Chapter 10

The social work task in the community

The main aims of this study were to see how elderly people and their carers participated in the decisions made about services; whether they were given a choice over services, and how satisfied they were with the procedures and the outcome. While we have considered the views of the elderly person and their carer, the views of the workers involved throw a different light on the subject. They are personnel working for large bureaucratic organisations which have finite resources; they are also workers with specific roles, such as home care or domiciliary care organiser, or with specific skills, developed through experience and professional training, as is the case with social workers or social work assistants.

We have already seen that in terms of service delivery and social work support for older people, the three authorities in this study had very different structures, and even within authorities there was variation (see Appendix). In broad terms, the London borough operated specialised social work teams, while in the southern authority – of the three areas chosen for study – one area operated through a large generic team; one made a division between work with children, families and people with learning difficulties, and elderly people, people with physical disabilities and mental health issues, and the third operated specialist services for elderly people run from residential care homes used as resource centres for both domiciliary and residential services. In the northern authority, social work teams were all generic and the majority of work with elderly people was undertaken by domiciliary care organisers. Although operating a specialist system, the London borough had fewer qualified social work staff working with the elderly and had developed home care to a greater extent than the southern county.

Because of this variation interviews were carried out with a range of workers: first, with those who had been directly responsible for the elderly people interviewed within the sample. These included 15 social workers in the London borough, all of whom were specialist workers with the elderly, 20 social workers in the southern county (of whom 13 were specialist and 7 were generic) and 5 social workers and 11 domiciliary care organisers from the northern authority. In addition, we interviewed 11 team managers from across the three authorities. The number of interviews with social workers in the northern authority was
restricted because of the few social workers with elderly people on their caseload in that area. We interviewed these social workers partly to examine why they did not see elderly people, and partly to compare their views with those of the social workers in the other areas.

Characteristics of professionals
In spite of the small numbers of professionals interviewed in this study and the fact that they cannot be said to be representative of all the social workers, domiciliary care organisers and team managers in their areas, it is worth looking at some of their basic characteristics, as factors such as age, sex and experience may all have a bearing on their attitudes to their job and their practice when working with older people. Here the term ‘social worker’ is used to cover a number of posts including senior social worker or consultant practitioner, social social worker and social work assistant or welfare officer. As Table A.21 shows (see Appendix), we interviewed a large number of welfare officers in the London borough and a larger number of social workers in the southern area, while in the northern area, we interviewed more domiciliary care organisers than social workers.

As Table A.20 shows (see Appendix), the majority of the social workers in the London borough and the southern county were female, as were nine of the 11 domiciliary care organisers. Only in the north were the majority of the social workers we interviewed male, reflecting perhaps their preference for generic social work and, not surprisingly, given the managerial responsibility, five of the 11 team managers were also male.

Social workers in the London borough and the southern county were of a similar average age in their late forties. The domiciliary care organisers were also predominantly middle-aged women. Social worker in the north were the youngest respondents on average, while team managers were also slightly younger than most front-line workers.

In terms of training and the degree to which respondents held social work qualifications, we can differentiate between two groups – (i) team managers, senior social workers, consultant practitioners and social workers, and (ii) social work assistants, welfare officers and domiciliary care organiser. In all three areas, the respondents in the first group were more highly qualified with the majority having obtained a CQSW or its equivalent.

In this respect, the southern county had the greatest number of qualified respondents, with nine (senior) social workers with CQSWs, one with a diploma in social work, two with CSS qualifications and one with a letter of recognition from the Home Office for childcare. In addition, two social workers without any social work qualifications had a degree and one had a teaching qualification for working with blind people.

Three of the five generic social workers in the northern authority had a CQSW, one had a degree and was just embarking on a CQSW course, and one was a registered mental nurse. In contrast, only two of the nine welfare officers
from the London borough had any social work qualifications, although two were
SENs, and only two of the 11 domiciliary care organisers in the northern authority
had had any formal training at all.

Table A.21 shows that the respondents from the London borough were more
likely to work part-time than those interviewed in the other areas. However, this
was true of both welfare officers and social workers.

An examination of caseloads and responsibilities shows that, in this study,
differences between areas were stronger than differences within areas. Thus,
welfare officers in the London borough carried out similar duties to their social
work counterparts, and this was similarly true of social work assistants and social
workers in the southern county. Levels of responsibility may have differed, but
social work assistants and welfare officers in the London and southern areas had
more in common with social workers than with the domiciliary care organisers
in the northern authority, even though, like the domiciliary care organisers, they
lack social work training. Organisational structures in these three authorities
tended to outweigh other considerations, and in the discussion that follows all
those involved in social work casework are described as social workers.

**Caseloads**
The organisation of social work in each authority was affected the size of
caseloads carried by different workers. In the London borough caseloads for
part-time social workers (predominantly untrained) ranged from 15 to 26 people,
and for full-time workers from 15 to 30.

In the southern authority, within the two areas operating either generic or
partially specialist teams, full-time workers could have caseloads ranging from
50 to 87 people, with the percentage of elderly people ranging from 30 per cent
to 100 per cent. Part-time workers had an average of 38 people with the
percentage of elderly people ranging from 3 to 90 per cent. Workers with blind
or partially sighted people had much higher caseloads, 200-250 people, of whom
90 per cent could be elderly. In the one area operating specialist teams in this
authority, full-time social workers had an average active caseload (that is those
seen by a social worker) of 54 and part-time workers 25. Social workers in this
area also managed those cases in receipt of home helps and therefore a total
caseload for a full-time worker could be in the region of 200 to 300 cases.

