SEVEN

Social work: profession among professions

At one time, British passports required you to state your occupation. One of my friends looked at mine, which said: 'social worker'. She said: 'You don't do social work, you're an academic or perhaps a manager or a writer'. My view of my identity at one time or another, and mostly at the same time, is all of these things. But my work colleagues are clear. The medical director and nursing director know that I was trained as a social worker, and have written books and articles about various aspects of social work. When registration of social workers was introduced, they know, because the personnel manager checked, that the GSCC, the English registration body for social workers, has registered me. That registration entitles me in English law to call myself a social worker. I manage an area of provision called 'psycho-social and spiritual care', which includes various departments. One is called 'social work', led by a 'director of social work'. This is different from the spiritual care department, which has a 'spiritual care lead' (an ordained minister of religion). The day care unit is different again. It is managed by a music therapist, and includes complementary therapists, nurses, various other kinds of art therapists and a horticultural therapist. The mental health team comprises part-time psychiatrists at various levels of training, led by a consultant psychiatrist and professor of psychiatry. All these different departments provide recognisably different elements of our overall palliative care service for the slice of south London that we cover. They are themselves recognisably different from each other. Everyone working there accepts that the various professions involved in 'psycho-social and spiritual care', including social workers, are different from doctors, managed, except for the psychiatrists, by the medical director, and nurses, managed, except for those in the day unit and complementary therapies, by the nursing director. Those exceptions, managed by me, make for a complicated pattern of professional and organisational responsibility.

Even in this fairly small-scale voluntary organisation, there are people within a complex system of occupational labels, many of which are widely regarded as professions. Chapters Five and Six pointed to ideas about accountability in organisations and how this is connected with

the distribution of power in society. In our organisation, as it happens, people called 'social workers' are not employed outside the social work department – except for the chief executive and myself, senior managers who are also as it happens social workers, but could be from any professional group. A separate project helping children with bereavement employs some registered social workers, but not called by that title. How does it work, then, that I and the music therapist manage nurses and 'allied health professionals' (AHPs), and I manage doctors (the psychiatrists)? We do it in a variety of ways. The hospice has a contract, which I manage, with a psychiatric healthcare NHS trust, and psychiatrists are professionally responsible only to psychiatrists for their professional work. If anything goes wrong, my job is to require the consultant psychiatrist to comply with the hospice's requirements, but his job is to judge what is appropriate in psychiatric decision making. We negotiate; well, actually we have lunch together every so often and talk over how things are going and what we could each do to improve things, but we would negotiate within our responsibilities if there were a problem. The music therapist manages the organisation of the day unit, and the AHP (he is registered as an AHP), does music therapy and gets advice from the nursing director on things to do with nursing. All the nurses have separate professional group supervision, unconnected with the management structure. The hospice pays independent consultants to provide independent professional supervision for the spiritual care lead and the music therapist in their professional work, because they are managed by a social worker, me.

Many complexities occur in any organisational structure. In many services, there are complicated relationships between people with different professional identities and knowledge and skill bases. What does this mean for social work? Is it one of those professions? How does it, with its particular identity, interact with other professions?

This chapter therefore asks two questions:

- In what ways is social work professional?
- How does the multiprofessional element of much social work affect its position as a profession?

The next section explores various meanings of 'profession'; the following two sections explore how social work fits with those meanings through looking at how it has sought to become a profession, and the critique of this. I then examine how multiprofessional work affects its position as a profession.

Occupations, jobs and professions

These questions bear on the nature of social work as an occupation, rather than as an activity. Is social work, or in what ways is it, a profession, or is it 'just' a job? There are some commonsense understandings of 'profession' to consider:

- *As paid rather than unpaid activity.* We sometimes say that someone is a professional because they are paid and employed to do a job, rather than being unpaid and an amateur. A professional footballer is paid, while the participant in a Sunday league is unpaid. Social work is such a job, but some people also do voluntary work, or work at social services tasks without being a social worker. What distinguishes paid social workers from them? Is it only the pay?
- *As implying a recognised type of job.* We sometimes use 'profession' as a polite way of asking what someone's job is, at parties or on forms. Sometimes other occupational groups such as police officers or teachers complain that they have to do social work as part of their tasks. Thus, they simultaneously recognise it as something different from their occupation, but also imply that doing it would be possible for them if they did not have other important priorities in their work.
- *As implying high quality.* We sometimes say that someone did 'a very professional job' or that she is a 'real professional'.
- *As a description of a special category of occupation.* We talk about the medical and legal professions, but we would not generally refer to the 'plumbing' or bricklaying' profession: these are crafts or trades. The ticket collector at the station has a job, but not a craft, trade or profession.

