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Community Medicine Essay Competition

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Essay Title - Social Work and the Elderly -
A Problem of Definition.

INTRODUCTION

"I have lost my passion: why should I need to keep it
Since what is kept must be adulterated?
I have lost my sight, smell, hearing, taste and touch:
How should I use them for your closer contact?"

T.S. Eliot,
Gerontion.

Society has changed a great deal since churches and monasteries started a kind of desultory social service for the elderly about a thousand years ago. There are now many more old people in our society both in relative and absolute numbers and their impact on the caring services steadily increases. There are fewer young people to look after the aged and more women now marry and have jobs than in the past so that as the old people become, increasingly, the very old (Coni, Davidson and Webster 1980) there is a need to plan and examine the roles of all who care for this group of people whose contribution to making our present welfare-oriented society is not the least of the reasons why their care should demand our close scrutiny.

Social work in Scotland was united from diverse areas under the Social Work (Scotland) Act, 1968. With the increasing number of old people in society there has been a growth of discussion among social workers that has attempted to define their own role in a specialty where so many other caring professions are involved. I hope that I can show that while the role of the social worker is an important one there is a great deal of role defining to be done in that there is little agreement about what a social worker does or should do for his elderly client.

Social work with the elderly, not unlike geriatric medicine, is not a popular speciality (Brearly 1975, 1976; Rowlings 1981). These authors

indicate that the huge demand for resources can depress a social worker who finds that the better he is in discovering need the greater is the difference between that need and what he is able to provide. Other discouraging aspects of the work are that the social worker is often called in only when the family of the old person is in crisis and the worker becomes involved in a great deal of stress; the forming of satisfactory relationships can be difficult with an old person suffering from sensory loss and who is culturally and linguistically strange to the worker; old people are often slower (Charman 1979, Rowlings 1981) and need more cues to take action than other client groups; and the worker may hide his fear and anxiety of death and age behind euphemisms such as 'senior citizen' or 'OAP'. Perhaps due to these factors social workers tend to take an inactive role in the problems of old clients and aim to preserve the status quo rather than aim for growth. (Rowlings 1981).

But there are positive sides to the work: the social worker's prime concern is not with the pathology of the old but the life forces that are still intact and capable of restoration (Milloy 1964). Prinsley (1982) agrees with this supportive role, opining that "Frailty needs support - sickness needs treatment." He also encourages the worker that flexibility of responses are appropriate - alternative solutions must be sought to seemingly similar problems e.g. the very different needs of an old man who is isolated and failing to cope with those of a woman in the family home who has gone off her feet and is incontinent. Fixed attitudes towards the provision of resources, Prinsley says, have lamentable long-term effects.

The richness of the work is also emphasised by Brearley (1975, 1976) when he indicates the information-collecting role of the worker as a member of the caring team; the different needs of each client in different situations; the need for the worker to see old age as a time for change and progress and his ability to break down the barriers to theses advances; and the challenge of an enlightened approach that tries to support the old person in his own home whenever possible.

This flexibility, though, should not prevent the worker from asking precise questions and relevant questions - Rowlings (1979, 1981) suggests a core set of questions to all clients and also recommends that all old people should have access to, if not assessment for, social work. Despite this attitude of general availability Hunt (1978) was still able to report that one quarter of the elderly living in the community had had no visits in a six month period from any health and social service worker. Even of the bedfast and housebound one third saw the GP less than once per month. The social worker had not even been seen by one in ten of the isolated elderly who were bedfast. A majority of every group studied, even the most ill, did not have home helps. The challenge for social work has still to be met. We will now examine the various areas in which the social worker can support and care for the elderly client.

MATERIAL RESOURCES

Although Brearley (1975) warns of the 'need for bath seat-death-end of case' approach, Goldberg has shown (1975) that old people are grateful for material help. Domicilliary services such as lunch clubs and day centres can be used to keep the old person at home. The domicilliary service most experienced by people is the home help. The home help often develops a close relationship with the elderly client and can be an important source of feedback to the social worker who can save much time by using home help accounts to plan for after care and support. In this care the social worker will be aware of other local authority and voluntary services such as meals on wheels, laundry, chiropody, holiday clubs, etc. All of these can be used to prolong the life process of the old person in his own home. Two points to be remembered are that while day centres are a social service, the day hospital is a health service and the old person who is discharged from the day hospital can find herself short of an important source of

social intercourse. Secondly, the social worker should be able to look at the problems of the elderly person in a wider framework than that of material provision as such a perspective can mask the pattern of the person's development and its results in terms of present needs. The social worker will also find the elderly client grateful for the provision of home aids that make a safe home environment on the advice of the occupational therapist. Small services such as transport from hospital to residential care serve to keep the old person oriented in sympathetic company when facing a new and frightening change of circumstances.