Finally, in the northern authority, where the domiciliary care organisers were
responsible for much of the domiciliary work with old people, the caseloads of a
full-time domiciliary care organiser ranged from 200 to 350 people. In contrast,
the case-loads of the five generic social workers interviewed varied from those
who, at the time of the study, had no elderly clients, to one who had four elderly
people out of a case-load of 33 people and another who had eight out of 32 people.

**Social work with elderly people**
Before considering the findings from this study it is worth reviewing some of the
trends to have emerged from research into social work practice with elderly
people which will provide a framework for our discussion. In 1982, Goldberg and Connelly carried out a comprehensive review of social care for elderly people. In their section on social work practice, they outline a range of activities where social workers can be involved with elderly people: ‘...in assessment, in mobilising resources which range from domiciliary services to admission to residential facilities, in advocacy on their client’s behalf, in counselling and casework with both the elderly and their carers, in coordinating services and in community work’ (Goldberg & Connelly, 1982, p85). These themes were reiterated by other writers on social work practice with older people (Rowlings, 1981; Marshall, 1983).

However, at the time they found that much of the work undertaken was service-led rather than person-centred, and social workers appeared uncertain about their aims and their roles (1982, p85). In part, this uncertainty stemmed from the development during the 1970s of a task-centred approach to work with older people where the importance of giving practical assistance and meeting immediate needs was to the fore, services which in many cases could be provided by those other than social workers. Again Goldberg and Connelly state: ‘...consumer studies indicate that practical services, establishing links with other agencies, and advocacy are experienced as very helpful by different kinds of clients and in particular the elderly. Hence it is probably the social worker’s gatekeeper function, skilled short-term intervention, and above all her role as mobiliser and co-ordinator of support services, that are of crucial importance and need evaluating’ (1982, p89).

Those advocating the decentralisation of social services with the creation of a patch-based system saw greater recognition being given to the skills and knowledge of unpaid carers and paid workers, such as home helps (Hadley and McGrath, 1980). In these circumstances the social worker acted more as a resource person for other groups of workers, or as a community worker engaged in community development, organising volunteers or working with voluntary organisations. Therefore the social work role was beginning to change and diversify. In 1986, Bowl’s discussion of ‘progressive’ social work with old people emphasised the client’s right to self-determination; challenged the growing power of professionals and highlighted the role of social workers in raising levels of consciousness concerning the structured dependency of old age and the impact of ageism (Bowl, 1986).

By the late 1980s, as the number of very frail old people living in the community had increased, the concerns and needs of informal carers were being highlighted, the range of service providers had diversified and the focus on short-term intervention had given way to a recognition that there was a need for a model of long-term care which involved a greater degree of care planning, care-coordination, monitoring and review. The best known model of long-term case management with elderly people to emerge during this time has been the Kent Community Care project which has been replicated in Gateshead and Gwynedd (see Challis, 1990; Challis and Davies, 1986). In these initiatives social workers have been given a budget to use in order to maintain clients within the
community and to improve their quality of life. Acting as case managers, they have been encouraged to work imaginingively and introduce new procedures, for example paying informal carers. As a rule, expenditure on a case was not to exceed two-thirds of the cost of a residential place. This model of case management that formed the basis of the proposals outlined in the White Paper, *Caring for People* (Department of Health, 1989, p21).

Other projects have also looked at ways of developing the case manager role, and in particular certain aspects of the role such as assessment. In Gloucester health authority, community care coordinators have been appointed within primary health care teams. In this innovative project, researchers worked with the care coordinators to develop a biographical approach to assessment which has proved beneficial in developing links between informal and formal care based on a detailed understanding of the individual’s needs and circumstances (Dant et al, 1990). This study emphasises the skills needed to carry out a holistic assessment.

**Specialist or generic social work**

These examples of developments in practice have been paralleled by a debate over the need for specialist or generic social workers. In the main, social work is dominated by work with children and families, and while there is a view that work with elderly people should be seen as a part of work with families, and should not be separate, little has been done to raise the profile of such work within generic teams. Indeed research has shown that within conventional social work practice almost all the priority groups affected by community care policies are afforded low priority (see Black et al, 1983; Wenger, 1984). The exception has been where social workers have worked in specialist teams, and the creation of specialist teams working with elderly people is often seen as a form of positive discrimination which creates a pool of knowledge, attracts resources and encourages new ways of working. The development of a long-term care model of working with elderly people may lead to greater specialisation with the need to organise work around particular groups of clients (see Challis, 1990, p18).

In the present study where specialist teams operated only in the London borough and in one area within the southern authority, there was an overwhelming feeling by a majority of respondents that there should be specialist social workers for elderly people: 36 out of 40 social workers; eight out of 11 team managers and nine of the 11 domiciliary care organisers felt this way.