These distinctions are not clear. The cook in a high-street café might have a job, their colleague in the restaurant next door might have a craft, their colleague in the restaurant with 3 Michelin stars for cooking might have a profession. What distinguishes them is public recognition, effort and training, and an approach and attitude to what they do. These distinctions are partly, in many people's minds, about quality. In a job, you try to provide a good service that people find acceptable, or turn out a good product. A craftsperson achieves satisfaction from a product that represents a special quality. A professional does both of these, but seeks to achieve high quality because of altruism, a wish to benefit others rather than themselves. People think that this disavowal of self-interest is important because the expertise involved in professions

means that the people using professional services often cannot control the quality of what the professional does, and the work often exposes them to risk, or an uncertain outcome. Evident altruism is a mechanism to reassure service users that professionals will act in their best interests. However, this does not assure successful outcomes, since what is judged successful is different from what might be in your best interests or what you might want. A craftsperson, on the other hand, might simply want to achieve a result to meet their own standards, whatever the customer thinks, and somebody 'just' doing a job might be careless if the pay is not enough or the manager is not keeping them up to standard.

Professionalisation and social work's development

The four meanings of profession are related, however. Being paid rather than unpaid, being in a recognised job, and carrying out a task well are related to the idea of a special occupation. Professionals profess: that is, they claim that expertise makes their occupation special. They seek to define an area of specialisation that is theirs alone (Wilensky and Lebeaux, 1965: 285).

Social work during the 20th century took this path of professionalisation, as a voluntary occupation for middle-class women became a job, around the time of the expansion of social work during the First World War (Payne, 2005c). An important early influence was a famous speech at that time in 1915, by a North American educationalist, Abraham Flexner. He argued that social work did not have important characteristics of a profession. This led social workers into a quest to achieve Flexner's markers of a profession. A progress report by Greenwood (1957), after the formation of the unified American NASW, still claimed that social work in the US had not achieved these markers of professional standing. British social workers at this time, in divided specialist groups, similarly sought recognition of social work as a professional entity partly as a way of achieving unity.

Success came through a unified local government department responsible for social services through the implementation in 1971 of the recommendations of the Seebohm Committee (1968); the Scottish social work departments in local government were formed the year before. At much the same time, the North American sociologist Nina Toren (1969) described social work as a semi-profession. She argued that it would always be impossible for professions like social work to achieve full professional status. Among the reasons was that social workers were employed by agencies that could limit their capacity to use discretion based on expertise and knowledge. The professionalisation debate in 1970s Britain reflected the concern that bureaucratisation and poor responsiveness to community and client needs meant that the achievement of unity had not necessarily achieved a profession (Glastonbury et al, 1980).

Knowledge development was also a factor. Nokes (1967) argued that welfare professions should not be based on an exclusively scientific basis with a technocratic, rational approach to knowledge. He argued that welfare professions expressed and communicated ideals of caring and concern in society. By promoting social relationships and interactions, welfare professions facilitated solidarity in societies. He also usefully distinguished an idea of 'treatment' in welfare professions from medical treatment. He argued that welfare 'treatments' are only partially in the control of the professionals, who provide space, time and environment to facilitate personal and social change. The control that professionals provide lie in the planning and operation of the environments in which service users may have opportunities to grow spontaneously. Similarly, Sainsbury (1980) reported research on family work from which he argued that an important skill was to orchestrate a social work team's work effectively, matching and developing skills in the team to changing need.

At the same time, Halmos (1965) argued that 'counselling' has to some extent replaced the traditional advice-giving professions of the law, medicine and the Church with a more secularised and accessible form of response to the more complex social difficulties of industrialised societies. These counselling occupations have shared views of human nature and of appropriate social responses, that have come to influence the organisation of many social institutions, including business organisations (Halmos, 1970). Halmos' analysis draws a parallel between the group of 'counselling' occupations, of which social work is one, and more general historical and social trends. Social work developed alongside the same professionalising social trends and, at least at some times and in some quarters, its ideals have had recognition and even influence. Such views connect with the debate about what kinds of knowledge are acceptable for professional status. A long-standing opposition between interpretivist and positivist views of knowledge (Brechin and Sidell, 2000) has affected social work in the late 20th and early 21st centuries. Interpretivists argue that all knowledge is interpreted by human thought and therefore responds to the social and historical contexts in which it originates; positivists that there is an unchanging objective reality that can be observed and defined.

Social work developed and codified knowledge as a basis for claiming a distinctive professional group. The 19th-century charity organisation societies from which social work practice methods emerged were committed to 'scientific charity': '... these pioneers of practice considered scientific inquiry to be the systematic study of causation through gathering thorough and helpful facts' (Orcutt, 1990: 126). Germain (1970: 26) argued: 'The scientific commitment had seemed to promise social casework a secure position in the profession'. When, in the 1970s, it seemed that science showed that social work was ineffective (Fischer, 1976), it seemed that one of the arguments for social work as a profession was gone.

Questions therefore were asked about the process of professionalisation, and whether social work should follow this route for development. There are three approaches to professionalisation; this account is based on Brint (1994); Freidson (1970, 1994); Turner (1987); and Hugman (1991).

