of private residential homes in relation to the needs of Britain's apparent 'demographic time bomb' or ageing population:

> From 1979 to 1990, as the number of places in private residential homes for older people increased from 37,000 to 98,000, central government expenditure increased from 310 million to 1.2 billion pounds (Oldman, 1991: 4-5, quoted in Harris, 2002)

Second, Griffiths reinforced the idea that informal support provided a viable and cheap alternative, and should be harnessed whenever possible. Third, the Report argued that social work had an important part to play in such a process. The cumulative political stance of these policies revealed an assumption that people in need, such as the disabled and older people, were economically and socially dependant, and thus represented a *burden* not only on formal services, but also on the communities in which they lived (Symonds, 1998a).

Jones (1983: 24) further stresses the thinking underpinning the economic imperatives to reduce the 'nuisance of dependence':

> For the state, the nuisance of dependency runs along two main dimensions. First, the growing proportion of GNP consumed by the old through benefits, pensions, beds in long-stay hospitals, etc., runs contrary to one of the principle objectives of capitalist policy, namely that the costs of reproducing and maintaining labour should rest primarily on the shoulders of the workers themselves through the family. Second, the resources required and used by the old and the handicapped cannot be regarded from the viewpoint of profit accumulation as being a lucrative economic investment.

According to Foucault (1971) an excluded but easily identified social class has always been sought and maintained since leprosy scarred European society during the middle ages, and introduced the concept of exclusion into European culture. The place of the leper was eventually replaced by 'vagabonds, criminals, and deranged minds' (ibid: 7). Exposure of excluded groups to the public allows attention to be drawn from the activities of more dominant social classes. The dependant, as with the 'underclass', allow an easily visible and regularly demonised social group to emerge in the heart of the community, at which the frustrations and anger of the public can be readily directed if need be.

The perpetual reference to dependence by ministers and in many parts of the media (Jones and Novak, 1999), particularly throughout the 1980s but continuing today, allows the client to be seen almost as an enemy or pest, drawing from the heart of the state and people in the community. The term dependency has certainly entered the social and health care practice vernacular. My own experience has illustrated that families or clients are regularly dismissed or stigmatised as 'dependant' by budget conscious managers, and also by health professionals and some colleagues.

Social work however was not alone in facing the political wrath of neo-liberalism. Dramatic changes were also apparent in most other welfare professions, notably in relation to health care through the creation of internal markets and establishment of "trusts" (Ham, 1996; Sharkey, 2000), and education. Jones and Novak (1999: 159) discuss the experience of the teaching profession:

The teaching profession was one of the early targets for reform. Berated as obsessed with trendy fashions and opinion dating from the 1960s, and with teaching methods 'in which', according to Margaret Thatcher, 'the old virtues of discipline and self-restraint were denigrated' (cited Levitas, 1986: 7), methods of child-centred education were criticised amongst claims of failing standards and demands for a return to traditional forms of whole-class rather than individual child-centred teaching.

Parallel with the experiences of social work, education also experienced the brunt of radical pieces of legislation such as the1988 Education Reform Act, which established the National Curriculum and led to compulsory examinations for children of 7, 11, 14 and 16 years of age (Jones and Novak, 1999: 159). Radical reform then was felt throughout welfare occupations, and similar ideological themes were applied (marketisation; New Managerialism (discussed later); audit and inspections, and so forth) across the public sector. Despite this, as I shall argue in both my data chapters and within my conclusion, the experience of social work has been very different for one important reason. It will be argued that whereas teachers still continue to teach in classrooms, and nurses still nurse within hospitals, and so forth; state social workers no longer perform social work! Chapter 3 in particular will illustrate their now predominantly administrative role that allows no real opportunity to regularly engage in traditional social work activities with clients (communication, advocacy, counselling, group work, surveillance, and so forth).

The Care Manager

Along with two white papers published in 1989, the Griffiths Report was instrumental in leading to the NHS+CC Act (1990): a piece of legislation that alongside the Children Act (1989) would help transform the personal social services. Both Acts together would eventually lead to the marketisation of social care, as well as an increasing emphasis upon the adoption of business like management styles; the deskilling of the social work role through the establishment of care management work practices; and as previously discussed the establishment of independent providers of care services (Means et al, 2003)). Such has been the impact of the two Acts on social work that I shall refer to them together as representing a 'big bang'.

The Griffiths Report (1988) contained themes that were clearly linked to two key influences; that of a preoccupation with economic prudence, and a political will that emanated from government, and was concerned with the promotion of the market alongside an increasingly authoritarian moral concern with the competence and accountability of welfare professionals. The Report was critical of the set up of community care at the time and suggested that local authorities should take a lead role in any reform. Social workers as 'case managers' would set up packages of care for individuals deemed in need, and local authorities would gain control of their own budgets. It was argued that more could be obtained from existing resources and that responsibilities needed to be more clearly defined, particularly as regards the accountability and performance of staff (Sharkey, 2000). After considering alternatives for some time the government eventually accepted the majority of Griffiths' recommendations, and enshrined them in the landmark NHS+CC Act 1990.

His proposal for a minister of community care was however rejected, and case managers were instead referred to as "care managers". The NHS+CC Act was revolutionary in its promotion of the private sector in the delivery of social care services, and the transfer of responsibility from the Benefits Agency to local authorities as the main funding body of support services in the community (Clements, 1996).

Despite much of the NHS+CC Act being taken up with change in the NHS it is still clear that the Act's references to the new role of care manager were enough to articulate a very different role for social work (Postle, 1999). Most apparent is the distinction drawn between 'purchasers' and 'providers', with care managers taking responsibility for the commissioning of care services rather than encouraging any direct provision of support services, as had been the case historically. Such a role alone made it abundantly clear that client contact would be reduced significantly in favour of the administrative roles that purchasing would inevitably require. Despite this, idioms and rhetoric held within the Act such as 'empowerment' and 'needs-led', as well as the apparent desire to de-institutionalise former patients from long-stay hospitals (Sharkey, 2000), appeared to communicate within an empathetic social care vernacular that appealed to some influential figures within social work at the time (Butler and Drakeford, 2001). Despite this the Act, and most of its sentiment, were clearly in keeping with the logic of a neo-liberal government, most notably in relation to establishing markets and privatising many care services (Harris, 2002).

The Quasi Market

The development of quasi-markets, and more broadly the marketisation of welfare, is now generally acknowledged as a consequence of key political events dating back to the mid 1970s. Deakin (1994:62-63) emphasises in detail the short life of the Keynesian welfare state, and the sudden demise of 'big government' during the 1970s. According to Deakin the sterling crisis of 1976 ended any desire to maintain such structures, and initiated the dawn of the market as the apparent antidote to all that was wrong with the welfare state and Keynesian economics. Any commitment on behalf of government to full employment was quickly abandoned, and public expenditure became viewed as not the potential solution, but the cause of a wide range of social and economic problems.

The introduction of the quasi-market however was not entirely initiated on the basis to simply cut costs. Wistow and Barnes (1993) argue that state bureaucracies were also regarded by critics as impersonal in their delivery of care, and were also considered to be self-seeking and lacking in accountability. It was argued that monopoly provision had at times led to abuses of power and neglect for the interests of service users. The Audit Commission in particular had argued that any change that redressed the power balance between professionals and clients could only benefit the system as a whole (Audit Commission, 1992). Despite this, Self (1993: 56) asserts that 'government by the market' was intended not simply to transform welfare, but the nature of the state itself, including a desire to reduce the power of state professionals including social workers.

The eventual split between purchasers and providers of support services, and the developing quasi-market, of independent and statutory organisations, offered the potential for competition to flourish within the realms of community care. Competition, as the classical economists insisted, and government continued to stress (as it still does), offered a potentially emancipatory force in which choice for 'consumers' would allow high quality services to prevail (Le Grand, 1993).

The development of a quasi-market had many problems to overcome. Wistow et al (1994) describe in detail some of the problems encountered by state agency managers in attempts to introduce social care markets. In a study of 25 local authorities during 1991, they found widespread support for the concept of needs-led home based support in the community. However there was also genuine scepticism about the use of markets in social care, and a widespread belief that such business-like policy was inappropriate for vulnerable clients.

Le Grand (1993) for example, notes the possible differences between the traditional theoretical 'consumer' and a person with a disability or mental health problems. There is also the fact that within the quasi-market set up it is the care manager that makes many of the key decisions such as what services to attempt to purchase. There was also evidence that the independent sector was both unprepared and unable to fulfil its role as service providers to vulnerable people (Means et al, 2003: 60-61), a point still maintained today by critics. Finally there was widespread evidence that social service departments, and social workers, lacked appropriate training in their proposed role as purchasers of care services (Sharkey, 2000: 4). Nevertheless in a later study with the

same authorities, Wistow et al (1996) acknowledged a change in attitude by April 1993, as the process of change was nearly complete:

> [The study] provides evidence of changing attitudes towards social care markets on the part of social services Directors and Chairs, including a growing tendency to see such markets as mechanisms with potential for achieving social goals (ibid: 5)

Such an apparent desire by social work to perpetually accommodate the political desires of government, regardless of how contrary their policies may be to the interests of the 'service users' that they serve, means that real questions exist against the occupation's claims of a resilient sense of compassion felt for its clients. Holman (1993: 45) for example, takes to task the occupation and its leaders for accepting neo-liberal policies such as marketisation, and going on to believe that poverty and inequality are 'acceptable'. Jones (1999) takes this further, and suggests that contempt has often been a characteristic of social work practice with clients:

> '....even the most cursory reading of some of the key texts that have been used on social work courses over the past century reveals a most extraordinary tradition and contempt for large segments of social work's client population...For all the language of compassion and empathy there is running alongside it another language of hate and contempt - a principal paradox of social work under capitalism' (ibid: 42)

The social work occupation then, in offering little resistance to marketisation, and indeed in some ways embracing it, merely maintained a historical tradition. Such a tradition, that of serving the interests of the 'profession', and viewing clients as dispensable, is one that has been acknowledged as being common within the traditional professions, or occupations with ambitions of acquiring professional status. In an influential book, Johnston (1972) articulates the power dynamic that holds together the relationship between professional and client, and allows the interests of the professional to dominate. Parry and Parry (1979) in a study of the medical profession, argue that such a bond is a peripheral concern, in contrast to the desire on the behalf of the professional to acquire a monopoly of practice. The studies reveal professionalism as a strategy of self-interest, with the altruistic values claimed by professions merely helping to conceal a desire for power and dominance. The discourse of social work then might be viewed as an occupational strategy, with the client providing a dispensable means to an end.

Despite this, there still remain questions as to why social work accepted marketisation with so little resistance. A common explanation proposed is that the occupation has never achieved full professional status, and therefore remains more vulnerable in the labour market than a more established and powerful profession such as medicine, which has always been able to restrict any statutory influence (Witz, 1992). Certainly social work's relationship with neo-liberal governments hostile to the support and care of vulnerable people has shown a persistent tendency to comply regardless of the consequence (Holman, 1993: 40-48). This is despite the claims to compassion and support (Thompson, 1993; Braye and Preston-Shoot, 1995) that have become a hallmark of the occupation's stance:

contemporary social work is losing the struggle against a particular form of social authoritarianism, as well as a moral and political conservatism that it has failed to either recognise or confront....There is, however, in our view, a real cost in the flexible exploitation of ambiguity which has allowed social work to retain the semblance of loyalty to its own values, while carrying out the bidding of political masters with very different ideas and purposes. (Butler and Drakeford, 2001: 7-8)

The development of quasi-markets in social care has led to numerous problems, most of which have had the opposite effect regarding claimed attempts to achieve both equity and efficiency in the market. From a theoretical stance Le Grand et al (1992: 130-131) identifies the many potential hazards of developing quasi-markets of social care. They include a lack of direct choice offered to clients; the possibility that care managers may serve their own interests rather than those of the clients; the likelihood that competition between providers, or even services, may not prevail in less profitable areas of supply; and the possibility that care managers may seek out clients who demand less services due to their lower cost. They conclude that:

...quasi-markets in social care may overcome some of the problems for efficiency and equity associated with government intervention. But, as forms of market, not surprisingly they suffer from some of the problems associated with markets. There is no easy solution to the problem of providing social care equitably or efficiently (ibid: 131)

The consequences of the initial establishment of care management and quasi-markets soon became apparent to local authorities. Their new responsibility for funding formal social care, notably in relation to residential and nursing home support for the elderly previously funded by the DHSS, quickly became a burden, and it was apparent within months that the financial demands of community care were considerable (Sharkey, 2000). Local authority SSDs responded by lobbying government, placed added pressure onto the voluntary sector and scrutinised clients to ensure that full social security benefits were being utilised. Despite this, by the end of 1993 it was clear that such measures were not enough to cope with the sheer demand for social services in the community (Nocon, 1994). Other more radical measures were soon undertaken in an attempt to curb the escalating cost of social care, which was no longer the direct responsibility of central government.

Confronting Cost and Dismantling Support

The changes implemented by the majority of local authorities in April 1993 led to a complete shake up of social work's attitude towards the provision of care and support. One of the most documented remains the sudden emphasis upon cost and finance, and the gradual dominance of a previously alien business culture into social work (Baldock and Ungerson, 1994). Newly titled care managers suddenly found themselves spending an increasing amount of time undertaking 'financial assessments', and completing 'care plans' and contracts, and idioms such as 'efficiency', 'effectiveness' and 'capital assets' began to creep into the social care vernacular. A sense of alienation was experienced by many employees to the culture developing in the newly structured world of 'community care' (Hadley and Clough,

1996). Such a world appeared to communicate in abrasive and crude terms, in contrast to a prior lexicon that was enriched, superficially perhaps, with more appealing and tender terms such as advocacy, therapy and empowerment.

Despite this, the language utilised remained merely the wrapping on the parcel. Of more concern to service users remained the often-brutal actions (notably refusing or reducing services) of local authorities and social service departments (SSDs) that soon developed. Severe under-funding for social services, as well as increasing costs for services from the expanding independent sector providers, led to a dearth of formal provision in the community for essential services (Means et al, 2003). Social service departments were in real trouble financially in the first couple of months following April 1993 (Sharkey, 2000), and the measures utilised in response were radical.

To begin with, local authorities, following advice from the Audit Commission (1996: 10), were quick to establish an 'eligibility criteria' so that care managers and potential users were clear as to who was entitled to any services. Categories established tended to range from high priority, relating to clients experiencing emergency and crisis circumstances, right down to low and non-priority. Although each priority class in theory justified an assessment, in practice as time progressed and money became more scarce (Sharkey, 2000: 12-19), social work increasingly only funded support for need due to personal catastrophe and emergency issues (Carey, 2003). Eventually resources became so scarce that authorities set up 'panels', usually made up of senior SSD managers, to consider each application for any proposed service by any care manager. Thus care managers discovered another task as part of their new role, that of the fortnightly panel application in which attempts were made to access services on

behalf of people usually living in the community at high risk or extreme danger. Such a 'ration culture' left many care managers in the often-uncomfortable position of realising that a client was unlikely to receive a service prior to any assessment beginning.

More forthright authorities decided to simply cut current services. The now infamous decision of Gloucestershire council to cut the services of 1500 people in 1994, led to a number of clients taking the council to the High Court in protest (Mandelstam, 1998). By the time the appeal reached the House of Lords, support was provided in favour of the council's decision by a vote of 3 to 2. This was despite the fact that many clients affected by the policy were disabled, blind and living alone without any informal support to provide for their essential personal care tasks. With the success of the case for Gloucestershire there followed an avalanche of authorities apparently keen to follow suit (Sharkey, 2000: 14). Typically reductions, or the cancelling of care packages, will follow a formal review by a care manager (Carey, 2003). Indeed many SSDs have set up specific review teams since the Gloucestershire decision in order for care managers to scrutinise existing care packages.

There has also been a tendency for authorities to create a ceiling for the maximum cost of a care package that they will fund (Sharkey, 2000). Such ceilings, which inevitably have tended to fall over time, have encouraged some service users prematurely into residential and nursing homes; displaced opportunities for clients to express any sense of independence through the medium of formal support, or placed extreme pressure upon families and friends to provide support, since few services remain available (Carey, 2003). Finally authorities have, for some time, charged

service users for formal support. Charging usually follows a means test for clients, and in practice tends to lead to clients contributing part of their benefit each week towards the cost of any services provided (Sharkey, 2000). Such a policy causes a range of additional problems for care managers, as many clients such as older people and people with learning disabilities, can be stubborn or confused owing to their medical condition, and thus refuse *essential* services on principle or due to a fear of debt and so forth. It is also common that clients simply cannot afford charges. Charging also takes account of personal savings, which again discourages consent for services by clients. Such decisions can at times have fatal consequences, as will be explored in later chapters.

Despite such radical measures on behalf of local authorities, they still generally failed to substantially reduce overall financial demand for community care services (DOH, 1999). As time has proceeded since 1993, a growing sense of despondency has been identified in social service departments (Jones, 2001; Postle, 2001). With financial imperatives now dominating, many believe that social work's historic distinction between the deserving and undeserving poor has intensified, with some writers arguing that in practice the antiquated Poor Law has been resurrected following such sudden change (Jones, 2002). Such a period of rapid change nevertheless clearly required encouragement from above. Two influential ways that this was achieved included the encouragement of a scientific management style into social work, and the imposition of clearly articulated procedures for employees to follow, leading to an intensification in the process of deskilling. Such issues will now be considered in turn.

New Managerialism

With the break up of the monopoly on service provision that social work had previously acquired, the alternative proposed was intended to draw from a 'customer-centred network of facilities and services run by managers' (Clarke et al, 1994:73). The mixed economy, or indeed business of care, would require a strong management culture to encourage the radical changes which had been implemented since the early 1980s. Central in such a push for change was 'New Managerialism', a response to the proposal by critics that public services lacked 'proper management' (Pollitt, 1993; Clarke and Newman, 1997). White (1999:116) identifies three themes apparent within the New Managerialism. First, the establishment of decentralised operational units or teams, as well as greater centralised control given to both organisational strategy and policy. Second, managers would provide the important role of encouraging greater competition in the field of social care. Finally, surveillance and monitoring has been increased, which includes more emphasis upon inspection, audits, and reviews of practice. More specifically Cutler and Waine (1994:14) believe that New Managerialism has imposed the belief that social services 'can be promoted at lower cost when the appropriate management techniques are applied'. Such stances offer important arguments, but in some ways they over-simplify the motives that have led to the push for a new culture of 'strong management' in social work.

New Managerialism, strongly encouraged by the Audit Commission (Kelly, 1991), offered a distinct political strategy on behalf of government that attempted to transform the structure and culture of welfare, rather than merely tinker with targeted components. Pivotal to such a policy remained the strategy of dispersal, whereby

power is used to 'discipline and transform the old institutional sites of ...the bureau-professional regimes of the welfare state' (Clarke and Newman, 1997: 29). Dispersal encouraged the shrinking of the public sector, and encouraged a central role for non-statutory players, including independent and charitable providers, and, to a much lesser extent, service users. Social workers were made increasingly accountable not merely to their front line managers, but also senior managers who influence budget allocation, and voluntary and independent sector employees and managers. Dispersal also ironically subjects both social workers and their managers to greater centralised control, most notably that of fiscal pressures, the desire for greater competition and, perhaps most important of all, clearly defined procedures and working methods. Managerialism acts as an ideology, which represents a part of a broader scheme that:

> makes sense of ...dispersed power in a practical way. It actively seeks 'responsibility' and seeks to further disperse it as a corporate and individual good. It promises 'transparency' within a complex field of decision-making. It is committed to the production of 'efficiency' in the pursuit of super-ordinate objectives. Managerialism represents the cement that can hold together this dispersed organisational form of the state and, in its customer orientation, claims to be able to represent and service an individuated public. (Clarke and Newman, 1997: 30)

Front line managers exist as not merely strict monitors of the role of care managers, but are themselves also subordinated to organisational procedures. Social work in general then becomes procedure-led from top to bottom, and also becomes more accountable to exterior gazes, such as from non-statutory sectors of care and service

users. New Managerialism was also part of a broader picture regarding the 'New Public Management' of welfare. Here, the new culture of budget orientation and accountability, marketisation, choice and competition impose upon the assumptions of welfare (Dunheavey and Hood, 1994: 4).

The dramatic changes generate a culture of perpetual accountability and monitoring, as well as allowing hierarchal lines of discipline to emerge. Procedures determine day to day practice, and budgets further restrict the capacity of practitioners to fulfil their intended role. Despite this, managers constantly remind care managers of the cultural value of efficiency and effectiveness, and are expected to transmit the financial imperatives central to the organisation. New Managerialism then is not merely about the application of 'scientific management' into social work, but instead offers an important contribution to a bold and grand scheme regarding the 'hollowing out' of welfare, and the intensification of work loads and responsibility (Pinch, 1997:45-56). The clearly defined and hierarchal structure helps to define role and purpose, and encourages each agent to internalise the distinct values of the market so embraced by the national "centre", and core points of the organisational "periphery".

The restructuring leaves the front line care manager vulnerable due to the intensed accountability and expectation generated. Not only do they comply with their immediate managers' instructions, they also find themselves open to queries from managers and employees in other non-public sectors, as well as service users themselves, who will regularly be frustrated with their (non) allocation of rationed services (Morris, 1994). The decentralised (and centralised) structure brings forward the care manager as pivotal, and leaves the agent potentially accountable to all the

players in the structure. The overall emphasis upon procedure does however affect all sectors of the organisation, and managers are just as exposed to the process of deskilling, one important consequence of such change.

Finally Harris (2002: 80-83) discuses New Labour's 'Best Value' project emanating from the White Paper 'Modern Local Government: In Touch with the People' (DOE, Transport and the Regions 1998). According to Harris (ibid: 80) the ambitions of 'Best Value' are 'far more comprehensive than anything attempted by the Conservatives'. Most prominent in the policy was that the structure of community care would not change (Carey, 2003: 133), but instead there would be an implementation of national performance standards and targets, particularly in relation to numbers of assessments and care plans completed by care managers; why and how services are provided; encouraging consultation with the business community and service users; and encouraging more competition between authorities in order to improve efficiency and effectiveness. The policy appeared to build on the ideological demands of the Conservatives, and more recent research has suggested radical consequences. The University of Warwick (2001: 15) found that there was increasing pressure on local authorities to sell off their 'in-house' (or own) services in favour of the private sector, as well as cut the salaries of remaining residential staff bringing them closer to that of the 'minimum wage' private sector. Newman (2000: 55) also identified considerable pressures on local authorities to cut costs in order to meet the figures identified in 'Best Value' targets. My own data, discussed in chapter 4, illustrates the intensification of 'information farming' encouraged by the sudden demand placed on front-line managers to collect more data and process performance targets (such as increase the

numbers of assessment forms completed by care managers), rather than actually provide any *role* or *service* to clients.

Harris (2002: 82) identifies the policy as intensifying the trend set by the Conservatives of turning social work into a business:

> ...under 'Best Value' the drive for efficiency continued and intensified the quasi-capitalist rationality initiated by the Conservatives. This drive was supported by the way in which 'Best Value' forced public services into a 'business performance' mould, with an emphasis on quasi-business results, increasingly defined by government performance targets.

Deskilling

The formation of care management during the 1990s dramatically speeded up a process first identified during the 1960s: that of deskilling through increased bureaucracy. Such as a process immediately followed the Seebohm reorganisations, as Leonard (1968: 303) acknowledges:

> The kinds of organisations in which social workers are employed are getting bigger, especially local authority departments. As organisations increase in size, they require a central administrative structure which ensures that the activities of the members of the organisation are all directed towards the official objectives. The bureaucratic structure of a social work organisation

aims at securing predictable behaviour from social workers in conformity to policy. (Cited Jones 1983: 113-114)

Radical social workers particularly picked up on this theme, and tended to explore Braverman's (1974) famous study of scientific management *Labor and Monopoly Capital,* in order to emphasise the predictable tasks encouraged through managerial control leading to the formation of 'Seebohm factories' (Simpkin, 1983). Harris (1998: 844) in contrast, argues that social workers in the 1970s and early 1980s enjoyed far more technical autonomy and control than current care managers, although they were still restricted in their capabilities by an 'ideological subordination' imposed by legislative and organisational demands. Local government at the time, in contrast to the NHS, had more autonomy from central government in how it interpreted both policy and legislation, and many social service departments took advantage of this. Of course departments were also not at the time subjected to the additional constraints that severe under funding (ibid, 856) and excess demand would later impose (Jones and Novak, 1999).

Despite an acknowledged prevalence of a deskilling process surprisingly little has been published on the subject by social work academics themselves. Indeed such a discourse is conspicuous by its absence in relevant academic journals and books, leaving only a handful of writers acknowledging the extent of its impact (for example: Ife, 1997; Dominelli and Hoogvelt, 1997; Jones, 2001; Postle, 2001). Care management with adults has particularly been identified as encouraging a loss of technical skill and overall autonomy, although it has been argued that care management techniques are used in statutory social work with children (Morris, 2000;

Powell, 2001: 19). Along with the impact of marketisation and New Managerialism, social work has experienced the almost complete removal of its soul following the dramatic imposition of change, as Ife (1997: 24) asserts:

> Many of the ideological and organisational foundations of social work practice, as traditionally understood, seem to be crumbling, and it is not clear whether what will take their place will be able to support the social work profession in anything like its present form (cited in Powell 2001: 21)

Jones (2001) in a study of just over 40 social workers in local authority departments (including teams working with children) across the north of England, paints a depressing picture of employee despondency and anger in response to change, leading to the establishment of what he refers to as 'a grim place' inside such work settings:

> The manifestations of stress and unhappiness in today's local authority social service departments were various, serious and pervasive. Social workers talked of how commonplace it was to see colleagues in tears. I heard stories of social workers throwing all their papers on the floor and walking out, of people locking themselves in rooms or just disappearing from the office for hours on end. Going sick for some time each week or month seemed routinized in many agencies and was one of the most cited examples of a stress survival strategy. (ibid: 551)

The monotony of the tasks engaged in each day, as well as the considerable workloads, pressures and lack of resources, had led to a sense of disenchantment for

tired and despondent staff. Dominelli and Hoogvelt (1997), appearing to draw from Ritzer's (1993) 'Mac Donalisation' thesis, argue globalisation has impacted upon the marketised and 'technocratized' role of social workers, encouraging routine and predictability to persist in order to confine employees and cut costs:

> ...British statutory social work has become more fully integrated into the market economy. Its concern with the creation of professional relationships through which therapeutic work with individuals seeking to maximise adaptive responses to their life situations has virtually disappeared. In its stead has come a preoccupation with creating packages of care which are delivered by other 'contracted' caring professionals and the balancing of budgets (Dominelli and Hoogvelt, 1997: 46)

Such writers make it apparent that despite little acknowledgement from the social work academic community, the consequence of structural change, from whatever origin(s), has impacted considerably at grass roots level for front line statutory social workers in particular. De-skilling encourages, if not determines, distinct modes of practice from an employee imposed with externally prescribed ritual and routine. Care management has been identified as encompassing distinct and clearly articulated procedures that allow little room for manoeuvre or choice in day to day activity. Bureaucratic tasks determine role, as care managers administrate the assessment of clients and then attempt to construct packages of care from competing providers. A loss of choice takes with it autonomy and inevitably power, and employees feel frustrated at what appears to increasingly resemble a factory job. Care is reduced to an administrative activity for the front line employee, and social work is confined to the

local authority office as more and more work takes place close to the desk, fax, photocopier and telephone. Such a process and culture of work is revolutionary in statutory social work, as social work's history and indeed public image has always assumed regular contact with clients.

The lack of interest in the deskilling process from social work academia is of particular interest, and may be best explained by the apparent desire by social work to achieve full professional status, or as close to it as possible. Open acknowledgement of such a process would merely discredit further social work's standing, including within the universities. Publicly recognising deskilling would also limit any justification for social work publications to continue to publish texts on group work, counselling, advocacy, therapy and empowerment; skills which are now arguably of little purpose or value to statutory social workers in their work. One of the tragic ironies of such a stance has been the compliant contribution to the process of deskilling on the part of many colleges and universities that 'train' social workers. Dramatic changes in the structure and nature of courses has led to a receding academic curriculum content for social work students (Jones, 1996). Deskilling then may be viewed as a complex process that actually begins at the college rather than in the work place, and is further discussed below.

Thoughtless Practice

Social work education has a long history and one that has experienced significant change. The various councils that have each influenced the content of courses have, since the 1970s, remained uncomfortable about the amount of critical social science

material that students are exposed to (Jones, 1996). The Central Council for Education and Training in Social Work (CCETSW), which up until recently controlled and regulated the content of courses has tended to go to great lengths to assure the limited critical nature of course contents, and instead has embraced the needs of an increasingly authoritarian state, as Jones (ibid: 209) insists:

> The creation of the CSS in 1975 through to the later review of the Diploma in Social Work course in 1994/95 is a story of British social-work education accommodating the demands of an increasingly authoritarian state in which the role and nature of social work are being transformed. It is a process that has and is continuing to involve the demonisation of major elements of social work's client populations in order to legitimate the policy imperatives of increased surveillance and limited resources
>
> A culture of 'anti-intellectualism' has persisted (Jones, 1996), with a preference for non-critical and pragmatic training techniques to persist. Sociology in particularly has been all but removed from course contents, its links with radical theorists such as Marx, Gramsci and Foucault, among many others, has left government and their council opposed to such ideas contaminating the apparent impressionable minds of student social workers. Such anxieties have significant consequences, such as a lack of preparation and understanding given to students of the causes and effects of poverty upon clients, leading to ignorance being encouraged for many middle class students in their eventual practice. Such a policy also encourages potential discrimination and oppression to prevail, and can encourage ideas such as the

deserving and undeserving poor distinction to be more clearly articulated within the social work discourse.

Although some resistance was maintained by social work academics with the creation of both anti-discrimination and anti-oppressive practice material onto courses, such modules have received criticism of being tokenistic, and 'individualistic' in outcome (Butler and Drakeford, 2001). Just as importantly the substantial changes experienced for care managers in the nature of their work, notably the stringent office based procedures that are now followed, mean that the possibilities for such political action are limited.

Course content for social work has also been influenced by an 'NVQisation' culture (Jones, 1996), which has effected social care training in general. It is here that the training process translates into a distinct apolitical vernacular, centring upon pragmatic ability, and the capacity of individuals to complete individual work tasks. CCETSW, encouraged by the Conservative government at the time, imposed a distinct language onto course leaders in the mid 1990s and, as Butler and Drakeford (2001: 10) contend, turned 'ideology into values,...critical capacity into competency and...collective struggles into an individualistic anti-oppressive practice'. Competence centred training discourages critical capacity from individual students and instead centres upon a person's capacity to functionally engage in simple tasks such as 'speaking on a telephone' or 'work in a team'. The directives appear to conform to Ritzer's (1993) 'Mac Donaldisation' thesis, whereby efficiency, calculability, and predictability epitomise corporation like work cultures that are forced upon humble employees. Ritzer's thesis is further explored in chapter 8.

The process of deskilling then begins well before social workers qualify and enter their fields of practice. Political pressures upon social work's training council have led to pressures for course material to emphasise apolitical and dehumanising pragmatism in contrast to any desire for an articulate and coherent understanding of the complex issues that newly qualified students quickly engage with once they begin formal practice. Over the course of their two year training, or three years beginning soon with the new degree, students are prepared for what are regimented and predictable tasks that now epitomise care management and social work. Such themes are explored in my data chapters, notably chapter 3, which explains the tasks that care managers now complete each day.

Conclusions

Although social work has had a long and varied history dating back to the nineteenth century, there are core beliefs and schemes of practice that have been retained in the soul of its discourse. Particularly a moral discipline has persisted which concerns itself with a distinction between deserving or worthy clients and undeserving or worthless people. It has also been suggested that a rigid and unsophisticated understanding of the appropriate norms and beliefs that clients should possess has persisted, and such an emphasis has tended to encourage a pathological gaze into the heart of a client's personality, in order to study and confront possible personality flaws and inadequacies that are often believed to be the cause of a person's problems. It has been argued that such a stance is crude and simplistic, as it tends to ignore the profound impacts of social class, culture and structures upon individual life chances.

It is also possible that such a historical discourse perhaps goes some way to explaining the lack of resistance by social work to the ideological stance of the New Right, since there is much in common between the beliefs of both camps.

With social work increasingly coming under the wing of the post-1945 welfare state, formally so by the late 1960s, its practice and means of training have been strongly influenced by the policies of government. Although the 1970s now almost appears as a golden age due to the autonomy enjoyed at the time by local authority SSDs, the occupation has long since experienced a shortage of funding for the demand provided by its client population, and has always been expected to engage in an increasing number of bureaucratic tasks. Much of this bureaucracy involves the collection and processing of information about clients, an essential form of surveillance regarding apparent social 'anomalies'. Despite this, such under funding increased under the Thatcher administrations in the 1980s, and the level of bureaucracy that newly formed care managers engaged with increased substantially after the NHS and CC Act (1990) was implemented. This might also be considered as part of a process of increasing rationalisation, one consequence of which is the deskilling of the social work role. It has been also argued that the recent policies pursued by New Labour such as 'Best Value', have tended to build upon the marketisation and rationality themes established by the Conservatives.

The marketisation of social care, and indeed more broadly the public sector, has led to writers such as Hugman (2001) contending that what has now emerged is 'post welfare social work'. It is here that there exists a lack of structure to the purpose of social work, which has been influenced by post-Fordist outcomes such as those

encouraged by the development of a (deregulated) service and market led economic base, and the uncertainty and risk that post-modernist society has experienced (increased crime and labour migrations; more temporary and "flexible" forms of employment; the break up of the extended family and the establishment of less traditional gender roles; mass communication systems and globalisation; and so forth). Jones and Novak (1999) are more specific and emphasise the demonisation and abandonment of the poor that has resulted over the past twenty-five years, notably through the influence of a New Right ideology that persists, and indeed appears to continue to grow in influence. There appears little doubt that dramatic change has occurred by recourse to a disciplinary discourse that has openly encouraged a predictable and compliant form of social work to emerge. Such social work is nevertheless encouraged to retain its often-conservative moral principles, and then allocates on condition, occasional rationed support to a limited number of people from time to time.

It has been argued that deskilling has also had a considerable impact upon social work training and practice. Such deskilling might be considered to be part of the ideological attack on the principle of welfare, or may even be part of a broader global attack on labour: one that demands a predictable and ideology free work force; a collection of individuals that are able to respond at will to the whims of government or business, and fickle wants of a precarious market. It has been suggested that social work has shown little resistance to such a deskilling process. Indeed many quarters of the occupation, such as large sections of its academic community, have failed to utilise their power and influence, and have instead largely ignored not merely the impact of the process, but denied its overall existence. It has been suggested that in such

circumstances - as with the social service directors and chairs that eventually welcomed the marketising principles of the NHS+CC Act (1990) - career and financial interests of the self have tended to take priority over the plight of other people.

CHAPTER 2

PREVIOUS STUDIES AND METHODOLOGY

Introduction

The intention of the second chapter is to explore past research projects into social work teams, and also detail my ethnographic research process and facilitate an account of how my information and data have been collected, analysed and interpreted. The chapter is divided into three parts. First, consideration is given to four in depth studies of local authority social service departments or teams over the past twenty-five years. This is in order to utilise one of the most important, if not core, techniques of ethnographic research, that of analysis through comparison with previous works (La Fontaine, 1985:19). The second part of the chapter explores the process of ethnography itself, particularly the techniques that I utilised in my collection and analysis of data. Finally the third section introduces each social work setting where my research was carried out, and also reveals the five core research topics that I explored during my survey. It will briefly describe the locations where each team was based at the time of the ethnography.

Parsloe's (1981) investigation, with assistance from colleagues in Keele and Aberdeen universities, offers a detailed analysis of 'the task of the field worker in local authority Social Service departments and their equivalent in Scotland and Northern Ireland' (ibid: 13). The research throws up many points of interest, notably the ambitions of team members and the relative autonomy that they enjoyed when the research was

carried out in the late 1970s. Parsloe's research relies on many formal interviews with social workers, in contrast to Pithouse (1987), who studied just two children and families teams over the course of 12 months during the mid 1980s, using ethnographic techniques. Similar themes are identified, except that due to Pithouse's time spent with front-line social workers more information is provided as regards the nature of the area office and the relations and communications between social workers. Third, as already addressed in the first chapter, Jones' (2001) more recent bleak study of post Children's/NHSCC Act teams in the north of England will be further explored for comparison. Finally this section looks at Hadley and Clough (1996), who offer an investigation into the effects of the community care reforms on professionals during the 1990s, and also explore the impact of change upon the role of health, as well as social care professionals.

In relation to my research method, the social anthropological tradition of ethnography is what Atkinson and Hammersley (1983: 1) define loosely as 'participating, overtly or covertly, in peoples' lives for an extended period of time, watching what happens, listening to what is said, asking questions - in fact, collecting whatever data are available to throw light on the issues that are the focus of the research'. This part of the chapter will also consider some of the key theoretical schools that have shaped the development of ethnographic techniques.

Previous Studies

Parsloe (1981), in an ambitious government funded study of 32 area teams, identifies distinct qualities across each SSD studied. To begin with, Parsloe found that social

work teams accommodated a variety of clients and needs according to the 'generic' system. The 'mixed bag' approach led to social workers typically carrying cases from all client groups, although there was a bias found towards time spent with children. The many tasks of a social worker included attempts to engage in "preventative" work, particularly where possible future demands on departments might be alleviated by any prior interventions, but also included work that might simply improve the 'quality of life' of a client (ibid: 93). When quizzed about their priorities of work however social workers were unanimous in identifying what they referred to as 'statutory' work always taking precedence:

> The answer, in fact, hardly varied from the Western Isles to an Inner London Borough - it was 'statutory' work. This phase is vague and imprecise. When we probed we found that it referred to children in care, or to work with families and children which either came from the courts or might lead to some public investigation by a court or inquiry if things went wrong. (Parsloe, 1981: 93)

Despite this, the author could only find one authority that had a written formal hierarchy of 'priority work': with 'danger to life and limb ' for a client at the top of the list, and 'there would be greater expense to the authority at a later date [without intervention]' second to bottom of a list of 9 priorities. A lack of formal procedures within social work departments was indeed one of the key findings of the research, and Parsloe also identifies a significant degree of autonomy enjoyed by front line social workers in their role. There were procedures, but formal documentation and guidelines were not apparent:

What were lacking, or developed only embryonically, in most teams, were detailed forms or guidelines which assisted members of the team to make comparable assessments of the clients they saw on duty, and to select from a similar range of possible services when planning work. They also lacked shared criteria for considering who in the team should do what work.....In other words, they lacked common instruments for assessment, work planning, work allocation and case and workload management (ibid: 60)

Harris (1998: 846), in considering Parsloe's study, suggests that accusations of the application of scientific management principles into social work by 'radical social workers' were overstated, and tended to ignore the autonomy enjoyed at the time by the occupation. Indeed Parsloe (1981: 92-3) goes on to talk of a guidance free 'vacuum' existing in departments:

It was apparent that, in general, management had laid down few policy guidelines for the way teams undertook their work. Decisions about the way duty, intake and allocation were managed seemed to be made by the teams themselves....Teams often appeared to make decisions in a vacuum which was seldom filled by guidance from headquarters (quoted in Harris 1998: 848)

Supervision of social workers by their team managers also tended to be irregular and informal. Indeed Parsloe (1981: 131) suggests that many managers regularly offered 'support' and 'advice' rather than 'formal supervision'. In an earlier publication Parsloe and Stevenson (1978: 53), drawing from the same study, suggest that social workers

themselves often decided topics to be discussed at any 'supervision' meeting (quoted in Harris, 1998: 848).

Parsloe's (1981: 162) eventual prescriptive theme is one of a need to empower team leaders to gain 'knowledge, skill and confidence' so as to allow them the opportunity to offer leadership to social workers. Priority is given to education and training for managers, but there is also a clear systemic approach (apparent in so much social work research), which draws upon the functionalist ideals of Talcott Parsons (1951), in which it is argued that the team as a whole should be encouraged to support each member. Within her text Parsloe (ibid: 188) also appears keen to encourage a 'top down' culture to emerge, one in which a more 'assertive management' culture would provide structure and stability to the (permissive) system.

Pithouse's (1987) in depth ethnography of two Welsh children's teams throws further light on the managerial dynamic, and also considers team relations and attitudes towards clients on behalf of social workers to a greater extent. He draws an important distinction between front line and senior managers, and argues that the former enjoyed an important degree of autonomy from the latter. This allowed scope for negotiation between social worker and front line manager, and in general there was a tendency for 'good practice' and competence to emerge as a shared goal. Again a permissive culture was identified, although this is not recognised as implying negative consequences, as suggested by Parsloe's study:

> ...[front line managers] demonstrate to their teams their independence from higher management and their disinclination to intrude overly in the workers'

day-to-day practices. They engage in a delicate blend of reciprocal dependencies. For example, the workers depend on supervisors for advice and support, protection from higher scrutiny and the private resolution of performance problems that do not injure member conceptions of competence. (Pithouse, 1987: 64)

Pithouse (ibid: 65) further argues that front line managers considered themselves to be very much members of the team, and even distanced themselves from senior managers, who were at times dismissed as 'pen pushers'. Front line managers effectively participated in social work tasks, and were regularly embroiled in the complex issues that the work entails. Contact with clients was regular, as was time spent 'in the field'. Pithouse (ibid: 65) uses a quote from a front line manager to stress this point:

> I always make sure I'm available during the day for the team. They can come in with any query and I'm here. In the evening I catch up with the admin' - it's the only way I can work....you see the real work's out there in the field - that's where the real issues are. The social workers are out there and the pressure's on them - not me- but I'm here all of the time for them.

The social service office provides a source of security for social workers and their team manager. It provides protection and support from the at times hostile outside world, and a strong sense of togetherness is detailed. The work itself again, as Parsloe was particularly keen to stress, has a lack of formal structure and procedure. But the workers interviewed by Pithouse suggest that this is due to the nature of the work that

they have chosen to pursue a career in. Social work cannot be regimented and predictable because people, and the issues confronted, are unpredictable and varied. Each day is different, and time is rarely spent engaging in monotonous activities:

> Social work is not a monotonous series of identical activities but essentially the varied practices of workers who largely regulate their own daily efforts. (ibid: 47)

But Pithouse also suggests that much of the work does not have a positive outcome. Despite some workers suggesting that intervention is always positive, most were either uncertain or pessimistic:

> Some assume their efforts are always beneficial, irrespective of outcomes. Others believe their efforts will have little influence but persist in the hope of future beneficial outcomes. The 'good' worker carries on despite demoralising results. (ibid: 47)

However the anxieties and frustrations of the task often lead to contempt being felt towards clients. Clients are regularly blamed for the failings of interventions, and also at times dismissed as 'unworthy, dangerous and exploitative' (ibid: 85). Rather than blame the organisation or other structures, social workers regularly find clients an easy target of blame. There are however good 'customers', but these tend to be quite obscure and not discussed within the team, in contrast to what Pithouse (ibid: 51) refers to as the 'notorious consumers'. Although a distinction is regularly drawn

between worthy and worthless clients, there is also a broad acceptance of clients as morally challenged:

> In short to be 'like a client' is to act with questionable moral purpose. The significance of these observations is not to point up practitioner foibles but to indicate that the 'client' is typically viewed as a diffuse problem species. (ibid: 86)

Such a judgemental stance implies the fostering of class-specific discrimination in social work attitudes towards clients. There is also ambivalence to the cause of social problems expressed by the social workers, and an understanding of poverty as not the problem of social work, as one worker articulates:

> Most of my clients are what I would call poor, we all work with people who are generally the least well off, we end up with all the problems that other agencies can't cope with, but there's nothing we can do about it! I can't solve poverty, all I can do is work within the family, there are often problems there that lie behind, yes? I don't ignore the fact that they're poor but my work isn't in that area, that's got to be a national or wider political thing (ibid: 83)

The work then is issue led and is considered at the local level, particularly in relation to recent cases carried by the social workers at the time. Such work is varied, unpredictable, interesting and generally manageable. Much of the activity relating to cases occurs behind closed doors and is hidden - such as in the home, court or area office - hence Pithouse's description of social work as an 'invisible trade'.

Less than ten years later (and following the implementation of the NHS and Community Care Act, 1990), Hadley and Clough (1996) offer their findings from a series of in depth interviews with professionals working within the parameters of community care. As well as care managers, there were also interviews with health professionals completed, most of whom were employed by community health "trusts" and/or working in community multi-disciplinary teams. Throughout, the authors depict a grim picture of crisis and stress held within a (community care) system that appears under considerable strain. It is argued that work intensification and budget-led practice have had a considerable impact upon the performances of staff. Poor communication is also maintained between different disciplines, but particularly between health and social care professionals.

The authors detail their interviews with individual workers, and in one example a manager of a mental health social work team articulates how in his view compliance has become an essential ingredient if good career prospects are to be maintained:

> who doesn't make waves and doesn't criticise the system and doesn't raise her head above the parapet [becomes a 'model team leader']...If they bring out a policy that is just unworkable, never say it is unworkable. Just accept it and work with it as you can. (ibid: 143)

The authors interviewed occupational therapists, nurses, managers, care managers, voluntary sector workers and a geriatrician, all of whom emphasised a reorganised system under considerable strain, which they argue is failing to meet the needs of the

clients and patients that they serve. Indeed the interviews suggest a system that appears to have relegated the client or patient as a cause of priority, in favour of maintaining and protecting the function of (health and social care) organisations.

Finally, Jones (2001) offers one of the first in depth studies of social work after the revolutionary Children's/NHSCC Act(s) in 1989 and 1990 respectively. As detailed in chapter 1, over 40 interviews with social workers/care managers, who had been practising for at least 8 years, in the North of England led to a range of bleak findings that present many different findings to those presented by Parsloe and Pithouse. Many of Jones's findings however are not isolated, and have been backed up elsewhere to varying degrees (see also Henwood, 1995; Dominelli and Hoogvelt, 1997; Postle, 2001). Far from there being a relaxed and supportive environment in the locality office, as presented by Parsloe and Pithouse, Jones (2001: 551) suggests that there now exists a perpetual sense of stress and despair inside SSDs. Workloads are considerable for social workers, and high staff absenteeism persists as an established norm. The absenteeism inevitably helps to generate further work, which helps to maintain a vicious cycle. Bureaucracy is excessive from the view of the workers interviewed, and can no longer be left for an hour or two in the evening, as detailed by Pithouse. Instead it must now be completed throughout the working day.

Front line management has also changed from Parsloe and Pithouse's depiction as participant and supportive colleagues. Instead regular routine and monitoring by managers ensures that 'production line' bureaucratic rituals are completed. Indeed of particular interest remains the removal of clients as the major cause of employee stress, as suggested by Pithouse, and the establishment of what Jones (ibid: 551-558)

refers to as the new 'stress from above'. The agency and government are the cause of such stress, particularly by generating so many procedures and routines, and failing to provide support for tired practitioners. It is also argued that whilst demand has increased substantially regarding client need, budgets have steadily decreased leaving little room for manoeuvre for practitioners to provide for conspicuous need.

Finally, workers in Jones's (2001) study argued that their contact with clients was now extremely brief and formal, in contrast to Pithouse's (1987) description of regular (but often strained) contact outside the SSD with clients. As with Hadley and Clough's (1996) study, paperwork has now become the key daily activity performed by social workers inside their office base, and is no longer something that can be left as an afterthought for the early evening. The picture painted then is one of a routine job completed in at times 'grim' (SSD) surroundings, which perhaps goes some way to help explain the recruitment crisis currently facing state social work (Parton, 2001).

The summary of each study detailed above is intended to illustrate some of the significant changes that have impacted upon social work. Each study will be referred to in part when my own findings from my ethnography are presented over the next five chapters. It is hoped that the studies will help to illustrate the extent of change that has occurred over a relatively brief period of time (from Parsloe, 1981; and Pithouse, 1987; to Hadley and Clough, 1996; and Jones, 2001); and the manner in which statutory social work has developed and changed as a form of welfare provision over the past 25 years.

Ethnography and 'Regimes of Truth'

During my 18 months employment in a large inner London older people's team, a post-graduate student would occasionally arrive at the department and complete a series of 30 minute interviews with care managers. Such PhD students were usually from the University of London and they were keen to investigate the changed world of social work and the experiences of the relatively recently formed care managers. Although such interviews were usually either structured or semi-structured, it was apparent from my own experience, or feed back from colleagues, that problems were evident from the method utilised. Care managers later complained that they had forgotten to mention important points about their work during the interview, not simply because they were brief, but also because they had taken place either during or after a stressful working day. Some people felt self-conscious about having their voices recorded, and were uncomfortable about discussing colleagues, managers or clients. It was apparent that bias had influenced the method; that is single and brief interviews were and are not the ideal means to enter the world of the care manager. One important reason for this (among others) is the very nature of the work. As acknowledged by Pithouse (1987), and referred to earlier, social work is unpredictable due to the nature of the issues experienced by clients, and confronted by professionals. There are good and bad days, times when the job is rewarding and fulfilling, such as when you access services, and times when everything appears bleak due to a period of extreme stress or regular disappointment.

When applied appropriately ethnography offers an antidote to such hazards, and allows a thorough and articulate study of a targeted range of issues over an extended

period of time. This is because studying a specific group for a period of time allows the ethnographer the opportunity to witness and experience specific events and forms of organisational change over time; as well as the (behavioural and emotional) responses of actors held within the system (Atkinson and Hammersley, 1983). Reading Pithouse's (1987) small study in comparison to Parsloe's (1981) grand nationwide series of interviews there appears a difference in quality and findings. Pithouse offers a thorough and intelligent exploration of 'real people' in a stressful job, and is able to consider many complex issues in his write up. Although Parsloe found many findings of interest, there is within her narrative a sense of superficiality, notably regarding the author's desire to find structure and purpose within organisations that she is not a part of. Ethnography offers day-to-day contact with people being studied, and in the process dynamics and themes of interest should be encountered and detailed in a comprehensive long-term study (Cicourel, 1964; Leach, 1982; Atkinson and Hammersley, 1983).

Ethnography however is not merely concerned with participant observation of actors in motion, and is indeed, like all research, deeply political. La Fontaine (1985: 15-19), in emphasising its origins in social anthropology, stresses the two motives that should always be part of any ethnography. First, if people are to be studied they should be as part of an understanding of the influence of, and engagement with, wider social forces and structures. These might include policies of a particular organisation, or the influence of legislation, procedure or government policy. However they might also include influential and "unseen" dynamics such as strategies used to obtain full professional status on behalf of social workers; or the method of "social closure" utilised by an occupation to guard privileges (Turner, 1992); or the impact of

discrimination and exclusion on clients and colleagues due to the influence of gender, class, disability or ethnicity. The second objective is to compare and contrast previous studies in the hope of exploring any understanding further. It is for this reason that I have chosen the four studies already explored, and attempts will be made to compare each during the five chapters that follow.

Ethnography developed as a research method through social anthropology, whose diverse history has particularly drawn from the functionalist traditions of Malinowski (1922), and the structural-functionalism of writers such as Radcliffe -Brown (1948). Functionalism proposed a world that appeared to denote individuals almost as 'cultural dopes', unaffected by history and always keen to internalise dominant ideologies and the beliefs of a group. There was little accommodation given to conflict or change, and institutions and habits were seen as interdependent:

> Functionalist anthropologists concerned themselves with the interdependence of institutions within a limited context of time and space; conversely they did not concern themselves with the speculative reconstruction of historical process. (Leach, 1982: 28)

The work of anthropologists such as Malinowski and Radcliffe-Brown, but also the later trend of 'structuralism' established by Levi-Strauss, have however received a more damning criticism, particularly during the 1960s. Barnard (1990: 59), for example, suggests that such ethnographers were never able to shake off criticism of a racist bias in their 'scientific' studies of 'savages' in 'far off lands'. Such ethnographers were considered to be an important part of colonialism, with their publications even

believed by critics to assist such a form of violent exploitation by providing valuable information about the people who inhabited colonised lands (Barnard, 1990: 59-62). Further, Levi-Strauss's attempts to identify and contemplate structuralist universal laws across all ethnic groups, notably through identifying an apparent exchange of 'signs' between non-French speaking people, appeared limited and out of touch by the late 1960s:

> ...confronted by issues central to the anthropological enterprise, Levi-Strauss sidesteps them. Instead of realising or construing the issues of 'doing ethnography' as political ones, he constructs them as, on the one hand, 'scientific' difficulties, and on the other as 'personal difficulties' and offers the objectivist approach of structuralism as a solution to the one, and ethnography-as-autobiography to the other. Even the question of the relation of 'native' models to the anthropologist's models is formulated in purely 'scientific' terms and not in terms of the political relationships under-lying the construction of these models. There is a failure of nerve of classic proportions and it is this failure that was recognised at the barricades of May 1968 in the slogans that proclaimed 'structuralism is dead' (Barnard, 1990: 62)

The critical reaction to structuralism led to a range of epistemologies emerging in an attempt to overcome the inherent flaws of the theory. Marxism, but more so symbolic interactionalism began to replace the limits of structuralism, and influential theorists such as Pierre Bourdieu went further and attempted to construct their own methods of practice (Jenkins, 1992). Post-structuralism particularly has had a profound influence upon the social sciences since the apparent collapse of structuralism through the

1960s, although one of it's most radical thinkers Foucault (1971; 1975), offers no easy solution to the delicate matter of the political consequence of research. Foucault offers social research as a social and historical process or *culture* that, like social work, offers an important form of surveillance and control (ibid, 1975). Whatever the findings or political stance of the ethnographer, such detail will, it is claimed, help to fulfil any desire to survey and manipulate populations. Distinctions of what is true and false are encouraged, and emerge through research, leading to the establishment of 'regimes of truth' or theories, which help to strengthen power dynamics established by dominant groups. Social work provides a classic example of this, and such themes were addressed in the first chapter. Social work journals and publications in their denial of the process of deskilling and under funding of community care, as well as offering unsubstantiated claims of social work's capacity to empower clients, have helped to establish a 'truth' of professional activity that allows problems such as poverty, deskilling and oppression to either disappear from view, or appear as being positively confronted, reduced or even eradicated.

One of the purposes of this research project is to offer the possibility of 'resistance' to established 'regimes of truth', such as the many optimistic claims of the benefits of 'competent' social work practice that currently fill the libraries and bookshops of universities. By drawing attention to, or even researching, issues that are ignored or dismissed, a form of resistance emerges that challenges an established 'truth'. Such resistance however never guarantees change, and as already noted, compiled and published information can be responded to in a number of ways, many of which may ignore the claims or advice of the author.

Ethnography then has a chequered history, but the techniques used remain, and it is now an accepted method in non-anthropological subjects such as sociology and human geography. The use of theory is now more varied, although in general an acceptance and better understanding of social conflict is one of the key influences to have emerged in the method during the last 30 years (Asad, 1986). The original process of studying undiscovered islands, territories and people does however have certain significance in the study of care managers. At the time I began my ethnography little had been published on community care and care management, and as I suggested in my introduction, much of what had been published at the time appeared to describe a very different world to that experienced by students and practitioners each day. One of my ambitions is that the ethnography will attempt to more accurately detail and reflect the 'truths' I have uncovered in the largely undiscovered world of care management.

Finally it is important to acknowledge the potential flaws of any ethnography. For my own study, the fact that I was myself a trained social worker working amongst (stressed) colleagues meant that accusations of bias, such as in relation to detailing the views of managers to whom I, like my colleagues, were subordinates, remain possible. Further, the stresses and strain of the social work role depicted by Hadley and Clough (1996), as well as Jones (2001), might well generate a sense of frustration on behalf of the ethnographer. This may lead to emotional (depression, apathy) or physical (tiredness) responses at the time of study, which potentially can contaminate any techniques of data collection and analysis. In my opinion there is no real way that such a risk of subject analysis at some point can be completely avoided. Rather a firm acceptance of the potential for bias to distort research findings on behalf of the

ethnographer, as well as the important ethical consequences of a partisan study, must be realised and appreciated by the researcher at all times (Atkinson and Hammersley, 1983).

More recently some (post-modern) anthropologists have argued that all ethnographies are inevitably subjective, and it is better if the reflexive researcher accepts this, but still attempts to detail a *contested* interpretation of the world that is being described (Barnard, 2000). I think this is an important point, and must admit that owing to the deeply emotional themes that I confronted during my extensive study, there is *possibly* bias running throughout this text. Despite this, I still insist that there remains an important ethical imperative to the study, in which an attempt is made to draw attention to issues that have perhaps been previously neglected by other researchers who have attempted to study social workers.

Ethnographic Techniques

Atkinson and Hammersley (1983: 2) offer a comprehensive study of ethnographic methods, in which ethnography is considered 'simply one social research method, albeit a somewhat unusual one, drawing as it does on a wide range of sources of information'. They offer advice on a series of techniques that attempt to move beyond the 'quantitative' and 'rationalist' assumptions of positivism and naturalism, towards a more reflexive, qualitative and critical revision of the ethnographic gaze.

To begin with, once a topic of research has been established, consideration is usually given to prior studies or theories utilised, at times with a view to later comparison to

the ethnographers' own findings (ibid: 28-32). I have identified four studies for comparison above, and have also considered a number of themes that have impacted upon social work in my first chapter. The next concern of 'sampling' offers a common source of criticism, notably due to the typically small scale of ethnographic studies:

> One of the limitations often raised in connection with ethnographic work is that because only a single case, or at any rate a small number of cases, is studied the representativeness of the findings is always in doubt.... However it is a problem that also arises with experimental research and one to which there is no easy answer. (Atkinson and Hammersley, 1983: 44)

My sample drew from time I spent with 5 SSD teams in 2 different cities of England (including the capital) between 1998 and 2003, and is larger than most ethnographies. The duration of the study (5 years) is again much longer than most, and I believe allowed an adequate period of time for my targeted issues to be explored. Atkinson and Hammersley (1983: 48) also suggest a strategy of 'selection' as regards what is observed, and for how long, by the ethnographer. Researchers, they claim, may instinctively want to 'try to see, hear, and participate in everything', but a more balanced approach of allowing time for reflection and writing is likely to lead to the collection of 'data of better quality'. Due to my long period of study I was exposed to a wide selection of data to consider, and periods of critical reflection, during regular bouts of respite. As already identified, the very nature of social work is unpredictable, but there are periods when activities of stress are less, and reflection is more readily accommodated.

Access (ibid: 54-76) is often a major obstacle to the ethnographer, but as a qualified social worker in a time of staff shortages and excessive demand, I was allowed a degree of choice as to where and when I worked. Movement between client groups and locations was relatively easy, particularly with the expansion of "agency" work in the occupation, and there has been a move away from "permanent contracts" being granted to social workers in employment. With a now established culture of increased migrations of staff between departments and specialities, I could possibly move to any part of the country and find work in a relative short period of time.

Regarding 'field relations' (ibid: 77-104) I was very much a 'colleague' and 'one of the team' in relation to the people and events I was studying. In that sense the typical space filled by the ethnographer as 'acceptable incompetent' (ibid: 93), and as fulfilled by Pithouse (1987) in his own research, was avoided. This allowed the luxury of actually engaging in the work tasks themselves, and being recognised as holding the same power (or non-power) and status as colleagues. It also permitted valuable experiences that many other studies would have had little access to, such as regular client contact and personal experience of key events such as supervision and organisational restructuring. I believe my study was of "relative interest" to colleagues, but nothing more. Again the nature of the work, particularly the fact that it is stressful and unpredictable, mean that agency concerns and attention quickly move on to more pressing issues. I also felt it important not to overstate my presence and interests, or not to 'stare' as part of the research gaze. As Atkinson and Hammersley (1983: 82) point out. 'it may be very threatening to hosts if one pumps them *constantly* about matters relating directly to research interests'.

In the field concern must also be given to listening intently to feedback and opinions expressed by hosts, but Hammersley and Atkinson suggest that less specific questions are usually more appropriate in the field. Ideally 'open-ended' questions that can act as a 'trigger' to topics of study are usually the most appropriate tool for investigating research topics (ibid: 113). Again I tried a more subtle approach, and avoided attempts to forcefully direct topics of conversation on to people. My five identified areas of study (identified below) were actually regularly discussed amongst team members, almost certainly due to the fact that they affected day-to-day work experiences. It was therefore rare for me to need to prompt discussion on such topics, and I found my data literally 'ran' to me without encouragement.

One of my chief concerns, which is also a potential hazard for ethnographers in the field (ibid: 144-173), was that of how I would record any emerging data. In response I kept written notes, and detailed word for word quotes from colleagues that reflected opinions held by a number of people. They were scribbled into my notebook in a form of improvised shorthand during the day, and then placed onto my computer during the evenings. The draw back of this approach is that all of my quotes collected and presented in this thesis are brief, but this is a small price to pay. A Dictaphone would have proven too difficult to carry each day and keep for such a long period (5 years), and I believe would have been unnecessary. My observations and recollection of colleague behaviour, and changing organisational policies and procedures, tends to offer the majority of, and in my opinion some of the best data that influences this study.