Social workers and domiciliary care organisers commented on the low priority given to elderly people within generic teams. One social worker from the southern authority spoke of her concern about social work with elderly people: ‘I think the elderly have been a very neglected group. I have only ever done work with elderly people and I know that it’s difficult for social workers to carry a general caseload and find time to listen to elderly people. They are slow in speech and thought, and it takes time to get to the real problem, and they need so much that putting together the package of care takes time; getting into
residential care takes time. I think that younger people are more accepting of social workers. Our older generation are very self-reliant and so often find it difficult to accept help. If we are specialists for them then they are more trusting, they get to know you and it helps.

Another social worker from the north, where a generic system operated and where social workers did very little work with elderly people, regretted the low priority elderly people had in his area: ‘There should be specialists in every sphere. One person can’t be adequately au fait with the knowledge necessary for providing help in every area. To say they can go from dealing with an abused child to an 84-year-old is not possible. Child care seems to gobble up all the resources – people, time, finances – unless you have specialists, who can say, “We are concentrating on an area of work.” Everything has to be prioritised and the elderly aren’t very high on that list. Here they’ve been pushed off – not just elderly people but people with a physical handicap as well.’

This view was supported by a team manager from the south who was now involved with a specialist team and saw it as a way of creating resources: ‘Before, I don’t think that enough concentration was given to the needs of elderly people – it was a bit hit and miss. If they were on the caseload of a social worker with child care responsibilities, as soon as there was a crisis on a child care case you had to run – there was no way of avoiding it. We’re protecting the elderly people by giving them the workers interested in their needs. You acquire knowledge and create resources.’

Specialisation is obviously more practical in that workers can become knowledgeable about certain services. There was also a view that particular skills were needed for work with older people, as this social worker from the London borough pointed out: ‘I think that the idea is that elderly people don’t need qualified workers and it’s not true. Elderly people have sexual problems and problems with money just like everyone else. They need counselling when bereaved, many are lonely and have no family to support them. And there are other problems – hearing and mobility problems.’

One social worker saw herself as an advocate for older people – ‘We are the voice of the voiceless’. And a team manager from London also saw specialisation as raising the profile of a neglected group: ‘As you get older you have multiple problems and I think elderly people need champions. In a generic caseload you get pushed to the bottom of the pile. In a specialist team you become a spokesperson for them within social services’.

Only six of the social workers, domiciliary care organisers and team managers thought there was no need for specialist social workers for elderly people. Comments centred around a view that ageing was just another part of life and that workers did not need any special skills to work with elderly people. In fact, some saw it as an advantage that skills developed with other age groups could be used with elderly people, and that the problems of elderly people should be seen within the wider context of the family.
A team manager from the northern area said: ‘I think it should be generic. The dangers with specialisation are that you only come to look at the elderly person in a family, and a social worker should look at the whole family.’

Two social workers from the London borough – already part of specialist teams – felt that specialist social workers became isolated and removed from mainstream practice. One commented: ‘It becomes a bit of the ghetto of social work. I don’t like that. You don’t need any other skills. I think it would be an advantage if some of the skills used with other age groups could be used.’

A team manager from the north saw value in a mix of generic and specialist workers at a local level: ‘I still think we should aim for a patch-based generic service, although maybe there should be someone with special skills and interests within them.

But do specialist workers with older people necessarily have to be social workers? We have already noted the trend during the 1980s towards giving other care workers with elderly people greater recognition. Given that the DCOs in the northern area were key workers in the delivery of services to elderly people, we were interested to know whether they thought there was a need for social workers for elderly people, a question that was also asked of team managers.

It is interesting that although nine out of 11 domiciliary care organisers had said there should be specialist social workers for elderly people, six said that social workers were not needed as the domiciliary care organisers were doing the social workers’ job. They took the view that although specialisation was a positive thing, the work did not necessarily have to be carried out by social workers. One domiciliary care organiser said: ‘I think the DCO is quite adequate really, unless there are cases of granny-bashing. Specialists are needed because, when you have generic social work some are great with elderly people, but with others the interest is not there. Many clients don’t want a young slip of a lad. They need understanding.’

However, a number of domiciliary care organisers commented that their real concern was with home care and that they did not have time to deal with areas such as admission to residential care, mainly because their managerial function with home care staff left them with little time to spend visiting clients: ‘It’s a role we very much enjoy, but there’s more and more being added to our job. The management of the home help service is changing and we are taking more of a role in training home helps, so we can’t do everything.’

A thoughtful domiciliary care organiser commented on the limitations of the domiciliary care organiser’s role: ‘Elderly people have a whole set of problems. They need a lot of counselling – marriages and relationships change. They need to cope with bereavement, loneliness and ill-health. Their position within the family changes – they may have been respected before and now they may feel that they have been dumped. We can offer something but there is a lot more to offer. We try to but we can’t. We are resource managers. We may try and spend an extra half an hour with a person but then we find we can’t go back.’

In the main those domiciliary care organisers in favour of a specialist social work input were aware of the many complex problems which people could face
in later life but found their own work was often so demanding that they knew they did not have time for other aspects of working with old people.

