

# **SOCIAL WORK AND SOCIAL NETWORKS**

A thesis submitted for the degree of Doctor of  
Philosophy

by

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### **Abstract**

An exploration of the relationship between patterns of social interaction and social work practice which incorporates thirteen publications. The thread running throughout is the way in which new forms of social care practice are made possible by cross-boundary linkages. A 'Critical Review' sets the context and analyses the works. This is followed by the first published work which applies anthropological models to the study of social marginalisation. The second publication introduces the social network concept and investigates patterns of reciprocity and dependency in social care. The next section of the thesis consists of a 'commentary' on the Griffiths and Wagner Reports. This is followed by a closely related work arguing that there is a fundamental opposition between market and network models of social and community care. The thesis then looks at the ways the culture concept can be used to illuminate the cross-boundary practices associated with community care. The concept of culture and its relationship to cross-boundary working is developed more fully in the next section where it is argued that collaboration culture is paradoxical because it incorporates both respect for difference and a commitment to collective action and that resolving this paradox through collaborative work is a complex and skilled activity. The next section introduces a comparative dimension and suggests that studies of collaboration could be based on looking at the ways in which modern welfare systems try to solve the problem of potential fragmentation and lack of coherence. The work which follows on from this makes use of discourse analysis and network analysis to compare and contrast the rhetoric of partnership and collaboration with the way in which individuals think about their day-to-day cross-boundary work. This raises questions about the changing nature of working relationships in the field of social care and is followed by an investigation into the nature and effects of globalisation on social work in Europe. 'The Co-operation Concept in a Team of Swedish Social Workers' is an attempt to develop a cross-national framework for the analysis of community care focused on the cross-boundary networks of a team of hospital based social workers in Stockholm. The thesis then returns to somewhat broader concerns by means of a work which investigates the contribution of theories of social interaction to theories of social work. These concerns permeate the penultimate section on networking but in a more applied and specific way. The book which constitutes this section of the thesis argues that there is a distinctive theory of networking and that it can be applied to the whole range of social welfare and social care specialisms. The final work explores the impact of globalisation on the ways in which social workers currently experience their roles and develop their sense of professional identity.

# **Social Work and Social Networks: A Critical Review of Works Submitted for the Degree of Doctor of Philosophy at Brunel University**

**By Steven Trevillion**

## **Initial Statement on Works of Joint authorship**

There are two works of joint authorship submitted with this application:

Beresford, P. and Trevillion, S. (1995) *Developing Skills for Community Care: A collaborative approach*, Aldershot and Vermont, Arena.

Trevillion, S and Green, D. (1998) 'The Co-operation Concept in a Team of Swedish Social Workers', in Edgar, I.R. and Russell, A. (eds) *The Anthropology of Welfare*, London and New York, Routledge, pp.97-119


### *Developing Skills for Community Care: A collaborative approach*

This book was also based on a research project undertaken jointly with Peter Beresford. The introduction was written by Peter Beresford. Chapter one was largely written by me with the exception of the first paragraph. The first part of chapter two was written by me (up to page 30). Chapters three and four were entirely written by me. Chapters five and six were written by Peter Beresford. Chapter seven was written by Peter Beresford, but this part of the research was undertaken jointly. Chapters eight and nine were written by me as was the conclusion. This division of responsibilities largely reflected the way in which responsibility was divided for

different parts of the research project. Peter Beresford focused on the work with users and carers while I focused on the work with the professionals. I led the final workshop session which synthesised the two 'strands' of the project.

*The Co-operation Concept in a Team of Swedish Social Workers*

This chapter was written solely by me but made extensive use of transcriptions made by David Green who was at that time employed as a research assistant in the Department of Social Work, Brunel University. The joint authorship is a recognition of David Green's contribution to aspects of the methodology and his active participation in the data collection phase of the work in Sweden.

Signed:  Steven Trevillion

## Part 1 : The Works and Their Context

### 1.1 The Works

All the works submitted either have been or shortly will be published and all have been subject to formal or informal processes of peer review. Other published work on different subjects has been listed separately. Conference papers, professional magazine articles, review articles and book reviews have not been included in the works submitted but many of the shorter published pieces were initially presented as conference or seminar papers.

1982 'Welfare, Society and the Social Worker' *British Journal of Social Work*, vol.12, no. 1, pp.23-33 (refereed article).

1988 'Conferencing the Crisis: The application of network models to social work practice', *British Journal of Social Work*, vol.18, no.3, pp.289-307 (refereed article).

1988/89 'Griffiths and Wagner: Which future for community care' *Critical Social Policy*, issue 24, winter, pp.65-73. ('commentary' refereed by the editorial collective).

1990 'Post-Griffiths Networking: A study in contradiction', *British Association for Social Anthropology in Policy and Practice Newsletter*, no. 6, summer, pp.12-15. This later became the journal *Anthropology in Action* (unrefereed article).

1993 'Networking and Community Care-A Cultural Issue' in Trevillion, S. ed. *Networking and Community Care: An anthropological perspective*, London, Centre

for Comparative Social Work Studies, pp10-18 (chapter in edited conference proceedings).

1995 With Beresford, P. *Developing Skills for Community Care: A collaborative approach*, Aldershot and Vermont USA, Arena (jointly authored book).

1996 'Towards a Comparative Analysis of Community Care' *Social Work in Europe*, vol.3, no.1, pp. 11-18 (refereed article).

1996 'Talking About Collaboration', *Research Policy and Planning*, vol.14, no.1, pp.96-101 (refereed article).

1997 'The Globalisation of European Social Work', *Social Work in Europe*, vol.4, no. 1, pp.1-9 (refereed article).

1998 With Green, D. 'The Co-operation Concept in a Team of Swedish Social Workers', in Edgar, I.R. and Russell, A. (eds) *The Anthropology of Welfare*, London and New York, Routledge, pp.97-119 (chapter in edited book).

1998 'Social Interaction Theory and Social Work' in Fachverlag HFS Zentralschweiz (ed.) *Reclaiming Science: Social work theory and social work research in the making, fifth inter-European symposium of schools of social work, Lucerne Switzerland April 25th to April 28th 1997*, Lucerne, Fachverlag HFS Zentralschweiz, pp. 69-79 (chapter in collected conference proceedings).

1999 Forthcoming- second edition of *Caring in the Community: A networking approach to community partnership*, completely revised and with a new title: *Networking and Community Partnership*, Aldershot and Vermont, Ashgate, submitted here as a pre-publication manuscript (authored book).



1999 Forthcoming- 'On Being a Social Worker: Globalization and the new subjectivities' in Chamberlayne, P. Cooper, A., Freeman, R. and Rustin, M. (eds) *Welfare and Culture*, London, Jessica Kingsley, submitted here as a pre-publication manuscript (chapter in edited book).

*Other Major Published Works not submitted:*

The following major published works have not been submitted because they focus on themes too distant from that of the submission to be included or are insufficiently research oriented for the purpose of this submission or because they represent earlier versions of submitted works:

1985 With Andrew Cooper 'Survival and Change: Working with angry men', *Journal of Social Work Practice*, vol.2, no.1, November. Re-printed in 1996, with a new introduction in Newburn, T. and Mair, G. (eds) *Working with Men*, Lyme Regis, Russell House Publishing, pp.11-21 (refereed article).

1992- First edition of *Caring in the Community: A networking approach to community partnership*, London, Longman (authored book).

1995 Trevillion S. and Beresford, P. (ed.) *Meeting the Challenge: Social work education and the community care revolution*, London, National Institute for Social Work (edited book).

## *1.2 Introduction and Early Influences*

The works submitted explore the relationship between social workers, service users, carers and other professionals in a rapidly changing but consistently 'unjust society' (Jordan 1990). They focus on patterns of interaction and 'emergent social properties' (Mennell 1980, p.51) and claim to produce insights into questions of collaboration and participation. At the heart of this body of work is a set of ideas about networks and networking which it is argued can form the basis of a new kind of social work suited to the complexities of contemporary practice.

While all the works fall within the domain of applied social science, they build upon ideas which originate within sociology, social anthropology and social psychology. A number of general influences, therefore, need to be acknowledged at the outset.

With the possible exception of 'Griffiths and Wagner: which future for community care?' all the works seek to develop and apply ideas which can be traced back to Simmel's attempt to develop a 'geometry of social space' (Cosser 1971, p.215) which included an early exploration of concepts such as 'mediation' and 'conflict resolution' (Simmel 1950, pp.122- 153). They also embrace the idea, further developed by Norbert Elias, that individuals are related to one another through 'networks of interdependency' and subscribe to the project outlined by Elias when he argued that 'one of the central problems sociology must set itself is to make these networks more transparent and thereby to prevent them carrying their members along with them so blindly and arbitrarily' (Elias 1978, p.108). A concern with making patterns of interdependency more understandable and controllable by those involved permeates the submitted works.

Network analysis has enabled the works to pursue these aims by re-framing the question of interdependency in terms of 'connectedness' (Bott 1971) and in doing so has made it possible for the works to address two key problems of social work theory:

- Social work and other social welfare practices need to find ways of working directly with individuals and families while taking into account the broader social context. Network analysis provides a meso-level analytic framework which forges links between the micro-world of individual interaction and the macro-world of economic and political forces. The works build on this to develop new network frameworks for practice.
- Barnes (1954), Mitchell (1969) and Bott (1971) opened up ways of thinking about the transition between the 'traditional' and the 'modern' in terms of the way in which individuals actively make choices and informally mobilise their social resources so as to respond effectively to the everyday challenges of their lives. The submitted works apply these ways of thinking about human agency in network contexts to problems of collaboration, participation and co-ordination in social work and social welfare.

The history of attempts to apply network thinking to social work practice begins in the 1970s (Speck and Attneave 1973). There was an early cross-fertilisation with systems approaches (Caplan 1974) out of which arose a central preoccupation with the characteristics of the social support network (Auslander 1987) so that by the 1980s a number of general models of professional intervention (Froland, Pancoast, Chapman and Kimboko 1981) were starting to appear alongside more specific 'brokerage' theories relating to self-help (Grant and Wenger 1983).

In the British context many of these ideas were absorbed into the community social work approach (Barclay 1982) which explicitly linked the social network approach to social work practice by associating it with the 'punctuating' of boundaries and the

setting up new 'chains of interaction' at a local level (Smale, Tuson, Cooper, Wardle and Crosbie 1988, pp. 62-66). Some aspects of this approach survived the demise of community social work, itself and were a strong influence on the early stages of the research programme. Atkinson (1986) developed ideas about ways of developing social support networks and Day showed how professional social workers could enable individuals to make the transition from institutional to community life by focusing on 'opportunities' and 'choices' (Day 1988, p.281). The most obvious link, however, is with the work of Philip Seed who used the term 'networking' to describe 'any action to develop, sustain or utilise the client's network potential' (Seed 1990, p.29).

The works are concerned with the inter-organisational dimension as well as the interpersonal dimension and so general theories about the changing nature of organisational structures and systems (Burns 1963) and more specific ideas about inter-agency linkages and 'teamworking' have exercised a considerable influence on them.

Studies of self-management and participatory decision-making in teams (Gilmore, Bruce and Hunt 1974) and attempts to formulate the problem of collaboration in relation to questions about values, assumptions and face-to-face interaction (Gregson, Cartlidge and Bond 1991, p.2) helped to shape the approach taken in the submitted works. In particular, insights about the relationship between 'social proximity' and the 'quantity and quality of communication between professionals' (Bruce 1980, p.69) led me to focus on the internal characteristics of 'collaborative networks' and research on the relationship between cognitive stances and 'protocols of behaviour' (Schon 1983, p.231) together with that on interprofessional language problems (Pietroni 1992, p.8) helped me to formulate questions about network culture.

Another area of applied social science which helped to shape the research programme is the literature on care management. Early American work emphasised service co-ordination (Austin 1983) and network meetings (Steinberg and Carter 1984, p.23). The first British experiments with care management similarly argued that higher levels of service integration would lead to higher levels of effectiveness (Challis and Davies 1986, p.219-231). Overall, it has been the principle of service mobilisation based on partnership rather than the more recent emphasis of the care management literature on service purchasing and centralised control, which has had the most influence on the submitted works.

The final major intellectual debt is to the pioneers of what has come to be known as 'emancipatory' or 'participatory research' which has been defined as 'collaborating with people to produce their own accounts and analysis' (Beresford and Croft 1993, p.74). This has been significant in that it has helped to move the research programme increasingly towards reflexive research methodologies and research questions focusing on the way in which action and understanding can be linked together.

### *1.3 The Research Programme as a Response to Change*

All the works submitted here can be located in a context of rapid organisational and professional change in the field of social welfare. The first edition of *Networking and Community Care* (not submitted here) made this explicit:

Case management, multi-disciplinary teamwork, the debate about citizenship and partnership and much else besides are busy transforming the nature of social work. Out of this process of change a new practice

is emerging which is clumsily but irrevocably known as *networking* (Trevillion, 1992,p.1).

It has been argued that all professionals operate in a 'habitus' which generates a 'feel for the game' (Bourdieu,1990,p.9). But a 'feel for the game' is dependent on predictability and a certain measure of stability. Change in the external environment brings this into question. The research programme tries to come to terms with the new challenges and opportunities facing social workers and in this way, restore to social workers a 'feel for the game'.

The 'habitus' of 1970's British social work in the aftermath of the Seebohm Report was dominated by the idea of delivering preventative services to the most 'needy' members of society (Jordan,1976, p.157-170). But the 1980's progressively demolished these 'categories of perception and evaluation' (Peillon 1998) and generated radically new conditions for practice encompassing new legislation, the organisational context of social work, the power of professionals vis-à-vis other stakeholders and far reaching changes in the nature of British society, itself. The effect was to raise questions about fundamental categories such as 'the nature and role of family', 'neighbourhood', 'community' and 'professional helping', 'the nature, purpose and organisation of social welfare' and the relationship between social workers, service users, carers and other professionals. As early as 1982 there were strong indications of a loss of public confidence in the profession and that social workers themselves were going through an identity crisis. 'There is confusion about the direction in which they are going and unease about what they should be doing and the way in which they are organised and deployed (Barclay,1982,p.vii).'

The Griffiths Report added to uncertainties by ignoring social work altogether (Griffiths 1988) and the arrival of a New Labour Government has done nothing to reassure those yearning for a return to the world of the 1970s. Instead, the theme of

partnership and the need for professionals to work much more closely with one another in new multi-disciplinary teams and alliances is a key feature of contemporary social policy. Professional social workers now inhabit a world utterly changed from that of the early 1970's. The focus then was on a professional service delivery role. It has now shifted to a preoccupation with ways of working closely with others to ensure that an appropriate range of services is delivered. Restoring a 'feel for the game' therefore involves creating a new 'habitus' associated with new skills, new ways of working and new definitions of roles and relationships. This is the fundamental challenge to which the research programme has sought to respond since its inception in the early 1980s.

#### *1.4 Theoretical Framework and Research Questions*

The nature and status of social work theory has been thrown into question by the rapid changes which taken place in the organisational and policy environments of social work practice. Howe, argues for a shift away from modernist certainties to a new kind of mission based on a postmodern awareness of uncertainty. 'The role of the social scientist and the social worker in the postmodern world is not to cure, control and legislate according to alleged universal standards but to interpret and understand one world and present it to another' (Howe 1994, p.523).

Postmodernism is not the only contender for the right to define the nature of contemporary social work theory. One of the most influential schools of contemporary social work is that associated with 'effectiveness research' (Macdonald 1994) which is rooted in a positivistic epistemology of a distinctly modernist kind. This appears to hold out the promise of new 'habitus' based on a self-consciously scientific approach to theory and practice but tends to ignore the problems raised by the postmodernists and others regarding truth and certainty.

These conflicts represent more than different ways of understanding the 'world' of social work. They represent struggles between different visions of that world. How do the works relate to these conflicts and what is the vision of the social work world to which they subscribe?

Within the context of ontological strife represented by contemporary social work theory, the research programme on social work and social networks sits somewhat uneasily, apparently straddling positions which others might regard as irrevocably opposed to one another. This is a direct result of the stance taken by many of the works which relate interdependency to processes of interaction deemed to have an objective reality even though they can only be grasped through an understanding of the meanings associated with them by those involved.

The questions and problems which the research programme has sought to address are congruent with this vision of the world. These include questions about the way in which new patterns of interaction can be promoted and how changes in these patterns of objective relations can generate new subjective perceptions about self and other. They also include explorations of the way in which network links can challenge existing power structures and open up new opportunities for empowerment, investigations of the relationship between skills, culture and network and critical deconstructions of professional and governmental rhetoric. This broad framework of ideas has also generated comparative approaches to the problem of collaboration, and re-interpretations of the globalisation concept in the light of social interaction theory, re-formulations of the problem of subjectivity from a social network perspective and attempts to re-define social work in relation to community partnership in general and the development and maintenance of 'task communities', in particular. Overall the attempt has been to find a new ground for social work theory which can generate



reliable 'categories of perception and evaluation' by addressing rather than ignoring complexity and uncertainty.

### *1.5 Development of the Research Programme*

The pattern of development in the works presented here is characterised by an overall concern with social interaction and the social work process, although, at times, the emphasis has shifted between policies and practices and from specific skills to background theories and concepts.

Although the earlier work on social networks and networking was strongly influenced by some of the technical features of social network analysis, this is less evident in the later work which tends to concentrate more on questions of power sharing and social inclusion. In recent years a major focus of the research has been the question of collaboration. What began as an interest in skills and skill development has extended into more fundamental issues associated with culture and subjectivity. At the same time, there has been a significant 'turn' in at least one strand of the research programme towards the use of comparative and anthropological approaches. This is exemplified in 'The Co-operation Concept in a Team of Swedish Social Workers' and 'On Being a Social Worker: Globalization and the new subjectivities'.

## **Part 2: The Works**

### *2.1 Welfare, Society and the Social Worker*

The first work differs from the others. It makes no mention of either social networks or community care. It is included here because it focuses, like many of the works, on the relationship between social identity and social interaction, the way in which interaction patterns can promote social inclusion or social marginalisation and the application of anthropological models (Douglas 1978) to studies of social work practice.

This work examines the social work interview as a 'status degradation ceremony' (Goffman 1968) and an argument is developed which draws on the concepts of 'liminal' spaces (Turner 1974) and classificatory 'anomaly' (Douglas 1978) to explain the processes lying behind this.

Other authors have also examined the helping process from a critical perspective and used phenomenological insights as an alternative to simplistic models of class struggle (Jordan 1979, Simpkin 1979, Rojek, Peacock and Collins 1989). The unique contribution of this piece is the central image of 'Welfare' as a symbolic inversion of the social order kept in place by the rituals of 'helping'. However, the argument proceeds as much by metaphor as by logical argument and this creates a number of problems.

Because it is so reliant on personal experiences, it is not clear how the model of 'welfare liminality' can be tested. One strategy which might have been adopted would have been to have identified some more objective indicators of the key processes. Semi-structured interviewing or group discussion methods of the kind used in some of

the later works would have added to both the richness of the data and the strength of the argument. As it is, what is left is suggestive rather than fully convincing. But what the piece lacks in methodological rigour is to some extent compensated for by the use for the first time within social work of anthropological models of liminality - originally developed to explore questions of socialisation and social integration - to illuminate questions of stigma and social marginalisation .

## *2.2 Conferencing the Crisis: The Application of Network Models to Social Work Practice*

In this article the processes of help and support are analysed through the lens of social network theory. Although this generates a new range of problems and questions, it also enables many of the methodological problems of the earlier work to be overcome by providing a set of meso-level concepts to bridge the gap between micro-level interactions and macro-level concerns about social marginalisation. The article also marks a major shift away from an exclusive focus on the client/worker dyad and towards a new focus on the relationship between 'normality', social welfare practice and social networks. This first attempt to link social work and social network theory is undertaken on a very small-scale using examples drawn from the author's own practice experience.

The subject matter of this work is the breakdown of social care networks. This is conceptualised as a process of crisis formation and the 'crisis system' is analysed from a social network perspective. This approach links the formal descriptive power of network analysis with the dynamism of systems perspectives. While not based directly on network assembly theories (Speck and Attneave 1973) the conferencing model has some connections with the network assembly principle of helping social networks to move from a 'dysfunctional' state to one which is more 'healthy'. But because it

focuses on the idea of the 'interwoven' network rather than the family networks which are the focus of 'network assembly' the article can also be located within the debates about community social work and inter-agency work.

At the core of the work is an argument for a practice strategy designed to transform a crisis prone 'dependency governed system' normally consisting entirely of an informal social network to a more open and interwoven 'reciprocity governed system'. This 'conferencing' strategy is defined as 'a way of structuring time and structuring relationships in order to enable the network system to move out of a position of crisis.' (p.302). By suggesting a 'partnership' response to emotional and practical needs (p.306), the work tries to establish a dialogue between the sociological concerns characteristic of community social work and the psychological theories and concepts associated with crisis theory (Caplan 1964) and crisis intervention (Langsley, Kaplan, Pittman, Machotka, Flomenhaft and Deyoung 1968). In this process social network theory is asked to play a particular role by mediating between concepts of 'community support' and concepts of 'crisis'.

Like many of the works, this one addresses both theoretical and practical problems. The central theoretical problem which it investigates is the relationship between the intensity and fragility of highly interdependent but non-reciprocal systems of care, the emergence of crises and their subsequent resolution through shifts in the pattern of interdependency. The practical problem which it addresses is how a conferences structure can be used to resolve a network crisis.

In so far as the article achieves its aims it is because the concept of 'crisis' is described in developmental terms, allowing the question of how to promote supportive relationships to be linked to that of crisis resolution without falling into the trap of seeing one as opposed to the other. But the work is formal and schematic and relies for its strength less on empirical evidence than on its ability to make sense of material

familiar to readers from their own practice. This is not entirely successful. A strategy like this can lead to the charge of convenient editing of the material to suit the argument and the absence of triangulation makes it difficult to fully rebut this charge.

The opposition between 'dependency' and 'reciprocity' now appears to be rather too simplistic (Morris 1993). The concept of 'dependency' has become highly politicised and identified with New Right critiques of the Welfare State (Hutton, Hutton, Pinch and Shiell 1991) with which this work might therefore appear to be aligned even though 'dependency' is here used as a synonym for 'directedness' and is opposed not to independence but 'reciprocity'. Another weakness of the argument is that it tends to ignore the possibility of real conflicts of interest and is rather too sanguine about the power of the social worker. In the light of subsequent work on participation (Beresford and Croft 1993), the article appears to have rather too much faith in the ability of the social worker to act as an 'honest broker', at all times. Overall, the argument would be strengthened by a wider range of practice examples although, even as it stands, it remains 'falsifiable' (Popper 1963) by social workers and others in practice situations.

In spite of these weaknesses, the idea of an intolerable intensification of meanings embedded in non-reciprocal patterns of exchange lends itself well to the practical problems presented to social workers and care managers and has contributed a model of process to the debate about social support.

### *2.3 Griffiths and Wagner: Which Future for Community Care?*

This piece was commissioned as a 'commentary' by *Critical Social Policy* on 'the Griffiths Report' *Community Care: Agenda for Action* and the Wagner report, *Residential Care: A positive choice*. It takes the form of a comparison, not only of two

government sponsored reports, but also, of two distinct ideologies. It includes predictions about the future as well as evaluations of policy and at the core of the argument is the assertion that 'in spite of the present hiatus, it is Griffiths rather than Wagner which is likely to determine the future pattern of community care' (p.73).

One of the distinctive features of the work is the use of a form of discourse analysis (Foucault 1972) which enables it to include reference to the way in which the reports establish their relationship to the reader and to link this to their ideological positions and positions within the political and policy-making processes, as well as to the content of the reports. Griffiths is described as 'the insiders report', whereas Wagner is described as 'the outsiders report'. The former is located within a pattern of centralised and exclusive decision-making while the latter is described as a 'public' document open both in its mode of investigation and the way in which it lays out evidence and conclusions. In this way, the work can be seen as an early forerunner of subsequent attempts to develop postmodern accounts of social policy (Taylor 1998).

The use of discourse analysis enables the work to argue that the reports are linked to two different concepts of community. 'For Wagner, the community is essentially the opposite of the stigmatising and coercive inheritance of the Poor law'. The Wagner Report is seen as identifying 'citizenship' as the route leading from stigma and segregation to full participation in community life. 'In the case of Griffiths, community has little to do with de-stigmatising public welfare. rather, it seems to be identified with the notion of the care "market" as a transforming agency'. The thrust of the argument is that the Griffiths concept of 'community' is defined in opposition to the perceived problems of State Welfare.

#### *2.4 Post-Griffiths Networking: A Study in Contradiction*

This was published shortly after the appearance of the commentary on Griffiths and Wagner and is in some respects a companion piece. Like 'Griffiths and Wagner: Which future for community care', this short article represents an exploration of aspects of the ideological shifts associated with community care. However, the focus of *Post-Griffiths Networking: A study in contradiction* is specifically on the way in which apologists for the reforms make use of terms such as 'networking' to describe social processes which have more to do with market and contract based relationships than the qualities usually associated with social networks. It therefore links the policy focus of the previous work with the core of the research programme on networks and networking.

The work surveys the characteristics ascribed to social networks by Barnes (1954), Bott (1971), Mitchell (1969), Whittaker (1986) Garbarino (1986) and Srinivas and Beteille (1964) and on the basis of this argues that more attention needs to be given to the experiential side of network construction and maintenance than is possible within the instrumental, market oriented activities promoted by those responsible for overseeing the development of the community care reforms.

A typology of network characteristics is introduced and used to strengthen the critique of orthodox case/care management. This is a theme returned to in the first edition of *Caring in the Community: A networking approach to community partnership*, which was published two years later. Overall, network analysis is used in this work as a tool for the critical analysis of social policy.

The weaknesses of the piece are largely those associated with its brevity. Fundamental ideas are introduced with little discussion or explanation and partly for this reason, the piece could be seen to imply that social networks in themselves contain and/or

generate certain kinds of progressive social values. This is self-evidently untrue and the fact that the article does not specifically address this point or seek to show how the properties of network fields can be analysed without making these kind of claims is a major weakness. Nevertheless, the central point that market relationships and network relationships are qualitatively different is clearly demonstrated. In the intervening years, we have seen how attempts to adopt market-driven models of care management and commissioning have failed to generate that elusive spirit of 'partnership' widely recognised as an essential component of community care, primary care and child care.

### *2.5 Networking and Community Care- A Cultural Issue*

This is an exploration of the relationship between culture and the new network-oriented practices being developed in the field of community care, a theme returned to in a more comprehensive fashion in *Developing Skills for Community Care*, jointly authored with Peter Beresford. This work focuses on the need for a 'new kind of language' - one drawing on concepts of culture to generate holistic understandings and practices.

The competing claims of different definitions of 'culture' are investigated, beginning with Schein's popular notion of 'basic assumptions' (Schein1985) and then moving on to consider the different conceptions of Durkheim, Malinowski, Levi-Strauss, Saussure, Bateson, Elias and Simmel. This survey leads to the conclusion that for social workers and others involved in networking and community care, the most helpful ideas are those which see 'culture' as an emergent phenomenon, not linked to unchanging clearly bounded social groups but coming into existence at particular times and in particular places as a result of the establishment of subjectively meaningful patterns of social relations. The 'culture bearing' and 'culture changing' potential of the networking paradigm is described as a 'meta-cultural practice' characterised by a



'concern with pattern and process, sensitivity to meanings, acknowledgement of difference, commitment to cultural empowerment and reflective methodology' (pp.16-17).

This is a highly theoretical and, in many ways, quite speculative paper but it introduces some ideas which are further developed in the later works. It was in some respects ahead of its time. When this piece was written, the concept of culture was almost exclusively debated only in relation to issues of ethnicity and 'multiculturalism' and therefore seen by many as of little value in wider debates about social policy (Anthias1992). In recent years, however, the culture concept has re-emerged as something which is of central theoretical importance to the study of social and public policy as demonstrated in the edited collection *Welfare and Culture* in which the most recent work will appear.