An example remained the criticism and hostility often expressed towards front-line managers on behalf of my social work colleagues, which is further explored in chapter 4. Any general trends emerging (data) were again logged at home on my computer, and discussed in regular supervision meetings with my supervisor at Liverpool University. Atkinson and Hammersley (1983: 145-167) draw a distinction between observational and interview data, and analytical notes and memos that may be made. As time progresses clear trends should emerge as regards both observations studied and interviews completed. These were identified (indeed many within my first 6 months of research) in my study. As detailed below trends emerged from the strong opinions held and expressed by my care management colleagues and their emotional and physical responses to change (notably depicting their conspicuous sense of boredom, apathy, depression, regret, tiredness, and absenteeism).

Finally as regards analysis of data, and a final write up, a number of concerns were apparent. Methods utilised vary, for example Atkinson and Hammersley (1983: 215) suggest the possibility of the 'natural history' approach, in which the text is constructed around the procession of events in the field, almost like a diary. I felt that such a method was inappropriate for my research, since so much data was collected over such a long period of time, and there was no predictable procession of events. More appropriate appeared that of the 'thematic organisation' approach (ibid: 223-227), in which data is presented as regards broad themes of analysis, which usually emerge during the data collection. These are presented below as regards the five identified 'research topics', and they are individually explored in each chapter of the ethnography. My five themes of analysis were firmly established after 6 months of research.

My ethnography included semi-structured interviews with all of my colleagues. The issues covered concern bureaucracy and procedure; management; budget led practice; work with other professionals; and attitudes to clients and the availability and quality of services. These topics will be discussed in more detail below. As well as formal interviews, or more general discussions, participant observation was constant. I soon discovered care managers are generally keen to offer their opinions on a range of topics, and little encouragement, if any, was required to gather opinions from my colleagues on my research topics identified. I kept notes about my findings throughout, but it was not long before clear patterns emerged regarding the areas of study identified.

Opinions were usually expressed in a forthright manner, and were generally unambiguous. Although I changed the organisations in which I worked, and spatial settings or areas/cities in which they were based, any difference of opinion expressed (in relation to my 5 areas of research) by practitioners were, for the most part, negligible. Most notably procedures and working methods in each team were remarkably similar, if not homogenous. As an organisation with such clearly defined working methods, statutory social work appeared to discourage individual forms of expression. The ethnography utilises pseudonyms and does not name any of the boroughs in which I worked. This is to ensure confidentiality for my colleagues.

Finally my status as an insider studying colleagues who were performing the same tasks as myself, offered an unusual source of analysis. It offered direct experience of the very themes that were being so regularly discussed (management; deskilling; lack

of motivation, and so forth) by colleagues and therefore I believe offers a rare opportunity to present data that was rich and revealing, and not merely drawn from observation and/or interview. I was allowed to complete assessments rather than merely discuss them; personally experienced rejection at panel or felt that anger and hostility of clients or relatives when funding for a care package was not allowed. I also had to cope with all the many new regulations and procedures that emerged every year, and watched as colleague after colleague moved to other areas of employment or took early retirement. Many others had no other career options available and were too young to retire, and their work remained as almost a form of torture that I was able to appreciate since I was myself completing the same monotonous tasks and following the many instructions.

From London Onwards

Following qualification I began work in London and then moved to a large city in the North West of England. The area social service teams where I worked and researched are each discussed below.

<u>Team 1</u>

I began my ethnography in a large inner London older people's team that had a total of 18 qualified social workers (male and female), 3 middle managers (all female), and 1 senior manager (male) on site. The team dealt exclusively with the over 65s, but included clients with mental as well as physical disabilities in their typical caseloads. The team covered the north of the borough, with another similar sized team, based 2

miles away, covering the south. The total population of the borough was just over 250,000, and this included a large proportion (32%) of ethnic minority communities, as well as rates of unemployment well above the national average of the time. The borough suffered high unemployment and had a reputation for a high degree of social deprivation and poverty, which was apparent in the surrounding areas of the SSD, and the clients that we typically served.

The team was distinct in many ways, including the fact that many care managers (and administrative staff) were temporary workers from abroad; notably three white South African females, and one female from each of Canada, Nigeria and New Zealand. Only three men were members of the qualified staff including myself, and the most dominant group in the team, comprising over half the staff, were what might be loosely termed 'working mothers', many of whom were lone parents. In the five social work teams where I was based, working mothers (especially as lone parents) always dominated in terms of numbers of total staff, and it is apparent that social work, as well as social care more generally, is dependant upon this group which provides a vital source of labour. In terms of age most care managers were between 30 and 40 years of age, and had been qualified for less than 10 years. Aside from two care managers, veteran social workers from the 1970s and up to the mid 1980s had moved on elsewhere, retired or entered management.

The services provided by the team included day centre placements, home support, respite and long term residential and nursing care placements. Referrals to other professionals, notably occupational and physio-therapists were also common. Nationwide charities such as Mind and Age Concern also provided a limited number

of services. Despite the high proportion of ethnic minority groups (predominately of Afro-Caribbean origin) living within the borough, it was apparent that black people did not utilise social services in proportion to their numbers in the borough. It was rare to be allocated a black client, despite the fact that the borough had over 30% of its population from ethnic minorities. This was a similar outcome in the other boroughs that I worked.

The team had a low rate of absenteeism in comparison to the other boroughs where I later worked, but one third of the borough's staff were recruited temporarily from private agencies. According to my senior manager, agency staff work out cheaper in the long run due to the fact that no sick pay or pension is necessary, and they also have the important advantage of being able to be laid off if 'the budget is running low'. Crucially agency staff are only paid for every hour that they work, so long term absenteeism due to 'stress', as has now become so common, is discouraged. I spent a total of 18 months working for team 1 in inner London, and also had the privilege of a permanent contract during my stay.

Team 2

After leaving London I quickly found work through an employment agency in a borough adjacent to one of England's major cities. The borough is rural in most parts, but has many urban pockets, including a major city not far from where I was based. My temporary employment was again with an older people's team, although this time its size, and the population it served, was small in comparison. There were six qualified social workers in total, including myself, with two "social work assistants"

as additional members of the team. Our 'patch' was a mixture of residential areas that contained mostly semi-detached houses, and more deprived areas, including council estates and run down terraced houses in densely populated areas. The important difference from London was the non-existence of high-rise and tenement accommodation, which accommodated the majority of my previous clients. This is significant for older and disabled people in terms of crime, as they remain extremely vulnerable in such environments, particularly of a night.

The team had one female middle manager, a middle-aged veteran social worker who appeared keen to inform me that she had warned her daughter against following a career in social work. I discovered during my ethnography that such advice is routinely passed down to the children of veterans, all of whom were also keen to inform me that they 'wouldn't enter the profession now'. The team was split equally by gender, and four out of the six qualified social workers had been qualified for longer than five years. Our patch had a history of long term unemployment and a relatively high crime rate, although much lower than in my previous borough. We were housed in an old secondary school, and each previous classroom contained a different social work team. The building contained a looked after children (LAC), physical disability, and older people's team. It also accommodated housing and administrative council staff.

As with all older people's teams the turnover of casework is high. Cases are also varied, although most tend to concern a demand for "home care", day centre attendance or respite. Quite regularly however we dealt with a need for re-housing. Social housing was in such short supply in every borough where I worked, so

typically a person who required "urgent" re-housing might wait up to two years for a housing association or council property. It is no exaggeration to declare that a majority of our client "needs" would either disappear, or more likely would never have emerged, if good quality housing had been available to clients.

The team was friendly and hard working. The borough was relatively well financed in comparison to many others, and I nearly always received financial support towards care packages that I asked for from my supervisor. Staff absenteeism was rare, and although I was always busy, I was not over-burdened with work as I had been in the previous location where I worked. I remained in team 2 for a total of 6 months, until the contract ended.

<u>Team 3</u>

My next location was a large NHS hospital that was also occupied by BUPA in parts. It was based in the same borough as team 2, only in a rural district close to a motorway. The hospital had six floors in total and each care manager covered 4 wards. Despite the fact that the hospital accommodated every health profession, and voluntary organisations, the hospital trust felt that there was not enough room in the building for social services, and the team was based in what previously had been the nursing quarters. The fact that such accommodation was based outside of the hospital in many ways symbolised the attitude towards social services. We were clearly held in disdain by many of our health colleagues, despite the fact that our role in speeding up the discharge process was, to quote one of my colleagues, 'as important as the

surgeons'. There were 12 social workers in the team, and one middle (female) and senior (male) manager on site.

The accommodation was dreadful. It was cramped and stuffy and created a sense of anxiety and conflict amongst the stressed and overworked staff. Half the staff were temporarily employed from agencies, and generally they did not remain for more than a couple of months. I lasted 6 weeks. The majority of cases were older and/or disabled people. Essentially care managers' set up packages of care in order to speed up the discharge process. In comparison the team were well funded for services because the Trust was keen to get patients out of the hospital as quickly as possible. The morale of staff was low due to their poor accommodation, their low-status amongst hospital staff, and their intense workloads. I was the only male member of staff other than the senior manager of the team. Although my stay was brief the placement provided a valuable insight into the working relations maintained between health and social care professionals.

Team 4

My next placement with the employment agency was with a learning disability social work team close to the city centre of a major city in the North of England. At full capacity the team comprised of 6 care managers and one middle or 'team' manager. However three staff were absent on long term "sick leave" when I first arrived, and including myself, there were only three care managers running the team. The team manager was also absent with "stress" and the team was being managed from afar by another manager who occasionally dropped in. Learning disability care management

is different from work with older people due to the specific needs generated by the disability, and the less demographic pressures (numbers of applicants for services) on departments in relation to the 'aging population'. In theory care managers should have more time to spend with clients, and the turnover of cases should not be as great. Despite this I discovered that caseloads were still high and demand for services was always in excess of the care managers ability to respond. Thus clients would regularly wait up to 2 years for allocation to a care manager, and my manager informed me that she had 'at least 70 cases waiting for allocation at any point in time'.

The team was friendly and eventually resumed full working capacity once people gradually returned from sick leave over my first 6 months of the placement. The "patch" was densely populated and the districts covered were all areas that contained high levels of poverty and social deprivation. Indeed the area is notorious with local people for high levels of crime, particularly regarding drug use and prostitution. Much of the work evolved around "duty", and nearly all of it concerned varying forms of crisis for clients or carers. The work was also intense and unpredictable, and related to issues as diverse as homelessness, addictions, domestic violence and carer breakdown.

The team was based in a small office and at times the atmosphere was extremely tense. The stressful nature of the work, and sense of confinement generated in a small setting, meant that conflict between team members was regular. The local authority also had a dearth of available funds in its budget. I was with the team for a total of one year.

Team 5

Owing to staff shortages elsewhere I was eventually moved from team 4 to another learning difficulties team within the same authority. The team was situated on the outskirts of the city, and covered a variety of areas, this time including a mixture of middle class suburban and more deprived areas. The team was again located in a previous secondary school that housed social workers related to children and families; older people and physical disability social work.

The team consisted of 7 care managers (2 male) and 1 middle manager (female). The work was initially less duty based, but this type of work increased as more and more staff took sick leave due to stress. The casework consisted of the usual mix of home care provision, social support, and day centre attendance and respite support. As the work placement was with the same local authority however, the financial restrictions on available support continued. We were continually informed that the building we were based in (previously a secondary school) would close in the near future, and we would eventually move to a larger building (discussed below).

My colleagues typically carried around 35 cases in team 5, and 30 in team 4. Inevitably there was *always* pressure to take on more cases in each team.

Working Environments

Each team in which I was placed had its own distinct characteristics, but there was much in common with all. Of particular note were the work locations, and the

impression they conveyed to employees and clients of their relative worth. The buildings were old, drab and often damp. Any carpeting or décor was generally tacky and cheap. The furniture we utilised was bland or tawdry, and often on the verge of breaking. Again our essential equipment for administrative duties such as faxes, shredders, telephones or photocopiers, were usually well past their intended life span, and indeed some did not work. Teams 3, 4 and 5 had no computer facilities at hand, despite the fact that I had been informed that information technology would play a key role in my social work tasks during my DipSW training. Team 2 had one computer to share between all staff, but team 1 had a computer to share between each two members of staff.

Towards the end of my final placement in team 5 radical plans were in place for us and other teams to relocate to a purpose built local authority building on the outskirts of the city in which I worked. The building, which I visited prior to my final placement ending, contained two large open offices that together would eventually house no less than 150 social workers. Such a plan was unprecedented in social work's history, as I could find no evidence of similar mass "factory like" locations that have housed so many social workers in such a cramped and impersonal setting. The building's interior was sterile, much the same as a job centre or DSS office, and staff morale prior to the move appeared to plummet to new lows. Despite some resistance from trade unions the move eventually went ahead, and our manager informed my team in meetings that similar developments were also planned 'throughout the country'.

Research Topics

I had decided relatively early on during my ethnography the areas of study that I would target for my research. In order to structure my time appropriately and not wonder off on to an unsuitable range of possible topics, I decided to study 5 pressing issues that would each be investigated through establishing a research question for each. The questions were in response to my DipSW training - including essays, reading, lectures and placement experiences - and my first couple of months of employment. The themes of study were all ones that I felt required special attention, and I discuss each topic, and my reasons for their selection, in more detail below.

I tried as much to remain concentrated on the five areas of study, but inevitably other findings emerged which are detailed in my data chapters that follow.

The five research questions that were explored are as follows:

1. Are bureaucracy and procedure the core components of care management?

The question is a response to early investigations into care management that noted a prominence of bureaucratic tasks in the new role (Utting, 1994). However academics such as Sheppard (1995) propose that care management is merely a 'new' form of social work (which is constantly progressing), and contains key themes such as the desire to assess and provide for clients. The question is also a response to the reactions of my colleagues on the DipSW course who returned in disbelief at the extent of administration tasks that care managers were involved in each day.

As well as the volume of bureaucracy, and extent of procedure, I felt it was important to explore to what extent such changes improved services to clients and allowed a previously criticised organisation to become more efficient and effective. Did such work hinder or improve the role and working conditions for care managers, and the nature of interventions for clients? Question 1 is explored in chapter 3.

2. Are management styles, particularly 'strict' Taylorist forms of their application, an intrinsic part of the culture of care management?

As explored in chapter 1 the literature on care management and social work has tended to place great emphasis upon the importance of management styles in developments in welfare over the past 25 years. Question 2 is explored in chapter 4, and attempts to address to what extent such literature is accurate in its depiction of increasing business style management techniques being applied to social work, and the apparent reduced autonomy and discretion available to front line employees.

Are staff intimidated or even bullied by such techniques, assuming they are applied as Harris (1998) and Jones (2001) suggest? Parsloe (1981) and Pithouse (1987) paint a very different picture, one of management support and participation in social work tasks. But these studies were prior to the advent of 'community care' reforms and the birth of the care manager.

3. Do budgets influence the role and practice of the care manager?

Dominelli and Hoogvelt (1997), among many others, argue that financial restrictions now restrict choices available to care managers in their attempts to serve the interests of their clients. Certainly my own placement experience had suggested that budgets were an important part of care management culture, and it was apparent during 1995 when I was on placement that resources were in short supply. But some writers such as Postle (1999) have argued that such a resource led culture allows new skills to increase the capacity and choice available to social work to transform itself and become more dynamic, as in line with the apparent flux of post-modern society. Such a discourse will be explored in chapter 5.

4. To what extent is good multi-disciplinary practice a part of care management?

One of the central themes of government's "community care" policy during the early 1990s was a demand for a 'seamless service' between different, and at times opposing, professions in the community. Particularly, an improvement in relations between health and social services was seen as a prerequisite for the development of community care policies (Sharkey, 2000: 11). My fourth research question explores this topic in chapter 6, and asks whether such a 'seamless service' has been created, and if so what are the tangible benefits for clients?

5. What is the quality of services available to clients?

Since it has been proposed by government that the personal social services, as with other sections of welfare, should be run more on the lines of business (Le Grand et al, 1992), chapter 7 attempts to assess such services in terms of their overall standard to

service users. The chapter will consider availability and satisfaction to clients according to need and draws from feedback from care managers, clients and the people who offer the services themselves. Particularly it will look at core and essential services such as home care, day centre, residential, nursing and respite care services. My research includes an analysis of all available services, including those provided by the independent sector (private and voluntary organisations).

In some respects this is the most important part of my research, since any 'business' is usually judged on its 'product' or 'services' available to 'customers'. The chapter will also however consider demand and need, notably exploring such themes as the apparent break-up of the extended family, the increased role of informal care providers, and the increase in social deprivation identified in a range of studies (Jones and Novak, 1999). Despite a plethora of publications concerning social work and care management, the quality of available services to clients rarely features as an issue of concern in any such articles or books. I find this quite astonishing, since the quality of services provided to any client should at least be of some priority to any 'profession'.

Conclusions

As one of the oldest traditions in qualitative research, ethnography, in its original incarnation, allowed the exploration of undiscovered lands, ethnic groups and cultural traditions (Leach, 1982). Although at the time such discoveries concealed a tradition of violent appropriation through imperialism, modern ethnography can attempt the discovery of more local concerns and issues, and should proceed with an ethical understanding of research outcomes and the groups that are studied - ideally with a

view to encouraging positive change (Atkinson and Hammersley, 1990: 14-16). It has been suggested that the new world of care management itself signifies in part an undiscovered country. As argued in chapter 1 such an undiscovered country is one that has only been selectively described and assessed in publications, and one of the consequences of my research is the possibility to propose a 'different truth' through evidence discovered during my ethnography.

My long-term ethnography of 5 social work teams, 3 of which were based in two of England's major cities (including the capital), has offered the potential for a thorough investigation of the (perhaps rhetorical) claims of government, policy makers and academics. I wanted to get beneath the surface of a piece of legislation (NHS+CC Act) that claimed to want to empower and support (via services) vulnerable clients in the community.

The following five chapters of my ethnography include an attempt to consider key themes prevalent in past research, in order to contemplate the extent to which many 'regimes of truth' in relation to issues such as new managerialism and the quality of services available to clients, and so forth, compare with my own (and my colleagues') experiences. It also allowed me the opportunity to consider the pace of change that social work has experienced over both the past few years, as well as over the past three decades. I also wanted to know what is it actually like to work as a care manager. My findings are both startling, and at times, disturbing.

CHAPTER 3:

ADMINISTRATIVE CARE

Introduction

In chapter 1 it was proposed that one of the consequences of the reform of welfare state sectors, including social services, had been the intensification and rationalisation of work processes (Pinch, 1997: 45-56). An important consequence of such reform for social work following the revolutionary NHS+CC and Children Acts ('big bang') - which had encouraged the formation of quasi-markets of social care and redefined social workers as 'purchasing' care managers - concerned not merely an increase in day-to-day workloads, but also an increasing amount of bureaucratic tasks for care managers to complete, as well as an increasing number of clearly stipulated procedures to follow. Research had suggested that social work had been de-skilled (Dominelli and Hoogvelt, 1997; Jones, 2001) since the implementation of these two Acts, and I have suggested (in chapter 1) that such a process actually begins at University, when students begin their social work training. Despite such evidence, some academics have denied the impact of the process of deskilling on the profession, and have instead argued that such reform has merely signified the continuation of social work's capacity to adapt to social change (Sheppard, 1995: 273-293). Some writers have argued that care management has offered a new opportunity for positive change; one that epitomises our new 'post-modern' world of perpetual flux (Postle, 1999). Finally Thompson (1993; 1998) and Payne (1997), and many more social work academics, continue to argue that clients' lives can be dramatically altered through the

positive interventions that social workers can apparently supply through their capacity to empower (notably through the use of advocacy, counselling and group work).

In this chapter I draw from my ethnographic evidence to explore the extent to which bureaucracy and procedure have increased over time, and the impact that this has had upon the opinions held by care managers concerning their new roles. From this data alone I believe it is apparent that the optimism expressed by the likes of Thompson (1993; 1998) (for many years now) is misplaced; or to be more specific, completely out of touch with front-line social work. I shall also consider the two pre-NHSCC/Children's Act studies carried out by Parsloe (1981) and Pithouse (1987), which is where I begin.

Before and After the 'Big Bang'

As detailed in chapter 2, Harris (1998: 839) has argued that the claims of 'loose knit radical social workers' that pervasive scientific management processes had reduced the level of discretion available to front-line practitioners, during the 1970s and early 1980s, had been overstated. Indeed using evidence from Parsloe's (1981) study of 33 area teams, Harris (ibid: 847) proposes that considerable autonomy was enjoyed by social workers, and by team managers in their role, owing to local authorities' capacity to 'make policy choices about the activities undertaken (and the extent and form of them) and organisational choices (on structures, practices and procedures)'. Indeed Parsloe (1981:60) is emphatic in stressing such a level of autonomy, even going as far as to suggest that in terms of essential instruments such as 'detailed forms and guidelines' many workers' 'only aid was their diary'.

As suggested in chapter 2 Parsloe (ibid: 60) also discovered a lack of procedural instruments for completing even the most basic of social work tasks, such as the assessment:

> What were lacking, or developed only embryonically, in most teams, were detailed forms or guidelines which assisted members of the team to make comparable assessments of the clients they saw on duty, and to select from a similar range of possible services when planning work. They also lacked shared criteria for considering who in the team should do what work. Nor was it apparent that teams had shared ideas about the kinds and amounts of work members should undertake. In other words, they lacked common instruments for assessment, work planning, work allocation and case and workload management.

Teams did however have some procedures, but these were generally loosely defined. As Parsloe (ibid: 60) makes apparent 'without such procedures it would be unrealistic to use the word 'team', even in the vague and general way in which it is used in the social services'. The author also goes on to acknowledge a lack of support provided for staff, particularly as regards helping practitioners deal with anxiety. In an attempt to explain such a permissive culture Harris (1998: 844-851) identifies a 'stratified social work labour process' in which the at times tenuous relationship between central and local government, as well as middle and front-line social work management, allowed a degree of autonomy to prevail in each strata. As was detailed in chapter 1, such relations would later change with a more authoritarian New Right government

that utilised a number of instruments, such as encouraging more pervasive managerial techniques, as well as attempting to centralise power, and draw it away from local government (Clarke and Newman, 1997). As was also suggested in my first chapter, there is also now more expectation regarding the role of welfare employees, particularly concerning accountability, work intensification and the increasing rationalisation (through procedures and rules) of their roles. This process had been identified by Clark and Newman (ibid: 30) as encouraging a steady process of 'dispersal', whereby dispersed instructions increase employee 'responsibility' throughout the structures of welfare, most prominently at a local level.

Regarding more recent studies, both Hadley and Clough (1996) and Jones (2001) have presented bleak depictions of the experiences of front-line social workers, as well as health professionals and managers (in the former study). Each are presented as spending an increasing amount of time engaging in bureaucratic tasks as part of their work in the SSD office. Prior to the 'big bang' Pithouse (1987: 53) reveals little evidence of an office-based occupation, although he does acknowledge that the office at times provided a 'sanctuary' from the 'hostile' outside world. Regular contact with clients, both at the office base and "outside" does generate a tension in the relationship between practitioner and client (due to the provocative issues encountered in the work, particularly in relation to child protection and compulsory removals from parent(s), and so forth). But still the "community" is where social work tends to take place, rather than the area office, and contact with clients is regular and often informal.

Dominelli and Hoogvelt, (1997) offer a post-big bang assessment of care management in which traditional social work has been compromised by neo-liberalist influences in part encouraged by globalisation. Again, as with Hadley and Clough (1996), social work has been reduced to a series of office based clerical tasks, the consequence of a long since identified process of 'deskilling' (Jones, 1983). Contact with clients did not end with such a process of confinement, but was now significantly reduced to brief formal contacts in relation to a care manager asking set questions from a form, or communicating from the office via telephone conversations or letters (Carey, 2003).

As already stressed however many disagreed with such an analysis, or simply appeared to deny the extent and consequence of such change. For example Sheppard (1995:vii-viii) argues that care management is merely a new form of social work, many elements of which lead to good practice:

> ...elements of care management, it seems to me, are no more than the endorsement of good practice. I cannot see how anyone really interested in providing a good service can protest about systematically undertaken assessments in which, as far as possible, the consumer has considerable influence, and in which what is provided is reviewed and evaluated.

Later, in his concluding chapter, Sheppard (ibid: 273-274) continues:

> ...the changes represent an aspect of the 'nature' of social work: that what constitutes social work is itself, to a considerable degree, subject to change. Even the profound changes arising from the ideology of the New Right have

left in core elements of social work. The interactionist dimension and the concern with the consumer as subject are implicit in official guidelines on care management. These, indeed, provide opportunities for social work....The three core social work approaches identified: interpersonal skills, working with social networks and social supports and task centred practice are of the greatest relevance to the practice of care management.

Postle (1999: 23-24) echoes these sentiments, but also recognises the potential for change that care management provides:

> Many staff feel dissatisfied with the changed nature of their work, often dichotomously positioning social work and care management in their description of the changes. They demonstrate this positioning by, for example, contrasting the bureaucratisation of care management with what they see as the more interpersonal nature of social work. However, a closer examination reveals this dichotomy to be false. 'Social work', with unresolved disputes about its professional identity and its unclear and ambiguous nature, was never a clearly defined entity and was in many ways ripe for change.... care management is in the process of being, rather than an entity which has become. As such there are seeds of opportunity for further challenge and change.

An important question that remained for my research then was whether the deskilling process, assuming it existed, had reduced the discretion of front-line care managers, and taken from them their past cherished interpersonal skills (advocacy, counselling,

therapy etc) in favour of more rigid office based routines. Or whether such claims have been overstated, and in the process ignored the 'good practice' that care management had encouraged, as well as the potential for flexible exploitation of increased choice that these changes have perhaps facilitated. The first section of my research hypothesis asked 'are bureaucracy and procedure the core components of care management'. This question will now be addressed, by presenting a distilled summary of my findings from the first part of my ethnography.

The Role of Care Manager

Although some warning had been provided during the two-year diploma in social work course, only the start of 'qualified' employment truly introduces the uninitiated into the world of care management. From the outset qualified work generates immediate responsibility, especially in the challenging climate that care management/social work has found itself in over recent years. To begin with staff shortages are common, and were apparent in most of the teams that I worked in. Even when absenteeism was not high in a team (T1 and T2), there was still far more work to go around than care managers to respond to it. Complex cases, typically concerning issues in relation to abuse or neglect, were generally allocated to care managers every other week. Just as a worker began to start work on the previous allocation of intense cases, a new batch was prepared and passed out by the front-line manager. Many new workers were initially surprised by the steady build up of casework, as well as the work that the one-day a week on duty would typically generate. Inevitably, since

workloads were usually high, there were times when a sense of crisis emerged in the settings of the area office, as the following care managers revealed:

'I'm carrying far more cases than I can ever hope to give attention to. At times I miss meetings or forget to do the most basic, and usually important things for one or more clients because I'm either doing something on, or left over from, 'duty'. I 'chase my tail'...When I get home I often think 'oh I forgot to do this or that' Louise T4

'We get no support when a staff member goes off and we're only entitled to an agency replacement if the person has been absent for 6 months [due to a lack of resources and due to the fact that absent social workers receive full salary during their first 6 months absent]. At this point they usually return because their salary is halved, so in effect no one is replaced unless many people are off at once'. Karen T5

'It's impossible to cope with this many cases. If none of them 'blow up' then its fine, but when does that ever happen. I have no time to visit any of these people [clients] and rarely complete a [care package] 'review' every 6 months as we are supposed to because I am simply too busy... It's not just the number; it's also the issues that we have to deal with. I've been doing this for [25] years now, and the issues have steadily become more and more intense.' Jackie T2.

'No social worker can now complete all their work on time or even manage to keep on top of it. It's just all this bloody paperwork we have to complete. It's

so monotonous, and it rarely leads to any help being provided [for the client]'

John T1

Because of staff shortages in some teams (notably T4 and T5) many of the core tasks that the care manager was intended to complete did not receive the intention required. This was usually due to a lack of time available for adequate attention to be granted to each case that was allocated. In theory, once a case had been allocated to a care manager by a team manager, the front-line worker should read through the file or referral notes prior to making any contact with clients or family members. This however regularly did not happen (due to a lack of time), and some workers argued that this scenario created anxiety around the area office, which encouraged care managers to by-pass one of their skills, that of case analysis.

Following the initial assessment (financial assessment/assessment of need of client/assessment of carer - 3 forms) of a client's/carer's needs, some form of intervention might follow leading to the establishment of a 'care package'. Each form completed would need to be then photocopied and sent to the client/carer/next of kin. Interventions which followed typically included the provision of day support, home care or respite, all of which would need to be arranged (with providers) over the telephone, and usually involved faxing sheets of information over to the providers (of services). However more complex responses included the process of finding a permanent residential or nursing home for a client (a range of complex forms to complete), or finding emergency accommodation for a person who suddenly found that they were at risk of becoming homeless.

Each care package established would require a 'care plan' (1 form) to be completed, which detailed the times at which a client attended a day centre, or a support worker arrived to meet a client. Such forms would need to be again photocopied and posted to the next of kin, client and providers. Transport might also be required to and from a day centre which would again lead to telephone calls to arrange such a set up, and other forms to be completed and faxed to the relevant departments. In theory a 'review' (1 detailed form) of any care package would need to follow every 6 months, particularly following any initial establishment of a care package, in order to consider its consequence. Again such a form would need to be photocopied and sent to relevant people. There were many other forms to be completed as part of the job in relation to the establishment of care packages. Most prominent remained the panel application form in which a care manager would apply for a service to a panel of senior managers. Such reports were detailed and usually around 3,000 words in length. The panel application was essentially an essay detailing and justifying why a care manager believed that a service was required by a client. Such applications were nearly always related to clients who required essential services, and who remained extremely vulnerable in the community without them. But despite this, it was often the case that such applications were failed, and refused due to a lack of available resources. The panel also meant that care managers were effectively competing against one another for scarce resources, and the quality of their reports tended to increase (slightly) their chances of accessing whatever resources remained. Such competition was in relation to services that were difficult to access, such as specialist and supported (by formal carers) accommodation. Inevitably some resentment and conflict remained between some care managers in relation to such competition.

Care management tasks were intended to proceed in a strict routine following the allocation of a case. The process usually being: assessment; care package; care plan; review. However owing to the fact that my colleagues would typically carry more than 30 cases at any one time, such a process proved difficult (if not impossible on occasion) to complete, and the final two tasks were at times abandoned. This potentially left a vulnerable client at considerable risk, particularly if a care package was failing to provide for any identified needs. Other tasks following assessment included any referrals to be made (2 forms), usually to health professionals, and applications for accommodation or certain benefits (many varied forms).

With a caseload of 8 or 9 clients, as is typical for a student on placement, each care management task would be completed in time. However with many qualified care managers carrying between 20 to 40 cases at any one time, this became difficult. In each team where I was based care managers struggled to keep up with their intended tasks. In general, once initial work such as the assessment of need was completed following allocation, and perhaps a care package had been agreed through the panel, clients were assumed to be relatively safe in their environments, and little if any contact was then made with them. Such assumptions were often misplaced, as will be explored in chapter 7. With the stress generated by the intensity of workloads, as well as the consequential inimical work environments in which people were based, care managers regularly appeared tired and depressed. There were typically glum faces all around each team in which I was based. My colleagues perpetually expressed their frustrations, and occasional anger, due to the nature of the 'soul destroying' and repetitive work. This again further encouraged a sense of despair to form, leading to low staff morale, as the following care managers articulated:

'The job provides no relief whatsoever any more. I remember a few years ago before all the changes came in when I used to do things like take a group of kids (clients) to the cinema, or perhaps help a disabled person with their decorating for a couple of hours... [now] we all seem to just sit around the office with the phones constantly ringing and everyone trying to sort out their file or complete yet another bloody form. Everyone looks fed up, and so they should because if were honest with each other its a crap job' Anne T1

'I don't know if you have noticed but when 5 o' clock comes there is a rush to get out of the door and into the car to get home. It wasn't always like this, years ago people stayed back to complete their day's work, make up for time spent with a client etc. Now everyone is off straight away.' Ron T2

I remember my first placement at a small (one team) SSD in north Swansea. The tired looks on the faces of despondent staff appeared somewhat eerie at the time. Fellow students returned from placements and articulated the depressing and grim atmosphere of typical social work offices. One fellow student argued that colleagues (on placement) appeared 'lifeless'. It was as if the staff had had their life force drained from them by the tedium of the job. The intensity of the work, and the high expectations usually expressed by front-line managers, were not necessarily the main cause of such frustration and anxiety however. The two most common sources of grief expressed by care managers remained the paperwork and the lack of contact with clients, and both are explored below.

The Paperwork

By far the most common complaint expressed by care managers regarding their role, was the belief that they spent too much time completing bureaucratic tasks (Lymbery, 1998). With a more diverse range of 'service providers' to monitor, including those from the independent sector, as well as the 'purchasing' that had become a central responsibility for care managers (Means et al, 2003), the volume of paperwork required for completion increased dramatically after the implementation of the NHS+CC Act 1990 in April 1993 (Hadley and Clough, 1996: 30-31). In many respects such had been the scale of increase in administration work, that the new role that had emerged appeared as a very different job in the view of many care managers (Postle, 2001). There can be no understating just how much stress and frustration care managers felt about their need to collect and process large volumes of information each week. As well as the assessment documentation, which was usually completed in the presence of a client, a number of additional forms, previously discussed, followed which left care managers feeling despondent towards their role, which appeared alien to the image of social work as a community profession.

Due to the intense workloads, case files quickly began to bulge, and desks at the area office were usually littered with stacks of forms and various pieces of administrative paraphernalia, such as staplers, pens, hole punches and so forth. Care managers also spent long periods of time photocopying file notes; faxing care plans to providers; writing letters; and attempting to complete at least some of the care plan review documentation. Indeed, much of the tension in the area office was generated by the frustration and anger felt by care managers due to the banality of their repetitive tasks:

'It [social work] has always been a job which entailed bureaucracy but since we became care managers for 'consumers' the extent of the paperwork has escalated beyond reason. It there existed a purpose for most of it I wouldn't mind as much but there is just so much unnecessary duplication'. Karen T1

'There appears to be no break at times from the bloody paperwork! One form follows another, then the information goes on file and chances are, is never read by anyone...we are clerks now, not social workers!' Paula T3

'Everyone is just so fed up with it. There appears to be a different form for us to fill every month, just add that to the many others we are expected to complete. It's mind numbing.' Ruth T5

'We never had anything like this under the 'generic system'. You were expected to keep a diary sheet and some other stuff, but care plans and complex review documentation [etc] was never around. Obviously as well you never dealt with financial assessments and figures for costing and panel and all the other stuff we are expected to deal with... Generally [in the past] you also received some support from the admin lot, but most of those have been laid off or took early retirement like everyone else' Ron T2

The team members also felt isolated in their work, which called for an efficient response, and concentration upon individual cases. Managers no longer helped out as

they had in the past, after all they had their own bureaucracy to complete. But the banality of the tasks and procedures, and the high volume of work expected for completion on individual cases, meant that the job could become a very lonely process for the care manager.

The Labyrinth of Procedures

Each administrative task tended to be part of a 'chain' of procedures that encompassed the care manager's role. The completion of one form often called for another to be completed and photocopied, which then lead to another, and so on. For example, the assessment of need form would usually lead to a call for a financial assessment form to be completed, in order to means test a client's capacity to contribute towards the cost of a service (charges). Once a financial assessment form had been completed a panel application would be made using a separate form, which might then lead to a care plan form being completed, and so on. A stringent chain of procedures was thus established, and the job was usually picked up very quickly by a student, or newly qualified employee. Indeed it was often the case that a newly qualified worker was just as 'competent' at the care management role as a veteran social worker.

Procedures, however, were not merely limited to what particular form to complete and when. Indeed a strict protocol existed for a range of tasks, ranging from 'how a telephone is answered' to how to 'write an appropriate letter', and so on (appendix 2). Such regulations again further alienated already perplexed care managers, as the following people explained:

'I'm told that there is a member of the council who rings people up to assess how they answer the phone. We have been given very clear guidelines on how to speak to people, write letters, answer the phone, and so on…we are often treated like children and they wonder why we are all pissed, 'off sick' or keen to take voluntary severance.' Pete T4

> 'Fill this form out, attend this meeting, arrange this review, write a letter this way and send it out at this time, and on and on it goes.' Paul T1

The impression given to employees through such strict routines was that workers were treated like children by 'the powers that be', and many care managers believed that they were viewed as either lacking basic intelligence, or simply could not be trusted. The procedures, which were carefully monitored by front-line managers in supervision (explored in chapter 4), constructed 'concrete corridors' down which the employee was encouraged to pass. To many of the social workers interviewed; the job resembled a production line factory post, in which predictable and simple tasks were followed in strict routine. Any anomalous activity, such as talking in a friendly manner with a client on a telephone, or agreeing to lend your own money to someone in need, was deemed 'unprofessional', and was usually punished if discovered, by a verbal warning from a manager in supervision. Rigid routine and clear procedure encouraged predictability, and also allowed managers to know where their staff were, and what tasks they were likely to be completing and when. But for the front line care manager, a sense of despondency soon formed. Such experiences also led to a sense of regret developing amongst care managers for deciding upon a career that had become very different to that originally envisaged:

'A few years back when I was laid off I had a simple choice between social work and teaching. I made the wrong choice. A friend of mine did teaching and I have so much regret at not looking into it more beforehand.' Bill T4

'Both my parents were social workers and to be fair to them they did warn me beforehand! They've both told me they wouldn't come into it now. I just regret the time I've wasted doing the training and doing this job.' Linda T5

'I'm just fed up being a 'do gooder'. You get no thanks from anyone outside and you are treated like a child in work. I must find something else before I am too old.' Paula T1

The emotions expressed by care managers became almost as predictable as the tasks that they completed: anger; regret; despondency; frustration and so on. The strict routine that the job demands takes with it any sense of challenge or purpose.

A Lack of Contact

As was suggested in chapter 1, one of the most distinct elements of social work during its history has been its close affinity, and regular contact, with its diverse client population. Despite this, one of the inevitable consequences of the increase in bureaucracy is a lack of time available to spend with clients (Lewis and Glennester; 1996; Stanley, 1999). Indeed it was usually the case that care managers and clients only met during the completion of brief formal procedures, such as the assessment or

review process. However, even during such formal gatherings, a set of pre-determined questions was read out aloud by the care manager from a form collected from the locality office (see appendix 1). Any brief contact with clients was thus strictly controlled, again by procedure-led administration.

Care managers continually complained that they assumed that they would be allowed the opportunity to explore the dynamics and issues related to client need when they began their training at college. The process of training had implied that social problems were complex, with a range of dynamics influencing an individual's personal experience of disability, age, gender or mental health. As detailed earlier, it was also suggested at college that a social worker's capacity to read and respond to a range of social problems required use of a series of adept skills (Thompson, 1993; Payne, 1997; Mullaly, 1997). Despite this, a limited fraction of time, in which contact with clients was structured and regulated by a prescribed piece of bureaucracy, allowed little opportunity for such skills to be expressed. Inevitably practitioners again felt angry and cheated, at what they perceived to be the removal of one of their key roles:

> 'The sad thing is that most people do not understand how our role has changed so dramatically. Clients, relatives, their friends, even other professionals ring up or write demanding where I have been over the past couple of months.' Lisa T1

'That was one of the real privileges of the job, getting to know someone and, well, noticing how you had improved their life - even if just a bit. Not

anymore though, although I do know of some colleagues who continue such work in their own time. I'm too busy at home unfortunately. Paul T4

'When we were social workers it was completely different. The office would be empty for days on end sometimes, not like now! I know some friends, mostly mums, who have had to leave because they cannot complete their 'mother tasks' such as collecting kids from school under the new regime.'

Paula T1

'I think it's the worst part of the job not really knowing who it is you are working with. We have these huge files on people and yet our true knowledge of them as people is now very limited. They are basically numbers on a file.'

Bill T4

> 'I read my questions from the [assessment] file and then write down [the client's] answers. That's it, next time I might see you is if I have time for a quick review, assuming the panel allow you any support.' Jill T4

The lack of contact had important consequences for the care managers. They felt that they were regularly failing to explore people's needs, and in consequence, were merely guessing in their professional response or intervention. The impression given then was of a series of superficial rituals (assessment/ review) that failed to explore the needs of a client. Such formal processes also alienated clients, their relatives or friends, and other professionals. Such people assumed that care managers had time to spend exploring the need of clients, and indeed, many would argue that this is

essential before, at times, dramatic changes are made to a person's life. A client who is uncertain over a possible move into residential or nursing accommodation on a permanent basis is unlikely to want to be rushed into such a life transforming event. It is not merely a change of accommodation, as many of the bureaucratic procedures and routines appeared to assume. The lack of time available for care managers to concentrate on such clearly sensitive and difficult life events meant that what in effect had been reduced in practice to a set of administrative 'procedures' were often rushed and completed without a chance to analyse or consider any additional circumstances (family needs, long-term client needs, appropriateness of locations, and so forth). In that sense care managers argued, during my ethnography, that much of what they did as part of their established role (and there are many more examples) was oppressive. Their anger reflected resentment that was acknowledged by care managers as a consequence of their continued deskilling.

Deskilling

The care managers I interviewed felt that they had been robbed of their cherished skills, such as counselling, group work and other forms of therapeutic intervention, as well as their capacity to advocate on behalf of clients, and offer a more thorough understanding of the complex dynamics related to human need. What they now provided was a mechanical and bureaucratic response to crisis, which at times was superficial or inappropriate. Care managers argued that they had become de-skilled by a series of enforced procedures that now determined their role.

The assessment provides one example of such a process of deskilling. Assessment has long been cherished as one of the core skills held by social workers (Coulshed, 1991), and I, as with many students on the DipSW course, had been informed that past forms of social work had tended to pathologise clients (particularly working class mothers and families) in stressing character flaws such as 'addictive personalities', whilst failing to consider the profound impact of structural consequences such as poverty and unemployment. Such a broader understanding of clients would (ideally) lead to the emergence of more appropriate and 'holistic' assessments (Thompson, 1993). Despite this, a glance at a typical assessment form used for adults (appendix 1) reveals a rigid infantry of pre-determined questions that may imply little faith in the capacity of the care manager to complete the process using their own initiative and professional judgement. For example page 5 of the assessment document provides a table related to the 'self care' [of a client]. Here the 'tick box' form assured that care managers could easily navigate around a list that attempts to quantify the extent to which a client requires formal assistance. Rather than allow the care manager to write such a report, the table appeared to simplify tasks, and limited the options available to the writer. Care managers also complained that the forms were each identical regardless of the client that was being interviewed. Thus they appeared 'mass produced' with a couple of care managers comparing the review and assessment forms to 'menus in a wimpy' and comparing their work with clients as 'very fast food'.

It was argued that such forms failed to acknowledge either that clients might exaggerate their capacity, so as to appear more independent due to pride, or may be

embarrassed at the pointed nature of the formal questioning. Interviews with some workers also suggested that some assessment documentation might be designed in such a way as to avoid picking up potential risks or dangers to a client, as the following children and family social worker argued:

> 'The core assessment form appears to stress only the 'strengths' of a child or their family networks or placement. There is no actual space given to discuss risks to health or dangers in relation to a child's safety. In other words I believe that the department does not want us to formally acknowledge them.'
>
> Paula Looked after Children Social Worker T5

Thus the assessment documentation has the potential to represent an important political act. Front line managers regularly scrutinised the completed forms and would often demand that sentences were reconstructed or taken out of the form. For example, in one borough in which I worked care managers were not allowed to document that clients require '24 x 7 support' even if they were significantly disabled and required such attention. This was because, as the manager was very keen to stress to us, 'if we write that down we may have to provide it'. The assessment then (in tandem with an eligibility criteria) becomes a political tool that at its most potent *encourages* exclusion, (through refusing services following its completion), and indeed allows such a process to become almost a precise art (through the use of so many clearly structured and pre-determined questions). Many of the assessment forms that were used were constructed by social work academics from established University departments (notably Bristol), illustrating the effort that went into their careful construction.

Previously the assessment process has been regarded as one of the most skilled tasks that the social worker engaged in, and required a number of meetings between social worker and client before it could be completed. More recently however, a brief visit was all that a care manager's time would allow. Social workers argued that the emergence of clearly defined bureaucratic forms to structure and determine their roles removed choice, skill and power from the practitioner. Inevitably the simple tasks held in a scaled multiple-choice format generated more frustration for care managers:

'My dad is a labourer and he could do my job' Lisa T5

'The forms are restrictive, everyone knows that, and well, it doesn't generally take long to pick up the job. Many of us still try to do other stuff such as counselling in our own time, but finding the time is difficult, and well what's the point? Jill T4

'There was a lot of resistance to the 'tick box' type forms at first but now everyone has just accepted them. They make life easier in some ways and you never forget stuff, but together all of the forms just make the job so dull. I think you could pick someone off the street and teach them our job in a week.' Jane T1

But frustration with the process of deskilling was not simply about a person's desire to engage in stimulating work. Deskilling takes away a person's capacity to choose, or apply knowledge to events in work, or assist people in need. The many procedures to

follow and documents to complete help to create the image of a didactic work culture of perpetual instruction, in which autonomy, and power, are removed from the employee:

> 'I feel embarrassed at what has happened to the job. It's just so simple and dull, and we're all pissed off, and yet not doing anything about it. People look fed up here now, there's no more fun or sense of belonging, it's just a case of 'do the job' and go home.' Paul T4

> 'I don't think we have any power anymore. We are always following instruction, doing our little tasks, and watching our backs. It's a crap job we all accept that. My niece was even told in school not to bother with social work; even the bloody career offices are now warning the kids about the job!' Paula T1

> 'I know that word has got around to other professionals about our new role because friends tell me. It's so embarrassing; we must be the butt of so many jokes. And I also get the feeling that the public views us as stupid as well' Jean, T1.

As well as the impact of the deskilling process on the image of social work, there was also recognition by the care managers that they have inherited a social space in which their *responsibility* had increased. So many expectations appeared to come back to the care manager, not simply from above, as is well documented, but also from below and either side.

Blamed for Everything

One important consequence of the role of manager and purchaser of care services for care managers has been an increase in (professional) responsibility. In sum, everything appeared to come back to the front line care manager. The client and next of kin had understandable expectations of receiving a service following any assessment, particularly if they had waited up to two years for a care manager's attention, as was often the case. Other professionals, such as GPs, community nurses or managers of a day centre, expected a response from a care manager to a client's need that they themselves may have identified in their own community based role. A care manager's superior would also expect efficiency and competence to prevail, despite having first hand experience of the lack of resources and extent of the bureaucracy. If a service was not therefore forthcoming, or a practitioner was failing to cope with any excessive demand, it was the care manager who always appeared to take responsibility and blame:

> 'We appear to take the blame for just about everything that goes wrong. I spend so much time apologising to other people and yet often it is not me who is to blame... I have told people that the panel has no money left but they just think I'm making excuses and ultimately I am to blame. It's no good mentioning your caseload either, no one is interested in the other work you have to complete.' Sue T1

'As people still use the word 'social work' more so than 'care management' everyone assumes you should be in regular contact with clients, and completing practical tasks for them as before. This is not possible anymore.' Anne T1

'Everything comes back to us. If a support worker fails to turn up it is the care manager's responsibility and not the company that provides the worker! If the panel refuse a service then we are to blame. If all of the work is not done then your manager is keen to know why, and so on.' Ruth T5

Responsibility appeared to pivot around the shoulders of the care manager, despite the fact they often had little influence on many of the outcomes, such as the decisions made by the panel, or the competence of individual care providers. During the time when services were exclusively provided by the local authority, or social workers themselves, there was more of an acceptance of such responsibility. Workers realised that as they provided the service, or worked as part of an organisation that did, then they inevitably held some responsibility as part of their job. Despite the fact that there were now so many factors that the care manager did not influence (such as *provision* of individual services; paying providers for services, and so forth), they were still assumed by many to be responsible for so much due to their status. For example despite the fact that local authority financial departments dealt with payments to service providers and charges to clients, the care manager was usually the first to be contacted if anything went wrong or queries remained.

One effect of this was that care managers felt that they were being 'persecuted' by just about everyone around. Telephone calls from providers, clients, relatives, or other professionals would bombard care managers throughout the working week. Inevitably further frustration felt by employees enclosed in a tense and usually small setting often led to anxieties being taken out on one another; just one method by which care managers attempted to cope with the stresses that the job generated:

'I feel as if I am not doing my job right when things continue to go wrong. Why is a service not provided when it should be? If a service is provided why is it not of the quality intended? Each week provides more and more problems and stresses, and I appear to take the blame for everything.' Lisa T3

'The GP wants to know why I haven't done this or that, as do the relatives or the client themselves... My manager moans about my performance, or even colleagues may moan that your work is not up to scratch, despite the fact that they are doing the same job. It's just impossible, no wonder everyone looks half dead and at the end of their tether.' Paula T5

'We are expected to produce miracles by people at times. Why weren't you here at this time; why is there no service for this person; why didn't this person (support worker) turn up on time; why did my relative have an accident at the day centre?' Bill T4

'It is not unusual for disputes or arguments to erupt between us; I think it's an inevitable consequence of a stressful job. As we continue to deal with crisis

as the tension mounts it's inevitable that people will fall out with each other.'

Ruth T5

For the care manager the pressure of work begins on Monday morning, and continues to intensify throughout the working week. From the telephone calls, to people turning up unexpected at the office, there was little respite from what appeared at times as perpetual expectation in the community. The outcome was that due to expectations regularly not being met in the community (through the provision of services), care managers became figures of resentment to those outside the area office.

We've Been Cheated

Some care managers spoke of being cheated by opting for their chosen career with the statutory social services. They expressed a sense of regret towards entering an occupation that appeared to be in terminal decline. As well as the repetitive tasks, and lack of client contact, there was also a pessimism felt about the future of the occupation, and its chances of survival. Veteran social workers had not only witnessed their occupation in decline, but had also acknowledged a receding amount of support given to clients. The withdrawal of therapeutic services, which were generally dismissed as an 'unnecessary luxury' by most managers, was only part of a broader rationing of what were once considered core services. Such a bleak process had helped encourage a strong cynicism and pessimism to become part of the care manager's disposition.

Care managers also spoke of being cheated by being given the impression at college that they would engage in group work, counselling and advocacy work following qualification. It was felt that training courses failed to prepare students for what was to follow. However, the two practice placements on social work courses surely should provide adequate warning to anyone in training of what to expect. Veteran practitioners talk with sentiment of the past, when client contact was regular, and work provided a sense of achievement, and allowed the routine application of skills. Whether this is true I will never be sure, but Pithouse's (1987) study certainly did not depict stressed and discontented workers to the extent that my own research has.

Bring Back Generic Social Work!

The sentiment held for the past was strong for some workers, and the support for a return to the 'good old days' also extended to the opinion of managers. The general view was that generic social work had allowed more autonomy for the practitioner, as well as encouraging more skills to be developed in a freer form of stimulating practice. Generic social work had less of the bureaucracy that care management now encompassed, and I was informed that social workers rarely carried cases for longer than a couple of months, before being given 'a new batch'. There was also a variety of challenges in the typical generic caseload. The descriptions by veterans evoke images of a very different job:

> 'You would be given a set of new cases every couple of months and they could include anything. Child protection work, issues around addictions or mental

health and so on. Your manager regularly went out with you to meetings, especially if they thought you were in any danger, unlike now.' Gina T1

'The job was not in anyway monotonous like now, where everything is so predictable. You felt challenged and needed, you also at times provided genuine assistance because there was so much money available in comparison to today. Charities would look on in envy at the financial resources we once had, now we are basically working in poverty.' Liz T4

Not all was viewed as perfect during the era of generic social work however. Some care managers felt that there was 'a lack of structure' in the past, and that some people took advantage of their relative autonomy:

'I think the system worked better, but there were people who took advantage. Some people you would not see for days on end, and many were not doing the work that they claimed outside of the office. But I think it's gone from one extreme to another, there are now too many regulations and rules.' Jane T1

Another worker spoke instead of the abuse of power that sometimes was evident in the past, especially against clients:

'Some of the theories were very oppressive when applied to clients. Especially ideas from psychology such as 'denial' which were used at times to force things onto people that they did not want or really need.' Peter T5

It was also argued by some care managers that children received all the attention of SSDs at the time and older and disabled people were viewed as low priority. A return to generic work now seems unlikely, and with the intensification of bureaucracy and procedure now having permeated all client specialities, it would be unlikely to resemble past methods used anyhow. I believe the sentiment of workers was more in relation to changes that had come in parallel with the reconstruction of specialist SSD teams; such as marketisation, increasing regulation and rationalisation, new managerialism, and inevitably, the work intensification.

Poor Health

One rarely explored consequence of care management is the impact of the job upon practitioner's health. I recall students returning from their placements when I was at Cardiff and commenting on the fact that 'many social workers look ill'. Certainly the stressful nature of the job is unlikely to encourage good health, and can indeed have potentially fateful consequences. But just as relevant remains the time spent confined to a desk, and the lack of exercise generated by the new role. My colleagues were certain that being a care manager was detrimental to their health, some even linking the role to the onset of major pathologies such as heart disease, cancer and diabetes:

'I think the sheer stress that the job encourages through so much expectation makes you feel ill in itself. However I also find that since starting work in social work I smoke more, get very little exercise and eat too much chocolate. I suppose it is all a coping strategy.' Paula T1

'I have no doubt that my diabetes is linked to my job, thinking about it perhaps I could sue the authority as in America. My weight just shot up once I started work here, I never actually ate chocolate until I qualified.' Paul T3

'Obesity is really common in social work because you are too tired and worn out to exercise when you return home and you get very little exercise on the job. I remember Bill telling me that the job was killing him after his first heart attack, and that was why he retired.' Jane T5

'I had a heart attack a couple of years ago whilst at work. I was only 38 and suffered chest pains in the morning whilst on duty. The doctor informed me that the stressful nature of the job definitely contributed.' Alan T1

'I know very few people who do not smoke in social work, and as people say, every team has two alcoholics in it. But it's the only way you can cope with stress and depression; and then there's the boredom that the work creates.' Rob T4

'We had a case last year of a social worker having a stroke on a busy Friday afternoon in one of the [children's] teams [offices]. I believe she considered suing the council due to the lack of staff and pressure people were under, but I don't think she did. She 's now living on benefits and is paralysed down one side of her upper body' Paul (Unison officer and Children social worker) T5

The banality of the work, as well as the pressure and expectations from other people, had also encouraged practitioners to turn to cigarettes, comfort food, caffeine or alcohol amongst other stimulants. This was generally regarded as a 'coping strategy', and one that was unavoidable. Some people spoke of joining a gym, and there was a relentless but sporadic 'diet and giving up smoking' culture amongst many practitioners. Practitioners also felt that there was no recognition or support provided by managers regarding personal health - although it is worth noting that many managers suffered from the same symptoms. As already identified, long term absenteeism was common amongst care managers, some even being incredibly frank about their time off:

> 'I usually put about six weeks aside to take 'off sick'. A doctor will always give you a sick note if you tell them your job and say you are suffering from stress. It's the only way I can cope.' Ken T2

> 'A six month leave of absence is common in social work; one of the perks of the job! Your pay is halved after six months so most people tend to return then.' Debbie T4

> 'It's [absenteeism] one of the reasons why agency workers are now everywhere; they don't get sick pay so are rarely absent.' Sue T1

Despite some practitioners taking time off deliberately and exaggerating absenteeism in order to cope with the monotonous and stressful nature of the work, many were absent due to genuine illnesses, some with fatal consequences. It was apparent that

poor health was common in social work, made even more intense by workers obligations at home, as well as at the office.

Research by the Employers' Organisation in 2000 revealed that social workers have the highest numbers of days off work due to sickness of all professionals. In contrast to an average of 9 days absence a year, social service departments reported an average of 15 days absence per employee in 1998/99 (Community Care, 2000a). In response community care magazine completed a survey of 500 social workers which revealed that three-quarters identified depression and stress as their cause of illness and absenteeism; whilst eighty per cent questioned stated that their stress began following their first job in social services (Community Care, 2002a).

Pragmatic Responsibility and Life's 'Little Luxuries'

In view of all the many complaints that practitioners made of their occupation, important questions remain regarding why people continue in their monotonous, unrewarding and health threatening occupation. Two motives were most commonly expressed, neither of which concerned the apparent altruistic grounds often assumed for entering social work. Despite this, altruistic ambitions were stated as a motive by a moderate minority, and will be discussed below.

My interviews with colleagues suggest that the first and most common motive for entering care management remained personal responsibility, notably the compelling desire by mothers to provide for their children. Care management is, as social work has been historically, female dominated (Finch and Groves, 1983; Morris, 1991). Yet

I found that lone parents made up a substantial number of the total people working in care management and social work. Essentially the cost of parenting by oneself is substantial (Wilson, 1977), and care management provided an above average source of income that helped considerably with the cost of parenting. Indeed other non-qualified sources of employment such as care and support work provide only a fraction of the resources to working mothers (Green, 1988), and many more recent qualified workers had come directly from training through many years spent working in residential homes or for private care agencies. However even the working mothers who were still in relationships or married with their children's father were still often expected to pay for their children's upkeep, so again care management provided an important source of essential income.

The second most common motive expressed concerned the maintenance of a relatively high standard of living. Essentially a care manager's salary, particularly if a person worked for an agency (a typical local authority salary at the top of the scale is £24,000; agency £30,000) could guarantee what one person described as a 'reasonable middle class lifestyle' that allowed access to a pleasant house in a residential setting, regular holidays abroad, a 'nice car', and a range of what one practitioner referred to as 'life's little luxuries'. Practitioners talked of such rewards 'justifying the job' and even 'making it bearable'. However this was more the case for my placements *outside* of London, as in the capital much the same salary was worth considerably less in view of the high cost of property and living.

I was informed by colleagues that care management was predominately an *economic activity* for most practitioners, and rhetoric regarding 'empowerment', so regularly

articulated by academics and politicians, was simply wishful thinking in practice. Indeed, although only a couple of people made direct reference to the fact, it became apparent that many people actually entered care management to escape minimum wage employment, such as that provided in most sectors of the burgeoning care industry. For example, it was acknowledged by practitioners that a lack of alternative sources of well-paid employment existed. One interpretation of this finding is that many people engaged in care management and social work, are actually 'trapped' in their work due to personal responsibility and economic motives. Certainly this appeared to be the case for many workers, but it throws into question the altruistic motives often assumed to prevail in the pursuit of social work's ambitions.

Some Sense of Purpose, and a Career I Suppose

Despite the prevalence of economic motives expressed, there were care managers who felt that they genuinely assisted clients in their work, and had entered the occupation for more altruistic motives. Such motives were commonly expressed by the more recently qualified, or workers who had not long transferred from posts in charities, or other parts of the independent sectors of care. One possible interpretation of this outcome is that statutory social work and care management reduces practitioners' optimism for positive outcomes over time, or more dramatically takes from people their original altruistic ethics, or sense of justice and hope. One employee even went as far as to suggest that care management 'turns people into fascists'. Certainly it became apparent that the stressful working environment and culture encouraged intolerance to grow and be expressed by practitioners.

There were also practitioners who considered care management and social work to be a viable career option, and one that offered genuine opportunity for the future. Again the more recently qualified tended to hold such career orientated or optimistic views:

> 'Although I've just qualified I want to become a manager as soon as possible. I think I have a lot to offer, and indeed there were a lot of people on my course who specifically wanted to enter management.' Adam T1

> 'I still think there are a lot of options available. Some people want to become managers, whilst many want to 'make a fortune' by opening up a children's home or whatever. There's a lot of money to be made in care now you know.' John T3

My own research revealed that a new generation was slowly entering social work with more cynical motives. The gradual formation of a privatised care industry (Harris, 2002) over the past ten years has meant that there are people who enter the occupation with a genuine belief in the merits of 'strong management' or venture opportunities. This is a development I wish to explore further in chapters 9 and 10, where I will suggest that a 'radical right' is now active in statutory social work, in contrast to the supposed much more recognisable left, of which I could find little evidence.

There were also practitioners who felt that social work offered a career, and yet stated no ambitions to enter management or to make money. They simply believed they were helping other people by offering support and other means of formal care, and at times were able to provide it. Indeed many of the practitioners who worked with older

people or clients with disabilities had had direct experience of such a specific 'client group'. For example, there were practitioners who themselves had a disability, or had either children or a sibling who were disabled. Such employees often found many of the organisations' policies difficult to accept, particularly the retrenchment and rationing of support that continued during all of my placements.

Coping Strategies and Resistance

Practitioners spoke of having a number of coping strategies for the extreme stresses and boredom that the job encouraged. They included some of the topics already covered such as smoking and drinking, exercise, and 'planned absenteeism'. However people also spoke of deliberately attempting not 'to take work home', a habit they had perhaps first engaged in when they began their career. Indeed there was also apparent an unusual logic amongst some practitioners, which perhaps draws from other 'professional dispositions' such as medical practitioners' notorious arrogance towards their patients' opinions (Illich. 1975), that it is more 'professional' to be unconcerned about clients' circumstances. Such denial strategies are an important way in which practitioners refuse to accept many of their more brutal activities in the field, and indeed such stances are in my view essential requirements if a practitioner wants to enter management.

I found little evidence that practitioners actively engaged in strategies of resistance against the policies and procedures of the organisation. To be fair however, the options available to practitioners to resist policy are extremely limited owing to the unequivocal nature of the many procedures established. Essentially care managers

have little choice but to follow procedure if their clients are to access any of the resources left to buy services. There were two one-day strikes in total during my ethnography, but both of these were related to practitioners' pay. The stewards of the major trade unions such as UNISON were at times active in disputes, but such political activity always concerned internal disputes and there was no formal activity regarding issues relating to clients and service delivery. Again this appears to offer more evidence of Johnston's (1972; 1977) argument that despite generating rhetoric to the contrary, professions ultimately look after themselves.