- The *naturalistic* approach (for example, Perkin, 1989) sees professionalisation as a natural part of the increasing complexity of society and changes in the structure of society towards more middle-class occupations, rather than routine factory work. What needs to be done is more complex and needs broader knowledge that is hard for people to hold in their heads. Consequently, jobs become more specialised and people become more expert in smaller areas of understanding. Routine and manual work becomes less important, and is done by machines. Bell (1974) argues that these developments are integral to a post-industrial society where knowledge-based service occupations are more important than labour in manufacturing.
- A *social order* approach suggests that occupations of a kind that develop altruistic services are important in maintaining the social system. They develop a privileged position in society because their services are socially valued. Their high valuation arises because they accumulate characteristics including theoretical knowledge and skill, specialised training and education, usually in universities, the testing of members' competence, the development of professional associations and the emergence of a professional code.
- The *occupational control* approach suggests that professionalisation is a way of structuring the relationship between experts, patrons and clients. Professionals gain prestige and social distance from their clients through their expertise, which excludes clients. External regulation and social control of the professionals is then required, because the average client cannot hold professionals to account. Regulation of the use of the expert knowledge is undertaken by the profession.

Professionals, the public interest and the critique of expertise

More recently, it has become clear that occupational groups are increasingly subject to external influence, through complaints systems, consumer movements and other systems of accountability. People are much less deferential in the 1990s than they were in the 1950s. Governments and public bodies have taken greater responsibility for regulation of professions, often in search of financial controls, than they did in the 1950s. They claim to do this on behalf of their constituents, in particular non-expert consumers.

This raises the issue of the public interest (Saks, 1995). If the state or the public has an interest in the provision of a service and how a profession is organised, how may that interest be represented? There might also be differences in view. Saks (1995), for example, looks at alternative medicine, where there are major disagreements about whether it is worthwhile, in which powerful medical profession interests are often critical of practices that they disagree with. This means that politics arises around professionalisation, because power is used in institutional relationships to resolve disagreements, by professions, both professional organisations and individual professionals, and by others. This politics arises between organisations and individuals around who should have the authority to decide what actions may properly be taken as part of a professional activity. This then leads into questions of knowledge and, further, into education, since deciding what knowledge is 'true' and what education effectively conveys 'accurate' knowledge also raises matters of disagreement, in which groups representing particular interests disagree, and engage in power relations to achieve ascendancy for their point of view. This politics is a separate issue from whether knowledge is 'true' in that it represents what all the evidence, when collected and assessed rationally and without bias, shows to be the case. The extent to which it is possible to say that something is true varies, depending on the type of thing we are looking at and the care and clarity with which the evidence has been accumulated. When it is not absolutely clear that something is true, a politics will often arise around the debate about whether it is true, with people trying to use political power to have their position accepted as true.

The 1970s and 1980s saw a further debate, in general and in social

work, about whether professionalisation was desirable. This focused on the conflicts of interest between professions, the public interest and the interests of service users. Wilding (1982) summarises the critique of professional power, arguing that seeking power through such claims disadvantages people whom professionals seek to help. There are seven points of criticism, and I give some examples that might apply to social work:

Excessive claims and limited achievements: Examples of this are criticism of claims that casework in the 1950s could deal with a wide range of human problems, evidence in the 1960s that it was ineffective and the evidence-based practice movement's argument that much social work is based on faulty assumptions rather than available evidence. Not all such claims are created from within the profession itself. Unrealistic expectations are laid on the profession from outside. Government and the public, for example, have laid upon social work in many countries the expectation that social workers can protect children at risk of being abused in their own homes, while being able to avoid excessively punitive action against parents. Evidence of effectiveness of social work is at the small scale, rather than presenting achievements of wide social significance.

Failures of responsibility: Scandals about failure to act have affected social work. There have also been problems with heavy-handedness where social workers have official or bureaucratic roles, the frequently poor quality of residential care, and the inadequacy of services. Social workers say that these are exceptions rather than the rule, and that many failures stem from poor resources for services rather than professional inadequacy. Organisations and professions often make such points when protecting themselves from criticism. While much social work may be helpful, it is still often experienced as oppressive or failing. Attempts to professionalise social work have been frustrated by such issues. For example, Malherbe (1982) argued that managerial control was the most important way of ensuring clients' needs were met and that accreditation had not worked well in the interests of clients in other countries. Parker (1990), reviewing this debate, emphasised how, in the 1990s, changes in the organisation of social services by fragmentation due to privatisation of services, made managerial control less possible. Instead, greater inspection and regulation of non-state services had grown up, but this did not provide for the supervision of standards of work. However, most countries have increased the level of regulation of social workers, by accrediting their qualifications or standing as practitioners, and the UK followed suit by establishing under the Care Standards Act 2000 councils in each of its constituent countries to register social care workers. This led in April 2005 to 'protection of title', so that only registered people could call themselves 'social workers'.

The claim for neutrality: Expertise and a 'scientific' knowledge base are claimed to give professionals independence from political pressures, because they are more knowledgeable than others about what is true in that area of knowledge. Therefore, they should be able to make decisions altruistically in the best interests of the people they serve, rather than pursuing their own or other sectional interests, because otherwise knowledge comes from political power rather than a rational assessment of the evidence.

The knowledge base of social work is criticised as inadequate to support claims for effectiveness. Social work decisions often reflect fashionable or organisational, political or social objectives rather than concern for the individual needs of clients. The second criticism of neutrality is that social work is always on the side of those governing, those with power, against the governed, those without power. It might be argued that social work is more aware of this issue than many professions, and thus less liable to be unconditionally oppressive. It is also, as we saw in Chapter Six, more inclined to do something positive about it. A third criticism is that professions are inherently about enhancing their own power, and oppression of clients inevitably derives from that objective.