The different roles of social workers and home care or domiciliary care organisers were also considered by team managers and a distinction made between the need for specialisation and the need for training. A team manager in the northern area thought training and status were important: ‘There should be specialists, but the DCOs are that. But DCOs are very bad at becoming qualified people. I think DCOs are a very important part of a team and can play a very important role but because they are not qualified they don’t seem as qualified as social workers. Then the DCOs resent not being given the same status. If there were specialist social workers for the elderly then elderly people would get intensive support. DCOs seem to be intuitive about elderly people, but intuition is not enough on its own. Social workers can bring the professionalism and the training.

A team leader in the southern area, where the majority of social workers were qualified, was concerned that elderly people’s practical and emotional needs should be met: ‘I think some non-social workers can bring the practicalities together but the elderly person will miss out. I’d worry that there were some aspects of the case being missed. We were trying to move away from social work assistants. Why do elderly people deserve any less than the skills given to children and handicapped young people?’

The need for specialist social workers who were trained to meet the needs of elderly people was supported therefore by the majority of respondents in this study, although it is fair to say that some of the untrained welfare officers from the London borough felt that experience was equally important to training. However, there was a strong feeling that elderly people needed more than just practical assistance and that this was best provided by social workers. Also, given the needs of very frail elderly people living in the community for long term care and the development of case management, there is an even greater need for key workers to develop skills in assessment, planning, coordination of services and on-going monitoring. While some of the domiciliary care organisers in this study felt that this was their job, others acknowledged that they were really only dealing with a specific part of the work. The implementation of the changes proposed in the White Paper Caring for People appears to favour greater specialisation of social work for specific groups in society.

It is against this background that we consider the services offered to elderly people in the three authorities as seen by social workers, team managers and DCOs. First, we consider the resources in terms of actual services available to help people within their own homes, and then go on to discuss in detail how elderly people ‘get into the system’, how they are assessed and how their needs are met.

The provision and use of services
Our understanding of how social workers and domiciliary care organisers work with elderly people and their carers needs to be set within the context of what
resources they have to offer. During the last decade there has been a move towards a mixed economy of welfare services provided by a combination of statutory, voluntary and private sector agencies. To date the private sector has seen its main interest in the provision of residential care homes and nursing homes. Here we are concerned with services which help to support people in the community and so it is perhaps not surprising that the domiciliary services commonly available in the three authorities were provided predominantly by the public sector and, to a much lesser extent, the voluntary sector.

**Public sector services**

A knowledge of the range of domiciliary services available and their current take-up is crucial if the worker is to give the client and their family sound information and advice. We began by asking social workers and domiciliary care organisers about the availability of 16 services commonly supplied by the local authority and the health authority. We followed this up by asking about the proportion of the elderly people on their caseload who were currently using these services.

The basic services – social work support, home help/home care and intensive home help/home care, meals on wheels, occupational therapy support, day care and district nurses were common to all three authorities, although some services were better resourced than others. The occupational therapy service especially was said to be stretched in parts of all three authorities, with staff vacancies. Occupational therapists were said to be difficult to recruit due to the national shortage. There was less consensus about the availability of other services such as family placement schemes, paid good neighbours, getting up and going to bed services, bath nurses, and physiotherapy and chiropody at home.

In the southern area a budget had been allocated for a paid good neighbour scheme but most respondents had either never used it or had found people unreceptive, as this social worker commented: ‘We had a budget allocated but I never found it worked. Neighbours either wanted to be neighbours or didn’t, and so it never worked.’

Community chiropody was a luxury in all the authorities and many respondents said they suggested private chiropody. Most chiropodists operating under the NHS did so from a hospital or clinic and there was usually a waiting list. The other problem with attending a clinic was transport as this social worker from the London borough pointed out: ‘I find that the chiropodists really want them to go to the clinic. But the problem is how are we supposed to get them there?’

Visits by district nurses were usually for specific tasks such as giving injections and changing dressings. Some areas had special bath nurses but they appeared in short supply and comments were made that either the district nurses gave baths or the old person would be encouraged to go to a day centre for a bath. In one part of the London borough the district nurses thought that home carers would be carrying out bathing as part of their enhanced role. A social worker
explained: ‘The district nurses said they wouldn’t undertake bathing because the home carers could take over. But they didn’t. No-one gets someone out of the bath on their own because you need two people. So the home carers give the elderly person a strip wash instead.’

None of the domiciliary care organisers interviewed knew what proportion of the elderly people on their admittedly large caseloads were visited by the district nurse, but social workers with much smaller caseloads were also often uncertain. Only one of the five social workers from the north said that between 10 and 29 per cent of their caseload of elderly people were seen by a district nurse. In the southern authority only eight of the 20 social workers responded that between a tenth and an half of their caseloads were in receipt of such services, while in the London borough 12 out of the 15 social workers mentioned between a tenth to over a third of their cases. This lack of precise information was seen in the following comments. One social worker said: ‘Sometimes I don’t know who’s having the district nurse’, and another from the London borough felt that the district nurses should keep them more informed: ‘I’m not certain about who has it currently because the district nurses are very naughty about letting us know those things’.

Again information regarding the involvement of other health workers – health visitors or geriatric visitors – was also patchy. In the northern authority the majority of domiciliary care organisers and social workers did not know what proportion of their clients received these services. In the London borough eight of the 15 social workers interviewed said that none of their clients received such a service and yet 11 of the 15 had said that the service was available in their area. And in the south where 18 of the 20 social workers said that the service was available only half could give some indication of the proportion of clients in receipt of such services – seven just did not know.