There were a number of important developments that affected day-to-day working conditions. These included the introduction of a 'clocking in' card for care managers in T1; the regular introduction of new forms to complete in all teams; increased accountability for staff throughout; and the continued reduction of "budgets" available for service provision. Such policies were always accepted and received no resistance from front line care managers; instead people simply moaned to one another about any such changes.

Different Approaches

Although care management has helped to encourage the formation of an elaborate network of procedures that an employee is obliged to follow, there is still a surprising variety of ways that the role is interpreted and applied. In general, agency workers had less freedom in how they interpreted procedures, since they could always be easily replaced if a manager perceived their methods as being inappropriate. For permanent

local authority staff, who still dominate most SSDs, there was far more room for manoeuvre, and in some ways this allowed a type of resistance to be expressed in practice.

One of the most prevalent areas where care management has been interpreted by permanent staff was that which appeared to suggest a continued desire to 'still do social work'. That is many permanent staff, but particularly in T4 and 5, continued to avoid much of the 'paperwork', and instead preferred to go out and visit clients and engage in other forms of traditional social work, including investigative and even some attempts at preventative work. Such employees were unequivocal about why they did this, and as one stated, 'It's not boring like all the admin we have to do'. Despite this offering a hint of resistance, in practice such methods regularly resulted in clients receiving inappropriate services, or none at all, because the required procedures and administrative tasks had not been followed. Another consequence of such methods is that other people eventually had to complete the tasks not followed by the permanent caseworker, usually through the duty system.

Some permanent workers chose to ration their administrative tasks to a bare minimum (by being succinct in their form completion), which allowed more time with clients - whilst others even took much of their bureaucracy home to complete. Despite this, I still failed to find evidence of practitioners engaging in therapeutic social work activities such as counselling or group work. More likely practitioners would use their 'non-bureaucracy' time to explore family dynamics, and work with other professionals.

I also found evidence that there remained a significant minority who had found the change to care management a culture shock, and who were struggling to either complete their tasks or maintain an interest in their role. Such employees regularly became absent for long periods of time, and were always on the look out for "ways out of social work".

Professionalism and the Denial of Care Management

Although practitioners complained regularly about the extent of bureaucracy, and acknowledged the process of "deskilling", they still cherished their belief in professionalism. Care managers considered themselves to hold professional values of commitment, competence and the application of ethical practice. Further investigation suggested that practitioners did not want to 'shoot themselves in the foot' by overstating the extent of de-skilling, to the detriment of their own status and public image. Professionalism I was informed implies 'a capacity to do a job', and also includes the application of knowledge and altruistic values into practice.

Many care managers also resisted the title of 'care manager'. That is, they still considered themselves to be social workers despite all the changes, and it was rare for anyone to describe themselves as being 'a care manager'. One assumption from this finding is that care management is resisted as it signifies excess bureaucracy and other forms of deskilling. A related assumption from the finding is that practitioners are in denial regarding many of the changes, and continue to cling to their past identity and a time when their skills were more readily utilised. There was clearly a difference between the practitioners who had worked as social workers for many years, and more

recently qualified care managers. The former still attempted to continue with some aspects of social work, even if only through the use of the office telephone (to give advice to or support a client). The more recently qualified however, particularly if from agencies, were always effective in completing the dominant bureaucratic tasks, and rarely attempted to engage in any traditional social work activities. In many respects perhaps this was the only interpretation of the job that they knew.

Best Value

In the first chapter I discussed the introduction of New Labours 'Best Value' policy in 1999, which was essentially an attempt to introduce national performance standards and targets into social work, much the same as had happened to education during the 1990s (Harris, 2002). The policy first became apparent to me during my second placement, and was most evident with regard to my front-line manager always appearing keen to collect the number and date of assessments, reviews and care plans that myself and my colleagues had completed. By the time of my final placement a sense of panic had appeared to enter the culture of my team, not so much from care managers but their respective supervisors. Administrative detail within files began to be carefully checked during individual supervision sessions by front-line managers, particularly in relation to a concern for a possible visit from social service inspectors. 'We have to be careful with our files in case the inspectors decide to pay us a visit' was how one manager stressed the importance of form completion and file maintenance. The performance indicators that were established (zero to three stars) clearly motivated management and above, but were of little interest to front-line managers. The authority for which I worked in my last two placements achieved just

one star, but later attempts to achieve two did not translate into more or better services for clients. On the contrary emphasis was placed by managers and above on completing more forms (assessment, review, and so forth) as well as possible, which again took even more time away from that allowed with clients, relatives, and other professionals.

SSD's appeared to increasingly persist in order to complete prescribed forms on time, in the right format, as well as keep files as tidy as possible. The sense of persecution already established within teams by the dramatic changes imposed by the NHS+CC Act intensified, and I also noticed that more and more agency staff were dismissed by front-line managers owing to their alleged inability to complete paperwork either on time or in the right manner. Front-line managers became increasingly obsessed with the make up of client files, and they also began to spend more and more time in front of their computers inputting client data on to hard drives instead of actually spending time speaking with team members or providers/clients. The quality of provision of any service to the public, one of the *theoretical* ambitions of the 'Best Value' policy (Harris, 2002: 81), continued to suffer since in *practice* we continued to become ever more preoccupied with our administrative roles.

Conclusion

Regarding my research question that asked 'are bureaucracy and procedure the core components of care management', the answer is an unequivocal yes. Firm procedure and repetitive administrative tasks, which essentially provide a means of instruction for employees to follow, now dominate both social work and care management. They

do so to such an extent that prior skills, which offered forms of control over work techniques and methods, have now been stripped from the occupation in a brief yet dramatic period of reform (the 'big bang'). What now remains of the occupation is a series of clearly defined and predictable tasks for the practitioner to follow which, as will be explored in the next chapter, allows the opportunity for more adept surveillance to be made of individual employees' manoeuvres and schemes of practice.

For some the consequences of change have been dramatic. As well as the stripping away of once cherished skills and the significant reduction in practitioners autonomy, care management has also generated hazards to personal health. Both the stressful working environment and the methods of practice applied, have helped generate potentially fatal consequences for care managers' health. The locality office as the new arena in which 'social work' takes place, as well as the high number of administrative tasks that practitioners are expected to complete, have meant that the world depicted by Parsloe (1981) and Pithouse (1987) now appears as a distant memory, a 'golden age' in which employee discretion was for the most part evident, and the application of knowledge and skills was common. Revolutionary change has helped to generate a confined and hostile setting within the locality office, in which a rigid discourse of instruction and staff compliance persists. The perpetual engagement in mechanical (and therefore dehumanising) activities leads to despondency developing towards work among staff, and apathy amongst long-term practitioners towards their role was not uncommon.

Despite this I have also found evidence to suggest that many practitioners have attempted to resist the development of care management by utilising a range of *individual* strategies. These include bouts of prolonged absenteeism; a resentment of bureaucratic obligations; the selective 'bypassing' of administrative duties; as well as some attempts to still complete many 'social work' roles outside of the area office. Despite individual examples of resistance however, I found little evidence of more ambitious attempts to overcome or resist the continuing extent of change. Indeed owing to the pragmatic responsibilities that many employees have at home, notably regarding children, even more radical means of reform would be unlikely to lead to forms of group, or even mass, resistance.

CHAPTER 4

MONITORING THE FRONT-LINE

Introduction

The previous chapter considered the changed role of front line care managers, one that appeared to be quite distinct from traditional pre-'big bang' social work. Notably it has been argued, from evidence provided by the data collected, that care managers are now bound by a complex labyrinth of (administrative) procedures that have reduced their discretion and confined them to the locality office. Inevitably the care managers that I spoke to and observed were frustrated and angry, most notably due to the fact that they appeared to be perpetually engaged in repetitive and 'soul destroying' activities, that often appeared to lack purpose. This point is particularly explored in chapter 7, where the often-poor quality services (sometimes) provided for clients are considered in more detail.

This chapter considers the role of front-line managers, or 'team leaders' as they are often referred to by care managers. Each social work team will typically constitute six care managers and one front-line manager. My research question for this chapter asked if 'management styles, particularly 'strict' Taylorist forms of their application, [are] an intrinsic part of the culture of care management?' Braverman's (1974) now famous exploration of 'Taylorism' (or scientific management) drew a distinction between the execution and conception of work, in which employee's mundane tasks (execution) were in contrast to the use of knowledge by managers (conception) to

control the employment process. Management held discretion and, at times, utilised monitoring skills and forms of instruction to control employees. An inevitable outcome of such a paradoxical culture of work was the continued de-skilling of labour, a process long since recognised as affecting care managers and social work in general (Jones and Novak 1993; Dominelli and Hoogvelt, 1997; Harris, 1998; Carey, 2003).

The chapter explores my data to ask whether a culture of Taylorism is now apparent in social work. The data is again considered in relation to the studies of Parsloe (1981) and Pithouse (1987), which suggested a more permissive culture of work at the time for both front line managers and social workers. The chapter will also consider the data in relation to the neo-liberal influenced process of New Managerialism discussed in chapter 1, which ironically argued for more innovative and entrepreneurial schemes of work within the public sector, particularly emanating from a firm management backbone.

New Managerialism and Social Work

Some questions remain as to whether the New Right were entirely responsible for New Managerialism, especially since evidence exists that some Labour run local authorities were also keen to pursue such a policy in the early 1980s (Gyford, 1985). In general however, the neo-liberal project identified strong management as an important component of their ambitious disciplinary project (Hoggett, 1991). As explored in chapter 1, an 'ideological quest' to encourage or impose hegemonic business trends into an apparent wayward public sector was an important part of the

New Right project, and social work, along with health and education, received particular attention during the 1980s and 1990s (Jones, 1999: 47-49). Quite simply, as Pollitt (1990: 1) articulates, New Managerialism assumed that 'better management will provide an effective solvent to a wide range of economic and social ills'. As explored in chapter 1 however, its assumptions were part of wider changes that encouraged the development of the quasi-market of social care and the decentralising and reduction of social service funding. Further changes included a notable increase in social work's role in surveillance, and the application of the important skill of gate keeping finite resources from apparently 'dependant' clients outside (Jones, 1999: 47). New Managerialism might be viewed as being part of a distinct hegemonic discourse (Harris, 2002: 56-60), one that appeared obsessed by a desire to apply the principles of market economics, and implied contempt for anyone requiring assistance - particularly if they happened to be living in poverty (Holman, 1993).

New Managerialism however also generated an important conflict of interest, namely between professional discretion, and the desire for managers to control and contain any activities engaged in expressing such autonomy (Exworthy and Halford, 1999: 12-14). Research has illustrated a distinction between the effects of New Managerialism on different sectors of welfare. For example, Jones (1999; 2001) suggests that social workers and care managers had lost much of their employee discretion, and were now firmly controlled by their supervisors. Harrison (1999: 53) in contrast has noted the autonomy still enjoyed by medical practitioners in the NHS:

> Although managerial reforms begun after the Griffiths report (1983) clearly offered something of a challenge to clinical autonomy, a review of empirical

> research carried out between 1984 and 1990 concluded that, despite defeats over the form of the Griffiths [New Managerial] innovations, the medical profession had experienced little, if any, resulting loss of autonomy.

The discretion still enjoyed by doctors is almost certainly due to their long established professional status and power, something which social work has always struggled to acquire (Parry and Parry, 1979). This has left social work particularly vulnerable in the labour market, and as I argued in the last chapter, its lack of resistance to neo-liberal ideological reform (Jones, 1999: 47) has merely added to its predicament. Indeed it has been argued that due to dramatic reform over a relatively short period of time, social workers have been transformed 'from semi-professional to state technician' (Jones and Novak, 1993: 204).

The question that remains is whether New Managerialism really has resulted in discretion being held at the disposal of empowered managers, in contrast to deskilled care managers, as Taylorist processes would suggest. Or whether managers are as deskilled as the very care managers who they apparently so carefully monitor, as Harrison (1999: 53) has implied in his research into managers in the NHS.

One change which occurred for managers, however, was that they became much more *externally focused*; they were increasingly compelled to respond to government agendas and were consequently less able to respond to internal professional agendas.

If the latter is evident, then questions remain as to why social work has so passively accepted being dragged 'from pillar to post' without showing any hint of a response. Holman (1993: 47) in particular has criticised social work for its passive response to dramatic change, and its apparent 'enthusiasm' for reform, and its implied desire to, among other things, accept 'that gross inequality is acceptable' (quoted in Jones, 1999: 48).

Some studies (particularly Dominelli and Hoogvelt, 1997) have suggested that New Managerialism is merely part of much broader phenomenon, notably that which concerns the changing face of market capitalism, on both a national and international level. This is an important part of chapter 8 in particular, but for now three epistemological stances are of relevance to this chapter. First, Harris (2002) argues that social work is now part of a quasi-business, which first developed under Thatcherism, but has since proceeded to develop under New Labour. The ideas and methods of the profit led private sector have now imposed themselves onto social work, and New Managerialism is an important part of 'running the business':

> The diffusion of quasi-capitalist rationality, as part of a quasi-business discourse, and the consequent similarities that have developed between running private sector businesses and the social work business have tended to be ignored, even though the achievement of such similarities was one of the main goals of the Conservatives' reforms (ibid: 75)

Harris (2002: 46-49) perceives New Managerialism as being part of a two-pronged attack by neo-liberals upon social work. That is alongside marketisation, it offered a

distinct ideological scheme to transform the occupation by injecting ideas and organisational techniques directly from the private sector. Second, Jones and Novak (1999) have identified New Managerialism as part of a broader project to abuse, demonise and abandon the substantial and increasing number of people who live in poverty. Such abuse, they suggest, has been a key ambition of the New Right sponsored authoritarian state - and New Labour, despite their regular use of rhetoric to the contrary, offer little respite from such brutal policies. Finally Ritzer (1993: 12-14) offers a distinct hypothesis, in which he identifies a 'MacDonaldisation' process evident within market capitalist states around the world. Here the fast food corporation, and its emphasis upon strong management in its drive for predictability, efficiency, calculability and control, is seen as influencing many other sectors of the economy, including health care provision. Certainly, as described in chapter 3, care management would appear to contain strong evidence of each of these characteristics, particularly regarding its role and purpose.

Previous Studies

As explored in chapter 3, Parsloe (1980) and Pithouse (1987) depict largely permissive statutory social work teams, and management styles, as not being subjected to elaborate procedure. Management styles and techniques were also identified as lacking structure, with many teams even showing little evidence of 'formal supervision' (Pithouse, 1987: 131). Again policy and procedure were not a priority from the point of the managers in the study:

In general, the task of supervision concerns individual staff and the work they do, and has three major components: checking that agency and team policies are being carried out and that work is of an adequate standard; enriching the service to the client; and assisting in the worker's professional development. In our study the last two aspects seemed to receive more attention from supervisors than the first (ibid; 131)

Although Parsloe was keen to stress a lack of procedure and structure in the culture of statutory social work, there was some evidence of an emergence of rationalisation within the occupation. Vickery's (1977) 5 part list of client symptoms and issues is referred to by some of the social workers interviewed by Parsloe; the Scottish based Royal Institute of Public Administration (RIPA) drew up a published 13 part list of the role of social work assistants (Jeans, 1977), which was recognised as of influence by Parsloe; and the British Association of Social Workers also drew up a 19 part list of social work roles (BASW, 1977) that was responded to by some teams (Parsloe, 1980: 78-83). In other words, the rationalisation and procedurisation process that would later be identified as a key consequence of neo-liberal hegemonic logic, was openly pursued *within* the profession well before such policy came to the fore nationally. I believe that such self-imposed rationalisation is again in relation to social work's desire for full professional status, and the power and privileges that come with it (Johnston, 1972; Parry and Parry, 1979; Witz, 1992). This is but one example of an important part of my thesis that I will detail later in this chapter but particularly in my concluding chapter: that neo-liberalist values and methods (including moral and

political discourse) have support *within* social work, and are not merely imposed onto the occupation.

Parsloe found that managers engaged in social work tasks, particularly as regards providing support on difficult cases. This was also found to be the case by Pithouse (1987: 65-67), who offered a more qualitative and thoughtful study, in which 'sympathy' and 'care' were identified as important attributes of a good manager:

> The team leaders assiduously maintain a sentiment of diffuse concerns for the social workers. They are available throughout the day and can be observed hovering by the team, talking, encouraging, eager to listen to any difficulties and offering brief enquiries into the troublesome or topical issues of the private and occupational lives of the membership. (ibid: 65)

Team or front-line management appears as a delicate game, in which attempts are made to avoid upsetting practitioners by offering 'advice' instead of addressing evidence of incompetence by more formal methods. Sympathy is always assured for the practitioner for one simple reason; the manager has her/his 'own experience of doing the job' (ibid: 65). Management then is a two way process, and gaining the 'trust' of team players is an important part of the process (ibid: 64).

Pithouse (1987) nevertheless recognises the power held by managers as part of their role, and identifies that control is part of the management task. As well as 'guidance and advice' there is also the need to maintain 'standards' of work for practitioners. Finally he acknowledges the importance of employee discretion, and also front line

managers' regular attempts to underline their 'independence from higher management' to team members (ibid: 63-64).

As well as the discretion enjoyed by front-line workers, there is a subtle yet supportive form of management presented, which is essentially non-confrontational. It also relies upon the use of sympathy and support as important attributes to not merely encourage performance, but also to assist practitioners in their confidence and capacity to complete their chores. In some ways however, Pithouse's depiction may be criticised for presenting too rosy a picture of management and practitioner relations; one that perhaps ignored inevitable conflicts and power struggles typical of organisations. Despite this, he does appear to suggest like Parsloe (1981) that the distinct techniques later utilised or imposed by the apparent hegemonic discourse of New Managerialism were less apparent, as no reference was made in either study to such a culture of work. This appears again to strengthen Harris's (1998) proposition of the permissive work culture apparent within the initial SSDs during the 1970s and early 1980s.

Who Wants to be a Manager?

My experience of five managers over a period of four years helped to reveal what is an extremely demanding and unrewarding job. There are the benefits of an increased salary and status, although the salary is only marginally higher than a front line care manager. The manager is perpetually in demand, and her confinement to the office setting is all but permanent through the typical week. Such is the level of

responsibility, and again sheer scale of information to be processed, that the role requires the manager's presence to be maintained in the area office at all times. The only time when managers generally leave the building is when they attend the all-important panel (at which decisions are made to commission or reject care managers' applications for services), or perhaps attend a 'strategy meeting' with members of senior management.

Many of the care managers revealed a lack of desire to become a manager. The job was identified as generating too much stress and too few rewards:

> 'Who would want to do it? The pay isn't much better, you never meet clients, you're stuck in the office and nobody really likes you.' Paul T4

> 'I don't think you have much freedom as a manager, and there is so much expectation and responsibility. I mean look at Anne (manager) she's always so tired and fed up.' Ron T2

> 'I think it's much worst than our job. You never get to leave the office, and they (managers) always appear to be staring into their computers and typing. And of course you would have to deal with the likes of us, hardly a picnic!... I'd like Ken's (senior manager) job however, because you're away from all the trouble. I mean we never see him' Bill T4

'I would find it extremely frustrating to be a manager. If there is not a crisis outside (the department) then there is more than likely to be one inside. Absenteeism, stress, us lot (care managers) always moaning!' Debbie T4

'She's (manager) always stressed out and unhappy, who would want that every day?' Adam T1

There is an acknowledgement then from care managers of the stressful nature of their supervisor's role. There is also a recognition that times have changed considerably over recent years, and the job of manager has changed as much as that of the social worker. The pressure upon departments has intensified due to chronic under funding and increasing demand for the few services available, and the front line manager holds responsibility for the performance of staff. Inevitably complaints, both formal (written) and informal (vocal), are regularly dealt with from clients, next of kin, friends or even, at times, other professionals. The front-line manager has to account for all her staff, and inevitably the refusal of the department to fund services that are often essential to accommodate a vulnerable person in the community.

The managers' role then has changed with all the reforms, not least due to increased expectations and the fact that there are now far more tasks to be completed. As with the care managers much of this change translates into vast quantities of information to process, and inevitably the ominous plethora of forms always waiting to be completed.

Managing Bureaucracy

More than managing people as such, front-line managers are more likely to dedicate most of their time to the management of information. As discussed in the last chapter, increased emphasis on performance indicators, notably of front-line staff and teams in general, has meant that careful consideration is given to collecting information regarding tasks completed by care managers. Thus managers are always keen to gather data in relation to employee case work, dates of relevant assessments and reviews completed, as well as any other "indicators" such as referrals made by a care manager, to who and when? Most of this information is collected in formal supervision sessions and is immediately placed on computer. Unlike many front-line care managers, team leaders always have a computer, and it is here that most of their collected information on "performance" is carefully stored:

'Anything that can be measured is placed on the computer. The time between a case being allocated (to a care manager) and an assessment, or allocation and when a service is commissioned is collected. But you can't really quantify the quality of the assessment, so we don't bother with that'. Bill, manager Physically Disability Team

As discussed in the last chapter the collection and processing of such information became an established process after the 'Best Value' programme was introduced. Data collection was stressed as an essential part of the organisation regarding the need to 'get as many [perfomance] stars as possible for the authority' as one manager put it. Client files, rather than the quality or presence of their services or problems, appeared

to suddenly become the concern of managers and their supervisors. One manager stressed to me the pressure she was now under 'to come up with good figures' in relation to how many assessments or reviews were completed in as short a time as possible. Such pressure she argued did not persist for the *quantity* of services provided however, rather the completion of the procedural forms was really all that appeared to matter. In one union meeting that I attended a care manager voiced the conflicting interest that the star ratings generated:

> 'It's common knowledge that if the authority are put on 'special measures' [poor performer] then the people at the top get the sack or move on and the council is then given additional resources for services. Many of us would like this, but managers appear to want as high a rating as possible in order to maintain or further their careers'.

If this claim is true then it is clear that an intense conflict of interest would appear to be structured between managers and their subordinates as to what interests are now served through the organisation. Some colleagues went further and suggested that a conspiracy persisted regarding the social service inspection process, which they argued was deliberately prepared for prior to any visit from the inspectors. Thus a warning of a visit from inspectors was implied, in response to which well-maintained files of 'happy clients with lots of services' would be deliberately prepared. Although much of this information appeared to be speculative, it was clear that the structure of work in relation to the new audit culture generated a further conflict of interests between managers at all levels but particularly those 'at the top', care managers and their clients. The process also appeared to ignore issues in relation to resources and

quality of services available, preparing instead to stress the quantification of working procedures. Many managers however were themselves sceptical of the whole project, as the following detailed:

> 'It's [best value] a bit of a joke really, we just spend more time doing less social work and instead completing endless reports, working on 'strategies' and collecting information such as dates [of assessment] from care managers...My friend works in a bank and she can't believe what we actually do in social services – she believes I am describing the job of an accountant or merchant banker, only without the salary!' Dave team manager children services T5

When a case is allocated to a care manager it has normally been ranked according to how much work (and time) it is likely to generate, so that careful consideration can be given as to whether the employee is getting on with their job or not. The distinct stages in the care management process (referral/assessment/care plan/ review), and the fact that each stage has its relevant form, also allow the careful monitoring of an individual employee's use of time. In essence the surveillance process does not rely upon an individual manager's competence to manage, instead it makes such a pivotal role easy through such scientific measures that consider rank (of difficulty of case allocated), process (of time taken to complete relevant forms), and a need for the analysis of such data collected. Although social work's role in the surveillance of client activity has long been acknowledged (Jones, 1983), it would appear that watching the activities of people *within* the organisation is now just as important.

Managers must also process a high number of referrals that come into the department each week by post, telephone or fax. There is always a high number of cases waiting allocation, and such is the back log that many clients eventually passed to a care manager have waited up to two years before receiving any formal attention. Inevitably a client awaiting such allocation will become frustrated, as will their relatives, and hence managers spend much of their time writing formal letters in response to complaints.

Supervision

Formal supervision is an important part of the manager's role. Typically a care manager will receive supervision every two weeks, and it will usually last around two hours. The nature of supervision has changed with the creation of the care management process, and there is now less time spent on issues related to client need or staff anxieties. Instead supervision provides an important period of time in which a care manager's performance is carefully scrutinised and assessed.

As argued in the previous chapter care management is essentially a collection or chain of bureaucratic tasks. Most of these tasks translate into relevant forms to complete, one following another. Once such forms have been completed they then go inside an ever-expanding client case file. The labyrinth of bureaucratic tasks to complete mean that managers are always keen to scrutinise case files during supervision. Essentially if a task has been completed there will be a relevant completed form present in the file. This process has been encouraged by the need for performance indicators,

although it was also apparent prior to the advent of 'best value', as I noticed when training on placement prior to qualification. Form completion as 'evidence' of task completion means that surveillance does not need to be visible at all times, rather the many forms themselves maintain much of the surveillance of the care manager, as a manager may ask to see them at any point during the week (Carey, 2003).

Managers ensure that care managers carry their numerous files into their personal office prior to supervision. Once supervision begins there is an almost immediate desire for managers to root through files in order to ensure that relevant paperwork has been completed. Thus topics of discussion that might have typically been addressed throughout supervision in the 'days of social work', such as clients' emotional or physical needs, are no longer of much relevance to the culture of care management. Indeed such issues are now all but obsolete, a quaint tradition of the past which now appears increasingly redundant. Instead supervision sessions are dominated by discussions of whether relevant forms have been completed, and if so what is the quality of the information gathered and how long did it take to complete?

Supervision therefore often provides a stressful experience for the care manager, who will always have to ensure that their files are in order and up to date prior to the event. Inevitably it is not an occasion or ritual that is enjoyed by team members:

'years ago we would discuss our circumstances or the issues that we addressed as social workers - particularly regarding clients. Now such issues are barely mentioned; we are simply giving out dates of reviews or stipulating whether our cases are 'active' or 'non-active', and having our files checked.' Claire T5

'Personally I resent having my files checked every couple of weeks. I am a little untidy, which in the past was a source of humour to the team, but now we have become so 'anal' -everything is in its place. Again we are being treated like children' Jane T5

'I don't feel the current culture of work is fair on some excellent social workers. Look at Lisa [colleague] her desk is a mess because she is very untidy but she is also very competent and committed to her work.... She [manager] just wants everything tidy and in order and ready to go on to her computer.' Barbara T3

Not everyone agreed however, and some workers appreciated supervision because it helped them to become 'more organised'.

Another topic to be addressed in supervision will inevitably include any new allocations. It is here that potential for conflict exists as a manager is always keen for practitioners to take on more work, regardless of how much they are already carrying. Inevitably care managers will have to justify with good reason any attempt to refuse new cases, and they are rarely successful. A distinction is usually drawn by managers between cases that are 'active' and 'non-active'. Inevitably if a care manager is not carrying enough active cases, regarding clients that still require work completed, then new allocations are inevitable. The manager wants as much work processed as possible so is always keen to allocate. There exists pressure to hurry work, and the

luxury of any complex assessment of need or appropriate review required for a client is bypassed.

Inevitably due to such surveillance-orientated dynamics persisting within social service departments managers are often uneasy and uncomfortable about many aspects of their role. Indeed of my five managers, two went absent for a couple of months with stress. This included one manager who had a "complete breakdown". The pressure on managers is therefore extreme, and many struggle to cope with the responsibility and high expectations that their job imposes.

I'm as Deskilled as the Care Manager

Inevitably due to the extent of the bureaucracy (faxing/photocopying/telephone calls) and paperwork (reports/forms/letters) that managers have to complete, it can be argued that they are just as deskilled as the care managers. Indeed one manager made this point to me during my third placement, declaring that she was 'as deskilled as the care managers'. The role of manager requires only very limited technical skill, and knowledge of procedures again appears to supersede all other priorities. As with the care manager routine and ritual are important aspects of the job, and there is again an inevitable duplication of mundane tasks throughout the day for the team leader. Indeed it could be reasonably argued that managers are actually more deskilled than care managers, since they have no real involvement in procedures such as the assessment or review, and any contact with clients or other professionals becomes a rare event.

The extent of predictability and routine for managers brings to question claims that care management has allowed Taylorism to enter the world of social work. Although managers do plan and supervise staff, they are rarely able to utilise adept skills, or draw from pools of knowledge in order to complete their predictable and mundane chores. Indeed one of my managers had come directly from a charity before she began to manage in my statutory social work team. Despite no experience of care management or statutory social work she was able to pick up her role as team leader in a matter of weeks, and was soon considered to be a competent practitioner. This experience was remarkably similar to that of newly qualified practitioners who enter care management straight from college, and regularly become as able at their new role as care managers who have practised for many years. Thus the deskilling through a simple breakdown of predictable and easily learnt tasks appears to have as much relevance to the front-line manager as the care manager.

There was recognition from some managers of the changing nature of their work. As well as the claim that managers are just as deskilled as care managers, another remarked about his image to clients and other people outside:

> 'I think we are just faceless bureaucrats to a lot of people who come into contact with us. I think many people who come into contact with us also believe we lack compassion...I, like all of us, have my own problems at home, and I don't have time to worry about other people' Mark, Looked After Children team manager T1

There is then recognition, even from managers, that their role has detached itself from the ambitious claims of government, academic publications and official leaflets. That social work has struggled to project itself as a compassionate profession is not merely an opinion held by many members of the public, it is also recognised as being limited in scope by the very people that provide the service. It is rare to hear rhetorical idioms such as inclusion or empowerment in a typical social service department, and such words are never spoken by managers when they meet with care managers. In general, care managers and their supervisors view such rhetoric with extreme scepticism, for some they persist as values and beliefs that are detached from their own world of work.

Stress From Below

Inevitably with the responsibility that management brings there is also a backlash against the principles of management. Such resistance by care managers however is rarely political, such as protesting against the rationing of services for clients or the surveillance of staff. As suggested in chapter 3, such stances are rare, and instead resistance is more likely to concern individual grievances regarding absenteeism; access to benefits such as holiday or sickness pay, or, in relation to attempts by care managers to keep their work loads at a reasonable level.

There were a number of conflicts between an individual member of staff and their manager during my placements. Despite this, such instances were isolated and ran only for a short period of time before being resolved. On a couple of occasions an argument broke out in the team office between a team member and her manager when

other people were present. However the conflict was always resolved on the day, and on each occasion any argument was related to the stressful working conditions in which people were confined. It was however just as common for arguments to erupt between care managers themselves; again such strife was related to the stressful working environment in which people were placed and the tension generated by heavy caseloads to process.

There was never an occasion during this research when a group or team joined together to confront management, despite there being a wide range of potential issues on which grievances could have been expressed. Policy was always accepted, and the only evidence of substantive resistance remained the moaning that persisted between team members. Despite this it was apparent that a 'healthy scepticism' existed towards management, although there were no means by which any resistance was articulated. In general people simply opted for 'an easy life' and continued with their tasks whilst grumbling to one another on occasion.

Despite moaning about their managers, care managers were clearly dependent upon their supervisor for advice. During the two occasions when a manager went absent my colleagues went to great lengths to try to get a replacement from their senior manager. I was informed that they felt 'vulnerable' without a manager and 'needed somebody to be there in case something went wrong'. In other words despite all the individual complaints about managerial competence and role, many care managers actually needed the presence of a manager, and felt vulnerable if one was absent. Such a paradox is not unusual. For example, in my last chapter I noted how care managers

often articulated the extent of their deskilling, whilst later they were keen to express their cherished sense of professionalism.

From the point of view of front-line managers themselves I was informed that care managers prove 'a difficult group to manage'. Team members originate from a range of backgrounds and diversity appears to epitomise the occupation. On a number of occasions, usually in supervision, a manager would complain about her difficulties in attempts to 'control so many egos'. As I have previously suggested there is a clear distinction to be made between staff with a permanent contract, and the increasing number of short term agency staff. In essence it is more difficult for managers to be confrontational or strict with permanent staff, as they possess a considerable amount of potential to resist such schemes. As one care manager so astutely noted, 'there's no point in trying the strong management way because [permanent staff] will just go off sick' (Paul, T4). This option however is not available to agency staff, and therefore their power to opt for this form of resistance is significantly less. Agency staff only require one week's notice prior to their contract being terminated by a front-line manager. It was not unusual for agency staff to experience such sudden dismissals, usually because their paperwork was not in order or completed on time. For permanent staff a lengthy process of verbal warnings and official meetings with senior managers will need to precede any attempts at dismissal. I never witnessed a permanent member of staff being dismissed by a line-manager, despite the fact that some were not committed to their work. I discovered that due to their position, agency staff usually have little choice but to accept any new cases allocated to them, and typically carry more cases than many permanent members of staff. It was also apparent that some members of staff had more confidence and were more assertive

than others in resisting new allocations, which meant that other care managers (including some permanent staff) with less confidence at times carried considerable caseloads.

The restricted power that front-line managers hold over most permanent staff (who in general made up at least two thirds of teams in which I was based) however throws into question many of the assumptions of New Managerialism, and illustrates that such attempts at confrontational approaches, as are more apparent in the private sector, are not always successful. The permanent contract offers the care manager a substantial source of protection from 'strong management', and it is likely that this is why such contracts are now becoming increasingly rare in contrast to more 'flexible', but expensive, agency staff.

The Team Meeting

Team meetings involve care managers and their front-line manager, who chairs the meeting, and are intended to discuss any issues in relation to work. Despite this the team meeting is of interest because it is here that the local authorities policies are usually communicated to care managers. The many changes (regarding policy and procedure) that epitomise social work and care management mean that such meetings are important regular events. Meetings usually took place once every three weeks on my placements, lasted for two hours, and provided a potential arena in which staff could respond to council policy or air any other concerns. Much of the content of meetings related to the increasing rationing of services, as well as related policy issues such as the general 'selling off' of local authority services, such as day centres and

residential or nursing homes. This was a common policy in all of the authorities where I worked, and is acknowledged as indicative of the establishment of a quasi-market of social care in Britain (Sharkey, 2000: 10-18). Each month we were usually informed by our manager of a new local authority residential home or day centre that was being "sold off" to the private sector or closed down. Research from the Department of Health has revealed that between 1979 and 2000, the number of NHS nursing home beds decreased from 480 000 to 189 000. In contrast, between 1983 and 2000, nursing home beds in the private sector increased from 23 000 to 193 000 (Kerrison and Pollock, 2001: 566).

Policy and references to such events as 'restructuring', which usually meant a move to a new building and a possible merger with another team, rarely received much response from team members. This was not however due to a lack of concern, instead such had been the fast pace of change over recent years that most staff felt 'punch drunk' and had learnt to simply accept change as now being an intrinsic part of the culture of their organisation. The increasingly clearly defined eligibility criteria in teams 4 and 5 provided a classic example, which over my two years there became more and more aggressive in its exclusion of vulnerable people. Despite this staff members simply accepted the policy, and there was no vocal resistance given to such an openly oppressive policy. For the most part care managers sat around in a circle for the team meetings looking as bored and tired as usual. The perpetual burden of 'bad news' continued during placements, usually related to the authority attempting to save money and make cuts.

The nature of the discourse and vocabularies used within meetings were of particular interest, because as in supervision, the language of the market became an ever increasingly dominant vernacular at such gatherings.

The Business Vernacular

Inevitably with the establishment of a quasi-business of social work or care, notably regarding the purchaser/provider split and the proliferation of independent sector providers of services, a business vernacular soon became an important part of the culture of care management. Team meetings, supervision or simply individual conversations between manager and team members contained many references to business idioms. These included off-hand references to strategies, quality, contracts, team spirit, touching base, cost, efficiency, 'agile' offices or re-structuring. Whereas care managers rarely communicated in such a vernacular, front-line managers appeared to have internalised the language of the market.

Despite their regular use of business language, many managers at times appeared uneasy about their often-brutal decisions to refuse support to clients. Policy continued to drift further and further to the right during all of my placements, particularly as money to purchase services for clients became more and more scarce. Despite this, the measures continued to receive no resistance, and indeed continued full steam ahead.

Business ideas were not simply restricted to a use of words however. Care managers regularly worked on tasks that, as one colleague put it, '[were] supposed to be the

work of accountants' (Bill, T2). Care managers argued that they were not trained to complete financial assessments, or wrestle with the often-complex maths required to construct the total annual cost of a care plan for the panel to consider. As eligibility criterion became more clearly defined, and resources more scarce, panels would demand, via the front-line manager, that care managers should provide more and more financial and a range of personal data on clients and prospective care packages for them to consider. It was also stressed that 'cheaper options' should always be searched for from other providers of housing or support, and so forth.

Our Burden of Need

One of the consequences of the firm business stance taken by front-managers was an apparent lack of concern given to people in need. Care managers regularly referred to their managers as being 'uncaring' or 'heartless', particularly when they regularly made instinctive references to 'the budget' or 'cost' when a demand for an essential service was made. Many managers appeared to establish an unemotional guard or mask behind which they hid throughout the day. Some however even claimed that they were still providing for all those in need, even when it was abundantly clear from everyday evidence that this was not the case. This suggests more than a little denial in the managerial strategy to cope with the daily high stress levels.

Some managers in the five teams also seemed to suggest that client need was an annoying burden on the department. 'Oh not him again' would come the cry from a manager informed that a relative was demanding formal support on the other end of a telephone. Such responses were relatively common and suggested that the interests of

'the corporation', as some care managers called their authority, were the primary concern. Inevitably care managers were often quick to criticise their managers:

> 'I think there are times when she can appear caring, but plenty when she is without emotion and heartless.' Paula T5

> 'She's just a typical manager; they're all the same aren't they? All they care about is their precious budget or their career.' Lisa T3

> 'I think once you become a manger then that's it, you are voting with your feet. The interests of the organisation become before all else and bugger the clients or staff!' Anne T1

> 'As a care manager you're fighting your employers to access services. But all we can do really is put the application in the panel basket. Despite this it is your manager who takes the applications to the panel and, ultimately decides there and then whether to argue for your case.... the manager has rarely met the client, and did not carry out the assessment. This is not the way it was supposed to work according to the (NHS+CC) Act!' Tom T5

The argument that clients were "too dependant" on services was used during supervision and team meetings, and according to one of my managers it was a 'very popular [idea] with the director'. There was also the belief expressed that too much was often expected of social services by clients and their families. Social services,

according to one manager, was only one part of a number of council agencies providing support, yet expectations were rarely as high for other providers:

> 'Years ago social work made grand claims of its potential to support people, indeed many outside the profession still do. People assume that anyone in need or who is disabled etc must be provided for by us. But we are not the only sector of the council that helps in the community'. Bill, manager Physical Disability Team T5

Such opinions became increasingly common as the research progressed, and as I shall explore in chapter 6, there was an increasing emphasis on departmental and managerial attempts to transfer 'problems' to other sectors. When I was based in Team 5 this culture was referred to by a recently qualified GP as 'the merry-go-round', whereby due to economic forces clients would find that they were perpetually passed from one department to another.

There was also a pragmatic sobriety amongst managers, epitomised by the quote above, that also found sympathy with many care managers. The desire for an apparently 'sensible' attempt at departmental prudence appeared to imply that the responsibility of departments was often considered an unfortunate chore, which in itself suggested that clients themselves, however vulnerable or disabled, were often viewed as a burden.

The Radical Right and the Dehumanising Organisation

Although little attention has been given in research and publication to the influence of the radical right *within* social services it was apparent during my placements that such beliefs were both evident and active at all levels of the departments. As well as the economic determination and pro-business ethics and actions expressed by managers, there were also popular beliefs regarding concepts such as dependence, and the moral obligations that clients and their family/friends should hold for themselves. It was also apparent that the longer a person had been part of the organisation, the more likely they were to express such views. This was most apparent in the clear distinction between many of the opinions expressed by students, and some long-term practitioners and most managers. This included the behaviour and attitudes expressed by most of my managers who were open about their attempts to avoid any contact with clients; explicit in their open desire to cut services currently available to a client or alternatively provide no services if possible. Such actions would allow the right impression to be given to senior-managers, and 'career obsessed' front-line managers, as they were generally referred to by care managers. Students were more likely to discuss issues relating to tolerance, or care and support for clients (although this could be cynically interpreted as the students trying to fulfil placement competencies), whilst the seasoned care managers were often more cynical and sceptical about such stances.

One possible explanation for such a contrasting set of stances, relates to a trend that I found more evidence for and is revealed throughout my findings. That is, the social service department appears to encourage a dehumanising culture that allows

resentment and intolerance to prevail for many of the people that are exposed to the 'institution' for a long period of time. It literally grinds people down, and takes from them any hope, optimism and positive beliefs they may have previously held. The bureaucracy and lack of funding play a key role in generating an almost 'misanthropic virus' to prevail within the structures of the building, one that manages to encourage a person to transform their original concern and empathy for clients, into a distrust and resentment for vulnerable and oppressed people. Such reactionary discourses as that of 'dependency' both reflect and add to this process, but most of the damage is caused by a day-to-day engagement with banal and repetitive tasks, as well as the high-pressure stresses that work intensification involves. This process was not lost on the practitioners themselves:

'The job wears you out and takes any sympathy or patience away. I remember when I first started and would always offer clients lifts to meetings or back to their home or whatever. Now like most people I don't bother, and quite frankly I get annoyed when I get pestered on the phone by such people, especially when I have so much to do.' Lisa T3

'You begin to resent people, colleagues included, as you become more and more frustrated with the job. I meet up with some of my old (health) colleagues at the hospital and they look healthier and are more upbeat and happy... But they are still out working in the community, and they don't have anything like our workloads, it's easy for them to appear so upbeat.' Ruth T5

It was also apparent that some workers were ambitious, possibly from the beginnings of their career, and simply did not care about clients or their apparent problems. Some workers appeared to thrive in the intensifying business culture that was being created. Some were quite open about their feelings:

> 'I think the people we serve should try to help themselves a little more, stop expecting help from everyone around. If you don't like the benefits you are receiving, why not simply get a job!' Tony, Looked after Children (LAC) Social Worker T5

> 'I'm really fed up with the hassle I get from homeless people close to the shops where I live. I don't understand why they don't simply do something about their predicament?' Claire, Student Social Worker T3

> 'I'm not really that interested in a child once they go into a [children's] home. The less I see of these little horrors the easier my life is made. Some colleagues don't even want to bother responding to allegations [of abuse], I mean at least I'm not that bad.' Rob, LAC Social Worker T4

Bouts of Compassion

Nevertheless there were occasions when managers revealed their sympathies for clients, or indeed expressed doubts towards the more extreme policies that appeared to be becoming increasingly common throughout my placements. There were occasions when people were reduced to tears and were clearly disheartened by the

apparent cruel decisions made at panel, or by those in charge of the budget. When 'cut back' policies were unveiled in team meetings, such as the tightening of the all important eligibility (for services) criteria, some managers would state that they did not agree with the policy, or that they did not believe 'that the council would get away with it'. Of course the council always did get away with it, since, as I'm sure many who made such decisions were aware, the very people we served rarely attempted to access "legal aid" in order to challenge such decisions, or offer any other form of resistance. That we tended to serve predominately vulnerable people living in poverty, who traditionally do not challenge decisions made by organisations such as health and social services, was a fact not lost on panel members or many other people within social services.

Managers did at times express their concern for care managers when it was apparent that they were under considerable stress. Sympathy and support were evident within the team, although it did not necessarily last for long. This was most notable during times of staff absenteeism, when, despite initial concern, some front-line managers would increasingly become keen for people to return to work regardless of their domestic or health status.

Control Techniques

Inevitably managers appreciated their role as supervisors, and accepted the need to monitor and challenge staff who defied the procedures and principles of the organisation. As acknowledged above, files and bureaucracy offered an important source of staff surveillance and control, and anyone who appeared slow to proceed

with necessary paperwork, or indeed appeared to be completing them incorrectly, would always be confronted in a tactful but effective manner. Letters written by care managers always needed to be formal, brief and appropriate to the occasion, and there existed strict office protocol in relation to a range of tasks such as how to write a letter or answer a telephone (see appendix 2). Assessment forms were always completed in an attempt to collate as much information as possible, often regardless of whether money was left to purchase a service for the client, which itself appeared as a peripheral concern.

Time keeping and attendance was also an important area monitored by managers, and each visit outside of the building would need to be brief and fully justified. Front-line managers monitored movement in and out of the building, and in some teams different technologies were introduced to monitor staff more accurately. For example, in Team 1 a digital 'clocking in' card was introduced, from which managers could print out the times that staff were outside the office building throughout the week In another team where a colleague of mine was based, mobile phones were given to care managers, and many received calls during assessments or meetings with clients from their manager who was apparently 'keen to check [their] safety'. A large blackboard was kept in the office of teams 3 and 5, and each member of staff was compelled to identify on the board where (and who) they were visiting, and when they were likely to return. Again managers watched this board throughout the day, often leaving their office just to check the board every hour or so. Staff surveillance and control was an important part of the manager's routine, and a key reason why staff often felt that they were 'treated like children'.

Participant Management

In theory, the participation of managers in case or duty work was not intended to be part of care management culture. Such work was, according to my managers, supposed to be the sole jurisdiction of care managers. Managers it had been assumed would dedicate their limited time to the monitoring of staff, procedures, policy and resources. This ideal however was rarely followed for three reasons. First, the intensification of bureaucratic work related to care management, second the high demand for services from clients, and an increase in such demand since the community care policy began in 1993. Third, and related to the first two points, the regular long-term staff absenteeism within care management teams, which often reached crisis point, that is where no staff other than employees hired from an agency were at work. Due to such factors managers would have little choice but to participate in duty work particularly, but also casework at times. Overall however most of a manager's time was still spent in her office, with periods of time spent on duty or case work being brief and hurried. Such work, as I will argue in chapter 7, was nearly always related to personal crisis experienced by clients living in the community, and thus demanded immediate attention.

When they assisted in duty or casework, managers might assist care managers by making important telephone calls or faxes, writing letters, attending case related meetings or completing assessments or reviews. This was never an ideal situation, but was a regular occurrence for the reasons noted above.

Conclusion

A number of important changes have been noted regarding the role of front-line managers since the studies of Parsloe (1981) and Pithouse (1987). First, relations between the manager and her team have tended to become increasingly formal and tenuous under care management. I could find little evidence of Pithouses's (ibid: 65) depiction of managers always 'hovering around' to offer support and advice to team members. Instead they were usually stuck in their office either talking on the telephone, or more likely typing on their keyboards or reading through case files. Indeed Pithouse's (1987: 64) depiction as management as a 'delicate game', which relied on support, sympathy and trust for team members, appears much less evident.

It has been argued that managers are themselves as deskilled as care managers, and usually will have an equal number of monotonous bureaucratic chores to complete through the working day. Consequently, as care managers were always keen to remind me, there is now 'a lack of support' on the front line. Employees are also, as one care manager put it, 'very isolated and alone'. This contrasts sharply with Parsloe's (ibid: 131) finding that policy, procedure and work standards were a peripheral concern of managers. My own findings suggest that such formal concerns are now of the highest priority in the typical social service department, arguably much more so than the provision of any essential services to clients. Instead policy and procedure, particularly concerning how information is collected and processed, appeared as the single most important task that care managers and social workers undertook.

It has also been found that like their staff, managers have now also lost much of their discretion. Again they are subjugated to an elaborate range of bureaucratic procedures that, in effect, almost make decisions for them. Thus the distinction drawn between managers and front-line staff in the Taylorist model is not as apparent for care management, since managers appear to experience as many of the deskilling forces as their subordinates. Despite this, procedures still allow a more disciplinary culture to prevail for managers, since supervision is always regular, and surveillance of forms and staff movements is now literally written into the very structure of the organisation. Thus the 'conception' role identified by Braverman (1974) for managers is apparent, only it significantly deskills the manager since the role is so firmly procedure based. There is also regular evidence that managers themselves engage in the 'execution' of work, although this is more incidental rather than planned.

Front-line management is not a role that is generally popular with many care managers. The job is viewed as boring and predictable, as well as requiring a considerable amount of responsibility. Overall the environment of work for care managers and their supervisors appears to be founded upon an elaborate and complex 'web' of procedures and instruction that is totally didactic and allows no sense of autonomy or creativity to prevail. Inevitably work stands to represent a burden to the employee, whose general compliance to regulation and procedure merely adds to their predicament. As I have already suggested many permanent (contract) workers had a degree of power with which to resist the constant changes (new procedures, less funding, reorganisations, and so forth) that appeared to further restrict their autonomy. Yet this rarely occurred, and workers complained to one another rather than organise

and confront their source of anxiety. In essence, such apathy merely made things worse.

Finally it has been argued that the marketisation of care, explored in the next chapter, as well as the deskilling and intensification of work processes, have encouraged a culture of intolerance to emerge in social work departments. A preoccupation with business like concerns for cost-cutting and economic prudence appears to have removed any desire to accommodate client need on behalf of what increasingly resembles a cynical organisation. This is further explored in the next chapter.

CHAPTER 5

BUDGETING WITHIN THE SOCIAL CARE INDUSTRY

Introduction

The past two chapters have presented care management and statutory social work as offering a distinct brand of formal care. In contrast to previous attempts to offer therapeutic, preventative or advocacy techniques (Coulshed, 1991; Thompson, 1993 Payne, 1997) as part of a broader range of social work practices with clients, it has been argued that care management has essentially disposed of such 'luxury' services, and instead has reduced the employee to little more than a confined bureaucrat or office clerk. It has also been argued that this experience has been repeated for care managers' front-line supervisors, who also find themselves trapped in a matrix of procedural instructions, which leaves them regularly moving from one tedious task to another throughout the working day.

Although a drive for accountability on behalf of central government has played an important part in this outcome, of more importance has been the conversion of social work into a business (Harris, 2002). As was argued in the first chapter, the transformation of social care into a quasi-market constituted a revolutionary cultural change for social work. The re-creation of the social worker as care manager was also part of broader events, such as an increasing emphasis upon limiting public expenditure, reducing public provision and increasing the role of the independent sector (Jones and Novak, 1993). Essentially social care and social work has gradually

become to resemble a business, and has moved substantially from its prior stance as an almost 'non-capitalist' industry:

> Social work offered a niche in [the] 'non-capitalist' sphere and accounting for the development of the social work business is inseparable from analysing the destabilisation of that niche and its subsequent transformation ...the culture of capitalism has colonised the public sector as business thinking and practices have crossed the public-private sector divide and been transplanted into activities such as social work. As a result social work has shifted to operating in accordance with a 'quasi-business discourse' within which the explicit or implicit assumption is that social work should, as far as possible, function as if it were a commercial business concerned with making profits. (Harris, 2002: 5)

Harris offers a compelling argument detailing the transformation of (statutory) social work into a business. He notes the lack of choice open to clients within the quasi-market and the poor quality of many services (ibid: 144-145); the unlikely outcome in practice that social workers will always seek the best (rather than easiest to arrange) forms of care for clients; the often time consuming and expensive process of arranging and establishing contracts of care by social workers (ibid: 146), and so forth. Harris (2002: 142) also notes how a small quasi-market scheme (or experiment) by Kent social services watched by Challis and Davies (1980), so impressed Griffiths that it influenced his white paper in 1988, which led to the NHS and CC Act, 1990. That is, a small study carried out in very different economic and political times led to

a nationwide policy (community care) fifteen years later, that differed significantly in relation to outcomes (Harris, 2002: 142).

However, despite his important publication, I believe Harris has overstated the role played by social work itself, and its status amongst other (independent sector) contenders within the business arena. My own research suggests that such has been the reduction of power, influence and discretion for care managers and social workers since the 'big-bang', as well as the impact of the deskilling and proletarianisation trends previously explored; that their role, and that of their organisation, is a generally low-status and peripheral part of the broader business empire (in relation to power and influence). The role of care managers and statutory social workers is now, for the most part, not concerned with social work, but instead with the *administration* of key parts of a vast 'social care industry'. Such administrative roles include (among many others) the assessment, care plan, and review processes, and the organisation and arrangement of financial affairs related to means tests, contracts, financial assessments and client charges. Whereas social work would once have dominated within the all important field of formal care as part of overall welfare *provision*, particularly when (prior to the 'big bang') most services were owned and run by social service departments themselves, it now merely monopolises clerical assistance to facilitate the running of what is an extensive (post-Fordist) service industry, which includes a range of 'new contenders' regarding service provision, mostly drawn from the independent sector. The clerical input of care managers provides essential support to the social care industry by completing core tasks such as the assessment and review as well as allowing negotiation to persist between various organisations and

individuals with often conflicting needs and wants (client, relatives, friends, health professionals, day centre managers, support workers, care home proprietors, and so forth). Care managers link together such fractions through their many procedures (telephone calls; assessment, letters, contracts, and so forth) and allow a degree of fluency to persist between various individuals, groups and what I term care 'outposts' or 'micro-institutions' (residential, nursing and children homes, day centres, supported accommodation and so forth). Social work's crucial administrative role is in direct contrast to social work's previous standing as an 'invisible trade' (Pithouse, 1987), which concentrated on working class families as the key client group (Jones, 1983), and provided occasional didactic or support centred client interventions in relation to group work, local authority care assistance and other forms of (peripheral) service provision.

As I shall argue in chapter 9, without the essential input of care managers the social care industry would struggle to function. It is also my belief that in relation to its *function,* they represent the most important workers within what is now a major British (service) industry. Despite this they still have limited power within the social care industry, and this I believe is due to their lack of political intelligence and motivation. This is not merely the fault of social workers however; in chapter 9 I will attempt to isolate many social work academics (as well as associations such as the British Association of Social Work [BASW], and the Association of Directors of Social Services [ADSS]) as being particularly guilty of poor and apolitical research and commentary that has for the most part failed to identify and support the traumas and stresses experienced by clients and front-line workers, and highlight the significant changes that have occurred in social care over the past twenty years.

Community Care and the Cost of Social Services

One of the distinguishing features of welfare legislation during the late 1940s was the neglect of community services for people with mental health problems, learning difficulties and the physically disabled (Means et al, 1992: 160). Such a diverse set of client groups tended to be accommodated in long stay institutions, although it has been acknowledged that their needs were still poorly funded in relation to children and the acute sick. Despite some legislative changes to remedy such a disparity, significant change was not evident until the 1980s (ibid: 161). During the mid 1980s concern over the dramatic increase of social security costs for residential and nursing home placements (Sharkey, 2000), and demographic pressures related to a rapid increase in the number of older people, encouraged the closing down of large mental handicap and psychiatric hospitals (Clements, 1996). Alongside the closures governments placed increased emphasis upon the provision of community care services (Symonds, 1998b).

As was discussed in chapter 1, a succession of reports, most notably by the Audit Commission (1986), and a white paper published in 1989 (Department of Health, 1989), led to local authority social service departments taking the lead in the community care reforms. Of particular interest was the eventually established care managers' role as 'enablers' of reform; attempts to reduce the role of SSDs in directly providing services; the subsequent encouragement of the independent sector in providing care services; and the transfer of financial responsibility from central government (Social Security) to local government (local authority) for the funding of

residential and nursing home placements. The final change concerning the transfer of responsibility for funding to local authorities would prove dramatic, particularly concerning the demographic pressures mounting on services regarding Britain's "ageing population" (Pritchard, 1995). Soon after the NHSCC Act (1990) began to be fully implemented within most local authorities during 1993, SSDs suddenly began to appreciate the high cost of residential and nursing home services, and realised the lack of resources available for many other services:

> ...curbing social security spending was at the heart of the government's policy. The community care measures imposed on the local authorities were used as a way of limiting or capping the increasing social security spending. However, within a matter of months many local authorities were finding it hard to meet the financial demands of community care. (Sharkey, 2000: 13).

The new responsibility of social service departments for residential and nursing care for Britain's "ageing population" would quickly result in vast portions of their budget being spent on such provision:

The figures below show the distribution of social service authority money for the 75-plus age group in England. As can be seen; nearly two thirds (64 per cent) of expenditure goes on residential and nursing home care (Audit Commission, 1997; 34):

Table 5.1: Distribution of social services budget for over 75s in England 1996

Residential Care:	46 per cent	
Nursing home care:	18 per cent	
Home Care:	28 per cent	
Day centres:	5 per cent	
Meals:	3 per cent	(Sharkey, 2000: 42)

Essentially the majority of community funding was spent on institutional forms of accommodation, particularly residential and nursing homes. In addition a lack of resources available to realise the rhetorical ambitions of community care legislation, particularly concerning providing support for people in their 'community' homes, would soon lead to measures carried out by SSDs, and their care managers, such as "charging" poor people for essential services; refusing formal care for those in need (Drakeford, 1998: 223-226); cutting established packages of care for clients or considering personal savings in more clearly defined means tests (Sharkey, 2000: 12-16). Such increasingly draconian measures implemented by SSDs led to accusations that social work was becoming defined by financial restrictions, which in turn were exploiting the rights of vulnerable people:

> ...an emphasis on managing budgets and living within their parameters has meant that service provision which had at least attempted to be needs led became budget led. 'Clients' who are legally entitled to services may find that they are refused them in practice because the department's allocations under a particular budget heading have been exhausted by meeting the claims of

> people who have come earlier in the queue...vulnerable people are finding their rights being whittled away without a meaningful struggle taking place over them. (Dominelli and Hoogvelt, 1997: 59)

The establishment of a quasi-market of care would also further add financial pressures upon local authorities. Of notable interest was the '85 per cent rule', whereby local authorities were compelled by central government under the NHSCC (1990) Act to purchase the vast majority of their services through the 'transition grant' from the independent sector, thus helping to establish a social care market in which private and voluntary sector services would eventually come to dominate. Care managers soon discovered in consequence that the appropriation of essential services for clients became increasingly difficult owing to the relative (high) cost of available services, and an increasing lack of resources. Such a scenario, which inevitably led to an intense rationing of services, inevitably generated tension between care managers and their clients (Jones and Novak, 1993).

Although individual social service teams typically found that they struggled to fund the demand for services in the community, gross expenditure on the Personal Social Services has increased dramatically over the past ten years. For example, over the ten-year period from 1989-90, gross expenditure on social services 'almost trebled in cash terms and more than doubled in real terms' (DOH, 2001: 1). In 1999-2000 gross expenditure was estimated at £12 billion, an increase of 11% on the previous year (ibid: 2).

However the figures only tell part of the story. Of particular significance is how the money is spent, and where the funds now tend to be targeted. Most notable is the fact that older people now receive approximately half of the total social services gross expenditure, with the majority being spent on independent sector residential and nursing homes (DOH, 2001). Typically a local authority will spend half of its gross expenditure for social services on residential and nursing provision. This proportion of expenditure is always increasing reflecting demographic pressures; for example, 'since 1998-99 gross expenditure (in cash terms) on residential provision has increased by 9%' (ibid: 3). Such provision has also changed significantly since the mid 1990s, most notably regarding who provides the care:

> …gross expenditure (in cash terms) on residential provision for older people in independent [residential and] nursing homes has increased by 12% since 1998-99 and has nearly trebled since 1994-95. In contrast, gross expenditure (in cash terms) for older people in local authority homes has remained static since 1998-99 and has fallen by 10% since 1994-95. (ibid: 3)

As previously noted, prior to the early 1990s such expenditure did not come out of the social services budget, but was instead funded centrally through the Department of Social Security (DSS). The rise in independent sector provision has also affected all client groups regarding social service provision. Children services, which together with older people account for approximately three quarters of total social services gross expenditure (ibid: 1), has experienced the same rise in independent sector, and fall in local authority, provision. Again the same trend of increased and dominant independent sector provision is evident for home care and day centre provision in the

community (ibid: 4-5). The table below illustrates the now dominant independent sector delivery of residential and nursing homes, as well as continuing decrease in what is now a peripheral local authority source of formal care support:

Table 5.2: Adults: Local authority supported residents in staffed residential and nursing care at 31 March 2002 (thousands)

	1997	1998	1999	2000	2001
All staffed homes	236.3	249.4	254.7	259.1	255.4
Local authority staffed	58.8	54.5	50	47.2	42.3
Independent residential	111.5	121.9	131.1	138	141.2
Independent nursing	66.1	73	73.5	73.9	71.8

(Adapted from DOH, 2002: 1)

As I have discovered from my practice, the cost of independent sector residential, nursing or children service provision is still high, despite the fact that most staff typically receive no more than a minimum wage. Pay for local authority care workers is (slightly) better but overall the social care industry is renowned for its extremely

low pay and high work loads (Community Care, 2003a), predominantly fulfilled by women (Community Care, 2000a). Prior to the introduction of the minimum wage, the Association for Residential Care (ARC) carried out research into the likely impact of the policy, and discovered the low pay that social care staff typically receive:

> The cost of a care home place would rise by more than 35 pounds a week in one-third of homes if a national minimum wage were set at 4.50 pounds an hour, according to preliminary results of a survey [of 314 care homes] by the ARC....Domiciliary care costs could rise by more than 1.50 pound an hour, if employees were obliged to pay staff 4.50 pound an hour, and day [centre] care could go up by more than 4 pound per day at such rates.
>
> The survey also revealed that some employers are paying extremely low wages. Three of the respondents claimed a minimum wage of 2.50 pounds an hour would have a 'significant' effect, defined as a rise of between 10 and 35 pounds a week for residential care. One said there would be a 'major' effect, an increase of over 35 pounds, at this level (Community Care, 2000b: 5).

