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isw

International Social Work
2023, Vol. 66(3) 919–935
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DOI: 10.1177/00208728211058775
journals.sagepub.com/home/isw

Challenges for social work with older people in the first COVID-19 pandemic state of emergency in Portugal

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Abstract
This article seeks to understand the needs and difficulties of intervention with older people during the first state of emergency in Portugal due to COVID-19. The results show that these professionals faced challenges they never experienced before and necessitated support to carry out their work in an emergency. The difficulties resulted, not only from the chronic vulnerabilities stemming from the disinvestment of public policies in recent years but also from the uncertainty that the pandemic brought to social interventions. Despite all this, social workers have demonstrated their ability to protect themselves and older people and their families, thus leading to overcoming some of these challenges.

Keywords
COVID-19, older people, Portugal, professionals, social work

Introduction

The disease caused by the SARS-COV-2 coronavirus (Directorate General for Health [DGH], 2020a, 2020b) was classified as COVID-19 by the World Health Organization (WHO). This pandemic began on 31 December 2019, when the Wuhan Municipal Health Commission in Hubei

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Province, China, reported 27 cases of pneumonia of unknown cause. And on 9 January 2020, the Chinese Center for Prevention and Disease Control informed WHO of a new coronavirus, SARS-COV-2. By February 2020, this virus had already infected at least 11,844 people in that country (Changhai et al., 2019), making it an epidemic.

On 11 March 2020, WHO elevated the category from epidemic to pandemic when the virus spread to other countries. The status of a pandemic is considered when a disease (epidemic) occurs with an unusual frequency in each region and for a given period (Magalhães and Machado, 2014). Pandemic declarations require the elaboration of a conceptual framework for global governance and require governments to take preventive measures and public health promotion activities involving the exercise of authority (Villarreal, 2016). An example of this is the declaration of a state of emergency with norms and rules of conduct that prevent and mitigate the pandemic.

Despite these measures, COVID-19 had a dystopian impact on older people around the world (Mendonça, 2020), especially those residing in long-term care in nursing homes. Since the beginning of the pandemic, cases have been reported of older people abandoned in residential homes, others found dead, or left on their own, due to abandonment and lack of available professional care.

WHO (2020b) reveals that more than 40 percent of deaths related to COVID-19 are linked to long-term care facilities, with figures reaching 80 percent in some countries. 'Residents of long-term care institutions faced a high risk of death due to lack of preventive measures and inadequate resources, as well as reduced access to essential health services' (p. v). But at the same time, good news emerged with instances of older people, aged 90 and 100 years old, who have recovered from the disease.

The dilemmas and challenges for social intervention in working with older people are constant as the pandemic has created new inequalities (Pentaris et al., 2020), accentuating isolation and dependence. Comorbidities, poverty, gender and race were strong determinants in these cases (Cox, 2020). Older people have multiple diseases and comorbidities, not only making them even more susceptible to COVID-19 but also limiting access to essential resources and goods (Fratino et al., 2020).

In times of pandemic, older people are ordered to take shelter and stay at home. Social confinement imposed itself inside and outside these installations, and all human interaction was conditioned by a new barrier in the form of masks and face shields. As argued by Pentaris et al. (2020), 'social distancing/shielding created an immediate risk of social isolation, especially for the older people who depended on care and already had few opportunities to engage with community resources' (p. 738). The elderly are a vulnerable group, who were doubly excluded from society due to social distancing (Seifert, 2021).

The daily lives of older people in long-term care or home care services have changed. Confinement and social distancing have led to greater social isolation and symptoms of mental illness in older people (Algarin et al., 2020; Haider et al., 2020). The increase in these problems is related to the mortality of older people, which mostly occurred in hospitals, nursing homes and residential homes (Carr et al., 2020; Pentaris et al., 2020).

In social terms, older people are one of the most important groups in developed societies, contributing to development and social cohesion. Despite this importance, they are also one of the most excluded, and prejudice must be fought. COVID-19 unveiled the social and health inequalities discovered in the older population, especially the most vulnerable (Coronini-Cronberg et al., 2020; Pentaris et al., 2020). But COVID-19 also highlighted their resilience and ability to learn new skills in these difficult times (Garcia et al., 2021).

But it was the situation of abandonment and death in residential homes that alerted society to the living conditions of the older people and generated a broad debate on interventions in this area (Béland and Marier, 2020). The debate was not always consensual, as one group assumed that it was the state that should manage these institutions and another group considered that private institutions of social solidarity should be given more authority (Béland and Marier, 2020).