Such figures are reflected in the following comment from a social worker from the southern authority who felt that she knew little about the role of health visitors: ‘It’s difficult to know if they visit any of our clients as they are based in the GPs’ practices.’ And another viewed health visitors in this way: ‘They are a rarity and not much use unless you are under five.’ This lack of knowledge and lack of communication was striking and is a great disadvantage if the aim is for social services staff to coordinate a package of care services for an elderly person.

To a certain degree these findings reflect a hierarchy of knowledge, with workers being most confident about the traditional services provided by their own authority, but less confident about new or less well-used services such as family placement schemes, with a number of workers being really uncertain about the services provided by the health authority. These trends were reflected in the estimates given by social workers and domiciliary care organisers of the proportion of elderly people on their caseloads receiving health services. But this was also true of other services. In many cases respondents were unable to give a precise figure and offered rough percentages or just did not know, as the following analysis shows.
It is not surprising that more than 80 per cent of the social workers interviewed in the London borough and the southern authority said that their clients had social work support. Indeed it is more surprising that they did not say 100 per cent, as the elderly people had been sampled from social work lists. In the northern authority, where social workers spent little time working with elderly people, 80 per cent of the domiciliary care organisers did not know if people on their caseload received any social work support. This lack of communication between social workers and domiciliary care organisers in the north reflects the very separate and distinct nature of their jobs, but is perhaps a telling commentary on liaison within the neighbourhood offices.

While the home help service was a popular service in all areas with 50 per cent or more of the clients receiving the basic service, the number receiving an intensive home care service offering more than just a cleaning service was much smaller. In the London borough and the south a majority of social workers said that less than 30 per cent of their caseload had an intensive home care service and for half of these workers this was less than 20 per cent. If we take the caseload of a full-time worker in the London borough as 22 or for a specialist team in the southern authority as 54, then were are talking about six or fourteen (ie. 25 per cent) people respectively. The domiciliary care organisers in the north reported that less than 20 per cent of their caseloads received intensive home care services, that is 40 out of 200 cases. Of course, much depends on the definition of ‘intensive’ home help or home care.

For the other services, patterns amongst clients were more variable and reflected both individual need and local provision. What is noticeable though is that in the north, where the domiciliary care organisers had large caseloads, many did not know what services their clients were receiving other than home help/home care. Given that the five social workers interviewed in this area had a very specific involvement with a small number of elderly people and that the vast majority of elderly people were seen by the domiciliary care organisers, this lack of information raises some concern. The home help or home carer has a more intimate knowledge of the old person, but they are not the worker with responsibility for coordinating services. It appeared that nobody was in a position to carry out that responsibility in the northern area.

In the outer London borough and the southern area variation reflected local provision and the breadth of knowledge of the individual worker involved. For example, in both authorities more than half of the social workers reported that more than 50 per cent of their clients received occupational therapy support. For the meals on wheels service, the majority of social workers in the south said 50 per cent or more of their clients used the service. But in the London borough comments varied between areas and may have reflected the fact that here the meals on wheels service was organised and delivered centrally through workers in the Civic Centre. So while all social workers said there was a meals service, the proportion of clients said to be in receipt of the service varied from 10 to 100 per cent.
Short-stay care, family placement schemes and paid good neighbours were all services more commonly used in the southern area than in either of the other authorities, whereas a getting up and tucking in service was more frequently mentioned in the London borough. A home chiropody service was said to be available in all three authorities and yet only six of the 15 social workers in the London borough and nine of the 20 in the south reported that a proportion of their clients used the service. With this service, as with others, the data given often reflected either local circumstances or the particular characteristics of individual caseloads. Nevertheless, it is apparent that many workers were not able to report accurately on the services currently being provided to their clients.

Of course the 16 services discussed with social workers and domiciliary care organisers, while they form the backbone of domiciliary provision, are not the only services available, and respondents were asked if there were any other public sector services provided which helped elderly people to remain within their own homes. Some thirty additional services were mentioned across the authorities ranging from well-established health services such as community psychiatric nurses to less well known provision such as special dustmen (northern authority) and low vision clinics (southern authority). In the London borough the volunteer liaison service was mentioned by a third of social workers, whereas the community psychiatric nursing service, volunteer service and sitting service were commented on in the south. The domiciliary care organisers from the north mentioned in particular sitting services and laundry services.

**Voluntary sector services**

For a social worker or domiciliary care organiser to maintain up-to-date information concerning statutory services can be quite a task, as we have already seen. In addition, workers are also expected to have a knowledge of services provided by the voluntary and private sectors. Respondents in all three areas were aware of and recommended community based services run by the voluntary sector, although this was particularly true in the southern area. In contrast, private domiciliary or community based services appeared less well established and few knew anything about them.

The most commonly used voluntary services were day centres or social clubs (particularly in the south), dining centres or luncheon clubs (especially in the London borough and the south), volunteer visitors, voluntary transport, sitting services, church groups, gardening services and decorating services. A large number of other groups and services were mentioned – thirty five in all – ranging from the well-known Crossroads Care Attendant Scheme to radio loans, visiting hairdressers and a service which brought animals to the elderly, called ‘pat-a-dog’.