## *2.6 Developing Skills for Community Care: A Collaborative Approach*

This book is based on the central premise that networking and participative ideas have something distinctive to offer to the rapidly developing field of collaboration theory. This field can be traced back to early work on interprofessional health care groups (Gilmore, Bruce and Hunt 1974) and has since been dominated by visions of 'mutual understanding' and 'shared accountability' while lacking any clear ways of producing these desirable goals. *Developing Skills for Community Care: A collaborative approach* tackles this problem by looking at the relationship between inter-agency work, service user and carer participation and day-to-day service delivery.

The work is an analysis of the skills needed for effective community care practice and in particular, the skills needed to work together with a wide range of different 'stakeholders'. However, it is also an attempt to operationalise the culture concept introduced in the previous work and apply it to the sphere of community care. This

was the first research programme on the subject of skills and skills development to bring together the perceptions of nurses, social workers, service users and informal carers and to use the culture concept to evaluate the data, arguing that there is a specific 'collaboration culture' and that without it the ideals of community care cannot become a reality.

'Collaboration culture' is defined as a set of ideas and values generated by 'respect for difference and commitment to collective action' (p.15). Collaborative strategies are, thereafter, broadly defined as attempts to resolve this 'paradox'. Chapter one shows that 'collaboration culture' can be contrasted with both the bureaucratisation and standardisation associated with collectivism and the competitiveness associated with 'contract culture'. Collaboration is presented both as a culture and as a system of social support which can be compared and contrasted with alternative forms of 'care'. This is a form of Weberian 'ideal type' analysis which allows key characteristics to be identified and the point to be made that collaboration can 'transform community care policy and practice at every level' (p.23).

The book then examines the need for collaborative activity to be supported by the acquisition and deployment of a new set of skills and this leads into the major part of the book which is concerned with the description of a particular research and development project. Some of the initial questions facing the project are described in more detail in the methodology section but this part of the book also addresses some substantive issues such as the discovery of a close relationship between the way in which needs are perceived and the readiness to consider situations in terms of collaboration. Chapter three begins to explore some of the outcomes from the first stage of the project and in particular, the message of the community care diaries kept by professional participants. Issues such as the nature of interprofessionalism and the importance of negotiation are highlighted and debated. Chapter four begins to explore a number of core themes in depth including issues such as the building of relationships,

the implications of multiple perspectives and the handling of conflict. Chapters five and six are largely the work of Peter Beresford. Therefore I will not comment on them here except to say that they focus on the concerns of service users and carers and are integral to the argument of the book.

Chapters seven to nine are concerned with the results of the project and identify the skills associated with 'collaboration culture'. The book explicitly links these skills to the process of building a collaborative network . One other feature of the approach taken is the recognition of variable skill levels, combined with the discovery that even the most inexperienced practitioner can be expected to develop certain basic skills linked to core values.

The book is, essentially and simultaneously, an attempt to re-define the nature of collaboration, a comprehensive profile of collaboration skills and a plea for skills research to be undertaken in a more collaborative spirit. It is only one among many books and articles devoted to the subject of collaboration published in the 1990s ranging from the general (eg. Alter and Hage 1993) to specific works focusing on the care programme approach (eg. Dube 1995) and community care (eg. Ovretveit 1993). There is an existing literature on relationships between health and social care professionals and it is not alone in seeking to develop a profile of collaborative skills (eg. Payne 1993). Where it is unusual is in its approach.

Rather than trying to clearly limit or separate the subject of collaboration from all the other issues associated with community care, the project which the book describes locates collaboration within the context of a far-reaching set of challenges to the nature and direction of welfare (pp.1-3) and links it to the full involvement of the various stakeholder groups. This is reflected in the methodology which is not concerned with conventional concepts of training but instead with helping individuals and groups to use their experiences as a starting point from which to develop their ideas about

working together. The concept of 'stakeholding' has attracted considerable interest but the debate relating to it has been conducted at the level of political philosophy (Deacon 1998) and neither before nor since the publication of this book, has there been another attempt to explore working with stakeholder networks in a developmental framework.

This stakeholder approach undoubtedly creates some difficulties. From time to time, the focus of the book is uncertain as it stays with the various issues raised by the discussion groups as these flow across the whole landscape of community care.

However, the benefits are clear by the end as the groups forge a consensus about what seems significant to them. In many ways, it is not the profile of skills which is most interesting, but the process used to define them. In principle development projects like this could be duplicated across a range of social policy and social services issues and make a major contribution to the review of fundamental concepts and assumptions..

While this book draws on the concept of 'networking' as well as that of 'involvement', it focuses more on the qualitative characteristics of particular linkages and the skills needed to develop 'collaboration culture' than on the ways in which organisations might set about developing collaborative networks within the constraints imposed by their histories, resources and external opportunities. The organisational pre-requisites and entailments of collaboration are under-researched, perhaps inevitably so, given the methodology and overall aims of the project. The next phase of the research programme (represented by 2.7) sought to gain greater insight into collaboration in a particular organisational context.

## *2.7 Talking About Collaboration*

'Talking about Collaboration' summarises the results of research on two social work teams in the London Borough of Camden. This work analyses patterns of network

interaction in considerable detail. It demolishes a number of conventional beliefs about collaborative working in the 1990's and therefore can be described as 'negative research' within the context of a rapidly developing literature on teams and teamworking which can be traced back to the 1970s but which had received a major impetus from the community care reforms of the 1990s - rightly perceived by many people to depend on the successful working together of different groups of professionals in multi-disciplinary teams (Webb 1991, Ovretveit 1993). Although this literature had generated some valuable insights it had tended to rest on some unexamined assumptions about the nature and direction of teamwork that 'Talking about Collaboration' sought to question.

Discourse analysis is used to expose the underlying assumptions of dominant concepts of teamwork as exemplified in the work of Payne (1986). This world picture is contrasted with that which emerges when talking about the pattern and mode of social interaction. A key distinction is made between two kinds of 'talk'- Standard Collaborative Talk (SCT) and Specific Interactional Talk (SIT) - and this distinction underpins the argument. Unusually, discourse analysis is combined with network analysis to produce these two paradigms and the piece as a whole is methodologically eclectic, combining qualitative and quantitative approaches.

The limitations of the argument are those imposed by the small-scale nature of the research project on which it is based. It does not show that conventional teamwork is a chimera, nor does it contribute to the debate about the relative success or failure of collaborative initiatives. To answer these questions one would need a different kind of research project. Rather, the strength of the piece lies in the way it questions commonly held assumptions about collaborative processes and relationships, for example, it shows there is no necessary connection between 'liaison' activity and practical collaborative work and suggests that the presence of well developed

networks focused on individual social workers may not always contribute to the growth of collaborative networks focused on teams and organisations.

## *2.8 Towards a Comparative Analysis of Collaboration*

This paper set the scene for a major re-orientation in the research programme, in that for the first time, the questions asked are comparative and specifically European in nature. It picks up and develops themes present in the previous work, beginning with a critical review of the way in which collaboration is discussed in the British literature. The argument echoes aspects of that put forward in 'Talking About Collaboration'. But here it leads to an attempt to re-conceptualise the problem of collaboration rather than to simply critique the dominant discourse.

'Comparative approaches have been strikingly absent from discussions about community care. But arguably it is only through the process of comparison that it will be possible to discover the new and more holistic perspectives which are needed if we are to make progress in developing a framework for thinking about collaboration'  
(p.14)

The comparative approach is, in short, seen as a way of gaining a better understanding of the process of collaboration and therefore, ultimately, a way of understanding the British experience more fully than would otherwise be possible.

The article suggests that conventional distinctions between institutional (British) and solidarity oriented (Continental European) welfare systems (Spicker 1991) mask the real distinction which is one of an opposition between State and Community in British thinking which has little parallel in Continental Europe and the absence of a professional language within the UK capable of linking the objective of social

integration to policy, law and practice in a coherent way. The work argues that new developments in community care now make it vital to establish such a language. It also argues that the question of collaboration has emerged as a central one right across Europe, as institutional structures are increasingly found to be wanting and new forms and modes of relating are explored in a number of different European countries.

This work differs from conventional typological approaches to the problem of comparison (Midgley 1997, pp.92-97) by focusing on a shared problem (of coherence) to which there may be different responses. While this article is theoretically ambitious, it is limited by its reliance on secondary data about European systems. It exposes the limitations and ethnocentrism of some contemporary British thinking but it cannot do more than indicate a new set of research questions focusing on the empirical exploration of different solutions to the problem of 'coherence' and in particular the relationship between welfare rationales and day-to-day patterns of linkage across organisational boundaries (pp.18), a theme which is returned to in one of the most recent works 'The Co-operation Concept in a Team of Swedish Social Workers'.

## *2.9 The Globalisation of European Social Work*

This article focuses on the impact of globalisation on European social work and in particular the way in which it has become associated with new patterns of work and accountability which are '...reshaping the fundamental values and philosophies upon which modern European social work has been built' (p.1). It is related to the theme of social networks and social work in two ways. First, it constitutes part of the broader comparative project outlined in the previous work. Second, an interest in globalisation is the logical outcome of an interest in patterns of interaction and interdependency which cross boundaries of all kinds. There are clear precedents in the work of Elias on

the 'civilising process' (Elias 1982) - one of the corner stones of early global theory and even in some of the much earlier statements by Simmel.

Building on the aspects of contemporary globalisation theory (Robertson 1992), this work starts from the premise that globalisation is both an objective and subjective phenomenon. The article looks at the various waves of globalisation that have brought social work to Europe and now are serving to transform it. The modernist core of what we have come to regard as traditional social work is traced back to the 'Americanisation' of Europe in the post-war period and this complex of ideas and practices is contrasted with the more recent wave of globalisation which is seen as containing a postmodern epistemology associated with new forms of governance and new types of inter-organisational 'networked' patterns and modes of service delivery.

In focusing on the way in which the identity of social work has been moulded in the past by the trans-national movement of individuals and ideas and is now being re-moulded by the global market-place, the article implicitly takes issue with the proponents of comparative theories of social work based on the emergence of distinct welfare regimes. While the argument for the existence of such regimes may be valid, the article shows that neither purely national perspectives nor perspectives based on mutually exclusive groupings of states can account for key professional developments. In this respect, the article can be seen as a critique of aspects of the work of Cannan, Berry and Lyons on European social work (Cannan, Berry and Lyons 1992) as well as more generally pointing to the limitations of the welfare regime thesis, itself (Esping-Anderson 1991).

The other major debate within which the work can be located is that about post-Fordism, on the one hand and postmodernism, on the other. While these debates have gone on in parallel and to some extent have been seen as opposed to one another (see Carter and Rayner 1996), it is suggested here that they should be seen as



complementary aspects of the same historical development. One of the strengths of the work is the way in which political, economic and organisation theories are brought together and applied to the dilemmas of contemporary social work. Out of this community care emerges as a 'transitional discourse'

The concept of 'globalisation' itself is, perhaps, taken too much for granted in the article which could be accused of seeing it in reified terms as a historical/economic/technological force rather than as an explanatory framework or theoretical construct. However, in practice, the argument escapes from any tendency towards determinism by linking globalisation to the opening up of social work discourse to a range of different 'voices'. This reintroduces agency into the debate about global networks and serves to counterbalance what might otherwise be a major weakness in the work.

### *2.10 The Co-operation Concept in Team of Swedish Social Workers*

This work aims to help to establish a cross-national framework for the analysis of community care but focuses largely on one ethnographic study of a team of kurators or medical social workers based in a hospital in north Stockholm. It builds on the ideas originally introduced in 'Towards a Comparative Analysis of Collaboration', especially that of an empirical investigation of the relationship between patterns of interaction and patterns of thinking about the problem of coherence in a post-institutional climate of welfare reform.

Midgley has recently characterised approaches to the study of comparative social welfare as either concerned with comparing social conditions or social services (Midgley 1997, pp 12-14). To this can be added the welfare regime approach of Esping-Anderson (Esping-Anderson 1990) and in social work, in particular the vignette group discussion model associated with studies of child protection systems

(Cooper, Hetherington, Baistow, Pitts and Spriggs 1995). All encounter serious epistemological difficulties and only the latter resembles, in any way the anthropological approach taken here. But whereas the vignette approach relies on perceptions of one system from the vantage point of another, the approach taken here tries to escape from the problems of relativism by combining intensive ethnographic techniques with an analytic framework based on a re-interpretation of Douglas's 'grid and group' analysis (Douglas 1973, pp.77-92).

In a way which has links with earlier critical analyses of collaborative theories and assumptions in for example 'Talking About Collaboration', the starting point for this work is the continued influence of progress theory and social evolutionary paradigms. It begins with a discussion of the continuing influence of Darwinian and diffusionist metaphors in debates about community care and proposes a rejection of nineteenth century ideas in favour of a comparative matrix based on the 'grid and group' analysis, in turn, based on Bernstein's concept of 'restricted and elaborated code'. In this re-formulation, however the focus shifts away from a Neo-Durkheimian classification of societal 'types' to an investigation of a problem associated with social change where the key issues revolve around the collapse of institutional care and the search for new public meanings. In particular, the matrix which is created directs attention to the problem of negotiating new meanings across boundaries and without the dichotomous certainties associated with institutional regimes.

The rest of the chapter is concerned with making use of new primary research data from Sweden to begin to fill in some of the spaces in the model. This material allows explorations of ideas and values to be undertaken concurrently with analyses of interaction patterns and a grid and group analysis of welfare systems enables the work to explore the problem of establishing new welfare rationales for cross-boundary working.

The broad thrust of the piece is to show how ideas and patterns of interaction are intertwined with one another and how the co-operation concept can be distinguished from the dominant UK models of collaboration. The strengths of the work are derived mainly from the richness of the data and the use of the overall analytic framework to locate specific ideas and practices in a broader context of cultural change. The main limitations are those of most forms of qualitative inquiry. It cannot claim to have uncovered a 'Swedish model' only one that exists within a particular network in a very specialised area of social welfare provision. Likewise, no attempt is made to engage in a formal comparative analysis. But by showing how one particular social work team in one particular place is involved in networking and thinking about its network practice the chapter contributes some data to the broader exploration of alternative strategies for solving the cultural problems associated with the introduction of community care.

### *2.11 Social Interaction Theory and Social Work*

This chapter aims to lay the groundwork for a new approach to social work theory, arguing that current developments within social work have led theory into a cul de sac of competences which conceals a retreat into pragmatism and the effective fragmentation of the intellectual basis of social work. In many respects this critique echoes that of a number of recent commentators such as Howe who have argued that the intellectual moorings which at one time gave shape and consistency to social work have come adrift (Howe 1994). However, it tries to go beyond simply charting the contours of this problem and argues that a coherent framework of ideas is still a possibility and that these ideas are to some extent already present within the broader domain of social science theory in the form of theories and concepts of social interaction.

A series of related propositions about social work are examined, starting with the proposition that 'social work theory is a theory about the relationship of the social worker to a matrix of social relations...' (p.71) and looking at the potential of different kinds of game theory to offer explanations of the kind elaborated on by this and subsequent propositions. The work concludes that a version of Simmel's ideas combined with those of Moreno and the network analysts offers a sound basis for social work theory and suggests that theories of this kind may also be more compatible with a shift towards participation and social inclusion than those derived from more traditional paradigms.

The major strengths of the piece lie in its synthesis of theories and models and the systematic way in which theoretical prerequisites are made explicit. The major weakness is that no empirical demonstration is given of how a theory of this kind might actually make a difference to the practice of social work. However, the problem which the chapter addresses is not primarily, one of action, but rather, one of thought. It is not argued that social workers cannot intervene effectively in particular situations but that they cannot do so knowing that their actions are grounded in a coherent sense of what social work is. Therefore this empirical weakness is not perhaps, as significant as it might at first appear.

### *2.12 Networking and Community Partnership*

This forthcoming book builds on three research projects in the UK and Sweden and also draws on the personal experiences of the author as a social worker. It is the second edition of a book originally published in 1992 by Longman under the title of *Caring in the Community: A networking approach to community partnership*. The new edition will be published by Ashgate and the manuscript is currently at the copy editing stage. It is in this form that it is submitted.

One of the features of social work as a discipline over the past twenty years has been the retreat from serious debates about methods of intervention. There have been few attempts to go beyond the well established categories of individual casework, groupwork, family work and community work. This may, in part, be due to a belief that all possible levels of intervention are to be found somewhere in this range of methods and there is literally no need or space for any other method. To the casework orthodoxy that dominated the 1950s and early 1960s (eg. Biestek 1961) was added community work (Gulbenkian 1968) and groupwork (eg. Papell and Rotham 1966) in the 1960s and subsequently family therapy (eg. Walrond-Skinner 1976) and behavioural methods in the 1970s. From then on the focus shifted to broad strategies rather than specific methods. The three most important of these were the unitary method of the 1970s (eg. Goldstein 1973), the radical social work movement of the 1970s (eg. Bailey and Brake 1979) and the community social work approach of the early 1980s (eg. Barclay 1982)

While the networking approach espoused by the book has some links with the values of radical social work and more especially community social work, it has more in common with some of the earlier 'methods' in that it is concerned with skills, techniques, roles and processes. Networking can thus be seen as a contribution to the methods literature but one which tries to link the question of 'method' to fundamental questions about the nature and purpose of social work in a rapidly changing society. The book is an attempt to develop a theory of networking and to show how this theory can be applied to illuminate key issues associated with both task and role in a complex social welfare environment. It is designed to address the need to establish partnerships which recognise difference but simultaneously allow people to work together. While adopting a critical attitude to some of the rhetoric surrounding the partnership principle, the book draws on stakeholder theory, theories of collaboration and applied

social network analysis to produce accounts of assessment and intervention in a number of areas including care management and child protection.

The context within which this work should be located is the long-standing debate about the role and contribution of informal processes of communication and mobilisation to the promotion of social welfare aims and objectives whether couched in terms of 'well being' or 'quality of life'. Most of the literature in this field draws implicitly or explicitly on concepts of 'social support' and 'social network'. The latter, in particular can be traced back to the pioneering work of Bott, Barnes, Mitchell and others between 1954 and 1969.

The early work on social fields or social networks only began to be applied to the analysis of social welfare problems and issues in the 1970s with the advent of 'network assembly' (Speck and Attneave 1973) but soon began to influence a wide range of research programmes from those associated with exploring the 'buffering of stress through network relationships (Cassel 1974) to those more concerned with family and neighbourhood networks (Collins and Pancoast 1976). By 1981 some of these authors were trying to build sophisticated models or typologies which identified different types of social networks and network strategies for 'linking formal and informal support systems'. Certainly, by the middle of the 1980s a distinctive vocabulary and approach had emerged with writers such as Grant and Wenger suggesting that professionals could act as 'brokers' while setting up self-help schemes. The community social work movement incorporated many of these ideas and they continue to influence many aspects of community care planning and provision.

While *Networking and Community Partnership* draws on many of these earlier paradigms, it differs from all of them in one key respect. Virtually all of those who have made use of applied social network analysis have seen themselves as working either with family or neighbourhood networks or within the territory defined by Bayley

as the 'interweaving' of informal and formal systems of care (Bayley 1978). In contrast, this book seeks to develop a paradigm of networking which is not identified with any one type of network but rather is focused on the task of creating partnerships of all kinds across the whole field of social welfare activity.

Although the work is biased towards social work and social workers, reference is also made to community work and health promotion. It is not dominated by traditional concepts of 'neighbourhood' or 'community'. Rather, the key concept around which it is organised is the idea of 'cross-boundary work'. The need to find ways of transcending the limitations imposed by organisational, cultural and professional boundaries drives the argument forward and locates it within current debates about new ways of thinking about and organising social welfare. It does not embrace market ideologies but can nevertheless be legitimately described as a book about the post-welfare state in that accepts that the future direction of social welfare is likely to lie in the direction of cross-sectoral and inter-agency partnerships of all kinds rather than with collectivist institutions.

This is a book about welfare practice but it is also a book about theory. Although it has a number of secondary aims it should be judged principally on the extent to which it fulfils its aim of developing a 'general theory of networking'. Much of this is contained in chapter two which consists of an extended discussion of a five-fold model of networking composed of:

- the re-structuring of the interpersonal domain
- building communities
- promoting flexibility and informality
- maximising communication possibilities
- mobilising action-sets

The form of the argument is an exploration of each one of these elements in turn using evidence from three research projects together with evidence drawn from practice experience.

The other key theoretical chapter is Chapter 4 in which the concept of 'community brokerage' is introduced and analysed. Community brokerage is defined as 'strategic linking work which is associated with the development of community partnerships and task communities'. This focus on linking work separates it from the advocacy tradition associated with service brokerage (Brandon 1995). Rather, it builds on mediation principles outlined in the first edition of this book in 1992 and which have subsequently been applied to a wide range of social welfare problems and tasks (eg. Dube 1994). It is here, in relation to community brokerage that the concept of a 'task community' is developed. 'Task communities' are described as complex networks containing many differences, yet able to generate some sense of common purpose and identity. It is these special kind of networks with which community brokers are concerned and the chapter analyses the various sub-roles or role 'components' associated with the process of making and maintaining these 'task communities'. Some might see this extension of the community concept into a world of complex task based roles as both illegitimate and unnecessary. However, the justification is that partnerships can only become meaningful to those involved if they begin to generate some of the qualities commonly associated with community life and that the problems currently associated with building successful partnerships may, in part, be due to the failure to attend to this issue.

In seeking to outline both a general theory of networking and a more specific theory of community brokerage the book runs the risk of confusing the reader but some attempt is made to avoid this by stressing that while brokerage is an aspect of networking not all forms of networking involve 'community brokerage'. This is exemplified by the discussion of inter-agency networks in chapter 5 where agency networks based on



central co-ordination ('systems brokerage') are distinguished from those which are based on shared responsibilities (the 'representation' principle).

The book does not attempt to answer all the questions one might have about networking and the conclusion raises some new questions about evaluation and issues around power and control. Nevertheless, it remains optimistic about the potential of 'relational' concepts and perspectives (Wasserman and Faust 1994, p.4) for developing new and imaginative solutions to the problems of welfare.

### *2.13 On Being a Social Worker: Globalization and the New Subjectivities*

This work sets out to develop a 'sketch for a new model of "professional" subjectivity' (Trevillion 1999, p.1) linking individual subjects to concepts of 'culture', 'interdependency' and 'figuration'. The context in which this should be seen is a debate about the nature of social work which has been heavily influenced by the broader crisis of confidence in the profession but which has also been shaped by responses to hermeneutics (Yelloly and Henkel 1995), postmodernism (Lane 1997), globalisation and managerialism (Dominelli and Hoogvelt 1996) and the drive towards competency based models of practice (CCETSW 1989) and ways of researching 'effectiveness' (Macdonald 1994).

The work acknowledges that the question of subjectivity is central to social work and social work theory but argues that this does not imply a collapse of theory into complete relativism and individualism. Rather, there is an attempt to link the question of subjectivity to that of social interaction and in particular, the specific patterns or 'figurations' within which social work is practised and about which social work theory might speak. By relating subjectivity to changing patterns of professional interaction 'On Being a Social Worker' is able to re-frame the debate about social work and social

work identity within the context of a debate about complexity and globalisation. This, in turn, leads to a focus on the question of culture and the ways in which 'technologies' of social care can generate new cultures through their ability to generate new types and patterns of social network. To this end, the relationship between the new systems associated with the delivery of community care and the re-ordering of network relationships is used as an exemplar.

However, the work avoids implying that culture and subjectivity are determined by technology. Rather, what is proposed is a comparative project focusing on the 'relationship between felt experience, culture, technology and social network which would seek to explore the different "figurations" and subjectivities emerging in the context of globalization'. Globalisation itself, is perceived less as a monolithic force and more as a way of talking about cross-national tendencies towards the re-configuration of working relationships.

One of the strengths of the piece is the way in which it draws together the threads of a number of different debates and shows that they are connected with one another. This produces a countervailing weakness. The complexity of the argument is such that it sometimes verges on being confusing rather than clarifying and it is probably only the examples which prevent this from actually happening. As it is essentially a call for a new wave of comparative studies drawing on concepts of culture and 'figuration', the value of this piece is probably best judged in hindsight, in that the strengths and weaknesses of the conceptual framework are only likely to become evident in the context of trying to develop the empirical work which needs to follow.

### **Part 3: Concluding Statement**

At the beginning of this review, it was suggested that the works as a whole have sought to create a new *habitus* for social work associated with a new view of the professional world. This has gradually become clearer as the research programme has developed. It is one associated with an expertise in the exploration of interdependencies and opportunities in a context of change and uncertainty. To this project, the works have contributed a number of new perspectives and insights associated with a view of social workers as network specialists.

The roots of the programme lie in my experiences as a social work practitioner, even if in recent years this has been augmented by a series of research projects. Although much of what has been submitted might be regarded as general theory all of it is an attempt to enable social workers, community workers, nurses and others to work more effectively within the context of a rapidly changing and potentially confusing welfare environment. In that sense, it should be regarded as theory for practice rather than simply theory about practice.

A claim for originality runs through this review. It is one based on the critical and comparative analysis of current practices and the development of a set of interlocking concepts of network intervention. While many of the works focus primarily on community care, the core concepts of 'networking', 'community partnership', 'brokerage' and 'collaboration culture' are applicable to a wide range of activities including child protection and health promotion. It has been argued that by introducing these and other related ideas to the literature on social work and social welfare practice, a significant and original contribution has been made to the development of the discipline at a time when fundamental questions are being asked of it.

# Welfare, Society and the Social Worker

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STEVEN TREVILLION

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## SUMMARY

This article attempts to locate some common stereotyped transactions between social workers and their clients as elements in the production of distinctive welfare identities. By comparing this process to that of a rite of passage, the client is found to be like a ritual subject frozen in the moment of transition between social categories and thereby denied a place in society. An opposition is accordingly presumed to exist between Welfare and Society. The matrix of stereotyped expectations which derives from this opposition is shown often to intrude on the relationship between social worker and client, constituting a pressure to resolve the tensions produced by anomaly through the imposition of a welfare identity on the client. In this respect, the special vulnerability of marginal groups is noted and a brief discussion then follows of the characteristic qualities of ascribed welfare identity. Through Welfare, Society is found to displace imaginatively its sense of entropy beyond the moral community. But the essential link between Welfare and Society remains and increasing social disorder brings the paradoxical feature of this strategy to the fore. The preservation of the social order requires increasing concentrations of entropy to be symbolically located in Welfare and as a result Welfare comes to take on the aspect of a threatening and subversive entity. In conclusion, it is suggested that behind the apparent 'crisis' in social work lies a crisis in the management of social entropy.

As a practising social worker, I am uncomfortably aware of having a role other than that of professional altruist. With many of my colleagues, I share a sense of participation in some grim ritual of social decomposition evoked and enacted in tandem with the recognized interactions of the social work process. Being unassimilable to 'professional' awareness—that state of mind which permits the organization of work in advance and its explication after the event in ways deemed appropriate to a 'therapeutic' task—this unnerving sense of things falling apart has no language with which to manifest itself directly. Rather, it constitutes an aura of disenchantment or, more precisely, an ironic counterpoint to the events of any social worker's day. It comes closest to the surface in that black

humour which is the characteristic currency of office conversations in any social work agency. These jokes conjure up a world in which the canons of the therapeutic model are rigorously over-turned. Both social workers and clients are herein represented as respectively ludicrous and perverse, bound together in mutual dependence in a crazy dance of death. At one level, such jokes can be seen simply as mechanisms for the release of tension and frustration; but at another, they clearly allude to a profound unease which cannot find expression in any other way.

This unease is all that is left of a 'discursive field'<sup>1</sup> effectively silenced through its transformation into a 'professional' model. This field is created and simultaneously denied by the social work process. To reconstitute this field we cannot rely on any of the categories of 'professional' thought as these belong to the phase of denial. We are forced to base our search for an explicit representation of the silenced discourse of Welfare on the confused sensation of a world turned upside down that is part of the shared subjectivity of social worker and client.

To base an analysis on something as poorly defined as this invites the criticism that this is purely a personal view. In so far as my own subjectivity is a key element in this account, the charge is justified. However, I would argue that numerous statements made to me or in my hearing by my colleagues and clients lead me to think that, in this account, they will find an echo of their own feelings.