RESIDENTIAL CARE

This was provided by the 1948 National Assistance Act for those who by reason of age infirmity or any other circumstance need care and attention that is not otherwise available. The social worker is the instrument who will admit the old person to care and in this function he often has to find a balance between the wishes and needs of the old person as the client will see it as second best, often, nomatter the state of their previous home or the excellence of the facility. The request for help that leads to care will vary from the holiday admission where a caring relative wants a break for a week or so, through the patient who needs a little social rehabilitation (the care-treatment-rehabilitation schedule of Brearley, 1975) to the desperate cry for help that leads to long term residential care (the custody-containment-rehabilitation schedule of Brearley, 1975).

After the call for help the social worker must be quick in accurately collecting information to reveal the accomodation, health and other reasons that have led to the call for help. The result has to be a clear picture of what is happening to the old person in his wider environment including the sources of pressure that have led to the request. It is important, then,

that a full assessment and discussion with all concerned have taken place before the formal request for admission. The social worker should not then force the old person onto a long waiting list for admission, his task is to prepare the old person to leave home in the right way and to look forward to a move that has been taken in the best interests of the client.

Ideally the social worker should allow the client to visit the home in order that she can assess it for herself. The entry to care can also be smoothed by the worker if he makes sure that the client is neatly turned out and then driven to the home by him and allowed to meet a few residents on arrival (Rowlings 1981). This continuity of support can be furthered by the social worker looking after the house and property of the old person in view of the possibility of a return home. On my own attachment I did see sensitive visits to care establishments that resulted in happy future residents who were driven by a familiar social worker to a home where a few recently familiar faces had a cup of tea ready to welcome. What I did not see was any question of a return home (suggested by Brearley 1976) and the reason for this may have been that the shortage of care places results in the most needy being admitted i.e. those who only just meet the standards of independence demanded by care and who soon become older and further from a return home. As regards holiday admissions there was little place for these in Fife and the few places set aside for this were easily oversubscribed.

Brearley (1975) warns of the cynical use of the residential care waiting list as a way of seeming to be doing something for the client. Also, he does not encourage those old people who want to put their names on the lists as future insurance - a practice I observed among geriatricians who felt they were simply being realistic in view of the evidence. Brearley also warns that a forced choice will often be an unhappy one and

encourages the full involvement of the old person at every stage in decision making.

Finally, it is relevant to ask if the idea of this further stage of segregation of the elderly, nomatter the good intentions and the caring nature of it, who have been victims of pensioning-off and all kinds of prejudice that society has about the old, is in their eventual interest.

ADVICE AND ADVOCACY

Age Concern (1974) suggest that the advice and advocacy function of the social worker is important because the statutory agencies have no coherent policy of ensuring the take-up of benefits. They felt that the caring agencies had too many packages to publicise; that publicity was left to administrators who put the emphasis on accuracy rather than impact leading to underselling of the benefits; and that forms were badly constructed. They found more stigma associated with benefit than rebate and suggested a personal help service for the elderly. These suggestions are questioned by the recent work of Kerr (1982) who has found other important determinants of non-uptake of benefit.

The advisory side of social work is looked at by Brearley (1976) who sees the social worker as someone who can take pressure off an elderly, often isolated, client and clarify the areas of problem and alternatives to action. The worker can act as a filter, letting problems reach the old person at a rate that does not overwhelm his capacity to solve them. The family can also benefit from the worker's advice in that many will try to cope beyond the point of feasibility and they can then be prevented from feeling guilt when the elderly relative leaves them while the social worker should try to prevent

feelings of rejection in the old person.

I found that many nurses in geriatric wards saw the social worker as someone who took over the client's business when benefits were being spent by others or when there was no-one else to manage it. Nurses also saw social workers as useful people to call in on the death of a patient with no family or to organise a welcoming committee at the client's home on discharge.

FORMING RELATIONSHIPS

Most commentators of social work with the elderly will emphasise the importance of building up a relationship with the client. Brearley (1975) sees casework as a mixture of the provision of material resources and time spent with the patient. The social worker must try to integrate the past, present and future of the client into a pattern that provides a meaningful continuity for the worker and his client. He sees the emphasis on formal procedures of care admission, for instance, as a way in which the social worker can preclude his feelings of guilt and conscience which can result from impotence. Also, the residential worker tends to avoid direct relationships with clients but they are encouraged to develop a rapport with the residents so that they can better appreciate and anticipate problems of coping.

Absolving the adult child of the old person from the sin of not being omnipotent is also a role that Milloy (1964) sees as an important one for the social worker added to the need to empathise with the client. Milloy, though, demands more: that the worker has thought out his own feelings on death, bereavement and loss and that the social worker makes an emotional investment in each case, a professional, feeling investment,

not a personal one. It is assumed that this attempts to make up for the lack of energy the old person has for investment - the little that is left is all put into everyday living. This theory seems to be getting at something real that I experienced when working with old people but Milloy's writing makes so many undefended assumptions and is backed up by so little evidence that I feel forced to put these ideas down as grand sentiment rather than tested hypotheses.