An earlier article further highlighted the extremely low pay that epitomises the sector:

> Most care workers and voluntary staff will be better off if the government accepts a minimum wage recommendation of 3.60 pounds an hour....Care workers, who are among the poorest paid in the UK, earn an average of between 3 and 3.50 pounds an hour [less than 7, 000 pounds per year],

according to the National Care Homes Association. (Community Care 2000c: 3)

In general, local authority carers are paid at least 2 pounds more per hour for their work, which helps to explain why their numbers continue to decrease in the quasi-market environment. For example, 60% of home care services in London were provided by the independent sector in 2002 (Community Care, 2003). Despite this, in relation to a recruitment crisis in social care that continues today, the Association of Directors of Social Services (ADSS) dismissed links between poor pay and recruitment:

> The ADSS said the problem was not just about money…The sector needed to revamp its image to boost recruitment, said Hilary Simon, spokesperson for the ADSS older people's committee…."At the end of the day it's not money that gets home care staff to work in the morning, it's about personal rewards." (Community Care, 2000a: 4)

My own research, including interviews with care workers and care managers who previously worked in such a job, suggests a very different scenario to that presented by the ADSS. They discussed their long work hours, lack of rewards, and wages that maintained them in debt and often struggling to buy bare necessities. Many had a lower standard of living than the clients that I detail in chapter 7, and throughout my fourth and fifth placements so bad were their working conditions and pay (despite the minimum wage) that many had left to work in recently opened supermarkets. Indeed

the recruitment crisis in social care was so bad towards the end of my last placement that few formal carers were regularly available from independent or local authority providers despite the fact that I had received some funding from panel.

In sum, the 'big bang' legislation of the late 1980s and early 1990s has allowed a lucrative independent sector (that relies on low wage female workers) to expand (Community Care, 2000b). This has particularly been the case for residential and nursing homes for older people, which have expanded significantly within the independent sector over the past twenty years, at the same time that responsibility for financing the sector moved from the DSS to local authorities (and came out of the social service budget). Kerrison and Pollock (2001: 566) detail the expansion of care homes in the independent sector since the late 1970s and early 1980s. For example between 1983 and 2000, the number of beds in this sector increased dramatically from 23 000 to 193 000; whilst local authority beds decreased from 480 000 to 189 000 between 1979 to 2000.

Resources were, according to the NHS and CC Act (1990), intended to support clients living in accommodation within the community. In practice, this has not been the case, and instead most funding is targeted into long-stay care homes (DOH, 2002). Such policy, which raises questions as to the sincerity of 'community care' reforms to support people 'in the community' (Means et al, 2003), and has led to criticism that the intended or claimed policy of 'de-institutionalisation', has in practice become one of 're-institutionalisation' (Sharkey, 2000).

The Social Care Industry and the Demise of Social Work

In many respects the formation and development of an industry of care over the course of the 1990s, which continues today, can be linked to broader economic and social trends. Of note is the decline of manufacturing, including traditional industries such as coal mining, textiles, steel and ship building, as a source of mass employment, and its gradual replacement by service sector industries such as finance, tourism, and retail (Massey, 1988). Although such a trend had been apparent since the late 1960s, by the 1980s the contrast between such 'industries' as a source of employment were stark:

> In the mid-1950s the UK had been perhaps more industrialised than any other country in history, with more workers in industry than in all services; yet by 1983 there were almost two service workers for every industrial worker. (Hall, 1991, quoted in Turner (1995: 3)

The policy of community care following the implementation of the NHS + CC Act (1990), as well as the encouragement of further marketisation of public care services offered by the Children's Act (1989), allowed a social care industry to develop which offered a valuable source of employment to regions throughout the UK. The care industry is composed of a disparate range of services scattered throughout regions but they are particularly prevalent in major cities. It is made up of residential, nursing, children's homes and supported living accommodation (or 'micro-institutions'), as well as day centres, nurseries and the many different independent domiciliary and support care companies. The industry is widespread and scattered, literally peppered around

the 'community', and as I have already explored, relies almost entirely upon 'minimum wage' female employees. My own research suggests that many such carers have few qualifications and as 'casualised' employees have limited rights related to maternity leave, holiday and sickness pay (Community Care, 2000b). In other words the care industry, to which care managers provide valuable administrative support, is one of the most exploitative industries to emerge in Britain over the past 20 years. It appears to function through the adept utility of 'sweatshop' female labour (Community Care, 2000b), and in the five teams that I worked, drew predominately from deprived communities in order to maintain what can be for some proprietors is a high profit industry of care. Kerrison and Pollock (2001: 566) note some of the disturbing consequences experienced abroad, which now appear to be imminent here, of moves to privatise social care:

> Experiences in the United States (US) and Australia have shown the lack of political will to promote the interests of residents against the interests of the industry and its shareholders. In Australia the industry successfully lobbied to replace legally enforceable regulations with less effective accreditation schemes; this has had disastrous consequences. In the US the industry successfully opposed the introduction of robust standards for minimum numbers of staff, and the result is continuously declining health outcomes for residents. The risks to residents of nursing homes in the UK are considerable as subsidiaries of large US multinationals enter the UK; some of these companies have come under scrutiny in the US for fraud and embezzlement of government funds and for abusing patients.

One of the important consequences that I have found from my research that flows from the establishment of a social care industry, has been the demise of social work. This is not merely the transformation of state social workers into care administrators, but also the broader rationalisation and proletarianisation of social care staff throughout the industry. An ever increasing emphasis on (NVQ influenced) rigid procedures and routine in unappealing working environments (Harris, 2002: 104); the low pay and status that defines the experience for many care workers (Community Care, 2000b); and the influence of quasi-market forces, and the aggressive profit motive that now so saturates the delivery of care services (Holden, 2002), have exploited proletarianised staff who gain little satisfaction from their work. The emphasis upon efficiency in such environments has, as with the care managers, helped to generate a despondency and apathy from staff who see their work as lacking stimulation (Community Care, 2003), and being about as appealing as factory work (Jones, 2001). The dehumanising impact of the procedure based 'care factories' encourages social care processes to become formal and contrived, and important human attributes for vulnerable people such as compassion and care become increasingly lacking as tired and despondent staff find themselves moving from one relentless chore to another (Scheper-Hughes, 1997: 20-22; Carey, 2003; Harris, 2002: 180-181).

I recall my own experiences of working in nursing homes in London and Swansea during the early 1990s. In one home staff were disciplined for "talking to residents" because they should have been "cleaning toilets instead". Such experiences have been regularly echoed elsewhere to me by both front-line care staff and care managers who later trained to be "social workers". They discuss or recount regularly being

encouraged to continually engage in domestic chores and ignore the 'customers' who reside in the properties:

> 'I worked in a residential home for older people a couple of times. Those places are awful, the old people are just placed in front of the telly for hours on end and nobody bothers to arrange a day out for them or offer much else in terms of stimulation.... They were treated like cattle' Rob T1

> 'They have always been depressing places but since they were privatised and taken from local authority control I did assume that they would change regarding better treatment for residents. In fact they have got much worse in my experience...I suppose days out cost money to the firm because you have to hire a coach and driver; cheaper to keep them in next to the television!' Jan T3

> 'I placed a child in a kids home a couple of months ago and it's costing the authority hundreds of pounds each week. But they haven't even bothered to find the poor child a school yet, and as I, and my colleagues, have discovered in the past, they won't bother unless we get on to them. But we simply don't have the time.' Jill Looked After Children's Team T5

> 'Most of the kids from these homes seem to end up in the prison system or working as prostitutes or whatever. The places are expensive but dreadful, the staff aren't interested in the kids and the owners never seem to be there.

Probably holidaying in Barbados or cleaning their new Jag.' Bill Looked After Children's Team T5

'The only motive for a social worker to open one of those places is greed. I believe you can clear all your initial expenses [to set up the home] in a year, and from then on you are rolling in money.' Tom T5

The experience is little different for residents, as the following extract from a children's home resident reveals:

> When I first went into care the children's home was OK, but after a while I discovered things were not as innocent as they looked. Every person in care has been through some bad experience or committed some wrongful act. We all believed that nobody cared about us, loved us or wanted us. This is the cause of most drug and alcohol abuse...It was mainly a way of coping with our problems. At a young age it's not easy to have faith in adults. That is how it was. There were social workers and care home staff but how can you build trust when they are forever moving on? ...There was no discipline, or if there was, I never noticed it. All I remember was pocket money being used to pay for anything we broke....Even now it's going on in children's homes, I've been in myself, nothing seems to have changed. 'Gary' (full name withheld) is in a young offenders institution. (Community Care, 2000d: 3)

The quote above, as well as the findings from research into services such as that provided by Morris (1998; 2000) and discussed later on, mean that questions remain

as to the purpose of interventions via institutions such as care homes (including local authority). They appear to often generate more problems than solutions, and are often little different in outcome for residents than the home environments from which such vulnerable children have apparently been emancipated (Morris, 2000).

Previous Studies

Parsloe (1981) makes a brief reference to the cuts in central government funding during the mid 1970s, that, in retrospect, as with the cuts of the first two Conservative administrations that followed during the 1980s, were mild in comparison to the financial predicaments that would later so dominate the activities of social work departments (Harris, 2002: 38). Despite this there is little reference in either Parsloe's or Pithouse's study of financial scarcity as a dominant concern of social work departments. Parsloe (ibid: 96-98) does however go on to briefly discuss issues relating to 'rationing', but this is as much related to prioritising work, as regards finding *time* available for individual cases. Such rationing she argues, is an inevitable consequence of the social work task:

> It is difficult to describe rationing without sounding critical. This is not my intention. There is no apparent limit on the work which teams could undertake if they had the resources, and so every team, even in the best conditions, must operate some form of rationing. (ibid: 96)

The author suggests a need for greater 'filtering' of work by departments. Interestingly her researchers could find no evidence of services being withdrawn from clients, itself now a regular occurrence in departments:

> Rationing by ending service was not something we observed in our study. However, most accounts of caseload management suggest that, before introducing a system of management, caseloads have to be pruned of cases no longer requiring or responding to social work help. (Parsloe, ibid: 98)

During this period, relations with managers, clients and colleagues appear as just as, if not more, important issues to front-line workers. Certainly Pithouse (1987) depicts political concerns and anxieties related to how social work is practised; why team dynamics evolve; and how practitioners consider supervision and management processes, as being just as important factors for the front-line practitioners. These remain the philosophical and pragmatic issues of interest to the skilled practitioners being observed, and are in contrast to later studies that articulate the establishment of a work culture motivated by procedure and economically determined priorities (Jones, 2001; Carey, 2003).

Hadley and Clough (1996) in their interviews with a range of health and social care professionals working in community care, depict a depressing sense of frustration and anxiety relating to work intensification and the perpetual rationing of increasingly finite resources in the public sector. What emerges from the interviews is that the rationing of services had now become the priority of both health and social care forms of welfare. Other objectives, such as providing support or accommodating need, were

now almost peripheral concerns, and such a culture had added considerable pressure to the lives of practitioners. One interview with a senior manager in a social service department illustrates the frustrations felt, and the wider implications for experiences outside of work. The pressures of work were now encouraging him to set up his own private care agency:

> …there was a significant cost to his home and family life. His wife would say that he was constantly whingeing when he got home and he knew that that's what he did - moan about the social services organisation….The senior manager's plan was to establish a private provider agency, employing his own care staff, which would give him 'an opportunity to deliver quality services in a way which was no longer possible, given current constraints, within social service departments'….This involved a complete mind change from work in social services where he had been trying to ration services; now he [*claimed* he] was trying to stimulate and develop them. (ibid: 38-39)

Jones's (2001) interviews with front-line care managers and social workers convey the same sense of anxiety and frustration; with the maintenance of a "budget" now apparently superseding any other priority that the organisation may wish to concern itself with:

> And of course I was regaled by talk of budgets, and not only their appalling paucity to meet the needs of clients, but also the manner in which budget management and control had become the key concern of the agency, stripping out its welfare ideals in the process….This is how one community care social

worker explained the difference: 'Being a care manager is very different from being a social worker as I had always thought of it. Care management is all about budgets and paperwork and the financial implications for the authority, whereas social work is about people. That's the crucial difference'. (ibid: 552-553)

There is then an evolution over the past thirty years, but one that has intensified since the late 1980s, of the social service department developing almost into an organisation that each year is increasingly more concerned with bureaucratic and financial priorities. The organisation appears to increasingly lack concern for either its employees or 'customers', preferring instead to target its attention and interests around farming information and saving money. Inevitably, as I have found with my interviews, care managers quickly become disillusioned with their 'craft', and work is perceived as a predictable set of routines that lack purpose.

Research Question

Part 3 of my research question in chapter 2 had asked whether 'budgets influence the role and practice of the care manager?'. I was concerned with the extent to which practice had become 'budget led', as commentators such as Dominelli and Hoogvelt (1997) and Jones (2001) had suggested. What were the consequences for the nature of social work? Has such an outcome led to further disenchantment with the role and identity of the occupation? And has it perhaps led to more de-skilling by reducing practitioners' discretion further? However in consideration of the significant amount

of money spent on social services, perhaps practitioners were simply wasting valuable resources, as governments continued to imply (Sharkey, 2000: 3).

Budget Led Practice

As previously suggested practice in the five teams that I worked in was unquestionably budget led. Although social service teams and their care managers were all compelled to complete assessments of needs for new clients, it became increasingly rare for services to materialise in response to recognised need identified through the assessment. Following applications to the 'panel' (which are forwarded after the assessment is completed, then typically refused) care managers were encouraged to ask clients 'to look elsewhere for help'. More specifically, care managers were asked by their front-line managers, or members of the panel, to encourage close family members (who are nearly always women in practice) to provide any requested support. This is despite the fact that clients are rarely referred to social services without being in a position of personal crisis, that is they are typically either living alone or with a disabled or elderly relative. However, team 3 was an exception to this trend, and care packages were more readily commissioned within the hospital that I worked. This I believe was due to 'bed blocking', which at the time was a concern to the trust, and care managers within team 3 played an important role in speeding up the discharge process by establishing small but temporary (usually 6 weeks assistance with cooking/cleaning) care packages at home for recently discharged patients.

Each team tended to behave differently regarding the lack of available funding to support services. For example, when I worked in Team 1, an inner London older people's team, there were some funds available to commission essential services. This at times included services in the community, but most of the resources were tied up in providing long-term placements in private sector nursing and residential placements. During my spell with the authority, attempts were continuously being made by the authority to define more clearly who would be allowed into a permanent placement in either a nursing or residential home. For example, a new eligibility 'rule' emerged at the time within the department, which decreed that unless a person required two people to help them transfer from a bed to a wheelchair, then they could not gain access to a nursing home. The 'two to transfer' rule openly excluded many clients with nursing care needs, and was introduced, as my manager pointed out, 'to save money'. This rule was also active within the authorities in which I later worked.

My community placements with two learning difficulties teams (T4 and 5) brought me into a new environment of extreme resource scarcity. Learning and physical disability, despite the infinite rhetoric of compassion and empowerment generated by social services, is in practice considered 'low priority' in comparison to older people and children services. Within teams 4 and 5 this point was made abundantly clear. It was rare for any of my applications at panel to lead to a service being commissioned, despite the fact that each application concerned clients who were in real danger of physical or psychological harm in the community without such support. Typically, potential dangers for clients made apparent to the panel included the possibility of physical harm or sexual abuse, but such hazards appeared to make no difference to the outcome. 'The panel members believe our clients are too dependent'

was how one manager helped to explain my latest rejected application to the panel board.

Again practitioners feel frustrated. Their jobs become a series of bureaucratic routines, such as the completion of the assessment and panel applications, only for no tangible outcome to emerge regarding any services provided for a client:

'We fill out those dreadful forms with pages and pages of information and then our applications are each week rejected. What the hell is the point?' Anne T1

'The position you're put in is extremely difficult. The client or family are overjoyed that after such a wait they are finally getting a visit from a social worker. Then with all the questions about needs asked [on the assessment form] it gives the impression, no *expectation*, that something is coming. Then you ring up and have to tell them that there's nothing available and the panel rejected the application. I've been screamed and shouted at and had people crying or begging for help, but what can I do? Then you may see someone from the [client's] family in the street and they either stare or come over and confront you. I had a man screaming at me once in the middle of the [shopping] precinct because we refused services to his [disabled] daughter, everyone was looking over' Lisa T3

'Its fine for the panel [members] to tell us to go away and tell the client to go elsewhere, but we have to face these people throughout the week, usually by

phone. It really grinds you down working for a council that appears not to care' Fiona T1

'Getting anything out of this department is like trying to get blood out of a stone. Sometimes I just feel like being honest and saying 'look we have no money; you have no chance of receiving *anything* from us!' Debbie T1

> 'As well as all the other pressures we have to contend with we also have to cope with people crying on the ends of the phone, and the sometimes daily abuse from relatives who are livid that we are not providing for the client.' Ronnie T4

References to the budget dominated team meetings and supervision sessions, with managers regularly making reference to the fact that the authority 'has no money'. Despite the fact that each financial year begins in April, it is not unusual for departments to be without funding by September or October. There is however always some funding kept aside for emergency cases that come to the attention of the 'duty' officer, and it is through the duty process (sudden emergency issues such as physical accidents on behalf of clients or the hospitalisation or breakdown of a carer) that most services were accessed by the time of my last placement.

Scrutinising Need

Budget scarcity has many implications for practitioners. One of the most apparent remains the pressure on departments and managers to justify their refusal of services

to clients. This has in many ways become one of the key roles that managers and departments engage in within their "strategies". The introduction of 'eligibility [for services] criteria' throughout the 1990s was part of a clear attempt by social service departments to justify any reduction or withdrawal of services to clients. Indeed as time progressed more and more specific eligibility criteria were created by departments in order to make services increasingly difficult to access by clients (Sharkey, 2000: 68). The Audit Commission (1996) encouraged the principle of eligibility, and its purpose was soon apparent to all who worked within social services:

> ...it is through the eligibility criteria that resources are rationed, that is, 'need' is equated with 'resources available'. This mechanism severely limits the idea that provision can be determined either by need or by the right to services. (Sharkey, 2000: 13)

Soon after the NHS and CC Act (1990) was implemented the principle of eligibility quickly turned upside down the rhetoric of the Act which had implied that 'meeting need' was the underlying principle that care managers should seek to address (ibid: 12-14). Long-term practitioners spoke about the dramatic changes around the mid 1990s when practice was 'transformed' in a short period of time:

> 'Initially there appeared to be plenty of money around, particularly April 1993 when all the changes occurred. But then we quickly realised that we were running out of money and we were being told that we were being too generous. Then more essential services were literally 'banned', and as time

went on more and more services became out of reach. Now you [the client] are simply refused a service or you go on a never ending waiting list, which is essentially a refusal.' Carol T2

'To begin with cleaning [support services at home] was stopped, then social support, then cooking. Then we were told 'only washing and dressing allowed' like we were serving animals, and then that became almost impossible to access.' Gary T2

The assessment of need completed by care managers soon became a means to justify *refusing* services. Practitioners were encouraged by their front-line managers (in meetings/supervision) to be specific about following the many questions on the forms (appendix 1) so as to scrutinise whether help was really needed by a client. In effect the assessment soon became an interrogation of clients and their family members, the purpose being to find reasons not to provide a service. Clients and their relatives/friends would appear confused at the number of personal questions asked during the assessment, not realising that such questions were often present to entrap vulnerable people, as the following care manager argues:

'The [assessment] forms have tended to become more detailed and specific in their questioning of clients' needs over recent years. We are informed [by our manager] that this is in order to *target* support on those clients most in need. As anyone here [team] will tell you this is nonsense as it's just a means to *justify* providing nothing, and can provide a useful source of 'evidence' for the council if anyone dares take us to court' Carol T2

Review (of services) teams were also set up in order to specifically cut already existing services. Review officers (care managers) were encouraged by their managers to scrutinise people's needs via the review form (appendix 1) and support received, in the hope of reducing or cancelling existing care packages. Again clients and relatives/friends would attend the 'reviews' not realising that their purpose was to reduce any formal care currently received. When in T1 I was placed in such a review team, but was moved back to assessment after a month because I had failed to cut any services from the 15 or so reviews I had carried out. A colleague informed me that such an attitude and approach meant that I 'would never make it into management!' Despite this many of my colleagues were more successful with their "culls", and as the weeks progressed existing services would be "slashed" by review officers. Indeed in teams 1 and 2 (which dealt with older people), it appeared that more hard line and ambitious (or arguably naive) workers were often chosen for the review sections of the team(s).

Preparing for Panel

Following initial contact with a client and any members of their family, and the completion of the assessment form (usually at their home), it is then up to the care manager to decide whether an application to panel for services should be made. As previously detailed, as time has progressed, and resources have become increasingly scarce, front-line managers have insisted that panel applications must contain 'as much detail as possible'. Over time panel applications have gradually evolved into 'essays' regarding client need. As already identified however, such a large document,

which essentially describes and highlights client vulnerability, does not guarantee that an application will succeed.

Panel members earned a reputation amongst care managers as being 'ruthless', due to their persistent refusal to commission services. I discovered that the attitude of care managers was forthright and cynical, namely panel members (who were mostly senior managers) were seen as being interested in their 'careers and salaries', and couldn't care less about clients. Despite such cynicism, care managers were regularly reminded by their front-line managers that there remained 'no money available' to commission any services, unless they were urgent. In paradox, the refusal to commission services often led to client health risks (such as a fall) identified in the assessment (and panel essay) occurring on a future date, which would then lead to *more* services being commissioned through the duty system for such cases. Thus the rationing culture obstructed any preventative work being done, which in the long run meant that more money was spent attempting to accommodate accidents that could have been avoided. There were times however when such 'accidents' were fatal.

Writing panel documents took up a considerable amount of time, and drew from information collected at the assessment, over the telephone and through a variety of agents such as care providers, family members and health professionals. Care managers argued they if they had 'a reasonable chance' of success at panel then the 'tedious work' would be worthwhile:

> 'I usually do all my panel stuff on a Tuesday. It does take up a lot of time but it is the only way to get services.' Paula T5

'I put so much effort into the applications yet rarely see any reward. They appear to want to know everything … It's not easy gathering all the figures [for cost] and contacting relevant people [providers] in time. And of course whilst you are doing it you know full well that you are unlikely to receive anything' Tom T5

'I think if I knew there was reward at the end of it all it would make the whole business much easier. But doing all the work knowing full well that there is little money available just destroys your motivation and confidence.' Lisa T3

In my first three teams (older people) panel applications were only necessary for residential and nursing home applications; whereas care packages and day centre placements were usually considered for commissioning by the front-line manager. However in teams 4 and 5(learning disability) all applications for services needed to go through the panel. The older people's team in the same authority as T4 and 5 also needed to go through the panel for any service, and I believe that as resources for community services become more and more scarce, so panels will continue to scrutinise *any* application for services throughout the country. Such a trend also encourages a need for more and more information to be collected and presented by care managers.

Find the Cheapest

Inevitably in a resource driven organisation that attempts to cope with limited funding there is considerable pressure to find the cheapest available services. Thus there remains extreme pressure upon providers of services to cut costs considerably in order to increase their potential for attracting 'business' from care managers. As one senior manager in a large care provider (which supplied services to T4 and 5) pointed out to me, there was 'enormous pressure' on providers to make services as cheap as possible:

> 'Staff are normally our highest overhead and so we attempt to pay as little as possible if we can get away with it. But one of the problems of our 'minimum wage' policy to staff is that we struggle to recruit or just end up with people with no qualifications or experience. Many of my carers soon leave when they realise how much work is involved in supporting people, and they can earn more in Asda but with less stress.'

Another manager, this time from a private residential home, was more frank in describing the purpose of his organisation:

> 'We exist to make a profit and that is first and foremost in Dave's (owner) mind. We have a high turnover of staff due to the crap pay and working conditions but he [Dave] does not care because this place makes a lot of money. It's sad for the residents because they do get attached to people, especially the ones without any family, but, to be honest, I do not actually think Dave cares.' (John)

The impact of the demand for cheap services has been considerable for all providers. Some, which catered for specialist needs, have either fallen in number or disappeared altogether; as the following care managers argue:

'We used to have an excellent day centre specifically for Dementia sufferers run by the Alzheimer's Disease Society but that closed down a couple of years ago. Quite simply it was too expensive and we were eventually told not to use the site. But they provided an excellent service which was geared to the specific needs of the client group.' Wendy T1

'Finding homes that provide respite to schizophrenic sufferers is now almost impossible, and indeed many of our services have to be bought outside of the authority [if you can get funding]. One of my clients has to travel 40 miles each day to attend her day centre, and fortunately her dad agreed to take her each day, otherwise we [the authority] would not have paid for the taxi.... There is simply nothing any nearer, and the only way such a service can make money is if the building can be accessed by clients from 4 or 5 authorities nearby. It's the same with specialist day centres, whereas every authority would have had many prior to the changes [NHS and CC Act] now there is just one between many authorities... This also means that the demand is high and the waiting lists are likely to be long.' Paula T5

'I suppose the owners just think why bother opening a day centre for lonely or disabled old people when I can make far more money through a children's or nursing home? The services grow from where profit is available. It's very sad but I just have to tell Mr Roberts [client] 'I'm sorry you're lonely and suicidal in your damp flat but there's now a two year waiting list for the few day centres left [assuming it gets through panel].' Anne T1

The impact of the resource driven culture for care managers has led to a lack of quality services available for clients, and encouraged low-cost, and generally poor quality service providers, to flourish. It was apparent that profit had now superseded any attempts to provide quality services to vulnerable people. Despite this, there are still clients for whom councils are compelled to provide services, such as vulnerable children and older people requiring residential care. Such clients, with high risk or emergency needs, have helped to maintain providers in this sector to continue since quasi-market principles were introduced during the early 1990s. But such sectors have experienced substantial changes since the reforms in the early 1990s, and there has for some time been evidence of 'private monopoly' providers emerging (Kerrison and Harrison, 2001), despite the NHS and CC Acts (1990) *apparent* attempt to encourage competition among providers. Sharkey (2000: 41) notes how 'in 1998 the private medical insurer Bupa became the UK's biggest provider of residential and nursing homes'.

A recent article in community care highlighted Holden's (2002) research into the emergence of independent sector monopolies in the provision of care, and some of the consequences:

At local level many social workers may have noticed the growth of large commercial companies in the residential and nursing home market. New research [Holden, 2002] shows that a concentration of long-term care by large companies, some of them international, is occurring throughout the country… What do these changes mean for mean for social workers and service users?

First, increased movement between providers of long-term care may mean a lack of staff continuity and problems with morale. Both impact on residents. Their lives can be further disrupted by changes in the home's practices and systems. Some homes may not continue running and can close.

Second, there may be increasing standardisation across homes leading to reduced choices for residents. Homes run by one company generally have to conform to its ways of doing things. Staff may have less flexibility.

Third, Holden raises the possibility of a decline in quality of care. Concentration or monopoly provision can mean systems rely on regulation to ensure standards, but this may be undertaken at a low-level and thus miss important elements. (Community Care, 2002: 4)

Financial Assessments and Charges

Despite the fact that many sectors of the welfare state, such as education and health, are not allowed to charge people for their services, local authorities have the power to charge clients for services accessed through social work departments. This became legal under section 17 of the Health and Social Services and Social Security Adjudication Act 1983, and led to 95 per cent of local authorities charging clients for services, according to research carried out by Mencap in 1999 (Sharkey, 2000: 15). Charges are only a fraction of the overall cost of any service but to a person on benefits they normally represent a substantial part of their meagre income. For this reason it is not unusual for clients to refuse services they urgently need owing to a fear of further debt or anger at the policy, as the following care managers suggest:

'When charges came in I simply could not believe it. There was a lot of resistance by people but in the end the policy has stood. We've all had clients who refuse services once you mention the charges'. Karen T3

'With old people it's a particular problem because some are very careful with their limited income. Clients always moan about the bills that come through the door, many claim I never warned them, which I always do. I don't think it's fair but I think it's a small issue in comparison to many of our policies.' Adam T1

'The policy just makes us seem more and more uncaring, and I'm not surprised many clients resent us. I was happy as a support worker, now I have to face all this every day!' Claire T5

The financial assessments also tend to cause some problems. Such assessments are often carried out alongside the assessment of need and ask set questions from a form related to personal savings and benefits/income. The financial assessment is a form of means testing, and for many care managers it is a task that they do not feel should be part of their job:

'I resent all the accountancy type aspects to the job, all the figures we play with in working out costs of [care] packages and stuff like the financial assessment. I don't think it is social work, and I always feel uncomfortable asking an old woman to go and get her pension and bank book.' Jane T5

'I think most of us are uneasy about looking through people's bank statements and benefit books, and of course it does our reputation no favours. I mean they [clients] have so little money and yet are desperate for services that they assume are going to be free.' Liz T3

If a vulnerable person does refuse services due to the charging policy of the authority then there is little that a care manager can do. Some relatives agree to pay the fees but many clients have no immediate family and simply continue to live at home with a high risk of accidents or physical harm. Indeed I was informed that some care managers had left their posts because they could not sleep at night over worries for

clients' safety. It was also common for colleagues to tell me that they did not enjoy their weekend because they were worried about a client's safety.

Cutting Benefits

As well as the issue of charges, care managers also spoke about the difficulty they faced accessing benefits that not so along ago would have been relatively easy to appropriate for a client. This was particularly the case for disability benefits that were now proving increasingly difficult to gain. For example Disability Living Allowance (DLA), once a taken for granted benefit that provided essential support for disabled people living in the community, was now proving 'almost impossible' for new clients to access:

'I find DLA is now getting harder and harder to access. Most of my clients nearly always got the [better paid] higher care component in the past, which allowed them to buy support and live a reasonably normal life without constraint. Now you require medical examinations and other forms of evidence and even then you are not guaranteed success. You are also more likely to receive the lower or middle rates if anything.' Liz T3

'DLA is so important because potentially it allows access to other benefits as well. You cannot apply to the Independent Living Fund (ILF) for services unless your client is on the higher rate of DLA, and the ILF is now one of our chief sources of income for client services.' Sue T5

The squeeze on benefits (Novak, 1988; Finn and Murray, 1995), which has actually continued to intensify since the Labour Party returned to power in 1997 (Jones and Novak, 1999), was in the opinion of care mangers making their job ever more difficult. There was again a sense of hopelessness and despondency evident amongst the staff. The feeling that everything was simply getting worse continued to be articulated throughout my four-year study, and I collected so many responses that clearly expressed low morale:

> 'Every day just seems to get worse. You begin to wonder what it will be like in 10 or 20 years time, what type of society will we be living in.' Bill (UNISON rep and Looked After Children's social worker) T5

> 'You just feel like running away from it all. All the forms, moans and changes for the worst. When will it ever end?' Anne T1

Of course other core welfare benefits have also been affected, such as housing benefit, income support, job seekers allowance, and so forth (Finn and Murray, 1995), which again reduced the options available to care managers, and their capacity to help people in need. Housing benefit had once been easy to access and was seen as an essential means of allowing disabled or older people to feel safe in their accommodation within the community. But again this benefit was proving difficult to access as applications often took months to process, and many landlords refused tenants who required an application for housing benefit. Community Care grants through the DSS had once allowed a person on benefits the opportunity to move home

and buy new furniture, but again this option was now increasingly limited to people in dire straits.

The local social service department had also been affected by such changes in policy. In all the teams that I worked emergency loans or petty cash had been taken away from duty teams as an option for a client in desperate need. In the past when a client visited an office and informed the duty officer that they had no money for food or gas tokens, the officer had the discretion of giving petty cash to the client. But this practice had been recently stopped in all the teams that I worked in and it was now the policy of the department to tell clients 'to go to the DSS'. Of course each duty officer is aware of just how difficult it would be for a person with learning difficulties to secure cash from an unsympathetic DSS officer stood behind a thick glass window. It is of no surprise then that the department was often considered to be 'heartless' by many of its employees.

Other Sources of Support

Despite the tightening of regulations regarding the availability of benefits and other sources of support for clients there were still (at times) other options available to care managers. As referred to in one of the quotes above, benefits regarding independent living such as the independent living fund (ILF) have helped provide support when monies were not available through the social service budget. In teams 4 and 5 the ILF had been consistently applied for to support packages of care, and had allowed clients with learning difficulties to live alone with support. The ILF is funded through central government and so does not draw from the limited local authority budget. Despite this

a client must be on the higher care rate of DLA to access ILF, which as I have already argued, is now difficult to access.

There are also local voluntary organisations that offer "free services" such as shopping and training, usually from volunteers. One problem with such voluntary organisations however is that they tend to differ from authority to authority, and while some authorities will have many services available through a well organised voluntary sector many others will not. For example in T1 there was a good network of voluntary organisations that offered a range of services and different types of support. However in T4 and 5 there were few voluntary organisations that offered services to clients, particularly regarding the social support which was so in demand. It is also important to remember that many larger voluntary organisations such as Mencap and Age Concern charge for their services.

The End of Therapeutic Care

One of the important consequences of the community care reforms, and associated changes in British social welfare generally since the early 1980s, has been the disappearance of therapeutic approaches of support for clients. As I argued in chapters 3 and 4, care managers spoke with a sentiment for the past, when they practised 'proper social work'. Regarding the view of proper social work, care managers talked about wanting to be 'away from their desks' and 'working in the community with clients'. Further investigation revealed a desire by care managers to practice therapeutic approaches such as group work, advocacy and counselling, which had now disappeared from practice. One veteran social worker, who had been in social

work since the late 1960s, discussed the success he had had during the 1970s with the use of the now defunct group work:

> 'I worked on one council estate where there was regular accusations and referrals of [physical] abuse against children. We (the team) initiated a series of group work sessions for parents that were essentially educational, informing people of the psychological and emotional consequences of violence towards a child. That initiative dramatically reduced new referrals to the team for some time and was a great success.' Peter T4

Peter informed me that such children would now be taken into local authority care without a second thought (assuming time and resources remained), and any underlying causes of the problem would be 'dismissed' by the SSD.

Care managers felt that the emphasis on budgets and rationing, as with the bureaucracy, pressurised them to provide 'quick make-shift responses' as one care manager put it. The establishment of a type of 'emergency service' had encouraged services to be reduced to the most practical, yet tedious, of tasks such as help with dressing a client at home. Thus the nature of the tasks dealt with each day appeared to lack not merely much skill, but also much interest. In the words of one care manager, the experience 'of social work' was now little different from 'working at Jacobs [biscuit factory] in the 1970s'.

Care managers identified therapeutic approaches as an important part of their "profession", and it appeared to them as if clients were no longer worth providing

with such approaches. Ironically many therapeutic approaches are still available through the National Health Service, usually through a referral from a GP, and include counselling and many forms of alternative medicine. This suggests that the skills that have been removed from social workers have been "picked up" by other professionals. Also the emphasis on budget led practice and rationing has inevitably had a considerable impact upon the continued de-skilling of the care manager and social worker.

Conclusion

My research has illustrated that care management is now increasingly dictated by economic factors, particularly regarding the severely restricted budgets available to social work teams to purchase services for clients. A change in the structure of funding for social services following the reforms of the early 1990s, most notably since local authorities were made responsible for residential and nursing home placements, has meant that only very limited resources are now available for domiciliary and day support services, that are in such demand for community based clients.

Care managers have found that despite recognising extensive demand for services in their work, usually from vulnerable clients living in the community with limited if any social support, there appear few options available to them to provide such support through their departments. Thus, despite following work-based procedures such as assessments of need and financial assessments, such procedures regularly lead to no tangible support being provided for vulnerable clients. Inevitably the experience of

regularly being rejected for applications for services through the panel further alienates care managers who are already bemused by the tedium of the excessive paperwork they engage with each day.

It has also been argued that the use of limited resources to fund practical (but essential) tasks such as help for a client to wash and dress himself/herself, has further deskilled care managers in their work. This is because therapeutic services once practiced in the generic social work model, are now considered an 'unnecessary luxury' in the world of care management. Limited budgets therefore have added to the de-skilling process identified earlier as a consequence of care managers' new role as purchasers of care services.

It has also been noticed how the rationing of services, and the stricter rules that now police the applications for benefits by clients, have led to an increasing number of vulnerable people living in real danger of harm or abuse in the community. The fact that assessments carried out by care managers regularly remark upon such dangers (many of which later materialise), and present them in detailed form to panels, only further confuses and angers practitioners when they are routinely refused access to services.

Perhaps most significantly it has been argued that the development of a quasi-market of social care has helped to establish the formation of a vast and elaborate care industry. It has been suggested from my research that the care industry is now an important part of the British economy, particularly regarding the generation of employment opportunities for staff throughout many regions. I have discovered

through my work and interviews that the social care industry is also one of the most exploitative and oppressive forms of business around, relying as it does on armies of carers, most of whom tend to be women from relatively deprived backgrounds. The industry of care tends to offer such workers casual minimum wage employment, with long hours, intense work tasks to complete and limited benefits regarding employment benefits.

CHAPTER 6

WORKING WITH HEALTH

Introduction

One interpretation of the role of the personal social services in the community, offered by a front-line manager and quoted in chapter 4, spoke of a need not to consider the provision of any such services in isolation from others. The manager was referring to the role of other providers in the arena of community care, and indeed suggested that previous interpretations and understanding of social work had (naively) overstated the possibilities that the occupation could offer alone in practice:

> 'Years ago social work made grand claims of its potential to support people, indeed many [academics, researchers, BASW] outside the profession still do. People assume that anyone in need or who are disabled etc must be provided for by us. But we are not the only sector of the council that helps in the community. Housing is an obvious example, and good quality accommodation will sort out many problems, yet it is difficult to find. Good street lighting will make an older person feel safer in the community, and reduce risks, and so on.'
>
> Bill, manager Physical Disability Team

As I shall attempt to illustrate, the quote above is representative of a new belief or discourse that is current within local authority social services that attempts to encourage responsibility for client/patient provision *away* from purchasers, such as

those represented by health and social services. My research has suggested that a culture of referral has been established, whereby departments attempt to move work to each other in an attempt to cope with escalating demand and intense workloads. This is (again) most likely a result of economic forces following the marketisation of the NHS and creation of a social care industry.

Although I have so far concentrated upon the experience of social work, the NHS and CC Act 1990 actually paid more attention to what would soon become the 'purchasers/providers' of health services within the NHS (Ham, 1992). Such change would lead to the creation of an internal market within the NHS, change that would later be complemented by the sudden marketisation of social care (Harris, 2002).

This chapter concentrates upon an important aspect of both social and health care provision within communities. That is, policy guidance which argued for a 'seamless service' to be encouraged for 'customers', as part of joint service provision within the arena of community care (DOH, 1990). Such guidance identified a lack of communication between different social care and health professionals and agencies, which it argued impaired the provision of effective services for people in need. More recently the Labour government has identified a 'Berlin wall' existing between health and social work professionals and agencies (DOH, 1998). To what extent is this true, and what are the views of social workers and health care professionals? First it is important to consider the complementary changes that impacted upon the NHS from the early 1990s.

Radical Health Care Changes and the 'Berlin Wall'

The NHS and CC Act 1990 led to radical changes for the NHS, similar to those later experienced by social work (Sharkey, 2000: 5). There was the establishment of independent 'trusts' within the health service for both hospitals and community services; the eventual employment of (community) nurses by such community trusts; GPs were able to opt to take charge of their own budgets (later rescinded by Labour), choose particular services from hospitals and employ their own nurses; and trusts eventually established a degree of local independence from prior central forms of NHS control (Ham, 1996). As long stay hospital services were phased out, so competition was encouraged for contracts to run services for a set number of "patients" in hospitals or by community trusts.

Despite talk of establishing an inter-agency 'seamless service' as community care developed, a tension soon emerged between health trusts and local authority social service departments regarding who should provide support and care for people outside of hospitals (Lewis and Glennerster, 1998). Yet again the problem appeared predominantly economic, with rationing of finite resources helping to generate cost shunting regarding who was responsible for either (free) health or (means tested) social provision (Sharkey, 2000: 77). Again, as with social care, competition that was supposed to lead to lower costs between trusts appeared difficult to generate, with provider monopolies tending to persist (Le Grand, 1993). Also the historical conflicts and disparities between health and social care providers were further intensified by the changes; previous attempts to bring the sectors together, such as through joint planning and financing in the 1970s and 80s, had also proven unsuccessful (Wistow

and Brooks, 1988). For some the decision to place social services under local authority control (instead of the NHS) had encouraged a divide between professionals that persists today, and has perhaps led to outcomes with detrimental consequences for service users (Sharkey, 2000: 74-78). These include a lack of communication and contact between sectors both in hospitals and trusts; but perhaps more important from the service users' point of view remains the later establishment of eligibility criteria, means testing and service charges by social service departments: inequitable policies that would in theory not be legal under the NHS (Carpenter, 1996).

Despite New Labour's sentiment regarding inter-agency collaboration however, the government still maintained that major (structural) change was not to be followed in order to encourage better working methods between sectors (DOH, 1998b). Means et al (2003) suggest otherwise, and argue that New Labour, through policy initiatives such as health improvement programmes (HiMPS) and primary care trusts (PCTs), appear to view any collaboration as health service led:

> ...HiMPS were clearly to be driven by health. How this new system was intended to mesh together with community care planning was not articulated but it was hard to avoid the conclusion that the new Labour government was looking more to health than to social services to be the lead agency in planning across health and social services (ibid: 120)

The implied subjugation of social to health services would seem a likely outcome of policy initiatives that allow only a minor role for social work (Bradley and Manthorpe, 2000). Despite this, others still argued that nothing radical was being

proposed, and policy appeared mild in contrast to the strong rhetoric expressed. Particularly, methods employed to encourage more collaboration, such as (occasional) specific 'pooled budgets' and lead commissioning, appeared tokenistic to many (Sharkey, 2000: 79).

Labour's policies regarding community health appeared to be based more on keeping costs down (Poxton, 1999). Policies such as HiMPS, and the continuing emphasis on encouraging primary care and preventative health techniques, appeared to build on the Conservative policies and failed to confront policies which directly affected patient and service user health, such as the marketisation principles and the continued use of firm eligibility criteria for social care provision (Mencap, 1999). Nevertheless, an apparent desire to encourage health rather than social service domination in relation to new Labour's initiatives is of interest: with some academics even arguing that the end of statutory social work may be imminent (Glendinning et al, 2002; Means et al, 2003: 216-217).

Finally it is important to recognise the significant differences in funding that both the NHS and social services receive. For example, the social services budget of 12.9 billion pounds (for all client groups) from 2000-2001, was equivalent to just over 1% of the total NHS budget of 879 billion pounds for the same year (Baldock, 2003: 370). With education receiving 905 billion pounds, and social security 1,953 billion in the same year, it would appear that the personal social services are very much a 'residual' part of the welfare state (ibid: 370). There are also important power differences between health and social care staff, with (among other things) more recognition and respect given to doctors and nurses by members of the public than to

social workers (Butler and Drakeford, 2001). This is despite the continued and alarming high incidents of medical negligence; and the failure in outcome and even damage that many forms of medical intervention encourage (Illich et al, 1970; Illich, 1975; Witz, 1992). For some groups however, such as the disabled, professions (and occupations that aspire to professional status) are united in their apparent contempt for the client and patient, whom historically they have (apparently) always attempted to dominate and control (Swain et al, 2003: 134-136). This point is further addressed below.

The Medical Model

Although it has been argued that the impact of marketisation upon both health and social services has helped to generate further divisions, some commentators (Payne, 1997; Thompson, 1993) argue that ideological differences also remain. Most prominent is the criticism expressed by a section of social work academics (and some health authorities) of the medical model, an apparent narrow definition of intervention that emphasises a patient's pathology (Thompson, 1998). It is argued that patient problems, including behaviour and attitudes, are traditionally narrowed down to an illness that can only be confronted by an appropriate pathogen or medicine. Disability studies is one section of academia that has been particularly critical of the medical model, as Swain (2003) et al emphasise:

The medical model of disability provides a conceptual framework within which disability can be understood, assessed, experienced, planned for and justified. The central focus for this model lies in its location of disability as an

individual problem tied to the functional limitations of the bodies of people with impairments. The medical model reflects wider cultural assumptions around individuality, personal autonomy and self-determination...[it] reflects and reinforces dominant ideas about individuals and their roles within society; it values conformity and asserts the significance of self-reliance. (Ibid: 22-23)

Historically such biomedical pathologies have included madness, a handicap, idleness, a criminal disposition, being a member of an inferior 'race' (eugenics) and homosexuality; each of which are apparent character flaws or illnesses that need to be addressed.

Despite much posturing and rhetoric by social work academics (Payne, 1997; Thompson, 1998; Dominelli, 2002) the stance of 'social' good 'medical' bad is open to criticism of being simplistic and crude. Most apparent is the fact that social work's intervention historically has itself relied on a narrow and pathological interpretation of socio-political phenomena such as poverty and unemployment; one which often assumes that character flaws inherent in 'undeserving' clients are usually the source of an individual's problems (Jones and Novak, 1999). Indeed the need to apply moral disciplining to an apparently deserving poor through casework can be traced back to social work's Victorian origins and beyond (Dowling, 1999: 11). Social work has also gone to great lengths to emulate psychiatry and medicine in acquiring full professional status and power (Parry and Parry, 1976) and if a process of client/patient abandonment has been established over the past two decades, as Jones and Novak (1999) suggest, then such epistemological disputes suddenly appear not only trivial but remote. Aspects of post-modernist theory also offer a useful insight into such

discursive disputes, since it has been suggested that the use of knowledge *in general* by the expert offers a source of power that is utilised to create and dominate the patient and the client. That is, theory (including social models) facilities methods and procedures under which the practitioner arguably pursues individual interests and maintains a dominant relationship with the client (Corker and Shakespeare, 2003).

My own experience in practice however was that any epistemological disputes, in relation to the medical or social model were rarely (and often never) identified as a sources of anxiety by practitioners. In comparison to say resource rationing, work intensification or bureaucracy, such a tension appeared as a peripheral day to day concern. To clients or patients however, at the brunt end of practitioner assessments and decisions, such a dispute about methods employed may well carry more significance.

Other Studies

Broadly both Parsloe (1981) and Pithouse (1987) make only brief reference to health care professionals. Parsloe (ibid: 33) makes a quick reference to health care teams in order to discuss her views on the establishment of 'good teamwork', and makes reference to the GP (as part of primary care) utilising social workers alongside nurses and various 'technicians'. Pithouse (1987) draws on his ethnographic data exploring childcare social workers, to note the hostility and tensions that persisted with health workers, particularly GPs:

> The child care workers also have reservations about health service staff. While several spoke of good relationships with health visitors and GP's, they seemed to share the view held by other workers that doctors view social workers as subordinates who will deliver a service on demand. (ibid: 21)

Despite the recognition in research of a strong link between poor health and poverty (Black Report, 1982; Townsend, 1988), tensions with health service providers appeared as an important point in Pithouse's research. This perhaps illustrates the importance of struggles for power that so often dominate in relation to professional interests; struggles that possibly transcend any rhetorical claims to support clients or patients (Johnston, 1972; Illich, 1975; Bourdieu, 1991, among many others). This is however not to deny the arrogant stance of doctors in attempts to enforce their authority within their chosen field or territory of knowledge (Foucault, 1971). Nevertheless just as relevant to both Pithouse and Parsloe's studies was their lack of reference to health care professionals in general, which again appears to suggest a lack of multi-disciplinary work in the delivery of social work.

Hadley and Clough (1996) find little evidence of any improvement in working relations between sectors, despite interviewing a number of health care workers and care managers. They do however highlight the considerable impact of change upon both; noticeably the sense of turmoil generated by marketisation upon practitioners, and the continued rationing of services and medicines across both health and social services. In general then past studies have tended to highlight poor communication and conflict between sectors, but as time has progressed dwindling resources appears to have generated further tensions (Sharkey, 2000: 5-10).

Research Question

My research question had enquired to 'what extent is good multi-disciplinary practice a part of care management?' This was intended to consider care managers involvement with other organisations as well as health, notably independent sector and local authority housing and domiciliary support providers who we tend to work alongside at times. The question was intended to consider the extent of inter-agency practice and communication.

A Berlin Wall?

My research findings suggest that depictions of a 'Berlin wall' persisting between health and social care professionals is too simplistic and ignores many of the key problems that discourage joint-agency practice. There are many obstacles that I have discovered which continue to prevent the maintenance of effective collaborative work; most but not all of which are beyond the influence of respective front-line employees. To begin with physical location is a key barrier to effective collaborative work. When I was based in a multi-disciplinary setting (the hospital in team 3) contact with professionals such as nurses, dieticians and occupational therapists was regular, and genuinely helped with my practice, and the services that were provided for patients. Care managers typically play a key role in hospitals in that they tend to speed up the discharge process by providing intermediate support, through support workers, in the community for patients (usually covered for up to 6 weeks after discharge). Indeed, as I stated in the previous chapter, when I worked in the hospital setting I was

never refused an application for a care package, which is almost certainly due to the politically sensitive topic of 'bed blocking' which hospital care managers directly confront and alleviate with their interventions (Wilkinson and Miers, 1999). My (hospital care management) colleagues generally believed that health staff were supportive in their work:

'It's hard work and I feel that we have 'low status' in the hospital with the medics despite our [important] role. But I have always found most of the nurses, physios, and occupational therapists approachable and of help. I only wish the doctors could be less arrogant and not dismiss us almost as 'donkeys' that carry the patients away!' Jan T3

'Having everyone on site, including the citizens advice [bureau], makes everything work so well. I've never been refused help or support from other [agency] staff' Lisa T3

'There are differences at times with some staff, but most of the pressure is with the ward sister, who is usually following orders from the doctor to get patients out as soon as possible. Some of the people we discharge are simply not fit enough to leave.' Sue T3

'We spend very little time on the wards in comparison to everyone else because we have all the paperwork to process back at the office. I think relations with other professionals would be much better if we were again allowed to be social workers, and our understanding of patient issues would

facilitate a better and, at times, *safer* discharge. But I have now accepted that we are not going back to social work.' Liz T3

'People complain but we are very privileged in the hospital. I never set up anywhere near as many [care] packages in the community.' Paul T3

The fact that other professionals were located nearby within the hospital setting appeared to dismantle the apparent Berlin Wall. Colleagues who had once worked in community multi-disciplinary teams also supported this opinion:

> 'I've worked in a small multi-disciplinary learning difficulty team and there was lots of contact and collaborative work between professionals.' Rob T1

It was felt by practitioners that the fact that very few community teams were multi-disciplinary had tended to encourage the Berlin Wall between practitioners. Care managers felt that their contact with health professionals was poor owing to their location in another building, often several miles away. But this was not the only problem that persisted. Inevitably a lack of funding and rationing was (yet again) identified as having detrimental consequences for clients.

Rationing

The problem of rationing was seen as being detrimental to work in general. It was argued by the care managers that I interviewed that rationing, or a lack of resources to

purchase facilities or services for clients, hindered opportunities for appropriate means of inter-agency practice. Perhaps it is of no surprise that a lack of resources is rarely mentioned when politicians construct concepts such as the 'Berlin Wall'. Yet practitioners felt differently, and again expressed their anger;

'There are times when a doctor or nurse will look at you and say 'this [patient circumstance] problem is 'social'. It places responsibility on to us immediately and generates an immediate tension.' Sue T3

'So many problems which we accommodate are supposedly 'social' because the client is living in the community. Yet their problems are actually medical, such as through arthritis or whatever, but they [NHS] will not pay for a stair lift or support because it's 'in the community' and therefore 'social'. Alan T3

'We're competing against one another, and avoiding responsibility, when we should be supporting each other. The rationing generates unnecessary tensions and petty conflicts over who should pay for support and we [care managers] nearly always "lose". Tom T5

'I do feel that we [care managers] do not assert ourselves enough against the NHS, but then again we simply do not have the time or energy to advocate on behalf of clients for services.' Fiona T1

Despite this practitioners were cautious about being brought under the NHS owing to their anxieties about 'the medical model' and a possible 'loss of professional identity'.

When I pointed out that services for clients might be more plentiful if we came under the health service they appeared a lot more supportive of the idea. Many however were still uncomfortable with such change for the reasons stated. This once again illustrates the paradoxical nature of many of my findings. Practitioners tended to complain about a lack of resources, client charges, and *de-skilling* almost with as much passion as they did about the extent of paperwork and the lack of client contact; yet when a possible solution to many such problems was suggested it was treated with suspicion owing to a concern for *professional* identity. Furthermore, many care managers talked of concern that they would no longer 'be allowed to practice social work' if they came under the control of the NHS, despite the fact that many argued that they were now no longer allowed to practice social work as care managers.

Despite concerns about a lack of resources for services, which often led to arguments over whether the health service or local authority paid for care, such economic factors also led to other practical and immediate problems for care managers.

A Lack of Staff

The problem of staff shortages in social services (Parton, 2001) was not merely restricted to care managers. Local authority occupational therapists, who play an important role in work with disabled and older people, were particularly viewed as being difficult to access for client assessments at home. Occupational therapists can play an important part in ensuring a safe environment is established at home for a client, whether by adding appropriate stair lifts, rails or specialist access toilets or beds. They also offer advice on walking techniques and have walking sticks and

frames to allocate when deemed appropriate. Despite this, typically a client will wait many months if not a couple of years to see an occupational therapist owing to a backlog of cases awaiting allocation. This again generated substantial risks for clients living at home, particularly older people who had not passed through a hospital, where they would more likely receive an assessment. Because of the high demand for services in the community, an increasing number of occupational therapists (as with physio-therapists) were beginning to set up as private practitioners.

The lack of such core medical staff in the community, and the fact that most clients could not afford access to private occupational therapists, meant that contact with such professionals was becoming increasingly brief or rare. I also discovered that the extreme pressures on health and social agencies for services encouraged a culture of referral to persist, otherwise known as 'the merry-go-round'.

The Merry-Go-Round

With intense pressure on health and social care departments for services, all of which required assessment by individual practitioners before they could be considered for application on behalf of a client, I discovered that attempts are regularly made by both managers and front-line practitioners to deflect work away from their inundated organisations. Such a culture helps to generate the bizarre process of clients being passed around from department to department, with each agency attempting to pass the buck to each other. There might emerge a (common) quibble over what is a 'health' or 'social' need, or perhaps a couple of managers may enter a dispute over whether a client has a 'learning difficulty' or 'mental health' problem. Regularly the

client, often in urgent need of attention, will wait more and more time before such disputes are resolved and their need is assessed.

One recently employed GP spoke to me about the 'ridiculous' situation that had been established within his local area;

> 'There appears to be a merry-go-round in full swing here. I refer cases to social services and yet my patient appears to either never hear anything back or I later receive a phone call telling me I have applied to the wrong department.'

Care managers share this GP's frustrations;

> 'If a client is in danger and you need [to] section [under the Mental Health Act, 1983] then it's almost impossible at times. The psychiatrist is usually nowhere to be found, and yet is responsible for half the city, and I rarely get a response from the mental health [team] for the ASW [approved social worker]... both are required [for section] and difficult to find. The psychiatrist will ask you to find a bed [for the client], even though it is his responsibility, and then it is a real struggle for them to accept any need for a section, whatever the danger... The number of times one of my clients has been given tranquillisers just because they [psychiatrist] cannot be bothered doing the paperwork or whatever. ' Liz T5

The quote above was not isolated and many practitioners felt that they struggled to receive assistance from other practitioners, sometimes including practitioners from

their own agencies, to take *responsibility* for their role. It was felt that apathy persisted among practitioners as the following veteran [children and families] social worker (26 years experience), now working for a charity, explained;

> 'I am shocked by the numbers of people who simply do not appear to care anymore. Years ago we used to fight tooth and nail for clients but now so many people just cannot be bothered' Sally (T5)

The merry-go round then is not simply about intense workloads; it also reflects a lack of real interest or concern by some practitioners. Alarmingly practitioner apathy was not a minor trend expressed by just a few, it appeared extremely common in some of the teams and locations that I worked. Yet in many respects the lack of *motivation* was entirely understandable in view of the monotonous and intense 'tasks' that employees were now expected to complete. The lack of resources inevitably also encouraged a lack of motivation to persist. The culture of apathy was not however restricted to social workers and care managers, and many other practitioners working in the community appeared at times to be unconcerned about client need. This issue is addressed further in the next chapter.

Assessment-Centred Referral of Practice

As previously stated if a case is allocated to a practitioner by their line-manager the assessment always follows. As I have previously argued the assessment provides a key instrument by which a client can be *refused* services. In many respects this is why I believe so much information is collected during the assessment process; so as to

guarantee that adequate formal reason(s) persist on record for refusal of services if a client decides to appeal through a lawyer against any decision made. Indeed some of my managers were quite frank about this, one even pointing out to me not to use tippex on an assessment form but to scribble writing errors out instead 'in case the client takes us to court'. Such a culture has relevance for the process of referral. This is because the more information collected during the assessment then the more likely good reasons can be found to refer cases elsewhere, a process always popular with managers and some care managers.

The assessment of need then remains a delicate political 'ritual' during which a range of motives persists on behalf of a practitioner and their organisation. Care managers with drive and ambition and a desire to move upwards are able to illustrate to their supervisor their skill at saving funds for the department by creating a range of motives for refusing, or in the case of the review, cutting services. They are also able to demonstrate their imagination at being able to justify referring clients elsewhere. The more in need a client, then the more of a challenge is offered to the truly ambitious to 'take that person out of the system'. Ambitious colleagues boasted openly about their capacity to achieve such a 'goal', but were only a few in number.

Support and Co-ordination from Below

Much like my evidence gathered within the hospital setting however there were occasions when front-line practitioners worked in unison to support clients. Joint-assessments, although not regular, were apparent from time to time. When they did

materialise all practitioners felt that the process produced a better outcome regarding meeting client need;

> 'When I have received support that I have requested it has *always* been positive. Our training in health matters tends to be limited and so we rely upon the assessments of our health colleagues so much. It is such a pity that it [collaboration] is not more apparent and written into the system.' Ruth T4

> 'There are times when medical intervention is inevitable and supports the client's needs. Regular visits by a community nurse will prove vital on occasions, particularly for [supporting a person with] bathing, cleaning or the giving of medication; otherwise a person will simply forget.' Karen T3

> 'When I worked with older people I tended to rely more on support from health, and when it was offered it was important and helpful' Carol T2

Indeed whether support from other professionals is needed very much depends on the type of client group with whom the practitioner works. Older people and the disabled are likely to require much more support from health practitioners whether in the community or not. Again such work was again seen as perhaps inevitably reliant upon resources.

Less Paperwork and Less Deskilled

One impression given by the care managers that I interviewed was that health professionals have less paperwork to complete than themselves in their typical working week. This led to an emotional response by care managers who felt both angry and confused at why 'other professionals' were not expected to be so accountable through formal means of documentation and procedure. It was felt that one important consequence of less paperwork for health professionals meant that they had more time to engage in skilled tasks; that is forms of practice that drew directly upon the apparent skills that were supposed to be within the realms of trained professionals. To care managers, doctors and nurses appeared to be still allowed to practise medicine, whilst care managers 'filled out forms at their desks and answered telephone calls'. There was clearly a degree of jealousy felt towards their health colleagues;

'It just doesn't seem fair. I can never get hold of any of the [community] nurses because they are always out [in the community] visiting their patients. Why is it that we are stuck inside when the [social] problems are mostly outside? I just don't accept that you can 'do social work' from behind a desk.' Debbie T1

'Paul [friend and community nurse] spends at least half of the average week with his patients, the rest of his time he's attending meetings where he talks about issues with colleagues or whatever. The point is that he still applies his

skills where as we have no means to express what we were taught in college. When we are out of the office it's just routine and set questions.' Sarah T1

Although it was apparent from my own practice that health professionals do indeed spend more time with their patients, it is unfair to argue that they have only a small amount of paperwork to complete, and more freedom regarding less organisational procedures to adhere to. A couple of nurses who had trained to be care managers were quite frank about the routine that also dominated their own time spent on a ward;

'There was not the paperwork that social workers have to complete because you did not have to engage in any financial or care plan documentation. However on a ward all the medics are constantly taking notes and keeping their files up to date, particularly regarding patient development. It's essential really because we are always changing shifts and the next key nurse or doctor needs to know about any relevant changes in symptoms or medication. ...But I still think our [nurses] manner of recording was more succinct and less repetitive; care managers just seem to collect so much useless information that is never used.'

Just as relevant in such a comparison is the nature of the work undertaken;

'Nurses do unskilled work as well, such as bathing or feeding patients. But most of their work relies on methods developed through training, such as taking blood or feeling glands, and so on. Social work has so much repetitive

unskilled work as part of the job; indeed I actually believed at the time that I was de-skilled as a nurse - until I started working as a social worker.'

Despite their jealousy and resentment about the autonomy enjoyed by their health colleagues care managers actually received a lot of empathy and support from such peers. As one community nurse expressed;

'I just feel so sorry for social workers, indeed I know a lot of people do. You have all those cases and issues to deal with, the ridiculous paperwork and so little money. We're (colleagues) aware of all the difficulties you face in your work and I know that people feel for you all.'