The social work process attains its paradigmatic form in the interview. The 'professional' model of the interview represents it as structured around a client's needs and problems both internally and in its relations with preceding and succeeding interviews.<sup>2</sup> The role of the social worker is seen as one of catalysing the production of these interviews. By implication it is assumed that the social work process is, in itself, somehow embedded in the client. But recent work suggests that neither social worker nor client comes to the interview as a *tabula rasa*.<sup>3</sup> Both try to fulfil certain pre-determined needs and expectations. Both try to re-play primal developmental experiences and relations. This leads to a more sophisticated view of the interview as a tangle of convergent processes which the social worker is responsible for teasing out. Even so, the picture is incomplete. The interview is not merely a meeting place for social worker and client; it is a pre-existent niche within the framework of a Social Services Department. This niche is more than a space available for worker and client; it has its own implications which impose themselves on those within it.

As large bureaucratic organizations, welfare agencies, e.g. Social Services Departments, seek to manage their relations with the outside world by certain intake criteria.<sup>4</sup> The distinctive characteristic of welfare agencies is the way in which these criteria are anthropomorphosed so that there exists an unofficial typology of clients.<sup>5</sup> In so far as this has been

internalized by the interviewing social worker, there is pressure on the client to conform to an appropriate image. In order to provoke an acceptable response he or she is forced into a stereotyped portrayal. This is essentially an 'educational' process through which people learn how to become clients. Help is not directly available, rather it is filtered through certain client images and these images generalize problems and identify them with individuals. Typically, request for financial assistance is successful only in so far as the client is prepared to accept its encapsulation in an image of 'inadequacy'. This is not to suggest that financial problems may not conceal psychological or family problems but that the image of 'inadequacy', however it is expressed professionally, does not have a therapeutic function. Rather, it seems to have the purpose of marking out the person requesting help as 'a client'—one separated from other citizens by his or her 'clientness'. This ascribed quality of 'clientness' distinguishes the client from the social worker and through him from society at large.<sup>6</sup> This process occurs invisibly and in parallel with the casework relationship. The social work interview can thus be seen as a 'status degradation ceremony' whereby 'normal' identity is swamped by a deviant 'master status' which has the effect of retrospectively re-constituting the client as a deviant.<sup>7</sup> Such an explanation has the merit of drawing our attention to the complex play of 'normality' and 'deviance' in society. In this perspective a Social Services Department would have a role in the manufacture of deviance and my own experience accords well with this. But it becomes necessary to go beyond labelling theory if we wish to examine the full significance of the relationship between 'normality' and 'deviance' in the welfare context. 'Deviance' is not just distinct from, it is a contradiction of 'normality' and as such constitutes an inversion of the social fabric. In a sense, where deviance exists, society is suspended. Curiously, the most detailed work on the suspension of society has emanated from a concern with the analysis of social integration. Van Gennep<sup>8</sup> followed by numerous other researchers has established that the 'life-crises' of birth, marriage and death are the principal shaping moments in the life of an individual in society. As the word 'crisis' implies, these events constitute breaks in the surface of social experience, moments of transition from one state to another. These transformations are so radical that they need to be mediated by '*rites de passage*'. The social order is embedded in these rituals; but in themselves they occupy the spaces between social categories, acting as both mediators and boundaries. For example, a wedding mediates between the single and the married state and simultaneously differentiates the two.

Lying outside the normal flow of experience, 'rites of passage' often occur in special locations, e.g. churches, examination halls, hospitals—and may have their own rules of conduct, distinct from or even opposed to

those operating in the outside world. Following his symbolic separation from society, the ritual subject is in what Victor Turner has termed a 'liminal phase'. 'Liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention and ceremonial.'<sup>10</sup> It is as if only by a return to some primordial and essentially non-social condition of flux can the necessary metamorphosis occur and a new category arise, as it were, from the ashes of the old.

'Life crises' can thus be defined as moments of transformation which add up to a pattern of discontinuity. This pattern is an image of society inherent in its totality even in the liminal phase of a rite of passage, so that in the moment of its dissolution there is an assumption that society will return.

But let us suppose that the circle of dissolution and re-creation were broken and the ritual subject frozen in the moment of his transformation, in-the act of crossing over from one social category to another. Threshold points have no social content except as absences and negations. Through them we fleetingly experience a sense of radical dislocation and social death. For such a liminality to exist permanently in society implies the existence of rites whose purpose is not to effect social transformations but to assign certain social groups and individuals to this liminality, a condition of absence and in a certain sense non-being.

The labelling processes which have been found to exist in the practice of social work can be seen as rites which through the assignation of individuals to welfare liminality constantly re-affirm its tangible existence. The characteristic form of liminality is contradiction and in one way or another all those who are seen as belonging to Welfare are regarded as anomalies. Welfare is of and for anomaly.<sup>11</sup> Labelling can be seen as leading to a dramatic contrast between those who are and those who are not anomalous.

Anomaly is omnipresent. That which is and that which ought to be are rarely identical. However, by the deft use of social masks we, for the most part, succeed in maintaining our model of the world intact. Public admissions of anomaly tend to be confined to minority groups.

Those who are referred to Social Services Departments have often made public admissions of anomaly, i.e. their fundamental social identities have been brought into question even before they meet a social worker. Nevertheless it is in their contact with social workers that the full inscription of liminal status occurs, building on the original anomalous presentation. To give an example, in our society, the statuses of unmarried woman and mother are mediated by marriage. An 'unmarried mother' who finds that she needs to approach a Social Services Department for help may find that her problems are 'read' as anomalous features in the broad context of her status as an 'unmarried mother'. This 'reading' may be done through, as well as by, a social worker. The client/worker relationship

occurs in a matrix of expectations and highlights issues which others may re-constitute as evidence of a fundamentally flawed social identity.

Not long ago I became involved in such a case which shows the way clients can become the focal points of a system of contradictions. A young girl who had been consistently unable to resolve her relationship with her family and who had been labelled 'very disturbed' at school had recently been released from prison where she had been sent following a petty theft from a boyfriend. When sentenced, she was already pregnant and the baby was born before she was released. She wanted to keep the child with her. Her mother at first agreed to allow her to return home but within a few days she was forced to leave as a result of arguments. She thus became homeless and I became closely involved in trying to find her somewhere to live. As her social worker, I quickly became aware that in many quarters there was an expectation that I would take the baby 'into care'. The grounds for this action were thought to be so obvious as not to require detailed explanation. From this perspective any help which I could offer my client would later be transformed into evidence against her. This 'evidence' could essentially be summed up as a set of contradictory attributes.

As a single mother she contradicted the established view that children can only exist in marriage. In addition she appeared to possess other attributes antagonistic to the image of 'motherhood'. She was known to be willing to resort to her fists in an argument. Motherhood in our society evokes images of stillness, selflessness and peace to which any aggressive assertion of self is alien.

She was homeless and motherhood in our society is intimately associated with 'the home', the symbol of the private domain, the zone of affection and reproduction, the place at which the day begins and ends, the still centre of society.

She was thought to be 'disturbed' and thus unwholesome. In our society there is a tendency to regard the purity of the child as sustained by the purity of the mother from whom he draws his strength. This notion of maternal purity receives its ultimate expression in the image of the holy virgin and child.

She was thought to be a criminal and crime is associated with an antagonism towards society in direct conflict with the dissolution of the self in the act of physically and symbolically reproducing society.

In spite of the fact that there was no evidence of any serious neglect or cruelty towards the child, I was acutely aware of a steady increase in pressure on me to resolve the anomalies produced by the case. A resolution would have taken the form of some statutory action. This action would have institutionalized these anomalies by encapsulating them firmly in a welfare context. A new identity would thereby have been forged for my client. Luckily, I was able to resist this pressure and eventually she moved to



another area of the country. Welfare identity is thus simultaneously a resolution and institutionalization of anomalous identity.

An anomalous identity is the product of any claim to conflicting identities. It has the effect of destabilizing the classification system through which a society experiences itself and the world.<sup>12</sup> Such a system relies on the integrity of its boundaries. Anomaly implicitly threatens the social order. Where questions of social identity are involved the confusion of elementary social categories is embodied in individuals who are as a consequence imbued with a threatening quality for society as a whole. Paradoxically, in this way, the least powerful in our society appear to have the capacity to unsettle our view of ourselves and the world.

This is not a coincidence. Anomaly is not a property of any one group in our society but its potential effects are so disastrous that there is a strong impulse towards its management or concealment. Only those without social, political or economic resources are unable to do this. For the rest of society a threat to the integrity of social identity is invariably countered by stressing other non-contradictory attributes. This management of anomaly is possible because of the way in which social representations are metaphorically related. To give a single example, membership of a local 'Round Table' is assumed by those who know of it to imply other equivalent statuses in terms of money and family stability. Any suggestion of unorthodox behaviour such as 'adultery' or 'wife battering' can be to some extent counter-balanced by stressing the respectability of the subject in other areas of his life, the implication being that any discrepancy between familial conduct and other conduct is the result of some special circumstance and that essentially the subject remains a good family man.

Social resources are in this way transferable. Where discrepancy cannot be corrected all other statuses may become affected and the subject may experience a rapid social disintegration.

Some of the most interesting modern examples of this in England have been associated with 'spy scandals' centering on highly placed members of the governing elite.<sup>13</sup> Through the continuous interchange of social resources, social identity like water finds its own level. But there is a threshold point below which the process by which all social components are metaphorically related, starts to operate in a negative register. Those suffering from a total social economic and political 'poverty' may find that a collapse in any one area such as the loss of work may be enough to prefigure an anomalous social identity. Unable to bolster their social boundaries, they can only watch, spectators at their own disintegration as beings with a viable social identity—a disintegration encouraged by recourse to welfare agencies. The welfare relationship results in a reading of the associated problems of unemployment as evidence of the anomalous identity indicated by unemployment itself.

If society indeed experiences itself as a moral system<sup>14</sup> it does so as much by exclusion as inclusion, that is some are not of it and constitute a point of reference in opposition to which it can distinguish itself. The moral force of society is in this way claimed by those with sufficient social resources to maintain an elementary social identity unsubverted by anomaly. On the outer edge of this '*Gemeinschaft*' are those 'marginal' groups<sup>15</sup> whose social resources are barely enough to permit them to remain within it. These groups not only have a low capacity for successfully concealing anomaly but they are more exposed to the likelihood of disastrous circumstance causing a strain on whatever resources they possess. In this way they constitute a barometer of social entropy.

There is an intimate relation between crises of social identity and the condition of society. The former are both products and indirectly symbols of entropy in the latter. In our society entropy often takes the form of a growing disjunction between ideology and economy. At the same time as unemployment is manufactured in the economic system, the notion that adult male status is dependent on being in full-time work is fiercely upheld. This dysfunction is concealed behind a 'smokescreen' which consists of a theory whereby the unemployed are suffering from a weakening of moral fibre and are essentially to blame for their own plight.<sup>16</sup> Entropy is denied but the price of that denial is the scapegoating of certain groups in our society and in the act of denial a tension is created between the social order which is precariously maintained and the forces which are disrupting it beneath the surface. The scapegoats become not only offerings to entropy but representations of the tension created by its denial.

The rupturing of the moral/social order is displaced onto certain individuals in the form of blighted social identities but these identities themselves constitute a problem for society. Having created a nemesis society is forced to contain it. An anomalous identity is a challenge to the social order. If an anomaly is an emblem of chaos it is at root without structure and so without any boundary. Like 'dirt' it threatens to 'pollute' all around it.<sup>17</sup> The creation of welfare identities can be seen as a strategy for containing this 'pollution'. These identities are located not in Society but in Welfare as it is continuously created through the operation of institutions such as the DHSS and Social Services Departments.

In the same way that a special location may be sought out for a rite of passage, thereby containing its dangerous transformative energies, so likewise the welfare institution provides a place apart where chaos may be safely exhibited and contained. The welfare institution may be conceived of as a permanent invitation to express anomalous identity. It is an invitation which is only accepted when there is nowhere else to go; for the welfare institution is the location of a fundamental exchange. Continued physical existence is guaranteed and various immediate problems may be removed

whether financial or social but all normal social roles must be rendered up. Those who come to rely on welfare agencies are removed from the map of Society and enter on a new and ghostly existence in Welfare.

Having encountered a number of people in this position I think it is possible for me to make certain generalizations about the consequences of this. Firstly, such a person no longer has a direct relationship with Society. Most of his communications are mediated by one or more welfare agencies. This may result in the client or 'welfare case' being merely a spectator as different agencies negotiate about him or her. Secondly the 'welfare case' is deprived of the ability to generate new communications. He or she is preceded everywhere by the information contained in his or her file. The past directly shapes the present so that there is no possibility of spontaneity or innovation. This leads on to the third characteristic—the silence of the 'welfare case'. As everything is already thought to be known about him, no attempt is made to communicate with him. Instead a dialogue is manufactured with the file so that the client becomes little more than the vehicle for an elaborate ventriloquism. The whole performance is essentially repetitive, the projection of identical images of inversion whether in life-style or psychology onto those who have been forced to render up their social identity.

It is the dominance of the files<sup>18</sup> which paradoxically helps to maintain the non-historical character of welfare encounters. Yet it is the files which place these encounters diachronically. That this is merely a surface embroidery rapidly becomes evident if certain case files are subjected to a simple experiment on the following lines.

Remove all dates and then try to place the separate interviews in an order which would indicate some sense of progression. All too often, the last interview could be substituted for the first. Through the files, ritual masquerades as history. Even the arrival of new social workers barely affects the fixed character of the interactions recorded.

Relations between Society and Welfare are represented at the microscopic level by the ritualized transactions that occur between individual social workers and those of their clients, who have Welfare identities. If these relations are understood to be fundamentally characterized by opposition, many apparent mysteries are resolved. Although the meaning of different terms applied to those clients, for instance 'manipulating' or 'impulsive' may be superficially distinct, they all share the same negative value. Content or meaning is less significant than value and where the client is ascribed a negative value, the social worker is ascribed a positive one. Clients may be described by mutually contradictory terms but the value of those terms is consistently negative.

The welfare domain comes to encapsulate all that is anomalous in social experience. Entropy is projected onto certain individuals who are thought

to inhabit a separate domain beyond Society. An attempt is made thereby to symbolically purify the social order which is another way of saying that Society seeks to deny itself through Welfare. In doing so the fantasy of Society becomes dependent on the fantasy of Welfare. By opposing itself to Welfare, Society experiences itself as a moral entity. But chaos does not in reality emanate from Welfare and so, like a boomerang, entropy relentlessly returns to Society. Only by maintaining and accelerating the process of projection can an unstable equilibrium be preserved. As simultaneously person and non-person, the client with a Welfare identity is forever caught at the moment of his social dissolution. Here is the paradox. Society attempts to exclude Welfare but cannot do so because it needs some object on which to project its fantasies. Thus the welfare scapegoat never finally disappears into the figurative desert beyond Society like his biblical antecedent bearing the sins of the community but rather remains poised at the point of departure. Society cannot break its link with Welfare.

The strategy of transferring the experience of disorder to a carefully demarcated welfare zone would appear to operate relatively successfully so long as society remains relatively stable and the transfer of negative energy is also constant. However, if social disorder increases as it is doing at the present time in this country then the amounts of negative energy also increase as frantic attempts are made to re-affirm the workability of present social structures. As welfare institutions come to embody more and more entropy, they come to seem increasingly threatening. No longer simply convenient containers of disorder, they come to represent bases of subversion, reaching out to destroy Society.

The current fantasies<sup>19</sup> surrounding those who are dependent on welfare institutions would indicate that there may be some truth in this model.

The traditional opposition between Welfare and Society was camouflaged during the 1950s and 1960s by the heady optimism of the post-war social planners and their assumption that society was perfectable. One might wish to question even then how deeply entrenched was the notion that Welfare was simply an aspect of the general reconstruction of Society. But certainly one can link its decline with the change from a society which saw itself as expanding to one which sees itself as no longer growing economically and embattled by a universe which seems increasingly hostile. Now that the latter condition prevails the relationship of Welfare with marginality has come to seem one based on containment rather than reclamation.

As the shadow of Welfare lengthens over Society there has been a feverish bolstering of the boundaries separating the two. The controlling qualities of welfare institutions have come increasingly to the fore and one would expect this to continue (note, for example, the growth of statutory work in Social Services Departments). In the nineteenth century similar

processes led to the development of the Workhouse—a physical expression of the ‘great containment’.<sup>20</sup> In the present political and economic situation a similar crystallization of institutional responses to social disorder is surely not beyond the bounds of possibility.

The apparent crisis in social work is really a crisis in the relationship between Welfare and Society. By refusing to acknowledge anomaly as a part of social experience we have removed ourselves from a crucial source of transformation and regeneration. This energy grown threatening in exile now seems poised to revenge itself on Society.

## REFERENCES

1. Michel Foucault in *The Archaeology of Knowledge*, Tavistock, 1972 develops the notion that events can be read like statements within the framework of a discursive field and that the discovery of such ‘fields’ is open as an empirical enquiry. My own use of this concept differs from his because the discourse in question here is unrealized in overt statements—‘professional’ language—resulting in a far more tangential methodology.
2. The ‘professional’ model is not the product of any one school of social work, rather it is that broad tendency to regard the social worker and his or her agency as a purely responsive helping technology.
3. See Jordan, B. (1979) *Helping in Social Work*, Routledge and Kegan Paul, which can be contrasted with his earlier (1970) *Client-Worker Transactions*, Routledge and Kegan Paul, which still adheres to a ‘professional’ analysis of the social work interview.
4. Brown, R.G.S. (1975) *The Management of Welfare*, Fontana, p. 129.
5. Stereotyping of clients is a product of the ‘rationalism’ inherent in bureaucratic structures; Weber, M. (1947) *The Theory of Social and Economic Organisation*, Talcott Parsons (ed.) Hodge, pp. 324–325, 328–335; working in conjunction with labelling processes, see for example Goffman, E. (1968). *Stigma: Notes on the Management of Spoilt Identity*, Pelican. The agency thus manufactures its consumers.
6. *Ibid.*, pp. 11–55.
7. Schur, E.M. (1971) *Labelling Deviant Behaviour: its Sociological Implications*, New York, Harper and Row, p. 30.
8. Van Gennep, A. (1960) *The Rites of Passage*, Routledge and Kegan Paul.
9. Turner, V.W. (1974) *The Ritual Process*, Pelican, pp. 80–81.
10. *Ibid.*, p. 81.
11. For a detailed examination of the whole field of anomalous entities in society see Douglas, M. (1978) *Purity and Danger; an Analysis of Concepts of Pollution and Taboo*, Routledge and Kegan Paul.
12. Levi-Straus, C. (1972) *The Savage Mind*, Weidenfield and Nicholson.
13. The best known examples of this genre are ‘The Profumo Affair’ and ‘The Anthony Blunt Affair’.
14. Durkheim, E. (1954) *The Elementary Forms of the Religious Life*, London, Allen and Jones.
15. Herbert Marcuse (1972) suggests in *One Dimensional Man*, Abacus, pp. 199–200, that certain social groups have been excluded from society and through this exclusion constitute a potentially revolutionary force.
16. This is discussed by Jordan, B. (1976) in *Freedom and the Welfare State*, Routledge and Kegan Paul.
17. Douglas, M. (1978) *Purity and Danger: An Analysis of Concepts of Pollution and Taboo*, Routledge and Kegan Paul.
18. Bureaucracy is inseparable from files. See Weber, M. (1947) *The Theory of Social and Economic Organisation*, Talcott Parsons (ed) Hodge, pp. 326–335.

19. As scapegoats welfare recipients have a long ancestry. Norbert Elias (1978) *What is Sociology?*, Hutchinson and Co., p. 27, suggests that in the case of both Jews and plague victims 'anxiety and unrest about social miseries found release in fantasy laden explanations identifying socially weak minorities as the troublemakers and culprits so leading to their slaughter'.
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# CONFERENCING THE CRISIS: THE APPLICATION OF NETWORK MODELS TO SOCIAL WORK PRACTICE

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## SUMMARY

This paper is an exercise in model building. An analysis of social networks as systems of exchange leads to the conclusion that crisis referrals to social workers are generated by a particular kind of network and a particular mode of exchange. These modalities are characterized as modalities of dependency and are contrasted with those of reciprocity. It is further suggested that a model of 'good practice' for social workers can be logically constructed from this model of network process. The paper ends with a description of conferencing as an effective social work response to network crisis.

The bulk of social care in England and Wales is provided, not by the statutory or voluntary social services agencies, but by ordinary people acting individually or as members of spontaneously formed groups, who may be linked into informal caring networks in their communities. Care of this kind is often maintained only at great personal cost to the carers. For example, a substantial proportion of those receiving help, and in particular the very old and people with chronic physical handicaps, are largely or entirely dependent upon one caring person—often an unmarried relative and usually a woman. The demands made on the individuals concerned can become enormous, and it is scarcely surprising that some break down under the stresses and strains involved. The informal caring networks, in

other words, are vulnerable and fragile, and it is precisely when they give way that large numbers of referrals are made to social services departments and voluntary agencies. If social work policy and practice were directed more to the support and strengthening of informal networks, to caring for the carers and less to the rescue of casualties when networks fail, it is likely that the need for such referrals would be reduced. (Barclay, 1982, pp. 199–200).

Community social work may aspire to the elimination of crisis referrals to social work agencies, but crisis continues to be the characteristic point of initial engagement between 'informal caring networks' and social workers. When networks 'fail', there is likely to be what O'Hagan has called a 'plea for removal crisis' (1986, pp. 40–54). It is this 'plea' which often constitutes the social work referral and draws the social worker into the 'crisis system' (O'Hagan 1986, pp. 61–8).

In such a context, homeostatic models of network process are of limited value. What is needed is a model of network change capable of describing the characteristic features of network crisis. Moreover, descriptive adequacy is not enough. The practice value of any model of network crisis will be governed by the extent to which it is possible to derive from it guide-lines for 'good practice'. How far do existing models meet these requirements?

Present research on the subject of informal caring networks has been largely generated by the debate as to their existence as a significant form of caring (e.g. Abrams, 1980). As a result there now exists a rich descriptive literature confirming the prevalence of informal caring networks in at least some parts of the country (Wenger, 1984). There is also a useful literature on some of the qualitative aspects of family care (Nissel and Bonnerjea, 1982). Somewhat separately, there has been a continuation of the sociological tradition of network analysis (Garbarino, 1986) which has focused attention on the significance of exchange in network systems.

Whilst we may now know something about the homeostatic qualities of stable network systems, with the exception of Nissel and Bonnerjea's study we know next to nothing about the factors leading to network breakdown. There have been methodological reasons for this in some cases (Wenger 1984, p. 119). But there has also been a general lack of interest in crisis studies perhaps because crisis has been associated with the failure of the whole enterprise of community care.

But crisis need not be the end of prevention. An active engagement with the 'crisis system' can take the form of network 'support and strengthening'. In other words there is a 'community social work' response to network crisis.

But we do not yet have a theoretical model on which to base practice. This paper will attempt to build such a model by applying a set of



principles drawn from exchange theory and systems theory to material from my own experience as a social worker and material derived from published research. It will seek to show that there is a 'logic' of crisis in network systems which can be derived from the 'logic' of stable network systems but which is quite distinctive and characteristic. It will also seek to show that this 'logic' can be used to develop a method of social work intervention in network crisis. This method will be called conferencing, but will focus less on decision making as such and more on the ways that a network can be helped to move out of a position of crisis by attention to factors of network process.

## NETWORKS AS SYSTEMS OF EXCHANGE

Social groups have a clearly articulated structure which has been well defined by a number of sociologists. Not so networks. It has been difficult to define networks except in terms of what they lack. Elizabeth Bott combines a positive definition of a social group with a negative definition of a network.

In an organised social group, the component individuals make up a larger social whole with common aims, inter-dependent roles and a distinctive sub-culture. In network formation, on the other hand, only some, not all of the component individuals have social relationships with one another. In a network, the component external units do not make up a larger social whole; they are not surrounded by a common boundary (Bott, 1957, pp. 58-9).

This tendency towards negative definitions reflects a theoretical problem in defining something which does not appear to be generated by 'top down' principles of social organization but rather by 'bottom up' processes of social interaction. Even in a relatively 'close-knit' network, the high level of 'connectedness' is a function only of the number of relationships between 'component units' (Bott, 1957, p. 59). This is not to say that there is no link between 'network formation' and social structure. Relatively close-knit networks are for instance associated with relatively high levels of social homogeneity (Bott, 1957, pp. 103-12). But network growth is always organic and incremental.

The strength of a group lies in its internal structure and organization; the strength of a network lies in the quality and quantity of links between 'component units' and ultimately individuals.

Network links have to be constantly re-forged through face to face contact and therefore, characteristically *the pattern of network relationships is indivisible from the processes of network interaction.*

Whilst it may be the case that there is a potential for a network

relationship in a certain type of social context, without a process of social interaction there can be no manifestation of this potential. It is not enough, for example, that two people should live next door to each other, for them to have a neighbourly relationship. They might not even know each other's names.

According to Garbarino (1986, p. 35) networks are founded on the principle of 'mutual exchange'. In the case of a neighbourly relationship, 'mutual exchange' could and often does cover anything from feeding each other's pets to caring for each other's children if one or other is sick. In addition, holiday souvenirs and birthday and Christmas cards may well be exchanged across the garden fence. It is characteristic of informal networks that instrumental actions and expressive gestures become woven seamlessly into the fabric of relationships. The mobilization of social resources and the development of emotionally supportive relationships go hand in hand as different aspects of the network exchange process.

As time passes, mutual exchange is likely to become increasingly rule governed. Spontaneity will become less important and a sense of mutual obligation more so. The subjective reality of a network exchange system will be a system of mutual obligation. Following Mauss's classic description of gift exchange (1970, pp. 37-41), we can divide this into an *obligation to receive and an obligation to repay*. At any one time these different obligations will be distributed around a network. But they are also stages in the network process and so with each sequence of exchange, the obligations rotate around the network.

#### ZONES OF EXCHANGE

Network relationships can be mapped in accordance with a principle of *relative frequency of exchange* where frequency is defined as the number of exchanges with ego in any one period of time. The ratios of exchange can be represented by a series of concentric rings. The central 'zone' will be characterized by a high frequency of exchange and the outer 'zones' by progressively lower frequencies of exchange (see Fig. 1 for a hypothetical example).

In Fig. 1, ego's relationships with A B C D E F G and H are distributed among the various 'zones' of exchange. The boundaries between zones are arbitrary but serve to clarify the relative position of particular relationships in terms of frequency of exchange.