This dual visibility, of fragility and resilience, also challenged the policies of ageing, social intervention and the role of social workers in promoting a paradigm shift in these policy areas (Berg-Weger and Morley, 2020; Brennan et al., 2020).

Considering the relevance of social workers in these organizations in Portugal, and the management of the pandemic, in this article, we question the needs, difficulties and challenges faced by social workers in these social facilities and community services for older people, in the first wave of the COVID-19 pandemic (from March to June 2020).

Social work in a pandemic

Social workers are deeply involved in promoting public health, especially in addressing the social determinants of health and in the context of this pandemic, but their contribution is not always recognized (Ruth and Marshall, 2017). For Dominelli et al. (2020),

> Social work is a profession at the forefront of this pandemic. How we live and learn from this life experience will shape and determine how we respond to subsequent waves of the virus and future public health emergencies that may confront us globally and locally. (p. 5)

Social workers must take a critical position on policies. At this point, Banks et al. (2020) assumes 'many social workers have been strongly critical of government and agency policies and rules, especially for the newly created procedures to work during the pandemic, which has diminished the right to receive services for many users' (p. 5).

Theoretically, social workers work at various levels, not only at the micro-level, at the front line, but also at the meso-level, in the design of contingency plans for organizations, and at the macro-level in the design of structural policies (Walter-McCabe, 2020). The integrated intervention challenges these professionals to activate the profession's values and the code of ethics to carry out best practices to promote the safety of the population and themselves (Carvalho, 2020b; Walter-McCabe, 2020).

Amadasun (2021), Barbé et al. (2021), Cox (2020), Dominelli et al. (2020) and Pentaris et al. (2020) highlight the role social workers have played in the COVID-19 pandemic. In addition, they highlight the link between social work and this pandemic crisis, which has challenged professionals to reinforce the values of dignity, social justice and the defence of human rights (Amadasun, 2021).

As Barbé et al. (2021) argue, social workers 'are witnessing the emergence of a new world scenario with an increase in new social needs' (p. 282), especially in vulnerable groups such as the older people. Social work must defend their rights; in case of suspension, reduction or cancellation of services (Pentaris et al., 2020), and confinement in residential/older people's homes. In these cases, professionals are challenged to highlight their core values, with multiple actions, from meeting basic needs, strengthening resilience, supporting loneliness and trauma, to defending older people, and establishing efficient communication and information mechanisms to prevent the risk of abuse (Cox, 2020; Pentaris et al., 2020).

For Barbé et al. (2021), social workers 'build resilience and take specific actions to allow people to identify symptoms and/or problems, as well as intense emotional reactions triggered by this

traumatic event' (p. 282). On the contrary, they can promote communication and protection for older people, reinforcing their mediating role between informal networks (family networks) and formal support networks (community networks).

COVID-19 allowed these professionals to use new technologies that provide care, as well as new forms of intervention (Berg-Weger and Morley, 2020; Brennan et al., 2020; Dominelli et al., 2020; Peláez et al., 2020). In a pandemic situation, the use of information and communication technologies has been widespread, for example, computer applications (Peláez et al., 2020). This has allowed social workers to communicate with the older people and their families through the 'guarantee of daily phone calls, service delivery door, virtual health visits, and telephone education and prevention and news updates have become part of the practice of social work' (Berg-Weger and Morley, 2020: 456).

Is important that collaborative intervention and `compassionate social communities employing new and innovative methods (e.g., virtual/telematic delivery formats) and intervention diversity (e.g., laughter, mindfulness, meditation, reminiscence and horticultural therapy, body movement, eg exercise, dance and yoga)' (Berg-Weger and Morley, 2020: 457). Others, such as online events and webinars, were useful to reflect and demystify the social practice of work (Peláez et al., 2020).

The impacts of the pandemic challenge on social policies and social workers have improved responses for older people, making them more efficient, that is, with quicker responses. This intervention must be articulated with social and multidisciplinary professional teams (Brennan et al., 2020). It is important to follow the guidelines from the International Federation of Social Workers (IFSW, 2020) and other theoretical statements from O'Leary and Tsui (2020) and the International Association of Gerontology – (IAG) (Chhetri et al., 2020: 472) to prevent the effects of COVID-19 in the case of older people.

The IFSW focuses on the foundations and values of the profession in times of crisis, and presents opportunities to rebuild better, more inclusive and more stable societies and also long-term social solutions. Leary and Tsui (2020) argue that social workers should work with other professions, connect with vulnerable people, provide care and support, encourage the strengthening of civil society, fight against injustice, protect the natural environment, exchange experiences, focus on hope, reflect and learn from this crisis, and be creative and tender with communities.