Health colleagues regularly expressed such empathy and support to me without encouragement. The changes that social work had undergone over the past decade had not been easy to miss by peers and clients alike. Despite their lack of political resistance the care managers that I talked to felt that they had been singled out for 'special attention' by the government. Why had they become so de-skilled and confined over the past decade in contrast to many other welfare professionals? Certainly there were teachers who spoke through the media about the endless reports they were expected to complete regarding student progress, as well as their relentless examination procedures and marking to consider (Davies, 1998). Yet it was argued by care managers that teachers were still allowed the opportunity to *teach* for a few hours each day in a classroom. Such an opportunity to practise and utilise acquired skills (counselling, support, advocacy) did not exist to 'practice social work' for care managers, unless a person was prepared to 'do it in [their] spare time'. This finding

appears to support Jones' (2001: 553) suggestion of a right wing backlash (later supported by New Labour) against social work's so- called relativistic morality and 1960s roots [which are] seen by the neo-liberals as being amongst the principal culprits of dependency culture.'

Figures of Fun and Heartless Bureaucrats

A number of colleagues felt that their reputations amongst health peers had been tarnished by their new role as care managers. Possibly a degree of paranoia had set in regarding their image (and therefore status/power) with other professionals, but still they insisted that they had become so de-skilled over recent years that they were now viewed almost as 'figures of fun' when they entered multi-disciplinary arenas such as hospital wards and locations for review meetings. Thus care managers talked of being almost ashamed and embarrassed prior to important multi-disciplinary meetings;

'To be fair they don't happen regularly but I just feel so uncomfortable. I was in a MDM [multi-disciplinary meeting] recently and agreed to visit a client who had been sectioned and was accommodated on a ward. Anyway the mother turned to me in front of everyone and quipped 'that will give you a chance for a day out'. A couple of people smiled, it's like everyone appears to know what a joke we have become; we seem to have no dignity amongst colleagues, clients and relatives.' Sue T3

'I enter the ward and feel no pride for what I symbolise, it is soul destroying. I am certain that [care managers] are laughed at by people including the

> patients. People used to be embarrassed telling others that they were social workers because of their image of taking kids away from people. Now we are seen as heartless bureaucrats by many people.' Lisa T3

Although I found mostly support and empathy from other professionals regarding the experiences of social workers over the past decade, it is fair to concur with the care manager's feelings that a tarnished image is something that is difficult to overcome. It is also of relevance if relations with other workers (and clients) begin to become affected. Care managers felt that due to the impact of their de-skilling, which had reduced them to 'form filling robots', they no longer held dignity and self-respect amongst peers and clients, and were thus 'not taken seriously' regarding important events such as meetings and assessments. This implies a significant reduction of power and influence not merely on an individual (and psychological) level for stressed workers, but also in relation to structural dynamics and relations of power between and around peers, relatives and clients.

The New Social Workers?

It was argued by a minority of colleagues that health professionals had 'filled the void' left by the removal of social workers from the community. The continued emphasis upon primary care (and health promotion) within the NHS had led to an increase in the number of community nurses and health workers at grassroots level (Burrows, Nettleton and Bunton, 1995). According to my interviews and personal experience such workers did appear to spend at least half of their time in the company of patients, whether offering advice or practical support such as through bathing or administering

medication. The care managers argued that such workers were now essentially 'doing [their] work [whilst they] remained in the office'. As I suggested in chapter 3 the sense of confinement was a particular sore point for care managers who felt both frustrated and impotent in their redefined and circumscribed roles.

Again this scenario was used to argue against the use of the medical model in practice, and it was felt that the (apparent) emancipatory potential of social work was not likely to be expressed by medical practitioners, who I was informed, 'pathologised patients'. Although I believe much of this sentiment is a result of the anger and frustrations felt by the current working arrangements for care managers, the point does have some relevance. Assuming that health professionals have replaced social workers there is the possibility that a lack of understanding may prevail regarding the disadvantage and oppression that persists on a social level for disabled and older clients in the community.

In general however I do not feel that health professionals working in the community are able to fulfil the therapeutic and advocacy *potential* that traditional social work at times offered. To begin with they are unlikely to have the time, and many of their chores such as the administering of medication and dressing patients are again likely to be as de-skilling as those undertaken within the offices of care managers. Indeed many of the community nurses that I spoke to talked of 'having to rush from house to house' to complete tasks and generally had a 'quick in and out' routine established. Rather I have found that despite some differences, many of the changes in health practices since the NHS and CC Act 1990 have complemented the experiences of care managers (de-skilling, work intensification, rationing) rather than contrasted with

them. Instead I would argue that social workers' traditional roles have not been replaced as such, instead they are no longer provided.

Lack of Knowledge Regarding Health

One of the regular complaints made by care managers was the fact that they felt further de-skilled by their 'poor and inadequate' training prior to qualification. Particularly it was felt that their training had been too brief and had failed to prepare them adequately for 'the real world' of care management (Simic, 1995). The lack of resources had rarely been stated as an issue, much like the extent of crisis felt in social work teams regarding work intensification, staff shortages and client demand. However care managers also felt that an inadequate understanding of relevant health issues was offered in college training. This made many practitioners feel 'ignorant' when attending multi-disciplinary meetings or during the assessment process;

'I didn't receive any training in medicine when I did the course and I believe this is still the case. It just seems ridiculous when most if not all the people we deal with have health problems. A basic understanding of diseases such as arthritis or dementia would not take long to teach, and would offer so much help.' Anne T1

'I think it would be good to do a work placement in a health setting, or be allowed to shadow a community nurse or whatever as part of the social work course.' Lucy T2

'I believe that nearly everything we do is related to personal health or (poor) housing; certainly the few lucky clients that we provide anything for. Things like the social work theories are of absolutely no use whatsoever once you start work.' Gina T5

This problem had failed to be addressed by employees once a newly qualified worker began in a new post. It was felt that council-based training was equally as inadequate as that offered by colleges and tended to emphasise 'good practice, legislation and eligibility';

'I recently attended a typical training session and we were placed into groups and asked to list how our work methods might be improved. I was very excited at this prospect and began to write out all the problems we faced when the co-ordinator told us that the only thing we could not list was 'lack of resources' as we 'had to work within our means'. I mean that is *the* problem, and everything on people's lists was related to it.' Gina T5

'Training is nearly always about legislation because the council are terrified about being taken to court by our clients. I mean, let's face it most of what we do is illegal!' Jan T5

However some care managers were not so bothered and believed that they were more than able to 'train themselves';

'I have tended to train myself regarding health issues. You have to buy books yourself because the council doesn't provide anything, and much of the information can be picked up off the Internet.' Gary T2

It was apparent then that many care managers actually trained themselves, usually at their own expense. However this does raise concerns about practitioners who are newly qualified and are very quickly making key decisions about clients and the support they require. Thus self-training is not always a reliable means of offering an appropriate service by practitioners, and some care managers did not bother, or had no time, to find the relevant information in their own time.

Bring Us Closer Together (But With Adequate Resources and Less Bureaucracy)

Overall many practitioners were positive about the idea of working closer with health professionals. Despite this, my own research suggested that the desired 'seamless service' talked about prior to the NHS and CC Act (1990) appeared to have failed to materialise, and divisions and a lack of communication persisted between social and health care professionals and their agencies.

Despite this some care managers were clearly uncomfortable with the idea of becoming part of the NHS. Such anxieties tended to relate to an assumed loss of identity that would result as a consequence as well as a loss of power and influence that would be allowed for social work. Although the first point may hold relevance, the latter is particularly hard to sympathise with. This is in relation to the many care managers who insisted that they now had 'no power' anyway, and were already

'chained to procedures'. Surely the position could not get any worst under health? Not everyone agreed;

> 'People say things can't get any worse but they can and they do. Since I qualified over twenty years ago things have progressively got worse and worse; the lack of resources, paperwork, working conditions and so on. If we join health and have a consultant or hospital manager on our backs, someone who is only interested in diseases or saving money, it may well get worse and worse.' Paula T5

> 'I have a friend who works for a trust now [under mental health] and the social workers have been given a crap little cramp office worse then they had before and are treated like children in meetings. At least we now have a degree of independence' Tom T5

Again it is possible that such opinions expressed reflect the despondency already identified in previous chapters. It is also possible that opinions may reflect a 'fear of change' encouraged by the countless reorganisations and legislative initiatives that appear to have worsned working conditions and opportunities for social work.

One issue however that practitioners were in agreement about was the need for more resources and less bureaucracy. As I have covered these issues extensively I shall now move on to the issue of abandonment, an all-embracing trait that is further explored in the next chapter.

Abandonment

Although the argument offered by Jones and Novak (1999) that poor people have been both demonised and abandoned by the state is addressed in more detail in the next two chapters, the concept does justify a reference here. This is because the lack of communication between health and social care practitioners and providers that I discovered, as well as the lack of resources, have only helped to intensify the experiences of deprivation for the clients and patients; who often appear to be 'processed' (rather than provided for) by relevant departments. Indeed from my interviews with both health and social care practitioners I discovered a sense of apathy had developed regarding their sense of *purpose* to complete relevant tasks or procedures;

> 'Many of my colleagues just feel what is the point in making a referral to the social work department. The patient is going to wait forever to be allocated a social worker, and even then the chances of them getting anything from the local authority are slim.' Terry Community Nurse

> 'There does not appear to be very much that social services can offer my patients. This was very different a few years ago when social workers would ask the elderly or disabled [living at home] 'what do you want?'... There was then an important need to complete referrals on time, but now it just appears a needless form to complete and I don't like getting my patients excited about something they are not going to receive.' Karen Hospital OT

A GP was more frank in his opinions;

> 'What do you people actually do? I've never once received anything from social services despite all the patients that I have referred over!' Incoming DUTY telephone conversation with an angry GP Nov 2002 T5

Despite this care managers were equally as cynical regarding referrals to health;

> 'It's rare to be allocated a community nurse and you wait forever for an OT. It's the same with housing and the benefit offices.' Sue T1

The impression given then is of a web of organisations linked together by tenuous bonds of referrals and meetings; each together providing very little, if anything, for most of the people that they are supposed to serve. There are exceptions, such as the general practice, but regarding 'care in the community', clients and patients appear only likely to be provided for if their life is in imminent danger or at significant risk. Such clients and patients may not yet be totally abandoned, but for most this appears an all too grim reality.

Conclusion

During my five placements I found only occasional evidence of 'good multi-disciplinary work'. More often such practice was sporadic and brief, or indeed forced by specific events (emergency reviews) or the context of work (hospital). More often than not it was apparent that there was poor communication between health

professionals, care managers and their agencies, and only occasional attempts to work together to assist clients emerged. By admission of my colleagues themselves, such an outcome was detrimental to meeting client or patient need, and in practice regularly led to disjointed forms of intervention proceeding.

I found that three concerns remain at the heart of such an outcome. First, the inadequate resources available for services discouraged closer working relations for health and social departments. In sum, less services allowed less opportunity or indeed reasons for practitioners to meet, such as in review (of services) meetings. Second, the high work levels in relation to case loads experienced by both sectors meant that practitioners tended to concentrate upon the individual tasks that their work generated, and had little time left for multi-disciplinary practice. Joint meetings were time consuming and usually jettisoned in relation to practitioners' priorities. Finally (and in relation to the second reason), the physical location of staff, most of whom were situated some distance from each other in separate buildings, reinforced poor communications, and hindered closer working relations. When staff were located together (as in the hospital, T3), multi-disciplinary work was a regular outcome each week. Some of my recent conversations (September 2003) with colleagues based in a multi-disciplinary community team (learning difficulty) also support this.

Evidence persisted of poor training facilities and methods available for care managers in relation to health needs; a culture of referral or 'merry-go-round' persisting between relevant departments that lead to clients often waiting a considerable amount of time for attention; and a despondency and apathy held by some practitioners that helped to

add to the limited chances a client may have had of receiving any type of assistance or service.

More recently, it has been argued that the Labour government may be keen to dismantle SSDs and statutory social work altogether (Means et al, 2003: 216-217). The authors base this belief upon the fact that the Labour Party have thus far encouraged health to take the lead role in projects such as the HiMPs, and social workers play no direct front-line role in projects such as Sure Start. Labour also stopped social services from publishing prior annual community care plans early on in their first term (ibid: 216). Despite this I do not share the authors' pessimism. My main argument against their view is the crucial (administrative) role fulfilled by social workers in maintaining the (independent sector dominated) social care industry. I don't see how any other workers could fulfill this. For example, health professionals would almost certainly refuse to engage in so many monotonous bureaucratic activities that are so detached from their training and historical roles. Unskilled workers meanwhile may struggle to maintain the fluency within the industry that quick financial assessments, reviews and care plans demand.

These points are further discussed in chapter 9, for now I turn my attention to clients and their services.

CHAPTER 7

CLIENTS AND THEIR SERVICES

Introduction

This is the final chapter that presents my research findings and deals specifically with both clients and the (social) services that are available to them. At the end of the last chapter I noted how many health professionals had suggested that they felt it 'a waste of time' referring patients to social service departments because there was apparently little chance of them receiving any attention or services. Certainly I have explored the lack of funding available for services and the fact that care managers rarely have contact with their clients; but are there actually no services now available? If there are services still available what are they actually like, and do they fulfil any purpose for clients regarding any recognised need? What is it that care managers actually do if they do not provide social services for clients?

The chapter will also explore the changing circumstances under which clients now traditionally meet a social worker, and some of the dramatic social changes that have complemented the remoulding of social workers into care managers.

Care and Control

Social work's relationship with its clients has always been steeped in contradictory forces of will (Jones, 1983; Thompson, 1993). Although a concern for advocacy,

assistance and compassion has often been highlighted as key objectives by the profession itself (Thompson, 1993; Payne, 1997), a broader definition is necessary to understand the true nature of the occupation. Most prominent is the fact that social work has nearly always been concerned with the application of morality and other forms of discipline towards its client population. Distinctions drawn between a deserving and undeserving poor lay at the roots of organised charity and social work during the nineteenth century, with the former being viewed as able to be reformed whereas the latter appeared beyond assistance (Jones, 1983). Further, access to welfare services was usually offered at a price following any assessment; most notably there was a need for clients to discipline themselves morally in order to continue receiving any benefits on offer (Galper, 1975, 1980; Dowling, 1999: 12). Indeed when recognition is given to the elaborate assessment documents now utilised (appendix 1), as well as the paucity of resources currently available, it could be argued that such regulation has perhaps become more rationalised and strict. Certainly however it would be misleading to assume that care is all that is potentially offered by social services.

For Thompson (1993) social work offers a distinction between an offer of both forms of care and control. Control refers to forms of social control, and might include attempts to normalise or socialise an individual who expresses inappropriate and 'anomalous' behaviour or attitudes (crime, abuse, addiction, neglect, violence and so on). In this context social work has always maintained an important surveillance role in its application, one that appears to have become increasingly drawn from statutes and legislation (Braye and Preston-Shoot, 1995). Such a role has perhaps been reduced more recently, notably since the development of care management

throughout the 1990s, and the increasingly formal attempts to run a 'social work business' (Harris, 2002: 137). Here less contact with clients, and more time spent in an office surrounding (Jones, 2001), appear to suggest less urgency to provide forms of human monitoring. Care managers however still continue social work's historical trend of working predominately with poor and deprived clients (Dowling, 1999; Carey, 2003). Thus, there are important historical themes that still persist with the care management model, such as the fact that social work remains a class-specific activity, which has traditionally maintained power and dominance over the working class client (Jones, 1983). Indeed many depictions of clients in the literature suggest a ruthless pathological gaze that is detached from more recent empowerment led approaches:

> Even the most cursory readings of some of the key texts that have been used on social work courses over the past century reveals a most extraordinary tradition of condemnation and contempt for large segments of social work's client population. One of the main targets of this literature, the students on social work courses, are regaled with accounts which present clients as 'clamorous and greedy children who can never be satisfied' (Irvine, 1954: 27), as people whose 'dependency is pervasive and the client sucks from neighbours, shopkeepers, bartenders and news vendors as well as family members and social workers' (Richan and Mendelsohn, 1973: 15), and as people who deserve their poverty (Davis and Wainwright, 1996). For all the language of compassion and empathy there is running alongside it another language of hate and contempt (Jones, 1999: 42).

The formation of a 'social work business' through the development of quasi-markets offered (in theory at least) an opportunity for such misanthropic traditions to recede. Empowerment, through the reconstruction of the client as service user or customer, was embraced by many SSDs. Despite this such a 'fad' soon disintegrated in the face of economic crisis and rationing:

> In the early days of the newly established social work business, a much discussed inspiration for 'customer focus' was Peters and Waterman's *In Search of Excellence* (1984)...which claimed to distil what made the USA's top-performing companies successful. Being 'close to the customer' was seen as a key ingredient in their success and proximity to customers was embraced evangelically by many Social Service Departments. One social services director was so taken with *In Search of Excellence* that every social worker and manager in the department was required to attend a screening of the spin-off *In Search of Excellence* video. 'Close to the customer' was adopted as the motto and rallying cry in the department's new business style culture. The life of the motto was short, however. With the posters placed in social service locations across the local authority, customers added a 'd' and produced the motto 'Closed to the customer'. (Harris, 2002: 136)

Despite this Harris goes on to argue that an emphasis upon 'customer focus' has been utilised by managers to control front-line social workers, especially through a concern with worker accountability and competence (ibid: 137). Further, the client as customer through social work is rarely empowered, 'other than in the most abstracted and remote managerial business rhetoric' (ibid: 137).

As argued in the previous chapter however, some client-focused approaches view social work as maintaining a tradition long established by professions in general. Thus the profession allows an opportunity for the expert to maintain privilege and self-interest, with only limited concern for the client:

> Professionals have been perceived, by their clients and sociologists alike, as controlling, distant, privileged, self-interested, domineering and the gatekeepers of scarce resources. Furthermore feminists have spoken about the patriarchal nature of the professions where high-ranking doctors and lawyers, for example, tend to be white, male and with 'social connections'…The social status of professionals may thus depend more on existing power structures based upon gender, class and ethnicity, than on any claim to expert knowledge…Illich (1975) and Mc Knight (1995), for example, regard professions as disabling as they diminish people's abilities to look after themselves (Swain et al, 2003: 133)

Post-modern and post-structuralist theorists (particularly Foucault) have hammered home the almost sinister cloak of professionalism under which a power obsessed individual with considerable capacity to normalise the client hides:

> The judges of normality are present everywhere. We are in a society of the teacher-judge, the doctor-judge, the educator-judge, the 'social worker'-judge; it is on them that the universal reign of the normative is based; and each

> individual, wherever he may find himself, subjects to it his body, his gestures, his behaviour, his aptitudes, his achievements (Foucault, 1975: 304).

Since then however important changes have occurred in relation to neo-liberal anxieties regarding the apparent power that social workers and teachers have held in the past (Jones and Novak, 1993). Much of this power has been reduced through policy reforms that have demanded greater accountability, encouraged work intensification and given greater powers to a new public sector managerial class (Jones and Novak, 1999). It is important however to note the lack of impact that reform and managers have had over doctors (Harrison, 1999), as well as the increased opportunities that marketisation and financial deregulation have provided to estate agents, accountants, brokers and bankers (Sykes, 2003), as well as the 'ambitious' within medicine, teaching and social work (Harris, 2002).

Some interpretations however have stressed the beneficial role and good intentions that many professionals provide, particularly in relation to the learning, health and well being of the student, client and patient. Social work particularly (appearing to draw from Talcott Parsons systemic approach), has gone to great lengths to stress the potential benefits that the professional project can provide for the client if practice is utilised accordingly, and social workers hold a recourse to personal politics, ethics and morally sound principles (Braye and Preston-Shoot, 1995; Thompson 1998; Dominelli, 2003, and many more). Despite this, sociologists and groups such as the disabled challenge what they interpret as rhetorical and conservative assumptions that mask claims to power, self-interest and techniques of control (Swain et al, 2003: 134-136).

Previous Studies

As with the last chapter, the studies carried out by both Parsloe (1981) and Pithouse (1987) in general make little reference to the services provided for clients. Indeed reading Pithouse's study it is easy to wonder exactly what it is that social workers actually do for their clients, since little reference is made to any of the services provided by the two departments he studied. This is not necessarily a reflection of the quality of his research, it merely suggests that social work's role of service provision regarding support has perhaps always been a peripheral concern. But despite little reference to any provision of services, Pithouse does succeed in identifying the client along the traditional bi-polar lines of the Victorian pioneers of social work, suggesting that little has changed in outlook over a century later:

> ...it will be shown that the abstract, formal meaning of the client as worthy participant in the welfare endeavour is matched by practitioner folk-lore of the client as venal and unappreciative and in need of careful management.
>
> (Pithouse, 1987: 81)

Indeed, as I have previously drawn reference to, Pithouse (1987: 85) goes on to refer to the client as 'unworthy, dangerous and exploitative' from the view of many of the social workers that he studied. Thus the distrust is in contrast to the faith and empathy expressed to the 'worthy' and non-morally challenged client.

As explored previously Hadley and Clough (1996) as well as Jones (2001) tend to depict a world of intense bureaucracy and finite resources, in which both the social worker and client appear under considerable stress.

Despite some important historic continuities it is apparent that extensive change over the past two decades throughout the public sector has altered the relationship between the client and social worker. Some academics have stressed the empowered client model (Thompson, 1998), or the displaced opportunities that the social democratic past once offered (Harris, 2002). Others have emphasised the encouraged disciplinary techniques of authoritarian governments and the abandonment of the client (Jones and Novak, 1999), or social work's capacity to jettison clients if self-preservation is threatened (Jones, 1999). My own data revealed some startling findings.

The Service User

The concept of 'service user' emerged following the implementation of the NHS and CC Act 1990, to replace the previously used title of 'client' by social workers for the consumers of formal care services. This new title embraced by senior managers and members of the social work establishment at a local authority level had an important political significance that was not lost on front line practitioners. It represented the dawn of marketisation, and an acknowledgement that the developing quasi-market meant that ideas from business sectors were now to be internalised by state social work departments (Harris, 2002).

In some ways however the concept appeared to offer the potential for important rights to clients (Stainton, 1994). This however depended upon services being readily available to those in need, without which the promised promotion to service users, and the consumer rights it appeared to suggest, could never materialise. The fact that services quickly became rationed to a point where only those at significant risk of health hazards had any chance of receiving any support (Sharkey, 2000) meant, for the most part, that the relation between the care manager and (non) service user continued as before, or even offered more power to the care manager and their elaborate 'assessment' documentation with their role as gatekeepers to scarce resources. In general the term was not popular with the front line workers with whom I worked, and soon became abandoned by most practitioners for obvious reasons:

> 'I don't know of anyone who uses the term service user anymore? It was never really popular but there are managers who make the occasional reference to it. Personally I don't think the changes have made much difference to our relationship.' Adam T1

> 'Most people still use the term client, maybe its just habit.' Lucy T1

> 'I remember it was popular here for a couple of months, until the services quickly ran out and we all realised the ridiculous irony of the term. Personally I think 'customer' is even funnier, some of the managers still use that old chestnut....I mean you have to laugh, otherwise we would all go mad locked in this horrible place for days on end.' John T4

Despite this it was apparent following the 'big bang' that a more significant change in types of relations emerged with the fragmentation of SSDs into 'specialities'. Although different teams would now deal with different clients, such as older people, learning disabilities, looked after children and fostering and adoption, in contrast to the prior "generic system", a clear division in the type of client relations maintained soon became apparent. Of particular interest was the division between 'adults' and 'child care' teams, with the latter group recognised by those who have worked in such specialties as experiencing the emergence of an increasingly strained and antagonistic set of relations between themselves and their clients:

> 'My experience in children's team was awful. I was spat at, hurled abuse at in public, hit and generally intimidated by either the kids or their mums or family…You need to have a very strong personality to work in those teams, and I found that the few long term practitioners left were very 'in your face' type characters!' Maggie, Physical Disability Team (next to T5)

> 'The issues you deal with in the children's team are scary at times. One colleague was actually held by force at [the client's] home by a mother in an attempt to get her kid back. It's rare to build up any type of bond with such clients, not like with some adults. Generally I found with the children's teams that the family cause you most stress.' Rachel T4

For the most part my experience with adult teams was generally different. Such antagonism, fear of, and even contempt for clients was not as apparent, and indeed

empathy and support *appeared* to reflect the stance of many practitioners. In a sense this suggests that the emergence of social work specialisms during the 1990s, reflected in the distinction between social workers and care managers, has allowed almost two separate occupations to emerge, such are the contrasts in attitudes of staff and issues faced each week through typical caseloads of adults and children's teams. Previously there were always some teams that dealt specifically with children, but on the whole the majority of SSDs and social workers had held a 'generic' caseload (Pithouse, 1987). This issue clearly requires more research in the future.

Poverty

Despite such contrasts in team experiences there were similarities between the specialisms. A lack of resources and regular paperwork are the obvious examples, but just as significant remains the intense poverty that most families who come into contact with social workers/care managers experience (Bywaters and Mc Leod, 1996: 49). This was certainly my own experience during my placements. Despite the occasional middle class client, who typically had more chance of acquiring services (usually due to "threats" to appeal against local authority decisions through a lawyer), most clients were from working class poor backgrounds. This usually meant that a client and family would be living in poor quality housing; in an area that was deprived and had high incidents of crime, drug use, unemployment and poor local facilities such as libraries and shops; received benefits as their chief source of income; had limited life chances regarding educational or employment opportunities; had a history of poor health; and on occasion had personally experienced a form of physical or sexual abuse. In sum, many clients' personal experience of life, often on their own

admittance, was brutal. Despite this however care managers who had previously worked in children's teams acknowledged a disparity:

> 'I think that many of the families we came across in the children's teams were almost beyond poverty. Many had been through or were due to enter the prison system; many were also addicted to drugs and alcohol; had in the past experienced regular abuse at home and had never held down jobs, which they were probably incapable of doing... Some had never really been beyond primary school, could not read and struggled to communicate beyond shouting. I am not talking about one or two exceptions here, I am talking about most of the clients.' Fiona Looked after Children's team, T5

> 'But it [tension and stress] isn't simply the experience of social workers, a friend of mine who is a deputy head at a primary school talks about the 'two kids in every class' who smoke in the playground and swear out aloud in class. It becomes impossible to teach anyone, and these kids are only about eight or nine!' Paul T3

Such experiences are not absent from adult teams, but due to factors such as client age and disability there tends to be more people as clients of such teams who live around supportive extended families; have some next of kin with employment opportunities; and in general have little history of crime, deviance or abuse. This appears as a clear indicator that as time has progressed over recent generations, particularly for urban generations, their opportunities in life have become more and more restricted (Howarth et al, 1999). A crude rule of thumb perhaps, but for many social workers

with 30 or so years experience (and there are still a few left on the front-line), they have witnessed up close the receding chances and quality of life offered for thousands around the modern city (Oppenheim, 1993; Wilkinson, 1996). Research appears to back such opinions, as Hills' (1996: 4) research suggests:

> What was happening to incomes in the 1980s was very different from what had happened in the previous two decades. In the earlier 18-year period average incomes rose by 35 per cent. For no income group was the increase less than 28 per cent, and for the poorest group incomes rose by over 50 per cent. By contrast, in the 12-13 year period [after 1979] average incomes rose by 36 per cent – as much over this shorter period as over the previous one – but for the bottom seven-tenths of the distribution incomes rose more slowly than the average. Right at the bottom incomes stagnated. Measured after allowing for housing costs, real incomes at the mid-point of the poorest tenth were 17 per cent lower in 1991/2 than in 1979.

More recently, in a report published by the Joseph Rowntree Foundation Howarth et al (1999) found that between 1995/6 and 1997/8 the number of people on low incomes (less than two thirds of the national average), grew by more than a million, from 7 to 8 million. They also found that more than 2 million children lived in houses where no adult was in paid unemployment. Finally the total number of people living on below half the national average income (less than the government recognised poverty line) was 14 million, which includes 4.4 million children.

From the experiences of the care managers/ social workers that I interviewed there appears to be disparate (class) fractions that have emerged regarding 'life chances' for even members *within* the working class poor. Of particular significance appears the (continually) growing fraction, typically 'served' by children and family teams, that simply have no life chances whatsoever.

No Future

The lack of opportunities that persist for clients are all too apparent to most care managers and social workers. This is particularly the case for long-term practitioners, who have directly witnessed some of the dramatic changes that have impacted upon local areas over the past twenty years. Of the few veteran workers that remain on the front-line, the pessimism that saturates their view of the life of some clients is stark. They detail that key parts of their working 'patch' have 'gradually entered the Third World'. Generations of clients known to such veteran social workers appear to have each entered a more brutal and cruel world, one following another, and as time proceeds their children eventually emerge in a world that appears to offer nothing but a life of rejection, addiction, violence, crime and misery (Davis, 1997). Perhaps through their lengthy experience veteran workers are able to express sympathy towards people who fail to receive it anywhere else:

'I've dealt with one family over three generations, and each appears to become more removed from society. First there was mass unemployment, then drug dealing and finally abuse and prison... This is all that is offered for the children who are economically, politically and culturally deprived. For

some it is worse, I mean I have had a couple of children [clients] who died after they crashed stolen cars - but there was nothing on offer for them anyway.' Dan Looked after Children team T5

'In children services it eventually came to the point where we were so stretched as a department that we were only responding to clients considered to be 'at risk' [of abuse, violence, or physical harm]…Then, only a few years later, we only responded to children after they had *experienced* such risks. Now even many of these children are ignored because there is not enough evidence, just say a child's word against a parent… Indeed it's already got worse than this because we are now so understaffed that often we are simply too busy to bother sending anyone around.' Ken Looked after Children team T5

Such experiences are not exclusive to the young however. Mental health teams also confront the experiences of extreme poverty and deprivation throughout generations, and older people's teams typically witness clients living alone with few possessions and little money for food:

'It's not uncommon to come across (mostly) women living alone with nothing but their pension. Often they have fallen out with family members, have no other source of income, and are essentially waiting to die'. Harry T1

The assumption during training to be a social worker is that something can be done to change such oppressive life experiences for clients. Surely with the right attitude, and

enough motivation there must be means of helping deprived people, after all the social work lectures and texts perpetually informed us that we could empower clients. A brief stint in a social work team upon qualification soon teaches the newly qualified that such high ambitions are but fantasy. I recall a second year student joining Team 5, and after a couple of months' experience on the job, turning to a colleague and stating that 'we don't actually do much for people here do we?' The exclusion and oppression that clients experience outside the office appears beyond any real influence by a care manager.

One of the ironies that the marketisation policy has initiated into social services is some commonality in experience for both clients and care managers/social workers. The opportunities presented in social service employment for a 'life career' appear limited for the newly qualified; indeed I discovered an overall attitude that recognised such change. As well as the soul-destroying tedium that the job presented, it was made apparent that the only way up in social services (into management) brought with it an image of ruthlessness and corporation-like compliance with some colleagues. There appeared nowhere to turn, and many newly qualified graduates talked of social work offering either a way out of 'minimum wage' employment; a pragmatic second income; or a 'brief' transient career before later doing something 'serious and meaningful'.

The Shoddy (But Essential) Services

Assuming that a client is lucky enough to get past a front-line manager's interpretation of the eligibility criteria (following a referral), and then be recognised

as in need of a service (following the care manager's assessment), they will then need to get past the judgement of the panel in order to receive a service. This process, as I have already suggested, can take up to 2 years in time from start (referral) to finish (service begins). Of course it was rare for any client to get past all three obstacles, and the majority of clients who enjoyed services during my placements tended to have gained access to them some years previous, when they were more readily available. Alternatively some clients gained access to services through the duty system, following, say, an accident at home (see below). Finally a small elite of more privileged middle class clients may have enough money to buy services themselves from their own savings, with the care manager providing advice on purchasing. Such cases are rare however.

Care managers and social workers were quite open about their opinions on the services that were available to clients: a few were 'excellent but expensive', some were 'adequate', many more were 'awful'. The many independent sector nursing, residential or children's homes appeared more like makeshift prisons to many. On evidence collected at reviews (or from feedback from residents) the establishments tended to offer little interest in the development or quality of life of residents. Thus days out for residents were rare, assuming that they happened at all, and the quality of furniture and food inside such 'micro-institutions' was normally adequate at best. Staff, as I have previously noted, were usually discouraged from interacting with residents, due to their apparent need to continue with tasks such as cleaning toilets, making beds and washing walls. Toynbee's (2003) recent research into low pay led to her gaining employment in a private care home in London that catered for 140 elderly

residents. In her first week of employment she attended a training session on fire regulations and procedures that uncovered some disturbing practices:

> Our instructions were startling: if the fire bell goes, forget heroism, abandon the patients and get the hell out was the basic message. 'Suppose you are all residents', [The matron] said looking at us grouped in the residents' chairs around the television in the lounge. 'Suppose that television set blew up and caught fire. You should just leave the room, shut the door, set the fire alarm off, shout Fire! out in the corridor and leave them. Yes, I know it sounds terrible, but they are behind a fire door and if you open it the flames and the fumes will spread and kill a lot more people than *them.* Just get out.'
>
> (Toynbee, 2003: 182-183)

Such attitudes within care homes had not gone unnoticed to my social work colleagues. The grim and distressing places appeared to offer little more than a temporary home in which an older person might die, or a young 'tearaway' would be confined prior to release. Social workers and care managers were frank about their own experiences:

> 'They [homes] are dreadful places and cost the authority an absolute fortune. The owners rarely give a damn about the children and it is rare for any decent facilities to be provided regarding personal development or life outside [during adulthood]... One good thing to come out of our lack of money is the recent switch to adoption as a preferred option (because it is cheaper) - I think it is

better for the child but we are having problems finding foster parents.' Doreen Looked after Children team T5

'It just makes me so mad. They are making a fortune and yet never take the residents out anywhere, just leave them stuck in front of the telly. They also never do checks on staff; they will take *anyone* on.' Paul T4

'I struggle to find places [in homes] for my clients through the week, but if I'm honest I would never encourage a relative of mine to enter one.' Lucy T2

As I discussed in the last chapter, an increasing domination of core providers, particularly in nursing home care (Kerrison and Pollock, 2001), has restricted the choice and options available to care managers. To make matters worse, the lack of resources available from SSDs to fund packages of care (and therefore placements), has meant that many providers (including local authorities) are now falling out of an increasingly competitive market:

> The decline in the number of residential care beds has continued for a number of years, with a loss of some 7300 beds from the independent sector last year, alongside a loss of about 2500 from local authority homes (Community Care, 2003b: 4)

Such a decline in numbers of homes does not however reflect a lack of demand but instead a lack of resources. The same article in *Community Care* points to the still

substantial increase in demand for residential support likely for the next 50 years: 'the number of people needing residential care could rise from about 500,000 now to nearly one million in 2050' (ibid: 4).

Such are the tools with which social workers now work that looked after children (LAC) are removed from a place of danger (usually family home) and then placed into a form of accommodation (Children's home) that can, in practice, offer as much if not more potential danger (the experience of drugs, prostitution, abuse) than existed prior to intervention (Morris, 1998; 2000). A case of 'out of the frying pan into the fire'.

To the staff working within the care homes, the job offers a salary, however meagre, to pay bills and buy food (Community Care, 2000c; Toynbee, 2003). The children or older people at times appear as mere objects, whose care and future prospects often appear low on any list of many such organisations' priorities (Morris, 2000; Kerrison and Pollock, 2001). Planning for support is supposed to be the task and concern of the social worker or care manager, but they have little time to give to such complex dynamics (Morris, 1998); assuming they are not absent from work that is (Jones, 2001; Carey 2003). They are, as one care manager put it, 'expected to be everywhere at once by everyone'.

There was no real confidence expressed by care managers in any of the 'micro-institutions' of care available. However preference tended to be for local authority services which colleagues believed were more reliable and sincere. Certainly staff tend to be better paid in such care homes, and they are more likely to be longer

serving full-time workers (Community Care, 2003a). Perhaps based on instinct as much as experience, care managers felt that better paid staff tend to treat residents with more respect and have a higher morale, which research tends to back (Community Care, 2000c).

Despite this, Morris's (2000: v) study into the public support of children suggests that regardless of the provider, the life chances of children taken into care by local authorities are still poor:

> Compared with children in general, children who need the care of public authorities are up to ten times more likely to be excluded from school, 12 times more likely to leave school with no qualifications, four times more likely to be unemployed, 60 times more likely to join the ranks of the young homeless, 50 times more likely to be sent to prison and four times more likely to suffer from mental health problems. In addition, their own children are up to 66 times more likely to need public care than the children of those who have not been in public care themselves. (UK Joint Working Party on Foster Care, 1999: 6, cited in Morris, 2000: 4)

In an at times disturbing report Morris (2000) uses quotes from social workers, looked after children and support workers to detail a catalogue of failings in the attempts by authorities to provide adequate and humane forms of support to vulnerable children. Such children regularly face the experience of being humiliated and discriminated against by teachers and students at school owing to their low status as a 'looked after child'; are often treated by distain by support workers and social workers; are rarely

asked for their opinions except through the technical procedure of the review; rarely see their social workers; and face a life after care that usually consists of regular unemployment, addiction, crime and time spent in prison.

Regarding adult services supported accommodation tended to be a preferred option for any care manager, but inevitably once again the shortage of such accommodation made such an opportunity unlikely. For clients supported accommodation usually consists of life in a shared community house with other residents (typically 4 or 5). Such properties often provide constant support through two support workers for each shift. Inevitably the few residents mean that they receive more regular support and attention from support workers. The schemes are expensive but can be funded through central government benefits (Independent Living Fund, Transitional Housing Benefit) if a high level of need is assessed. Supported living offers a rare opportunity for care managers to place a client in accommodation that is likely to provide a decent quality of life:

> 'Everyone prefers supported accommodation but it is just in such short supply. I think the high cost of rent charged by companies [charities] such as MIND means that we will only ever be able to support a handful of lucky residents in such homes.' Paul T4

> 'We are still receiving the benefits now to fund such places [in supported living] but I read in *Community Care* that there are already signs that the government wants to pull the plug on transitional housing benefit; and the ILF

[Independent Living Fund] have now begun to scrutinise each application I have made.' Paula T5

Again everything appears to come back to cost, and care managers felt that they were expected to justify every penny they spent in all their various assessments and reports. Some care managers even spoke about being encouraged to 'feel guilty' about spending money on their clients due to the constant emphasis by managers upon budget limitations.

Clients that are lucky enough to pass through the eligibility and assessment maze do not usually find accommodation in supported living. Instead they are more likely to receive some practical or domiciliary support in their home. If they were lucky enough to be assessed during the initial community care changes in the early 1990s, they may also receive some hours of 'social support'. This is when a carer takes a disabled client out to places such as the cinema. Social support was once the bedrock of community support; now it has been placed alongside so many other forms of formal care and is considered 'an unnecessary luxury' (manager's quote). Local authorities once exclusively provided domiciliary and social support; now they tend to be provided by support staff employed by private care companies. Care managers stressed their struggle to obtain a reliable service for clients in this increasingly transient low wage labour market:

'Assuming you get the support through panel, and the client or family accept the charges, you then have a number of hurdles to face. Finding a carer to cover the work is difficult because so few people want to do it. They can earn

more money elsewhere for less hassle, and as we now provide so few hours it is often not enough to pay a person's wage... Then if the company finds someone they are usually only around for a short period of time before moving on, and quite regularly are completely unreliable and unsuitable.' Anne T1

'I've had cases of carers [employed by companies] being seen literally dragging clients through the city centre and then there are the allegations of abuse or stealing [from clients]. Jan [colleague] found out that one carer was also working as a delivery person and placed the client in the passenger seat of the van whilst he went about his "other job". One of mine [client] was lost in town by the support worker and later found by the police. These problems are happening all the time because the bloody companies will take on *anybody*.' Ruth T5

'If you [the employed carer] are supporting a person with learning difficulties in the home or community you are likely to be able to do what you want with him. The client is unlikely to question what you are doing, depending on the extent of the disability. I've had cases of support workers meeting their mates down the pub and telling the client to go and sit elsewhere.' Rob T4

Many care managers were philosophical about the emphasis on community support and believed that it failed to deliver in *practice*:

'It [community care] can only work when it is adequately funded. Everyone knows that it has been done "on the cheap". I never thought I would say this

but I actually now think that the large institutions were better for clients.

Despite all the problems at least they were warm, safe and well fed'. Rob T4

Some however were more sceptical and believed that any vision of 'care in the community' could never become a reality in practice:

'If it [community care] were adequately funded then the cost would be astronomical. As well as the additional support costs you would need to recruit so many staff to administrate all the additional assessments and transactions, I mean look at what we do now, we are all well beyond what we can cope with...Then there are all the problems that the system generates, such as the abuse of clients, and all the investigations and police type work it creates. I mean we [care managers] don't really have time to fulfil such requirements properly now, even though it is supposed to be one of our many roles.' John T4

In general care managers felt that the privatisation of social care, in respect of the *quality* of services that had emerged, had been detrimental to client experience and development. There were no front-line workers who argued for the current system to continue, and managers tended to agree that 'the system worked better before under the local authorities' wings' .

Day centres provide the final form of mainstream formal care. In general the day centres in the locality of my placements had not experienced the same extent of privatisation as other sectors of support. This is because high cost specialist day

centres tended to go out of business very quickly when the reforms emerged in 1993 due to the fact that they were considered "too expensive" by local authorities. Although local authority day centres continued to be closed down many still remained, particularly the larger sites that were cheaper to run. Again sheer demand had meant that as every year passed day centres became increasingly difficult to access for clients, and 2-year waiting lists for places were not uncommon. My own feeling was that day centres lay low down on the priorities of SSDs because they were not viewed as 'life or limb' or urgent to the often lonely and isolated clients who requested them. Thus the private sector had failed to establish a market in a sector that SSDs were reluctant to commission services within. As my final placement was coming to an end an authority nearby (Warrington) had taken the audacious decision to close down all of their remaining day centres. I know from experience with clients in T1 and T2 that such a decision would have removed one of the few minor pleasures that they had in their later life.

Despite their demand and indeed popularity with many clients, some care managers were not impressed by the day services available:

> 'The clients just look so bored. The buildings are dreadful as well, full of damp and old rickety chairs. The staff seem to try their best, but there is only so much that can be done inside. They should take the clients take out more.' Ron T2

> '[Again] when you look at the [cost] figures surely a new lick of paint or some new facilities would not be too much trouble. One of my clients loves playing

snooker but the table at the [day] centre has holes in the pockets and the green is all ripped. I think they [council] think, well he's disabled he won't notice the difference. They should also knock down those dreadful 1960s buildings and give the clients a new building.' Bill T4

'One of mine [client] fell and fractured his hip in Holt Hall [day centre], he's now permanently in a wheelchair and his brother is threatening to take the authority to court. They were understaffed apparently. No wonder the staff call the place Hell Hall.' Jane T5

Although the day services were far from perfect care mangers were still aware of how important they were to clients and family carers. As well as the company and stimulation that was available for clients, essential respite was also provided for carers at home. Such informal carers would not be able to cope without the break that the centres provided each day, and the pressure that they were under to support clients at home was usually considerable. Services previously available from SSDs, such as specialist holidays for clients and social support, had now been reduced significantly, and the pressure on carers was now often intense. It was not unusual for care managers to experience 'carer breakdown' within their caseload. Such cases included nervous breakdowns and suicide bids by long-term carers, as their strain continued to intensify each year. Morris's (1994) interviews with physically disabled service users in London revealed considerable pressure on relatives and friends to provide support for service users who are rarely allowed an opportunity to express independence. They detailed the guilt they regularly suffered owing to a reliance upon informal carers, many of whom had needs of their own:

[Formal] services were not flexible enough to enable people to make the most elementary choices such as when to get up and when to go to bed, or when to go to the toilet. Moreover, services were only available to people in their own home so they could not be helped to go out, either for social reasons or work....A failure of statutory bodies to provide services which enable people to carry on their daily lives and engage in ordinary personal relationships not only creates a very poor quality of life but it also undermines human and civil rights...Ibrahim describes the poor quality of life which results from a failure of social services managers to respond to the need for personal assistance. 'My father's helping me ....I don't feel very good about that, because you know he is an old man, retired, he's helping me and I like to give him a rest. But I haven't got any other help except him.' (ibid: 34-36)

In the past such events were largely prevented due to more support being offered and available, as well as the time once offered by social workers who would have had the opportunity to perhaps even practice preventative work. Now such techniques or approaches appeared out of the question.

The Inevitable Accidents and Catastrophes

With a lack of social support offered in the community, and a lack of time for care managers to monitor vulnerable clients, accidents and catastrophes inevitably occur. As funding for social support continued to recede during each of my placements, so such incidents became more common and severe. As I have already suggested

allegations that some clients were being physically or financially abused by support staff were not uncommon. However, clients were also at risk from the very communities in which they lived. This was particularly apparent during the two years I spent in a learning disability team. Here clients with a mild learning disability would often have their own flat but received limited support. Inevitably such clients, who often overestimated their own capacity for independent living, remained vulnerable in the usually poor districts in which they lived. The following care managers discuss some of their own experiences:

> 'One woman [with a learning disability] was raped by a gang of youths in the north of the city. The story made the local papers but not the national news. She lived alone and I know that she was promiscuous, but she would never encourage this [rape]. I don't believe she will ever recover; it would never have happened with adequate support.' Jane T5

> 'They come through 'duty' all the time. Client has a fall, gets lost, is beaten up and so on. I know from colleagues that there have been clients raped and forced into prostitution, particularly for some of our clients that don't appear [on the surface] to have a learning disability...We can do a risk assessment, but that does not increase your chance of getting increased support. Sometimes the client refuses any offer of support and there is nothing that can be done.' John T4

It also became apparent during my placements that clients with mild learning disabilities who lived alone were often targeted by certain youths. This is because

they can be easily manipulated at times to steal cars or generate funds via prostitution. It is often common knowledge in particular areas where clients with a learning disability live. Due to their loneliness it is not unusual for such clients to approach complete strangers in a desire to make new friends, and as their benefits are relatively high, this can make them an easy target for manipulation and abuse. There were clients who had deliberately been encouraged to become addicted to class A drugs so as to encourage a dependence that would later be exploited. Care managers were in no position to do anything about such events until after they occurred, since prevention work was now impossible. Sometimes the care managers would find out about such tragic events months after they had happened, and it is likely that there was far more going on which they would ever get to know. The following care manager discussed his experience:

'We tend to discover so much when it is often too late. I currently have a client [with a learning disability] who is in prison for [drug] dealing cocaine.... I only found out about it after the sentence had been passed. I'm trying to get him out; he's at great risk in there, from violence, HIV, and so on.... He tells me other people were encouraging him to [deal drugs], and I believe him.' Jim T4

My interviews with colleagues in older people's teams revealed a similar trend. They pointed to older people being targeted and exploited by youths. They also talked about the domestic catastrophies that had occurred in some homes due to a lack of adequate support provided. One care manager told me about the guilt she suffered after finding out that a client [older woman] with mobility problems had died after falling down her

stairs. The social service department had refused a stair-lift because of its high cost, and the woman did not have any money to pay for one herself (approximately £3000). I was later informed that the woman had discharged herself from residential care in order to look after her disabled son. The authority had refused to provide the support he required. Such incidents are not isolated and rare, and for care managers they have now become a regular part of their job.

A Lack of Concern

Although veteran practitioners offer more understanding and sympathy towards the plight of the client, this is not always guaranteed from other practitioners. Some care managers and social workers, most prominently those who worked with children, expressed at times a lack of concern for the experiences of the client. It was argued that clients had often nobody to blame but themselves for their predicament, and were often devious and untrustworthy, lazy or stupid;

> 'If there's no electricity then the lights won't come on. She's stupid and ignorant.' [reference by a child protection social worker to my young female client with learning difficulties who had had her child removed recently. I was enquiring about the social worker's reasons for removing the child] T5

> 'I couldn't care less about their chances. They're little fuckers.' [reference by child protection social worker to his clients when I pointed out the circumscribed life chances that looked after children typically experience]. T4

'To be honest with you I couldn't care less about them, I have my own problems to worry about' [again a reference to looked after children by a mental health social worker after I pointed out the alleged high incidents of abuse against clients within children homes]

'What do they expect us to do about it? Tell them we can't help or call the police if you're that concerned. Stupid child!' [Front-line LAC manager after a child protection duty call had come through to the T5 learning difficulty team by mistake. I had informed the manager of a LAC teenager who had been found drunk and sick in a local park during the day. A member of the public had taken the child home and assumed that the local SSD would provide assistance.]

The influence and impact of poverty, deprivation, a disability or lack of personal opportunity appeared of no concern to such workers, who expressed a cynicism not readily associated with the art of social work. Indeed it soon became apparent to me that the image of the social worker fighting for the interests of a client was actually an increasingly rare occurrence or myth for some workers. Many offered rhetorical sound bites that appeared to suggest concern, but closer examination revealed an *acceptance* of the misfortune that people on the streets were accustomed to.

It was possible that the optimism initially expressed by the newly qualified had been worn down by day-to-day experience. Certainly the drudgery of the job encouraged an emotional response most readily expressed in frustration and apathy. However (looked after children) social workers, more so than care managers, were faced with

regular torrents of insults from family members and clients themselves, and many had been physically attacked in the past. Typically clients explained to me, as Morris's (1994; 2000) findings also suggest, that they did not see or hear from their social worker often enough or believed they should be receiving some or more (as well as better quality) services. At times they, as well as their carers, lost their temper on the telephone or during formal meetings with care managers because they felt that their needs were simply not being considered or they were not being listened to. One carer spoke for many when he informed me in anger that:

> 'I've spoken to other people at the [day] centre and they all say the same thing. You never see your social worker and if you do it's for maybe half an hour in which case you will be asked hundreds of stupid questions... I mean I had a review a couple of months ago for my son and the bloody social worker never even looked me in the eye, she was just sat staring at this form and writing notes into it! 'I need some help because I can't cope' I shouted at her, 'I don't need endless questions that you have already asked me so many times before!' [during an assessment and prior reviews]. Tony, Carer for son with severe learning disability T5

It appeared that such experience for care managers had left many with a sense of resentment expressed towards clients, who they (mistakenly) viewed as another source of their problems. It is also possible that any lack of concern for clients was perhaps a coping strategy, a type of denial that protects the worker from accepting the continual misfortune and deprivation that the client experiences, and over which they as social workers now have little if any control.

Far away from the client

Many social workers argued that they no longer had any real relationship with clients. Their contact time was brief and formal, restricted to the set questions on the forms (appendix 1) or over the telephone. The workers struggled to find empathy for people that they rarely saw, and it appeared that the client existed almost as a distant if not abstract entity. The abuse regularly expressed by angry relatives of clients, or clients themselves, to their lack of formal assistance from the SSD had merely added to the tensions and lack of empathy expressed by social workers.

It seemed that the client registered now as being only a small part of the whole scheme of events within the SSD. Bureaucratic rituals and office-based procedures had now usurped other concerns, and diminished almost the very existence of the client from the point of view of the organisation. As detailed previously some new faces in the SSD environment, particularly students, initially expressed shock or concern at how an organisation that claimed to help vulnerable people actually appeared to almost pass them by on the way to fax information, write reports, create contracts or construct care plans. Veteran social workers also argued that the 'gap' between themselves and the client had grown wider during their careers. Again a reference to teaching and nursing is relevant, since although such professionals had also experienced similar marketisation changes over the years (Jones and Novak, 1999), they still inevitably had regular contact with pupils and patients throughout the working day. Such contact was now increasingly rare for social workers, and there

were times when up to three weeks would pass without me, or my colleagues, having any contact with a client. Inevitably this was because we had paperwork to process.

A Lack of Sincerity

My interviews with service providers revealed an acknowledgement that many of the staff employed were 'totally unsuitable' for work with vulnerable people. I also found evidence to suggest that many of the security measures, such as inspection procedures, were often either not followed or completed by staff who appeared disinterested in the plight of vulnerable clients. One colleague who had previously worked in a residential home informed me of how 'useless' the inspection teams for care homes typically were:

'I worked in a home in York and the owner was often drunk and his behaviour was inappropriate with residents. Anyway I decided to report him to the inspectors but they did absolutely nothing other than come out for a quick visit. They made it very clear to me that they did not think his behaviour was inappropriate, and in general it was clear they simply did not care. He just continued as before and nothing changed.'

Care managers informed me that informal carers regularly told them (in reviews) that formal support staff appeared disinterested in their routine (and low paid) work and some informal carers had even cancelled such much needed support because they felt guilty allowing their disabled son or daughter to be taken out in the community by an employee who clearly was not committed to the work.

Trapped

Care managers talked of family members and clients that they worked with being almost trapped in their unfortunate and stressful circumstances. There appeared few ways out for many, and life tended to offer a repetition of catastrophic and crisis related events. Often the same families had been known to social services over a period of years, and the predictable cycle of poverty, crime and abuse appeared established. Despite attempts at positive forms of intervention in the past on the part of supportive social workers nothing appeared to have changed, indeed it was more regularly the case that such circumstances simply got worse:

> 'We rarely seem to have any success in our attempts to help people, other than possibly offer brief respite at times. I've seen the same faces coming through these [social service departments] doors over many years now. First a woman will have trouble with her children attending school or due to considerable debts built up due to an addiction, then a few years later her children will have exactly the same problems, and so on.... There now appears a lot less tolerance, and the lack of options available to us because of the budget crisis, meaning that things just appear to get worse and worse.' Tony Looked after Children team T5

The 'cycle of deprivation' appears to continue with an alarming predictability, and the only real change noticed always seems for the worse. The same districts, families and clients receive attention from the SSD, and a lack of life chances appears to be passed

from one generation to the next. Familiar faces continue to appear at the reception of the SSD over each year, and the same issues (debt, neglect, abuse, violence) reveal themselves time and time again. A reproduction of poverty and deprivation appears inherited from one generation to the next for many clients, and the social worker has no power to prevent the transmission of misfortune from continuing:

> 'We simply have no powers to help these people anymore. I have to come out from my back office to tell the client that there is nothing I can do to help. We don't provide money for loans any longer...I have already tried to apply for benefits but failed...there is no appropriate housing available...our day centres are all full up.' Norman 24 years service T5

The quality of services on offer gradually become more and more unreliable and shabby; the likelihood of receiving anything on the basis of need recedes as each year passes; and the opportunities on offer regarding education, employment and housing appear to become more dire all the time for clients. Finally the 'issues' (violence; neglect; abuse; poverty, and so forth) addressed by care managers and social workers become more and more stark and disturbing as time moves on.

Although it may be fair to argue that social work has never delivered on its often-grand post-1945 claims of emancipating people from deprivation (Jones, 1999), it is apparent to some front-line workers that such deprivation can and does get worse for many of the powerless and vulnerable. The long term social worker practitioners that I spoke to acknowledged that services and opportunities were never great in the past, but also stressed that they had 'become *significantly* worse' over recent years.

Corruption

Although I could find no tangible evidence to support the claims, I was informed by some colleagues that they were aware of corruption involving social workers within the care management process. This was related to some care managers apparently taking clients to children's homes and receiving a 'tip' for the business from the owner(s). Another claim related to care managers taking clients to people that they had known for many years. Although this was rumour I was informed on a number of occasions by colleagues of this outcome. If correct it provides evidence that some of the problems quasi-markets encounter, as discussed by Le Grand (1993), have not been adequately explored. It also brings into question such theoretical assumptions that argue that quasi-markets will inevitably encourage better services for clients through the promotion of greater choice and competition, and that care managers will always seek to find the best available service for the client through knowledge of their needs.

Let the Women Do the Work

Many care managers also felt that the policies pursued by their employers were unequivocally sexist. The fact that formal services had been curtailed significantly over recent years had inevitably increased the burden on unpaid women carers (Community Care, 2000c; Means et al, 2003; Baldock, 2003). These carers had also experienced having to pay out of their own pockets through the SSD charging system for services. Managers, particularly the more senior members of staff, appeared quite open about the need for care managers to 'encourage the family to do the work'. Again

this offered further evidence of sexism within the personal social services. Senior managers also regularly referred to the problem of dependence in order to justify the policy of reducing or taking away services, as the following front-line manager explained:

> 'When I take the cases to panel it's always the same. I'm asked if the mum or sister can do more. People in this city are just 'too dependent' is now one of the most popular reasons given for refusing services.' Manager T5

The pressure placed on families and especially women over recent years has proven intense. It was not unusual for care managers to receive telephone calls during the day from a carer in considerable distress. Some carers even resorted to begging on the telephone for some respite or social support, usually whilst in emotional distress and crying. But the care manager nearly always explains the panel process, which will certainly lead to no services being offered in the majority of cases. For people with very little family support, which is not uncommon, such events prove even more oppressive.

The Exception of the Privileged

Another consequence of the poverty of resources that now so dominates social services is a readiness to challenge decisions on the part of the privileged and educated. Such is the fear of legal challenges to any refusal to provide a service, which itself could potentially lead to an expensive and time consuming journey "through the courts", that any threat to seek legal advice on behalf of families nearly

always leads to immediate surrender. Regularly middle class families challenge the decisions made by care managers, and in response such families typically get what they ask for. That such challenges are so class specific is all-apparent to care managers:

> 'Your chances of receiving a service are so much higher if you are well off. A letter from your lawyer can be drafted in days and will encourage an early allocation or get you the service you believe you are entitled to... Some of us, if we remember, advise other [poor] clients to seek legal aid, but I cannot remember anyone following my advice. I think the council are more confident anyway if you are not educated and [maybe] not as able to express your rights'. Sue T5

> 'Money always leads to more. If you are from a better area you are likely to get a care manager allocated earlier and receive services which are usually the best available.' John T4

As well as the threats to pursue legal action there are other less apparent forms of class discrimination apparent. Children taken into care appear to be always from deprived communities, despite the fact that social workers acknowledge that abuse does go on 'in all social classes'. Social workers for children informed me that, as with the adult teams, they were only now able to respond to crisis and high-risk scenarios within cases that usually involved allegations of neglect or abuse in relation to a client. Referrals increasingly came from other professionals, such as teachers and GPs, and time and time again attention to lone working class females appeared to

dominate the cries for attention from outside. Specifically I was informed that the Children Act's (1989) emphasis on parental *responsibility* for parents outside of wedlock (Thomas and Pierson, 1995: 64) had in practice encouraged attention to specifically target the regular allegations of abuse by poor working class mothers that the departments where I was based regularly received. With again little evidence of preventative work taking place in such teams, the role that many children's teams appeared to be now fulfilling was little more than a quasi-police role:

> 'We are just dealing with crisis and violence all the time now it seems. Allegations in relation to violence at school on behalf of a child, or a mother against child or child against mother... Neglect is also very common, but it's *always* crisis work, and more and more of our work is completed alongside the Family Support Unit [police]. But we only have a fraction of the workers that can deal with every allegation, and so inevitably many don't receive the attention they require...Few of us realised it would be this bad when we trained. I just live for my holidays abroad now.' Sue Looked after Children team T5

> 'It's the same people every time: poor people who live on council estates or elsewhere, usually young mothers. Typically they will have had very little education, will live alone, and may be addicted to drugs or alcohol, unlikely to have work or employment opportunities.... We don't really deal with *anyone* else.' Margaret Children and Family team T4

Processing and Reproducing Oppression

Overall it appeared to me as if the organisation existed to specifically manufacture and process circumscribed opportunities and misfortune for certain clients or families. The children's homes could always be relied on to churn out new adults who were adept in activities of crime who had received little access to education services. Many were addicted to drugs or alcohol by the time of their graduation from such a micro-institution, and social services were always keen to wash their hands of them once they turned 19. Inevitably many clients had no family members to turn to, and it was not unusual to hear of such clients ending up in prison.

Disabled and older people were soon left in their homes after possibly receiving a little attention through the assessment or after gaining access to a day centre (Morris, 1994). Those that had failed to get past the eligibility criteria or the strict assessment (most people) were quickly forgotten about. Indeed a file is now only created for a client if they *receive* a service, otherwise the system quickly forgets about them or their apparent claim for a service.

The more recent push to tighten eligibility had led to most new referrals into the department being refused allocation to a care manager. This is despite the pleas of GPs or voluntary workers, who insist in their referrals that allocation is essential for a client on health grounds. Thus the lack of attention or a service to a client will often increase their health risks, whereas, for some, long term access to a service may increase their risk of future health dangers (children in care). There is then a paradox within the specialities and social services in general; clients who benefit from services

such as lonely people who attend day centres, and those who become victims of them, such as clients abused at home by formal carers or in one of the micro-institutions. Just as social work may offer both forms of care and control, so it also offers different experiences depending on your age, disability, gender and social class, as well as the type of support you are attempting to access. With care managers and social workers generally being quite a disparate group regarding experience, political beliefs and level of motivation, the type of person you may be allocated following a referral is as much of a lottery as the type or quality of service you (may) receive.

The Empathetic Worker Whose Hands are Tied

Despite the cynicism and apathy that so epitomises the stance of many care managers; there are still genuine and sincere practitioners who believe in attempts to change even slightly the lives of clients. Such practitioners were few in number, and many continue to leave the occupation, yet they still exist and try their very best against all the odds. But it would be folly to pretend that their 'successful' interventions are regular and plentiful, far from it. Such is the scientific precision with which the organisation has been continuously restructured over recent years, that attempts to actually help people have become more difficult as each year passes. The relevant issues have all been discussed in detail already: chronic under funding; relentless and needless bureaucracy; strict procedures that emphasise eligibility and deferment to other departments; and work intensification that quickly crushes any ambition to offer assistance to many. That these constraints intensify each year means that the empathetic and aware practitioner increasingly becomes alienated in an organisation that appears to only be concerned with its own interests. Thus the teams in which I

(during the assessment/review or in supervision with a manager), and yet such risks have often been ignored.