It is more likely that two people in frequent contact with ego will be known to each other than that two people in infrequent contact will be known to each other. In other words, the higher frequency zones of exchange are also likely to be higher intensity zones of exchange. Where a

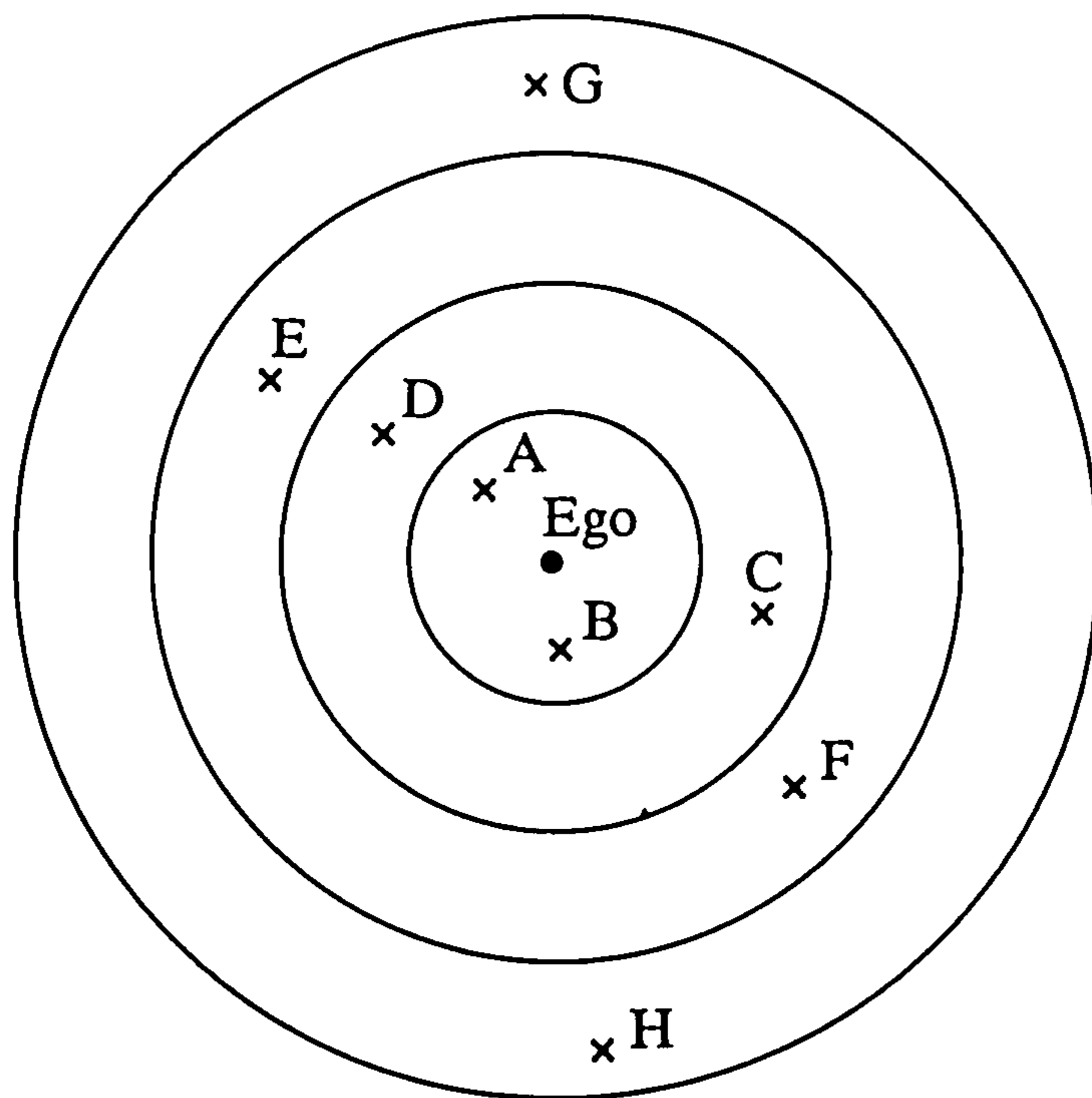


FIGURE 1.

network is composed of core and periphery, the core will be relatively 'close-knit' and the periphery relatively 'loose-knit'.

A sequence of network exchange is a 'text' which is constantly 'read' by those actively involved in the exchanges. This 'reading' constitutes the subjective meaning and emotional significance of the network relationship. A highly differentiated system of exchange will have a highly differentiated set of these readings. If we assume there is a link between level of contact and level of mutual emotional investment then the ratios of network exchange will delineate zones of relatively high or low levels of emotional investment. The core of a network would be an area of relatively high mutual emotional investment and the periphery would be an area of relatively low mutual emotional investment.

This hypothesis seems to be challenged by the fact that some people with whom one is in only infrequent contact may be of core emotional significance e.g. a brother or sister who emigrated to Australia many years ago.

It would be foolish to believe that a map of network exchange could constitute a comprehensive map of internal meanings. But it does provide a guide to those meanings which are invested in active relationships, i.e. the social dimension of meaning. Moreover active relationships tend to attract emotions and meanings to them. The next door neighbour whom one sees every day may come to resemble the brother or sister who emigrated to Australia and whom one has not seen for many years.

Personal memories are in this way expressed in day to day network interaction.

The generally lower level of emotional investment in peripheral relationships leads to a higher turn-over of these relationships than is the case at the network core. Peripheral relationships may over a period of time attain core significance and as it were gravitate inwards. But in many cases they will disappear and be replaced by new relationships.

The existence of a peripheral zone of exchange is associated with network growth and permeability and the dominant mode of exchange in such a network is likely to be mutual or reciprocal exchange.

#### FROM RECIPROCITY TO DEPENDENCY

Reciprocity governed network systems are likely to be both flexible and resilient. They will have a 'capacity to mobilise individual and collective responses to adversity' (Barclay, 1982, p. xiii) and therefore meet the Barclay definition of 'community'. As a result they are unlikely to generate the kinds of events or relationships which lead to a significant level of social work involvement. *A network is likely to generate a social work referral only after reciprocity has given way to dependency as the dominant mode of exchange.*

An increase in the dependency needs of individuals can have a significant impact on the whole modality of relationships in their networks.

The transition from reciprocity to dependency can be sudden as when an athletic and highly sociable man is seriously injured in a car accident and suffers brain and spinal cord damage which confines him to a wheelchair. The victim of the accident in this example may well be cared for by relatives such as his mother, wife or sister at considerable cost to their own social and professional lives. They may virtually cease to go out of the home and fewer and fewer of their old friends and acquaintances may continue to call to see them.

Alternatively, the transition may be gradual and cumulative, as when, over a period of years, a previously active and intelligent older woman becomes progressively more forgetful. At first, relatives, most probably a daughter, may do little more for her than her shopping to prevent embarrassing incidents. After a while however the confusion may worsen and a doctor may diagnose senile dementia. The daughter may then start to pay all her mother's bills. When her mother loses her pension book, the daughter may take charge of that, as well. Eventually, the daughter with or without help from the local Social Services Department may spend most of her day caring for her mother, cooking her meals and supervising her to prevent injury. By this stage, if not before, the

daughter will probably have had to give up her job and both she and her mother would probably be dependent on benefit income. The final stages of caring in this example would probably exclude all but a few social contacts. Mother and daughter would probably spend most of their time alone together.

The time frame may be different but the shift in the modality of relationships is the same in both examples. This transformation in the pattern of exchange can be represented diagrammatically.

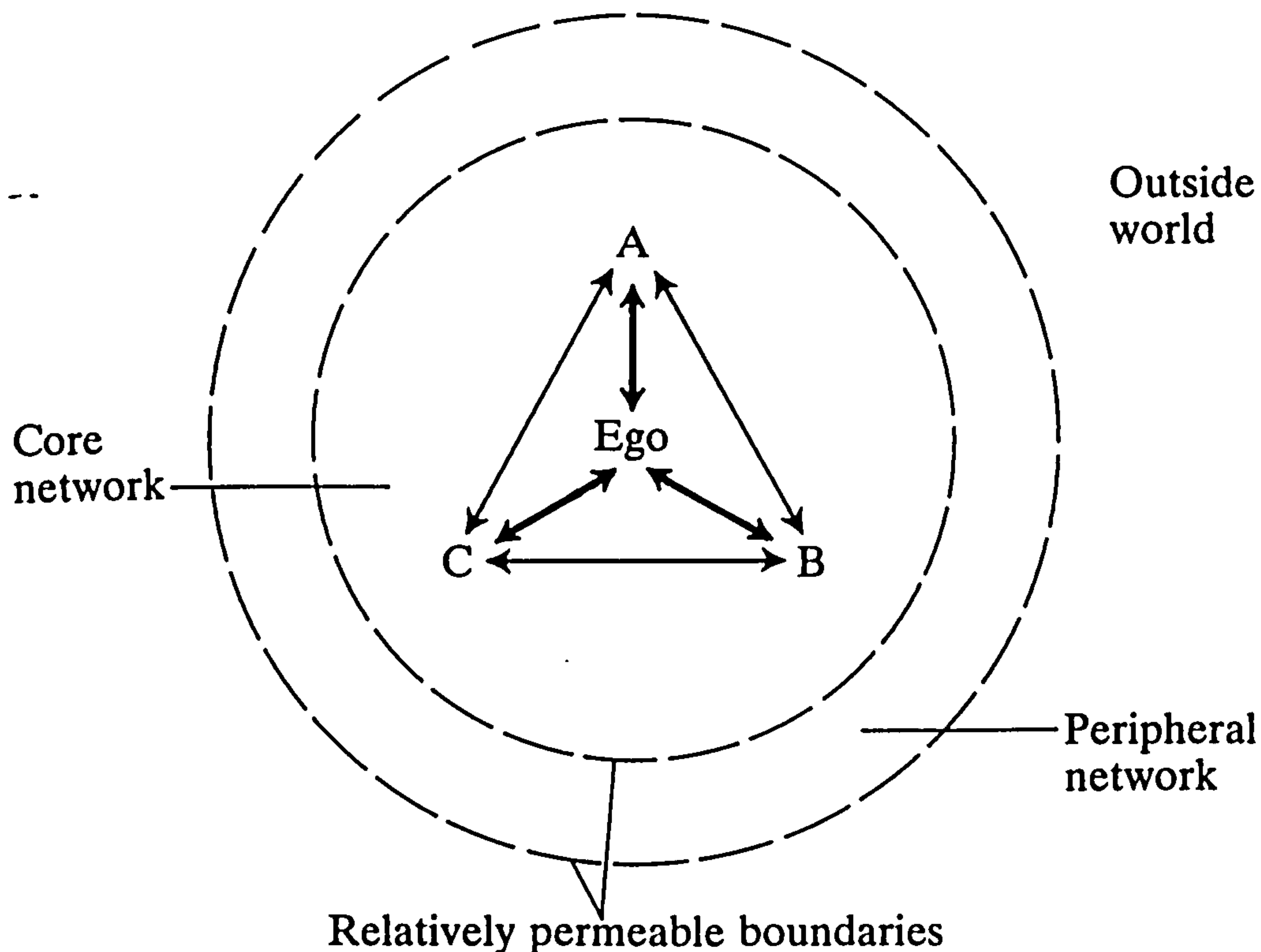


FIGURE 2.

Fig. 2 represents a hypothetical three person core network around ego set within a less intensive field of peripheral relationships. The total network boundary and the boundary between core and periphery is relatively permeable and the whole system is characterized by reciprocity.

Fig. 3, on the other hand, represents the same network after dependency has replaced reciprocity as the dominant mode of exchange. The network boundary is now relatively impermeable, reflecting the isolation of the network. There is no longer a distinction between core and periphery, so there is no zone of growth and change. The relationship between the 'carers' is now relatively weak and the main emphasis is on

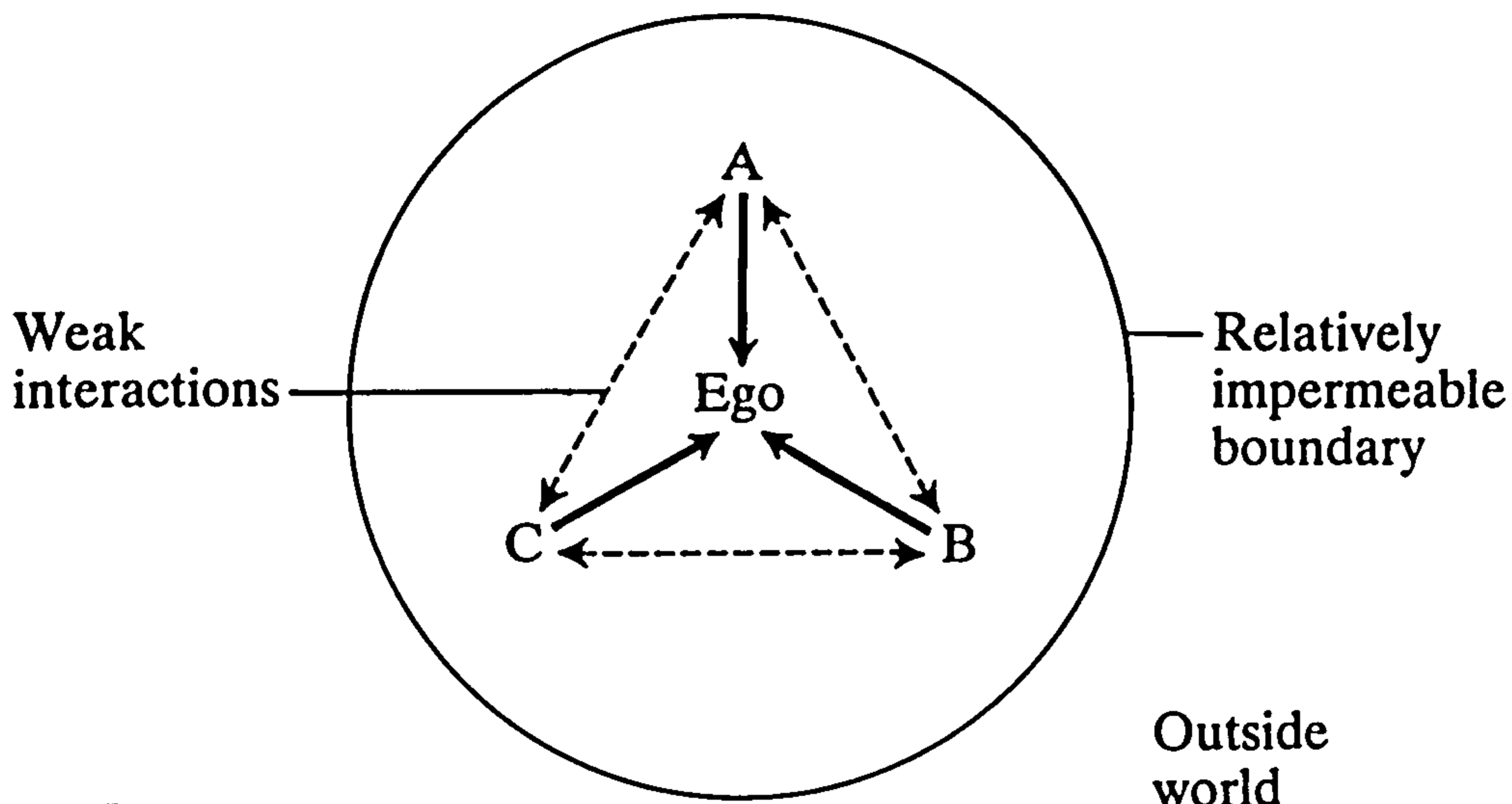


FIGURE 3.

interaction with ego. There is little reciprocity in this system which is dominated by the systemic implications of dependency.

A network which has lost its permeable outer skin and is reduced to a tightly bounded set of 'core relationships' is more likely than before to become a 'crisis system' and to generate social work referrals. For example, in the field of mental health 'small high density networks' are apparently predictive of 'schizophrenic episodes' (Taylor *et al.*, 1984, pp. 129-40).

The loss of the peripheral network has an effect on the values and meanings embedded in the residual network. Every act of exchange helps to develop or confirm an individual's 'personal constructs' (Kelly, 1955, pp. 105-83). If the possibility of new experience is reduced then network exchange is likely only to re-confirm existing meanings and values. *Under these conditions networks become increasingly orientated towards the past, impermeable to the outside world and resonant with fixed values and meanings.*

#### THE ISOLATION OF DEPENDENCY GOVERNED SYSTEMS

Isolation has been defined not just as lack of human contact but also as 'the absence of role relationships' (Bennett, 1980, p. 15). Isolation, in both senses, permeates dependency governed relationships.

People with a high level of dependence on the care of others tend to have a restricted range of social contacts. They also tend to be cut off from any way of identifying themselves except as 'invalids', 'patients', 'confused elderly', etc. These labels constitute a role of a sort but one in which an inability to be a 'useful member of society' appears to be a pre-

condition of its performance. For 'carers', the picture is remarkably similar. The strain of 'caring' often makes other more highly valued roles unviable. Many 'carers' are forced to give up paid work in order to continue caring for a dependent relative. Work roles have a relatively high status attached to them. 'Caring', on the other hand, is unpaid work and particularly if undertaken by a woman tends to be subsumed into a general notion of the caring/nurturing role of women. A low status deriving from gender based expectations is attached to 'carers' and this cannot compensate for the loss of higher status work roles. 'Caring' seems to require a withdrawal from the public sphere into the private sphere with a consequent loss of status and self-esteem.

Isolation from the 'outside world' and the sources of self-esteem inherent in it seem to go hand in hand with the mutual isolation of 'carers' who often have little time to see each other. Self-esteem can be significantly enhanced by mutual support (Barclay, 1982, pp. 76-7). But the 'caring' task is often so demanding that 'carers' cannot meet except for some immediate and practical purpose. As a result carers suffer a progressive erosion of their frameworks of emotional and practical support and the support they do get is likely to be highly ambivalent and conditional. Family and friends may feel neglected and put pressure on them to reduce their 'caring commitments'. This pressure can take many forms. Sometimes it can be quite explicit and uncompromising. A 'carer' once told me that she would have to reduce her commitment to her elderly neighbours because her husband had threatened to divorce her if she did not and her children had supported her husband in his ultimatum. In this sort of situation a 'carer' may feel unable to ask for support for fear of generating further loss of support.

Dependency governed relationships appear to generate 'isolation' and even individual acts of 'caring' seem to evoke a sense of what has been lost or 'sacrificed' in order to make them possible. Carers may be forced to turn inwards on themselves and on their relationships with those dependent on them for a sense of purpose and meaning.

At first sight the stability, perhaps even the very existence, of a dependency governed network appears to be problematic. 'Carers' seem willing to increase their contact with someone whose dependency needs are increasing and in so doing they seem prepared to suffer a loss of status, self-esteem and mutual support. Rational self-interest may play a major part in the peripheral exchange system of a network and perhaps accounts in large part for its disappearance in conditions of dependency but seems to have little influence on the actions of those who remain in the residual network.

Furthermore, the lack of reciprocity in a dependency governed network seems to cast doubt on whether it can be considered an exchange

system at all. In Fig. 3 ego seems to occupy a systemic position rather like that of a 'black hole' in astronomical theory, receiving everything and transmitting nothing.

Up until now, this paper has tended to equate exchange with the tangible gifts and services circulating within a network. This is now clearly inadequate as it cannot describe the type of exchange characteristic of a dependency governed system.

Every act has a consequence. 'Feedback' is part of any system of relationships (Bateson, 1973, p. 245). Exchange need not be conscious and explicit, it can be unconscious and implicit.

In an extreme dependency governed system such as the 'informal caring network' of a confused elderly person, every act of 'caring' will evoke a consequence even though the elderly recipient of services may be unable to respond or even to express gratitude. In so far as the 'informal caring network' continues we can assume that the consequences of 'caring' create the necessary conditions for other acts of 'caring'. This mechanism can only be understood if we see acts of caring not as spontaneous altruism (Titmus, 1970, pp. 209-21) but as expressions of a socially conditioned and gender specific 'obligation to care'. It is no accident that the roles of 'carer' and 'woman' seem often to meet and merge (Barclay, 1982, p. 200). Caring is an attempt to repay a 'debt' which can never be discharged because it has become fused with the identity of the carer. Caring validates the obligation to care whilst responding to its imperatives.

The isolation of carers enforces a preoccupation with their caring. The values and meanings generated by their caring are therefore likely to become of central importance in their lives. This leads 'carers' to become progressively dependent on those who are dependent on them. This is the exchange which stabilizes a system in which there is little overt reciprocity, rather its pivotal point lies on the boundary of the internal and external worlds of the carers.

The sign of loss is written across dependency governed network systems. Loss leads to dependency but dependency also generates loss. The 'cost' of caring is the loss of other significant roles and relationships but the 'sacrifice' of these roles and relationships paradoxically reinforces the central emotional significance of the caring task. *The carer's role becomes more 'meaningful' as it becomes more difficult.* But this equation contains the seeds of crisis.

#### NETWORK CRISIS AND THE SOCIAL WORK RESPONSE

A dependency governed network system achieves its stability by a progressive intensification of the meanings embedded in its relationships.



But a shift in the foundations of the system can bring the whole edifice crashing down. If carers feel they are no longer 'coping', whether because of a physical or mental deterioration in the person for whom they are trying to care or in their own capacity to care, then the caring system will turn into a 'crisis system' (O'Hagan, 1986, pp. 61-8). When carers communicate to others and to themselves that someone who has been dependent on them is now 'at risk' of death or injury they have to simultaneously recognize that their own acts of caring are no longer effective. Whether the dependent person has rejected the help offered or whether the carer's help is no longer sufficient to prevent serious risk the effect is to make it impossible for the carer to discharge the 'obligations' on which she has become increasingly dependent.

The theme of loss already so pervasive within a dependency governed network will be amplified by this rupture of the caring system. What is more, the theme will be heard loudest in the area which contains all the meanings which compensate carers for their isolation from other sources of self-esteem and self validation. The very acts which may have formed the pivot of the emotional life of the carer are now perceived as 'useless'. The crisis of coping is a crisis of meaning.

In such a situation carers might wish to turn for support to their own networks. However, as we have seen, these networks are likely to be highly ambivalent in their support. A crisis of coping is often likely to be perceived by carers' networks as a verification of their doubts about the wisdom of the carers' actions. They are therefore likely to emphasize the 'uselessness' of the carers' actions and may as we have seen use this opportunity to threaten carers with abandonment if they do not cut themselves off from the person who has been dependent on them.

Carers may feel themselves abandoned both by the person for whom they have been caring and the people to whom they might have looked for emotional support and this feeling is a part of the network crisis.

The emotional survival of carers is likely to be called into question at the same time as the physical survival of those for whom they have been caring. A referral to a social work agency at the point of crisis is likely to contain an *explicit fear for the physical survival of the identified client and an implicit fear for the emotional survival of the referrer*.

Where there is more than one carer involved in a situation, then the referrer is likely to be voicing concern on behalf of the whole caring network. The primary referrer may well continue to act as a broker between the informal network and the social work agency and as a barometer of network anxiety. When the referrer demands 'emergency action', she often does so on behalf of the network. The referral process at the point of crisis exemplifies the general principle that a high level of anxiety is associated with a closing down rather than an opening up of

communication. The formal and informal caring networks therefore connect in inauspicious circumstances. The social worker trying to mediate between these networks is likely to get drawn into some very powerful and 'primitive' transactions.

Network fears about emotional survival are transformed into anger with the social worker. Complaints by carers to the Director of Social Services, local MPs, councillors etc. are not uncommon. There may be angry or even abusive phone calls and social workers may seek to defend themselves by adopting an unsympathetic or hostile attitude to carers, suspecting them of 'dumping' their responsibilities on the social work agency. Both carers and social workers may suspect the other of malicious intent and develop elaborate conspiratorial fantasies. I have heard carers express the view that social workers leave frail people in the community in order to annoy the neighbours. I have also heard social workers express the view that carers who have devoted much of their lives to the care of another person were only doing it to get at their money.

We can look at the source of these problems in some detail by examining the dynamics of a typical 'plea for removal crisis' (O'Hagan, 1986, pp. 40-54). Over a period of months, a woman who has been caring for an elderly neighbour suffering from senile dementia comes to realize that she can no longer cope and that her neighbour is now seriously at risk. She telephones the Social Services Department to request an emergency admission to a residential home. Following an assessment visit, the referrer is told that a plan will be made to 'maintain the client in the community' by a package of services. The social worker is both imaginative and committed and within a few weeks a community care package is developed. The social worker tells the referrer that a home help will visit every day, a district nurse will come to bath the client, meals on wheels will be delivered and perhaps the client could be persuaded to attend a reminiscence group run at a local day centre.

The success of this 'package' is likely to depend on the support of the referrer whose relationship with the elderly woman could be used to help introduce the services. However, far from being relieved of her worries, the neighbour reacts with incredulity to the description of the 'package'. She feels that she is being told that her own caring was inadequate. She feels devalued by the social worker and makes various critical comments about the package. Ultimately the package does not succeed in preventing admission to a residential home, at least in part because the neighbour refuses to co-operate with social workers.

Although the social worker was seeking to involve the neighbour in the care 'package' by asking for her co-operation in introducing the service, the message received by the neighbour was that she herself was the problem.

If we make a comparison with a child care problem, these feelings may become more understandable. If a mother were to refer her child as needing help because he or she would not eat, the social work agency would be unlikely to respond by suggesting that in future the mother should leave the cooking and serving of food to experts as the task was clearly beyond her. And yet this is the message we unintentionally give to informal caring networks when we take on the role of 'experts'.

However the solution is not simply to recognize the referrer's views as those of an 'expert' and act in accordance with them. This is to abandon all responsibility. Moreover, returning to the example quoted above, if the initial telephone call led to an emergency admission to a residential home, the referrer might feel somewhat relieved in the short-term but her sense of undischarged and now undischARGEABLE obligation may cause her to feel guilty. The sudden disappearance of her elderly neighbour might reinforce the feelings of uselessness and meaninglessness which are part and parcel of any network crisis. The painful feelings she may have been hoping to jettison would be likely to remain with her as a legacy of the emergency response she requested and obtained.

The social work response to network crisis has to address its dual aspect, i.e. the threat to the physical survival of the dependent person and the threat to the emotional survival of carers. If it does not do so, then the agency will be likely to 'join' the system only to push it further into crisis.

There are four major strategies available to social workers when faced with a network crisis and a request for 'emergency' action.

1. *Removal of the subject.* This will normally be to an institutional environment of some kind. The traumatic effects of this kind of action on subjects are well known. What is much less known is the effect of emergency removal on the caring network. The models of network process I have outlined in this paper would suggest that 'emergency' removal is likely to intensify rather than resolve the emotional crisis of the caring network. Where 'emergency' removal is unavoidable, the impact on carers should be seen as a social work concern in its own right.

2. *Reassurance.* This is often perceived by social workers as a way of supporting the caring network. But if the model of network crisis I have proposed is correct, then this may have damaging consequences. To assure somebody that they can 'cope' when they feel they cannot 'cope' is to deny the reality of their feelings. Moreover, reassurance tends to identify the carer as the problem. Given that a network crisis consists in part of feelings of uselessness and meaninglessness such a re-definition of the problem can only add another twist to the spiral of anxiety.

3. *Taking over.* The 'neediness' of the informal caring network at the

point of crisis may provoke an over-reaction from the formal sector of care. Social workers may seek to 'parent' carers by taking over the responsibility of caring for a dependent person. As we have seen, this often meets with a hostile response. By taking over as 'experts' social workers may de-value carers and intensify the emotional crisis that precipitated the original referral.

4. *Conferencing*. This approach could be described as a way of structuring time and structuring relationships in order to enable the network system to move out of a position of crisis. The next section will describe the main features of this strategy and will seek to show that it is an effective response to network crisis.

### CONFERENCING THE CRISIS

Conferencing is a simple mechanism which involves a complex set of processes. The idea of calling a meeting of concerned individuals to discuss difficult issues will be a familiar one to most social workers. A network conference is not very different to any other kind of conference. It will have a Chairperson, a consistent membership and a particular subject to discuss. But those invited to attend will include members of the informal as well as the formal caring network. The conference thus presents an opportunity for a re-structuring of relationships which are currently in crisis.

At the initial stages, planning ahead for a conference acknowledges both the seriousness of the problem facing the caring network and the key roles played by all its members. It is an active response and needs to be described as such. In other words, a conference can be a mechanism for organizing resource packages which might include a formal as well as an informal component. The conference will thus communicate a willingness to respond actively to need but within the context of a partnership with the informal network. The idea of a network conference is in itself a statement about partnership and this theme can be extended and elaborated as time passes and the work progresses. The containment of network anxiety is unlikely to take place without some conflict and confrontation. Therefore opposition to conferencing should be expected. Indeed, paradoxically, confrontation with key members of the network over this issue may prove to be quite containing in itself. Boundaries need to be tested out and a responsive but assertive style can contribute to the reduction of panic. This was exemplified for me by the case of Mrs J, a seventy-five year old woman who was referred by her niece as needing compulsory admission to a Psychiatric Hospital Psycho-Geriatric Ward.

This woman's previous social worker had left some time ago. In her absence, the caring network had become increasingly concerned with the implications of Mrs J's deteriorating mental state and their own ability to cope with it. A series of ever more desperate phone calls to the 'duty social worker' led to the case being allocated to me. I proposed a network conference and because of the level of anxiety, I was obliged to re-state the need for a conference in an increasingly assertive way. It was difficult at first for members of the network to see a conference as a credible response to their problems. But gradually, the level of anxiety seemed to decline. Eventually the conference itself was almost an anti-climax. No medical intervention was proposed by members of the conference and I was left with a strong sense that many needs had been met prior to the conference by the constant re-statement of its necessity. In this case, active defence of the plan was the only intervention that was needed to enable the network to move out of a position of crisis. This is by no means a typical example of 'networking' but it does emphasize the relationship between the development of structure and the reduction of anxiety. Members of the caring network may feel devalued by the apparent failure of their caring when they feel they cannot any longer cope with the person who is dependent on them. The sense of self at such a time is very tenuous but can be reinforced by a structure of network conferencing.