Neglect of rights: This criticism is also about the powers that social workers exercise on behalf of society in pursuit of social governance. There are systems for complaint and occasionally appeal, but much decision making goes unobserved, is practised on shaky evidence and a poor knowledge base. Frequent scandals about particular cases have led to concern about social work's tendency to ignore rights in its everyday work, contrary to the rhetoric of its value system.

The service ideal: Professions are supposed to give priority to their clients' needs, and act from altruism in their work. However, use of industrial action to pursue salary payments, influence and conditions of service and evidence of incompetence or failures of service raise questions about the service ideal. Altruism is a controversial issue. It might be seen as natural (most human beings will help others) and as exceptional (most humans are egoistical). Seeing altruism as natural

connects with social order views, which accept that, in orderly societies, one individual helps another and societies organise to provide such help in order to contribute to the social order. However, Schwartz (1993) argues that market societies that assume individualism and autonomy for individuals are the least likely to encourage altruism among their citizens. Altruism may bring social work into conflict with some aspects of justice and equality, because it involves responding to people's needs whether this is fair to others or not. A strict points system for allocating a service does not sit easily with a more complex interpersonal assessment using discretion. Wakefield (1993) argues that one of social work's roles in society is to form the altruistic side of a range of services with alternative objectives, such as justice and equality. The collective interest in altruistic services being available becomes apparent only when a market-based society evades the social responsibility to offer them.

Transformational views argue, in opposition to this, that societies need to be planned and organised to combat this. Rather than altruism workers should primarily respond to the interests and wishes of service users, working with transparent, participative methods that involve users in dialogue and decision making. They should also use methods that are explicitly on the side of clients, such as advocacy. Services should be planned participatively. Workers should empower self-help and self-advocacy groups so that users are more able to take action themselves.

Therapeutic views of altruism treat knowledge development in a different, interpretivist, way. Following the work of Schön (1983), rather acting on principles of 'technical rationality', effective professionals in occupations that work with people have common techniques for improvising according to informally learned guidelines. They react to a variety of situations using these guidelines in a spontaneous, intuitive way. However, the variety and complexity of the situations that they deal with often present 'surprises' which their guidelines do not help them to deal with. They then reflect on the situation and adjust their ways of working to deal with it. In turn, this alters their guidelines for intuitive action. Reflective practice has become an important way for social work to be flexible, but still use knowledge when it is available. This approach fits the idea of social work as a practice (Chapter Three) since it is centred on the interpersonal interaction between client and worker. Practitioners adjust their practice in response to the stimuli coming from the people they serve. This respects service users and makes a role for them in the developing of social work, rather than seeing it as constructed in theory

or research by the profession and in higher education. As with other professions (Eddy, 1984), social work is inherently about the use of discretion, since it is often used in social service systems to deal with complex problems that are not amenable to merely administrative actions, and reflection is a therapeutic model validating discretion as part of knowledgeable practice.

Disabling effects: The argument here is a personal and social one. At the personal level, individualists argue that professions actively take away responsibility and impose control on people so that they are forced to act in ways that are alien to their culture and preferences. This might have been so in the Pakistani family with childcare problems, for instance. At the social level, people come or are sent to social workers for help, but eventually become dependent on that help. Then, personal and social capacities to deal with problems are gradually reduced. These criticisms come from transformational views, concerned for the empowerment of oppressed groups, and from social order views, concerned for the way in which dependence on the welfare state is created.

Lack of accountability: If professionals are independent, who are they are accountable to? Clients may not have power or knowledge to make them accountable, and professional associations may be more interested in mutual protection rather than abuses of power or incompetence. It is impossible to turn to complaints systems, courts or tribunals for rulings on every occasion. Many discretionary decisions are made in private and are not observable. It is difficult to explain to outsiders the complexity of social work decisions and issues.

Professionalisation has ceased to be an important objective for social workers for two reasons. One is that the complexity of the issues renders the debate unending. The critique of professional power and discretion, the questions about knowledge and expertise, and distinguishing between professions and other occupational groups are now accepted as matters of social processes and relationships between occupational groups, rather than problems of definition that can finally be resolved. The second reason follows from this. Social work is for practical purposes a profession. It is an accepted paid middle-class occupation, in many countries is regulated as such by governments or other processes, requires an advanced education, is widely recognised as a distinguishable activity, and is regarded as having a moral value.

This does not mean that occupations are equal in status, or equally approved of, or on the other hand, that there are no professions. Rather,

it accepts that the influence, knowledge base and boundaries of occupations will change over time, and that this will be influenced by social changes in the environments in which it exists. There is no point at which we can agree that social work is a profession, and that its knowledge and value base is distinguishable from that of other professions. Instead, we might say that in some places it is in some ways a profession; in other places it is in other ways not a profession.

Social work among professions

Various approaches to understanding and working on the relationship between professions are:

- organisational strategy and structure
- partnership working
- multiprofessional practice and teamwork.