The duty-dominated emergency service ushers into social work departments an atmosphere of perpetual crisis, risk and doom; one that further haunts the often-depressing atmosphere generated by the tedium of tasks that care managers are for each hour tied to. Telephones constantly ring, a colleague rushes about to fax an urgent care plan to a provider, and the duty officer prepares to respond to yet another call that comes through in relation to a crisis scenario. There are arguments and tears that accompany the looks of despair and abandonment upon the faces of the weary workers sat at their desks. Each appears to wonder how they ever ended up in such a job, which at times seems so detached from their initial attempts to help people in need. Soon another crisis will enter their world, and again they will discover the wonder of the 'quick cheap fix'. This is the now established policy of their organisation, yet again attempting in vain to keep the escalating demand outside at bay.

Conclusion

Regarding the initial research hypothesis my concern was generally with the 'quality of services available to clients'. I have found that the quality tends to be mixed, although care managers generally felt that most were poor or unreliable regarding what they offered in terms of client need. Many services were of a poor standard, but this has not been the key finding of my research. More significantly I discovered that only a limited number of services were available to clients regardless of need, and

most (referrals to departments) involved a substantial wait (up to 2 years) before receiving attention from a care manager. Further, the rationing of services has left many vulnerable people in the community living life at significant risk of harm regarding potential physical or mental health related accidents or forms of abuse. Sometimes the consequences can be fatal; indeed such "tragedies" were apparent during each of my placements. Despite this it was also clear that such events were now an *accepted* consequence of an era of regular change.

Despite a lack of quality services available, they are usually essential to the clients or their carers who receive them in the community. It has been argued that such occasional services are increasingly provided in response to crisis, and indeed social service departments are now beginning to resemble an emergency service that is based around providing sudden and unplanned responses to vulnerable clients living in the community at a high risk (Carey, 2003).

This chapter is the final one that deals with the presentation of my data. The remaining two chapters, as well as the conclusion, will consider attempts to explain what has been happening to employment and labour trends, social work and the experiences of clients. The next two chapters, which are theoretical, are divided into two parts. The first considers the disciplining of labour and the changes experienced in the labour market over recent years. The chapter looks at the influence of the New Right, as well as other explanatory discourses such as globalisation, post-Fordism, McDonaldisation and the idea of the evolution of the disciplinary *society* (as opposed to state). The second attempts to further explore the development of the social care industry, already addressed in reference to my data. Finally my concluding chapter -

the rise of the radical right - attempts to provide a summary of one of my main findings, as well as draw together other broad themes and issues encountered in my research.

CHAPTER 8

DISCIPLINING LABOUR

Introduction

In the next two chapters I will attempt to place my interviews, experience and other data collected into a theoretical context. This chapter deals predominantly with the experiences of social work in relation to broader political and social themes, notably concerning theories that attempt to explain the changes and effects of labour trends over the past twenty-five years. In this context the experiences of social work and care managers will be considered in relation to forces perhaps largely outside of their control, including many that have affected other industries and occupations.

From the many sociological discourses available for consideration I have attempted to select those that I believe are most appropriate in the attempt to explain my findings. I have also decided to draw from a *range* of theories that have attempted to explain political, cultural and social change over recent decades. Thus I shall not be offering any one grand-narrative (such as Marxism) in isolation, or fashionable schools of "ideas" or epistemological and ontological trends (most notably post-modernism), to *exclusively* explain what has been happening to social work. Instead I shall draw from different theories and influential thinkers (many related or symbiotic) over the next two chapters, in order to offer proposals for the events I have observed and experienced. Many such proposals are complementary in relation to any attempt to explain the data. Ideally I would like to propose that readers may themselves decide

from the 'epistemological menu' that I present their own preferred discourse(s) from which to understand or explain the extensive changes that have effected social work, labour and what little now remains of welfare. The reader may decide from the menu a theory or selection of theories, which they believe best explains some of the data I have presented in chapters 3 to 7. Alternatively they may identify flaws in each, and prefer to rely upon other, or their own, epistemological attempts to explain such change.

Fordism

Had anyone informed me a decade ago when I began my formal training for social work, that a publication then twenty years old which detailed the work of car factory workers would perhaps best prepare me for my new occupation, I may have been naive enough to be baffled by the suggestion. Yet on reflection Beynon's (1973) analysis of the experiences of production-line car workers working within the large Ford factory in Halewood and Speke, Liverpool, offers an ironic yet eerie evocation of the world in which I, and my fellow students, were to be thrown. Despite differences, the similarities in findings from Beynon's study in relation to my own data are stark.

To begin with Beynon identifies in the workers he studied a lack of commitment to the job or principles of the company:

> [The men] feel no moral involvement with the firm or any identification with the job. No one that I talked to thought that he'd feel too bad about leaving

Ford's for a 'similar job in the area'; seven of the sample in fact thought that they would be quite pleased. To quote a man on the cross feed:

'I bring books and crossword puzzles to work. This gives me something to think about when I'm doing the job. You walk out of here in a dream. I *will* leave soon. It's getting me down. It's so monotonous, tedious, boring. I was just going to make a convenience of Ford's for a few months but I'm still here. Not for much longer though. Yes: I'm leaving soon. I'm not happy here. I'm definitely not going to stay for much longer. (Beynon, 1973: 118)

The workers talk of a regret for mates left behind if they do decide to leave, but otherwise they express a clear frustration with the routines that they are forced to engage with each day; predominately for economic motives. There is also bitterness at choosing to work at the factory, notably after discovering how boring the work very quickly became. They also express regret at not deciding to choose another job or career that challenged their imagination, and allowed a degree of skill to be utilised each day. In this sense skill implies choice and a degree of autonomy, which the line will simply not allow. Similar frustrations and regrets are well documented in my data chapters, most prominently regarding the repetition of tasks that care managers are chained to each day, and the fact that many such workers feel alienated in relation to their lack of opportunities to offer support to vulnerable clients.

According to Beynon (ibid: 116) Henry Ford had estimated that up to 79 per cent of his factory workers could be fully trained in 8 days to do their job, while 43 per cent could start after only one day's training. In contrast due to the sheer number of procedures involved, care management takes a little longer before the worker

becomes 'proficient'. Despite this, unqualified students that entered each of my placements were doing most of the tasks that many qualified care managers had been doing for years within a couple of weeks. Indeed it was not unusual for a student on their first work placement to be left alone to complete their casework after a month or so of starting; as the following veteran practice teacher explained to me:

'I've had 7 students now and generally after a month I tend to leave them alone to get on with the work. I mean a student will typically be given around 8 or 9 cases on placement [over 4 months] which in comparison to [a qualified worker] is nothing really. They will ask questions but generally they always seem to cope....When it comes to the push the job is pretty simple really - and easy to pick up.'

Beynon (ibid: 116-117) suggests that speed is the key to success on the production line, and again in care management much the same rule applies. A simple truth is set in stone - the quicker the care manager processes any new cases and closes them, the happier the manager will be. Beynon also articulates workers' struggles with stewards and supervisors; the open conflicts and strikes; the conspicuous company desire for efficiency, and the limiting of cost and inevitably the importance of making profits. What emerges from his text is the inevitable *dispensability* of the men who produce the cars and make the profits, and the overall lack of concern for their well-being or interests on behalf of "the firm". That care managers felt little commitment to or concern for their managers or employers was also apparent; 'the corporation' as the council was referred to appeared to have little interest in their conditions of work, health or happiness, and instead appeared to continually generate more and more

monotonous tasks for them to engage in. The sparse nature of the at times rank working environments, and the diminishing rights (support; caseload management; training; sickness and annual leave) that workers cherished, merely added to the regret and frustrations felt by some care managers. As at Ford unrest was commonly expressed vocally, but instead there was little organisation regarding such measures as formal grievances or strikes; people merely moaned to one another or took time off sick. Perhaps higher unemployment, increased job insecurity and casualisation, as well as a weaker union movement help to explain this outcome. Perhaps also the differing class backgrounds of social workers or higher salaries enjoyed help to explain some of the conservatism.

Fordism as a discourse was developed by Gramsci (1973), and later achieved widespread recognition following publications by Aglietta (1979). It is a key 'regulation theory' and although it is always linked with Henry Ford's mass production techniques established in Detroit at the beginning of the last century, the labour process went on to be seen by many governments and industries as *the* way to organise work following the Second World War (Pinch, 1997: 71). Despite problems that would eventually escalate as time proceeded, Ford's emphasis upon the mass production of a standardised product proved a success for many decades. It emphasised capital-intensive working arrangements on a large site; an essentially inflexible or even cumbersome production process that would eventually help lead to its demise; strict and hierarchal bureaucratic managerial structures; the use of 'semi-skilled' staff to complete routine and mundane tasks on a line of production; and the tendency towards collective bargaining and industrial action on behalf of staff (Hakim, 1996; Steers et al, 1996). Much of the work was generally unskilled in

practice (Beynon, 1973), and a key drawback remained its lack of flexibility regarding what was produced, and the limited capacity of the public to buy the quickly produced products. Importantly Fordism drew from the 'scientific management' principles of the engineer Frederick Taylor (simplication of tasks; utilisation of 'time and motion' studies), and care management principles appear to owe a debt to Taylorist traditions (Carey, 2003).

Although Fordism is seen as very much part of the past by many (Painter, 1991), it is clear that parts of the culture and tradition still persist in many areas of the economy. The routine of care management, as well as the 'semi-skilled' tasks engaged in, and the hierarchal divisions monitored by managers all appear to echo the past. To the casual observer the work of social workers may well be interpreted as similar to work in a factory, and the link is not simply tenuous. That a process of deskilling appeared to increase in all of my placements as the work intensified and staff shortages became increasingly prominent, merely added more evidence of such similarity.

There are however important differences to the experiences of my colleagues and the workers described by Beynon. First, many care managers had a considerable degree of choice prior to entering what they considered a profession, and usually at least half had obtained a degree at University prior to entering social work. Of interest however I did note that more and more were qualifying via the undergraduate Diploma in Social Work courses run at local FE colleges. Second, the pay for the locations (except London) at which care managers were based was high in comparison to many other forms of work available. This illustrates social work's not entirely unsuccessful capacity to gain professional status and privileges. Third despite regular complaints

by staff about the buildings in which they worked, they were generally better than the at times brutal working conditions endured by the Ford workers. Permanent staff also had access to generous annual leave and a good pension scheme, and plenty of opportunity existed to move into other specialties of social work if change or a new challenge was needed. The option to pursue other training or career options was apparent, such as a post-graduate course or the approved social worker [for mental health teams] training course. Finally collective bargaining and industrial conflict appears an important outcome of the Ford culture of the time. As already detailed I could find little evidence of political action, and care managers appeared politically as a conservative group. For the most part, family and domestic responsibilities appeared to dominate as priority concerns.

Fordism as a theory also has important flaws. Most notable is an accusation of economic determinism, in which economic changes in capital accumulation are linked to political and social change (Bagguley et al, 1990). In addition, other influences such as those related to regional, ethnic, gender or class influences are often peripheral or not considered. Accusations therefore persist of a 'mass theory' riddled with generalisations (Watson, 2003: 68). Such criticism has relevance, and social workers certainly engaged with their role in different ways. For some it provided a second income to the family, others a part-time hobby, a career, or even in some cases a passion. For others I spoke to it had emancipated them from a previous minimum wage and low status occupation, notably in the social care sector. Such workers argued that on reflection it had failed to provide any previously assumed promise of a stimulating and rewarding profession; but still it was regular and secure work that offered a reasonably high salary. In teams 1 and 5 there was a relatively high

proportion of minority ethnic workers (approximately 15%), some of whom detailed their struggle to find secure work prior to entering social work. I was informed that social work 'appeared' more tolerant towards their minority status, on the surface at least.

Where Fordism has relevance however is in the Taylorist routines that I have detailed in chapter 3 and the firm managerialism evident in chapter 4. Workers were forthright about how such 'stress' *significantly* impacted upon their lives, and how work at times became reduced to a means to an end that provided limited satisfaction. The link between the monotonous nature of the work and employee alienation was extensive and regularly expressed vocally. Like Beynon's study however, why this never materialised into regular, organised and meaningful forms of resistance remains open to debate. When the deprivation suffered by clients, and recognised by the workers (chapter 7) is added to the analysis, the lack of protest becomes even more perplexing. This is an issue that is quite distinct from Beynon's study, as his workers merely processed cars rather than people.

Post- Fordism

Post-Fordism developed from a broad range of political and social changes that helped lead to a more disparate and fragmented social base in Britain (Harris, 2002: 32-33). In contrast to Fordism, it refers to employment policy and patterns of industrial organisation that are typically smaller and demand more skilled labour to develop products for smaller yet fiercely competitive markets. Flexibility and the capacity to change production for ever changing consumer demands is the key to the

theory (Boyer, 1988). As with Fordism, the discourse has never been concerned purely with economic and labour trends, but instead considers impacts far more deep rooted and relating to cultural and political dynamics and trends. Specifically post-Fordism has been identified as of influence to major phenomena such as the New Right, globalisation, and the retrenchment of welfare. State intervention is reduced in labour markets and welfare provision moves to the independent sector and families (Watson, 2003: 67).

Post-Fordism in Britain is generally identified as resulting from the social and economic crisis of the mid-1970s, a period of rising unemployment and general social unrest at which point the assumptions of welfare provision began to be questioned:

> Conditions of 'stagflation' lent themselves to the portrayal of public services as non-productive and a drain on the wealth-producing parts of the economy. As a result the post-war consensus came under siege.....the International Monetary Fund granted a loan in 1976 on condition that severe cuts were made in public expenditure and that a policy of wage constraint was introduced....the winter of 1978-9 became infamous as the 'winter of discontent' , with massive trade union action, which included social workers, in response to the curbing of pay demands and cuts to the 'social wage' through public expenditure restraint. With rubbish piled high in the streets and bodies unburied, British society was presented in the media as on the verge of collapse (Harris, 2002: 35)

The eventual election of the Thatcher administration would offer a radical departure from the welfare-orientated consensus of the past. This led to dramatic change, but even prior to the election of what was termed the New Right, it was apparent that the autonomy of the nation-state appeared to be receding . International competitiveness within a now global market quickly appeared as an obsessive priority of government, with a lack of concern for welfare provision complementing such an at times aggressive stance:

> [Western governments] urge us to come to terms with the fact that competitive life is nasty and brutish and that we are immersed in a life or death struggle for economic survival. In this struggle, the old ideas which ruled the modern welfare state - universality, full employment, increasing equality - are proclaimed to be a hindrance to survival. They are castigated as ideas which outlived their usefulness: they are no longer appropriate to the conditions of a global capitalist economy where investment, production, labour and consumption are all characterised by flexibility, transience and uncertainty (Leonard, 1997: 113)

The loss of autonomy by the state to the whims of the global market is a broader long-term outcome, but the process of post-Fordism has experienced many other characteristics over the past twenty-five years. These have included the decline of old manufacturing industries and the emergence of new-IT assisted forms of production; the emergence of more flexible or decentralised forms of work organisation; the establishment of a disparity between high-skilled and secure forms of employment in contrast to predominately low-paid and unskilled forms of (mostly female) casual

labour; the feminisation of labour processes; and the proliferation of technical and managerial classes in contrast to the decline in the 'blue collar' working class (Steers et al, 1996). Other changes have been identified that generally complement or are a response to such change, such as an increased emphasis upon intense (but passive) consumption on behalf of citizens that emphasises taste, appearance, and a struggle for individual consumer status and distinction (Bourdieu, 1984). Finally there is the apparent increasing influence of global corporations in dictating many spheres of life, including government policies (Albrow, 1996), as well as the establishment of a global division of labour that encourages the cheap production of ever changing products within the Third World for predominately Western consumers (Ferguson et al, 2000).

Post-Fordism might be viewed as a world phenomenon that celebrates the wonder of the market, and at the same time encourages flexibility and change with an almost misanthropic disregard for 'dependant' peoples, and developing ever more imaginative ways of exploiting wage labour for the benefit of a considerable minority. As a political force it is probably best associated with the New Right; as well as other inter-related processes such as globalisation discussed below. However for the purpose of this chapter Post-Fordism is utilised to consider changing work practices, and here it has considerable influence. Most prevalent as an outcome is that of flexible specialisation, which concerns 'the ability to adjust levels and types of output relatively quickly in response to variants in consumer demand without adversely affecting productivity or profitability' (Pinch, 1997: 75). This might be achieved through the use of IT, or the encouragement of workers to increase and vary the tasks they complete. Numbers of workers (numerical flexibility) employed will often need

to vary, with an increase in the number of temporary workers, part-time staff, sub-contractors and agency staff resulting. There is also generally more of an emphasis upon 'economies of scope' rather than scale as in the past, and an increasing concentration not so much on cost but a need to encourage (yet control) research, marketing and product innovation (Pinch, 1997: 76). Change then is widespread, and at times intense for both labour and society.

My period of research in social work of just under 5 years witnessed a work culture of perpetual change. Both temporary (agency) and 'permanent' (non agency) staff would literally come and go; one manager informed me that whole teams (usually 6 care managers) 'now rarely stay together for more than a couple of years'; movement to new buildings would either occur or be imminent; new procedures and forms to complete would regularly be announced in either team meetings or supervision sessions; and new regulations and rules of employment would also be dictated at regular intervals. Reorganisation became the buzzword in every authority that I worked, and just as staff had recovered from the last reorganisation another would soon be planned. Reorganisation normally meant relocation to a smaller or more cramped office; a reduced team or larger one consisting of a merger of teams with less overall staff to cover casework; stricter eligibility criteria for clients so as to make their access to the few services available even more difficult than before; the closing down of more local authority owned homes or day centres; and finally the reduction in employee rights such as access to pension schemes, holidays or sickness leave. As an employee I received no official explanation for any reorganisation, but two key motives or forces appeared active: first, the saving of increasingly scarce (economic) resources, and second, the process of continued *rationalisation* (discussed in more

depth in chapter 10), in which new forms of organisation and the calculated re-arrangement of working methods that demanded greater efficiency and 'output' were extracted from the same numbers of workers. Inevitably both trends are related and linked (Turner, 1992), and inevitably, as both generated more procedures and rules for workers to follow, this suggests a more coherent and planned organisation and monitoring of labour was active.

As is noted in my data chapters' change and flux were *constant* parts of the care management work culture, and in general staff were forthright in their view that change was generally for the worst. Of the few long term practitioners left, including some senior managers, there was regularly articulated a sense of being both drained and confused by all the changes that had occurred both inside and outside the different buildings from where they worked. There was also at times some discussion about the brutal lives now experienced by the clients outside, as well as the dire working methods now experienced by social workers.

Other similarities to the post-Fordist model persisted in my teams. There was the belief from many workers that change for the worst was all-apparent, and this regularly left staff feeling stunned, uncomfortable and depressed in their work environments. Despite the work intensification and ever more tasks to be learnt through quick training sessions, it seemed that routines that had previously led to worker satisfaction were now regularly dispensed with, and instead replaced with more mechanical and mundane procedures (notably in relation to reducing client contact further such as in the 'telephone review'). Further, the introduction of information technology merely generated more work in the one team where I was

granted my own computer. In teams 1, 4 and 5, colleagues also discovered that secretarial staff were laid off or moved elsewhere because care managers were suddenly expected to type their own forms, reports and letters.

The experience of social work has not necessarily been shared to the same extent in other occupations however. Nursing remains a similar 'semi-profession' in that it enjoys neither the power nor privileges of doctors or dentists, but at the same time limits the numbers of people entering to train for a career, and for the most part recruits, trains and delegates internally many of its own affairs (Witz, 1992). Yet nurses appear to have recently experienced a process of *up-skilling*; with assistance for more mundane tasks brought in and carried out by so called unqualified 'absorbers', allowing more opportunity for nurses to engage in other work. This however only tells part of the story:

> ...our findings show evidence of up-skilling among all types and grades of nurses, reflecting wider societal trends. Our data illustrates that specific nursing tasks are increasingly being delegated to health care assistants, that could be regarded as deskilling, but the content of nursing work is simultaneously shifting. We observed both a horizontal and hierarchal transference of tasks occurring. Nurses were released from some aspects of clinical work by junior or support staff, but only assume others' work, so that nursing increasingly comprises enlarged managerial, clerical and therapeutic elements....up-skilling is not necessarily synonymous with job enrichment, because positive accounts about the effects of consequent work intensification were hard to find. (Adams et al, 2000: 552-553)

The typical post-Fordist 'multi-skill' approach has different possible day-to-day experiences. If social work is continuing to become further deskilled, and other occupations with a similar degree of power are in contrast up-skilled; both are nevertheless united in their joint experience of continued work intensification with little evidence of job satisfaction being found in research. For social work, the image of a high skill economy offering increased employee autonomy and satisfaction appears somewhat remote. Rather post-Fordism appears in large parts to offer more of the same for many workers in relation to its Fordist predecessor: intense and largely mundane work regimes, with a resulting lack of employee autonomy and job satisfaction. This was the finding of Tailby and Whitson (1989) when they studied industrial firms in the UK who had introduced new technological innovations and work organisations. Workers in consequence experienced job losses, firmer managerial methods applied and increased levels of stress at work. As with my own research this brings to question the apparent new levels of autonomy available to workers due to flexible specialisation (Watson, 2003), or the potential benefits on offer through the formation of a new multi-activity society (notably celebrated by Beck, 2000).

Despite such problems however a few care managers were positive regarding the overall change initiated over recent years. Some women with children enjoyed the flexibility that agency work offered them, particularly in relation to allowing more time to complete roles such as having to take children to and from school during working hours. Others relished the opportunity that such 'casual' work allowed them, especially in relation to being able to move to another team or location if they were

not happy. However, many agency staff that I worked alongside resented their insecure work, and the fact that they appeared to be given bigger caseloads than permanent staff, who inevitably with long-term contracts tended to have more bargaining power.

In relation to the post-Fordist culture of service flexibility some care managers cherished and celebrated the wide range of products now available in shops, as well as the increasing number of leisure facilities available around the modern city. Such leisure opportunities, which included worker's increased capacity to travel abroad and buy products beyond their reach many years ago, meant that the drudgery of work was bearable in the knowledge that their quality of life had increased over recent years. Many people simply put up with their working conditions and were satisfied moaning to one another, due to their expressed belief that an improved life outside (due to improved living standards) was a complete escape from work. Again as regards a culture of flexibility some of the clients who were lucky to gain access to care services appeared to enjoy being able to encourage firms to replace disinterested staff if they appeared unsuitable. This however became more difficult for clients as my placements proceeded, and indeed care staff became more and more difficult to recruit on behalf of agencies, due to falling wages in an increasingly competitive market. The disparate experiences of post-Fordism appeared to depend very much on individual workers' or clients' circumstances, particularly regarding their likelihood of acquiring a service, or their work status or roles. For a few, due to personal circumstance, flexibility offered more choice, whilst for many it merely offered more forms of restriction.

Post-Fordism, like Fordism before it, has been criticised for its over-simplication and economic determinism. Some non-economic forces are largely ignored within the analysis (notably bureaucracy), and this issue is addressed in more detail in my next chapter.

The New Right

A broad yet distinct group of ideologies and factions that first became prominent during the mid 1970s, the New Right as it was termed appeared to offer a new force in global politics (Gamble, 1988). Questions still remain as to just how 'new' the New Right are, since many of its diverse beliefs are apparent in many earlier periods of political history, and are not merely confined to party politics (Deakin, 1994). As was also suggested above, forceful international pressures, notably from the IMF, appeared to increasingly encourage many of its policies (Healey, 1989). As is now well documented the New Right offered a break with the social democratic Keynesian post-war consensus regarding attempts by government to encourage full employment, and provide adequate state welfare systems. In contrast the New Right sought to celebrate the apparent possibilities offered by the unrestrained market, in which government and other forms of regulation and intervention were resented, and it was consistently and openly argued that public (particularly welfare) structures and institutions 'drained' wealth generated elsewhere (Minford, 1984; Esping-Andersen, 1998).

The New Right were not however merely concerned with encouraging economic change (Hall and Jacques, 1983). What perhaps generated as much (if not more)

attention was the exertion of a set of conservative moral stances, which seemed to contradict its economic led argument for smaller government. Instead a strong state appeared as a prerequisite for its authoritarian stance on a selection of issues, including (among many others) a belief in the 'normal' heterosexual family to an assertion of a strong, if not openly racialist, nationalism (Miles, 1993), and an obsessive drive to encourage a particular kind of moral responsibility on the part of citizens. Indeed many of the problems identified by the New Right with Britain's decline were linked to the actions of the state, including accusations that promiscuity and single parenthood were encouraged by 'liberal' professions such as social work (Jones and Novak, 1999). Ironically, as I shall propose in Chapter 10, my own findings suggest otherwise, notably that the social work profession possesses a lot of support at different levels for many key beliefs and values expressed by the New Right.

The strong moral stances taken received considerable support from large sections of the public (notably the skilled working class), leading to what Hall (1983) adeptly coined 'authoritarian populism'. Hall argued that 'authoritarian populism' offered a clear break with traditional conservatism, and rather than ignore the opinions of the masses, the rhetoric in its attempt to appeal to common sense logic, seduced (and exploited) people's prejudice and ignorance.

In questioning the institutions and practice of welfare the New Right ideology did not merely cut back on public services and take a strong moral stance. Some fractions also argued that poverty was indeed good for society, since it encouraged motivation and rewards for individuals if they worked themselves out of trouble (Wadden, 1997).

The fact that no market is ever free (Le Grand, 1993), and social realities such as disadvantage, discrimination, nepotism and educational privilege persist, were however conveniently ignored or denied by the authoritarian right. As previously addressed, cuts in benefits, health and education provision were also conspicuously and vigorously pursued as policy (Esping-Andersen, 1998), despite the dramatic increases of poverty and deprivation that followed throughout the country (Healey, 2000). During its six years in power New Labour has supported many neo-liberal practices and policies (Jones and Novak, 1999). For example, it has made no attempt to dismantle the quasi-market of social care, and many aspects of policies in relation to defence, health, education and so forth, appear remarkably similar to the Conservatives (Powell, 2003).

The influence of New Right policy upon social work has been revolutionary (Holman, 1993; Jones and Novak, 1993; Harris, 2002). This is particularly regarding the neo-liberal approach of establishing marketisation and new public managerialism as a prominent part of the occupation (Humphries, 2000). However its political conservatism has also had an important impact, such as in relation to the Conservatives' major pieces of legislation passed in Britain during their third term. These include the 'big bang', and the subsequent emphasis placed upon parental responsibility following the Children Act, 1989, and increase in family and charitable support (as opposed to statutory) following the NHSCC Act 1990 (both points are discussed further in chapter 10). In addition, throughout much of the British labour market, there has been an encouragement of low-paid and temporary forms of employment (Watson, 2003).

Finally, writers such as Hugman (2001) have discussed welfare in the *past tense* due to the extent of the New Right influence, and identify the emergence of what has been termed 'post-welfare social work'. Here welfare is not concerned with any prevention of social problems or anxieties, or indeed providing for any specific needs, it merely provides limited access to *occasional* run down and unreliable services. For social work this has been interpreted as the provision of an emergency service for a limited number of high-risk clients (Carey, 2003).

McDonaldisation

George Ritzer (1993) discusses the impact that the principles of the fast-food corporation are having upon society, and in areas of the economy such as higher education, health and social services. His McDonaldisation thesis draws from the work of Weber (among others) to offer a radical critique of modern work and culture. He identifies and discusses the emergence of an over-rationalised and predictable society:

> McDonalds and McDonaldization did not occur in a historical vacuum; they had important precursors that remain important to this day. The assembly line, scientific management, and bureaucracy provided many of the basic principles on which fast-food restaurant chains were built....The fast-food restaurant has become the model of rationality. Although it has adopted elements of rationality pioneered by it's predecessors, it also represents a quantum leap in the process of rationalisation. (Ritzer, 1993: 39)

Four elements are identified as being part of the McDonaldisation process. First there is a desire for 'efficiency'. This is achieved by creating clearly defined processes at work that 'simplify goods and services, and use the customer to perform unpaid work that paid employees used to do' (ibid: 61). Such a process usually encroaches not merely upon the autonomy of the employee, but also the customer. The second element is that of 'calculability' in which emphasis is placed upon the quantity or volume of products produced, with marketing making up for any lack of quality. Third is a desire to achieve 'predictability' in which 'a rationalized society emphasizes discipline, order, systematisation, formalization, routine, consistency and methodical operation' (ibid: 83). Finally Ritzer (ibid: 121) discusses the important role achieved in attempts to acquire 'control' at work, not merely of staff members and product, but also of the customer. Here non-human technologies play a key part:

> ...the future will bring with it an increasing number of non-human technologies with greater ability to control people and processes. For example, listening to audiotapes rather than reading books shifts control to those who do the reading on the tape: The mood, pace and intonation of the words are decided for you. You can't linger or rush headlong into them anymore...Perhaps the next step will be the refinement of artificial intelligence, which gives machines the apparent ability to think and make decisions as humans do. Artificial intelligence promises many benefits in a wide variety of areas (medicine, for example). However it also constitutes an enormous step in de-skilling. In effect more and more people will lose the opportunity, and perhaps the ability, to think for themselves.

Ritzer argues that the four principles have since been applied to whole industries such as health care and higher education. Social work's transformation under care management and marketisation has experienced similar themes as those addressed by Ritzer. The efficiency has been gained through the overall intensification of work processes and the reorganisations that have sought to apply more elaborate yet narrow regulations and rules (eligibility criteria, core assessments and review, monitoring by team managers, and so forth) to working methods. The calculability is maintained through, among other processes: the competence–led anti-academic and NVQ styled training methods, or the careful rationing of resources and services available. Predictability is established and assured through the many convoluted but clearly defined procedures followed by care managers, which ensure no individual influences by practitioners can, for the most part, occur. Finally control persists through new managerial techniques applied, as well as regulations, procedure and the limited options that remain for practitioners in their dehumanising work roles.

In relation Beynon (1992) argues that the work techniques and traditions long established for manual and industrial labour have now been extended into service sector employment. Here de-skilling is paramount, with again narrow and mechanical routines continuing to dominate the world of work for many employees. Frenkel et al (1999) point to the key role now played by front-line staff in the service sector. Here the employee is no longer hidden as before in the factory, but instead stands *between* the organisation and the customer. They argue that this role will typically require various skills from the worker as tastes and demands change rapidly over time. Social work however is distinct for two reasons. First the product on offer is unlikely to change that much as any purchase of formal care is often sudden during a period of

crisis and relies upon a limited selection of responses that have existed for some time (nursing or children's home; day centres; support workers). As a non-luxury good it might be argued that taste plays limited if any part, from the point of the customer. Second, as I have stressed at great length, social workers have very little direct contact with their clients, who rarely have the option to choose from a selection of products. Care managers' administrative role, and clients' lack of power, thus limit their capacity to enjoy the benefits of an ever-changing 'multi-skill' economy, as envisaged by the likes of Frenkel et al (1999) or Beck (2000). Further the increasing demand for their services through changing social trends such as the continued increase in poverty and the rise in the number of older people (Social Trends, 2001), mean that further (administrative) work intensification and de-skilling are likely outcomes. Each of my managers that I spoke to during my placements stressed that they had noticed that demand (referrals) was continuing to increase for their services despite the fact that staff numbers remained the same or reduced due to increasing absenteeism. For front-line workers this meant that more and more time was being spent within the office.

Ritzer (1993, 1998) has offered an original thesis that appears to have relevance to the changing face of social work, and goes some way in explaining why care management is so distinct from traditional social work. Most importantly however it also illustrates that changes within social work are not happening in isolation.

Globalisation

Globalisation is an increasingly popular yet broad and diverse discourse that appears to owe more than a little influence from the grand narrative and belief system

established by Marx (Ferguson et al, 2002: 8-25). In general the world is literally 'transformed into a single global system' (Abercrombie et al, 2000: 153), and this concept first became popular in the 1960s when sociologists such as Mc Luhan (1962) acknowledged the impact of communications technology which appeared to be almost 'shrinking' the world. Changes in parallel that continued the debate included the increasing influence of multinational corporations (MNCs) and the expansion of trade internationally, as well as the international division of labour (Abercrombie et al, 2000: 153).

Globalisation theorists now draw from many schools (sceptics, radicals, liberals, Marxists, and so forth), yet it appears that they are united on a number of fronts. First there is recognition of increasing economic growth on a world scale and the transformation of monopoly capitalism, which includes the expansion of a global financial market and the establishment of intense financial flows, both between and within nation-states. Such an economic trend has occurred in parallel with the growth in influence of the MNC and their capacity to move anywhere however far to establish production sites, and in order to set up environments that are receptive to their market interests. This includes a desire to relocate to areas were labour is cheap, and unions have limited, if any influence (Ferguson et al, 2002).

Second, at a political level, globalisation has witnessed the dominance of international agencies such as the World Bank, International Monetary Fund and the World Trade Organisation. Along with MNCs and global financial markets they are able to influence government policies within nation-states, by creating regulations or (in the case of MNCs) having the power to move if the policies of a particular country are not

suited to their needs (Abercrombie et al, 2000:153). Thus, in parallel with the post-Fordist thesis, it is argued that the nation-state has lost much of its autonomy and power (Ohmae, 1990).

Finally, as with the McDonaldisation thesis, it is argued that a form of cultural imperialism is apparent with globalisation. That is due to trends such as tourism, migrations, and the impact of the media (usually owned or dominated by MNCs) and high tech communications (such as the internet), a commercial culture or ideology of consumerism is encouraged and internalised by consumers. Such a homogenous but powerful ideology can displace more traditional or 'ethnic' values and means of expression (Ferguson et al, 2000).

Despite this sceptics question the true influence of MNCs and the mass media to influence or control human thought and behaviour, and also suggest that such forces can have an important and positive political impact of allowing greater resistance with mass communication enhancing such an outcome (Albrow, 1996). In addition, Ferguson et al (2000: 137) point out that such trends or ideas are nothing new, and quote from the Communist Manifesto (Marx and Engels, 1848/1973 : 71) to stress their point:

> The need of a constantly expanding market for its production chases the bourgeoisie over the whole surface of the globe. It must nestle everywhere, settle everywhere, establish connections everywhere.
>
> The bourgeoisie has through its exploitation of the world market given a cosmopolitan character to production and consumption in every country. All

old established national industries have been destroyed or daily are being destroyed. They are dislodged by new industries....that no longer work up indigenous raw materials, but raw materials drawn from the remotest zones, industries whose products are consumed not at home, but in every quarter of the globe... In place of the old local and national seclusion and self sufficiency, we have intercourse in every direction, universal inter-dependance of nations.

Although globalisation may not be a new development, new technologies, and the increasing dominance of monopoly providers and disparities of wealth, have perhaps generated new *opportunities* to speed up the process. Certainly the increased privatisation encouraged in Britain during the 1980s and 1990s of whole industries such as gas, electricity and large parts of welfare, appeared to wreck such almost 'non-capitalist' niches established during the post-war consensus (Harris, 2002). Dominelli and Hoogvelt (1997: 45) attempt to explain the influence of globalisation upon the privatisation of welfare, and its effects on social work in Britain. They suggest that this has led to a 'move away from publicly funded welfare provisions to commercial enterprises run by private entrepreneurs'. Further influence includes the 'loss of a public service ethic', the deskilling of and reduction in the power and autonomy enjoyed by professionals, and a consequential 'bureaucratisation of user involvement'. The authors detail a range of government-sponsored policies and legislative changes that have prepared an ideal environment for 'global market principles' to proliferate. Such changes they argue are not due to monetarism but more likely the influence of what they term 'the international capitalist class'. The Financial Management Initiative (FMI) of 1982, which allowed business managerial techniques to be introduced into

sectors of welfare, began the process, and was later augmented by the New Steps initiative (NSI) of 1988, which initiated 'contract government':

> ..the FMI and NSI were key mechanisms in the government's strategy of imposing business codes of conduct on to the public sector. This plan of action gave the state strong centralized control over strategic developments in the organisation of welfare services while simultaneously decentralising the detailed working out of its strategy to local players. In the case of social work, these were the local authorities, social service departments and probation services. Moreover, it enabled the government to reduce overall state involvement in the day-to-day delivery of services to users. (Dominelli and Hoogvelt, 1997: 51)

As detailed in chapter 1, during 1988 the Griffiths Report signalled a clear intention to inject business ideas and methods into social work. Contract government and quasi-marketisation would lead to new processes, such as the redundancy of social workers despite a growing batch of unallocated cases. Further consequences included the Taylorisation of the social work labour process; the direct influence of the private sector upon training methods, such as in the birth of NVQ-like 'competencies' for social work; quality control methods introduced to social care; the sudden influence of other professionals such as accountants; the development of 'budget-led' social work practice; the increased use of market influenced cultural concepts such as teamwork and efficiency; and finally the establishment of a 'mixed economy of care'.

One of the more prominent changes I witnessed during my placements was the increasing identification of local authorities and their role as being on a par with corporations. As well as staff who would make reference to corporate ideals and 'the corporation', there was also reference made to 'the corporation' in team meetings and letters passed to subordinates on behalf of the chief executive or director. The teams were encouraged to identify themselves as being part of a shared and broader organisation. Care managers spoke of 'losing [their] identity', and it was apparent that although we did work in isolation, there were moves to place many groups together, whether under the same large roof, as was planned towards the end of my last placement, or psychologically as part of the corporate rhetoric regarding utilising other services ('virtual team') or working in partnership. I have detailed already the emphasis upon cost cutting and efficiency, with such goals and ambitions seemingly superseding any desires to offer support to people in need. Indeed such a stance was eventually viewed as being out of touch with the new work culture established and in general there was the clear impression that workers who saved money and refused support were stronger and more competent practitioners. This stance was apparent in supervision, and front-line managers were regularly informed in meetings with their supervisors, training sessions or at panel, that saving money was the now the most important part of their role. The following front-line manager (in T5) makes this clear:

'Its all about saving money now and getting more out of your team. This is stressed in training, meetings and [in my] supervision [with a senior manager]. We are always being told [by senior managers] that clients are too dependant; as apparently is our [local] authority in comparison to others.'

One care manager who worked as a double-glazing sales person during the evening to make ends meet, noted the similarity of the principles of her sales firm to that of the council:

> '[Double glazing selling] is basically the same as social work. Quick visit to the front door, ask a few questions, take some details and then leave a few leaflets. Then make some telephone calls. The manager [at the double glazing firm] is much the same as here [social work team], always going on about the team and being quick and polite to the customers.'

Of particular interest to the globalisation thesis is the question of the reduced autonomy (and thus power) of not merely workers, managers and social service departments, but also of government at a local and national level. Hyperglobalizers such as Ohmae (2000) stress the importance of a drive for marketisation, in contrast to more sceptical accounts provided by Hirst and Thompson (1996). There is evidence to also suggest that some governments are working in unison with corporations, and thus the *sharing* of power is another possibility. For example, the Blair government recently 'invited' a number of American corporations to enter the private nursing home market in the UK, despite the fact that a number of these componants are still challenging charges of neglect and abuse through court, brought forward by former patients in the USA (Kerrison and Pollock, 2001). Much as in the context of the Post-Fordist and McDonaldisation theses, which all share similar arguments, the increasing control and influence of large organisations, big business and corporations is stressed by globalisation theorists, with labour deemed as a commodity to contain, control, encourage and exploit (Watson, 2003). However, one thesis that would

question such theories is offered by Foucault (among others), and concerns the disciplinary society.

The Disciplinary Society

Although Foucault offered a distinct approach, his theoretical method was clearly influenced by Weber, Nietzsche, Heidegger, Althusser and Marx (Dumm, 1996). Views of particular interest to this chapter remain: the historical force of increasing rationality that it is argued is not necessarily a product of economic imperatives; the use of knowledge (including social sciences) to control and contain populations; the elaborate and dynamic range of discourses or disciplines, including those related to personal freedom and civil rights, that it is suggested emerge to monitor and prepare 'citizens'; the importance of the professional to offer an adept form of state surveillance, as well as generate their own forms of organised discipline; and the almost instinctive capacity of citizens to discipline themselves.

The nineteenth century offered a period in which new forms of 'therapeutic discipline' emerged to reflect the growing urban population, and this less costly form of 'corrective training' was required to reflect the demands for a reliable source of labour. For such a need distinct professions and careers emerged:

> Through the play of disciplinary differentials and divisions, the nineteenth century constructed rigorous channels which, within the system, inculcated docility and produced delinquency by the same mechanisms. There was a sort of disciplinary 'training', continuous and compelling, that had something of the

> pedagogical curriculum and something of the professional network. Careers emerged from it, as secure, as predictable, as those of public life: assistance associations, residential apprenticeships, penal colonies, disciplinary battalions, prisons, hospitals, almshouses. (Foucault, 1977: 300)

From networks of discipline emerged beliefs and 'human' sciences, each with their own professions and individual roles:

> ...the growth of the disciplinary networks, the multiplication of their exchanges with the penal apparatus, the ever more important powers that are given them, the ever more massive transference to them of judicial functions; now as medicine, psychology, education, public assistance, 'social work' assume an ever greater share of the powers of supervision and assessment...these mechanisms of normalisation [become] ever more rigorous in their application. (ibid: 306)

But despite emerging from and adapting to broader economic and political demands such professions, which essentially offer therapeutic disciplines by which to supervise and consider the human body, are able to organise and arrange themselves to the world around them, attracting and generating their own forms of knowledge and types of (opportunistic) power. Their role is for the most part one of surveillance through observation and record keeping, but they also have a capacity to confront inappropriate anomalies in behaviour, attitude or health. For social work, distinct professional practices that appear therapeutic and compassionate, such as group work and counselling, reveal a potential for the client to be observed, monitored, extract

information from: which will be assessed, analysed and responded to. A power dynamic of containment and domination assures that select values can be impregnated into the host who stands under the gaze of the trained expert. The client may be encouraged to think in a more 'appropriate' way, or alter behaviour accordingly.

The professions' sudden rise in power was considerable, and to the state they offered a form of intervention that is for the most part non-violent, subtle and cost-effective. Illich et al (1970) detail the influence and control that professions or 'experts' established throughout society over the course of the twentieth century, and suggest that reducing such power is a prerequisite for any society intent on allowing a degree of freedom for its citizens. The professions construct new forms of knowledge or adapts discourses to fit their own wants. There emerge 'sciences' of observation and assessment (Foucault, 1971: 159-168) that create a given truth: for social work the selective use of sociology and psychology have sat beside its attempts to classify and regulate its practice (Jones, 1996). Thus books and journal articles persist which consider the role of evaluating practice (Sheldon, 1983; Cheetham et al, 1992); or how to carry out appropriate forms of research in relation to care (Goldberg and Connelly, 1981); and how to assess and care for children (Fuller, 1985); or depressed women (Corney and Clare, 1983), and so forth. Such sciences, according to Foucault (1966), lead to a classification system and order with a distinct political purpose that includes a desire for power; a method of assuring surveillance of the client; and a means to contain and control practices from within. But the establishment of such order limits the spirit of the individual and leads to regulated and circumscribed acts and thoughts, among many other consequences (Foucault, 1970: 235-264). Crucially government policy and legislation do not generate the only forms of discipline and

control: the professions and practitioners are able to generate and add their own powerful and effective forms.

Despite social work's failed attempts to acquire full professional status, and enjoy the privileges of say, medicine or law, it has survived in many respects against the odds due to its capacity to adapt to the dominant political discourses of the times. Thus despite grumbles from many practitioners and some of its academics, it has quickly adapted to the marketisation of welfare, and found an important (administrative) role in the re-constructed industry of social care. That such a role is for the most part radically different from its practices of the past century; appear to have had little response from its various associations, councils, directors, local authorities, or academics. Also its redefinition to a more scaled down 'skeleton' emergency service, or its increasingly more didactic role regarding more readily aggressive forms of intervention used towards the family, 'mentally ill', devious or criminal, appear again to have been accepted largely without any resistance or outcry.

My placements illustrated a number of these related issues. To begin with, professionalism was certainly a cherished goal of practitioners, one that was indeed aspired to with zeal. It was viewed as implying competence, the internalisation of altruistic ethics and the capacity to utilise and apply appropriate forms of knowledge. Workers were well organised, ethical, firm when necessary, ordered their files and kept appointments. Although the procedures ensured a lack of autonomy the complex matrix of procedures and managerial monitoring could not work alone, it required the worker to create order into their practice. As I have stated, a paradox persisted which suggested that although individual tasks were simple the sheer number of them, as

well as the unpredictable nature of crisis work mean that self-discipline is important for the organisation to continue. Self-discipline was readily adhered to in principle and individual disciplines also emerged, whether regarding how files or desks were maintained, clients and other professionals were spoken to (formal/non-formal), or how much attention to different cases or projects was allowed each day. Different teams arranged their own methods of dealing with particular parts of work, for example one team had a different worker on duty each day in turn, while another took turns for different people each week. One large team gave two people the opportunity to spend a couple of months covering the duty work. Such organisation was not arranged by managers but by workers themselves. Individual practitioners also appeared to generate their own rules of assessment or exclusion. Some practitioners felt it appropriate to give little time or attention to particular families or clients, and there was also a distrust or resentment of people who appeared 'lazy', uncaring or who were addicted to drink or drugs. Informal moral discipline was active in all the teams that I worked in.

At its most basic, the disciplinary society suggests the presence of dispersed social power relations, and a disparate range of disciplines, held within the social body. Rather than arguing for points or nodules of power, most prominently expressed during the 1960s and 1970s at the height of structuralism and Marxism, it instead argues that citizens (including clients) are at times regularly able to acquire their own forms of influence through individual strategies. Thus the dictating and all embracing influence of corporations and governments is not denied but questioned; even leading to suggestions that such organisations can be used to *defer* blame and responsibility away from personal attempts to acquire power. It is difficult to deny that social work

has regularly generated its own forms of discipline that are independent of legislation and policy, and that many within its trade have influenced such an approach.

Conclusion

The chapter has been concerned primarily with new forms of organisation and discipline that have been applied to labour over the past twenty-five years. Here Fordism has made way for Post-Fordism, in which both the neo-liberal project and the apparent process of globalisation have maintained a considerable influence. A potent drive for flexibility, efficiency, regulation and profit appear to be rife throughout competitive labour markets, leading to increasing job insecurity, role valorization and work intensification for many employees. Although some might argue with the extent of influence of the neo-liberal project, it is difficult to deny that substantial change has continued to occur at a rapid pace for those engaged in work, and that legislative and policy change influenced by the right has been apparent. Social work, undeniably part of the welfare state that has been ideologically and politically attacked by neo-liberals (Holmes, 1993; Jones and Novak, 1999), has experienced profound change in a relatively brief period of time. Most notably it has witnessed a reduction in its autonomy and power and has experienced a radically redefined role that is now almost entirely bureaucratic. Its contact with its client groups is now reduced, and its workers continue to face intense working regimes that offer ever more mundane tasks to complete each year.

Finally it has been suggested that much of the new disciplinary intent and change is not necessarily the complete result of powerful external forces, such as those provided

by government or the market. Instead it can be argued that responsibility lies in part with the occupation. Here a desire for professionalism (and power) has encouraged a range of disciplines to emerge regarding the formation of rules, regulations, procedures and belief systems, that have ironically further distanced social work from client communities and intensified its deskilling.

CHAPTER 9

THE SOCIAL CARE INDUSTRY

Introduction

The second part of my theoretical analysis attempts to consider the changed world of social care. Here it will be proposed that what was once an almost isolated semi-profession known as social work, has since been transformed to a low skill and low status occupation that provides administrative support to a broader service 'industry'. Much of the analysis in this chapter continues in the mould established in the last chapter. That is I will attempt to draw from influential theorists who have not for the most part applied their work to social work in Britain. Particularly I will draw from Pierre Bourdieu, Ivan Illich and Roland Barthes in an attempt to apply such (broadly) 'post-structuralist' thinkers to the workings of social care.

With a paucity of critical publication available on social work, most of which I have already drawn from, I will be limited to using the above theorists and my own research findings for much of this chapter. I will, as in the last chapter, also attempt to draw examples directly from my data as much as is possible to sustain my argument.

Birth of a New Industry

The 1990s witnessed a radical transformation of social care and social work. Most notable was the establishment of competitive quasi-market principles to the delivery

of care services, with a push by government to break the monopoly of local authority control of service provision. This led to the increase in independent sector care services and the gradual receding influence of public sector "providers". The introduction of a split between 'provider/purchaser' of services was also established, as well as the encouragement of a New Managerial work culture and the role of SSDs as "enablers" of care provision under the guidance of "care managers". Harris (2002: 43) argues that such initiatives 'changed fundamentally the operation of Social Service Departments and the practice of social work'. Harris also goes on to argue that such developments were quickly arranged initiatives in response to the escalating cost of residential home care provision then paid through the DSS, and despite initially being restricted to care services for adults, were soon extended to child care services such as fostering and children's home care provision. However for the government of the day the motives of marketising care were political as well as economic:

> …the Thatcher government had both the motive and the opportunity for reform, an opportunity enhanced initially by a sense of [financial] crisis. In relation to social work, the Conservative government launched an attack on the bureau-professional regime …The attack was two-pronged and brought together marketisation and managerialism. The Conservative reforms were crucially important in establishing the social work business. Whilst previously different operating conditions and dynamics had been considered to exist in non-capitalist state services and capitalist enterprises, the 'common sense' of the market was now pervasive, making quasi-capitalist rationality more extensive and more dominant than previously. (Harris, 2002: 54)

Harris also goes on to stress an important point: that is, with the implementation of market principles, social work's attention suddenly shifted away from *client concerns* towards the *running* of the new business.

My own data adds support to such an argument. As was revealed in chapters 5 and 7, marketisation has left the client resembling little more than a nuisance in view of the sudden need for local authorities and SSDs to save money. The NHS and CC Act (1990) had just been implemented when I began my first placement in Cardiff in 1993, and as each year progressed over the next decade, the client appeared to become further detached from the concerns of each department in which I worked. Care managers were increasingly encouraged by their supervisors to base their ever more elaborate assessments around being as prudent as possible in relation to "commissioning" services. Some front-line managers spoke with regret about their ever-growing need to process and allocate new cases, almost as if such tasks had become an annoying chore. At the same time the attitudes and new vernaculars of the 'industry' became increasingly alien to the values and ethics of many colleagues. This was in relation the increasing impact of the business culture at work, which was now stressed perpetually by managers who encouraged colleagues to regularly prioritise the financial implications (to the local authority) of any support provided for vulnerable people.

In relation to care provision social work was now no longer confined to the role and responsibilities of the local authority SSD. Power gradually appeared to move more and more towards the (previously peripheral) independent sector (notably residential/children's homes and care support companies) over the ten years that I

worked. As detailed in chapter 3 the sheer demand for services also meant that an ever-increasing amount of paperwork intensified for care managers, and less and less time was available to review any established packages of care. In addition as demand increased (and SSDs continued to have less funding for services), vacancies in residential, nursing and children's homes became more and more scarce, with care managers eventually having no choice but to place clients anywhere that was available. Independent sector homes increasingly became sought after by care managers, in contrast to the past when local authority homes were always in preference. Due to their high workloads care managers also had limited time available to contemplate or pursue alternative forms of support, or question the quality of those already available. In this context power appeared to have gradually shifted into the hands of the increasingly dominant independent sector, and colleagues argued that they now had very little influence in the interests of their clients, other than to fight for ever dwindling resources (chapter 5).

Such was the demand for services on behalf of clients, most prominently due to the ever-increasing number of vulnerable elderly people and children requiring care, that independent care providers became established throughout the urban communities in which I worked. These ranged from day centres, to residential, nursing and children's homes. There were also care companies established on many high streets (Local Solutions, Julie Anne Network, Goldsborough are but three established nationwide companies), usually with a 'staff urgently required' notice in their window. The poor working conditions, low status and low pay offered meant that most of these providers also struggled to recruit adequate numbers of staff. For care managers carrying out reviews or assessments of need it became apparent that a transient social care

workforce was established. This led to colleagues arguing that some carers with little experience, training or interest in their work were finding their way into the social care industry. Clients would often become attached to such carers, but soon discover that such employees had later moved on to a 'better paid job in Asda'. Many social care companies continued to recruit poorly, and allegations of abuse committed by formal carers against clients were not unusual during some of the care plan reviews completed by colleagues, or the "duty" work undertaken.

A social care industry had been firmly established, yet to care managers it failed to adequately provide for vulnerable people, for the reasons discussed in chapter 7. This was particularly the case for the unfortunate growing numbers of vulnerable people living in extreme poverty.

Commodifying Care

My experience gained on my five placements suggests that the social care industry links together a web or network of provider agencies. The industry spans the length and breadth of Britain, and is made up predominately of residential, nursing and children's homes, as well as day centres, supported accommodation and various home care companies. One of the distinct features of such a spatially scattered and disparate industry is that there remains little communication between each individual outpost or nodule of formal care provision, and each is made up predominately of small and medium sized businesses, local authority run 'micro-institutions' or a 'chain' of providers owned by larger companies or corporations such as Bupa. Unlike a Fordist industry such as coal, gas, or manufacturing sites that produce cars or refrigerators,

the smaller and more diverse arenas of work within social care ensure that no real solidarity, coherent union activity or other forms of mass resistance are expressed by staff. Indeed labour is fragmented and dispersed by the many locations and different arenas of work. Thus the transient workforce of mostly working class females remains without much power for resistance to their poor pay and casual and temporary working conditions (Community Care, 2000c), as a lack of unity is inevitably easier to exploit on behalf of employers who are now mostly drawn from organisations that seek to make profits (Kerrison and Pollock, 2001).

Since cost is now established as an important priority in the purchasing of formal care services, the 'product' of care is reduced to a commodity to be bought on the open quasi-market. A lack of and indeed receding amount of resources available to local authority SSDs means that the commodity of formal care is carefully quantified and measured in order to ensure that contracts and negotiations are established, to make such a process run as smoothly as possible (and rationed resources buy as many services as is possible). However in reducing human care to a commodity to purchase (through the 'care package' principle), unquantifiable ingredients such as the *quality* of service provision; emotional support provided or the *sincerity* of responses to need become of little, if any, significance. With quantity and cost becoming the priority of the process in a resource and profit driven culture (Carey, 2003), the vulnerable client represents not a person or even 'collection of needs' but a drain on resources to 'purchasers' (care managers, SSDs, local authorities, and so forth) and a threat to costs (staff wages, bills, rent) and therefore profits on behalf of 'providers'. With care managers also embroiled in bureaucracy back at the SSD, and many clients being without a next of kin or other advocate, such a culture will increasingly encourage the

potential for clients to be viewed as either a nuisance or means to an end. There are occasional inspections of social care providers, but as I have explained in my data chapters many care managers discovered that such routines occurred rarely – typically once every year - with advance warnings usually given to providers. Indeed Kerrison and Pollock (2001) note how the number of care homes has increased seven fold since the mid 1980s, but the number of inspectors has increased only three fold.

With their ever-intense workloads, care managers, who are supposed to carefully review care packages, were rarely able to monitor adequately all the very many care providers in their (caseload) locality. Indeed the sheer volume of cases that SSDs typically 'processed' and care managers were allocated, also meant that clients increasingly became almost indistinct from one another (similar to the hamburgers in Ritzer's McDonaldisation thesis). Again the work intensification which led to office confinement also meant that care managers became increasingly unaware of the issues that affected clients 'outside'. Training facilities also tended to be restricted to teaching workers new procedures or interpretations of pieces of legislation, which meant that an ignorance of client issues appeared to be *encouraged* within the work culture. It was as if the clients and their issues were no longer of any significance or relevance, which at times allowed a lack of or inappropriate responses to prevail during or following procedures such as the assessment of need. The predictable arena of social work also appeared to call for a series of increasingly narrowly defined outcomes to be established, whilst the client as commodity in the transaction-led culture of care management continued to fade into obscurity.

Making Money Out of the Vulnerable

The social care industry is able to provide a degree of formal support to the vulnerable in dire circumstances, but does so on the assumption of generating funds or profits to specific 'providers'. Thus the non-profit sanctuary of the state has been withdrawn to such an extent as to allow now dominant independent sector providers to prosper.

Although this does include 'charities', it is clear from the financial data that care managers' process each week that many if not all charities benefit considerably from the income generated by their business dealings. A typical placement in a Mencap run home will cost approximately £700 a week, leaving a large amount of money remaining when all costs such as low wage staff and bills are taken into account.

Mencap's experience is shared with other providers who have managed to find and establish a niche in the business of care for the vulnerable. As discussed in chapter 7 recent research suggests that the independent sector, particularly in relation to large commercial companies and multi-national corporations, is beginning to dominate the provision of core services such as residential and nursing home provision.

The Care Administrators

The introduction of independent sector "players" into the quasi-business arena inevitably generated a considerable amount of work to be processed by care managers regarding a need to complete assessments of need, financial assessments, contracts, care plans, and the importance of a review of services. A means of communication was also inevitably required between the various fractions within the social care

industry, many of whom had competing interests such as clients, relatives, providers, support staff, managers and health professionals. The social worker as care administrator links together agents and people (independent sector staff, care home owners, and professionals with clients, family, and so forth), and connects care nodules (hospital with nursing home, school with children's home, and so forth) with one another, or with a customer (client). Care administrators literally hold together a 'web' of formal care relations by their crucial administrative interventions. Care administration developed as the important role that ex-social workers would conveniently fill following the implementation of the NHSCC Act (1990) in 1993, and the role ensured that negotiations 'outside' ran as smoothly as possible. Social care would struggle to be maintained without such tasks being completed by care mangers, and despite the tensions and apparent inadequacies of the system regarding responses to need, the industry is maintained due to the work completed by care managers. Without the many and varied bureaucratic interventions of the care manager it would be unlikely that such a system could continue to exist in its current form. Indeed such structures as the nodules of care and links between the informal sector and care providers would surely collapse, since any business or industry inevitably requires organisation, negotiation, as well as the exchange of contracts and transactions to be maintained and processed.

One reception worker (in T5) informed me that her and a colleague decided to count how many calls they received for care managers in the average (mid week) working day. No less than 332 enquiries from providers, relatives, clients, or other professionals, for 48 care managers (based in the building) came through to the reception that day. This figure does not include the many people who had a direct line

telephone number and called with an enquiry that did not go through the main office line.

The preoccupation with bureaucracy of the care manager also encouraged a further antagonism to develop with clients, as they were seen as never having time for visits, and thus gave the impression of being without concern. Colleagues often argued (or perhaps developed a paranoia) that no one else understood the sheer volume of bureaucracy that needed to be processed, and the fact that chaos appeared to ensue within the walls of administrative care. As time progressed care managers struggled to complete much of the paperwork, since so few staff were available and workloads were continuing to rise. As previously noted, it was also apparent that the extent of bureaucracy, generated a culture that appeared to *process* people rather than work with them. Thus the commodification effect of identifying large numbers of people as being almost on a par with inanimate objects was further highlighted. There was a movement of bodies into and out of care homes, day centres or other forms of accommodation that projected to the tired practitioner (who was surrounded by contracts, and other forms) a sense of not working so much with vulnerability as with objects. Thus the structure of the tense administrative care working environments dehumanised both clients and care managers alike, with only the successful proprietors of formal care services allowed the luxury of a smile throughout the working week.

Developing the Profession

There appears little recognition given to the frustrations and tensions on the front-line when leaflets or pamphlets (appendix 4) are passed to practitioners, or they log on to professional association internet sites, which go on to remind them of their apparent need to maintain 'professional status' and 'competence'. BASW for example, recently described as 'distant, elitist and remote' by a leading social work academic (Community Care archives, 2002b), appears to place all its energies into maintaining an image of resolve and determination on behalf of practitioners. Practitioners are reminded that social work "advocates" for clients and "empowers" them. The General Social Care Council (GSCC) code of practice (appendix 4) argues that 'social care workers... must [help] service users and carers to make complaints, taking complaints seriously and responding to them or passing them to the appropriate person'. In addition they must '[take] necessary steps to minimise the risks of service users from doing actual or potential harm to themselves or other people' and social care employers must '[have] systems in place to enable social care workers to report inadequate resources or operational difficulties which might impede the delivery of safe care and [work] with relevant authorities to address these issues.' In each of my placements managers were forthright in supervision and team meetings about care managers' important role of *discouraging* complaints from clients; striving to save resources in relation to reducing service provision wherever possible, including when client risks were pointed out in detail within panel application forms and then dismissed or ignored by panel members. As previously detailed, the GSCC code of practice was dismissed as 'rhetoric nonsense' by colleagues in Team 5, and most copies ended up in the bin.

The following practitioners offer their personal opinions on organisations such as BASW and the GSCC:

> 'I went onto the BASW site hoping to find something of use but it was just the same old rubbish. Social work is apparently an exciting profession to be working within and is always in transition. It draws from a diverse community and changes people's lives.'

'I mean you only have to look at the response from all the teams to that [social care council codes of practice] 'menu' (appendix 4) that they recently brought out. We 'promote independence' and 'minimise risks' to service users: what a load of nonsense! It did cheer a lot of people up when it first came out because

> I just remember everyone laughing at it aloud as they read the content. Most people [in the building] just put the thing in the bin'

My research suggested that such associations and councils had lost the faith of their workers who fail to identify with the positive world of work that they attempt to project. The scepticism and cynicism expressed by practitioners was not merely an emotional rant, but a response to many years of hard evidence to the contrary.