An invitation to attend is in itself a message asserting the continuing significance of the carers' role even though carers may feel they have passed beyond their coping threshold. It may help them to perceive a role and a meaning for themselves beyond this threshold, a process which can be continued in the conference itself where caring tasks can be made explicit and available for re-negotiation.

Loss of self-esteem is linked to an overwhelming and undifferentiated sense of responsibility amongst carers. The isolation of carers and the ambivalent support available to them can be counteracted by the physical structure of a network conference. Seated in a circle, perhaps for the first time, the caring network is made visible to itself as a group of people each with a contribution to make. Within the problem solving context of the conference carers can identify and negotiate appropriate, limited and complementary roles. As these roles become more clearly defined the conference becomes more inter-dependent and more aware of its common boundary and purpose. In turn, this growing awareness helps individuals to internalize a sense of their role as carers and to resist feelings of total responsibility and powerlessness.

Although a network conference has a problem-solving brief, the role of a social worker at a network conference is not that of 'expert'. The conference needs to collectively own its own decisions. It will not do so if these are identified with the social worker.

Sometimes social workers may feel 'seduced' into taking the role of expert by the apparent helplessness and passivity of the conference. There may be particular warnings here for male social workers and predominantly female caring networks. Gender based expectations can act as powerful reinforcers of group dynamics. On the other hand, social workers may feel devalued by the scornful remarks of anxious carers and may be 'stung' into proving their value as 'experts' both to themselves and to other members of the network.

The group dynamics of network conferences may push social workers into the role of 'expert'. But adopting this role, for whatever reason, is likely to undermine the conference process.

Where the role of 'expert' is adopted by social workers in response to the apparent helplessness and passivity of informal carers, the consequence is likely to be a further loss of confidence on the part of the informal caring network, leading them to conclude that they have little to offer in planning for the future care of the client. A belief that caring is something best left to the 'experts' will lead to the dissolution of the conference group, with members drifting away from a process which may appear to be irrelevant.

Where the role of 'expert' is adopted by social workers as part of a struggle for control and credibility with informal carers, the consequence is likely to be an intensification of this struggle. Competition between members of the conference for a monopoly of caring 'wisdom', will replace the welfare of the client as the central concern of the network conference. Relationships will be conducted in a 'warfare' rather than a 'partnership' mode and any victories gained by social workers are likely to be Pyrrhic ones hastening the disintegration of the conference process and perhaps the informal caring network itself.

The primary task of the social worker in the conference is to ensure the survival of the conference. A conference which can prove to itself that it can survive is making a powerful symbolic statement to its members about the manageability of its caring task. In contrast, a disintegrating conference is a powerful symbolic statement about the hopelessness of the caring task.

By acting as a 'chairperson', the social worker personifies the shared boundary of the conference group. By holding the boundaries of the conference group, rather than promoting particular answers to problems the social worker acts as a model who does not allow himself to be caught in rigid anxiety laden patterns of response. This can help network members to feel in their turn less defensively committed to particular 'solutions'.

Where, at an early stage and through force of circumstance, the social worker becomes identified with a particular 'solution' to the network

crisis, it will be important to recognize that the social worker will have become part of the crisis system and cannot therefore act as a boundary marker and boundary keeper. In the case of Miss H, a young woman suffering from a rare disease who was unable or unwilling either to speak or get out of bed, I found myself too embedded in the system through my increasingly desperate attempts to communicate with her. I therefore needed someone else to chair the network conference. Through the medium of the Chairperson, I was able, in this case, to distance myself from my earlier position and adopt a less rigid posture.

Where one person consistently undermines the decisions of the conference it may be that this person is acting on behalf of the conference membership to draw attention to an inequality of power relationships in the conference. The overly powerful person may be the social worker or it may be someone else. 'Rebellions' may therefore indicate a need for a restructuring of conference relationships. The angry feelings evoked on all sides if the social worker attempts to quash 'rebellions' of this sort can quickly lead to the disintegration of conferences as containing mechanisms.

In the case of Miss W, an elderly woman who had lost all interest in self care, one member of the network conference persistently took actions opposed to the desires of the conference. My attempt to impose the authority of the conference on her failed because it became evident that the argument between the two of us excluded and depotentiated the other members of the conference and eventually led to the collapse of the conference system. A network conference needs to develop its own authority. If the social worker tries to represent this authority too personally, he or she is likely to appear as a tyrannical figure, encouraging 'rebellion' as an act of protest by those who feel excluded from power.

The conference process encourages the development of a 'social care' group built on the nucleus of the old 'informal caring network' but often involving formal as well as informal elements. In crisis the informal caring network turns to the social work agency for help and the engagement between the informal and formal sectors of care is a pre-condition of the emergence of a 'social care' group. This process of engagement is a genuine partnership if only because any attempt by the social work agency to control the decisions of the conference would de-legitimize it as a boundary maker and maintainer.

Every decision the conference makes further transforms the informal caring network into a social care group. Roles and boundaries are progressively clarified. In turn these help to facilitate future communication and decision-making. The explicit structure of the conference contains an implicit structure supporting, valuing and containing members of the social care group. Conferencing as a method of networking

does not seek to re-activate a pre-existing informal caring network. Rather it tends to assume that network crisis is irreversible. The conference acts as a transformer of networks into groups and is a concrete manifestation of the necessary involvement of formal agencies in the future caring system.

The troubled interface between the formal and informal caring systems is managed by the conference and the movement away from crisis is inseparable from the continued involvement of the social work agency as boundary maker and maintainer.

### CONCLUSION

This paper has been concerned with social networks as systems of exchange. Its subject has been the social dimension of care, the subjective dimension of caring and the relationship between them in network systems when reciprocity gives way to dependency.

The growth of dependency is associated with a change in the modality of relationships in a network. Dependency could, in fact, be defined as the specific set of systemic features which characterize this transformation.

Overall, these systemic features seem to constitute an inward turning spiral of relationships and a corresponding intensification of emotional investments. The inter-twining of emotional and physical dependency is a characteristic of 'informal caring networks'. When crisis occurs it affects the totality of relationships and brings into question emotional as well as physical survival.

Every social work referral generated by a network crisis contains within it an explicit referral concerning the physical well-being of the 'dependent' person and an implicit referral concerning the emotional survival of the referrer and possibly other members of the caring network. These two agendas set the scene for the often conflict ridden encounters between social workers and carers.

Whilst acknowledging the complexity of the task this paper nevertheless seeks to show that there is a way of mobilizing a partnership with carers in the midst of crisis and out of the elements of crisis. The need to contain the emotional and physical crisis simultaneously lies behind the choice of conferencing as the preferred method of 'networking'.

Conferencing is now beginning to be used by a number of agencies as a method of community social work. However, the model presented here may differ from that used by some practitioners because of its focus on the remodelling of relationships rather than problem solving.

The priority given to the conference process is dictated by the nature of



network crisis and should enhance rather than obstruct decision making.

Network crisis and the implications of dependency cannot be understood without a model which can integrate social systems and subjectivities and thereby form a bridge between 'community social work' and 'psycho-dynamic casework'.

This paper is a contribution to the task of constructing such a model.

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# Griffiths and Wagner: which future for community care?

STEVE TREVILLIAN

## INTRODUCTION

1988 saw the publication of two reports with overlapping terms of reference originally commissioned by Norman Fowler during his tenure as Secretary of State for Health and Social Services. *Community Care: Agenda for Action* by Sir Roy Griffiths is his response to Fowler's invitation 'to review the way in which public funds are used to support community care policy and to advise me on the options for action that would improve the use of these funds as a contribution to more effective community care' (p iii). *Residential Care A Positive Choice* is an 'independent review of residential care' chaired by Gillian Wagner 'to make recommendations for any changes required to enable the residential care sector to respond effectively to changing social needs and to make recommendations accordingly' (p 1).

As its terms of reference indicate, the origins of Griffiths lie not only in the concerns expressed by the Audit Commission report (1986) *Making a Reality of Community Care* but also in the Thatcherite paradigm of 'value for money' with its underlying identification of the public sector with 'waste' and 'inefficiency'. The origins of Wagner lie less perhaps, in administrative anomaly than in a long series of 'scandals' in residential institutions of all kinds of which the allegations of ill treatment of boys at Acorn Grove Children's Home in Birmingham are but the latest example.

Whereas Griffiths has been generated from within the preoccupations of Thatcherism, Wagner seems to be more a case of a governmental reflex, the need to be seen to be 'doing something'. Although the two reports converge on the same theme, ie the integration of community care and residential care this difference is indicative of a range of other fundamental differences between them revolving around conflicting concepts of community.

## CRITICAL SOCIAL POLICY

### The media and community care

Griffiths has attracted a lot of media attention as the report the government tried to hide. But the glare of publicity has not illuminated any of the key issues involved in planning for 'community care'. Rather, with its recommendation (1.5.1) that there should be a transfer of resources from central to local government, Griffiths has come to mean one thing and one thing only, an embarrassment to a government intent on curbing the powers of local authorities. As a result the debate about community care has again been marginalised and Griffiths itself has acquired the spurious reputation of being a radical, anti-Thatcherite document.

Wagner has sought to generate a widespread debate about its recommendations, '*A Positive Choice* is written not only for politicians, policy makers and practitioners in the field of residential care; it is addressed to a much wider audience . . . almost the whole population' (p 1). A forlorn hope; Wagner has attracted little media attention outside the specialist social work press. This is sad but predictable given its subject matter. As the report itself points out 'residential services command little public support, and public interest is normally only aroused if there is thought to be financial mismanagement or if another scandal is given headline treatment' (p 1). Community care is only deemed to be newsworthy on the coat-tails of some other issue. Likewise, one suspects that it will only be its articulation with more pressing political priorities that may rescue it from its current state of limbo at the DHSS.

## GRIFFITHS

### The insiders report

Unlike Wagner, Griffiths has no ambitions to open up a debate in society. Rather, it is conceived by its author as an integral aspect of Westminster and Whitehall decision-making, 'the first stages in a flow chart' (p iii). It is brief – only thirty-six pages – and represents one man's view of what a 'national policy' of community care would entail. The report makes no claim to be based either on original research or the systematic collection of evidence (p iii) and can be reduced to a number of 'keystones' (pp vi-vii) all concerned with administrative accountability. These 'keystones' are:

1. A Minister for community care to act as a 'focus' for the new policy.
2. Primary responsibility for community care to lie with local authorities.
3. Funding of community care to be by specific grant contingent on the presentation of programmes representing 'value for money' by local authorities.
4. A requirement that collaboration between local authorities and the health service precede the presentation of plans to the minister for community care.
5. A 're-orientation' of local authority social services departments towards

the design and co-ordination of 'packages of care' largely bought on the care 'market' rather than provided by local authorities themselves.

6. Placing social services departments in a position of 'financial neutrality' with regard to residential care, making this form of care relatively more expensive than in the past.

Griffiths invites us to see these recommendations in non-ideological terms as the product of no-nonsense business acumen applied to a problem of administrative disorder. But this is in itself an attempt at closure of the debate about community care by implying there is nothing more to be said. The same message is imparted by the brevity and epigrammatic quality of the report and by the way the text excludes the general reader by suggesting in the way it is written there is only one legitimate reader, the secretary of state.

Griffiths begins with a surprisingly informal letter to the secretary of state. There are two jokes on the first page. As outsiders, we the public peer into this world of power and influence like day-trippers invited to admire the dining room of some stately home but not invited to dinner. This is not simply a matter of the style of the document; in this case the form accurately reflects the content. There is to be no debate about the 'content of policy'. The only questions to be addressed are those of 'machinery and resource' (p iii).

The Griffiths Report is an insider document written in the codes of Thatcherism and the language of 'managerialism'. This is hardly surprising given the impeccable private enterprise credentials of its author as a managing director of Sainsburys. The report on community care reveals a similar set of pre-occupations to the National Health Service report with its emphasis on tight budgetary controls and hierarchical management systems (Petchey, R. 1986, pp 87-101).

### **Managerialism and the denial of inequality**

In keeping with its managerial and technocratic ethos Griffiths identifies the problems of community care as 'roadblocks' (p v), irrational obstacles which can be swept away by the application of rational business methods. Thereby, the whole topic is converted into a 'rational male' exercise in systems management and uncomfortable questions of inequality and injustice are ruled out of court. As many of these questions concern women this sleight of hand is doubly patriarchal. Women appear in the report only in the guise of 'informal carers' and as another element to be managed. This process of denial is replicated in the area of racial inequality. The three sentences on 'multi racial society' (8.9), redefine issues of racial inequality in terms of cultural sensitivity and occurring as they do towards the end of the report marginalise the needs of black people. The impact of poverty on the lives of both the intended 'consumers' of community care and their paid and unpaid carers (Nissel, M

and Bonnerjea, L 1982) is likewise ignored. But then the report is not concerned with the empowering potential of community care either. It is an exercise in 'community care' as 'colonisation' and 'domination' or the imposition of 'preferred hierarchies of control on local social systems' (Abrams, P 1980, p 19).

### Devolution and centralisation

In one of his most quoted sentences Griffiths argues that 'community care is a poor relation; everybody's distant relative and nobody's baby' (p iv). His solution is to locate 'community care' unambiguously as a local authority responsibility (pp 1-2). A mis-reading of this recommendation has led to the widespread belief that the Griffiths Report proposes an increase in the powers of local government. In fact the report makes no mention of local democracy even at the formal level let alone any concept of community or user participation. Its managerial ethos excludes any consideration of these issues. Instead, the emphasis in the report is on the clarification of lines of accountability. By replacing the present system of multiple responsibility for community care, shared between the NHS, the DHSS and local authorities, with a new emphasis on the role of local authorities, Griffiths solves some administrative problems but creates new possibilities of control by central government of local government. At root this is the same strategy for increasing central government control as was employed in the Griffiths Health Service Review (Petchey, R 1986, p 93).

The most obvious aspect of this strategy is the recommendation that there should be a Minister of Community Care (6.19). This Minister located in the DHSS would have charge of the 'national policy' and would be responsible for 'monitoring' the performance of local authorities in achieving the objectives of that policy (6.21). But as important are the financial mechanisms by which the actions of local authorities would be both resourced and controlled.

To obtain community care grants, local authorities would have to meet various conditions of 'value for money' (6.35). Griffiths himself helpfully decodes the implications of this:

'Social Services authorities should not be allowed to become monopolistic suppliers of residential and non-acute nursing home care. Central monitoring of local plans and the distribution of grant should be used to prevent this, if necessary. Central government should not fund a general expansion of local authority run homes. The objective should be to encourage further development of the private and voluntary sectors' (6.49).

For good measure he then goes on to broaden this 'objective' to include domiciliary services and to suggest that comparative cost should be the major criterion of 'value for money' (21). In order to keep their costs competitive with

the private sector local authority employers of both residential and domiciliary staff would be forced to keep their wage bill to a minimum. In this context the new profession of 'community carer' (1.6.6) sounds like just another low wage occupation for women.

The second major element of this new structure of central government financial control is the proposal that the main community care grant should be dependent on a uniform set of 'indicators of need' (6.25-6.29). This is based on the assumption that those who can afford it will 'buy care from both the private sector and social services authorities'. Given the state of local government finance, the discretion to 'top up' funds from other sources would be largely meaningless. Making grants on this assumption would force local authorities to undertake rigorous means testing where they do not already do so and to move towards a more selective and necessarily stigmatising way of delivering social services. The financial penalties for stepping outside central government definitions of need would make it virtually impossible to do so.

### **Griffiths – a paradox of Thatcherism?**

These considerations inevitably lead one to ask why such an apparently impeccable Thatcherite document should have been such an embarrassment to the government. The answer may lie in its timing. Griffiths assumes a stable political relationship between central and local government, an 'interdependence of local and central government programmes' (5.14). It seems to belong to a phase when local government is little more than a method of devolving the implementation of central government functions to a local management board. Recent recommendations by the influential Adam Smith Institute to the government that local councils could be abolished and replaced with private companies (*Guardian*, 22.8.88) show that this is not necessarily a metaphor! While there is still some flicker of life in local democracy the government may have judged that the war is still on and the occupation will have to wait! The disintegration of services and morale in places like Brent strongly suggests, however, that it may not be long before Griffiths is implemented, perhaps in conjunction with the privatisation of local government in crisis ridden Labour boroughs!

### **WAGNER**

#### **The outsiders report**

Whereas the Griffiths Report is little more than an 'agenda for action', the Wagner Report is a detailed fact finding exercise. It is published in two volumes, one of which is composed entirely of commissioned research. The

evidence submitted to the Wagner committee is also published in a very readable form and it is easy to trace back the source of the recommendations to the research and the evidence. In this way and in its orthodox academic style the Wagner Report presents itself as a public document not as in the case of the Griffiths Report a private correspondence.

Whereas Griffiths sees any reference to the content of policy as outside its 'brief', Wagner adopts a critical attitude to society and in a more guarded fashion to government. Indeed its central focus is the need to transform a residential system still dominated by the shadow of the workhouse into a system of community care constructed on a foundation of full citizenship, freedom of choice and the right of those who become residents to expect a better quality of life in residential care than they could expect outside it (p 114).

Wagner has been more concerned with the quality of care than its management and because the quality of residential care is a reflection of its history the report correctly sees this history as its central problem. 'The history of institutions in this country has been dominated by destitution, madness and criminality' (vol 2 p 1). To do something about the 'demoralised state' of residential services, their perception by the public as a 'last resort' and their 'low status' (p 1) necessarily entails confronting an entire history of stigma and segregation and the report to its credit does not shy away from this task. However its emphasis on problems of 'public perception' (p 3) leads to an under-estimate of the continuing impact of race, class and gender inequalities on contemporary British society. These inequalities not only undermine the principle of 'positive choice' as Wagner claims (p 29), they largely determine the nature of the population of residential institutions both carers and residents.

Against the history of oppression which it has identified, Wagner evokes two key concepts; firstly, that residential care can be a form of 'community care' (p 3) and secondly that admission to residential care should always be an outcome of 'positive choice' (pp 27-28).

### Residential care as community care

'In *A Positive Choice* we seek to promote a fundamental change in the public perception of the residential care sector and of its place in the spectrum of social care. We believe that residential services can no longer be considered in isolation but need to be seen as part of the continuum of care in the community' (p 3).

Through the concept of community care Wagner seeks to 'normalise' residential care, to break away from the workhouse traditions of segregation and stigma. Following on from this conceptual leap there is then an attempt to deconstruct the whole notion of traditional residential care by suggesting that if care needs are separated from accommodation needs, a broad continuum of

care/accommodation permutations can be envisaged. At one end of this continuum there would be various forms of supported 'ordinary housing' and at the other 'group living', ie. the full integration of accommodation and care (pp 16-25). This is undoubtedly a radical reconceptualisation of residential care but it seems to be used only as a way of thinking about existing alternatives rather than a way of imagining new ones. Perhaps that is why the report seems to lose faith in this new language and continues to refer to 'residential care'.

The idea that residential care is community care leads Wagner to recommend that those living in residential homes should be enabled to have as much contact as they wish with those outside (pp 46-47). The boundary between residential homes and their surrounding 'communities' would in this way become more permeable and perhaps in an ideal world disappear altogether.

The final way in which community care could be realised in the context of residential care, according to Wagner, would be by establishing a 'partnership between care staff and informal carers' (p 45). This could be achieved by expanding the role of 'respite care' and enabling the residential establishment to function as an 'information resource' for informal carers (p 45).

### Residential care as a positive choice

The concept of 'positive choice' is Wagner's response to the traditions of coercion into residential care inherited from the Poor Law (p 3). Spelt out, this means that no one should be compelled to move into residential care simply because their care needs cannot be met at home and that the residential option should be just one of a number of real choices offered to individuals (pp 22-28). Moreover, Wagner recommends that 'every residential establishment should have a written brochure or prospectus setting out its aims and objectives, its basic values and principles and the range of services offered' (p 56). The existence of such a prospectus would enable informed, individual 'contracts' to be made and the extent to which aims were being achieved would form the basis of inspection and registration (pp 54-59). Where individuals are incapable of making a 'positive choice' then the 'nominated social worker' responsible for organising the whole process of assessment should be responsible for taking account of their wishes (p 9), and regular reviews would be held (pp 26-28).

*Positive choice* and *community care* are put forward by Wagner as the means by which citizenship can be restored to those living in residential care (p 114). However, a government committed to the creation of a permanent underclass is unlikely to be sympathetic to this objective.



## Resource implications

To implement its recommendations, Wagner envisages a major investment in the training of residential care staff (pp 70-91). As most of the cost of this programme would ultimately be passed on to central government the viability of these recommendations hinges on the government's willingness to resource the expansion of social work education. The refusal to countenance CCETSW's recent proposals for a basic three year QDSW suggest the resources for Wagner will not be forthcoming.

## CONCLUSION: 'COMMUNITY CARE' - SAME LANGUAGE, DIFFERENT MEANINGS

The 1982 Barclay Report *Social Workers and their Tasks* helped to re-constitute the social policy debate around the concept of 'community'. Henceforth, social workers would be obliged to 'tap into, support, enable and underpin the local networks of formal and informal relationships which constitute our basic definition of community' (Barclay, P 1982, p xvii). The Griffiths and Wagner Reports take the link between community and social policy one step further.

The continuities between the language of the three reports are clear. The idea of the 'care package' central to both Griffiths and Wagner has its roots in the idea of 'social care planning' floated in Barclay. 'The care manager', the 'community carer' (Griffiths) and the 'nominated social worker' (Wagner) can all be seen as incarnations of the 'community social worker' (Barclay). But this similarity of language is deceptive. At different times both the political right and the political left have expressed their ideas in communitarian language (Kamenka, E 1982 pp 3-42) and we know that the 'ideological dimension to the meaning of community . . . is ubiquitous' (Plant, R 1974, p 84). Communitarian language is the language of transformation but the direction of this transformation, the nature of the community ideal is governed by this 'ideological dimension'.

For Wagner, the community is essentially the opposite of the stigmatising and coercive inheritance of the Poor Law. It is through the restoration of 'citizenship' by 'positive choice' (p 114) that Wagner assumes residents will finally escape from the long shadow of the workhouse into the 'community'. At the heart of the report lies a belief that attitudinal change and a set of rights guaranteed by a benevolent state will bring freedom and empowerment to those who are oppressed and powerless. Wagner is thus revealed as a quintessentially liberal document which shows no understanding of the role of the state in Thatcherite Britain.

In the case of Griffiths, community has little to do with destigmatising public welfare. Rather it seems to be identified with the notion of the care

'market' (p vii) as a transforming agency. In the process of 'rolling back the frontiers of the state', community care becomes care management, a powerful business metaphor which attempts to banish the real world of pain, inequality and oppression to the margins of policy making. In effect, Griffiths de-politicises community care and offers us a sanitized vision of community as a well regulated supermarket.

The difference between Wagner and Griffiths is at root, the difference between these two concepts of community, a difference that amounts to an opposition between Thatcherism and Liberal Individualism. We already know the result of the contest between these two ideologies and so we can predict that in spite of the present hiatus, it is Griffiths rather than Wagner which is likely to determine the future pattern of community care. As Griffiths is based firmly on the Thatcherite dualism of a 'free economy' and a 'strong state' (Gamble, A 1988) we may therefore expect these principles to further penetrate the already tattered fabric of the welfare state.

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selection is based on undergraduate degree, resume, references, letter of intent and interview. A process of self selection operates in Canada and Israel.

Commenting on the international accounts, Tony Redpath of the ESRC said they gave him a very useful insight into the various aspects of training in applied anthropology. He was interested in the diversity of training regimes and wondered whether the US model would be appropriate to Britain. He said that the ESRC disbursed public funds for the training of post graduate social scientists but that the amount for such training had recently decreased. It was therefore important that the money should be spent on what is needed in the UK. The ESRC had initiated a consultation process with staff and students of various departments on the issues of extending the breadth of training in research methodology.

In the general discussion which ensued it was evident that Britain could benefit from the greater experience of other countries, particularly the US, in devising and running training courses. There was obviously a great demand as GAPP courses, as well as those at Brunel and Keele, have been grossly over-subscribed. It is also worth considering whether some training in applied anthropology should be integrated into undergraduate courses, possibly following the approach in Canada and Israel of involving students in applied research projects undertaken by departmental staff. The value of placements/internships of various durations and for a variety of goals, cannot be overstated. However, departmental time and resources have to be spent to initially create and later maintain and augment a network of extra-university institutional and individual contacts. In the US, much of the initial work in locating placements is done by staff specifically recruited for this task. Another strategy was to ensure that anthropologists working outside the academy had opportunities for maintaining contact with universities, and in the US, for instance, applied anthropologists serve as adjunct faculty and give papers and seminars, teach whole or part courses, help supervise students on placements etc. Their involvement in academic departments also contributes to the development of the discipline, particularly in the areas of theory and methodology. Two important curriculum components of the US courses that are worth highlighting are, firstly, training in a range of research methodologies and the use of computers to analyse data, and secondly, a study of American culture, as it was important to understand the dominant cultural system. It remains to be seen whether British anthropology will respond favourably to the stimulating and exciting ideas for training that emerged from the conference session.

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## Article

### Post-Griffiths Networking: a Study in Contradiction

Steven Trevillion

#### Introduction

"Social care workers will need to develop particular skills in the networking of services..." (Laming 1989, p.19).

My intention here is to submit the fashionable notion of 'post-Griffiths networking' to critical appraisal and to thereby show that it is in effect a contradictory notion.. To this end, I will adopt the simple device of returning to the first principles of network theory to show that the fundamental characteristics of the social field of the network cannot be reconciled with the Griffiths Report and the subsequent White Paper on community care.

#### On Social Networking

Disenchantment with the bureaucratic organisation of social work was a characteristic of the 1980s. Associated with the critique of the Welfare State emanating from both the Left and the Right, there was a search for an alternative way of thinking about Welfare. The idea of networking emerged out of the community debate of the early 1980s and increasingly moved into the foreground of social work theory but in a way which was practice led particularly by the innovations of 'patch' social work.

One major concern of networking has been with the practice potential of the Barclay Report's vision of a partnership between professional social work and the informal caring networks of society. Drawing on the work of Whittaker and Garbarino (1983), and Bayley (1978), the paradigm of the interwoven social support network was developed as: "a set of interconnected relationships among a group of people that provides enduring patterns of nurturance (in any or all forms) and provides contingent reinforcement for efforts to cope with life on a day to day basis". (Whittaker and Garbarino 1983).

'The social services seek to interweave their help so as to use and strengthen the help already given, make good the limitations and meet the needs'(Bayley 1973, p.343).

More recently, feminist (Dominelli and McLeod 1989) and anti-racist social work (Dominelli 1988) have begun to explore the network concept as a way of mediating concepts of personal support and campaigning work.

More generally, at a local level front line workers in different agencies have begun to collaborate in new and innovative ways with each other and with clients influenced by the network

concept.

### **Community Care, Case Management and Networking**

As we enter the 1990s there is a new surge of interest in the network concept. Undoubtedly, one of the major reasons for this is the way the principles of the social support network seem tailor-made for community care practices. The phrase 'post-Griffiths networking' is becoming commonplace and an explicit link has been made between networking and the case management principles of post-Griffiths community care by Sharkey (1989, pp.403).

And yet, and this is what I will argue here, there is a fundamental discontinuity between networking and case management as it is currently defined. Case management principles by seeking to introduce 'contact culture', hierarchical management systems and a market ethos, into the social field of the network are likely to change it utterly.

Networking derives its methods goals and styles of work from the five fundamental characteristics of the social field of the network. I will try to show that there is an irreconcilable conflict between each of these and the bureaucratic and market principles of the 'post Griffiths era'.