In their guidance for older people the IAG stressed the need for adequate sleep; measures to prevent depression; active exercise; adequate nutrition and maintenance of oral hygiene; social distancing; increasing support/social contact through communication technologies with family/friends (Chhetri et al., 2020: 472). At the same time, older people must have medical attention, be in ventilated spaces that receive sunlight and comply with safety standards regarding hygiene, disinfecting their hands frequently.

Social work with older people in Portugal and the contingency plan

In the European Union (EU), Portugal is one of the countries with the oldest population, 21.8 percent (Eurostat, 2020a). This ageing results from better living conditions and investment in public policies over the last 30 years (Capucha, 2014). However, despite access to better health and social care, the ageing population in our country continues to be a group at high risk of poverty, especially those who live alone and with comorbidities that make them dependent (European Commission, 2017).

The social protection system features a set of services such as the Day Centre, the Night Centre, host families, residential care, home care services, as well as the integrated continuous care

network. However, these facilities are not sufficient, as they only support about 13.8 percent of the older people who need care (Ministry of Labour, Solidarity and Social Security [MTSSS], 2015, 2020). Moreover, according to the same source, the coverage of these services is uneven across the country, with asymmetries between densely populated urban areas and rural areas.

Investment in this type of care is insufficient. For example, Portuguese public expenditure in this area was 0.1 percent of GDP (gross domestic product), the lowest value in Europe, except for Turkey (with 0) (Scheil-Adlung, 2015). In fact, the percentage of formal workers per 100 older people is only 0.4 percent, while Spain has 2.9 percent and Norway 17.1 percent (Scheil-Adlung, 2015). This leaves almost 90.4 percent of older people in the country without access to quality long-term care due to the lack of professionals in this area, while in the EU, the average is less than a third (30%) (Scheil-Adlung, 2015).

Neoliberal policies, in recent years, have negatively impacted older care (Ornellas et al., 2020), and the pandemic has revealed the fragility of public and social policies, putting at risk the older people who depend on home care services or who live in nursing homes that provide long-term care services. Although the mortality rate of older people in this first wave was not very high in Portugal (2000) (data from June 2020), the COVID-19 mortality rate affected older people more than the rest of the population (Portuguese Republic, 2020c).

Home care services and long-term care centres are state-sponsored and managed by non-profit organizations. Social workers, who work in these organizations, are responsible for establishing the link between the State and these organizations while defending the rights of older people and their families (Carvalho, 2020a).

In the pandemic, Portugal followed the recommendations of the WHO (2020a, 2020b, 2020c) and the European Center for Disease Prevention and Control. In February 2020, the DGH adopted a strategic tool designed to prepare for and respond to the potential virus epidemic called the National Preparedness and Response Plan for COVID-19 (Portuguese Republic, 2020a, 2020c).

This plan outlines the three phases of dealing with the pandemic: the preparedness phase, the response phase and the recovery phase, with three levels of response: containment, extended containment and mitigation. These general guidelines focus on forms of individual protection for workers and clients, including guidelines for teleworking and face-to-face care in the areas of health, palliative care, long-term care for older people, refugees, the homeless, among other groups, particularly the vulnerable (Portuguese Republic, 2020b, 2020c). As a result of these guidelines, the Social Work Professionals Association created its own guidelines for intervention in emergencies (Association of Social Work Professionals [APSS], 2020).

The Long-Term Care Unit Intervention Plan recommended that these long-term care units were responsible for their own contingency plans, thus placing a great deal of responsibility on these organizations. However, the guidelines and recommendations of the DGH were updated almost daily, leading to confusion between organizations and professionals when confronted with the reality on the ground.

Thus, in long-term care centres, accessible information mechanisms were created to disseminate contingency plans, self-care measures, and personal and family protection measures, keeping the information updated for all employees and users. Furthermore, multidisciplinary meetings were held to analyse the National Contingency Plan (Portuguese Republic, 2020b, 2020c), and an open debate on it was promoted, to clarify any doubts and work together to develop an institutional contingency plan. Posters were also placed at COVID-19 facilities, and the main precautions to be taken were placed at strategic points of these institutions (reception; entrance to each floor; dining room; professional offices).

General hygiene rules and respiratory etiquette were promoted, defining procedures for workers who had contact with the disease. Individual protection practices were also prescribed to users, to

the multidisciplinary team and the institution's employees, highlighting hand hygiene, respiratory etiquette and the use of personal protection equipment – such as masks and gloves. In addition, clarification sessions were organized on COVID-19, explaining the origin of the disease, how the virus is spread, the repercussions on daily life, the protections to be taken and the helplines that should be contacted in case of doubts.