Social work's attempts to secure professional status date back to the mid 1900s, and from the beginning the occupation was dominated by middle class women or some middle class men who utilised it (for experience) prior to entering a profession such as law or the church (Walton, 1975). Training began in the universities in 1884 and the

social sciences were plundered selectively in order to provide a knowledge base from which to practice (Hugman, 1991: 87). Recruitment and training ensured that the numbers of 'appropriate' and qualified workers were controlled by the occupation itself (Jones, 1979). Even 'radicalism' had its origins with the educated of the nineteenth century, and the key method of 'empowerment' was a distinct technique utilised over one hundred years ago, perhaps helping to explain its continued popularity in *higher education*:

> Higher education as the location of social work training in the UK is also related to the class origins of the nineteenth century social work. The settlements were university foundations, designed to give men in training for the (Church of England) priesthood, or to a lesser extent law, experience of working in poor city areas. Fuelled by a radical form of Christianity, this work was also intended to empower working-class people through the sharing of knowledge. (Hugman, 1991: 88)

A 'multiplicity of professional bodies' emerged in an attempt to regulate and control the various fractional forms of social work (caseworkers, almoners, probation officers) that had emerged up to 1970. Attempts continued (especially by BASW) to establish a form of registration, as had been achieved in medicine and nursing, but this proved difficult owing to a shortage of qualified social workers (ibid: 88).

Social work then has witnessed a historical approach between the specific concerns of its controlling and training bodies in higher education, and through its many professional bodies (ADSS, BASW, and so forth), and the interests of its front-line

practitioners. My data suggests that recent years, particularly the past two decades, have witnessed an intensifying clash of interests, as deskilling and receding employee rights and conditions continue to blight the experiences of front-line practitioners. A lack of acknowledgement, support and resistance, from what often appear from practitioners' and students' point of view as remote and elitist academics and associations, suggests that tension and strife *within* social work is not merely confined to the front-line.

The Care Vernacular

The French philosopher Roland Barthes, who concentrated on semiotics in his influential work, went to great lengths to stress the distinction between 'reality' and the other world created by signs, language and gestures. He argued that through the use of such signs (myths) power differentials were maintained:

> ...everything can be a myth provided it is conveyed by a discourse...A tree is a tree. Yes of course. But a tree as expressed by Minou Drouet is no longer quite a tree, it is a tree which is decorated, adapted to a certain type of consumption, laden with literary self-indulgence, revolt, images, in short with a type of social *usage* which is added to pure matter.
>
> Naturally, everything is not expressed at the same time: some objects become the prey of mythical speech for a while, when they disappear, others take their place and attain the status of myth...Mythical speech is made of a material which has already been worked on so as to make it suitable for communication. (Barthes, 1972: 117-119).

The Greeks, for example, created rhetoric, as a tool of persuasion, and Barthes identifies rhetoric as an important 'tool' utilised in the art of persuasion. Rhetoric can project a false reality that helps to maintain established norms and structures, and continue the power, benefits and privileges enjoyed by the "bourgeoisie" (Wiseman, 1989). Emphasis upon truth suggests a hierarchy of meaning that relate to status, power, and forms of domination.

Social work and care management are of particular interest because so much energy and effort are targeted onto the manufacture of rhetoric within social care that for the most part presents a world that is detached from the experiences of front-line workers and clients. Through academic publications, guest speakers, politicians, senior managers or directors of local authorities or charities, as well as representatives of controlling councils and academies, a world of justice, support and empowerment is presented. Such rhetoric, that for example will argue a case for what can be done (Thompson, 1993, 1998; Dominelli, 2002; appendix 4, and so forth), helps to not merely mask the reality of day-to-day life, but also helps to maintain and support the system as it stands. It motivates students and workers to believe that opportunities persist to challenge a system that can be unjust and unfair, but which they have the power to change. That few if any such opportunities persist in a bureaucratic and resource restricted organisation is therefore denied. The rhetorical language utilised is not mere words but powerful weapons in maintaining order, and indeed encouraging the discrimination and abuse that a lack of provision or adequate support help to assist:

The impact of aggressive falsehood is a matter of size, spread, and timing. The Hitlerian big lie traded on credibility-through-outrageousness. No one would dare say such a thing if it were not true! But the small lies that find their way into the streams of public information can be more harmful than the literal mendacity of one person defending himself against a just charge. It is not that the only lies affecting large numbers are those spread by the media, but other means - posters, circulars, word of mouth....We speak now, obviously, of *propaganda*, another of those tired expressions one seldom hears nowadays because *public relations* has taken its place (or *education*, or *consciousness-raising*: the propagandist does not coax, wheedle, indoctrinate, or inveigle the public into accepting his point of view, but *educates* it or *raises* its *consciousness*). The ultimate in power is achieved when a publicity apparatus is set up to generate its own financial feedback. (Bolinger, 1980: 115)

Social work has established its own (rhetorical) industry that works to present a united, adept and competent profession that offers support, counselling and empathy to clients, as well as other tangible means of assistance. That my own data projects a very different world suggests that such rhetoric, or ideology, must continue to be manufactured if any sense of order is to prevail. Beneath the important rhetoric, which social work has now manufactured consistently for decades (although the styles of the narratives are likely to change over time), careers are also established as part of an industry that needs to continue to project the image of a caring and fair profession. For social care more generally there is also a need to present new projects such as those of 'inclusion' in order to present an image that something is being done to encourage fair opportunities for disadvantaged people. That I could see no evidence

of such opportunities is neither here nor there, what matters is that rhetorical impressions are projected onto the minds of care and health employees during their training or work, in order to encourage motivation and commitment for their work and cause. The manufacture of a rhetorical 'truth' encourages a fluency to persist in the workings of the systems, and *attempts* to conceal the many consequences of policy and practice.

Barthes ideas appear in part similar to those of Neo-Marxists such as Althusser (1966), and certainly draw from the Marxian interpretation of ideology (Benton, 1984). Mills (1997: 28) recognises a distinction between the Marxist concept of ideology and the post-modern preference for discourse, a choice which she believes is political:

> For all cultural and critical theorists there has been intense theoretical difficulty in deciding whether to draw on work which is based around the notion of ideology or work which refers to discourse. These problems have to do with political orientation, which, in the pessimistic political climate of the 1990s, has meant that many theorists have found themselves more comfortable dealing with notions of discourse than aligning themselves to Marxist-inflected theories through the use of the term ideology.

Despite this it is also apparent that much discourse, if not all, is inevitably ideological, particularly if it is acknowledged that the use of language is inherently political and has consequence, whether to express domination (instruction) make claims or truths (via statements and depictions), or utilise 'linguistic strategies' to access resources

(charm, politeness, appropriate words) or refuse them, and so forth (Mills, 1997). It is my own claim that social work academia has generated rhetoric via forms of language and knowledge that depict a very different truth (care vernacular) to that experienced and expressed by most practitioners. This is further explored below.

Again this is an area of study that requires further research as it is apparent that there persists a widening 'gap' between often idealistic yet apolitical social work ideologies and the alienating experiences of clients and care managers.

The Use of Knowledge

In order to maintain any hope of acquiring professional status an occupation must create and draw from fields of knowledge (Johnson, 1972). Social work is no different, and has gone to great lengths in order to exploit the social sciences in order to create a firm knowledge base from which to practice. Such knowledge is manufactured and processed in academic books and journals, as well as being refined and reiterated in meetings, conversations, lectures, public speeches, internet sites, essays and practice guidelines. However as already suggested, the language of symbols that makes up such a refined discourse as the care vernacular is far from representative of the work experiences of care managers, and my interviews with practitioners revealed that their training had been inadequate in preparing them for work with clients.

Most prominent in complaints expressed by practitioners was the lack of information and knowledge offered that was related to health issues, such as common conditions

or pathologies that may have an impact on appropriate forms of intervention for clients. Anything from arthritis to diabetes to blindness may be included amongst many others. The language of social work also has a history of paying only scant attention to the cultural and political impact of poverty and class upon its client groups; preferring instead to concentrate on other non-class issues despite evidence that the majority of clients live in poverty (Jones, 1983), and social work, unlike most areas of welfare, is class-specific (Jones, 1999). Further the care vernacular has tended to insist that poverty and deprivation are the fault of the clients themselves:

> Social work has, since its origins in the 'charitable' efforts of the Charity Organisation Society during the last quarter of the nineteenth century, been deeply ambivalent about the poor. Throughout this history social work itself has not merely reflected dominant attitudes but has also been a crucial agency in the shaping and legitimating of those beliefs. Primary amongst these has been the view that poverty and inequality are not the most significant factors in the reproduction of the client population or of the multiple difficulties many of them encounter. Rather, this view has persisted in maintaining that the poverty and disadvantage of clients is not a result of social factors and systems but a symptom of the clients' inadequacy of character and morality (Jones and Novak, 1999: 80)

Social work knowledge also offers only occasional reference or acknowledgement to history or politics, and helps to conceal the lack of positive interventions that social work achieves in the community, by presenting an image of success through intervention, competent and person-centred practice, empowerment-led approaches,

and empathetic or therapeutic methods which are of benefit to the client. This is despite the fact that, as many front-line colleagues were keen to concede, such outcomes in practice are unlikely or unobtainable and conspicuous by their absence. The vernacular also helps to inspire and create new social workers, helping again to encourage the maintenance of an established order, as well as assisting in maintaining support for the social care industry. Among many others, Cheetham (1992) identifies (what were then) recent and dramatic aspects of change (marketisation) to social work, but at the same time attempts to blend such new 'social work interventions' with traditional practices that were already becoming redundant at the time. Inevitably no reference is made to recent policies in relation to the possible negative impact they may have:

> A last and extremely important aspiration concerns the relationship between [social work] intervention and outcome. Most social work interventions consist of more than one component and may include, for example, any combination of different kinds of practical help, counselling, supportive visiting, oversight or control, the behavioural, psychotherapeutic or family therapies, all of which have their own varieties. Ideally, therefore, in the interests of economy and efficiency, studies of effectiveness should be able to identify (and perhaps to cost) the outcomes attributable to each component. What, for example, was the impact for an elderly widower of the different components of his 'package of care' – domiciliary services or bereavement counselling? Were both essential and interlinked ? Could an equally good (or poor) outcome be achieved without the other? (Cheetham, 1992: 141)

In the tradition of the social work discourse the functionalist narrative throughout fails to acknowledge budget restraint, deskilling and work intensification, and instead argues that the social worker can take time to ponder and analyse a variety of interventions, including a wide range of therapies on offer to the client. (ibid: 122-126). Other core social work texts (Coulshed, 1991; Payne, 1997; Dominelli, 2002, and many more) continue in the same vein, and present to the social work student the impression of an enticing and fulfilling career ahead.

On each of my placements new graduates emerged from their training in the (misguided) belief that they would now not only be assisting and supporting vulnerable people, but also confronting forms of discrimination and oppression. As they each later admitted such ideals encouraged at college were simply not experienced or possible in relation to procedure based budget-led practice. The formation, sculpture and distribution of such knowledge also plays other important roles. As well as maintaining the air of a profession and enhancing individual careers, alternative 'truths' are concealed.

The Other Side of 'Truth': Processing and Maintaining Deprivation

Pierre Bourdieu has been an influential thinker regarding his studies of social class, culture and the workings of the education system, amongst many other areas of analysis. Of particular concern to his research is a preoccupation with forms of social and cultural domination and reproduction, as Swartz (1997: 6) highlights:

Bourdieu proposes a sociology of symbolic power that addresses the important topic of relations between culture, social structure, and action. Whether he is studying Algerian peasants, university professors and students, writers or artists, and the church, a central underlying preoccupation emerges: the question of how stratified social systems of hierarchy and domination persist and reproduce intergenerationally without powerful resistance and without the conscious recognition of their members. ...The exercise and reproduction of class-based power and privilege is a core substantive and unifying concern in Bourdieu's work. It is his ambition to create a science, applicable to all types of societies, of the social and cultural reproduction of power relations among individuals and groups.

As well as disparities in life chances between people there also persist accepted and unaccepted types of behaviour that are rewarded and punished accordingly. 'Normal' behaviour and values are inherited by some, who require little conscious effort to internalise and express such dispositions, or they are aspired to with great effort by others:

> The culture of the elite is near to that of the school that children from the lower middle class (and from the agricultural and working class) can only acquire with great effort something which is given to the children of the cultivated classes – style, taste, wit – in short, these attitudes and aptitudes which seem natural in members of the cultivated classes and naturally expected of them precisely because (in the ethnological sense) they are the culture of that class. (Bourdieu, 1974: 39)

Although much attention has been given to his work on the role played by the education system in reproducing class inequalities and a variety of disparate life chances, his work overall has more generally been concerned with the 'science of reproduction' and how broader organisations and agents contribute to the regularity with which societies maintain and reproduce themselves (Swartz, 1997: 6-10). My data strongly suggests that one of the more important roles that social work or care management achieves is the processing and maintenance, or more likely *encouragement* of, poverty. Although I have not the space to explore this process in detail, as it is at the very least a thesis in itself, I can still be brief in exploring the relevance of my data and findings. It is certainly of interest that social work's selective interpretation of theory has managed to almost completely avoid the theories of thinkers such as Bourdieu, who imply a radical critique of such welfare professions.

Reproduction appears most prominent, although it is certainly not exclusive to, social work with children. Here, as explored in chapter 7, the same families appear to come to the attention of social services, at times over many generations. Social workers' most dramatic, and increasingly common, form of intervention concerns looked after children by a local authority under the Children Act (1989). Here children considered to be at risk may well find themselves being removed from their parents and then living in a children's home funded by the state. It is not unusual for thousands of children to remain in such formal care for much of their childhood and early adulthood. Despite such placements, which cost hundreds of thousands of pounds, and generate much paperwork and many meetings, assessments and time for social

workers, it is none the less rare for any such interventions to lead to what is considered a 'successful outcome', as the following veteran social worker concedes:

> 'Drugs, prostitution, crime and prison are typical outcomes for a client after a long stay in a children's home. It is just so frustrating for social workers because so much money, time and effort has gone into the placement. In the short term you have taken the child away from a high-risk situation [abuse, neglect, and so on], but I would like to think that the outcome could be positive in the long-term...their performance at school is affected, many don't get jobs, I see these children change after sometimes only a brief stay in some of these places...It's getting worse, we don't have time any more to check if they are attending school or the placement is ok'

In work with children the wheels of social reproduction appear to move with the precision and strict routine of the hands of a clock. The same families come to the attention of SSDs and their employees, and the same old rituals and dynamics appear to be ever apparent. From violence to crime to abuse and circumscribed life chances, such events occur with predictable regularity for the client and many members of the next of kin. The more things change the more they remain the same, and veteran social workers stressed to me all the changes in legislation, policy and rhetoric they had watched pass by over the years, only to see the same old tragic events occur again and again with the same people. The word around the office of a successful outcome from a recent intervention offers colleagues but a glimmer of hope, but this is quickly dashed by phone calls throughout the day informing all of more crisis and failings.

But as the social worker above also suggests, the process of reproduction has in fact become more precise and intense over recent years. The lack of time that care managers or social workers have to spend with clients has meant that any voice of advocacy or more substantive assistance has been removed from the social work repertoire. Their confinement to the local authority office has meant that the social exclusion so emphasised by politicians in fact appears to have become far more acute. Veteran workers stressed the increase in crime, abuse and poor forms of intervention since care management was born, and their lack of power to offer any hope or assistance to the excluded. Some social workers talked of their 'radical interventions' of the past, including confronting absentee fathers about their lack of support for a family, or questioning slum landlords about their notorious properties or alleged racism. Such opportunities were considered to now be a thing of the past from the view of the veterans, and any hope that they offered of achieving the goal of positive interventions had now been removed.

By the lack of substantive responses the social worker helps to encourage misfortune and disadvantage. They have only their services now to work with, and these appear to quite regularly make things worse. But it is not only children who are affected, as Drakeford (1998) argues regarding community care policy:

> Despite the rhetoric of 'empowerment' or 'anti-oppression', the response which services offer to individuals...is all too often geared to confirming them in, and reconciling them to, their unhappy situation (ibid: 220)

Penhale (1999: 8) argues that the closing down of larger institutions and long stay hospitals has failed to halt the prevalence of abuse as this has merely moved into a new arena, namely residential, children and nursing homes: 'such homes can still be considered institutions by virtue of their organisational setting in which care is provided and finance is exchanged'. The author continues 'awareness of the possibility of abuse occurring within [such] institutions and the risk factors involved can effect decisions about the provision of care, and, for individuals, decisions about choice of care. Within the field of childcare, the publicised failure of care provided in some residential homes and schools, together with scandals relating to abuse within such settings has led to an increasing loss of public confidence in the ability of such homes to provide safety and protection for their residents. This has been coupled with a growing concern that there may not exist an absolute place of safety for young people' (ibid 10-11).

The Other Side of 'Truth': Social Iatrogenesis

Yet another influential thinker ignored by social work is Ivan Illich. One of Illich's (1975) most influential books was *'Medical Nemesis - The expropriation of health'* in which he explored the concept of iatrogenesis, or doctor-made illness. Here he argues that medical intervention offers a major threat to health, by encouraging a dependence upon what are often 'useless' or even dangerous forms of medical intervention:

> 'The medical establishment has become a major threat to health. Dependence upon professional health care affects all social relations.... A professional and physician based health care system which has grown beyond tolerable bounds

is sickening for three reasons: it must produce clinical damages which outweigh its potential benefits; it cannot but obscure the political conditions which render society unhealthy; and it tends to appropriate the power of the individual to heal himself and to shape his or her environment. The medical and para-medical monopoly over hygienic methodology and technology is a glaring example of the political misuse of scientific achievements to strengthen industrial rather than personal growth. Such medicine is but a device to convince those who are sick and tired of society that it is they who are ill, impotent and in need of technical repair.' (Illich, 1975: 11)

Illich attempts in great detail to illustrate how medical professionalism has entered every aspect of life and established a 'mafia-like monopoly' over the control of a person's life cycle and attitudes or beliefs. He argues that medical interventions are often cruel, dangerous or regularly do more damage than good, and include a capacity to lead to early and unnecessary deaths. Illich also explores 'social iatrogenesis' whereby medicine goes beyond mere clinical interventions and enters the cultural and social lives of populations. He also questions past successes attributed to medicine such as the apparent eradication of infections at the beginning of the twentieth century in 'developed countries'; believing instead that these were more likely the result of factors such as better housing and increasingly accessible supplies of clean water.

As I have explored in more detail in my data chapters, practitioners particularly, but not exclusively veteran practitioners, expressed in detail the damage that many of their interventions had inflicted on to clients. This was most commonly due to the poor and cheap facilities available, which had led to permanent yet avoidable damage

to clients' health or well-being. The example of a man who had fractured his hip during a fall that he suffered in an understaffed day centre remained one prominent but far from isolated example. Clients' being 'supported' in the community also complained about how they were 'treated like cattle' by underpaid support workers who had often fallen into 'minimum wage' care work through desperation rather than out of any interest. There were also the regular cases of clients being lost in city centres by support workers, or even of those being abused or having items stolen in their own homes by formal carers.

Regarding more long-term and extreme forms of abuse there were at times cases brought to care managers' attention of residents being abused in residential, nursing homes, or even day centres, issues or allegations that would regularly need to be explored or investigated, yet which rarely led to any substantive change that would prevent such events happening again. The many children (discussed above) who fell into prostitution or became addicted to drugs whilst in care, were again not uncommon areas of concern explored by social workers or care managers. That core services had tended to become more unreliable and under or poorly staffed as time progressed again merely highlighted such disturbing outcomes, and yet again long-term practitioners expressed in graphic detail the continued increase in tragic outcomes from a non-intervention or poor or inadequate forms of service intervention.

Morris (2000: 14) in her important and in parts distressing study of children services articulates the often abusive treatment of children in care homes, with many youngsters regularly treated with contempt or ignored by trained staff. In a recent publication (Broad, 1998: 45-53) highlights the many research projects carried out to explore what happens to children after they leave care. All come to remarkably

similar conclusions, notably that the 'ex-care population' typically experiences 'poverty, homelessness, instability, loneliness, and destitution in urban areas'. Ironically such outcomes are a symptom of what is still termed 'child protection' by the social work profession.

Illich's theory of iatrogenesis has tended to be broadened to also explore medical non-interventions, when these are clearly necessary. This issue has been highlighted particularly since the dawn of rationing first became apparent in the 1980s, and vacant hospital beds became increasingly difficult to find or medications became less readily prescribed by GPs (Ham, 1998). This is again of particular relevance for social work, and as I have explored earlier such rationing has essentially starved social services of the capacity to make appropriate and substantive forms of intervention to extremely vulnerable people. The consequences of non or unsubstantive intervention have at times been fatal, and care managers often carried around with them a sense of permanent guilt in response to failings that come to their attention when it was all too late.

Iatrogenesis again remains an area that requires further study and research.

The Other Side of 'Truth': Abuse and Abandonment

Jones and Novak (1999) stress the abuse and abandonment of the poor that has come to epitomise the policies and rhetoric of what they term 'the disciplinary state'. Such abuse is often a consequence of policies that may on the surface appear to imply compassion and concern. The role of social work provides but one example:

Social work, which was taken up from its charitable origins and expanded considerably by the state after the Second World War, represents for many people the compassionate and civilised face of welfare. Working with the most impoverished and often the most damaged casualties of poverty, it is seen as an indication of the nation's capacity and willingness to 'care' for its most vulnerable members. The revelations of systematic emotional, physical and sexual abuse that came to light in Britain in the early 1990s, in a succession of official inquiries into the care of children in state institutions, tells a different story. For some of the most vulnerable and abused, being taken into the 'care' of the state was the beginning of a process of yet further and organised abuse from those employed to care for them (ibid: 78-79)

Such abuse also expresses itself in other more articulate ways, such as in the attitudes held by some social workers towards the client population. These might include the emphasis upon clients having personality flaws or deficiencies, such as idleness, addictive personalities, a lack of moral dignity or a lack of capacity to manage money, which represents the apparent cause of their problems. But the poor might also be demanding in their desire for assistance, which might sit alongside their failure to take responsibility for their own misfortune. .

The evidence of abuse that I experienced was all too apparent; many practitioners indeed accepted the stance of their organisation, over which they argued they had no control. Clients were at times considered 'useless' despite the fact that little if any help was offered at the time. There was acknowledgement from many practitioners of the

increases in poverty and lack of resources but still clients were often treated with little if any attention. Morality was also often considered an important 'acid test' of personality or capacity, and was indeed regularly used to castigate or explain personal problems. Some mothers were said to have had 'too many children', whilst younger clients might be referred to as being 'devious or sly'. As I have also previously explained, I was given the impression that the more the care management role continued to frustrate practitioners, the quicker sympathy was lost for 'hard luck stories', and the more intolerant a practitioner might become. Some social workers, even developed a staunch misanthropic distrust of clients, and seemed to almost celebrate their capacity to refuse forms of assistance.

The abandonment capacity of social work was all too apparent for each day I worked. As I have explored in great detail previously, attention or services from the SSD were refused to clients as regularly as clockwork, despite the fact that need was always apparent and we appeared to deal almost exclusively with extremely vulnerable people, who regularly experienced forms of violence, neglect or abuse. As time progressed any services available, however shoddy, became increasingly scarce, and there were regular long periods of time, such as many months, when no services were available except to those people who were 'processed' through the duty system. That a lack of intervention led to further abuse being experienced by clients in the community was not unusual, and there were also occasions when forms of non-intervention were directly related to extreme outcomes including premature deaths.

The Emergency Social Services

As stressed in chapter 7, as my placements progressed and I became increasingly aware of the brutal reality of life for many clients, it appeared that the organisation and 'profession' for which I was an agent became more and more powerless in its attempts to offer any forms of substantive assistance. Eligibility criteria were forever being redefined in order to reduce potential requests for help or attention on behalf of clients; and organisational re-structuring led to ever more staff lay-offs despite the fact that shortages were already so acute as to make a mockery of the altruistic pretensions I continued to read about in social work publications. An impending sense of hopelessness appeared to haunt every SSD building I entered, and also a sense of boredom and despair appeared to remain in many of the hearts of the care managers I spoke to each day. People moaned about their excessive workloads, the lack of administrative support available, and the lack of resources and decent services. They also expressed their fears for the next imminent restructure, which would probably mean more lay offs and an enforced life of casual work (without benefits) for the victims with the latest employment agency to move into town.

I began to realise after my first couple of placements that what I now worked as part of was essentially an emergency service, one that was only willing to respond to crisis *on occasion.* There was no question of social services being able to provide for even the strict eligibility criteria's conservative understanding of need; quite simply neither our resources nor the services available would be capable of making even an attempt to achieve such a goal. Instead our provision had been so stripped to the bone that we could only accommodate a 'skeleton' emergency response to danger, abuse or crisis.

Thus the duty service took precedence, and care mangers lived in fear of the dreaded day when they would have to monitor such incoming duty calls. The experience was typically far from pleasant, and even the most hardened and cynical workers were left distraught on occasion when they confronted the at times distressing reality of life for many vulnerable people in the community. That such incidents never assured access to resources or services only further highlighted the desperate situation that departments and authorities found themselves in. For the care managers that ran such crisis terminals they signified in graphic detail the all too brutal reality of life in 'post-welfare' Britain.

Who Cares Anyway?

With a social care industry now only able to accommodate people living in impending danger, what of everyone else who happens to be poor, disabled, old, oppressed or abused on regular occasions? Where would they perhaps seek advice, comfort and support? What became apparent to me was that regarding formal services nothing was really available. The GP will simply refer a patient's problems elsewhere, most probably to social services, where they would be either again referred elsewhere or more likely placed alongside the many other piles of cases awaiting attention. A couple of years later that client might get a visit from a care manager, who most likely would then fill out a dossier of forms and much later telephone the client and tell them that ' I'm sorry but the panel has refused your application for services'. In essence unless in absolute crisis there are no formal means of support available unless a person has their own money available with which to buy services.

Following my own experiences and after interviews with colleagues it was apparent that families, friends and even neighbours tended to 'take up the slack' and fill the void left by the retrenchment of welfare (Finch and Grimes, 1983; Morris, 1991; Community Care, 2000c). More often than not women, often those in full-time employment and struggling to fulfil their roles as mothers, provided much of this unpaid support (Morris, 1994). For some however, particularly more transient clients who had often moved in order to escape a form of abuse at home, there regularly appeared to be nothing available (Broad, 1998; Morris, 1998). That such 'cases' of people in crisis with no means of support available was all too apparent, and seemingly forever on the increase, merely added to the lack of faith held by care managers in their organisation that claimed to empower and advocate on behalf of vulnerable people. As each week passed more and more access to support appeared to disappear before the eyes of colleagues.

Conclusion

The chapter has proposed that social services in Britain appear to have two fundamental roles. First, they provide essential administrative support to a network of formal care providers. Such a social care industry is both fragmented and disparate in its provision of care services, and depends upon a minimum or low wage army of female staff to provide much of its rationed forms of 'care'. More care however is provided free of charge by often reluctant and stressed unpaid carers who have little choice but to respond to the stressful circumstances that their vulnerable relatives, friends or neighbours find themselves in. When there is a response by social services it is nearly always administrative or formal, indeed distant or provocative in its token

response, and little else. Second social services now provide what increasingly resembles a makeshift or skeleton emergency service that responds on occasion to forms of abuse or crisis suffered by extremely vulnerable clients. Such an emergency service continues to respond to an ever-increasing number of intense high risk cases that are often difficult for care managers to confront. Typical examples remain cases that involve issues of abuse, violence or forms of catastrophe suffered by clients.

The social care industry is essentially made up of a wide range of disparate formal providers, ranging from small companies (domiciliary care companies), medium-sized businesses (children, residential and nursing homes) to nationwide companies (BUPA), or corporations, and large voluntary sector organisations (Mind, Barnardo's, Age Concern, and so forth). There are also local authority service providers such as day centres and care homes, although in general these are becoming ever more scarce (DOH, 1999). Alongside such formal means of support remains the 'unseen' informal sector of care that is usually made up of relatives, friends and neighbours of people who require support. My experience on placements has suggested that this 'unseen' sector of social work is arguably the fastest growing sector of the (unwaged) social care industry, that continues to receive less and less support (benefits, respite services) from local and central government.

It has been argued that any crisis suffered by social services is masked by an articulate care vernacular, a regularly generated and revitalised language of symbols and tokenistic gestures that through research, publications, speeches and lectures projects mythical but influential and ideological images of a caring profession struggling against the odds to provide for clients and empower them. Such myths hide the all too

brutal reality of a beleaguered and despondent occupation. It has also been argued that such a vernacular conceals such alternative 'truths'. Finally writers such as Illich have offered an important critique of the damage and abuse that professions can at times commit amongst clients or patients. His opinions, and those of many others, who suggest that professions ultimately serve their own interests (Johnston, 1972), appear to hold at least some 'truth'.

CHAPTER 10

THE RATIONALISATION OF SOCIAL WORK

Introduction

The final chapter attempts a summary of the most important research findings from my data, as well as striving to offer an overall explanation of my key results. I will further discuss social work's deskilling and budget-led work culture; the consequences of the central role of the care manager in the maintenance of the social care industry; and the establishment of social work as a 'make shift' emergency service that provides occasional but limited support to a small number of 'high-risk' clients living in the community. However more broadly the chapter attempts to consider two historic trends that I argue have had a considerable influence upon social work. They are, first, the tendency for social work to be guided by, if not embrace, a series of conservative and reactionary 'impulses' that impose considerable influence upon the activities of practitioners. Second, and in direct relation, the on-going rationalisation of social work, notably in relation to the role of the social worker being increasingly reduced to an elaborate array of mechanical procedures.

It is my own belief that the two influences truly came together during the establishment of the 'big bang'. It was here that the neo-liberal construct of civil responsibility and family and community support (away from the state) was firmly established, and articulated and codified into a complex matrix of scientific procedures that the individual social worker would have little (if any) choice but to

follow. Despite its at times brutal repercussions in relation to the abandonment of vulnerable client needs and its firm moral stance against a select number of poor 'single mothers' through the ideological procedures encompassed within the Children Act 1989 (explored below), there can be little doubt that the 'big bang' was a bold, intricate and sophisticated project that is arguably one of the greatest 'achievements' of the neo-liberal reign.

Radical Acts

The emergence of the Children Act (1989) and NHSCC Act (1990) initiated not merely the (legal) introduction of market principles to social work; they also introduced a distinct *philosophy* of care that appeared to draw directly from neo-liberal logic. For example, the Children Act (1989) introduced and stressed a concept since practised, and which has now become an accepted stance in social work with children and families, of parental *responsibility* in contrast to that of parental *rights*. Such an ideological construct also distinguished between the marital status of parents, and adopted a gender specific stance that isolated the role of the mother *outside* of marriage for special attention:

> [parental responsibility] is used in sections 2, 3 and 4 of the Children Act to emphasise that parents have inescapable responsibility when bringing up children and should not view the relationship with their children as based solely on parental rights. Parental responsibility is automatically conferred on both parents of a child as long as those parents were married at the time of a child's birth. If the parents are not married at the time of the birth, the mother

> of the child automatically acquires responsibility. (Pierson and Thomas, 2002: 329)

The Children Act did however, much like aspects of the NHSCC Act, contain what now appear as rhetorical attempts to stress the rights of a child, but again these were soon jettisoned by the sober reality of resource constraint within SSDs:

> The UN Convention on the Rights of the Child has provided an important moral framework for the duties of social services departments under the Children Act. However, during the 1980s and early 1990s, this moral framework often lost out to more dominant values: those associated with an emphasis upon business efficiency. Social service departments were required by central government during the 1980s and first half of the 1990s to be more efficient and to adopt an approach to the delivery of services which relied on costing assessments and services, and creating internal markets. (Morris, 2000: 5)

Despite a rhetorical stance that emphasised parental rights, Morris discovered outcomes and a similar sense of despondency felt by the social workers concerned with children services as my own has data revealed in relation to services for adults. Indeed her research data collected from child protection practitioners are remarkably similar to my own data:

> 'It feels as if our management just don't understand what 'working with children and families' is about. All they're interested in is budgets, bed spaces,

how many assessments you've done. You know, you have to build up a relationship with these kids in order to have any impact. But we've got no time for that, and, anyway, it's not what our managers are interested in.' (Social worker in the North- East of England: cited in Morris, 2000: 5)

The Children Act echoed many of the neo-liberal sentiments, both in theory and practice, initiated by the NHSCC Act. As well as encouraging the establishment of a quasi-market and new managerialism there was also a political concern with dependence expressed through a targeted emphasis upon civil *responsibility*. Whereas in practice the NHSCC Act openly increased the pressure upon informal carers to provide more (Harding, 1997), so the Children Act stressed the need for parents to take responsibility and self-impose discipline for themselves and their children. The core *philosophical* traits of the Children Act also appeared to strike a chord with many children and family social workers that I worked alongside:

'I don't agree with many of the changes but I still like many of the *principles* of the Children Act. Mothers should take more responsibility for their child's upbringing, I mean what is the point of having a child if you are not going to care and provide?' Annette LAC team

'I don't have a problem with the Act in *theory*, it's what has emerged in practice that concerns me. I think that most of my colleagues agree with its underlining principles, it's just how things have worked out in practice with so few services.' Carol LAC team

'I don't think [the Children Act 1989] stresses parental responsibility enough. Future legislation should be more detailed about the role of the parent – I think this would make our role clearer' Jane LAC team

'I think the *principles* of the [Children] Act have always been very popular within the profession; certainly with the social workers that I have worked with... It's just things that have emerged [in practice], you know, the usual things that people complain about such as the lack of funding, good quality [care] homes, and so on.' Margaret front-line Manager LAC team

I was informed that the Act was in general 'long overdue' and should in fact have been introduced 'earlier'. When I pointed out the sexist connotations of a piece of legislation that isolated female lone parents for special attention this appeared to be responded to by more of the pragmatic conservatism I had earlier identified in my work with adults. I was informed that in reality 'women do most of the work with kids' and so the sentiment appeared to accept things as they are rather than attempt to bring about change in relation to such established cultural norms. The *practical* consequence of the Children Act, namely the disciplining of the mother, also received support on the front-line:

'Most of the people we work with are mothers living alone and an attempt is generally made to get them to take responsibility for their child's upbringing. I know from colleagues that some other social workers years ago would attempt to confront the father in order to encourage him to take responsibility but we

simply don't have time for that anymore. I think it could be too dangerous today as well.' Gill Children Assessments Team T5

When I enquired about the typical clients that came to the attention of the child protection teams the responses were unequivocal. The quote below was representative of the child protection social workers that I interviewed:

'Nearly always young mums from deprived backgrounds, many with learning difficulties in my opinion. If we do get a referral for a middle class mum it is always to provide a form of support rather than investigate... I do try to help them ['poor single mums'] from time to time, but often it is a case of if there is no electricity the lights simply won't come on!' Maggie, T5.

Despite support within social work towards the ideological stance of such legislation, some practitioners were more sceptical. Notably (as with the NHSCC Act) it was argued by some that the legislative projects were 'attempts to save money'. Here the pressure placed on families, friends and communities to provide support for vulnerable adults and children was apparent to some front-line workers. To longer serving practitioners, their 'memories of more support' previously available was still fresh in their mind. However even some more recently qualified staff expressed their surprise at the lack of provision now available, and, as explored in the last chapter, a brief conversation with a veteran practitioner would emphasise that provision had tended to recede over time. However, many practitioners were either too tired or stressed to consider such political developments, some simply did not care:

> 'I have my own problems to worry about to be honest...We keep being told that the clients in this authority are too dependant, for some of my cases this is true...I try not to think about it too often, I have so many things to do at home as well as everything else.' Maggie T1

There were however also doubts expressed about the surge in independent sector nursing homes, and the motives that encouraged people (including some ex-social workers) to open such institutions. One veteran practitioner (in T5) noted how easy it was to set up a children's home, or indeed several. However, he also informed me that he believed that 'greed' was the principle motivator for setting up such a business in the independent sector. Despite this, a more recently qualified practitioner in T1 told me that 'many' of his fellow students on the DipSW course had expressed an intention to become '[social work] managers or [care] home owners as soon as possible on qualification'.

Holman's (1993) assertion that marketisation had received support from some senior managers and directors within social work is certainly of interest, but my own research suggests that the political and economic consequences of the neo-liberal inspired 'big bang' received support on the front-line itself. The potential opportunities provided by marketisation to 'get ahead' in social services via a managerial career, or by opening up a lucrative social care business, had inspired some practitioners and created 'new opportunities'. Add to this support for the neo-liberal ideological sentiment that saturates the didactic responsibilities *demanded* of parents and informal carers through policy initiatives and legislation, and together a

potent package of conservative values and economic liberalism offered appeal to an occupation that was born out of, and built upon, such foundations.

An Historic Discourse

Despite its relatively recent attempts to project a more 'liberal' image and set of belief systems, notably through schemes and projects such as anti-discriminatory and anti-oppressive practice, social work has tended to be built upon a range of didactic methods and beliefs that bear an uncanny similarity to the core values inherent within the neo-liberal project. These include a tendency to distrust the 'problem species' that is the client by front-line practitioners (Pithouse, 1987); to hold and express a personal sense of moral worth and superiority towards 'service users' who are generally ignored (along with informal carers) as part of the process of assessment and intervention (Macfarlane, 1996); and the 'hate and contempt' also often felt towards many client groups who are regularly dismissed as unworthy and dependant by social workers (Jones, 1999: 42). Such stances are buried deep inside the soul of social work, whether through its origins in Victorian England (Jones, 1978), or through a continued tendency to pathologise the client and concentrate upon individual or medical flaws (Oliver, 1990; Barnes, 1991; Corker and Shakespeare, 2003). The authoritarian practices that have been encouraged through such key and powerful pieces of 1980s legislation as the Mental Health (1983) or Children Act (1989), have also tended to receive only limited criticism from social work academics, which suggests that at the very least some support persists beyond Government and the front-line for their core ethics and values.

It is debateable whether the radical changes inherent within the 'big bang' legislation could ever be brought to life without at least some support for its principles and practices from sectors of social work. Rather than isolate and emphasise the role of government, legislation, and senior management, I would instead propose that support for many aspects of such policy is held within the hearts and minds of some practitioners and academics themselves. Put simply, it is unlikely that such legislative monsters could come to life without the will of many to add support to their movements. The collapse in formal care provision; the authoritarian components of the Mental Health Act 1983 and the Children Act 1989; the creation of quasi-markets; the development of private sector methods and forms of management, and so on: have all been accepted without much resistance by many within social work.

The 'big bang' provided a foundation on which a series of neo-liberal values and social work traditions were released. The merger of business structures, methods and theories; blended with conservative beliefs and prejudices around dependence and responsibility; were fused with a tradition of client-targeted distrust and contempt, to ferment and distil a potent brew that was released into distinct and elaborate (legislative) procedures that both empowered and restrained the SSD. The care manager was initially empowered by increased power over the client through the assessment of need, eligibility criteria and capacity to remove a child according to increased practitioner discretion (Broad, 1998). The Mental Health Act 1983 had also laid down similar legislative powers of assessment and incarceration on the approved social worker over the client with mental health problems. But as the front-line social worker may have gained increased disciplinary powers so they also lost important capacities to practise their traditional 'therapeutic' skills.

The key to such dramatic change remains within the procedures discussed at great length in chapter 3, and throughout much of the thesis. It is through the sophisticated array of (legislative) procedures (which the social worker *must* follow) that political power is so well arranged, organised and conveyed. Together the many compulsory procedures allow policy to be articulated in such an accurate and perfect means that individual pieces of legislation take on a new life. So well are their non-rhetorical claims distilled into practice, through the concrete corridors of conduct that they encourage the practitioner to walk, that a grand and nationwide network of mechanical tasks is formed. The working day for the social worker is reduced to a high number of banal bureaucratic procedures that the social worker completes, which allows managers the opportunity to monitor subordinates at will (by checking that appropriate forms/letters/faxing/photocopying have been completed), as well as ensure that resources are policed and other routines are followed by the worker. An insubordinate worker will be immediately revealed by their sheer incapacity to conform to clearly defined organisational protocol, which will include the number of (procedure based) visits made to clients.

The Education Act 1988 utilised a remarkably similar system of task-based procedures in which the development of the national curriculum and league tables ensured that the role of the teacher is cut up into a series of simplistic and bureaucratic procedures that the worker must dance to. Again a didactic ambiance is constructed within the arena of work, and the employee is submerged in a plethora of soul destroying and at times intimidating instructions that constantly pester and nag the frustrated person to move from one task to another.

The Rationalisation of Social Care

The 'big bang' continued and escalated a process of rationalisation that has long since been established in social work. From its first attempts to acquire professional status, to its immersion into the higher education system towards the end of the 19th century (Holman, 1991) and eventual acceptance into the bureaucratic machinery of the welfare state; as well as social work's long established capacity to conform to legislative procedure and policy, there is within the history of social work an established trend of becoming better organised, more procedural, with a will to quantify and assess, measure, arrange, and for trained workers to cluster around specific (functionalist) theories that bring order to the developing discipline of formal care. There is rank and hierarchy established, and precise tasks are isolated and broken down to specific details that take from the worker any choice or options.

The 'big bang' is of particular interest for two reasons: first, unlike other pieces of legislation (such as the National Assistance Act 1948 or Chronically Sick and Disabled Persons Act 1970) which also impacted on practice, the two Acts initiated an extensive and far more elaborate network of *compulsory* tasks that the senior and front-line workers were to follow in strict routine. Such a precise framework of compulsory duties intensified the process of rationalisation for social work considerably. But it was their (nationwide) scale and (procedural) organisation that made them so potent and effective in relation to their capacity to fulfil and extend their ambitious and bold aims that had first been initiated during the 1980s (marketisation, organised managerialism, increased client responsibility and informal

care provision, and so on). Second, the *political* intentions of the Acts were also cunning in their *rhetorical* and altruistic claims to assist the vulnerable child (remain with parents if at all possible) or disabled/elderly person (apparently released from cruel institutions), whilst in *practice* they took away formal support for the adult now living in often dangerous community environments (chapter 7) or selectively disciplined the lone parent at an organised pace (PP365-369), when and where it was felt necessary.

My own data suggests that neo-liberal ambitions are now literally written into or held inside every front-line care management procedure followed (assessment, review, eligibility, and so forth). Each task (completion of a form; telephone call; writing of a letter; meeting, and so forth) is held together almost like a 'chain' (Carey, 2003), and one procedure will lead to the completion of another: an amazing matrix has been created that compels the worker to complete tasks they were unlikely to even consider doing prior to the beginning of their social work training. Below is an example of how a care manager with 10 cases (clients' A-J) will typically complete a working day around some of the procedures to complete in relation to their caseload:

Table 10.1: Typical Working Day for a Care Manager with a Caseload of 10 Clients (A-J)

9am: complete assessment of need form in draft for client B at Client B's address.

Also complete financial assessment form if there is time.

10am: Return to office and begin to complete panel application form for client A, in response to completion of assessment of need and financial assessment forms for client A yesterday.

10.30am: Make telephone call to arrange visit to client C in order to complete review of services form.

10.45am: Photocopy client D's financial assessment forms completed last week.

11am: Write letter to client E reminding him of his responsibility to pay 'charges' (fee) for care services recently provided. Consult local authority guideline on 'how to write a letter' as this is likely to be checked by manager in supervision.

11.30am: Rewrite client B's assessment of need form completed in draft this morning. Be more specific and provide more detail as panel will ask for it to be resubmitted if it is judged 'incomplete'.

12am. Begin to complete a range of forms prior to supervision (Care Plan for client H; letters' explaining why services were refused to clients A, I, and J; day centre application form for client B, and so forth). Check files are in order for supervision later today. Also fax completed care plan for client E to provider. No time for lunch.

2pm: Supervision with front-line manager.

4pm: Continue completing relevant forms (see **12 am** above) as well as assessment of need form for client B began this morning. In supervision manager has asked for it to be 'reworded' to 'suggest less need is required'.

As can be seen from the table above there remains little if any discretion for the care manager in the completion of many procedures throughout the day. Whatever their individual beliefs or wishes - as on the production line of a factory - they have no choice but to fulfil the wishes and requirements of the organisation. So many procedures also allow the organisation to dispense with any 'foolhardy' ethical whims that workers may recklessly hold inside.

This is further emphasised by the careful measurement and control of finite resources, which apart from the collection and processing of information, arguably remains the most important role now undertaken by the SSD. As I argued at great length in chapters 4 and 5, resources were carefully scrutinised by a 'team' of front-line and senior managers at panel and budget meetings; and some care managers stated that they believed they were encouraged to 'feel guilty' about either spending resources or considering any applications to panel. A strict and didactic culture was established in which every pound was accounted for. In T1 care managers were shown a list of the '20 most expensive care packages' accommodated by the SSD, with the names of the 'guilty' clients and care managers responsible for creating or maintaining such packages appearing in bold print alongside the annual cost to the authority each year.

In T5 where I worked in a building that housed care managers who dealt with both children and adults, there were 100 different forms held in cabinets in relation to the work completed by both sets of social workers. It is difficult to imagine another profession or occupation that utilises such an array of administrative documents in its work. However, despite a sophisticated protocol of tasks already in place the force of rationalisation continued to build as more and more rules emerged, whether in relation

to work methods, sick pay and annual leave, or even where workers were allowed to smoke and when, if at all.

More broadly however forms of rationalisation do not merely relate to legislation and work procedures (Abercrombie et al, 2000: 290-291). Other cultures can persist outside (and inside) of work that add to the intensity and force of the dynamic. For example, the specific application of knowledge and theory to practice represents an important form of rationalisation (ibid: 291), and social work has always attempted to utilise some form of theory in its practice methods (Hugman, 1991). The use of knowledge will offer a means of containing and controlling the activities of clients (Foucault, 1971), with the use of specific theories allowing a more adept means of predicting and influencing behaviours under the gaze of the expert (Illich, 1975; Foucault, 1975; Bourdieu, 1991). The development of knowledge (PhD thesis on 'systems theory' or 'stress in the workplace'; BASW textbook on 'group work' or 'team work', and so forth) is largely independent of economic forces and can be utilised in order to improve the running of an organisation such as a SSD. The proliferation of internal attempts to regulate social work practice (BASW, 1977) have also persisted, and distinct and functionalist methods of research and practice (evidence based research, anti-discriminatory practice, and so forth) that continue to improve the smooth running and 'flow' of the occupation, and the organisation in which it is held, continue to prosper. Even theoretical methods that can appear therapeutic, and may from a distance appear constructive and enhancing to the client, can offer an important form of control and manipulation, as well as continue to provide a means of generating 'social care techniques' (as already discussed, educational group work or counselling remain good examples). Even 'emancipatory'

theories such as 'anti-oppressive practice' are likely in the *practical* domain of the 'expert and client' to offer new forms of manipulation and control. This is because such techniques are linked to specific (and contrary) procedures and legislative requirements, which as well as defusing the original political motives of the practice techniques, also enhance the essence and fluidity of the procedures and policy by initially providing the worker with a re-invigorated sense of justice, and therefore motivation and purpose. Thus, the student social worker fulfils the political ambitions of the NHS and CC Act 1990 through their task completion, helping to quantify the needs (as opposed to rights) of 'dependant' and anomalous people (such as the disabled) through the assessment, and that support is taken from communities and added pressure is subsequently placed on female carers. Yet bizarrely through internalising a theoretical stance the student *believes* that they are somehow 'empowering' the oppressed female through their use of more appropriate language during the assessment, that will ultimately lead to no additional service being provided or justify taking it away (through the review of services). After consulting one of Dominelli's (2002) many books on forms of anti-oppressive practice, the student professional may also be left with a 'warm glow' inside that will carry her to the next task, but the carer is faced with perhaps many years more hard labour taking care of her elderly and sick father. It may not be their initial *intention,* but in *practice* the just 'critical' theories applied to work methods under unjust legislation, policy, procedure, and so on, add a systemic and ideological fluidity to the workings of an *unethical* system.

Rationalisation might also emerge within the work environment of the professional as an almost obsessive drive to control, regulate, distinguish, intervene within the affairs

of, or simply dominate in various forms, the client (Johnston, 1972). It exists as a complex (power) dynamic (Turner, 1992), and it would appear that along with other professional projects (medicine, teaching, and so on), it has played a significant and increasing part in social work's relatively brief history. This is from both within (academic, professional and career aspirations) and outside (legal and statutory influences) the occupation. In important parts rationalisation is partly or completely independent of economic forces (Weber, 1978), but it nearly always complies to and is motivated by forms of power (career aspirations and other individual strategies to dominate and control; statutory and legislative means of regulating client and worker behaviour and values; professions' attempts to maintain privilege; claims to establish a 'truth' in contested interpretations of events by the expert; scientific research methods that deny or relegate other forms of 'truth', and so forth). This is particularly apparent with current social work, when in effect rationalisation in an extreme (administrative) form exists as potent a force for workers as the economic factors that mould the narrow forms of intervention available to the care manager.

It is also the rationalisation process, rather than any economic exploitation of front-line workers or disadvantage suffered by clients, that is at the heart of the frustration and alienation expressed by social workers. The social workers that I worked alongside resented their office confinement and monotonous work tasks far more than anything else. This was their greatest gripe in any hierarchy of complaints, and in complete paradox it has perhaps been social work's long held desire to acquire professional status, that has added to its increasing rationalisation.

Targeted Reform that Transformed an Occupation

Another important finding of my research is that state social workers rarely engage in "traditional" social work activities, such as group work or advocacy. Postle (2001: 17) is one of the few social work academics to acknowledge such an outcome. In her interviews with 23 care managers based in two separate teams, a selection of interview quotes appear to support my own data:

> 'You become like the DSS officer where you tick boxes...you tick the boxes and you do the sums and you're not looking, you're not doing social work and that's terrible' Care Manager

> 'There just isn't the time for them [care managers] to be giving of themselves in the way they were...I 'm not putting down the counselling, but it's got to be seen as something apart from what we do...we should actually be purchasing counselling skills, buying them in from a secondary provider.' Team Manager (ibid: 18)

But one of Postle's interviews with a migrant care manager, talking about her related experience in Australia, revealed an important distinction between social workers and other professionals; namely that social workers were more deskilled than many other workers:

'I was aware that we were all case managers [in Australia] but these other professionals in the team had *specific professional skills* that they could offer. For example the OT could not only act as a case manager but could provide 'functional assessments' as a provider, as a specialist, likewise the psychologist did psychological assessments, but what did the social worker do?...So I used to think then ...Where's my [assessment]...who's gonna buy a social work assessment?' Care Manager (ibid: 19)

My own findings suggest that despite similar legislative transformations in health and education, social work as a 'welfare profession' received special attention from neo-liberals in contrast to other occupations held within welfare. Research implies that despite additional paper work and increased managerial control nurses still spend at least some of their time *practising* nursing (Adams et al, 2000). Indeed, such an outcome is inevitable in an environment such as a hospital ward or GP surgery. Teachers again still spend many hours a day *teaching* children in a classroom, despite the similar excess bureaucracy that has now become a part of their job (Davies, 1998). Many social workers however, believe that they no longer *practise* social work (Postle, 2001). Morris's (2000) research has revealed not only an alarming description by looked after children of their virtual abandonment by social workers, but also a recognition from some unlikely sources of the extent of change, and need for reform in relation to the current role of the social worker:

We know that close attachments to one or two significant adults (not necessarily parents) make a major difference to the way children experience

situations which are potentially emotionally damaging. Young people have identified that they expect social workers to be significant parts of their lives, not to be merely passing through, filling in forms, chairing reviews, arranging contact visits. This view concurs with that expressed by Mike Leadbetter, Director of Social Services in Essex, when he said:

'I believe it's essential that we engage on a really deep level with children, in ways that hurt sometimes...Social workers need to *reassert* their professional place, working up close with children.'

The House of Commons Select Committee on Health concluded that looked after children would be better served if

'better-trained and better-resourced social workers were to *rediscover* their traditional role as confidants and champions of the children they look after.'

House of Commons Select Committee on Health, 1998, p. lxxvii

(Morris, 2000: 49)

As I have argued at great length, such has been the impact of the 'big bang', and marketisation in particular, that social work is now something that is completed by other people; mostly informal carers but also some community nurses, volunteers, teachers and even GPs, and so forth. Essentially the duty is fulfilled by people who are *permitted* regular contact with clients/ patients, and also have at least some time to give to such a role. The care administration role that encompasses the procedures followed and banal tasks completed by care managers means that social work is also something that academics lecture about, or write papers, books or give conference papers in relation to. Some medical professionals or volunteers are able to engage in limited forms from time to time by coincidence - but for the most part the role is now

fulfilled by a combination of low-paid formal carers (care assistants, support workers, and so on) or, and in far greater number, families, friends, neighbours, and even in my work experience, fellow clients. There may be occasional opportunities for state (and paid voluntary sector) social workers to reassert their 'social work' role during their brief contact times with clients (during assessments; telephone calls; meetings, and so forth), or indeed in their own time; but such opportunities are rare, and are likely to be unplanned, sporadic and superficial in outcome. In contrast, there is coordination, planning and rigid structure and organisation in the administrative and quasi-police interventions that care managers fulfil.

One factor that I believe helped to make neo-liberal reform so easy and extensive for social work was its lack of resistance to any change or reform. This political apathy or naivety - as well as related factors such as having no profession-centred trade union, an obsessive desire for professional status and a tendency to look to the state for legitimacy – has left it extremely vulnerable in the labour market. It is of no surprise therefore that the dull, undesirable, tedious but essential task of administrating the development of a private sector social care industry should fall to the personal social services. Quite simply, it is unlikely that any other occupation or profession within welfare would consider or accept such an unappealing and dehumanising role. That many directors and senior managers soon accepted their new role (Holman, 1993) when (as I suspect) they became aware of the potential financial benefits on offer comes as no surprise, but why so little resistance 'from below'?

Where's the Resistance?

Although there were plenty of moans and complaints about the organisation within the teams that I studied, I could find little evidence of tangible forms of resistance on the front-line. Workers that I could best describe as offering any form of resistance were usually individuals who had had some prior experience of poverty, disability or discrimination in the past. Such workers tended to hold liberal-humanist stances in response to the new culture at work. Many such workers are quoted in my data chapters and tended to discuss issues such as under-funding, poor service provision, the complex nature of need and the changes for the worse encountered. However such stances were rarely translated into forms of resistance.

The political stance of colleagues tended to comply with Mann's (1973) suggestion of employees' 'pragmatic acceptance' of circumstance and change. I could find no real evidence of a politically assertive 'class consciousness', and many of my quotes also suggest that people were not 'cultural dopes' hypnotised by right-wing ideology that contaminated their political consciousness. Instead people were aware of the consequences of policy but chose to accept it. There were different reasons for this, but most common remained a combination of pragmatic responsibilities regarding their children, mortgage payments and other 'non-luxury' *commitments*, and also there was evidence of a 'commodity fetishism' that appeared in relation to workers wanting to pursue hedonistic concerns rather than engage in forms of political resistance. People lived for their world outside the office and the job was merely a troublesome chore that paid the bills and allowed a combination of responsibilities and pleasures to be later pursued. Commitment to ethical principles such as the rights

of clients was expressed vocally but rarely transmitted to practice. My research suggests that even if the policies of the SSD were to continue to drift further to the right, such as through the introduction of private insurance schemes to fund social care or substantial increases in fees for services to clients, then they would be accepted with little resistance by front-line social workers.

I could also find no evidence of the 'radical left' that I had been told so much about in training. Indeed such workers would be unlikely to remain in an environment as hostile to any 'progressive' ideas as a social service department. Just as likely they would be encouraged to leave by their employers, and would likely feel extremely frustrated in such an adverse working environment anyhow. My own interviews with the handful of veterans that remained on the front-line suggested that the radical left never had any tangible long-term impact upon social work in *practice* because it never really had any significant support. It is likely however that even if such a movement were to exist it would never be able to gain any statutory or legal backing to allow the organisation and potent power currently enjoyed by the more pragmatically assertive right. My own interviews suggest any brief stint of resistance in the 1970s was also more concerned with (liberal) civil and human rights, and any militant or revolutionary groups were extremely small in number, probably quite divided, and unable to regularly translate their political beliefs into front-line actions. The Thatcherite isolation of 'liberal' social workers and teachers for special treatment, and tenuous links made between such professions and forms of promiscuity and deviance (Jones and Novak, 1993), were most likely based on bouts of paranoia and ignorance on behalf of an uncouth and reactionary right. In practice I feel that the 1960s generation or 'baby boomers' have offered no more a threat to established

political traditions and structures than any other previous generation: the few who have continued to provide long-term resistance would persist in any generation that they were born into. In relation to social work, my own experience and research suggests that the occupation (whether voluntary or statutory sector) cannot be used as a vehicle for social change or mass resistance. Put simply the will is not there, and any concern for clients is either lacking or superficial.

As already detailed, for care managers' resistance tended to be expressed by *individual* rather than group means. At its most common this tended to translate into long-term absenteeism; not adhering strictly to organisational rules or moaning about the manager or SSD; or (rarely) being 'insubordinate' and challenging the strict methods at times utilised by managers.

Moral Discipline and Provocative Methods

Despite the lack of resources available for supportive services, and an apparent perpetual demand for such services, many of my colleagues and their managers still needed to administer some form of intervention in order to fulfil their statutory and legal obligations. Consequently social workers were increasingly drawn into a series of 'quasi-police' roles that intensified as a consequence of resource restraints. A lack of services meant that one solution that remained for practitioners was often to take a more 'hard line' approach with relatives or clients. For example, clients with mild learning difficulties who at times were in trouble due to shop-lifting or the use of 'culturally unacceptable' language or behaviour expressed towards members of the public, often found themselves coming to the attention of their care managers. With

no services readily available, or waiting lists for support workers or day centres increasingly long, care managers found that they had little choice but to attempt more provocative approaches with family members or clients themselves; notably stern warnings (or threats) of the consequences of their behaviour. Thus disabled clients were regularly spoken to as if they were children in the hope such chastisement would mean that they did not commit further crimes that might mean that they ended up in the prison services (as happened on occasion). As the lack of funding for community care became ever more chronic as each year passed, so the interventions of care managers increasingly began to become more disciplinarian.

A pattern appeared to be established and held within the workings of the organisation. Care managers appeared ever keen to comply with and fulfil the wishes of a state apparatus that was only able to express forms of discipline and control to its citizens. There was no need to consider individual or group circumstances, instead an at times thoughtless and 'hard line' approach appeared to encapsulate the workings of a logic that was ever intent on maintaining order by any means possible. It is possible that this simply became habit over time, part of the procedural network within which work was now held. However my own assessment and experience suggested that the work intensification and stress that the SSD generated were helping to develop a political will within workers with elements that were similar to Hall's (1983) assertion of the 'authoritarian popular' disposition.

Workers in teams who dealt with children or mental health issues appeared to be spending more and more of their time 'sectioning' clients or 'removing' children from high risk scenarios within families. This has always been a part of the social work

role, but workers acknowledged that the number of such 'unpleasant tasks' was continuing to increase over time to the point where the job was beginning to resemble a police role. Many workers however had become used to the role, and some even enjoyed it, claiming it gave them a "buzz" and was better than "being stuck in the office".

Intolerance in a Tense Environment

As I have detailed, it was apparent in the tense and stressful working environments in which work intensification had become the norm that frustration was regularly felt on the part of my colleagues. This was of no surprise, as well as the intense pressures generated by managers appearing ever more keen to encourage more allocations and process faster assessments, there was also the pressure from relatives, friends and clients themselves to know why their request for a service had gone unnoticed. Workers from other departments such as "housing" and "contracts" would also appear to demand paperwork (care plans, financial assessments, and so on) completed by care managers. Representatives from service providers would also telephone care managers to enquire as to when they would be paid by the authority for the provision of a service. Colleagues spoke of living in fear when they ventured out shopping to the city centres, in case by chance (as had happened to some workers) they bumped into a relative of a client whose frustrations might take the better of them. Care managers spoke of being 'persecuted' from both inside and outside the SSD, and workers informed me that this was one of the reasons why they resorted to regular absenteeism.

One coping strategy that helped care managers deal with their demands from all around remained a resentment and anger expressed to the very people who appeared to 'antagonise' them so regularly. Thus as well as the 'demanding' managers, clients and their relatives appeared as easy targets on whom to vent spleen, and perhaps such anger assisted the care managers, to deal with their regular struggles to cope with high workloads. Thus intolerance and resentment of the constant "pestering outside the SSD" was at times present for workers who *ironically* had usually started their career with the intention of helping and assisting vulnerable people.

The lack of available training in relation to issues such as abuse, addictions, poverty and so on, had also helped to encourage an ignorance of such issues on the part of some workers. There was also no access to facilities such as books and other publications (which were rarely found in team offices), and care managers were often reduced to passively following many of the rigid sets of procedures established by the organisation. In consequence, knowledge concerning client experiences was often reliant upon common sense, and at times reactionary, responses to forms of need. Such ignorance allowed more right of centre ideas to at times prosper in practice, and although some care managers found the time to 'enlighten' themselves through their own pursuits of training or knowledge (at home), many simply did not have the opportunity owing to their many responsibilities outside of work.

The tensions and stress at work (and possibly home), as well as the poor work environments and lack of any appropriate training, meant that a frustrated client or relative keen to access a service often became a target of resentment or even hate. A vicious circle was thus generated between social worker and client, with both parties

increasingly ignorant of the worlds within which each party resided. For some workers as time progressed their frustration and anger led them further and further away from the ideals and values that had led them to seek a career in social work in the first place.