The importance attached by social workers and domiciliary care organisers to the voluntary sector in providing day centres, social clubs and dining centres was clear from the frequency with which these were mentioned. More than half of those responding said that they would recommend these services to an elderly
In particular, they were suggested where the elderly person was lonely, confined to their home and in need of company and stimulation.

A social worker from the southern area felt that centres run by the voluntary sector were sometimes more suited to the client’s needs: ‘It depends on the person. It is sometimes a good idea as a first suggestion if they live close by and if the type of group is one they might get more from. People meet people they have been to school with’.

They were also thought to benefit from meeting other people in similar circumstances to themselves. One social worker commented on a centre she recommended: ‘The only service we consistently offer is a day centre which is run twice a week by the Alzheimer’s Disease Society. This performs a vital function and offers support if the old person has Alzheimer’s Disease.’

In some cases the voluntary sector ran the service and so the worker had no option but to use it. For example a social worker from the south described how the WRVS ran the meals on wheels service. She said: ‘It’s not a question of “under what circumstances” we recommend the voluntary sector. They run the service.’

Other reasons given for using voluntary sector services included ‘special occasions’ such as Christmas visiting, when the old person was visiting their family and needed a temporary service, and where volunteers could be paid to do a specific task such as gardening or decorating.

In the London borough the social work teams had access to a Volunteer Liaison Officer who was responsible for recruiting volunteers and coordinating their work with the needs of the social work teams. Unfortunately, the pool of volunteers was in short supply, especially volunteer drivers, as this comment shows: ‘When you hear the government saying, "you’ve got to look for volunteer workers", we say, "how do you get them?" You’d think in this area there would be a lot. You may be able to get a volunteer visitor and there is the odd group – an arthritis club run by the OT and volunteers, and volunteers provide a "Sunday Break" one Sunday in four. People don’t always want a full day at a day centre. They might want a half day for a small outing. Also transport is a nightmare. It’s all right for a one-off but not on a regular basis. You can’t get the volunteers.’

Finding volunteers was also a problem in parts of the southern authority. A social worker described the problems of running a sitting service staffed by volunteers with few resources: ‘The sitting service should have been a joint effort by us and the Red Cross. But we’ve no funding from the county council. We need funds for administration and paperwork. Now if volunteers stay all night they get paid, but not if they are just there in the evening. We can’t get volunteers. I’m not surprised. I wouldn’t do it for nothing. We’ve got 15 or so volunteers but we have 3 or 4 requests a week, so you are always chasing your tail.’

Only six respondents (two social workers from the London borough and two social workers and two domiciliary care organisers from the north) said that they would not use services provided by the voluntary sector. Those in the north felt strongly that there was no need, as local statutory services were good enough. A domiciliary care organiser said: ‘We provide very good services and all for free’.
And a social worker commented: ‘I don’t suggest them probably because I’m linked into our services. They are not appropriate and clients are comfortable with the services provided (by the local authority)’.

**Private sector services**
The majority of respondents said they recommended private domiciliary services to elderly people where they felt that they or their family could afford it or if the local authority did not provide the service or it was overstretched.

One social worker from the south saw this as part of her role: ‘If we’re unable to provide the service, I’d say look at the private sector. It’s usually done through the relatives. It may be that they want someone to drop in at a specific time to see if they are OK. Where families are extremely well off we’d suggest they could find someone. I would recommend the private sector if I thought it appropriate. I’d see it as my role to find it. My role is to provide a service. There’s no point in getting precious about it. My starting point is the client.’

Another provided information if it was requested and, again, if she felt that a client might want a more individualised service: ‘Yes, I suggest private services if they ask me and if it was the sort of service that would suit her better, I’d give them details. A lot depends on who they are, their background and position in the local community and their financial status.’

Some workers also suggested that people receiving Attendance Allowance should use this benefit to purchase cleaning services or nursing cover. However, as this social worker from the north indicated, the Attendance Allowance does not purchase a great deal of support: ‘The private agency that offers nursing cover at night charges £30 a night, so you’d use your Attendance Allowance in one night.’

The two most common services suggested were private home helps and private nursing services, followed by night-sitting services and day care within private residential care homes. Other services mentioned included chiropody, taxi services, private gardening services, hairdressing and tucking in services.

A social worker from the south explained how they used private sector services in her area: ‘We’ve not got a cleaning service now. So if someone has money then it’s not appropriate to give them our home helps. We offer temporary home help until they find someone. We have some day care in private residential homes, but they charge £15 a day and I can’t get people to accept that. £5 a day is acceptable. It’s good to introduce someone as a long-term resident through day care but they have to offer it at a price people can afford. We also use private gardening services.’

Overall there was a less favourable response to suggesting private domiciliary services to clients than those run by the voluntary sector. However the reasons given by the 19 respondents who said they would not suggest private services centred mainly around a lack of knowledge of the availability of services or the fact that there were no private services in their area. A social worker from the south had no experience of the private sector – ‘I’ve never come into contact
with the private sector. I’ve never looked for them. I’ve never needed to look beyond what we’ve got’.