The working model of long-term care facilities has been re-adapted. The multidisciplinary team created isolation spaces for users/other professionals infected (or suspected of being infected) with COVID-19. The impact of this organizational model on employees and users was considered to promote a reduction in the number of close contacts between everyone involved. Professionals with special needs were protected, and the issue of workers' absenteeism was considered (Portuguese Republic, 2020b).

Measures were taken to restrict visits by family members and other people to users, and alternative contact options were proposed using telephone and video conferencing platforms. Activities planned with external users were cancelled (to avoid sources of contagion) or replaced by internal activities, and curricular internships were suspended. Measures were also taken to reduce the number of contacts among staff and employees while maintaining the institution's core operation. The staff's new working hours were set in 'mirror' mode (12 h + 12 h/15 days) with 15 days of quarantine. The plan's coordination team was responsible for allocating resources to protect staff, employees and users from the spread of the virus and promoting more frequent cleaning of the facilities, as well as liaising with community organizations (Portuguese Republic, 2020c).

Methodology

As noted, this article aims to understand the difficulties and needs of intervention with older people in the COVID-19 pandemic. A quantitative deductive method was adopted (Burney, 2008; Casilimas, 1996; Freixo, 2009) based on a questionnaire survey. This method was chosen because it is easier to access the target population at a time of confinement. Given the urgency to collect data, in this first phase of the pandemic, the study was exploratory, descriptive, correlational and explanatory, anchored mainly in the paradigm of positivism and post-positivism (Gales, 2010; Henderson, 2011; Locke, 2001; Mackenzie and Knipe, 2006).

The choice of a quantitative methodology entailed the application of a survey to social workers in residential/long-term care facilities or in in-home care/community services. The questionnaire included closed, mixed and open questions that covered the sociodemographic characteristics of the target population, the institutional framework and professional intervention in COVID-19.

The survey was sent via email to social facilities organizations (residential homes and home care/community services), listed in the 'Social Charter' in Portugal (Office of Strategy and Planning, 2020). We chose to send the survey link to the social facilities under the Ministry of Labour and Social Solidarity (about 15,000 emails were sent). These addresses were accessed and forwarded to the social workers of these social facilities.

The sampling was 'simple random', that is, it is a non-probabilistic sample, but fulfilling the levels of confidence and precision recommended in quantitative studies (Carmo and Ferreira, 1998). The survey was completed between 17 April and 15 May 2020, and the declaration of free and informed consent of all participants was guaranteed. A total of 510 valid responses were obtained. The responses were analysed in SPSS version 26, in which statistical analysis was performed, with the execution of several tests that made it possible to perform univariate and multivariate statistical analysis. In the descriptive statistical analysis (univariate), we determine the

quantities, means and standard deviations. The chi-square test was used in the correlation/association between the variables and in the multivariate analysis and determination.

The open questions were analysed through thematic and categorical content analysis, having been coded from calculating the number of times that certain characteristics occur. These characteristics were grouped into categories, being subsequently treated quantitatively.

In this study, ethical issues were considered. The survey included information related to the rights to participate in this study, as per the Declaration of the Helsinki and Oviedo Convention. Informed consent was obtained, guaranteeing the anonymity and confidentiality of the data collected in the research. Only professionals who freely consented to participate responded to the survey and were included in the study.

Findings: Social work during COVID-19

The respondents, social workers, were women (95.5%) and (4.5%) men, with an average age of 39.9 years old (min–max: 22–73). These numbers are aligned with the gender of the profession in Portugal, as women predominate by more than 90 percent (Carvalho, 2020a).

Their ages were mainly between 30 and 36 years (36.3%) and 40 and 49 years (34.3%). Most of these professionals carried out their activities in non-profit organizations, also called third-sector organizations (associations, holy house of mercy, cooperatives) (79.4%), and others worked in private companies (8.2%) and in the public sector, such as ministries (6.3%) and municipalities (3.5%).

In the case of the provision of services to older people, the main employers of social workers were non-profit entities, contracted by the state, or private organizations that offer residential homes (Carvalho, 2020a), followed by public services, central state, ministries such social security and health and municipalities. The employment contract was mostly of indefinite duration (73.9%), but also long-term contracts (15.7%), which represents certain stability in the workplace. Only 10.5 percent are uncertain jobs or short-term and part-time jobs.

The functions that these professionals performed were mainly manager or executive director in residential homes in the (41.2%) majority of the cases, and social worker (27.8%) and coordinator of home care services (24.3%). The others (6.7%) are related to functions such as project manager or consulting. However, these professionals, especially the coordinators, consider that they have no training in public health emergencies (82.7%).