The social field of the network is characterised by collective, participatory decision making (Barnes 1954, pp.51-54). In the fishing village of Bremnes where the social field of the network was discovered by Barnes, the communal, egalitarian participatory world of kinship, friendship and neighbourhood (ibid, pp.43-44) stood in stark contrast to the competitive, hierarchical world of economics and politics. Both Bott (1971) and Willmott and Young (1957) likewise emphasised the communal characteristics of well developed social networks and the association between a loosening of network ties and a loss of communality. Whilst there are strong traces of romantic attachment to traditional notions of community evident in these early works, nevertheless, it is clear that the discovery of the social network was based on a discovery of a distinctive set of social relations apart from and opposed to both the social relations of the market and the social relations of the bureaucratic organisation. If a network is indeed based on participatory decision making then it cannot be managed by one person. As Collins (1989) has recently pointed out

'the danger of over-emphasis on management control of care systems lies in dismantling individual power systems. While management is important, collaboration is also of the essence, and it is collaboration with all parties, at all stages, which holds the key to the provision of community care without revoking individual power and responsibility'.

One might add that it is only collaboration which genuinely acknowledges the participative nature of the social field of the network and can transform the rhetoric of the caring network into a

reality. The fundamental problem here is that the 'over emphasis on management control' in so called post-Griffiths networking is a product of the intrusion of the market and the organisation into a social field defined by its opposition to these principles.

The second fundamental characteristic of networks is the way in which these social fields are built up from interpersonal processes contained within a pattern of linkages between persons. This leads to a concern with small scale 'concrete' processes which are 'mapped' rather than seeking to explain social phenomena through abstract categories. Associated with this is a concern with the way the individual's experience of society is mediated by the network experience. This is what Barnes means by the phrase 'class is a category of thought' (1954, p.47). It is likewise implied by Bott when she says that the network is the 'primary social world'. The need to respect this experiential dimension led Srinivas and Bettleille (1964, p.166) to suggest that only a study of the 'subjective network', the network as it appears from the participant point of view, could hope to achieve the ambition of a 'concrete' analysis.

One might add that in and through our networks we invest part of ourselves in each other and through this process find ourselves. Networks do not just have functions, they also have meanings.

If the social field of the subjective network has to be apprehended as a totality, if it cannot be reduced to abstractions. If it has fundamentally, a signification which is only revealed to the participant for whom it is the 'social environment', then any attempt to define its nature from a case manager perspective in terms of narrow 'service specifications' (White Paper 1989, pp.5-15) would be deeply alienating. A functional service oriented approach ignores the way in which individuals construct and reconstruct their linkages with one another. A network has a continuing existence, a 'durability' which cannot be reduced to any one instrumental mobilisation (Mitchell 1969, pp.26-27). Moreover, a care market will define its 'goods' in terms of price and this price will complete the process by which network members will be alienated from themselves and from each other.

The third characteristic of the social field of the network and in particular that interwoven field of social support that is our primary concern, is its informality. This goes beyond the usual dichotomy of formal and informal network to an aspect of informality that includes both types of network. A network 'has no units or boundaries; it has no co-ordinating organisation' (Barnes 1954, p.43). Networks ramble rather like footpaths across the territorial divisions of society. This gives network linkages a particular character which is clearly pronounced in the case of interwoven social support networks. These networks always involve

personal investment in the construction and maintenance of linkages which extend across agency boundaries or even across intra-agency boundaries. Negotiation of new roles, inventing new ways of working together and even new loyalties to one another rather than respective agencies are all features of this informality as well as the more obvious informality of style and openness of communication one might expect.

Where relations are governed by the formalities of 'contract culture', where rights and duties are specified and specification is linked to price, there can be no space for the informality and essentially personal creativity of the network (see Malcolm Payne's (1986) distinction between 'contracting' and 'networking'). Contract culture reinforces organisational boundaries rather than dissolving them. Cross organisational links are strictly functional and involve few opportunities for network identification. Indeed the functional separation inherent in contract culture asserts difference rather than commonality.

The fourth characteristic of the social field of the network is that it is a field of actual or potential mobilisation, mobilisation by individuals of their networks for political purposes in Mayer's action set concept (1966) or mobilisation of 'action sets' on behalf of individuals (Barnes 1956) perhaps in response to the problems associated with a 'life crisis' such as bereavement (Boswell 1969). It was Boswell who pointed out that different kinds of crises might have the effect of catalysing different kinds of network mobilisations perhaps involving very different individuals.

For a set of relations to have a mobilisation potential a certain amount of interconnectedness has to exist. As I have already pointed out, contract culture inhibits interconnectedness and also therefore inhibits mobilisation potential. In a 'post-Griffiths network' resources cannot be effectively mobilised, they can only be bought or sold. Whether such a process will be experienced as sufficiently flexible, needs led or caring by members of the unpaid informal network or by clients seems doubtful.

The fifth network characteristic, closely linked to questions of mobilisations and at the heart of any understanding of network dynamics, is the fact that networks are fields of informal communication. Epstein described networks as 'chains of gossip' (1969) which construct network norms. The information which is transmitted around a network also therefore binds it together.

A lack of interconnecting pathways leaves individuals and agencies very dependent on a very few sources of information. The low interconnectedness of the case management situation prevents 'chains of gossip' arising and leaves care providers in a position where they cannot learn from each other. It is only the case manager who is in a position to reassemble the diverse messages about

the client but in reality even this is unlikely because the provider/manager relationship is of such a formal nature that important items of information may not be communicated if to do so would seem like gossiping. As a result, assessment of need and the ability of the network to adapt to changing needs would be undermined.

### Conclusion

To sum up, where the network is participative and self determining, case management involves a control culture; where the network is informal and interconnected, case management is formal and constrains interconnectedness; where networks are mobilised on the basis of perceived mutual identification, case management puts together service packages on the care market; where the network grows and develops because it is a communication network, case management prevents effective informal communication flow and thus lacks adaptive capacity.

The alternative to case management is not a return to the traditional neighbourhood debunked by Abrams(1980) nor an acceptance of the inevitability of gender based caring in isolated nuclear families, nor a retreat from the challenge of community care by creating new institutions. Rather, we must look to the network tradition itself remembering that it concerns the 'personal order of society' (Mitchell 1969, p.10). and so opens up the possibility of a personal and political practice informed by values other than those dominant in our society at the moment.

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(Steven Trevillion is Senior Lecturer in Social Anthropology and Social Work at the West London Institute of Higher Education). ©

## Research Report

### Becoming a Participant Observer in a Social Services Team

Monica Dowling

(For the purposes of confidentiality all names and place names have been changed)

#### Introduction

I am on the third year of a three year Doctoral Programme in British Policy Studies. My area of interest is the relationship between poverty and social work. I decided to use field observation of a social services team as my methodology because I am interested in finding a new way of understanding the relationship between social workers' attitudes and actions in relation to poverty. Using this method has led me to question the subjective nature of what I am doing, particularly in relation to Action Research.

#### My Own Background

Coming from a middle class background, with working class origins on my father's side and a social work tradition on my mother's, I commenced training as a social worker at 19. Throughout my course, my social work practice and social work teaching, I have been aware that discussions on

poverty were merely the academic framework within which social work took place. Social work is organised so that it treats 'clients' as individual cases or 'specialisms' without being aware of how poverty affects users of social services every day. Poverty awareness is not integrated into social workers' training and practice. My 'topic of investigation' is to see why this is so and how it might be remedied. It has persuaded me to give up a full time social work lecturing job, move to Sheffield and live on an ESRC grant!

My interest in ethnographic research has been a gradual progress, a curiosity as to whether the tales written on questionnaires by the 150 social work students whom I surveyed and subsequently talked to in taped group discussions really reflected what was going on in social services teams. I was also aware that surveys and interviews on social workers' attitudes to poverty (Becker 1987) were not necessarily the same as the reality 'on the job'.

I had been a detached youth worker supervised by Howard Parker at Liverpool University but missed out on writing a follow up book to his *View from the Boys*, "View from the Girls". However, this work gave me insights into how to observe/work in an extremely loose structure and also the determination to write my own report this time.

In spite of my own social network and the contacts existing between the University and local social service departments, finding areas in which to work proved more complicated than I had anticipated. My next task - the topic of this paper - was however to establish rapport with the teams I had selected to study.

Being a qualified and experienced social worker gave me the confidence to feel I could become a socialised stranger in a social work team. It has meant easier access (difficult though it was at first), to senior management and a common professional language with all of the social work teams I have visited. For example what does 'well I've done locum, so I know how to fit in quickly as far as duty's concerned' mean to the outsider? Comparing working tales with everyone in the Silverton team has made me wonder how previous observers of social services teams (cf. Smith 1980, Satyamurti 1981, and Pithouse 1987 and to a lesser extent Mattinson and Sinclair 1979) managed.

#### Settling In

To illustrate the settling in process, I shall describe how members of the team offered their help with the research. The team leader provided me with telephone numbers of local contacts at a preliminary meeting in December. He was keen that I should arrange interviews for when I started in January. He thought they would be useful. I suspect he was not sure that I would have enough to do hanging round the office. I did follow up some of the contacts. I also had plenty to do hanging round the office in a way that, he was relieved to find, did not interfere with his or other people's

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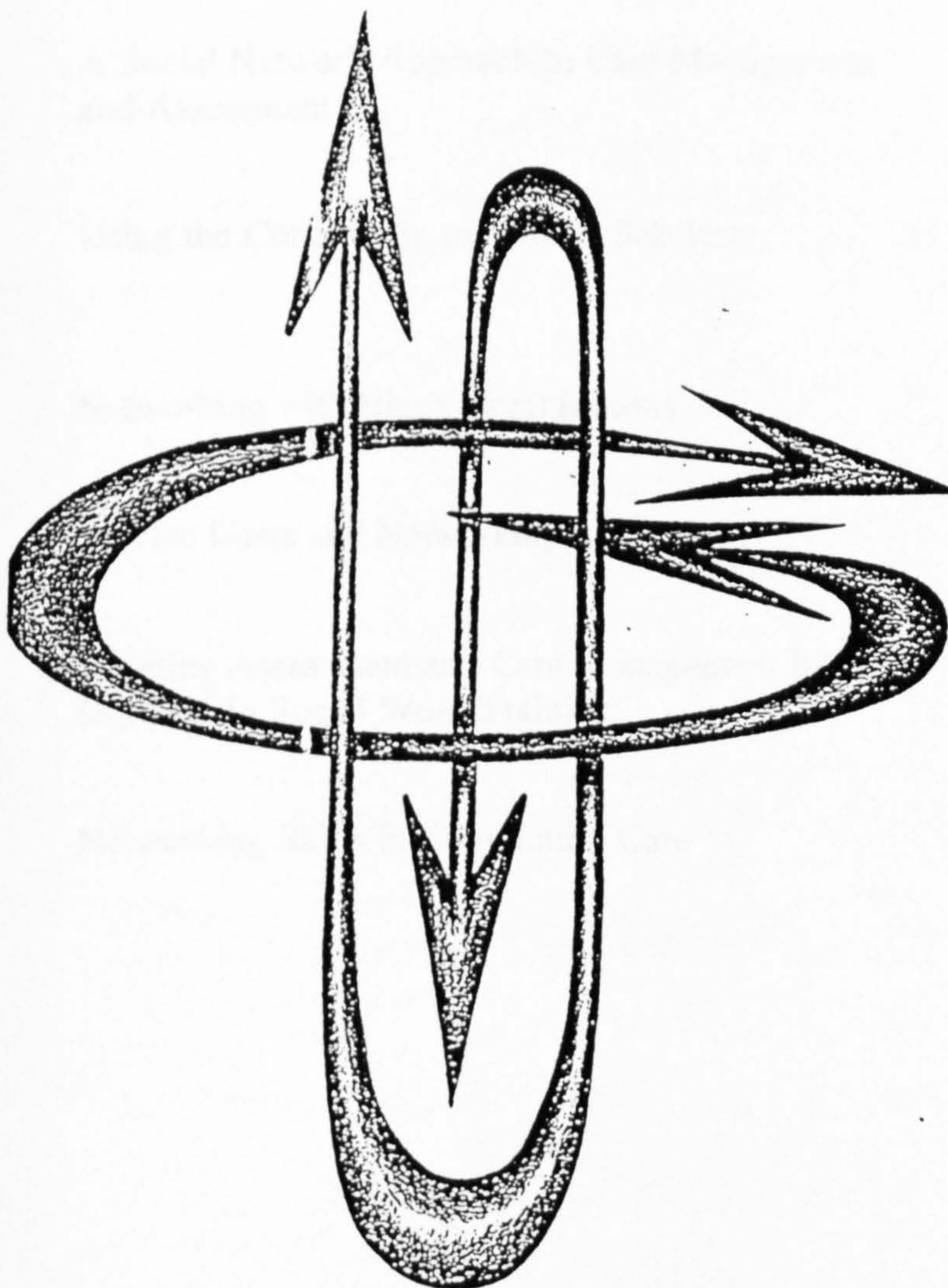
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## Networking and Community Care: An Anthropological Perspective

Papers presented at the Networking and Community Care Conference held at the West London Institute on 25th November 1992.

Edited by Steve Trevillion

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London  
May 1993  
£5

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## Introduction

All the papers in this collection were presented at a conference held at the West London Institute in November 1992 on the theme of **Networking and Community Care**. The conference was sponsored jointly by the West London Institute Department of Social Work and Social Anthropology, Social and Community Work, a branch of the British Association for Social Anthropology in Policy and Practice.

The conference was part of a long-term process of rethinking social work through the prism of the 'anthropological imagination' a process which began some years ago but which continues through organisations such as SASCW, the journal *Anthropology in Action* and a number of individual social workers, anthropologists and community workers. But the conference also emerged out of a belief on the part of the organisers that the interface between social work and anthropology might prove to be a very productive place from which to explore community care in general and networking, in particular. The intention was not to apply anthropological theory to community care practice in any obvious way, but rather to encourage participants to make use of the network concept to think holistically, reflexively, critically and therefore anthropologically about community care.

Whilst all the papers address the same subject, i.e. networking and community care, they do so from a wide variety of perspectives-not all of them obviously anthropological. There is no 'party line' here as there was not at the conference. But in their different ways all the papers try to explore the connections between the patterns of lived experience and processes of social support.

In his short paper on the relationship between social anthropology and social and community work, Iain Edgar notes that whilst social anthropology has made little or no formal impact on social work education, a shared interest in 'holistic' perspectives means that social workers and social anthropologists have much to learn from one another. He identifies a number of shared themes, e.g. the relationship between individuals and their symbolic environments, the relationship between self and situation and the concept of 'process'. More specifically, he also shows the way in which anthropological perspectives have enabled new critiques of community care to be developed.

One of Edgar's key themes- the centrality of the concept of culture- is developed in my paper on networking and community care which argues that for those social workers, nurses and others involved in community care networks a critical awareness of cultural issues is a pre-condition of 'good practice'. This paper also argues that a cultural approach to networking will have major professional implications; perhaps the most important being a new role, that of cultural 'broker' for which new skills may well be needed.

David Barrett's piece on 'snowballing' shows how a sensitivity to social networks is not only a vital part of community care practice but can also help us to undertake research amongst key groups of service users, in this case 'economically fragile older people'. Barrett's subject is the social incarceration of this group of older people through the deficiencies of current welfare policies, including the policy of care in the community.

One of the many interesting things about this paper is the way in which seemingly intractable research problems are resolved through a research methodology based on personal social networks. Although Barrett's work is framed in sociological rather than anthropological terms his use of social networks to redefine class is reminiscent of Barnes classic anthropological work on class in a Norwegian fishing village.

Philip Seed tackles the subject of Care Management from a social network perspective and shows in some detail how the analysis of the personal social network can provide the basis for community care assessments. Seed is particularly interested in the use of diaries to record social interactions and mounts a forceful argument for their use in helping to understand 'need' in highly individualised and person-centered ways. This aspect of Seed's paper- the use of social network analysis to illuminate the world of the service user- was particularly relevant for a conference on anthropological perspectives on community care.

Jo Taachi and Rupert Daniel make use of Edwin Ardener's concept of 'muted groups' to discuss the relationship between networking and empowerment. They show, from their own experience how voluntary organisations can network with one another and in this way shift the balance of power in their dealings with local government purchasers-an important lesson in how relatively less powerful groups of people can go about making themselves heard in the new 'mixed economy of care' rapidly emerging in the aftermath of the NHS and Community Care Act.

The relationship between support and empowerment is explored from a more personal angle in the next paper which looks at the part played by the 'informal, invisible support network' in the lives of Black people in this country. Shah argues that for a number of reasons many Black people have well developed skills and strategies in networking. This is partly because where there is no State welfare system, mutual support and assistance is essential to survival, partly because networking was the only way in which slavery and colonialism could be challenged and partly because Black people have been denied access to formal systems of support and have had to develop their own in order to survive. However, Shah points out that professionals need to do much more to support the networks of support and empowerment which have grown up and under the new community care arrangements there will be opportunities to do so.

Peter Beresford's contribution reviews the history of networking and helpfully reminds us of some of the ambiguities and complexities surrounding its use. He raises a number of fundamental questions about power and control when service users and welfare professionals try to collaborate with each other. He emphasises the importance of service user organisations and networking within the service user movement as ways of avoiding tokenism, colonisation and unrepresentativeness. But he also reminds us of the many obstacles in the path of networking and- echoing Shah's point- the particular problems of under-resourcing faced by Black and other ethnic minority groups as they attempt to network with one another and other service user groups.

The final papers focus on the issues raised by community care for professional identity and professional roles and the implications of community care for professional social work education and training.

David Best summarises his research on care management and outlines the broad issues that all Dip. SW. programmes will have to consider. Betula Nelson and I then report

briefly on some work in progress on the nature of networking as a set of post-qualifying 'competencies'.

We explore the way in which our methodology as well as our subject matter was informed by social network principles and our growing realisation that in studying networking we were in effect exploring a new professional culture. We then summarise some of our key findings, including the discovery that networking for community care appears to involve a truly multi-disciplinary matrix of skills. Finally we raise some questions to which we have no immediate answers, e.g. questions about the origins and dynamics of networking as a 'belief system' and why it is that this system should be so attractive to some professionals and so unattractive to others!

## Networking and Community Care - a Cultural Issue

by

**Steve Trevillion**

### Introduction

Almost everyone from the the Association of Directors of Social Services to the head of the Social Services Inspectorate seems to agree that the effective delivery of community care will be dependent on 'networking'. At the individual level networking will have to underpin care management. At the inter-agency level it will have to provide the essential framework for negotiation . At the community level it will be needed in order to facilitate the formation of community care plans. Moreover if community care is to be a genuine partnership, then networking will be needed to empower both service users and carers, so that they can exercise meaningful or 'positive choice' (Wagner 1988).

But although networking is supposed to be central to community care, our understanding of it is limited. In fact, what I have just done is rather typical of the way key questions have been evaded. I have described some of the things networking is expected to deliver but I have not said what networking is.

As soon as we ask not: What can networking achieve? but the more fundamental question: What is networking? the issues suddenly look much less clear. One of the first things that happens when one asks this question is that one is forced to recognise that the new language of community care which has been elaborated over the past few years is simply not up to the task of constructing an effective description of the networking process.

I will argue today that community care needs a new kind of language- a language of 'culture' because networking as the core community care practice can only be described in 'cultural' terms. I will also argue that if we have to draw upon cultural models and metaphors when talking about networking then this automatically makes anthropology a core intellectual discipline for community care practitioners.

### Care and Community - metaphors of Practice

At the moment, the dominant languages and models of community care have been derived from political economy- the concept of the care market , jurisprudence - the principle of contract and political philosophy- the 'citizen's charter.

Whilst all these models have some strengths, in that they enable us to think our way around some aspects of 'care', none of them, on its own, enables us to think about networking which involves thinking about 'care' in 'community' terms. Community concepts are notoriously difficult to define, but from Hegel onwards the concept of community has functioned as a holistic metaphor, a way of transcending- if only at the level of the imagination- perceptions of social fragmentation and personal alienation (Plant,1974,p.16).

Of the dominant community care models only that aspect of the citizenship debate which focusses on partnership, begins to touch on these issues. But concepts of

partnership which fail to move beyond the level of the individual and his or her 'rights' fail to understand that the 'ultimate moral basis' of citizenship is the community (Jordan, 1990,p70).

### **Reductionism and its Consequences**

The end result of removing the concept of 'community' from community care is reductionism- the breaking down of 'need' into separate components each of which can then be separately linked to a specific self-contained service. This is simply not compatible with networking.

What is missing is any way of easily representing the overall pattern or 'gestalt' of community care- the very gestalt' with which networking as an integrative and holistic enterprise is concerned. For example, the image of the care package, appears to be holistic. But in fact, the 'package' is little more than the sum of its parts and this reductionism is inevitable, given the limitations of the language of markets, contracts and citizen's charters. This reductionism reveals itself as soon as one asks how care packaging is going to work.

Care packaging must involve coordination. But how is the care management system going to ensure that coordination actually happens? The answers are illuminating: a unitary budget for purchasing services, a single point of accountability to ensure control and an inspectorial mechanism for monitoring quality and ensuring quality control.

I am not arguing against the importance of these things. But I am suggesting that these things do not add up to a 'community' approach to care. In this closed universe of discourse which defines itself as 'the real world', it is not surprising to find that social workers, nurses and others look towards task centered and behavioural approaches and ignore the rich vein of the community social work tradition, as they attempt to operationalise community care policies. Nor is it surprising to find the current discourse of community care driving Social Services Departments to become increasingly specialised in their internal organisation and 'targetted' in their approach at the policy level. As Challis points out these kind of changes are likely to have all kinds of consequences- not all of them intended (Challis,1990).

The irony is that at a time when so much lip service is being paid to the principles of integration and collaboration, it is becoming more and more difficult to achieve. In abandoning Seebom, we seem to have thrown out the holistic baby with the generic bathwater!

### **Holistic and Integrative Perspectives**

I do not wish to imply that market models, rights models or contract models have no place in community care. on the contrary, they all have their place in the process of delivering community care because they all address important aspects of it. But they do not and cannot generate networking. This is because networking is intimately connected with the principle that the whole is more than the sum of its parts. Networking only makes sense if we are able to think about community care in holistic terms and this means thinking of community care in terms of culture and community.

## **Networking - a Culture of Community?**

I have in the past defined networking as:

“all those activities which enable separate individuals, groups or organisations to join with one another in social networks which enhance communication and/or co-operation and create new opportunities for choice and empowerment for at least some if not all of those taking part” (Trevillion 1992,p.4).

This definition stresses the integrative role of networking and reminds us that the outcome of networking is a set of social network patterns and processes. More recently and specifically in connection with networking for community care it has become clear to me that the integrative potential of networking is linked to key principles or ‘basic assumptions’ (Schein 1985,p.6). In the course of research on networking skills the following picture emerges from talking to the professionals concerned with it on a day-to-day basis:

Establishing inter-personal connections, developing collective perspectives, drawing all those involved into a process of review and evaluation, taking a holistic view of situations whilst acknowledging different needs, values and skills, promoting mutual understanding, power sharing and ever broader patterns of collaboration and integration.

When people talk about these ideas they are effectively describing not just a set of techniques but a ‘culture’ a fundamental world shaping set of ‘basic assumptions’ (Schein 1985,p.6), moreover it is a ‘culture’ which is strongly oriented towards what most people would describe as community values.

Whilst people may go on to talk about purchasers and providers, complaints procedures, quality assurance, etc. these are secondary rather than primary issues. It is a certain kind of ‘culture’ which is seen as primary. I now want to move on to explore in more depth this idea of networking as a culture of community.

Networking as an integrative interactional practice, draws our attention to a whole range of issues which practitioners feel intuitively are of great significance but which are made invisible, perhaps even denied by the dominant models of community care. It is this ‘culture’ which although often silenced within the dominant discourse is helping to re-create a language of community within community care.

### **Culture: The Anthropological Contribution to Networking Practice**

Now one of the problems with any discussion about culture particularly in relation concepts of community is that it can lead to a certain kind of philosophical idealism in which ideas are seen as the driving force behind social change. Alternatively the culture concept may seem to imply some kind of reification of society in which individuals and their desires count for nothing. However, the concept of culture which I am proposing as a way of thinking about community care is neither idealist nor determinist.

I have already made use of Schein’s concept of culture as ‘basic assumptions’ but whilst this is a useful idea, it does not in itself make the break with idealism and determinism that we require of a useful practice paradigm.

This is where I think anthropology may be able to make a distinct contribution to the community care debate and the development of community care practices. If there is a

concept with which anthropology is most closely associated it is the concept of 'culture'. Like all fundamental concepts it is not easy to pin down. One reaction to this quality of elusiveness has been for anthropologists to ignore the concept all together in favour of more 'scientific' sounding notions such as 'social system'. But like the concept of 'community' they keep returning to it because it seems to convey something too important to ignore.

From the Durkheimian tradition we can draw on the idea of interaction as expressive of collective values or 'collective representations' (Durkheim,1974). But Durkheim reifies social processes in ways which are very unhelpful to us as we struggle to make sense of open rather than closed social systems and dynamic rather than static social realities. Moreover, networking is concerned with cultural innovation and Durkheim has little to say about this.

Radcliffe-Brown through whom Durkheimian ideas entered the British anthropological mainstream, recognised that culture could only be transmitted through social interaction and opened up an opportunity for thinking about the way in which social interaction might lead to culture change, but he quite spectacularly failed to take the opportunity to do this offered by his own insight (Radcliffe-Brown,1952, pp.4-5).

From the work of Malinowski we can draw on three key ideas. Firstly that culture has to be seen in holistic terms. Secondly that culture can be understood as a way of meeting need (Malinowski,1962,p. 203). Thirdly that culture is not essence or spirit but rather exists in terms of actual social practices (Malinowski,1962,p.174).

In taking on these ideas we must, however, also be careful to reject Malinowski's cultural and biological determinism.

From Levi-Strauss (1972) and his followers we can draw on the idea of culture as classification. This idea that our experience of life is fundamentally mediated through culture can help us to understand community care interactions in terms of the very different 'world views', values and expectations which all those involved bring with them.

From the semiological tradition often linked to structuralism we can draw on the idea of culture as a set of heavily encoded meanings and as a set of 'rules' underlying everyday social practices.

But we not only need to be aware that our interactions may be rule governed we also need to know how to change the rules. Both structuralism and semiology seem at times to be suggesting that culture is set in stone and this is neither true nor helpful to us in solving the everyday problems of community care. For example nurses and social workers may fail to communicate effectively with one another. We need not only to see how this failure to communicate is embedded in underlying assumptions, we need to feel able to do something about the problem. We need a model of culture which is much more process oriented than any we have considered so far and which helps us to understand culture change.

Bateson (Bateson, 1973) opened up the possibility of seeing cultural codes as capable of adaptation and transformation in conditions of contact and change. The kind of models he pioneered enable us to begin to think about interaction, communication, culture contact and cultural change and this is obviously very useful. But a wide range of

contemporary authors remind us that the cultural process is 'reflexive'. It is individuals who actively participate in the creation of their own cultures. Pedison and Sorenson argue that in the context of an organisation a cultural perspective focuses on 'social cognition and contextual sense making' by its members (Pedison and Sorenson, 1989, p.2). Networking too must recognise the creative paradox that it is individuals who both make and are constrained by culture.

The same authors also point out that not all those involved in the cultural process are necessarily involved on equal terms (Pedison and Sorenson, 1989, pp.19-20). We should always ask the question: Who owns the culture?

The post-modern tradition alerts us to the dangers of reification and reminds us that culture is dependent on interpretation. For networkers this means there is always a danger of creating patterns and then acting as if they were real.

In his novel Foucault's Pendulum Umberto Eco shows how the obsessive search for patterns- in this case the secret of the Templars -can create realities which can then begin to have their own life. Anyone trying to make use of cultural perspectives in their work should read this book as a kind of moral fable about the dangers of reification.

Perhaps the best response to this problem of reification is to see culture as an 'emergent' phenomenon. This is a theme which is present in the work of thinkers as diverse as Norbert Elias, the Ethnomethodologists and Georg Simmel.