Organisational strategy and structure

Organisational strategy and structure approaches seek to design organisations so that cooperation is enhanced. Early in the development of UK social services departments, for example, a great deal of research and consultancy work (for example, Rowbottom et al, 1974; Billis et al, 1980) sought to identify organisational designs that would help to bring different services together and manage them effectively. Part of this work was also to find ways of managing practice so that it met the overall objectives of government and departmental policy. These studies reflect a belief that structure and organisation were the main factors in understanding, changing and developing social work organisations.

At the time of local government reorganisation in 1974, for example, there was a belief in the benefits of corporate management, in which local authorities would plan and manage their activities jointly, instead of as separate specialised departments. Coterminosity, to ensure that the borders of local and health authorities were the same, was sought to promote better coordination, but was not achieved everywhere, and was later lost in many areas. Joint and then partnership working developed from that time: this account is based on Payne (1995); Hudson (2000); Lewis (2002); Charlesworth (2003); and Glasby and Littlechild (2004).

Lewis (2002) usefully identifies three aspects of the boundary between health and social care: financial, administrative and professional. The NHS Act 1973 required health and local authorities to set up joint consultative committees. Joint care planning, a structural way of encouraging cooperation on health, housing, transport and education (DHSS, 1976, 1977; Wistow, 1982, 1990), mainly focused on joint finance, an arrangement to transfer funds from healthcare to social services. From 1973, because of difficulties between Catholic and Protestant communities in Northern Ireland, an integrated structure of health and social services boards has worked successfully, similar to arrangements in the Republic of Ireland.

Under the Conservative government in power during the 1980s and early 1990s a stronger involvement of the private sector developed, and arrangements for regulation and cooperation developed. The NHS and Community Care Act 1990 introduced a marketised approach to health and social care (see Chapter Five), which led to a separation between the providers and commissioners of services, although in some cases these remained in the same organisation. This then led to joint commissioning of services, in which health and social care organisations jointly agreed the pattern of services in their areas. The different ways of funding health and social services authorities and the cumbersome joint arrangements limited the effectiveness of this.

Partnership working

The New Labour government elected in 1997 produced a discussion document, *Partnership in Action* (DH, 1998), promoting more extensive joint working between health and social services. The reasoning behind the proposals is set out in Table 7.1. This demonstrates the thinking that health and social services agencies and carers were to be formally involved in partnership; users are not mentioned. The three levels of joint working refer to planning and commissioning and then to the importance of working together to provide services; these relate to Lewis' boundary areas, referred to above. The focus on broader policy objectives, and in particular combating social exclusion and inequality, is an important sign that these health and social care policies are connected to the government's more general policy thrusts. This moves beyond the attempt to promote cooperation mainly by structural and organisational means. The Health Act 1999 permitted health trusts and social services authorities to delegate functions to each other and pool funds. The Health and Social Care Act 2001 made it possible to set up joint trusts for specific groups of service users, but, in many areas, the partnership arrangements organised under the previous Act were the preferred way of working. The Children Act 2004 requires movement towards complex joint arrangements for cooperation in

Table 7.1: Partnership working: New Labour policy

The Government's strategic agenda is to work across boundaries to combat social exclusion, encourage welfare to work, tackle inequalities between men and women and other groups and improve health in local communities. Both the White Paper "The new NHS: modern, dependable", and the Green Paper "Our healthier nation – a contract for health" emphasised the need for effective working between the NHS and local authorities (both in their social services functions and more widely), underpinned by the new duty of partnership, and set in the strategic context of a local Health Improvement Programme. The Social Services White Paper, due later this year, will emphasise the importance of the social services in this partnership. The National Carers' Strategy will look at the role of carers in this wider context. (DH, 1998: para 1.2)

Joint working is needed at three levels:

- Strategic planning: agencies need to plan jointly for the medium term, and share information about how they intend to use their resources towards the achievement of common goals;
- Service commissioning: when securing services for their local populations, agencies need to have a common understanding of the needs they are jointly meeting, and the kind of provision likely to be most effective;
- Service provision: regardless of how services are purchased or funded, the key objective is that the user receives a coherent integrated package of care and that they, and their families, do not face the anxiety of having to navigate a labyrinthine bureaucracy. (DH, 1998: para 1.6)

the interests of children, and at the time of writing arrangements are not fully formed.

Multiprofessional work

So far, then, we have seen that thinking about organisation and strategy as a way of achieving cooperation across health and social care boundaries has been developed towards promoting partnership, as a form of greater integration of organisation. The logical development of this was to promote the integration of practice. In this case, since the major division was seen to be between professions, the professional groups promoted a long-standing ideal of multiprofessional and interdisciplinary work as the answer. However, we can see from Table 7.1 that multiprofessional work is not a major priority for government action. Multiprofessional working has often been the local managerial or professional response to structural cooperation, rather than a government prescription. In other services, such as the local Connexions organisations to coordinate a response to young people