During the first wave of the pandemic, professionals remained in the organization (53.6%), and others were divided between staying at home a few days in the week (37.6%) and in the remaining days in the organization. Only a few (8.8%) had the possibility to telework. This reveals the high risk these professionals were subjected to in carrying out their activities with older people. It is important to mention that the majority (67.5%) worked directly with older persons, but the rest of them (32.5%) did not.

It is also important to say that many professionals (61.0%) work in residential homes, in long-term care, and in in-home care services (39%) and other community projects directly involved with older people and their families. Most of these professionals (74.5%) did not carry out home visits, but 25.5 percent of them have made home visits, especially in cases of providing basic needs and combating isolation.

In this exploratory study, we also wanted to know if social workers had access to protective equipment in the workplace and how they obtained it. Moreover, we sought to understand the needs assessment and to know if the professionals had training in the emergency crisis. We included these data in the type of workplace as ‘residential homes’ (61.0%) versus ‘home care/community services’ (39.0%) (Table 1).

Table 1. Face pandemic COVID-19 × workplace.

	Residential homes	Home care/ communities services	Total
	n	%	
Have personal protective equipment*			
No, they are not available	0.6%	0.4%	1.0%
Yes, but not enough*	**26.7%**	12.7%	**39.4%**
Yes and they are enough	**30.4%**	12.5%	**42.9%**
I don't work in direct contact with older people	3.3%	13.3%	16.7%
Access to personal protective equipment			
It was given to me by the organization	**56.9%**	**24.3%**	**81.2%**
I got them myself	1.2%	3.3%	4.5%
They're not available	0.2%	0.0%	0.2%
Right now I don't work with direct contact with older people	2.7%	11.4%	14.1%
Criteria were established to determine intervention priorities			
Yes, a list was shared with useful criteria to guide the practice	**43.5%**	**25.1%**	**68.6%**
Yes, but these are general guidelines and of little use in practice	8.2%	8.6%	16.9%
No, we have not received any referrals and there is no need	3.1%	2.2%	5.3%
No, we have not received any nominations, but it would be necessary	6.1%	3.1%	9.2%
There are specialized social workers in intervention in emergency situations at the institution			
Yes	12.0%	8.8%	20.8%
No	**49.0%**	**30.2%**	**79.2%**
There are teams/centres for emergency situations			
Yes	28.0%	16.7%	44.7%
No	**32.9%**	**22.4%**	**55.3%**
Total responses	**61.0%**	**39.0%**	**100.0%**

*$\chi^2 = 72{,}598$; df = 3; sig = .000 significant correlations between residential homes and home care/community services.
The most significant results are in bold.

In residential homes or home care/community services, there are some differences in access to personal protective equipment. Half of the professionals who provided care in residential homes (30.4% of the total) consider having sufficient protective equipment, and almost 12.5 percent in in-home care/community services felt the same. However, there is also a significant percentage of those who consider the equipment was insufficient (26.7%) and almost half (12.7%) in both cases. For most social workers, it was their employer who provided them with protective equipment (56.9% and 24.3%). That means the organization provided the protective equipment, gloves, masks and other equipment in most cases (81.2%).

Furthermore, most respondents consider having established some criteria to intervene in this context. And such a strategy was helpful for those who work in residential homes (43.5%) and those who do not (25.1%). The respondents identified a list that was shared between the general health and social security directorate with useful criteria to guide practice. However, a minority of the respondents (16.9%) assume that these guidelines were general and not particularly useful.

Table 2. Main needs × residential homes versus home care/community services (multiple response).

	Residential homes		Home care/community services	
	n	%	*n*	%
Psychosocial support to users	53	**9.0**	22	3.7
Visits/contact with families*	125	**21.2**	26	4.4
Protective equipment	15	2.5	13	2.2
Basic needs/food/hygiene**	28	4.7	78	**13.2**
Needs for accommodation, medication, economic support***	20	3.4	**37**	**6.3**
Human resources	8	1.4	2	0.3
Combat isolation/loneliness	41	**6.9**	49	**8.3**
Digital platforms and community responses	29	4.9	18	3.1
Outings, cultural activities	12	2.0	4	0.7
No needs are identified	10	1.7	0	0.0
Total	**341**	**57.8**	**249**	**42.2**

*χ^2 = 42,848; df = 1; sig = .000; **χ^2 = 67,190; df = 1; sig = .000, ***χ^2 = 18,081; df = 1; sig = .000, correlations between residential homes and home care/community services.
The most significant results are in bold.

It is also important to note that there are no social workers who specialized in emergency intervention (79.2%). But a minority (20.8%) recognize that such professionals exist. In more than half of the cases, these professionals are part of the emergency programme in residential homes (28.0%) and in in-home care/community services (16.7%).