Glendenning (1979) encourages social workers to use relationships with the elderly to produce useful change and not to see old clients as easy options who will fill up a social worker's list while not receiving much time. He cautions against the attitude that sees old people as needing social service and not actual social work. Pincus (1975) concurs and states that the bereaved, especially, need long supportive contact on a counselling or social work level.

Rowlings (1978) also encourages an understanding relationship with the client - much time might be needed, she suggests, to persuade an old person who has always done the housework that a home help is needed. She also gives examples (1979, 1981) of the use of reminiscence therapy in making hidden fears overt or in lancing emotional boils. Talents that can add to the present quality of life may also be uncovered in the relationship while the extension to actual touch between the worker and client has helped in certain situations, especially those of loss.

I feel, again, that these are worthy sentiments but feel also that the initiation of any relationship is all one way in that it is the social worker who is the leader and the old person is passive. This, according to the relationship theory of Bateson (Bateson 1973, Waddington 1977) can lead to what is called a negative schizmogenesis

in the relationship with the old person becoming ever more dependent. It is difficult, though, with the present lack of facility to envisage a client-initiated relationship even if this is desirable.

OTHER HEALTH PROFESSIONALS

An important aspect of the social worker's function is the communication with other health professionals and it is important to find out how these other carers view the social worker.

From a short review of mostly USA work Hardie (1975) found that doctors and nurses differed in their ideas of what constituted medical social work from the social workers themselves who felt they were not appreciated, often as a result of the difficulty of defining their task.

Brearley (1976) points out that the atypical manifestations of illness in the elderly call for a close communication network involving the doctor and health visitor while a voluntary visitor or home help, while giving the little care needed to keep the old person at home, can also be useful in giving information to the social worker about developments. This accords with the current thinking that the coordinated multidisciplinary team is the most effective provider to the old and needy. Williamson (1979, 1981) emphasises this and the need for 'total diagnosis' involving a team of professionals who have each other's mutual respect acting with the speed in the form of a case conference. This coordination, he says, is more important where there is greater medical and social need.

Smith (1973) agrees but laments the fact that so many doctors (and, as I found, nurses and therapists) see the social worker as someone who can 'play the social and welfare' and suggests that doctors and social workers work out their own relationship before inflicting their misunderstandings on patients. This is underlined by a recent article

on the sevices available to the elderly by Prinsley (1982) in which he mentions home helps, meals, chiropody, sight and hearing services, laundry, occupational and physio therapy, information services, neighbours, doctors and nurses with no mention of the role of the social worker. He sees the GP and community nurse as those important in maintaining the effectiveness and availability of the social services, pointing out areas of deficiency or waste and activating the appropriate helping service at the time it is required. Presumably the social worker is a kind of clerk to the doctor (who is not even mentioned in the index!).

Rowlings (1981) cautions that social work, health visiting and occupational therapy overlap and the importance for each group to know their common ground and expertise is important not least to prevent professional blinkering such that an OT sees a solution only in terms of aids, the social worker in terms of counselling only, etc. It was my own opinion that the reason this overlap did not lead to more friction - especially between social workers and health visitors - was that each profession was so overstretched leading to a situation where the workers were glad to think that even if there was no possibility of a client receiving social work they were at least getting the attention of a health visitor. If there are ever enough of all the carers to go round I think the demarcation sparks will fly - these are prevented just now due to a famine of carers who are too busy to fight with each other.

EDUCATION

There is an obvious obligation on the social worker interested in supporting the elderly to be educated in the many aspects of ageing which he will meet. McAlpin (1981) opines that "...work done in the

department of geriatric medicine is still improperly understood by the social work department." He finds that social work departments are too concerned with community care and "...a person in a hospital bed is a person catered for." McAlpine claims that in his area (Paisley) the health service and social work department are not coordinated in their care of the elderly.

Mortimer (1979) recommends education on the special nature and needs of the elderly at all social work levels with teaching on relevant acts of parliament, services and the nature of ageing (e.g. the different responses to illness found in old people). He also sees a need for good teaching models and face to face experience. Brearley (1975) agrees and wants the education to emphasise old age as a time of development rather than a static time - it has to be said here, though, that psychologists have tried, and failed, to meaningfully extend the study of human development beyond adolescence (Inhelder and Piaget 1958, Bower 1979) despite the claims of Milloy (1964) that old age is a 'stage' of development. Brearley, rightly, wants to see teaching on the great variability in the elderly, fear of death, physical incapacity, individual and group behaviour, dignity and respect all of which are important in our perceptions of the elderly andtheir perceptions of themselves. The importance of this is evident in Stevenson's (1979) realisation that social workers with the elderly have to deal with a wide range of problems that they have never experienced.