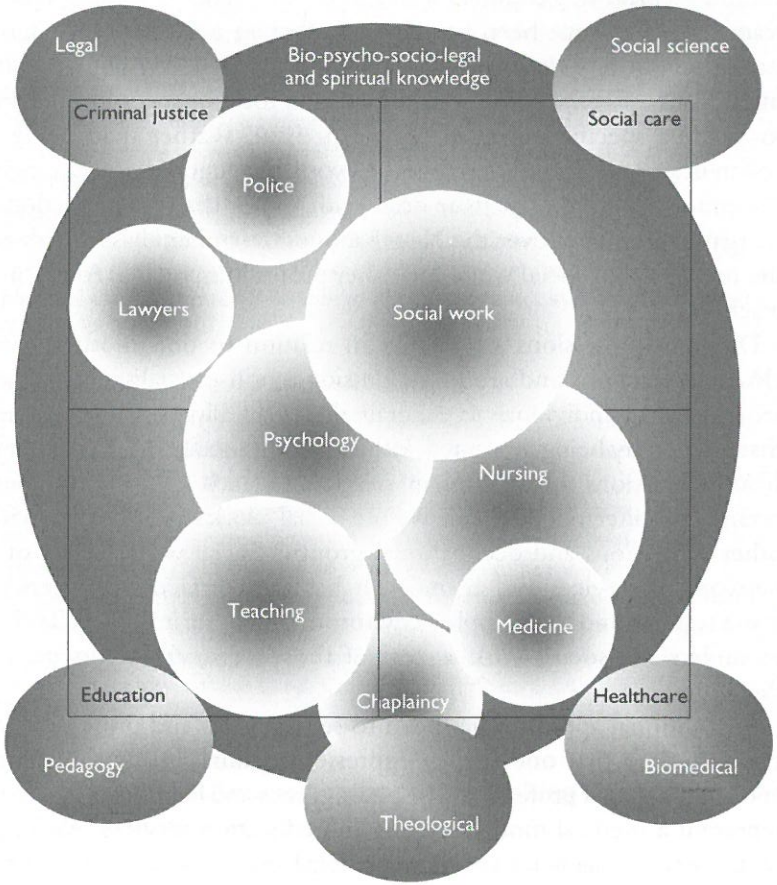
in the move from school to work, in community mental health and community learning disability teams, in youth offender and drug action teams, services have been brought together in a similar way. These structures put representatives of different local authority departments often from different professions together in local or specialised teams to tackle a specific group of people or issue. Rather than being a coherent strategy for multiprofessional work, although this is welcomed, the aim is a focus on the issue dealt with, rather than on professional reorganisation. Moreover, the New Labour government has formalised the regulation of social work and other professions, such as AHPs and teachers.

Different professions are in flux in relation to one another, have closer interactions and are based outside a non-specialist unit. They are expected as individuals to maintain their professional practice, rather than its identity being generated within a professionally led department. If all professions are in flux in relation to each other, with their boundaries altering, how can we see social work's relationship with other professions and occupational groups? Social work is part of a network of services and agencies. It has an interface with users of those services and the complex environment that surrounds us. Trying to understand social work as part of those networks seems useful, therefore.

A traditional approach has been to see agencies and professions as connected, so that one agency expresses organisationally the values and approach of a profession. Hospitals, clinics and healthcare agencies represent a medical model, schools and education services teaching, social services agencies social work, legal practices and law centres lawyers. This approach led social workers in Britain to value the foundation of local authority social services departments in 1971 as the culmination of the development of the standing of social work as a profession.

Figure 7.1 represents in the four squares four related services: criminal justice, education, healthcare and social care. Kamerman (2002), reviewing North American fields of practice, refers also to housing, employment and income transfers or social security, but the four areas in Figure 7.1 represent both at present and historically, sites where social work is strongly represented in the UK. The white-edged circles represent various professional groups. Psychological and social work straddle most of these services areas, while lawyers, the police, medicine and teaching are more involved with one specific service area. Nurses are mainly in healthcare but do extend into social care and education to some degree. All these are examples; many professional groups that

Figure 7.1: Networks of professions, knowledge and services



could be mentioned are excluded. All these services share a broad knowledge base, represented by the dark area lying behind most of the services and professions. Finally, specific areas of knowledge and skills inform particular services, social work being mainly based on the social sciences. Some professions, for example psychology, have a strong knowledge base and dominate the production and management of knowledge in that area, but do not have one service base; they operate as part of a wide range of agencies. Social work has both: identifiable social agencies in which social work is a strong element, a clear focus on broad social science knowledge and participation in a range of agencies where the primary profession and knowledge base is not social work.

So we can see these three aspects of connections between professions as sets of networks: a professional network, a service network and a knowledge network. We saw in Chapter One that social work's identity was formed in the professional network by people's paths into and away from the centre of social work. That centre can be regarded as where the knowledge network and the service network most strongly represent the profession. So a social worker is clearly identified with the social work profession if they work in a social care agency, using social work knowledge and skills, and is a member of a social work team and social work organisations. However, a social worker in a healthcare organisation, the lone social worker in a multiprofessional team, who is dual-qualified and also does a lot of family therapy, mainly working with psychologists and nurses, is much less clearly identified with social work.

Particular theories and knowledges are strengthened by some multiprofessional connections. For example, cognitive-behavioural work is little practised in social work, and not strong in social work education, but where there is a strong psychological representation in the team, it can be much stronger. I see the three networks as rather like plates in a pile, as each network, knowledge and skill, profession and service shifts, the strength of particular individuals' identity also shifts.