The strongest views expressed against using the private sector came from the north where, as we have already noted, there was a great deal of support for public sector provision. A domiciliary care organiser raised issues of accountability and the dangers of older people being exploited by private agencies: ‘I wouldn’t like to think I’d recommended somebody and they didn’t do a good job. You’ve got to have a way of monitoring who goes in. You’ve got to know who goes in. There was a case where a decorator killed an old lady.’

And a social worker from the London borough felt that private services were beyond the means of many of her clients and that this was a problem for people who just needed a basic cleaning service: ‘A lot of clients in this area only have their pension. Many of them want to keep their home but they can’t afford to run it.’ Without basic services such as cleaning, repair work and gardening many old people find that the upkeep of their homes can become too much for them.

Services for carers
The recognition of the hidden contribution of informal carers and that carers also have needs, has meant that some services are now more commonly seen as offering carers respite or on-going support. The types of service said to be of greatest benefit to carers by social workers were carers’ groups, sitting services, short-stay/respite care, day care and financial assistance. A social worker from the London borough gave this list of services: ‘Well there’s Crossroads, home care, day care, respite care, the district nurses, and help with finances, as they might be entitled to the Attendance Allowance or the Invalid Care Allowance.’

Another social worker from the south added: ‘...day care offers relief and there’s respite care in hospital. Also there’s a laundry service and an Alzheimer’s group run in the day centre.’ And one of her colleagues put it more graphically: ‘Anything to provide a break from the grinding down process is usually welcome.’

The domiciliary care organisers and social workers in the north were less well-informed about services for carers than the social workers in the other two areas reflecting the separation of their roles. One domiciliary care organiser knew the jargon but didn’t know of any services: ‘Caring for Carers do you mean? I don’t know of any services personally.’

Carers’ support groups have received particular publicity in recent years, and we asked respondents if groups were running in their areas. Three-quarters of the social workers in the London borough and the southern authority said there was such a group, whereas workers from the north tended to say there was no group or that they did not know of one.

Support groups were run either by local voluntary groups, such as the Alzheimer’s Disease Society, or were coordinated by a social worker or a community psychiatric nurse. One social worker in the London borough had been given the task of setting up a group: ‘It’s been going for about a year now. We
meet once a month. There’s a core group involving three or four carers and the district nurse. It’s what they want – not what I want. I sent out a questionnaire to all the members asking what they wanted. We have an agenda – information, introduction of new members and then I do relaxation sessions with them. It varies from month to month. We need more group discussions. There’s a lot of suppressed feelings and emotions that they could not express elsewhere. Through visiting old people I discovered the distress that many carers are under – some are on the verge of a nervous breakdown. Yet the focus was on the dependent elderly person and often the carer’s needs were overlooked. The carer’s never complained and yet they had that job 24 hours a day. They felt, ”It’s my lot, my life”. In talking to them I found they were an isolated group with no social life, no friends and no outlets.’

Work with carers’ groups allows some social workers the chance to develop their group work skills. A social worker from the south also ran a group: ‘We meet twice a month with a structured programme of things they want. It’s information giving and therapy. About ten people come regularly but we are always losing and gaining people. Some groups work – some don’t. I listen to what they want and try to give it to them. They love the relaxation tapes. I’m always there. I’m convinced that’s important. I like group work and I’m trained in it. If there’s a problem they can share it with me.’

However, in some cases groups had been less successful. They had been set up and abandoned owing to lack of support. A social worker from the south felt that some people were just not interested in sharing their feelings: ‘The people I’ve offered that to I haven’t had much response from. Sometimes it’s very difficult and they are reluctant to share the fact that they can’t cope with other people. They may be happy to share it with us but not a group.’

Of course, while the carer attends a group someone else has to care for the elderly people, causing problems, as this social worker pointed out: ‘They’ve talked about setting them up, but carers say, ”who’s going to take care of the person while I go to the group”. They’ve not got off the ground yet’.

In the main, support groups were felt by workers to be of great benefit for some carers, although it is interesting to note that the carers interviewed in this study were not so enthusiastic about groups. And, as this social worker from the north pointed out, they were not a solution to the needs of carers. In fact they raised an awareness of the need for more services, both practical and in the form of counselling: ‘I like them but they cause problems because people demand more services. They don’t lessen your work – they make more. They help carers because they help them let go. We hide behind the practical bit, but they know about that. We need to offer emotional support.’

**Services for the future**

All respondents, including team managers, were asked if there were any services which were not being provided at the moment which they would like to see introduced and whether they would like to see an increase in the provision of any particular service. The initial question produced a list of thirty-eight different
services, some of which were available in one authority but not in another, or were already being provided by the private and voluntary sectors in some areas but not others. Different groups of workers also held different priorities.

For social workers in London and the south the three most common needs were said to be night care or night sitting services, day care for elderly people with mental health problems, and transport. A social worker from London commented on the problem of having to fit elderly people suffering from mental illness into services where their needs were not catered for: ‘We have only a very limited resource for people with Alzheimer’s Disease. We have a day centre for elderly people which takes 300 people, and the people with Alzheimer’s Disease have to be integrated and this is not always suitable due to management problems. There is a big gap. Many of our residential homes also can’t cope with people with mental illness.’