RESEARCH

The intervention known as social work has to be carried out in a spirit of self-criticism that is the foundation for knowledge. There are many worthy sentiments in social work literature and much 'common

sense' but Brearley (1975) complains about how little measurement there is of the results of social work intervention in terms of change. This is needed for effective resource allocation. The Goldberg (1970) study found that social work intervention could improve the morale of old people in relation to circumstances and emphasises the importance of environmental and practical support. This and other studies (including the Cleator Moor study - Butcher and Crosbie, 1977) have shown the need for good initial assessment; the need to protect without over-protecting; and the need for special skills with the elderly.

There is recent research, too, that shows how rigorous psychological theories such as decision theory and cognitive dissonance can be applied to work with the elderly to aid the social worker. Kerr (1982) used a conceptual model to study the process of decision-making in old people who did not claim supplementary benefit while being entitled to it. The model had six constraints, each of which represented a threshold. He believed that applicants would be pensioners who found difficulty in making ends meet; knew that the benefit existed; perceived a likelihood that they were eligible; perceived some utility to the benefit; expected the advantages of claiming to outweigh the disadvantages; and who perceived their situation as stable. In around 150 previous non-claimants the model predicted the future claiming behaviour of the old people with 90+% accuracy.

From Kerr's results it seems, and he strongly suggests, that further general advertising would be ineffective in increasing claims; claiming would be facilitated if the application for benefit was more like that of rebate; and that an effective approach would involve intensive advertising, revising the means-tested procedure and allowing rebate and benefit to be claimed together.

Such research is a powerful ally to the social worker in that it

allows him to gauge, from general knowledge of a client, what she is likely to claim from the services. It replaces common sense by a scientific, yet caring, approach to the problems and needs of the elderly.

DEFINITION

From what has gone before it will be obvious that the role of the social worker in the care and support of the elderly has many facets. But social workers are at pains to define their role briefly and other workers constantly exhort them to do so in the face of different emphases perceived among social workers. In this section I will try to gather together some proposed definitions of the work.

Brearley (1975) sees the role as a concern with the alleviation of stress in social dysfunction which must be met by the flexible presentation of resources during the interaction. Tasks involved are assessment of need, communication, relationships of mutual trust and understanding and the provision of practical aid. Added to these are the identification of risk and the sense to realise the areas where little or no contribution can be made. Solutions to the multi-problems of the elderly should not be static but make use of the processes and dynamics of ageing - i.e. treating the old person as an open system (Waddington 1977), not a closed one.

Milloy (1964) wants the social worker to carry out a psychosocial diagnosis and treatment and resist the temptation to concentrate the treatment on the family while the old person is seen as something that has one direction - down. Milloy, like Brearley is an advocate of the tactical withdrawal when too great personality damage combines with lack of resources and knowledge.

There is little doubt as to the value of the recent contributions of Rowlings (1981) to this area. She, interestingly, suggests a more narrow definition of the social worker's role although one has to search for details. Rowlings suggests certain tasks such as advice, advocacy, information on rights, housing and finance, transport, aid-delivering, routine interviews and screening could be done by others including trained volunteers. This seems to take away the tasks that convince the sceptical that the social worker is doing anything at all and Rowlings keeps for the social worker such tasks as preparing the elderly for residential care and supporting the caring family. There does seem to be a contradiction, though, between her call for the separation of information-gathering and assessment and her claims as to the need for a trained, sensitive interview with the client - it would seem better to leave both of these tasks to the trained social worker. Williamson (1981) has also taken social workers to task for having no senior posts that involve service (unlike the medical profession) to clients; it would seem that success in social work involves a distancing of the best talents from those who need them.

The force of Williamson's argument comes from his belief that the social worker has a valuable role to play at all stages in the care of the elderly and the caring family and can bring information that is not available through other professions. Follow-up care, though, is seen as the job of either the social worker or the health visitor.

Butcher (1977) sees personal and group counselling as central to the role of the social worker and the health visitor. The social worker's task is also to add comfort and support in times of stress and to help clients gain insights into the nature of their responses to personal problems. Social workers, says Butcher, are also intermediaries, signposts, advocates who help clients make contact with

all services and agencies who can help them.

Finally, as Smith (1973) and Hardie (1975) have indicated, there is a need for the social worker to increase the understanding of their role throughout the caring professions. But, with the internal inconsistencies in the definition of that role, it is doubtful that this will take place in the short term. Their role, of course, cannot be fully realised in the present state of the caring services. As Gillespie aptly put it, "(Health and welfare services are both) trying to cope with a growing problem of inadequate resources; I have got fed up using the word resources, it is money, it is people and the right way of doing things..."

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