However, any such service is more complex than that. Hospitals, for example, contain a variety of professions as well as medicine, some of which are very powerful, but perhaps for different reasons. For example, nursing dominates many of the concerns of hospital managers because it is the largest workforce. Also, many large services contain different grades of practitioner. Schools have teaching assistants, laboratory technicians, playground supervisors and school meals staff. Some of these staff groups have a very high professional status, but are a minority group, such as liaison psychiatrists in a hospice – while liaison psychiatry is an infant specialism, other services find psychiatric expertise helps to deal with severe problems that are hard for other professionals to tackle. Others are present in large numbers, but have little status and influence, such as personal carers or home helps – there are many people in this role, but they lose influence because of low status, poor training, and the fact that their jobs are scattered and often part time. Some people appear to be marginal but have practical influence because of the centrality of their responsibilities, such as caretakers in schools – their influence comes from the reality that not a lot can be done in a school building without their help.

As we saw in Chapter Five, organisational approaches to

understanding relationships between professions and occupational groups focus on lines of responsibility. Legal responsibilities and power over resources are traced from the management body at the top, through lines of responsibility for work and accountability for resources. This approach looks at the interaction of networks of different professional groups, knowledge bases and services. Relationships between these groups are constantly changing. For example, nurse prescribers are developing to take up some of the less complex prescribing duties that were formally reserved for doctors.

Why is it, then, that if social work has a clear organisational, knowledge and professional base, it seems so insecure compared with other professions? Part of the reason is the importance of social issues for many other services; they cannot be so clearly set off from medicine, teaching and criminal justice, and social concerns seem of less importance than the main focus of each of these services. Healy (2000: 129) argues that the technical knowledge base is susceptible to contest by other professionals and users because it is perceived to be non-technical. Her answer to this is to develop knowledge together with others in relationships, so that they are part of the creation of understanding and accept the value of the process of social work rather than the content.

For example, a social worker was asked by a healthcare team to arrange a discharge; however, the patient's wife did not feel that she could manage her husband's illness at home, bearing in mind her own disabilities, which were unknown to the medical and nursing teams. The primary nurse argued that the husband actively wanted to return home, but his wife and stepdaughter thought that this was unrealistic. This seemed to have all the makings of a family conflict. The social worker first spent time with the wife exploring her ambivalence: the wife wanted to respond to her husband's wishes but also realised the limitations of their home and her capacity. She was helped by listing all the factors that made things difficult, and balancing these with the possibilities that might be offered by local services, which she was unaware of. She also feared the cost of a nursing home, and the worker explained how NHS continuing care funding could be made available, if a nursing assessment found that it was needed.

Then, the worker approached the husband and asked him to assess how he would want to be cared for at home, and list his own care needs. She then asked him to look at each item on his list and consider how his wife could provide for these, adding in her own knowledge of local services. It became clear that several needs could not possibly be met, and in the end he openly said he did not see how his wife could cope, but expressed his fears about going to a nursing home. The worker explained the process. After this preparation, she called a family meeting, including the primary nurse and a junior doctor. This examined the whole situation, drawing on the previous assessments done by the husband and wife. A nursing home was agreed on, and the assessment process set in motion. But, there were provisos. The family agreed that they would investigate and report on the nursing homes to the husband. The worker explained how each home would visit the hospital to do an assessment before the admission, so that the husband could get to know at least one person who worked there. The healthcare team also agreed to make a bed available, or find other care, if the placement did not work out, although privately they hoped that this would not be necessary, as they felt it would be a struggle. With all this preparation, many of the anxieties attached to discharge were removed.

Therefore, all professionals *are* their area of practice in any multiprofessional setting; they do not just bring a professional label that defines a sector of responsibilities, they do not just bring their well-honed knowledge, expertise and skill but their practice represents alternatives and balances to each other. They represent their profession by what they do.

Deprofessionalisation

We noted in Chapter Five a concern that the development of managerialist ways of controlling social work practice was reducing the professional standing of social work. There are a number of points to make about this argument. First, Chapters Five and Six show that this has been a long-standing argument about the fact that social workers' discretion relies on organisational or legal authority; it is not newly created by managerial changes of the 1980s and 1990s. Second, we have seen in this chapter that the 'project' by which social workers sought to gain professional status has been displaced by more complex understandings of the nature of professions and, referring to Chapter Six, the power and authority of professionals. Third, as the next chapter shows, a variety of social professions within any one welfare regime is possible; a single social work is not a necessary requirement, as at one time social work professions in the US and the UK seeking unification may have thought. As our understanding of the processes by which power, professions and organisations work has become more sophisticated, arguing that professionalisation of social work should take place, or that it has declined, seems inappropriate.

Charles and Butler (2004) summarise the following points of the deprofessionalisation thesis:

- power of organisational efficiency over professional values;
- contested and fluctuating knowledge bases and competing professional approaches;
- stress arising from conflict between workloads and professional expectations;
- organisational demands for mechanistic and depersonalised services, alien to professional practice;
- lack of devolved discretion;
- quest for certainty and risk elimination;
- drive for technical rationality;
- patriarchal, heterosexist, disablist and racist control encouraged by market competition approaches to service provision;
- relentlessness of organisational and professional conflict.