Night care was a particular issue for a social worker from the south: ‘We really need a night care or night sitting service. If relatives are away we need someone at night. We need someone to stay for one or two weeks.’ A colleague raised the problem of a lack of transport: ‘Transport is a big gap in rural villages. There are ordinary social clubs, but they can’t get there and they don’t like to take advantage of neighbours.’

The range of services not being provided was said to be substantial, and social workers in London and the south had no difficulty in giving their views on new services. However, some commented that the balance of services and resources between the health authority and social services departments also needed to be taken account of. Social services were sometimes said to be suffering from the lack of health services in an area: ‘I think introducing the home care scheme is covering up a crack in the health care service. Nursing auxiliaries have disappeared and home carers now do the bathing. That means we’ve got no money for other resources. The service is good but it’s overspent and it has to be cut back. This means the focus will be on personal care and not housework which is also important to people.’

Comments from social workers and domiciliary care organisers in the northern authority were more limited. Six of the 11 domiciliary care organisers mentioned gardening services and sitting services.

The two main services that team managers wished to see provided were intensive home carers and transport. A team manager from the north wanted a combined home help and sitting service: ‘I would like to see a combination of sitting service and the home help role – a rapid response home help service. At the moment they are kept separate because of the budget.’

The question concerning an increase in service provision led respondents to generate an even longer list of responses – 42 in all. However, once again, there were different priorities between groups. Social workers highlighted the need for more home helps, home care, transport, day care in general and especially for elderly people with mental illness. Day care was a special concern of respondents in the London borough. One social worker wanted day care provided closer to people’s homes: ‘More day care, local day care – in a pub or a house. For eight
to ten people, not eighty. One of my clients said, "Will I have to go to a dormitory?" We shouldn’t subject anyone to anything we would not want for ourselves.

The needs of elderly people with mental illness were near the top of everyone’s list, as this social worker from the south suggested: ‘The crying need is for more provision for the mentally frail. That is totally inadequate, and it should be provided in the community in which they live. They shouldn’t have to travel long distances. It does them more harm than good.’

Another social worker from the south had a shopping list of items: ‘Meals on wheels, day centres open at weekends, an extended laundry service and an enlarged chiropody service – three times a year is too little. I’ve cut an old gentleman’s toenails like horses’ hooves. He was told that he’d have to wait a year.’

Finally, team managers mentioned in particular the need to increase transport, day care in general, sitting services, occupational therapy services and the need for more volunteers. However they were also more concerned with how services were organised than the other workers. The problems of a lack of service flexibility was raised by a team manager from the north: ‘I’d like to see a large allocation of home help and sitter hours which could be used much more flexibly and imaginatively. Also transport. I’d like a pool of drivers who are more flexible, because drivers are usually volunteers and you have to take what they have available. You can’t make demands on them because they’re doing it for nothing and you’ve just got to be grateful.’

A team manager from London felt that transport might be one service to benefit from privatisation: ‘The main problem is transport. Everything is run for when they can come, not for the clients. That’s one area where it would be better privatised – so we can say we need it at 8 a.m. or 9 a.m.’

For many respondents, the list of potential services or services which they would like to increase seemed endless. However, there was also a view that, with an ageing population where people were living in the community into advanced old age, if you raised expectations about services, greater demands were placed on them. One team manager from the south felt that home care was a bottomless pit: ‘Home care resources – it’s a massive budget but it never seems to be enough, especially as we are talking about keeping people in the community for longer.’

Another from the north felt that getting the organisational structures right was just as important as increasing the services: ‘There’s a danger in just increasing services. You need fairly tight services at the organisational end. You need more DCOs and OTs to continually assess and see what’s needed. Then you respond to changes in demand.’

The responses to these questions raised a number of issues. While there was a recognition that particular services were needed, such as those for elderly people with mental illness and those offering respite care, comments also revealed a need for an increase in basic provision such as home care, meals on wheels and transport. Other services such as gardening and laundry services seemed peripheral compared to the need to maintain and expand some of these
more traditional services, yet, as we have noted, gardening and repair work can be crucial in maintaining people’s self esteem at home. Elderly people themselves were frequently more concerned about these aspects of their lives than any others.

This discussion of service provision and availability highlights the enormous range of services about which workers with elderly people should be knowledgeable. It is obvious that individual workers cannot be aware of all the services available across all sectors at any one time, and, in order to fulfil the role of coordinator, it may be necessary for them to have access to a data bank giving information about the range of and availability of services within a given area. If workers have access to this kind of information they may be better able to advise older people and their relatives about the options open to them. In particular, if services are to be offered by a range of providers, then information is also needed concerning the type of relationship or contract held between the authority and the service provider. The example of transport demonstrates the different expectations which can be held for voluntary or private sector provision. Is the service dependent on the good will of volunteer drivers or is it a privately run concern whose aim is to please the customer?

The provision of public sector services will come under closer scrutiny in years to come. In this study we could already see that authorities were making choices over where to put most resources. It appeared that resources were going into home care at the expense of the home help or cleaning services. The development of personal care services means that some tasks previously undertaken by health service staff have moved to social services workers, and the resource implications of this change needs to be examined. Finally, it is clear that in these authorities, staff saw the development of respite care and services for elderly people suffering from mental illness as two priority areas. Whether these are areas where the private sector will wish to develop substantial domiciliary services remains to be seen.