As demonstrated, these professionals do not have difficulties in accessing equipment and were involved in defining action criteria to prevent COVID-19 contagion. However, the lack of training in emergency and crisis is evident in both cases. As Carvalho (2020b) argued, training in catastrophes and emergencies is essential in the social work curriculum.

Concomitantly, statistical tests were performed to assess the association between the variables in Table 1. This analysis shows a significant association between access to personal protective equipment and the residential work context (*χ^2 = 72,598; df = 3; sig = .000). This correlation/association indicates that professionals who claim to have sufficient personal protective equipment predominantly work in a residential setting. While those who claim to not have personal protective equipment available predominantly do not work in a residential setting. However, some of these professionals (14.1%) do not work directly with older people.

Professionals' perception of needs

The survey included an open question related to professionals' perception of needs. This question and the results were assessed by categorical content. This type of analysis calculates the number of times that certain characteristics occur and groups them into categories. In this case 590 responses were obtained (Table 2).

It is important to maintain relationships with families, applying psychosocial and emotional support to overcome the trauma of isolation and the mandatory confinement of older people.

For those who work in in-home care/community services, the main needs were related to 'basic needs/food/hygiene' (13.2%), 'fighting the isolation/loneliness' (8.31%), and 'needs for

Table 3. Main difficulties and challenges × residential homes versus home care/community services (multiple response).

	Residential homes		Home care/community services	
	n	%	*n*	%
Visiting/contacting family members with the older people	**35**	**5.2**	12	1.8
Formal support and articulation between community services	**43**	**6.4**	**27**	**4.0**
Temporary responses to ensure isolation measures	22	3.3	10	1.5
Personal contact between professionals and users	14	2.1	**25**	**3.7**
In managing anxiety/uncertainty/fear	**61**	**9.1**	21	3.1
In planning and managing teams	6	0.9	7	1.0
Lack of human resources to provide care	**76**	**11.3**	**41**	**6.1**
In home visits – analyse the situations contextualized	6	0.9	10	1.5
In access to COVID-19 test	7	1.0	4	0.6
Access to protective equipment	29	4.3	21	3.1
In the management of information about COVID-19	22	3.3	16	2.4
For the older people to accept confinement	29	4.3	18	2.7
Telework management	6	0.9	8	1.2
Isolation of older people	23	3.4	16	2.4
Providing support to families	17	2.5	**27**	**4.0**
No difficulties	10	1.5	3	1.8
Total	**406**	**60.4**	**266**	**39.6**

The most significant results are in bold.

accommodation, medication, economic support' (6.2%). The results related to the satisfaction of basic needs stem from the fact that many older people must stay at home and cannot leave home, or cases of families struggling to survive due to lack of income from work. Therefore, it was necessary for them to strengthen home support, especially with meals and food, maintain security, and promote health, accommodation and economic support.

At the same time, statistical tests were carried out to measure the association between the variables in Table 2. At this level, there is a statistically significant association between those in a residential context, who predominantly need visits and contact from family members (*χ^2=42,848; df=1; sig=.000), and those in a community context who do not have this need. On the contrary, those in the community context predominantly require basic needs (**χ^2=67,190; df=1; sig=.000) and needs in terms of housing, medication, support from third parties and economic support (***χ^2=18,081; df=1; sig=.000).

Professionals' perception on difficulties and challenges

The survey integrated a question related to the main difficulties. The results were assessed by categorical content. This type of analysis calculated the number of times certain characteristics occur, groups them into categories and was treated quantitatively. In this case, we obtained 672 responses (Table 3).

Regarding the difficulties, both residential homes (RH) and home care/communities (HCC) professionals confronted several challenges: institutional impediments related to 'lack of human

Table 4. Practices × residential homes versus home care/community services (multiple response).

	Residential homes		Home care /community services	
	n	%	*n*	%
Use of online networks to contact users	36	6.2	34	5.9
Supervision/support/positive reinforcement for those working at the front line	**85**	**14.6**	**45**	**7.7**
Working in mirror mode/optimizing human resources	28	4.8	22	3.8
Comply with the rules of the General Directorate of Health to prevent COVID-19	83	**14.3**	**47**	**8.1**
Disseminate working methods/community institutions network articulation	31	5.3	28	4.8
Systematic assessment in need of users	60	**10.3**	**42**	**7.2**
Unanswered	27	4.6	13	2.2
Total	**350**	**60.2**	**231**	**39.8**

The most significant results are in bold.

resources to provide care' (RH: 11.3% and HCC: 6.1%); and 'the lack of the articulation with the community health network' (RH: 6.4% and HCC: 4.0%) prevail.