This concern is partly connected to the development of an organisationally mandated, routinised 'social care' or organising community care packages of services, rather than being involved in providing social work help. The shift of childcare and family social work to education departments removed the focus of social services departments on seeing the family as a whole, introduced by the Seebohm reorganisation in 1971. The development of many private sector providers rather than an integrated social work provision, which includes services, means that social work practice is much more fragmented. Development of healthcare social work specialisms is another aspect of fragmentation. Because of this, social work does not seem organisationally strong, in the UK, even though it is legislated for, regulated and is clearly identifiable as a separate occupational group.

Conclusion: social work, a profession among professions

In summary, then, we can see that social work is a profession, in the following senses:

- It is a widely recognised job, which people distinguish from related jobs.
- Its useful social functions include (among many others) social assessment, interventions to help people solve problems and achieve greater personal fulfilment, protection of people from risk, organising services offering useful personal help, exercising discretion based on investigation and understanding of complex social situations.
- It is recognised to require training at a higher education level and a degree of expertise.
- It is part of a general movement in society to create occupational groupings with their own hierarchies. These have a degree of autonomy in defining tasks and standards, but are part of large-scale organisations, dominated by the state.
- It has a recognised position in many societies as part of public provision in competition with other related agencies and professions. In competing for resources as an occupational group and as the dominant profession in a set of definable social agencies, it also has an accepted social role.
- It receives a degree of moral approval and recognition of altruism among its practitioners. They are not generally regarded as doing it for their own benefit, even if they derive benefits from doing it as all people who work do. Its value system (see Chapter Five) shows acceptance of moral responsibilities.
- It meets social expectations and carries out recognised social functions.
- It avoids oppression, exploitation and other forms of social damage in its work.
- It is generally regarded as competent and effective.

Against this, social work does not feel strong. If we are to understand the social nature of social work, we cannot neglect the preceding discussion of its characteristics as it professionalised, and views about that process. We can 'know' that social work is a profession, in the ways outlined above. Also, we must reflect and criticise that knowledge constantly, balancing it with our perceptions of actuality. In our practice, we must recognise the problems, contradictions and criticisms that the social process of professionalisation brings for interpersonal and personal work.

In a recent case, one of my social work colleagues worked with a large chaotic family with severe debt and housing problems. The mother was dying and being cared for by her teenage son, a daughter was failing to attend school, another daughter was supported in a housing scheme for people with learning disabilities and the mother's own mother was frail and elderly. A wide range of practical and interpersonal problems, dealing with housing, social security, school and the social services learning disabilities team were involved. The complexity of the reports back to the multiprofessional team, the range of contacts

and agencies involved and the emotional intensity of some of the interpersonal work impressed the medical and nursing team. They commented that they would not have known how to contact all these agencies, and would not have had the patience to sort out all these complex problems. Yet, they felt comfortable contacting healthcare agencies, and took endless time with caring tasks.

What Clausen et al (2005) call this 'jack-of-all-trades' role is clearly necessary, but hard to explain and justify, and the distinction between it and other professional tasks is hard to draw precisely. Yet, when Clausen at al (2005) explored the lives of people in difficulty because they were dying of cancer, they found that this kind of flexible practice would often have been useful, and when other professionals see it, they value it.

In multiprofessional medical settings, social workers embody the non-embodied elements of situations; in multiprofessional education settings, they represent the non-intellectual and social elements of educational development. In all settings, they respond to the borderline, non-standard elements of people's lives that cross organisational and professional boundaries and impinge on the main focus of the agency's work and the other professionals' interests.

EIGHT

Social works: global and local

I sat in a hotel conference room in a bombed-out city on the Croatian coast. Around me were representatives of all the new countries that were part of the former Yugoslavia. We were there to begin to recreate social work education in those countries; social work had not been strong before, but in several of the most Westernised countries it had become active, and our meeting included professors willing to help from Italy, Sweden and the UK. Some people had been driven through the mountains, because their borders with Croatia were still closed. Some of the countries that these people represented still had armies fighting each other. Some people found it hard to speak in the presence of representatives of countries and ethnic groups who had devastated their cities and families. Yet, in the week that we spent there, they ate and talked together, eventually drank and sang together and agreed a programme of development of social work. I returned 18 months later to visit another proud new country in the Balkans as part of the project. This time, it was me that was driven across the border from a neighbouring country, past bullet-pocked houses, past the UN tanks, to stay in a hotel still mostly devastated, covered in plastic sheeting, to give a lecture at the end of the first year of the joint social work course, and to launch a textbook. It was a symbol of improving cooperation between the former enemies. Most of the same people had travelled with some difficulty to get there. Two different parts of the former Yugoslavia were still at war. Yet we all talked social work, I lectured on social work practice and got a laugh for a joke about Harry Potter.

At that time, I also visited Beijing, to join a conference of social work educators at the Ministry of Civil Affairs College. Administrators and educators talked social work, where universities and colleges that I had visited two years before had barely had it accepted that this was a subject that they could develop. There was immense enthusiasm for the possibilities of this new profession. But the debate was about whether the country should follow Western models of social work, or create its own model. I visited Russia to discuss their developing social work, and was particularly asked about social pedagogy; I mentioned