Mrs B

Community Nurse

GP

Home Care

Day

Daughter

Social Worker

⟶ (red double line, solid arrow)	Duty to assess, and try to meet, needs
⟶ (bold dashed arrow)	Commissioning
⟶ (dotted arrow)	Liaison
⟶ (thin solid arrow)	Care

Fig (i): Working with Mrs B

In this case the social worker has responsibilities to assess, and try to meet, the needs of two people whose interests may not be the same: Mrs B and her main carer, her daughter. The social worker has commissioned the services of two provider agencies, one providing day centre care, one providing care assistants to support Mrs at home. (The social worker has arranged for her agency to enter into a contract with these agencies under which they are paid to provide a specified service.) The social worker also needs to liaise with other professionals involved in supporting Mrs B, in this case the GP and the Community Nurse. The Community Nurse is also providing care for Mrs B, so her input will need to be co-ordinated with that of the other service providers and with the daughter.

This is an example of a situation where the social worker who carries out an assessment of a case does not actually deliver the resulting, but commissions it from others ('care management'). In other contexts, social workers may be placed in the position of co-ordinating input from a number of different professionals, whose input is not under her control (as is the case with the Community Nurse in the above example), and trying to ensure good communication and clarity of purpose. Social workers acting as key workers in child protection cases, or acting as 'care co-ordinators' under the Care Programme Approach in the mental health field, are cases in point.

However the most important 'other' that a social worker has to deal with is the one for whom the service is supposed to exist, so I will begin by looking at this primary working relationship, the working relationship with the service user.

Note on terminology

I am making a distinction in this workbook between *care management* and *co-ordination*. I am using the former to refer to the management by a social worker of services which her agency has commissioned and is funding. I am using the latter to refer to the role of a social worker in co-ordinating services which are not under the control of her agency. As the example above shows, the two roles often overlap.

This is another instance of terminology which is not always used in the same way. The job which I have called care *management* is also often referred to as *care co-ordination.*

The distinction between the two roles is real. The actual words used will vary depending on which book you read, and in your own writing you will need to make clear how you are using the terms as I am doing here.

User Participation

I have more than once heard busy social workers remark in jest that their job would be fine if it wasn't for the service users. No doubt doctors and nurses sometimes say the same thing about patients and teachers about pupils. It is an old joke. The fact is, though, that in professionalised, bureaucratised systems such as exist in social work agencies there always seems to be plenty to do apart from actually dealing with service users – meetings to attend, forms to fill in, files to write up – so that it really *is* quite possible to lose sight of the fact that services are supposed to be there for their users.

And in fact no service *is* just there for its users. Social work services are there also to meet the needs of those who work in them, those who manage them, those who fund them and set them up: needs to earn a living, to feel important or comfortable or useful, to feel that something is being done. All kinds of other agendas exist which can crowd out the service users themselves – their actual needs, their perspective on what would be helpful – and this can result in services which (a) fail to meet users' needs, and (b) may be profoundly disempowering and oppressive in their effects. Different groups of service users may be vulnerable in different ways to being excluded in these sorts of ways.

> **Q** **EXERCISE 5.1: QUESTION**
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> Consider the following different subgroups within the general population. In what way could their perspectives being excluded by those involved in delivering social work services? How could this exclusion be minimised? (Of course there are many other groups I could have chosen.)
>
> - Children
> - Muslims
> - Poor people

It is extremely easy to overlook the viewpoint of children, because in our culture it is quite normal for adults to talk about children over their heads. Tragic examples from the real world are the cases of Victoria Climbie (Laming, 2003) and Jasmine Beckford (London Borough of Brent, 1985), both cases where social workers responded to the demands of intimidating adults and failed to notice what was actually happening to children in the care of those adults. In both cases, social workers saw children who were being seriously abused and failed to see the signs: both children died as a result. It is often easier to work with adults than with children, for a variety of reasons, so children protection workers need to be constantly vigilant about the possibility that they may be losing their focus on the child – and ensure that ways are found of getting the child's point of view.

Numerous different ways exist in which Muslims as a group might be excluded. An agency which provided residential care for old people but did not cater to the particular dietary requirements of the Muslim religion would be a case in point. It is difficult to see how an agency could fail to make mistakes like this if it did not involve members of the Muslim community in designing its services and/or if it did not specifically ask residents and potential residents about their dietary requirements and cultural practices.

Many social workers have no personal experience of poverty. Given that we tend to notice things that we understand from our own experience, it is therefore very easy to fail to notice the impact of poverty on people's lives if you have no experience of it yourself. In this context it is very easy for social workers to end up imposing middle class values in an environment where those values are simply not practicable. This could be avoided to some extent if social workers allowed themselves to listen to what service users are actually up against in their daily lives or, better, involved service users in developing the services themselves.

Braye (2000) identifies four levels at which users themselves may be involved in service delivery:

- Individual service users, or prospective service users, being involved in their own service.

- Involvement of groups of service users in planning services.

- Developing independent user-led services (i.e. non-statutory organisations which are actually run by service users.)

Involvement of service users in research

It is desirable that service users should be involved at all these levels in determining the nature of the services that they receive, for all of the following reasons:

Firstly, to do anything for other people which they are capable of doing adequately for themselves will tend to be disempowering in effect (that is: it will reduce people's confidence in their own ability to do things for themselves.) This is true in a general sense but it is *particularly* true when dealing with people who are accustomed to receiving negative messages about their own ability to determine their own lives (consider the case of a person with a learning disability, for instance, who has grown up receiving constant messages that he is incapable of making his own decisions). In this context, doing something for a person which they would otherwise be capable of doing for themselves contributes to real oppression.

Social work cannot overturn all the injustices of the world, but if our profession's traditional commitment to social justice is to mean anything at all, we should at least try to ensure that as far as possible our actions empower, rather than disempower, those we work with. Neil Thompson defines empowerment as 'seeking to maximise the power of clients and to give them as much control as possible over their circumstances. It is the opposite of creating dependency and subjecting clients to agency power.' (Thompson, 2001: 85).

Secondly, it is more *efficient* to involve service users in determining the nature of their own services, since the likely result of failing to do so is that they will be given services which are not ideally suited to their needs. Resources are then effectively wasted in the sense that they are not used to best effect. Imagine a restaurant where waiters dispensed food to customers as they saw fit without reference to the customers' preferences or dietary requirements. Social workers and other members of the 'caring professions' may like to see themselves as advocates on behalf of their service users, but the fact is that we all have our own agendas. David Brandon noted, for instance, in a discussion on advocacy for users of psychiatric services, that 'the advocate nurse, social worker or doctor has an inherent and critical conflict of interest. The alleged oppressor pays their salaries.' (Brandon, 1991: 118). Elsewhere, David and Toby Brandon speak of the 'fundamental tension of doing "what is best" for the client contrasted with doing "what her or she asks to be done" – whether we take instructions of give them.' They suggest that the problem of how a single individual could reconcile these 'fundamentally conflicting ingredients would be beyond the wit of a committee comprising the Buddha, Christ and Mohammed'! (Brandon & Brandon, 2001: 49).