But in residential homes, the following were highlighted: 'In managing anxiety/uncertainty/fear' (9.1%) and 'Visiting/contacting family members with the older people' (5.2%). Therefore, it was essential to maintain the normality of daily life with clients while also providing stress management and support to family members due to the lack of institutional visits.

In home care/community services, the following were noted: 'providing support to families' is one of the most difficult (4.02%) as well as the 'personal contact between professionals and users' (3.7%). Other difficulties identified were the management of the teams, with absenteeism resulting from the responsibilities of the staff in accompanying underage children at home.

The lack of protective equipment was one of the stressful problems among employees. Articulation with the community network identifies the lack of information and the disarticulation with the health delegate and social security system. Confinement has negatively interfered with access to information, essential for assessing needs with scientific and technical evidence. Thus, the impossibility of carrying out home visits to ascertain the information on the spot had an impact on the quality of the intervention, with apparent damage to those involved.

Concomitantly, statistical tests were performed to measure the association between the variables in Table 3. At this level, there was no statistically significant association in terms of the difficulties experienced by those in the residential context and those who are not. This means that the difficulties and challenges are identical in both contexts.

Perception of professional practices to face needs, difficulties and challenges

The research integrated a question related to the identification of practices, developed by professionals, to face the needs, difficulties and challenges. The results were assessed by categorical content. This type of analysis calculated the number of times certain characteristics occur, grouped them into categories and treated them quantitatively. In this case, we obtained 581 responses (Table 4).

The most evident practices are related to the importance of 'supervision/support/positive reinforcement for those working at the front line' (RH: 14.6% and HCC: 7.7%), 'comply with the rules of the General Directorate of Health to prevent COVID-19' (RH: 14.3% and HCC: 8.1%) and 'systematic assessment in need of users/clients' (RH: 10.3% and HCC: 7.2%). Other practices revealed in both cases (RH and HCC) are the 'use of online networks to contact users/clients' or 'disseminate working methods/articulation among community institutions' and 'working in mirror mode/optimizing human resources'.

At the same time, statistical tests were carried out to assess the association between the variables in Table 4. At this level, there was no statistically significant association in terms of good practices identified by professionals who are in the residential context and those who are in the community context. It means that the professionals' practices are identical in both contexts.

Discussion

In globalization (O'Leary and Tsui, 2020), the flows 'of human capital; of financial capital; of goods and information – are now partially distorted, blocked or even broken' (p. 273). In these circumstances, neoliberal policies have changed the day-to-day practices of social workers at four levels: (1) commodification, (2) consumerism, (3) managerialization and (4) de-professionalization (Ornellas et al., 2020). Private, non-profit organizations orient their action towards providing services despite being regulated by the public sector. In these contexts, the professional focuses mainly on management and managerialism.

The current pandemic has placed complex demands on social workers in developing their interventions with older people in residential homes or home care/community services. In this study, we can identify two types of difficulties and needs: those already existing before the pandemic and those that were significantly aggravated.

Examples of these pre-existing difficulties and needs were the lack of human resources, insufficient specialized training to work with older people and of adequate responses to these individuals' needs. Another difficulty is that of intersectional (health–social action) and multi-professional articulation. For example, certain norms emanating from the general health department to prevent COVID were challenging to put into practice in homes and the community. And as Ruth and Marshall (2017) argued, although social work has been involved in public health policy, these professionals have not been given the information, capacity or logistics to do so.

Regarding the needs and difficulties emerging from the pandemic, when setting out the contingency plans, we found that although the DGH (2020c: 2) recommended measures for these structures and services, each entity was responsible for its implementation. These organizations expressed difficulties in applying public health measures to the social sector, as some of them were impossible to implement due to the lack of logistical and human resources in both the home care services and the long-term care facilities. The fact that this was a new situation also implied the creation of norms by the appropriate authorities; however, there were some mismatches between the information produced by the health entity and the social security entity that oversees these responses.

These mismatches and pulverization of dispatches and norms, in an already difficult period, are destabilizing for the institutions and for the professionals who had to operationalize both at the level of direct intervention (with older people and families) and the level of team management and work processes, ultimately increasing their stress (Haider et al., 2020). We have also noted difficulties arising from these different reconfigurations of working methods, including those related to work–life balance.

In this context, the intervention focused on an individualized approach of psychosocial support to individuals and families in residential homes and community cooperation and participation in specific projects to respond to emergencies, reinforcing the role of mediators (Berg-Weger and Morley, 2020). At this level, the most significant difficulty was in managing crisis, fear and uncertainty (in the face of the dynamics arising from confinement in the home for users of home support services and day centres and the absence of visits in residential structures).