A view of culture which sees it as an 'emergent' property of social relationships and in particular social interaction is especially useful for social workers and others involved in community care practice. Defined in this way culture is present in every social situation, however fluid or informal it may appear to be. We can make use of this concept of culture in a number of ways. Firstly we can make use of it to understand networking as an historical phenomenon

### **Networking - Why Now?**

Where has the culture of networking come from? Everything I have said, so far, suggests that it is likely to have 'emerged' as part and parcel of a change in the way in which those working within welfare and users of welfare services relate to and interact with one another. This in turn suggests that the culture of networking is likely to be part of a much broader pattern of cultural transformation.

But how can this be when it seems to be very clear that the dominant culture of welfare is opposed in almost every way to the most basic features of the culture of networking? It is impossible to resist the conclusion that networking is an oppositional or subversive culture. Arguably, because of its links with empowerment it could even be described as a 'culture of resistance'- resistance to the oppressiveness of individualism and reductionism.

Whilst the emptiness of the rhetoric of networking within the dominant welfare culture could be seen as evidence of the weakness of networking as a practice, the fact that it has been recognised at all could be seen as a recognition of the power of the critique which it represents.

This raises some very complex questions which cannot be explored adequately here. But the essential point, is that the complex social, economic and political mixture which has



created the sterile reductionism of current community care policy has also created the conditions from which networking has 'emerged' as a critical practice.

### **Networking - a Culture of Change**

The culture of networking has emerged in a context of change. Moreover it is arguably in itself a culture of change embracing values of change and innovation which are very different to traditional concepts of welfare and welfare professionalism.

One has only to contrast our definitions of networking with the hierarchies and rigid divisions of labour inherent in traditional 'welfarism' to grasp the scale of the cultural change involved and to see that those practising networking are likely to become very involved in trying to change their organisations. The imperative for this is clear and unavoidable. For example, needs led services depend crucially on radical changes in organisational structure and the policy environment at a local level (McGrath and Grant 1992, pp.95-96). Networking as a needs-led practice will have to respond to this type of challenge.

### **Practice Culture and Cultural Practice**

One might say, any powerful set of practice ideas could be described in 'cultural' terms and to do so is only to state the obvious, ie. that there are intellectual fashions which tend to regularly change the nature of professional practice. One might for example argue that psycho-analysis had a profound cultural impact on British social work. So what is so special about networking. Why is it particularly cultural?

The answer to this perfectly valid point is that networking is not just another professional culture but rather one which is characterised by an orientation to what I would argue is a specifically anthropological concept of 'culture' embracing the totality of social practices and a commitment to a critical and reflexive awareness of its own 'emergent' nature. For the networker culture is both subject and object.

This takes us back to the roots of networking. Networkers are concerned with social networks and in relation to community care they are concerned with a very wide range of such networks from networks of personal social support to campaigning networks, from informal caring networks to inter-agency networks crossing the health/ social services and hospital/ community divides. But networkers are never concerned just with interaction, they are concerned with patterns of interaction and the rules, values and 'basic assumptions' which 'emerge' out of and feed back into these patterns of interaction.

Furthermore networking is action-oriented and I would argue that networkers are therefore of necessity cultural activists. For example, promoting communication and understanding, solidarity and the mobilisation of support are all cultural activities. Networking is not just a 'practice culture', it is also a 'cultural practice' because it is concerned with a whole range of essentially cultural processes (Freire, 1976).

Another objection to cultural models might be that the culture concept only makes sense within a bounded group of some kind. If cultural identity is an aspect of group identity and if we are talking about social networks rather than clearly bounded groups surely we cannot be talking simultaneously about culture.

The answer to this is to remind ourselves that it is more often minds which are closed

rather than social systems. Moreover, an 'emergent' approach to culture enables us to relate it to the patterns of lived experience and lived experience involves making sense of difference. One could also go further and say that it is the fact that networks always involve difference which makes a cultural perspective so imperative. Networking is concerned with questions of cultural difference, cultural brokerage and culture change. Because it is concerned with all these things, because it is concerned with cultures that are made rather than fixed or given, cultural questions become more, rather than less important.

I am referring here to the kind of questions that always arise when there is a need to create community, to make connections, build bridges and develop new perspectives. Because of this orientation, in some respects, it may be appropriate to think of networking in its community making mode as a meta-cultural practice.

### Conclusion

I have argued that networking does not fit with the current trend towards reductionism in community care policy and that this lack of fit arises because networking is based on holistic principles. I have tried to show that the dominant language and models of community care fail to address the very principles of coordination and integration which are their *raison d'être*. I went on to argue that networking can address these issues because it is both a cultural and a community practice and that it is based on an essentially anthropological approach to the nature of culture.

Having explored various models of culture to see what they can offer to us, I settled on a 'totalistic', 'emergent', 'interactional' and 'reflexive' approach to networking as a cultural practice and looked at some of the broad theoretical implications of this.

I would like to finish by now summarising the main practice implications of adopting a 'cultural' paradigm for community care work:

1. Concern with pattern and process at all levels of a situation. Networking involves paying attention to interactional patterns and all the cultural processes emerging out of and feeding back into them at an inter-personal, intra-agency and inter-agency level and a willingness to consider the connections between what is going on at different levels in terms of broad cultural themes. A classic example might be the work that needs to be done to reduce competitiveness and lack of trust between individuals, between different parts of the same agency, between different agencies and between professionals and user organisations if community care is to succeed.
2. Sensitivity to questions of meaning and in particular the way in which practice is culture bearing. As culture brokers, networkers are actively concerned with the development of new collective values and symbols. An example of this might be the way in which network conferences are organised, the venues where these conferences take place and the norms surrounding modes of interaction -all of which may be characteristic of the very special kind of culture developed by network members.

This sensitivity to meaning extends to awareness of the coded or message bearing nature of interactional processes. A care manager who communicates only on the telephone or only in affectively neutral terms or only about abstract quality standards is going to send very different messages about the nature of the

community care partnership than one who engages with carers, service users and other professionals on face -to- face and a day- to-day basis

3. The acknowledgement and integration of difference. Networkers always have to bear in mind that they are dealing with relationships between agencies, individuals and groups and that they are striving to develop an integrated whole out of disparate elements. This process of integration can be seen at a cognitive level as developing some kind of collective sense out of community care practices. The networker is a cultural facilitator-one who helps cultures to come together and make sense to all those involved. Moreover this process of integration must always be articulated around an awareness of 'need'.

But integration does not mean that we should forget that culture is a matter of interpretation or cease to be sensitive to cultural difference. 'Need' may be represented in very many different ways and networkers as cultural practitioners should therefore be healthily critical about the way in which 'needs' are represented especially by professionals. But nevertheless, an effective community care practice undoubtedly requires some kind of shared perspective on need. It is just that this should not be taken as a recipe for blandness. All cultures can and should contain diversity (Pedison and Sorenson, 1989,p.7). Rather it should change the way we look at issues such as assessment so that an effective needs led assessment becomes one which makes sense out of the diversity of images of need rather than imposing a single image on the situation.

4. Commitment to cultural empowerment. Interaction is the context in which culture is constantly forged and re-forged and the terms of interaction-the balance of power will influence the type of culture which is created. As networking is all about interaction this is obviously a key point. The kind of cultures we facilitate will be shaped by the way in which we handle issues of power and oppression. This means networkers have to be actively engaged in the way in which power relations are played out between different professionals, between professionals and service users and between service users and carers.
5. A reflective methodology. As described by Schon (1983)and others this involves placing yourself in the frame when trying to understand a situation and being willing to question your assumptions about the nature of the problem. Within the context of a cultural paradigm, this becomes a way of putting everything from your own personal values to agency and governmental policies and practices within the analytic frame.

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# Developing Skills for Community Care

A collaborative approach

Peter Beresford  
Steve Trevillion

*arena*

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# Foreword

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Radical leaps in social policy such as the one we have recently gone through always produce banner statements. The words 'collaboration', 'empowerment' and 'participation' leap from the mouths of speakers and from the pages of books and articles. An important first stage, but also one of danger. Good intentions can be wrecked by assumptions about agreement where there is none, and a failure to work on what must underpin intentions. This is particularly important in social care where practice is about the day-to-day detail and diversity of people's lives. Generalizations are not only inadequate, they are oppressive. An essential second stage is moving towards greater clarity about banner headlines, including differences of interpretation, and the sort of practice which is most likely to bring us closest to achieving change.

This book makes an important contribution to remedying the neglect of the development of practice at a time when the initial concentration on implementation has been concerned with organizational structures and procedures. The book is based on working with managers, practitioners, service users and carers, drawing on their experience to identify the skills and approaches needed for community care. Using a 'bottom up' approach, the authors have been able to model their own views about the importance of collaboration. Although they argue major changes are needed, there are existing resources which can be built on. Peter Beresford and Steve Trevillion make a strong case for giving a greater emphasis to skills such as negotiation, networking and information-giving, but they equally stress the importance of traditional ones, like relationship-building and communication.

Creating collaborative practice in social care will be achieved only through doing, analysing and disseminating research in a form which is useful to managers, practitioners, service users and carers. It will not emerge of itself. *Developing Skills for Community Care* combines these merits with being easy



to read and to use. Thank you Peter and Steve and all those who worked with you.

*Daphne Statham, Director, National Institute for Social Work*

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# Introduction

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## The challenge of change

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Massive changes in welfare generally and community care specifically are now taking place. These are making enormous demands for innovation and change on human service workers. The aim of this book is to help service workers make this move successfully. It seeks to do this by setting out a new collaborative approach for practice, consistent with the new values and goals of needs-led service and user involvement. The model of practice developed in this book is based on the practical experience, insights and proposals of service users, carers and practitioners.

The changes now taking place in welfare and community care are far-reaching. They include new welfare philosophy and legislation, changed structures and organizations and new theories developed by disabled people and service users. In Britain, health, local authorities and personal social services are all undergoing reorganization. There are new community care cultures, languages and roles, all requiring new skills.

How will workers negotiate all this, so that, in the words of one of the service users we spoke to, they are still in a position to help the service users they are working with? So far radical change has not been accompanied by the development of the radically different model of practice which it requires. Instead the response has often been to retreat to the past rather than to look to the future.

## **A new approach to practice**

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We hope this book will help change this. We believe that the collaborative approach to practice it discusses does not just offer another way of delivering traditional welfare services, but instead is a way of transforming the nature of welfare systems. It offers an alternative to the paternalism of the old state services and the new competitiveness of the market.

Collaboration is not a new idea. It is meant to be one of the foundations of the new community care. But it is one thing to make a rhetorical commitment to collaboration, another to make it a practical reality. The aim of this book is to provide agencies and practitioners with a basis for doing so.

While it does not duck theoretical, philosophical or value issues, the book is rooted in service users', carers' and practitioners' day-to-day experience. It develops practice from the bottom up, not from the top down. The book draws on a development project which involved service users, carers and practitioners in exploring and negotiating the skills needed for community care. The project was itself an exercise in collaboration and it demonstrated that a collaborative approach could work. This book seeks to communicate the lessons learned from both the findings and the process of the project.

## **Breaking down barriers**

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Perhaps the most exciting lesson we learned from the development project was that there *was* a way forward. Service users, carers and practitioners could work together and they could find common ground about skills for community care. No less important, the model of practice which grew out of their collaboration took into account the reality of limited resources, instead of ignoring it or being undermined by it.

This book has been written for human service practitioners who want to work in more equal and participatory ways. Its overall aim is to help workers support service users to have the opportunities, rights, choices and support which they want in their lives. It is for people who want to develop more collaborative ways of working with colleagues, both within and outside their own agencies, as well as with service users and carers and their organizations. The book provides guidelines, checklists and exercises based on the development project to help readers to monitor and develop their collaborative practice.

This book challenges many of the barriers that exist in community care. It connects the different world-views of service users, carers and practitioners and reveals the important areas of agreement between them. It shows that inter-agency collaboration and user involvement, which have tended to be

treated separately, are actually closely connected and entail comparable skills. It makes connections between user involvement, anti-oppression and anti-discriminatory working. It shows the overlaps between different professions and highlights the need to start from a notion of community care practice instead of from traditional professional disciplines. Above all the book, like the practice approach it advocates, rests on the belief that welfare and community care policy and services are likely to be most supportive and most cost-effective if all the key constituencies concerned – practitioners, service users, carers, and other local people – are fully and equally involved in shaping and controlling them.

## The structure of the book

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Now let's turn to the structure of the book. At the end of each chapter, readers will find a short summary of its discussion.

**Chapter One** focuses on collaboration. It examines the new emphasis on collaboration in community care and points out some of the problems in moving from rhetoric to reality. We see how collaboration unifies two key requirements in community care: cooperation between professions and the involvement of service users. We begin the process of defining collaboration and look at what collaboration may and may not mean in practice.

**Chapter Two** moves on to the development project on which the book is based. The aim of the project was to identify a core of skills associated with a collaborative approach to community care, in response to the growing recognition of the importance of training for collaboration in community care. The project was itself an exercise in collaboration, involving service users, carers and community care practitioners. Two ideas central to collaboration in community care are discussed – networking and user involvement – and the thinking which underpinned the project is also examined.

**Chapter Three** begins to look at what practitioners and managers in the development project had to say about community care skills. It explains how they were involved in the project and examines the first stage of this process, the community care diaries they kept of their day-to-day practice. Analysis of this shows a strong link between a needs-led and collaborative approach to practice, highlighting the factors which encourage collaborative practice as well as some of its characteristics.

**Chapter Four** reports on the discussions with practitioners about their practice. It examines a range of themes which emerged from these discussions about collaborative skills and explores their relationship with a collaborative culture. These include the management of conflict, resources, power sharing, support, the organizational context, building networks and training.

Chapter Five turns to the discussions with service users and carers. It describes the process by which they were involved in the project and then reports each group's experience of and attitudes to community care and the skills they identify for community care. It also focuses on their views of the range of skills required for collaboration by *both* practitioners and service users and carers.

Chapter Six moves on to a series of broader issues about collaboration and community care skills which service users and carers raised in the project. These related both to themselves and to service agencies and practitioners. They include differences between health and social services, the interrelation of skills and values, ensuring services are equally accessible to all communities, service users' and carers' own training needs and the implications of people having different levels of experience and involvement in community care. In the second part of the chapter a series of guidelines for involving service users and carers are offered, based on the experience of the project.

Chapter Seven looks at the final stage of the development project, the meeting which brought together service users, carers and practitioners and enabled each group first to explore its own views on skills and collaboration for community care and then to come together to exchange them with the others. It reports the set of skills which the three groups were jointly able to identify and prioritize and examines the process for the meeting which made this collaboration possible.

Chapter Eight looks at what we have learned about collaboration so far. Building on the development project, it sets out the defining characteristics of a collaboration culture and looks at how to develop one and what is needed for it to flourish. It offers a series of guidelines or checklists of the basics for practitioners who want to work more collaboratively. These basics include credibility, anti-oppressive values and empowerment. Then it looks at some of the training implications and offers a self-evaluation exercise for readers to check and develop their own basic skills in collaborative work.

Chapter Nine moves on from the basics to ideas for building a collaborative culture and examines the key skills needed to do this, including both interpersonal and inter-organizational skills. A set of exercises are provided for readers to test and develop their own collaborative skills. These include skills in communication, relationship work, empowerment, assessment and planning, collaborative working, and review and evaluation.

Finally, in a short **Conclusion**, we try to pull together the discussion about collaboration in community care and highlight some of the key themes which have emerged in this book.

# 1 Collaboration in community care

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## A cultural revolution

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The new rationale of community care in Britain puts the service user centre stage. For the first time, it explicitly states that it is the needs of service users, not of services, agencies, authorities or professionals, which should guide policy and practice. Service users and carers know that this is a promise rather than a cast-iron guarantee, but even so it still represents a fundamental change in human services, with potentially far-reaching consequences.

To make services more responsive in this way to the needs and wishes of those who use them will involve the development of a radical alternative to the traditional service-led culture which has dominated all aspects of the welfare state since its inception. In the words of the Social Services Inspectorate, who have in recent years played a major part in the implementation of government policy:

This will entail a progressive revision of organisational structures and procedures, but above all, a change in attitude and approach by managers and practitioners at every level that amounts to creating a new organisational culture (Department of Health, Social Services Inspectorate, 1991, p. 11).

So community care represents a cultural revolution. But what kind of cultural revolution? What is this new 'needs-led' culture that everyone seems to be talking about?

That there is more than one answer to this question is a direct consequence of the fact that community care itself is associated with at least two very different visions of need and the process of meeting need. These are a *market* and a *collaboration* vision. We need to look at them both before we go any further.

## **Meeting need through the market**

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This vision is based on an image of the service user as a consumer whose needs can be neatly quantified and then met through a flourishing care market. Services are assumed to be needs-led because competition is supposed to ensure 'the customer is king'. This has been described as 'super-market style consumerism' (Walker, 1993, p. 221).

Whether service users can ever be 'customers' in the true sense of the word is a much debated point, especially when there are few examples of these so-called customers actually purchasing services (Morris, 1993). But few would argue that 'contract culture' has not made a major impact on the way in which services are designed, purchased and packaged, which could be described as revolutionary (Hoyes and Means, 1993, p. 290).

## **Meeting need through collaboration**

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The collaborative vision of a needs-led or user-led community care system is one in which power is shifted from professionals to communities, service users and carers. It is one in which needs are identified through discussion, support mobilized through negotiation and a wide range of practitioners cooperate with one another across both traditional organizational boundaries and the new boundaries between purchasers and providers.

But, while market principles have become an increasingly influential part of the post-welfare state world, it is by no means clear that there has been a parallel collaborative revolution. On the face of it, this is puzzling. The involvement of service users and carers and the achievement of 'seamless' patterns of inter-agency and inter-professional work are explicit policy objectives (Department of Health, Social Services Inspectorate, 1991, pp. 2-3).

It may be simply that it takes time for people and organizations to change their ways. But it is also true that it seems to be much easier to encourage purchasers and providers to compete with one another than to cooperate with one another and involve service users and carers in key decisions. After all, competition allows community care organizations and individual practitioners to exercise a new kind of market power whereas collaboration requires that they share power both with one another and with service users and carers.

But even if we make the assumption that practitioners want to cooperate with one another, it is now clear that as the community care service environment has become more and more competitive, so it has become increasingly difficult for people to trust one another or to spend time (and therefore money!) developing collaborative relationships.



Another problem is the sheer complexity of the issues which seem to be raised by any attempt to move from rhetoric about collaboration to anything that might resemble collaborative practice. There are so many different individuals, organizations and professional interests involved, so many different perceptions of need and so many different priorities, that it may sometimes seem as if community care is a hopelessly tangled knot which will never be unravelled.

Even the government, while exhorting all those involved to collaborate effectively, has not been able to conceal the apparently daunting scale of the task. Quite apart from service users and carers who are themselves distinct if overlapping groups, there are many professions and agencies which it has specifically identified as needing to work together, such as:

Social workers, G.P's, community nurses, hospital staff such as consultants in geriatric medicine, psychiatry, rehabilitation and other hospital specialities, nurses, physiotherapists, occupational therapists, speech therapists, continence advisors, community psychiatric nurses, staff involved with vision and hearing impairments, housing officers, the Employment Department's Resettlement Officers and its Employment Rehabilitation Service, home helps, home care assistants and voluntary workers (Cmn 849, 1989, p. 19, s.3.2.5).

But before this apparent complexity leads us to dismiss the whole venture of collaboration as misconceived, we should consider the possibility that what may be making the problem so apparently insoluble is our way of looking at it.

## A new approach

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Conventionally, the involvement of service users and carers has been discussed as if it had little connection with the ability of practitioners to 'work effectively together' (Griffiths, 1988, p. 14, s.6.4; Cmn 849, 1989, pp. 13, s.2.20 and 19, s.3.2.6).

Only now have we begun to grasp what should perhaps have been obvious from the beginning. Collaboration with service users and carers, and collaboration between different groups of practitioners, should not be treated as two separate issues, but as part of a *single* transformation of the whole way in which we think about what has come to be known as community care. This is the cultural revolution for which we are still waiting.

## Community care and independent living

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During the forty or so years that the term 'community care' has been in existence, a number of different meanings have been attached to it. Initially it was used to mean moving people from large to smaller institutions: from hospitals, former workhouses and prisons to hostels and homes. Now it is also used to mean supporting people so they can stay in their own homes, and supported schemes to enable people to live in ordinary housing, as well as small-scale group living.

Disabled people and other service users increasingly challenge the idea of community care – a combination of two of the most contested, ill-defined and devalued words in the language. Shortly we shall see how many service users are critical of the concept of 'care' in public provision. For such service users the concept of community care is associated with inferior and controlling provision which is part of a segregated welfare system.

Rejecting this, some disabled people have developed instead the idea of *independent living*. It is helpful first to look more carefully at the word independent. Disabled people argue that in welfare services independent has usually been taken to mean people being able to do things for themselves and to live without support. They have therefore been defined as dependent because of their need for support: for example, to get up, dress, eat and get about.

Disabled people's concept of independence is related to the social model of disability which they have developed. This rejects an individual or medical model of disability, which sees the major cause of people's disability as their impairment, and instead highlights the disabling effects of societies which discriminate against and exclude people with physical, mental and sensory impairments.

Disabled people have redefined independence. They argue that it should mean having the support to ensure the rights, choices and opportunities available to non-disabled people, thus making access possible to employment, recreation, public transport, the environment and so on. So, for example, they say:

Here the term 'independent' does not refer to someone who can do everything themselves, a feat that no human being can achieve, whether they have an impairment or not, but indicates someone who is able to take control of their own life and to choose how that life should be led ... Independent living ... is primarily about giving disabled people access to and control of a range of community based services which enable them to identify and pursue their own lifestyle (Barnes, 1991, pp. 129–30).

Disabled people argue that independence should be measured not by the physical tasks that disabled people can or cannot perform, but rather by the

personal and economic decisions that they can make. Thus independent living means access to the support which enables each individual to live as they want to, and the same access to employment, housing, income, education and other services, rights and responsibilities as the rest of the population. Such a definition of independence does not deny people's interdependence. Independent living becomes the goal of user-led services.

The concept of independent living enables us to escape – at least in our imaginations – from the closed universe of 'care givers' and 'care receivers'. In a world in which choices become real and needs are defined in ways which suit individuals rather than welfare agencies, it is no longer possible for professionals to refuse to talk to one another or to fail to respond to service users and carers. Enabling independence is not about promoting self-sufficiency, it is about the process of developing flexible and user-driven networks of support – a process we would describe as collaboration.

To initiate this process, often little more is required than paying attention to what service users are actually saying. What emerges is often something very simple but, at the same time, far-reaching in its implications. This, for example, is what some black disabled people want:

The concept of Community Care will not be different for Black Disabled people. The principles of choice and independence are valued as much by Black Disabled people as they are by others. However, policy makers and practitioners must acknowledge and work with the fact that Black Disabled people need support to enable them to achieve autonomy and a lifestyle which they value as Black Disabled people (Begum, 1994, p. 144).

This challenges traditional, sometimes racist, community care practices. But it also clearly indicates a way forward for all concerned. Professional rivalries and organizational conflicts and misunderstandings do not disappear overnight. But a shared commitment to the key principles of 'choice' and 'independence' and a shared understanding of the key task of enabling black disabled (and other) people to obtain the support they want establishes a common framework and helps to put these problems into perspective.

## **Empowerment**

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It should be clear by now that we see collaboration as an empowering strategy.

There has been an enormous increase in interest in the idea of empowerment in both community care and human services more generally. Empowerment is now officially identified as a central function of community care,

as well as the purpose of professional practice. However, there is little clarity or agreement about the meaning of empowerment. Service users' definitions of empowerment tend to follow on from their strong sense of *disempowerment*. They experience oppression, discrimination and restrictions on their rights, opportunities and choices. Empowerment for them means reversing this situation. So for example:

Being empowered means having control over my life and being able to influence others. It means opportunities for people to influence the system collectively, to have control over our own lives (Evans, 1994).

This approach to empowerment is concerned with changing people's position in society. It does not ignore issues of personal empowerment, but these are framed in terms of ensuring people the support, skills and personal resources they need both to organize themselves and to participate to achieve broader social and political change.

Professional interest in empowerment is generally more narrowly concerned with personal empowerment: with people taking increased responsibility for managing their lives, relationships and circumstances in order to live in conformity with prevailing values and expectations and to change in accordance with professionally set goals and norms. This has led one commentator to suggest that the professional approach to empowerment has important regulatory as well as liberatory implications (Baistow, 1995).

Some service users reject the idea that professionals can empower them, arguing that 'we can only empower ourselves'. This is not a view we share. We believe workers can help service users develop personal empowerment by providing information and increasing people's expectations, assertiveness and self-esteem. They can also give people access to resources, opportunities, networks and organizations. In this way they can provide a helpful basis for service users to gain more say and control. But service users' and professionals' interpretations of empowerment may be different. This highlights the need for clarity when talking about empowerment and when using it as a guiding principle for working together.

## **Working together – rhetoric and reality**

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Unfortunately, empowerment is not the only word we need to be cautious about.

The popularity of certain other 'buzz words' can also be a problem. For example, the temptation for practitioners to describe any service users or carers with whom they are in contact as 'partners' may be irresistible. This desire for 'partnership' may be quite genuine. But good intentions are not

enough and the ease with which it is possible to use fashionable terminology may distract us from the messy and complex business of attempting to build genuinely collaborative relationships with service users and carers.

Likewise, with inter-professional or inter-agency 'partnerships'. There is so much emphasis on concepts such as 'the multi-disciplinary team' and 'teamwork in primary care' (Thomas and Corney, 1993, pp. 47–48) that professionals seem to feel obliged to use the language of partnership almost indiscriminately. This point was brought home to us at the very beginning of the project on which this book is based.

In response to questions about collaboration, many of those who took part – both social workers and nurses – tended at first to list all those professionals with whom they had some kind of regular contact as 'partners'.

In the context of collaboration, language is plainly even more slippery than usual. We therefore need to be clear about the words we are using and why we are using them.

## Partnership and collaboration

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Partnership is rooted in the concept of participation. When the social work profession gave 'client participation' a central place in its code of ethics (British Association of Social Workers, 1980), an important shift was made away from the notion of the 'client' or 'patient' as a passive recipient of services. Since then, concepts of partnership have been extended to include both relationships between practitioners and carers/families and the way in which practitioners relate to one another, that is to say, those issues which have often been separately described as 'multi-disciplinary teamwork' and 'inter-agency work' (see Trevillion, 1992, for a discussion about communities and partnership).

However, it has become increasingly clear that when it comes to trying to understand the ways in which practitioners relate to one another and to service users and carers on a day-to-day basis, the concept of partnership is not always helpful. This is partly because almost everyone seem to have their own ideas about what it means. It also needs to be said that for many service users and carers, the concept of partnership comes dragging with it a deadweight of disappointment, false expectations and denial because of the failure of those who promoted it most avidly to take sufficient account of conflict and inequalities of power and control (Morris, 1993). While not denying that it has some value under some circumstances, we will in this book make more use of the term 'collaboration' to refer to the various forms of working together.

## **Anxieties about identity**

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It has to be acknowledged that like empowerment and partnership the term collaboration is not without its problems. For many people it evokes the concept of 'betrayal'. But in making explicit a fear which we all have about selling out as the price of a closer relationship with those we have traditionally kept at arm's length, this image of collaboration as betrayal may actually help us to confront our anxieties and force us to separate fantasy from reality.

There may be times when we should refuse to collaborate if we feel that what is being asked of us is to forget who we are or to forgo our own legitimate interests and concerns. Of course, it takes courage to take a principled stand against this kind of collaboration. But on other occasions, even more courage may be required to do something to end the trench warfare which is sadly all too characteristic of relationships in the field of community care.

Furthermore, collaboration need not be an all-or-nothing exercise. In cooperating with others, we do not necessarily lose our own identity or values, any more than we necessarily safeguard our identity or values by refusing to have any contact with them.

Those, for example, in the social work profession who have responded to the challenge of community care by arguing for a return to a purer form of traditional social casework seem to us not only to be falsifying the history of the profession but to be, in effect, advocating a retreat from any active engagement with the contemporary realities of welfare.

To practitioners concerned about losing their identity in the collaborative process, we would say that the real choice is between courting irrelevance by seeking to protect an idealized image of the past or developing a new and more appropriate professional identity by accepting the reality of change and engaging with it in a positive and principled way.