The Wonder of the Market and the Corporate Managers

The marketisation of care was an important outcome of dramatic change throughout the 1980s and 1990s. But whereas I was informed by colleagues that its inception had been responded to by doubt and some resistance, towards the end of my placements it appeared as if the market had become a taken for granted and important part of contemporary social work. Thus the language of business began to be regularly used by managers in meetings, and colleagues had no choice but to discuss or detail to one another their completed "financial assessments", "contracts" and "care plans". Managers also dictated the benefits of "agile businesses", "skill escalators", "virtual teams" and clearly defined organisational "strategies", and it was at times proposed that teams would soon be "merging" after the latest "restructuring" was implemented.

The vigour and zest with which some managers communicated in such a vernacular was as if the market had almost solved all of the past problems and inadequacies that social services may have experienced. Yet all around chaos appeared to present itself from one day to the next as more and more staff went absent; less services became available; the telephone calls from clients in distress became more regular; and providers increasingly pestered departments for their urgent attention. Despite all such evidence to the contrary, the policy of marketisation proceeded ever onwards, with

more and more reorganisations planned and yet more local authority services "sold off" or closed down. The computers that managers spent so much time in front of created ever more elaborate graphs that projected future demands and the lack of resources ahead, yet rarely was it suggested to me or my colleagues in supervision that such a system may not be working. This was evident for care mangers each time that they attended a review and listened to a list of all the complaints from a relative about the latest "makeshift" care package created for a client, or picked up a telephone and heard the voices of clients crying at the other end. Yet still the system would proceed, with new formats of work always prepared for the next team meeting.

Although front-line managers complained that they were as deskilled as care managers, it was apparent that the status of being a manager also brought with it more responsibility and expectation from their own superiors. This included attempts to save or guard resources wherever possible; avoid contact with 'demanding' clients; encourage staff to complete prescribed paperwork and procedures as fast as possible; proceed with a 'mass' allocation of cases to care managers (appendix 3); and ensure that eligibility criteria were adhered to at all times. As time progressed during my placements such approaches appeared to become more extreme. The 'Best Value' policy appeared to leave managers with little if any concern with anything but the number of allocations achieved and the dates and numbers of assessments, care plans and reviews completed by a care manager. Eventually it appeared that some managers became so entwined with the new culture that they openly expressed anger at having to 'take so many applications [for services] to panel'. Above the front-line manager it was apparent that compliance with the wishes of the organisation was further adhered to, this was particularly in relation to protecting the sacrosanct budget.

Managers also became increasingly obsessed with time keeping, and the personal organisation skills, behaviour and dress codes of subordinates. They were also keen to monitor attendance and know the whereabouts of care managers throughout the day. Such methods merely added to the sense of persecution felt by front-line workers.

To Drift Further to the Right

The five organisations by which I was employed were little different in relation to their procedures, routines, staff and policies. In general the political culture of the departments clearly drifted to the right during the periods for which I was employed, and it was apparent to me that such a process was not merely continuing but actually *intensifying* in speed. Eligibility criteria became ever more clearly defined; services became more and more difficult to access; managers became ever more ruthless and detached from the wishes and needs of clients; and a hostile and intolerable working environment appeared to become ever more intense as each year passed.

That such a "drift" to the right now appeared impregnated within the structural and procedural machinery of social services meant that a few care managers expressed fear for the future of formal care services and the plight of vulnerable clients. As I have previously detailed, colleagues spoke of "being scared" about growing old or becoming disabled due to a stroke, and so forth. Such fears were more than justified, and fellow care managers appeared to attempt yet more personal schemes or plans to 'get [themselves] out of social services'.

My data also suggests that a 'radical right' now holds a significant influence over social work. The radical right expresses itself through the tolerance, acceptance or engagement with market reforms within social work by academics, practitioners, managers and directors. It is also apparent in the manner in which business values and methods have so impregnated themselves into the very heart of the SSD (Holman, 1993). The support for the principle of parental responsibility, dependence and encouragement of extensive community and informal care provision away from the state has also added to the force of influence. Finally the lack of resistance to on-going reforms that have included the extensive yet continued privatisation of social care; the further development of higher eligibility criteria; and the need within communities that appears before social workers each day within their case files, assessment notes or brief contact with clients suggests that support is not necessarily confined to senior managers and directors. The radical right expresses itself by sitting at panel meetings and instinctively refuses services despite the detail on the forms that call for urgent assistance to vulnerable people often living in extreme danger; it appears in front-line managers' offices and collects endless data that provides no assistance to any client; it assesses or reviews need with a realisation that nothing will be provided; it ignores the demands of the child who claims she is being bullied inside her latest care home; it disciplines front-line staff regarding inappropriate form completion or 'too much time spent with clients'; it moans when informed that a client has appeared at reception in considerable distress and wants the attention of her social worker; or 'sections' clients under the Mental Health Act 1983 and removes children at will under the guise of "child protection"; or carefully plans and constructs the latest eligibility criteria that will save the authority tens of thousands of pounds. Many

more examples persist, but it would appear that there is more than a little evidence to suggest that social work's political legacy (which harks back to the nineteenth century) is arguably better organised and more powerful than ever before.

In contrast to the radical left of the 1970s, social work's new extreme political movement has statutory, legislative and procedural support. It is organised and empowered by the concrete network of procedures that support a range of prejudices to be administered in a sophisticated and coherent manner. The distrust and contempt held for the client does not swim against the tide, but is instead supported and swept forward by a legitimate series of (neo-liberal) policies and Acts. Such procedure and legislation has embraced and married the intolerance and contempt that has always been a part of the social work disposition. There does exist anxiety in response, both on the front-line and in academic quarters. But my own interviews, and a look at the 'popular' literature (notably Dominelli, 2002; and Thompson, 1998) suggest that such resistance is predominately liberal-humanist rather than radical, and lacks power, organisation and is also fragmented and dispersed on the front-line.

The Science of Exclusion

With clearly defined eligibility criteria and budget led practice playing a key part in the lack of autonomy that social workers now enjoy (Sharkey, 2000), as well as the rigid construction of assessment and review forms utilised by care managers (Carey, 2003), the SSD appeared to have created a scientific means of accurately excluding many clients from gaining access to key services. Forms were specific and extensive in detail, and managers were always keen to scrutinise them, so that any recognition

of need ('unmet need') could be avoided on official documents such as the review or assessment (that the client received a copy of) if possible. For example, as a legal document the assessment form offers the client potential 'evidence' of their needs, and they may decide to utilise this document to legally challenge any lack of provision offered by a SSD (Mandelstam, 1998). But if such need is not written into the assessment document, or in contrast claims that such need simply does not exist, then it provides 'evidence' to the SSD that no provision of services should be made. Thus managers would regularly instruct social workers to change the details on their forms in supervision, so as to save the authority from committing to any service provision. Such methods had become part of the work culture in all the teams where I was based, and along with the ever tighter eligibility criteria, provided a 'brick wall' over which the disabled or elderly client would struggle to scale in order to access much needed services.

Thus the encouragement of disadvantage and exclusion appeared as an important outcome of the role of the SSDs studied, and one that the organisation at times appeared to embrace and place considerable energy and purpose into. Indeed the agencies seemed to become ever more inventive and open in their methods of excluding clients, by bringing out ever more specific eligibility criteria, or elaborate and extensive documentation (assessment and so forth), that would help justify the exclusion of clients. Forms continued to grow in size, and the questions that care managers were obliged to ask the often-perplexed client and relatives during the assessment or review became more and more forthright and personal.

The rationalisation process discussed earlier helped to generate a shield that protected the budget from the advances of the client. If the initial referral of a client to the SSD provided enough "evidence" to justify allocation to a care manager then the next "hurdle" that the client would face would be the assessment of need. If the assessment of need did not find good reason to reject an application for services, then the panel would be the next hurdle, assuming of course that the financial assessment and "threat" of charges did not discourage the client from continuing with any application for a service. If the client then "gets past" the panel the problem of finding a support worker or a day centre with a vacancy then persists. If this hurdle is overcome, a client may well decide (as happened regularly) after viewing the day centre that they would be happier (and safer) at home. All in all a complex series of rules, regulations and procedures exist to ensure that the client is excluded from ever being provided with a service.

Social Work 'Will Wither Away'

Some care mangers lived in fear of the future and what it might hold for them. Such pessimism was all too apparent and always around me. Most admitted that they tried not to think about the future and also dreaded the thought of becoming disabled or seriously ill in their old age. Exposure to the world of care management had a clear psychological impact on those in work and as I have already stressed optimism was not an attitude in abundance. It was also felt that social work was all but dead and had a limited lifetime remaining. The pessimism was more acute for long term practitioners who had witnessed so much negative change over such a brief period of time. One veteran who returned for a chat after taking voluntary retirement expressed

his relief and pleasure after taking a job 'for much less pay' at the local Sainsburys. Staff were so much happier there and people 'regularly laughed and socialised' he informed me. The place was 'nothing like social services where everyone moans all the time'.

It was argued by colleagues that social work was 'withering away' without any type of fight or resistance. The unions (such as UNISON) were 'a waste of time' and BASW, the ADSS and the General Social Care Council appeared little better. Change nonetheless continued unabated and people felt that the few core services that remained were unlikely to require as many workers to administer them as at present. Less and less people appeared to want to train to be social workers (Parton, 2001), as word seemed to be spreading about how bad the job was.

I am not as pessimistic as my colleagues in relation to the survival of statutory social work. Its current role is too significant in maintaining the social care industry, but despite this more radical reforms are still possible within the current system. Most apparent perhaps would remain the complete privatisation of social care service providers, and the introduction of compulsory insurance premiums to employees to pay for social (and perhaps also health) care. Such a radical response, although no more radical than the quasi-market at its time of introduction, would still require workers to fulfil a care management role. A possible outcome for social work, and continuing in the privatisation mould, might be the establishment of 'care consultants', who based at home with a computer, fax and telephone, would consult on the support options available to paying clients. Other permutations perhaps remain,

but in general I still believe that as long as a social care industry exists, current social workers will have a role to fulfil.

New Directions for Radical Social Work?

Although I have previously argued that radical social work has tended to influence academics and training rather than practice, there can be no doubt that current procedure based forms of care management allow new *possibilities* for the political exploitation of social work. Three issues persist as conspicuous options for the exploitation of current practices.

First, legislative documents such as the assessment of need and care plan review can be manipulated by workers to empower clients by utilising them to stress in vivid detail the need that arises out of typical cases allocated to a care manager. Each client has the legal right to receive a copy of their assessment (many are sent them by post as a procedure), and in my experience if a client takes this to a lawyer and threatens to pursue legal action against an authority in relation to non-provision of a service, that authority has always responded by providing services. Care managers are in a prime position to exploit their role in relation to constructing assessments and reviews, rather than complying with the wishes of their supervisors when asked (as is often the case) to utilise such documentation in order to provide no service or reduce established packages of care. They are also in a position to encourage clients to pursue legal action; many will be entitled to legal aid. Out of interest I was warned by my manager (T5) that this was a 'sacking offence' after she discovered that a couple of my clients had taken legal action against the local authority in relation to no service

provision. Indeed if it wasn't for the staff shortages in the team I probably would have had my contract ended, but such a rule would prove impossible to implement if a large number of workers were to utilise this approach. I also felt in each of my placements that many clients were in a strong position to sue the authority over the poor quality of many of the services on offer: this approach may also be feasible.

The second issue is in relation to the pivotal economic role that care managers play in supporting the social care industry through their many administrative interventions. As I have stressed within my thesis, this crucial role gives state social workers considerable power in the labour market which they are failing to either recognise or exploit. According to my data social work is no longer performing a peripheral role within welfare as it did throughout the 1970s and 1980s (Jones, 1999), what Pithouse (1987) referred to as the 'invisible trade'. The closing down of large institutions, and the growth in private sector dominated 'community services' (notably nursing and residential homes) (Means et al, 2003), has meant that the prior 'invisible trade' has been transformed into a major British service industry and key national employer. This is one consequence of the demographic shift in the population with older and disabled people now making up a significant section of social work's client group, unlike in the past when children dominated as the core group receiving attention (Pithouse, 1987). Social work is in a prime position to exploit its standing within the economy, something which other professions (notably medicine) have done to great effect (see Illich, 1975; Witz, 1992).

Finally social work academics have the potential to provide an important critical analysis of the current social care industry, and such research would be far more

effective than the current tendency to concentrate on individualistic, functionalist, idealistic and unattainable fantasy such as evidence based and anti-oppressive practice. An emphasis upon highlighting issues such as the lack of resources and services that are currently available to clients and communities; the often poor quality of any limited forms of service provision; the continued reliance upon, and consequences of, quasi-police interventions within social work; racism within social work; the work intensification and de-skilling suffered by front-line practitioners, and so on, would help to highlight, and probably confront, such 'hidden' dynamics. I feel it is also important that academics get involved in the very communities that they are writing about. The very nature of 'social' work means that it is important for academics to have more interaction with the people that they are detailing within their research. Schemes such as public lectures, open and advertised to clients, social workers and the public, and presenting some of the issues listed above, would go some way towards bridging the considerable gap that currently persists between the academic community and clients and practitioners.

Such solutions do exist as possible alternatives to current forms of practice and education but it would be naive to assume that they provide a solution to the long term (and historic) ills that have impacted upon social work. On a practical level the long term under funding of nationwide programmes such as community care, which has helped lead to a poor infra-structure of core provisions such as day centres and residential homes, allows limited opportunities for social workers to access services on offer (assuming they reach the commissioning stage). But just as significant, an important finding from my research related to the finding that many social workers appear to operate whilst carrying with them 'disposable' ethics. That is, they may

hold and vocally express altruistic principles (as well as retain these on a conscious level) such as in relation to client needs, but whenever pressed to support such principles in practice, they rarely allow them to threaten job security or personal needs and wants. Thus, such ethics are readily disposed of or discarded, sometimes quite casually, if individual (or notably family) needs and wants are placed in jeopardy. This again tends to add support to Johnston's (1972) assertion that professions strive to look after themselves, and regularly attempt to control or quash patient/pupil/client interests. Again I agree with his argument but have found that other factors such as employee work intensification and deskilling, as well as antagonistic relations with frustrated clients (leading to worker anxiety), amplify such a stance considerably.

Nonetheless such factors do pose considerable doubts in relation to any ambitions that radical social workers may hold. This is in addition to other long held concerns about working *within* a bourgeois state, as well as the many sympathisers and 'ethically flexible' practitioners that I have argued currently work within social work. My own contested belief is that as long as social work remains under the wings of the (bourgeois) state, it will always be compelled to pursue a series of narrow and oppressive policies that workers are unlikely to challenge.

The Unrecognised Emergency Service

As I have stressed throughout my thesis, due to the demand for its services and the issues that departments now face in relation to client need, social work is now operating as an emergency service that on occasion provides limited support to clients living in impending danger or at high risk of significant harm. Increasingly this is

provided through the duty system, although many of the traditional allocated cases also contain similar crisis centred scenarios. This outcome poses two related concerns. First, as the care management system was devised almost twenty years ago during the mid 1980s (Utting, 1994; Sheppard, 1995; Sharkey, 2000; Means et al, 2003), my data suggests that its bureaucratic and procedural structure is not suited to the issues that care managers confront each day in their work. Put simply, crisis and high-risk scenarios demand a quick and appropriate response that the current system is not able to provide. Currently the process of accessing services is generally slow and convoluted, with a range of bureaucratic procedures (form filling, photo-copying, telephone enquiries, and so forth) standing between a client and any given service. This does not appear appropriate for the few clients who are now permitted access to services, and this is currently failing to respond to clients in as brief a time as possible, as is required.

Second, care managers are not adequately trained to deal with many of the issues that they now regularly face on the often hostile front-line. They are rarely aware of how to cope with violence, aggression, poverty, or medical emergencies or needs, and so forth, if they come across them (which they will) during placement or when they begin employment. In addition most types of (therapeutic) social work training that continue on the DipSW (and I assume the new degree) have become redundant due to both the changing role of care management and the (crisis related) issues that care managers now confront in their work. Anachronistic training and work methods currently prosper in employment settings that provide risk and danger to the front-line worker, and client.

An important finding of this study is that social work also continues to feel the need to protect and justify itself in order to survive within the state apparatus. Despite this it has been argued that its role has changed significantly over the past 12 years, and its redefined role as administrator to a major British (post-Fordist) industry means that it has significant *potential* power in the labour market. It has been argued that without care managers the social care industry as a major set of businesses and national employers would literally grind to a halt. Social work has the potential to exploit its economically important role.

A strong emphasis has been placed upon professionalism and expertise within my thesis, notably drawing from Johnston's (1972) influential work in relation to the claims to power and forms of domination that epitomise such a distinct occupational strategy. I agree with most of his thesis but must add that for many of the care managers I interviewed the 'semi-professionalism' of social work offered protection against an at times ruthless labour market. This is particularly relevant in relation to social work's traditional female workforce (Hugman, 1991), and the low wages and temporary employment that most other care work now provides (Finch, 1984; Community Care, 2000c). I discovered that for some employees social work was as much, if not more, an asylum from the rigours of the labour market, which ironically 'protected' groups (notably lone mothers) from economic exploitation in addition to oppressing others (client lone mothers, and so on). Prior to social work, many of my colleagues had been employed within social care posts on short-term contracts and significantly lower salaries. Social work allowed them to escape such forms of work. For this reason I believe that Universities will always fill their vacancies on the new degree courses, and new generations will continue to enter the occupation. However it

is a tragic irony that we continue to exist in a society that perpetuates the exploitation of the exploited by the exploited.

Appendix 1

[redacted] CITY COUNCIL

[redacted]

CARERS ASSESSMENT

Name: | **D.O.B:**

Address: | **Tel No:**

GP: | **Address:**

Details of the Person you care for:

Name: | **DOB:**

Address: | **Tel No:**

Place of Assessment | **Date:**

Present at Assessment: (list below)

1.

Available material:

Our ability to assist depends upon full information including sharing the same with other agencies

Agreed: Yes ☐ No ☐

Typical Day

Comments

Are there any tasks you would prefer not to do?

Disability/Health (Physical, Emotional or Mental) Social or work commitments, which have or could impede your ability to provide care now or in the future:

Do you or the person being cared for have any specific cultural or religious needs?

Does anyone share the care with you?

Name: _____

Address: _____

What Assistance do you feel you need to encourage independence and choices for yourself and the person you care for?

Are you aware of the charges for the services should they be provided Yes ☐ No ☐

Benefits received/applied for as a carer. Please detail

Have you been given any Leaflets/Information about Carers Support Yes ☐ No ☐

Is there anything you would like to say that we have not already covered above?

Summary of Carer's perception of needs:

I have seen what is written down I agree with it (please sign below)

Carer: _____ **Date:** _____

Service User/Representative: _____ **Date:** _____

Form No 3C167 (April 94)

[redacted] CITY COUNCIL

HOUSING, SUPPORTED LIVING AND COMMUNITY SAFETY PORTFOLIO
TRANSFER/CLOSING SUMMARY

Service User's Name & Address:	D.O.B.	Identifier Number:
	Placement:	
	Legal Status Or Register:	

Please outline in the space below:-

1. Reason for referral.
2. Significant action/events.
3. Significant agencies/individuals.
4. Services received.
5. Present situation.
6. Aims achieved (see Care Plan).
7. Reason for transfer/closure.
8. Future social work action required (if any).

Date: _____ **Social Worker:** _____

Date: _____ **Team Manager:** _____

Note: This form should be located at the front of the summaries section of the section of the file. Continue the summary on a second sheet if necessary.

LIVERPOOL SOCIAL SERVICES DIRECTORATE

SUMMARY SHEET

Service User Name: **Identifier Number:**

Date:

Summary:

Signature of Social Worker: **Date:**

Signature of Team Manager: **Date:**

APPLICATION FOR EQUIPMENT OR ESSENTIAL PAYMENT FOR CARERS AND CHILDREN IN FOSTER CARE

NAME(S) OF CHILDREN:	D.O.B.	RACE:	DISABILITY:	EN ALLOW

FOSTER CARERS NAMES & ADDRESS: ROLL NO. RACE:

TYPE OF PLACEMENT: TEMPORARY [ ] EDT [ ] OTHER (please state):
PERMANENT [ ] STB [ ]

DETAILS OF FINANCIAL REQUEST:-

EQUIPMENT FOR CARER [ ] (specify & amount required)

ESSENTIAL ITEMS FOR CHILDREN [ ]

REASON FOR REQUEST:

SIGNED: AREA:
S.W. signature. DATE:

FAMILY PLACEMENT TEAM MANAGER'S RECOMMENDATION:-

BUDGET CODE:

Social Services Directorate
Record of Appointeeship

Service User Details

Surname

Forename(s)

Address

Date of Birth

Department of Social Security Details

D.S.S. Office

Contact Person

Tel. No.

Directorate Details

Community Services Division

North

South

Central

East

Hospitals

Office Base

Name of Officer dealing with case

Designation of Officer

Date Authority obtained from A.D.

Date appointeeship commenced

Form 4C34 (Jan. 1993)

APPLICATION FOR EQUIPMENT OR ESSENTIAL PAYMENT FOR CARERS AND CHILDREN IN FOSTER CARE

NAME(S) OF CHILDREN:	D.O.B.	RACE:	DISABILITY:	EN ALLOW

FOSTER CARERS NAMES & ADDRESS: ROLL NO. RACE:

TYPE OF PLACEMENT: TEMPORARY [ ] EDT [ ] OTHER (please state):
PERMANENT [ ] STB [ ]

DETAILS OF FINANCIAL REQUEST:-

EQUIPMENT FOR CARER [ ] (specify & amount required)

ESSENTIAL ITEMS FOR CHILDREN [ ]

REASON FOR REQUEST:

SIGNED: AREA:
S.W. signature. DATE:

FAMILY PLACEMENT TEAM MANAGER'S RECOMMENDATION:-

BUDGET CODE:

Appendix 4

Case File Monitoring

Team Code:.....

Suis No.....

Client Group.....

Tick appropriate Box

Requirement	Ye	No	N/A	Agreed Action
Basic Information				
Is file structure as per case File index?				
Are papers legible?				
Ethnic Origin entered?				
First Language entered?				
Practice matters Is front sheet complete?				
Copy of assessment on file?				
Evidence of assessment shared with service user and carer?				
Separate assessments of carer's needs?				
Has carer signed?				
Copy of care plan on file?				
Copy of review given to service user/car				
Copy of care/action plan given to service User/carer?				
Copy of Review on file?				
Copy of review given to service user?				
Contact sheets in File?				
Record of leaflets being given to service user /Carer?				
Is the 3rd party section used appropriatel				
Is there cross referencing in the contact sheets to other parts of the file eg 3rd pa section?				

Team Manager's Signature.....Date Completed.....

Group Manager's Validation.....Date.....

NB One Copy to Case File, CRT and social worker's supervision file (if action is needed)

APPENDIX 1: SELECTION OF A FEW FORMS USED BY CARE MANAGERS

LEARNING DIFFICULTIES

Standard and Complex Assessment Document

Type of Assessment *(Tick appropriate boxes)*

Initial Assessment: ☐ Level 2 Assessment ☐

Re-assessment replacing assessment dated: ☐ Level 3 Assessment ☐

1. Basic Details

Surname: ☐ Forename(s): ☐

Address (home): ☐

Telephone No. ☐

Address (current): ☐

Telephone No. ☐

D.O.B. ☐ Male ☐ Female ☐

Racial Origin: ☐ Preferred Language: ☐

2. Household Composition

Lives alone: Yes ☐ No ☐

Surname	Forename(s)	M/F	Age	Relationship

3. Advocate

Name: ☐

Address: ☐

Daytime Tel. No. ☐

Formal: Yes ☐ No ☐

4. Significant Relatives, Carers and Others connected with the household

Surname: Forename(s):

Address:

Telephone No. Age:

Relationship to user: Status:

Surname: Forename(s):

Address:

Telephone No. Age:

Relationship to user: Status:

Surname: Forename(s):

Address:

Telephone No. Age:

Relationship to user: Status:

5. Other Agencies Involved

Contact:

Agency Name:

Address:

Telephone No. Fax No.

Contact:

Agency Name:

Address:

Telephone No. Fax No.

Contact:

Agency Name:

Address:

Telephone No. Fax No.

Contact:

Agency Name:

Address:

Telephone No. Fax No.

6. Accommodation Details

STATEMENT OF ACCOMMODATION NEEDS:

Date:

7. Access/Mobility Details

Is an OT Assessment required? Yes ☐ No ☐

Date completed:

Is a lifting and handling assessment required? Yes ☐ No ☐

Date completed:

STATEMENT OF ACCESS/MOBILITY NEEDS:

Date:

8. Self Care

	Can do independently			Needs Assistance		Comments
	Unaided	With Difficulty	With Supervision	From 1	From 2	
Sleeping						
Waking up						
Getting up						
Going to bed						
Dressing/undressing						
Climbing stairs						
Getting washed						
Personal appearance						
Toilet						
Bathing/showering						
Personal hygiene						
Administer medication						
Summon help						
Eating						
Preparing snacks/drinks						
Using a washing machine						
Housework						
Ironing						
Weekly shopping						
Shop for single items						

Comments on Self Care

STATEMENT OF SELF CARE NEEDS

Date:

9. Communication

STATEMENT OF COMMUNICATION NEEDS

10. Service User Circumstances, Abilities, Attitudes and Lifestyle

11. Existing Services/Support Provided

	Morning	Afternoon	Evening	Night
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Respite Arrangements

Other Comments on Existing Services/Support

12. Carers

Who	Nature of Care Provided	[illegible]

Carers, Health, Services and Support Systems

Do the carer(s) come within the meaning of the Carer's (Recognition & Services) Act 1995 Yes ☐ No ☐

Is the main carer a child or young person? Yes ☐ No ☐

*(If **YES**, a Carers Assessment must always be completed)*

Age of carers: Under 18 Years ☐ 18-64 Years ☐ Over 64 Years ☐

Carers assessed as part of his assessment? Yes ☐ No ☐

Carers assessed separately? Yes ☐ No ☐

Have carers been given information about carer's support? Yes ☐ No ☐

BRIEF STATEMENT OF CARERS NEEDS

Date:

13 Physical Health Issues

Medical Details

Medication	Dosage	Frequency	Who Administers? Self/Others	Comments

Name of current named Health Care Worker:

If a named Health Worker is not currently involved, does a referral need to be made?

Yes ☐ No ☐

Please state name and address of current GP:

STATEMENT OF PHYSICAL HEALTH NEEDS

Date:

14. Mental Health Issues

Details of Mental Health Professionals Involved in the Person's Life

Name	Address	Role

Does a referral need to be made to an ASW? Yes ☐ No ☐

Please indicate why:

What is the person's legal status:

STATEMENT OF MENTAL HEALTH NEEDS

Date:

16. Risk

Risk to Self

Risk from Others

Are the Local Authority's abuse procedures required? Yes ☐ No ☐

Do Criminal Abuse Protocols need to be triggered? Yes ☐ No ☐

Risk to Others

Does a full risk assessment need to be undertaken? Yes ☐ No ☐

STATEMENT OR RISK FACTORS

Date:

[redacted]

Users Views (or those of an advocate)

Carers Views

20. Information to Service Users

Has the service users and/or carer been given a copy of the catalogue of leaflets?

Yes ☐ No ☐

Has the service user and/or carer been informed of the Local Authority's Complaints Procedure?

Yes ☐ No ☐

Has the Service User and/or Carer been given any other Written Information?
(Please specify)

20. Information to Service Users

Has the service users and/or carer been given a copy of the catalogue of leaflets?

Yes ☐ No ☐

Has the service user and/or carer been informed of the Local Authority's Complaints Procedure?

Yes ☐ No ☐

Has the Service User and/or Carer been given any other Written Information?
(Please specify)

21.7 Overall Priority for Care Planning

Priority ☐

Assessed by: _____ Date: _____

Assessment completed on (date): _____

Authorised by: _____ Date: _____

I agree/disagree that the information contained on this summary is a fair record of the needs.

Service users/
representative's signature: _____ **Date:** _____

If you disagree please briefly state why

Appendix 2

Customer Care Guidelines

Identify Yourself

- Always wear your badge, showing name, service area and photograph.
- Identify your service and name when answering the phone to both internal and external customers.

Answering the Telephone

- Answer the phone quickly, including phones on other people's desks.
- Make arrangements to divert your phone when away from your desk. Remember to undivert on your return.
- Answerphone messages should follow corporate guidelines.
- Don't keep callers hanging on - call back if delayed.

Writing to Customers

- Use plain language and reply to all correspondence in 10 working days or less.
- Be friendly - don't be too formal where it isn't required. Use someone's name if you know it.
- Use your plain language desktop guide.

Courtesy and Helpfulness

- Be courteous and helpful at all times.
- Listen carefully, understand and explain. Your tone of voice is as important as the words you use.
- Consider those with particular needs - the old, deaf, visually impaired or speakers of other languages.
- Be clear on timescales and inform people of progress.
- A smart dress code projects a professional image.
- Do not eat or drink whilst on the phone or in front of customers.
- Treat customers' property with respect.

Comments, Compliments or Complaints

- Read and follow the staff guidelines on the Council's Comment, Compliment or Complaint procedure.

Smoking

- Smoking is not permitted in council premises or vehicles (service users of residential and day care establishments apart).
- Smoking is not permitted whilst visiting private premises.

Other Services

- Avoid passing people from one department to another. If necessary, take their details and have the right person call them back.

Produced by Public Relations and Information Services' Graphic Design Unit *on behalf of* the Customer Care Working Party. *January 1999.*

Customer Care Guidelines

Always wear your badge and give your service and name when answering the phone.

Answer phones quickly, positively and to service standards.

Use plain language in all letters, memos and reports and reply within service standards

Treat all customers with the utmost courtesy, helpfulness and respect, whatever the circumstances.

Follow the staff guidelines on the Council's Comment, Compliment or Complaint procedure.

Smoking is not permitted in council premises or vehicles.

Don't pass the buck. Take responsibility for getting customers to the right person to help them.

Appendix 3

M.L. [redacted]
Team Manager
Learning Disabilities Team
[redacted] Locality
Supported Living ([redacted])
[redacted] [redacted] office

Dear Ms [redacted]

Re ① Caseloads/workloads ② Duty ③ Caseload Management

① [redacted] The members of the team are concerned about proposed changes to workloads. ~~[redacted]~~ They understand that 'non-active' cases will be de-allocated and held as 'dormant', while replaced by 'active' cases, plus a number of reviews per month. They consider that the reviews will generate work which they will likely personally take on as the identified social worker by the service-user/family. They consider that they already have a high workload with the 'active' cases they have. Cases removed as 'dormant' they consider would be ~~[redacted]~~ re-allocated to those if action required as the previously identified worker or that they would by directly approached by the service-user/family.

The team consider that they individually and collectively have had a difficult time over the last year and are just beginning to operate again, so that to be expected to take on additional work is inappropriate

Furthermore, it is a time of stress with the uncertainties of reorganisation and the recognition of the pressure on your time without an assistant to support the team.

② There is concern about the current arrangements for work associated with duty. The duty officer picks up work on duty [redacted] and continues with it beyond the period of duty, often for days and weeks. This is a form of self-allocation on top of a caseload. The team consider that work generated through duty should be dealt with by the duty officer on the day and then passed by yourself to

M. L. [redacted]
Group Manager (Children's
Supported Living (Adults)
Millennium House
60 Victoria St
C.2.

Dear Ms [redacted]

Re Learning Difficulties Team, [redacted] (Financial Assessm

At a union meeting on 24/2/03 the team expressed concern at a letter from yourself to service-users and/or their families which seemed to indicate that new financial assessments would be made in April 2003, without consultation with the staff expected to carry out this extra work and at a time of reorganisation and following an extremely difficult period in the life of the team from which they are still recovering.

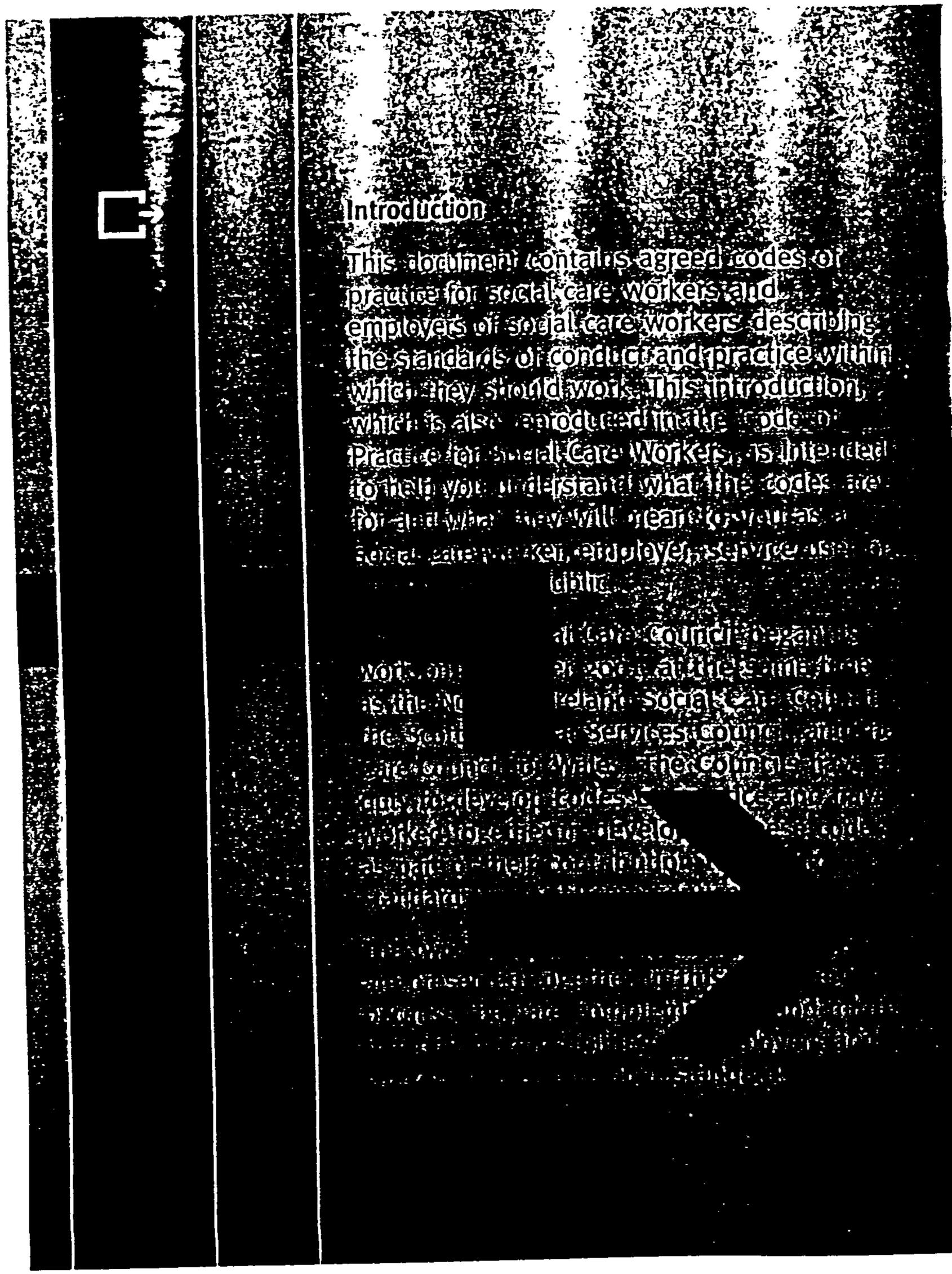
They, therefore, would appreciate an opportunity to discuss directly with you the expectation to see how such can be appropriately managed.

Yours

T D [redacted]
Shop Steward, Bellis Vale

Appendix 4

; FOR SOCIAL CARE WORKERS AND EMPLOYERS



What are the codes?

The Code of Practice for Employers of Social Care Workers sets down the responsibilities of employers in the regulation of social care workers. This is the first time that such standards have been set out at national level. The code requires that employers adhere to the standards set out in their code, support social care workers in meeting their code and take appropriate action when workers do not meet expected standards of conduct.

The Code of Practice for Social Care Workers is a list of statements that describe the standards of professional conduct and practice required of social care workers as they go about their daily work. Again, this is the first time that standards have been set in this way at national level, although many employers have similar standards in place at local level. The intention is to confirm the standards required in social care and ensure that workers know what standards of conduct employers, colleagues, service users, carers and the public expect of them.

The codes are intended to reflect existing good practice and it is anticipated that workers and employers will recognise in the codes the shared standards to which they already aspire. The Councils will promote these standards through making the codes widely available.

How will the codes be used?

The codes are a key step in the introduction of a system of regulation for social care in the four countries of the UK. The Councils are responsible for the registration of those working in social care. The register will be a public record that those registered have met the requirements for entry onto the register and have agreed to abide by the standards set out in the Code of Practice for Social Care Workers.

The Councils will take account of the standards set out in this Code of Practice for Social Care Workers in considering issues about the conduct and fitness to practise of registrants.

Code of Practice for Employers of Social Care Workers

The purpose of this code is to set down the responsibilities of employers in regulating social care workers. The purpose of workforce regulation is to protect and promote the interests of service users and carers. The code is intended to complement rather than replace or duplicate existing employers' policies and it forms part of the wider package of legislation, requirements and guidance that relate to the employment of staff. Employers are responsible for making sure that they meet the standards set out in this code, provide high quality services and promote public trust and confidence in social care services.

Status

The National Care Standards Commission and the Social Services Inspectorate will take this code into account in their enforcement of care standards.

To meet their responsibilities in relation to regulating the social care workforce, social care employers must:

- Make sure people are suitable to enter the workforce and understand their roles and responsibilities.
- Have written policies and procedures in place to enable social care workers to meet the General Social Care Council (GSCC) Code of Practice for Social Care Workers.
- Provide training and development opportunities to enable social care workers to strengthen and develop

SOCIAL CARE WORKERS

As a social care employer, you must make sure people are suitable to enter the social care workforce and understand their roles and responsibilities.

This includes:

1.1 Using rigorous and thorough recruitment and selection processes focused on making sure that only people who have the appropriate knowledge and skills and who are suitable to provide social care are allowed to enter your workforce;

1.2 Checking criminal records, relevant registers and indexes and assessing whether people are capable of carrying out the duties of the job they have been selected for before confirming appointments;

1.3 Seeking and providing reliable references;

1.4 Giving staff clear information about their roles and responsibilities, relevant legislation and the organisational policies and procedures they must follow in their work; and

1.5 Managing the performance of staff and the organisation to ensure high quality services and care.

2

As a social care employer, you must have written policies and procedures in place to enable social care workers to meet the GSCC's Code of Practice for Social Care Workers.

This includes:

2.1 Implementing and monitoring written policies on: confidentiality; equal opportunities; risk assessment; substance abuse; record keeping; and the acceptance of money or personal gifts from service users or carers;

2.2 Effectively managing and supervising staff to support effective practice and good conduct and supporting staff to address deficiencies in their performance;

2.3 Having systems in place to enable social care workers to report inadequate resources or operational difficulties which might impede the delivery of safe care and working with them and relevant authorities to address those issues; and

2.4 Supporting social care workers to meet the GSCC's Code of Practice for Social Care Workers and not requiring them to do anything that would put their compliance with that code at risk.

3

As a social care employer, you must provide training and development opportunities to enable social care workers to strengthen and develop their skills and knowledge.

This includes:

3.1 Providing induction, training and development opportunities to help social care workers do their jobs effectively and prepare for new and changing roles and responsibilities;

3.2 Contributing to the provision of social care and social work education and training, including effective workplace assessment and practice learning;

3.3 Supporting staff in posts subject to registration to meet the GSCC's eligibility criteria for registration and its requirements for continuing professional development; and

3.4 Responding appropriately to social care workers who seek assistance because they do not feel able or adequately prepared to carry out any aspects of their work.

4

As a social care employer, you must put into place and implement written policies and procedures to deal with dangerous, discriminatory or exploitative behaviour and practice.

This includes:

4.1 Making it clear to social care workers that bullying, harassment or any form of unjustifiable discrimination is not acceptable and taking action to deal with such behaviour;

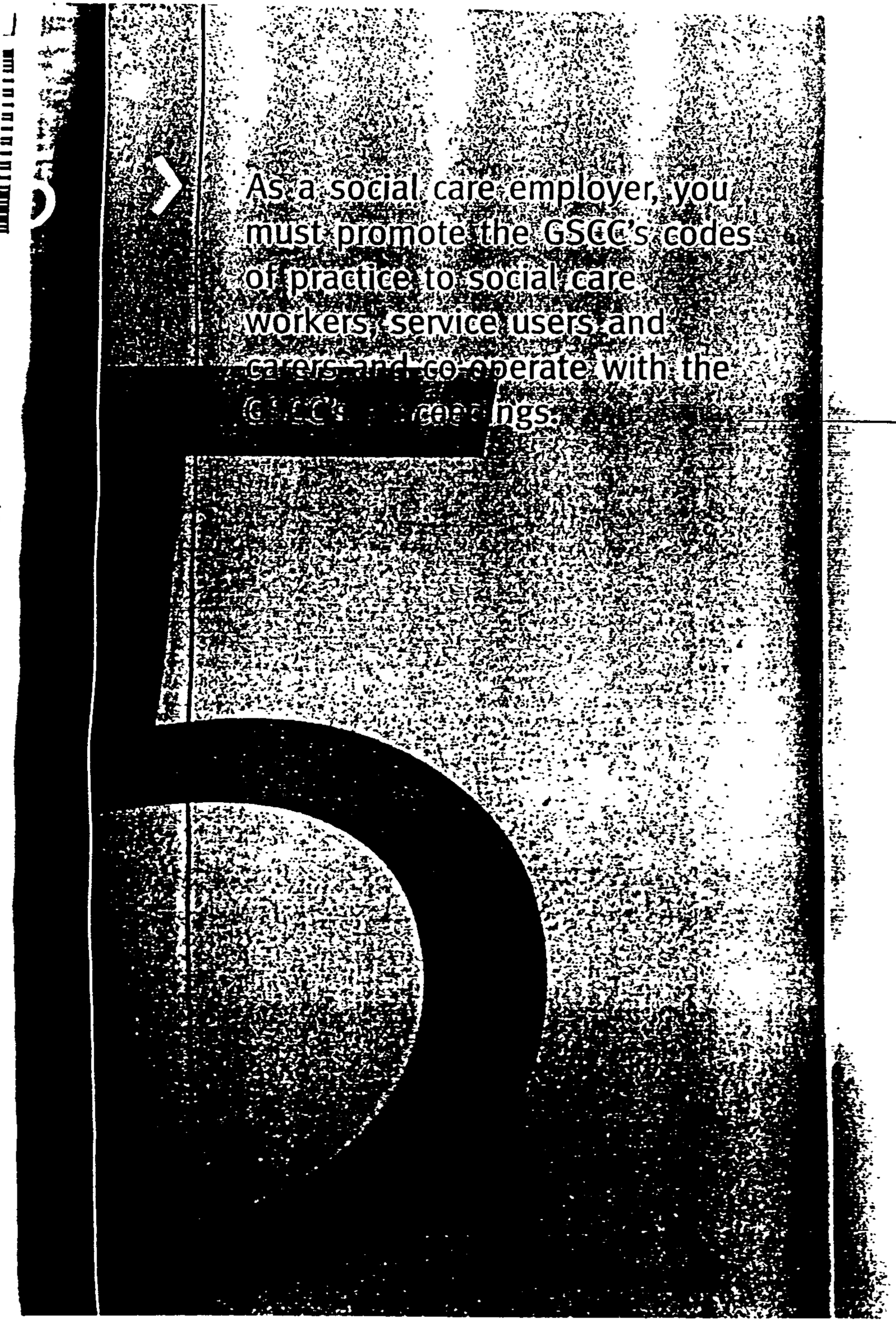
4.2 Establishing and promoting procedures for social care workers to report dangerous, discriminatory, abusive or exploitative behaviour and practice and dealing with these reports promptly, effectively and openly;

4.3 Making it clear to social care workers, service users and carers that violence, threats or abuse to staff are not acceptable and having clear policies and procedures for minimising the risk of violence and managing violent incidents;

4.4 Supporting social care workers who experience trauma or violence in their work;

4.5 Putting in place and implementing written policies and procedures that promote staff welfare and equal opportunities for workers; and

4.6 While ensuring that the care and safety of service users is your priority, providing appropriate assistance to social care workers whose work is affected by ill health or dependency on drugs and alcohol, and giving clear guidance about any limits on their work while they are receiving treatment.



This includes:

5.1 Informing social care workers about this code and your responsibility to comply with it;

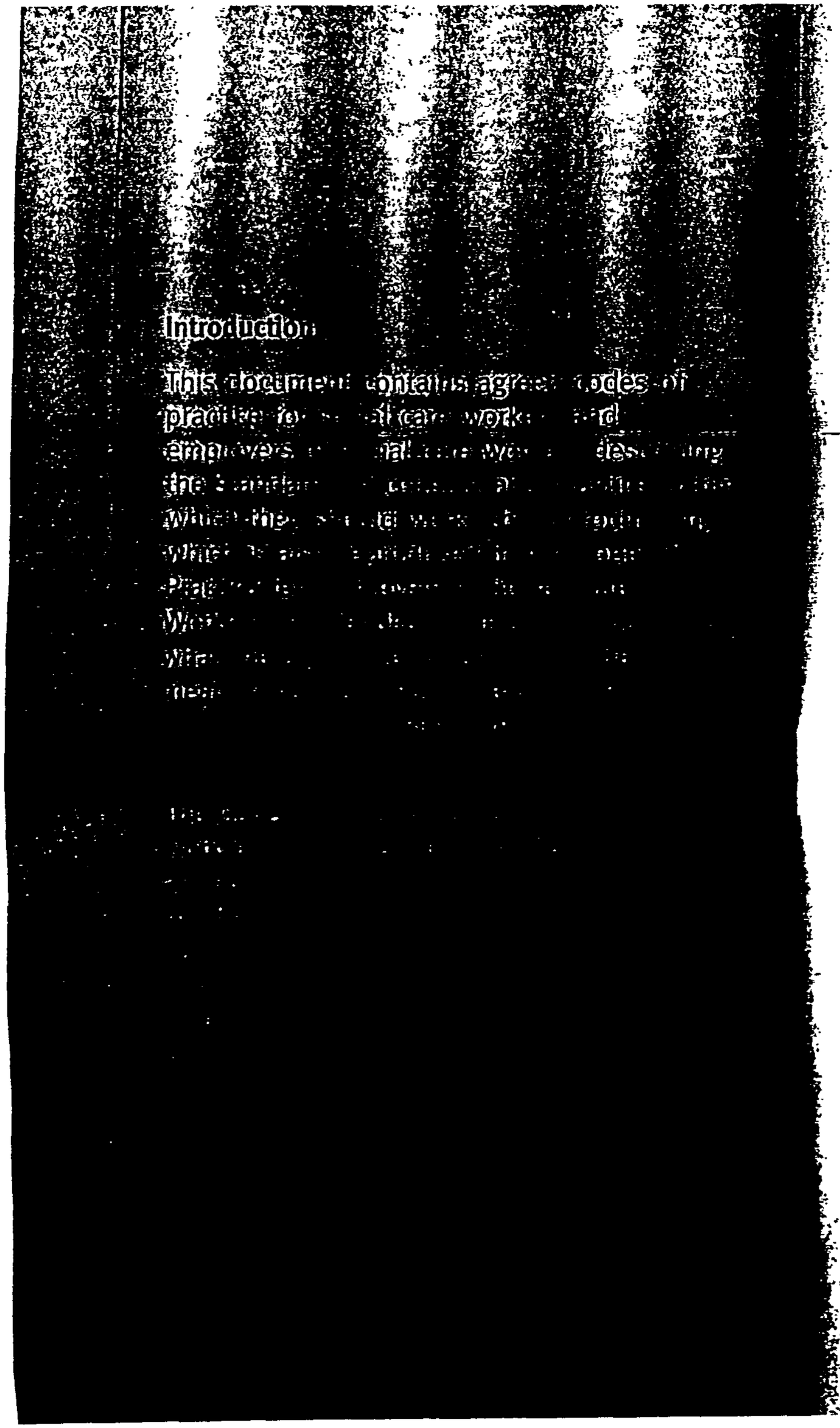
5.2 Informing social care workers about the GSCC's Code of Practice for Social Care Workers and their personal responsibility to meet that code;

5.3 Making service users and carers aware of this code and the Code of Practice for Social Care Workers and informing them about how to raise issues through your policies and, if necessary, contact the GSCC in relation to the codes;

5.4 Taking account of the GSCC's Code of Practice for Social Care Workers in making any decision that relates to the conduct of workers;

5.5 Informing the GSCC about any misconduct by registered social care workers that might call into question their registration and inform the worker involved that a report has been made to the GSCC; and

5.6 Co-operating with GSCC investigations and hearings and responding appropriately to the findings and decisions of the GSCC.



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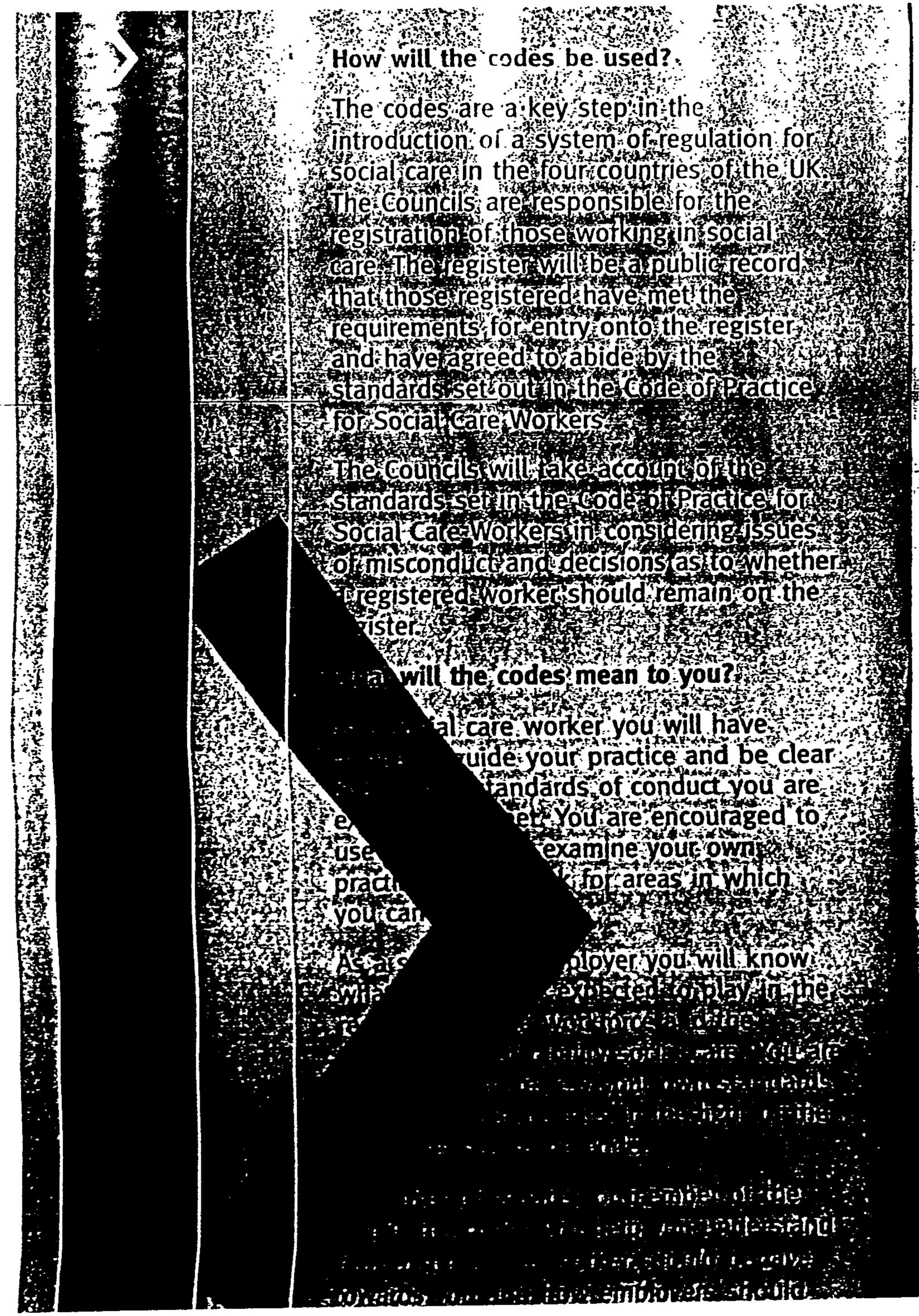

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The Councils will take account of the standards set in the Code of Practice for Social Care Workers in considering issues of misconduct and decisions as to whether a registered worker should remain on the register.

will the codes mean to you?

al care worker you will have uide your practice and be clear tandards of conduct you are er. You are encouraged to examine your own for areas in which

ployer you will know ded to play in the

Code of Practice for Social Care Workers

The purpose of this code is to set out the conduct that is expected of social care workers and to inform service users and the public about the standards of conduct they can expect from social care workers. It forms part of the wider package of legislation, practice standards and employers' policies and procedures that social care workers must meet. Social care workers are responsible for making sure that their conduct does not fall below the standards set out in this code and that no action or omission on their part harms the wellbeing of service users.

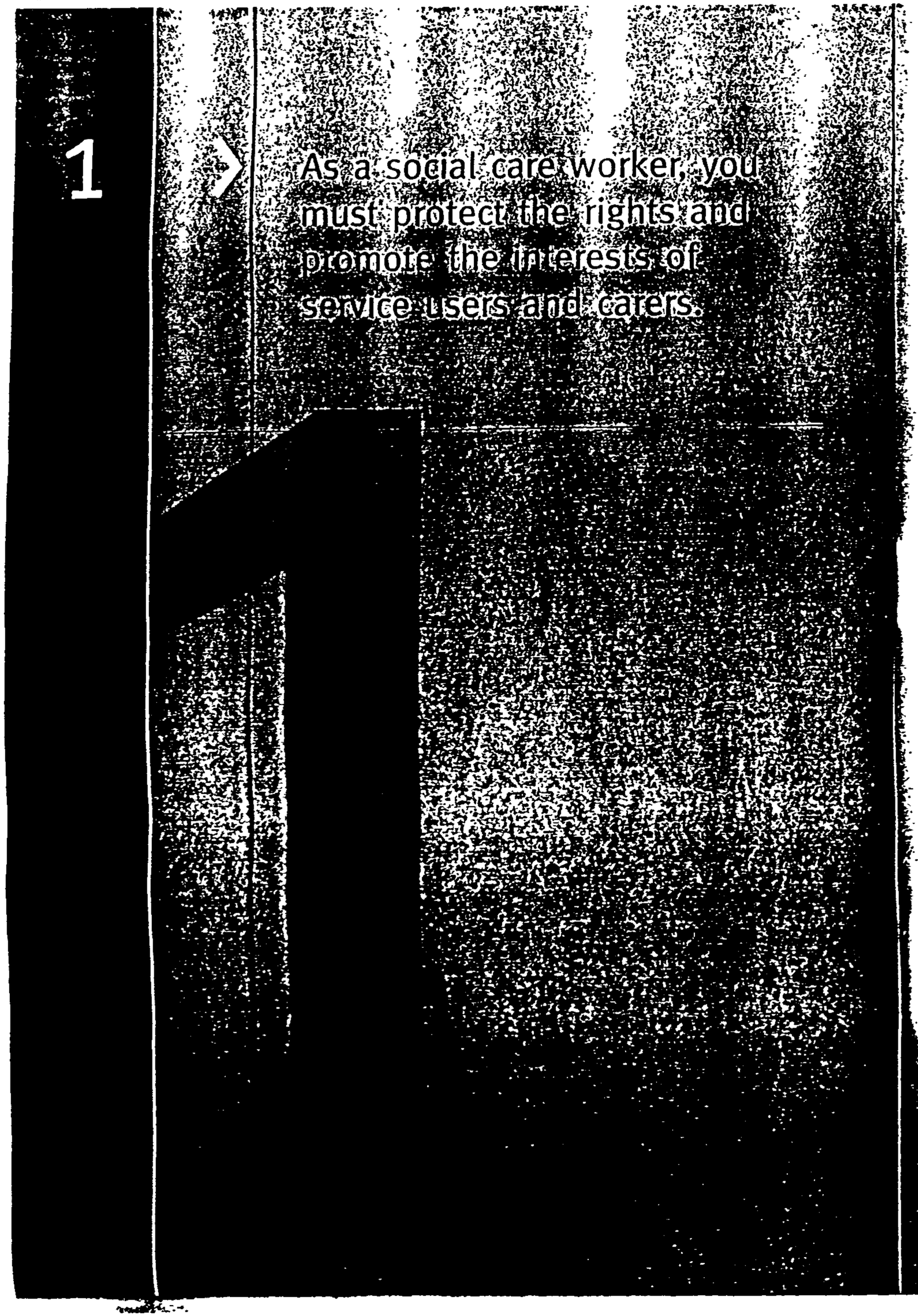
Status

The General Social Care Council expects social care workers to meet this code and may take action if registered workers fail to do so.

Employers of social care workers are required to take account of this code in making any decisions about the conduct of their staff.

Social care workers must:

- Protect the rights and promote the interests of service users and carers;
- Strive to establish and maintain the trust and confidence of service users and carers;
- Promote the independence of service users while protecting them as far as possible from danger or harm;
- Respect the rights of service users whilst seeking to ensure that their behaviour does not harm themselves or other people;
- Uphold public trust and confidence in social care services; and
- Be accountable for the quality of their work and take responsibility for maintaining and improving



This includes:

1.1 Treating each person as an individual;

1.2 Respecting and, where appropriate, promoting the individual views and wishes of both service users and carers;

1.3 Supporting service users' rights to control their lives and make informed choices about the services they receive;

1.4 Respecting and maintaining the dignity and privacy of service users;

1.5 Promoting equal opportunities for service users and carers; and

1.6 Respecting diversity and different cultures and values.

2 ›

As a social care worker, you must strive to establish and maintain the trust and confidence of service users and carers.

This includes:

2.1 Being honest and trustworthy;

2.2 Communicating in an appropriate, open, accurate and straightforward way;

2.3 Respecting confidential information and clearly explaining agency policies about confidentiality to service users and carers;

2.4 Being reliable and dependable;

2.5 Honouring work commitments, agreements and arrangements and, when it is not possible to do so, explaining why to service users and carers;

2.6 Declaring issues that might create conflicts of interest and making sure that they do not influence your judgement or practice; and

2.7 Adhering to policies and procedures about accepting gifts and money from service users and carers.

3 ›

As a social care worker, you must promote the independence of service users while protecting them as far as possible from danger or harm.

This includes:

3.1 Promoting the independence of service users and assisting them to understand and exercise their rights;

3.2 Using established processes and procedures to challenge and report dangerous, abusive, discriminatory or exploitative behaviour and practice;

3.3 Following practice and procedures designed to keep you and other people safe from violent and abusive behaviour at work;

3.4 Bringing to the attention of your employer or the appropriate authority resource or operational difficulties that might get in the way of the delivery of safe care;

3.5 Informing your employer or an appropriate authority where the practice of colleagues may be unsafe or adversely affecting standards of care;

3.6 Complying with employers' health and safety policies, including those relating to substance misuse;

4

As a social care worker, you must respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people.

This includes:

4.1 Recognising that service users have the right to take risks and helping them to identify and manage potential and actual risks to themselves and others;

4.2 Following risk assessment policies and procedures to assess whether the behaviour of service users presents a risk of harm to themselves or others;

4.3 Taking necessary steps to minimise the risks of service users from doing actual or potential harm to themselves or other people; and

4.4 Ensuring that relevant colleagues and agencies are informed about the outcomes and implications of risk assessments.

5

As a social care worker, you must uphold public trust and confidence in social care services.

In particular you must not:

5.1 Abuse, neglect or harm service users, carers or colleagues;

5.2 Exploit service users, carers or colleagues in any way;

5.3 Abuse the trust of service users and carers or the access you have to personal information about them or to their property, home or workplace;

5.4 Form inappropriate personal relationships with service users;

5.5 Discriminate unlawfully or unjustifiably against service users, carers or colleagues;

5.6 Condone any unlawful or unjustifiable discrimination by service users, carers or colleagues;

5.7 Put yourself or other people at unnecessary risk; or

5.8 Behave in a way, in work or outside work, which would call into question your suitability to work in social care services.

6 › As a social care worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills.

This includes:

6.1 Meeting relevant standards of practice and working in a lawful, safe and effective way;

6.2 Maintaining clear and accurate records as required by procedures established for your work;

6.3 Informing your employer or the appropriate authority about any personal difficulties that might affect your ability to do your job competently and safely;

6.4 Seeking assistance from your employer or the appropriate authority if you do not feel able or adequately prepared to carry out any aspect of your work, or you are not sure about how to proceed in a work matter;

6.5 Working openly and co-operatively with colleagues and treating them with respect;

6.6 Recognising that you remain responsible for the work that you have delegated to other workers;

6.7 Recognising and respecting the roles and expertise of workers from other agencies and working in partnership with them; and

6.8 Undertaking relevant training to maintain and improve your knowledge and skills and contributing to the learning and development of others.

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