The dilemmas presented refer to the fact that professionals do not have specific training to intervene in emergencies, situations where there is no room for confinement when positive cases of COVID-19 are diagnosed, and to the management of how each older person experiences the situation. The intervention is now focused on an emergency response assistance strand rather than human and social development, intersectoral and networking intervention.

The existence of situations considered as 'good practices' do not always fit this definition. For example, in a crisis, the professional must have the ability to adapt and creatively respond to the public health emergency scenario (Wang et al., 2021). In this case, they are required to ensure the greatest degree of well-being and safety of the clients, as well as of the teams providing care, activating networks and resources, moving forward, during less than favourable conditions. These experiences of social workers working with older people in a pandemic situation can be useful in identifying important avenues of intervention for the necessary reconfiguration of policies and social responses in ageing (Berg-Weger and Morley, 2020).

The experiences of social workers during this first wave of a pandemic can be valuable to change the status quo of intervention in this area (Berg-Weger and Morley, 2020). It is important to leverage the skills acquired with new technologies to involve people in activities and decisions that concern them, and to develop post-trauma support projects and to combat ageism (Brennan et al., 2020).

Policies for old age and home care regulation must be integrated between health and social services; they must be multi-sectoral and multi-service by deepening interdisciplinary collaborative networks. Social workers should be leaders in the design, implementation, monitoring and evaluation of policies, promoting the quality of responses and promoting the rights of older people, given their profound heterogeneity.

Social policies must pay attention to these specific dimensions and contexts. Neoliberal policies centred on managerialism and control homogenize professional practices. If policies addressed the differences brought about from professional practice, they would strengthen the role of social workers and could respond more effectively to the everyday needs and difficulties of older people and their families by promoting their capabilities.

Potentiality and weaknesses

In addition to these considerations, it is important to understand the study's potential and weaknesses. Despite the period of data collection being necessarily short and in a particularly intense period of work, it captured a vital portrait of the intervention of 510 social workers working with older people, showing the complexity of this area during a public health emergency and had the potential to capture phenomena as they were occurring.

In future studies, it would be interesting to capture its evolution over time, seeking to identify what strategies were adopted by social workers throughout the different phases of the pandemic, what working tools were created for this purpose, what plan was drawn up for the reopening of day centres and the admission of visitors to residential care, and what training spaces and times were created and used by social workers.

The fact that the great majority of the social workers who took part in this study are in the middle of their working life and have stable labour ties is a sign of hope. Although with the proper training, we can still count on them for many years to come. The experience they have acquired will be fundamental to defend the common good and respond in a quick, qualified and motivating way to future crises and pandemics. In addition, these data can be useful for future research on the subject and for making comparisons with other countries.

Conclusion

Globally, the social work profession has adapted and 'bent with the flood' of the COVID-19 pandemic (Dominelli et al., 2020), and Portugal is no different. This country has one of the most ageing populations of the European continent and has initiated a programme to combat COVID-19 based on compulsory containment measures with the establishment of a state of emergency. Consequently, the pandemic has not yet been as severe as in other European countries; for example, during the first COVID-19 pandemic state of emergency, the number of older people who died was low compared to other European countries. But it has mainly affected older persons living in long-term care facilities.

The impact of the pandemic and the emergency measures has been devastating for the social sector (Pentini and Lorenz, 2020). In both short- and long-term care, this could have a profound effect on the macroeconomics of the country, not only for consumers but also for businesses, as there will be an unexpected and unprecedented economic downturn (Baldwin and di Mauro, 2020). This scenario has direct and indirect consequences in the context of social work intervention in general and with older people, with contradictions placing individual freedoms in competition with the need for greater collective solidarity (Pentini and Lorenz, 2020).

Social workers in this field require a continuous augmentation of their knowledge, which is only possible through a solid investment in continuous training, which accompanies the effervescence of social changes. The process of qualification for social workers must enhance the development of skills and strategies of action, not only at the level of direct intervention with older people and families, but also at the level of participation and dynamization of interdisciplinary, interinstitutional and intersectoral, and collaborative networks at the level of management, leadership and coordination of teams, resources and organizations.

Whatever the governments say and do, success in addressing the pandemic is dependent on what individuals are willing to do (Paul et al., 2020). In this context, proximity to populations, especially to those in socially vulnerable situations, social workers can play an important role in shifting the paradigm from a hospital-based response to a more effective and sustainable community-based one. As O'Leary and Tsui (2020) assume, in this 'Global Village', social work can help lead the pandemic response.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

The authors received no financial support for the research, authorship and/or publication of this article.

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