## **Is collaboration just common sense?**

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While accepting that collaboration is important, it could be argued that it is just common sense – people learning how to get on together, hardly something which one needs to write a book about. But it is precisely this common-sense view about collaboration which needs to be challenged, because it prevents us from asking the questions we need to ask. We can illustrate this by looking at three 'common-sense' notions about collaboration which are in fact very misleading, because although they all begin by stating an obvious truth, they go on to draw misleading conclusions.

Collaboration is working closely with somebody else (Rao, 1991, p. 14).

[Therefore, anybody with whom we work closely must be someone with whom we are collaborating.]

Is this really so? What about members of the same team? Or the relationship between supervisors and those they supervise? Both involve close working relationships but neither is necessarily an example of collaboration. Collaboration has to involve something more than simply working closely with other people, otherwise it becomes so broad as to be meaningless.

Collaboration involves having a good relationship with other people with whom one is working (Rao, 1991, p. 31).

[Therefore, those whom one feels closest to, like most or have the least conflict with are those with whom one is collaborating.]

This is not always true. A good relationship, if this is defined as a trouble-free relationship, may be a product of *not* working closely together rather than doing so. Moreover, a difficult relationship may be difficult precisely because those involved are trying to work through conflict in the spirit of collaboration rather than trying to ignore it (Payne, 1993, p. 49). Collaboration often involves taking the risk of having some conflict in order to build a meaningful working relationship.

Collaboration is based on a perception of common interest (Trevillion, 1992, pp. 22–37).

[Therefore, the concept of collaboration applies only to relationships between those whose interests are identical.]

This is a distortion of the true picture. While a perception of common interest plays an important part in collaboration, that does not mean that we should assume a complete convergence of interest. Ask yourself, are your interests the same as those of all the carers and service users you know? Are they the same as those of the other professionals you work closely with? In many ways, it is the need to negotiate different interests which is the hallmark of the *collaborative process*.

While recognizing that the concept of collaboration may necessarily be somewhat fuzzy at the edges, these examples show that we need a definition of collaboration and one which is strong enough to take account of the issues that have just been raised.

## Definitions

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If we turn to the dictionary for help we find that 'collaboration' is usually associated with:

*a process by which two or more persons 'unite' or 'come together'*

and

*a shared task or purpose (Oxford English Dictionary).*

It is not simply friendship or general socializing. Collaboration is a process of 'working together' and, as it involves shared aims and goals, all those involved in collaboration presumably must have an opportunity to help define those aims and goals. Moreover, the fact that the task is a shared one implies that those involved need to work together. In other words, there must be a collaborative task if there is to be a collaborative process.

The dictionary also helps us to distinguish between collaboration and total amalgamation. Collaboration is not about 'combining into one uniform whole' (Oxford English Dictionary) but about the coming together of a number of *different* individuals or groups for a *specific* set of purposes.

This notion of a level of difference which is never entirely lost, however deep or lengthy the collaboration, means that collaboration is always, at least in principle, *reversible*. Those who collaborate retain their own separate identity while simultaneously demonstrating a commitment to one another. The test of this is something we know only too well. Those who collaborate at one point may cease to collaborate at another! The process of collaboration can never be taken for granted.

To sum up:

*Collaboration involves different individuals, groups or agencies working together towards agreed aims and goals on matters of mutual interest and concern by effectively and equitably deploying their collective resources.*

What this definition shows is that where collaboration exists, the advantages are obvious. What it does not reveal is that the process of developing collaboration is by no means straightforward.

*Collaboration involves sharing power and negotiating issues connected with different perceptions, values and interests so as to promote the collective ability to work together.*



This suggests that it is by looking at the collaborative process that we will begin to see why collaboration poses such a radical challenge to traditional ways of working and amounts to a new kind of culture.

## The culture of collaboration: a creative paradox

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One way of thinking about the culture of collaboration is as a set of 'basic assumptions' (Schein, 1985, p. 6), simultaneously motivating those involved in collaborative work and helping them to make sense of the processes in which they are engaged (Pedison and Sorenson, 1989, p. 2).

Always and everywhere the mainspring of collaborative culture is a paradox – respect for *difference* and commitment to *collective* action. The creativity of the collaboration will often spring from the tension between the idea that 'the whole is greater than the sum of its parts' and the principle that differences must be acknowledged and valued. The strength or otherwise of a collaborative culture is likely to reflect the extent to which this paradox is resolved.

But developing a collaborative culture cannot be achieved simply by redesignating social workers and nurses as 'care managers' or by reorganizing social services departments and health authorities. It involves a distinctive kind of approach to the way in which community care should be defined and delivered.

In the following sections we compare and contrast collaboration with other models of welfare and explore the implications for community care.

## From collectivism to collective action

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Traditional collectivism draws its inspiration from the belief that the state can act as the embodiment of the community and overcome the competitive and overly individualized features of contemporary society.

But although collectivism starts with the desire to rebuild relationships shattered by the development of individualism, experience suggests that it is led by its own logic to take power away from individuals and give it to the state. Cooperation and collaboration then become little more than *metaphors* vaguely connecting the organizations of the welfare state to the *ideal* of community. State welfare is not incompatible with the principle of collaboration, but does not in itself guarantee that the planning and delivery of services is characterized by either shared aims or joint patterns of working. Indeed it has been argued that the lack of this kind of reciprocity is one of the defining features of state welfare organizations (Benn, 1982, p. 52).

As far as the UK is concerned, the irony is that in attempting to recreate the community through the medium of state bureaucracy, collectivism did little or nothing either to address the problems of confusion and fragmentation characteristic of welfare services themselves or to overcome the alienation of the users of services from that which was offered to them in the name of the community.

Collectivism fails to deliver a genuinely collaborative form of welfare provision because it fails to recognize that, while the state may represent 'the community' at a symbolic level, it is, at a practical level, organized around the same principles of hierarchy and division of labour which it is expected to overcome.

Collaboration in any meaningful sense has to be based upon more than an attempt to bureaucratize and standardize in the name of the community. It has to be founded on an acknowledgement of, and a respect for, the differences that characterize every facet of society and the welfare systems that have been set up to meet its needs. From this perspective, the challenge of community care is to find ways of doing this which also enable all those involved to work together on the planning, purchasing and delivery of services. In other words, it involves a shift from collectivism in which the state acts for the community to a more direct form of collective action, one which recognizes differences as well as commonalities.

Collaboration as a principle of community care involves a fundamental reorientation in thinking about the relationship between welfare and community, from a set of services offered by the state on behalf of the community to a process of building support in which all those involved come together to define needs and to contribute collectively to the meeting of them. The role of the state continues to be associated with the principle of equity, but this objective is no longer identified with the bureaucratization and standardization of services.

## **From contract culture to collaboration culture**

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Competition creates a zero sum game in which there are always losers as well as winners. Even if there is cooperation, it is in the form of a business contract – a short-term arrangement under the terms of which both partners gain. Here the relationship counts for nothing and indeed represents nothing other than mutual self-interest (Benn, 1982, p. 45). Community care has encouraged the growth both of competition and of precisely this kind of contracting process – an approach to health and social welfare which is often referred to as 'contract culture'. This has little in common with what we would like to call 'collaboration culture'. We have no wish to introduce

any additional jargon into a field which already has more than enough of it; however, it seems to us that collaboration is as much a culture as it is an activity and that linking the two words together in this way serves an important purpose.

### **What distinguishes collaboration culture from contract culture?**

Collaboration culture values complexity, celebrates difference and yet retains a belief in the importance of power sharing and the need to develop a shared vision of both ends and means. In a collaboration culture there is a strong emphasis on collective action – something which is entirely absent from, even contrary to, the spirit of contract culture. One of the main effects of the introduction of market principles into welfare has been increasingly to fragment services and make planning and collective action more, rather than less difficult (Challis, 1990, pp. 65–85). It does not seem likely that the disintegrative power of the market can be transformed into an integrative mechanism just by redesignating it as a quasi-market (Le Grand, 1990). Markets may bring all kinds of benefits but collective action is unlikely to be one of them.

And yet we cannot leave the debate there. In the same way that the state continues to fulfil an essential though somewhat changed role in a collaborative context, so too the market will clearly form part of the welfare landscape in which the new culture of collaboration will be built.

We do not pretend to have a full answer to the question of how to reconcile two such very different principles. At a practical level, one obvious way of beginning to do so is to identify and acknowledge any conflicts of market interest at the early stages of any collaborative venture. But perhaps we should not assume too readily that collaboration and competition are always and everywhere opposed to one another. The presence of market elements, while certainly acting as a constraint upon collaboration in some areas, should not be seen as making it impossible to achieve in others. It may be that competition will increasingly create a need for collaboration. This may not be as contradictory as it sounds.

By making competition manageable, collaboration will increasingly provide an essential framework of predictability within the market which might be of mutual benefit to all those involved in it. There is some evidence that this is precisely what happens in the commercial sector itself (Alter and Hage, 1993, pp. 44–80). It may not be too far-fetched to suggest that in the field of community care the development of such networks may eventually start to have an impact on the nature of the market itself, but with what results we cannot at present tell.

To sum up, while collaboration is philosophically distinct from collectivism and competition, it is compatible with a continuing role for both the state and the market in social welfare.

## **Collaboration and managerialism**

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Collaboration culture may be compatible with both markets and the concept of state welfare, but is it compatible with being part of an organization, particularly in an era of what has come to be known as *managerialism*?

The answer we would give is that collaboration may not be compatible with managerialism, but then we would also argue that managerialism is not the same thing as effective management! What we mean by this is that the term managerialism is usually taken to denote an obsessive preoccupation with systems of control. This kind of mechanistic, inward-looking approach to management is quite out of tune with current thinking about what makes for an effective management system.

The new orthodoxy emphasizes that the most effective organizations are likely to be ones in which small, highly autonomous units are in constant communication with the outside world and in which managers manage not by diktat, but by developing a shared sense of values and commitments (Peters and Waterman, 1982, pp. 89–118). This is precisely the direction collaboration is likely to take any organization and leads us to believe that its principles and practices can be fully integrated into modern management cultures without any need to compromise on basic principles.

## **Beyond the public and the private**

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One feature shared by both collectivism and contract culture is the acceptance of a fundamental distinction between the private and the public domains of community care. Both collectivism and contract culture assume that there is a basic divide between the private world of what has come to be called 'informal care' and the domain of the state or the market. These domains are seen to operate according to very different principles and the result is community care policies which effectively fail to address the everyday reality in which the private and public domains intermingle and 'interweave' (Bayley, 1978, p. 31).

On the other hand, one strength of the collaborative approach is that it is applicable across the whole range of community care situations, especially those which straddle the private/public domain. In fact, collaborative principles form the essential bedrock of those interwoven social support net-

works which are so characteristic of community care and which consist of service users, their friends, relatives and neighbours, domiciliary care services, health and social work practitioners and others.

## **Collaboration in practice**

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It is now time to apply some of this thinking to community care practice. A hypothetical example will help us to do this.

A social worker and a district nurse have been working in the same locality for five years. Their offices are situated about a mile from one another and they spend much of their time visiting and working with the same section of the local population: older people and those relatives, friends and neighbours involved in supporting them.

Let us suppose that, in all that time, the social worker and the district nurse have had no face-to-face contact. This continues to be the case even though they are currently working with the same person, Ms Anderson, a woman of 85 who is partially sighted, with severe arthritis, supported mainly by her daughter but also visited occasionally by her son.

Although it was the district nurse who initiated the referral about Ms Anderson which led to the involvement of the social worker, she did so in writing and did not follow it up with any direct contact. In the past, the social worker has made referrals to the district nurse in exactly the same kind of impersonal fashion.

Both the social worker and the nurse see their roles with service users and carers as that of 'experts'. Neither of them attaches much value to the views of those they work with. If they had been asked, they would have justified this by arguing that while they have an obligation to obtain as much information as possible about 'problems', they alone have the knowledge and skill to solve these problems because they are qualified professionals.

For her part, Ms Anderson is not very happy with either the general approach or the attitudes of these two practitioners. She feels she was not consulted about the referral to the social worker, which focused on her 'need' for a day centre. If asked she would have said that she did not want to go to a day centre but would like to have discussed ways in which she could go shopping and visit friends more frequently. Instead she was forced to explain this to the social worker when she first visited, but got the impression that the social worker was not really listening to her because the conversation kept returning to the subject of day centres.

Most of us would have little difficulty in recognizing that this is not an example of collaboration. The practitioners are isolated from one another

and do things *to* elderly people and their families and friends, rather than *with* them. Ms Anderson experiences her relationship with them as quite oppressive. She has not complained about her treatment, but only because she has not been made aware that she has the right to complain and she would be worried about doing so. The non-collaborative stance of the social worker and the district nurse is supported by a very traditional kind of professional belief system which lays claim to a specific and exclusive body of knowledge and skill. It follows from this that neither of them recognizes any accountability other than to their own organizations and line managers.

While the pattern of care in this situation fails almost every test of quality and value for money imaginable, managing to be both ineffective and oppressive at the same time, it also has a self-perpetuating quality which means that change is unlikely to be generated from within the system. We list some of the features associated with it below. Although they are drawn directly from this particular example, we would suggest that they are in fact characteristic of a certain kind of community care system.

### **The isolated expert system**

The isolated expert system is associated with:

- High levels of professional power.
- A traditional professional belief system based on the notion of the professional as expert.
- Indirect communication between practitioners.
- Poor communication with, and little notice taken of, service users.
- Little or no communication between practitioners and carers or others involved in the situation.
- Resistance to change.
- Line management accountability only (no accountability to service users and carers).

But what if the social worker and district nurse find that they are constantly getting in each other's way? What if one arrives to visit at the same time as the other, or they both quite separately decide to contact two local volunteer organizations to ask for a volunteer to visit and two different volunteers turn up? What if Ms Anderson, perhaps encouraged by her son on one of his visits, finally begins to challenge the quality of the service she is getting and the way she is being treated? What if her daughter, as the key carer involved, also complains about these things – the fact that nobody has spoken to her about her needs and that there is so much confusion between the practitioners that her mother is becoming quite distressed?

The chances are that there might then have to be a change. It is likely that the practitioners might start having more contact with one another and with Ms Anderson's son and daughter. But it is also likely that this pattern of contact would be of a reactive nature, oriented towards resolving one particular problem after another and characterized by a high level of acrimony and continuing problems of communication. There is no reason to believe that either the general approach or the attitudes of the practitioners to one another and to the family would change.

Again, most of us would have little difficulty in recognizing that this is not an example of collaboration. Although there is a lot more contact between all those involved than in the first scenario, there is little evidence of any change in underlying values or beliefs and no evidence of any attempt at cooperation. We would argue that all this is characteristic of a certain kind of community care system which we describe below.

### **The conflict-laden system**

This system is associated with:

- High levels of professional power.
- A traditional professional belief system.
- Direct but reactive communication between practitioners.
- Confused and inadequate communication between practitioners and service users.
- Poor communication between practitioners and carers or others involved in the situation.
- Instability.
- Line management accountability only.

So far, we have explored two extreme forms of non-collaborative activity – one characterized by isolated expert activity, the other by conflict and confusion. However, it does not follow that simply avoiding one or the other of these extremes ensures a collaborative outcome.

Let us suppose that the social worker and the district nurse in the second example are encouraged by their managers to reduce the level of conflict and confusion to manageable proportions by redefining the boundaries of their respective roles in more appropriate ways, such as meeting with one another if there are problems and providing more information to service users and carers to enable them to challenge decisions they are unhappy about in a more planned and formal way. This package of measures might well succeed in improving the situation. But although isolation on the one hand and conflict and confusion on the other have been avoided, has collaboration actually been generated?

The answer must surely be no. There is still no sense of any attempt to establish what we have referred to as collaboration culture. Ms Anderson may now be more able to complain but she is no more able to influence assessment and care planning than before. No initiative has yet been taken to assess the needs of her daughter and it is not clear how she might contribute to the process of planning future support for her mother. Likewise the social worker and district nurse may have created new mechanisms for solving problems, but they have not created any opportunities for sharing their perceptions; there has been no attempt to work out common goals or shared processes of planning and organizing work; and there is nothing in place which would enable tasks to be shared.

..Although there is more emphasis on accountability, it is defined strictly in terms of service provision. There is no evidence of any attempt to create a sense of shared accountability for the way in which the work is undertaken. Finally, although the 'expert' belief system has been played down in the search for ways of reducing conflict, it has not been effectively challenged and still underpins day-to-day activity, effectively disempowering service users and carers.

Arguably, the biggest obstacle to the development of collaborative work lies not in the first two scenarios, but in the final one. Here the extremes of isolation, conflict and confusion have been avoided or overcome, but there is little or no evidence of what we have called collaboration culture and the pressure for change has been reduced.

It is all too easy to interpret relative peace and quiet as collaboration – particularly now when the terms 'collaboration' and 'partnership' are on everyone's lips – and therefore for all of us to convince ourselves, and attempt to convince others, that we are collaborating when we are simply co-existing. All these characteristics are representative of a third type of non-collaborative community care system.

## **Managed care**

The managed care system is associated with:

- High levels of professional power.
- A traditional professional belief system.
- Direct, systematic but reactive communication between practitioners.
- Clear but limited and reactive communication between service users and practitioners.
- Clear but limited and reactive communication between practitioners and carers or others involved in the situation.
- Complacency.
- Some limited accountability to others apart from line managers.



In contrast, bearing in mind our provisional definition of collaboration and the issues raised by the example we have just given, it seems reasonable to believe that any set of community care arrangements claiming to be collaborative would have to satisfy certain criteria. Putting these together enables us to begin to glimpse what a collaborative community care system might look like.

## Collaborative support

This kind of system is associated with:

- Acknowledgement of issues of power and control and attempts to empower service users, carers and others in less powerful positions.
- A collaborative belief system.
- Direct, pro-active communication between practitioners.
- Direct pro-active communication with service users.
- Direct pro-active communication with carers or others involved.
- Change and responsiveness.
- Multiple accountability (accountability to all those involved including service users and carers).

## Summary

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In this chapter we have looked at the relationship between collaboration and other aspects of community care. We have explored some of the conflicts and misunderstandings associated with ideas such as empowerment, partnership and collaboration and then pointed to the need for a new approach which recognizes the links between the involvement of users and carers and the development of effective patterns of inter-agency and inter-professional working. Collaboration is much more than a particular activity which might be undertaken from time to time for particular reasons. It has been argued that there is such a thing as collaboration culture which is very different to contract culture, but which has a similar potential to transform community care policy and practice at every level.

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## 2 New skills for a new culture

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### Responding to the challenge

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If there is to be a cultural revolution associated with collaboration in community care, we can now see that it must focus on power sharing and relationship building, and it must take place in a complex practice environment in which there is much that is pulling in very different directions. How is this going to be achieved? One answer is through training. But what is needed is not a quick technical fix, rather something which recognizes the fundamental nature of the issues involved.

This was the challenge which we sought to address through a project called Developing Collaborative Skills for Community Care. In the following sections we describe how the project came about and how we sought to put our initial ideas into practice.

### Background to the project

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We approached several local social work agencies, one of which in turn approached a local health authority, and in this way the Collaborative Skills in Community Care Project Consortium emerged.

We received a small grant from the Central Council for Education and Training in Social Work and set to work.

## Culture or competency?

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Early on in the life of the project, we recognized that there was a tension between what we saw as the essentially cultural nature of the challenges posed by community care and the dominant traditions of skills analysis.

We saw skill as grounded in a whole set of assumptions about the nature of professional role and identity. But the contemporary emphasis on an ability to evidence 'competence' through a specific, pre-determined set of outcomes (Central Council for Education and Training in Social Work, 1989) seemed to ignore the need to contextualize questions of skill.

Our concern with the relationship between skill and culture led us to formulate a different kind of approach, which retained a commitment to the idea of 'knowing in practice' (Schon, 1983, p. viii), which is associated with the competency-based approach, but which paid attention to a number of key issues all linked in one way or another with the idea that collaborative skills were likely to form part of a coherent practice culture.

We wanted to produce something which was not imposed on practice but grew out of it. In so doing, we wished to ensure that the experiences of those directly involved in community care were clearly represented in the contemporary debate; we were astonished at the relative lack of interest which had been displayed in what people were actually doing, what they thought about it and what they wanted in the future.

We did not want to produce an account of key skills which was so lengthy and complex that nobody would ever be able to make effective use of it to develop their own practice. In the context of community care, this was a real risk. There are so many different kinds of collaborative activity that any concept of 'core skills' will tend to disappear. This is similar to the problem some have encountered when trying to define care management tasks and skills – the problem of the 'Swiss army penknife' where the practitioner is meant to be 'not only a good assessor of individual need, but also a local community worker, service developer, budget manager, computer programmer, advocate, and possibly staff manager, as well' (Peck, Ritchie and Smith, 1992, p. 35). We sought to overcome this syndrome by focusing on the collaborative process itself.

There are many different views about community care even among those most intimately concerned with it. We did not want to assume a false consensus at the beginning but rather work towards building one towards the end of the project. We felt that no one group could lay claim to speaking for others and that it followed from this that we needed to involve users, carers, social workers and nurses in the project. We would have liked to involve other groups as well but had to recognize that this would be impractical.

Finally, we felt it might not be easy for those practitioners who were directly involved in community care to describe what they do and why they do it, or for service users and carers to say how they experienced the things that practitioners do and what they value most about them. Culture is often implicit rather than explicit. But, in our view, the opportunity of working together with others was likely to provide a context in which these implicit assumptions and values could be made explicit.

Putting all these points together we drew the obvious conclusion about collaborative skills, which was that they can only be analysed in a collaborative way.

## **Aims**

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Having clarified these basic points we felt able to draw up a statement of our aims. These were to:

**Identify a culture and a core of skills associated with a collaborative approach to community care and rooted in the day-to-day experiences of service users, carers and community care practitioners, which were meaningful to and valued by all of them.**

We used the term 'practitioners' to denote both those involved in direct face-to-face work with service users and carers and those involved in facilitating this work as managers. As far as we were concerned, both groups were practitioners in the sense that they were both involved in the community care practice system, whether directly or indirectly. To talk about practice without reference to management, or to management without reference to practice, seemed to us to be nonsensical, especially in relation to community care.

As we were engaged in a small-scale project, there was a strict limit to the number of people with whom we could work. The particular practitioners we chose to work with were nurses and social workers. But from the beginning, we recognized that many of the issues identified by the project would be likely to be ones relevant to other professional groups, as well as to those such as home helps who might not constitute a traditional profession but who play a vital role in community care.

## **Networking and involvement**

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In looking to translate our aims into action we were very influenced by two ideas: *networking* and *involvement*. To some extent, this was for very per-

sonal reasons. We were already very interested in these ideas. One of us had been engaged in promoting 'involvement' both as a researcher and a campaigner for many years. The other had been similarly engaged in promoting and writing about networking for a considerable time.

From the beginning, therefore, we had to acknowledge that we were not disinterested observers or commentators. These concepts meant something to us. We were committed to them as ways forward for community care, and we saw the development project as a way of helping others to be committed to them as well.

In the following sections we briefly outline the ways in which ideas about networking and involvement have contributed to our understanding of collaborative work and collaboration culture.

## Networking

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### A new way of working together

During the late 1980s and early 1990s a new practice began to emerge, one drawing on the concept of informal and innovative relationships. Often, but not always, they were of an *ad hoc* nature, involving individuals, groups and organizations joined to one another in ways which encouraged communication, cooperation and new opportunities for choice and empowerment. Increasingly, people began to refer to this approach as 'networking'.

The focus was on:

- Enabling interpersonal relationships to grow in contexts where trust was often a scarce commodity.
- Actively promoting a sense of involvement in collective endeavour and thereby enabling those involved to meet one another's needs or at least share one another's problems.
- Replacing fixed expectations with a commitment to flexibility and informality.
- Enhancing the growth of communication networks.
- Mobilizing people and resources (Trevillion, 1992, pp. 36–37).

Originally associated with community social work and community development, networking has come to be seen as a central issue in community care.

## **Networking and care management**

Care management is often associated exclusively with 'purchasing' and by extension 'contract culture'. But it is also concerned with identifying need and 'co-ordinating' services (Austin, 1983, p. 16), and as such has generated a renewed interest in processes of inter-agency collaboration and collaboration with service users and carers. For example, it has been suggested that:

an empowering approach to assessment and care management has to recognise that assessment involves an understanding of a social situation, of the pattern of relationships in which a person's needs are perceived by somebody as not being met. It is not just the assessment of an individual but of the relationship between them and the people with the resources to support or to change the situation (Smale and others, 1993, p. 43).

More generally, it has been argued that care management is concerned with 'building up linkages' (Payne, 1993, p. 2):

Among the main elements of case management are: developing a range of alternative services which can be called into play for particular people; using the network of services and contacts in a community to identify people in need; negotiating and bringing together services in a package that works; following up the way in which services work together; and adapting this work as services, needs, and preferences change and checking and evaluating how the services work together. All this obviously makes developing the skills of working together with informal carers and other services a more central part of social work than it is with many conventional casework services (Payne, 1993, p. 3).

It is these and other aspects of care management which have brought networking to the fore in discussions about community care.

## **From the multi-disciplinary team to the collaborative network**

Among professionals, particularly those working in health settings, there has recently been an upsurge of interest in inter-professional collaboration, not just because of community care but because of the renewed interest in community-based 'primary health care'. Primary health care has been described as 'nurses, doctors, social workers and therapists working together to provide co-ordinated services' (Jones, 1992, p. 25).

But this interest has been accompanied by an increasing realization that the concept of the 'primary care team' may be quite misleading. The classic image of a team is of a tightly knit group of professionals with a fixed membership and a clearly defined set of common tasks. But it has become increasingly obvious that team boundaries in the real world are not fixed in this way.

There is no longer any agreement on what constitutes a primary health care team. In fact, it has been argued that different tasks will often require different teams (Jones, 1992, p. 26), and it is becoming clear that what health professionals appear to associate with teamwork is not a fixed structure or a fixed task but more dynamic and less tangible concepts such as patterns of 'roles, relationships, communication and mutual understanding' (Hutchinson and Gordon, 1992, p. 37).

It is these kind of considerations which are leading to a shift of focus away from the notion of multi-disciplinary teamwork towards the notion of developing collaborative multi-disciplinary networks. Because it is more flexible, the concept of the collaborative network can be extended much further than the older concept of teamwork. It is perhaps no exaggeration to say that this shift marks a sea change in attitudes to working together for community care. With the shift to the concept of the collaborative network comes a commitment to a new vision of community care as a set of open-ended and participative relationships linking practitioners, carers and service users together in a mutually beneficial and more or less integrated way.

### **Networking and the project**

In general, we saw networking as important because its emergence signalled a willingness to rethink all kinds of taken-for-granted professional ideas in the search for effective forms of collaboration, and because it seemed to be based on a set of ideas which effectively opened up community care systems of all kinds to processes of involvement, communication and power sharing.

### **Involvement and empowerment**

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The second strand, or discourse, informing this project, that of involvement and empowerment, is a much broader one than that of community care professionals' growing interest in networking.

Since the 1970s people who use community care services have increasingly set up their own groups and organizations, such as organizations of disabled people, people with learning difficulties, older people, people with mental distress and people affected by HIV. There are now a large and growing number of such organizations. They operate at local, regional, national and international levels.

These groups are increasingly seeing themselves as part of a movement, identifying themselves with other new social movements, including the gay and lesbian, women's and black people's movements, and pointing to



their shared characteristics and goals. They share a number of key qualities with such new social movements. For instance, they:

- Experience institutionalized social oppression.
- Recognize and value their own particular history and culture, and frame their activities in political terms.
- 'Come out' about themselves and assert their identity instead of trying to keep 'in the closet'.
- Take a pride in who they are.

Oliver offers a helpful description of the new social movements:

These movements have been seen as constituting the social basis for new forms of transformative political change. These social movements are 'new' in the sense that they are not grounded in traditional forms of political participation through the party system or single issue pressure group activity targetted at political decision-makers.

Instead they are culturally innovative in that they are part of the underlying struggle for genuine participatory democracy, social equality and justice, which has arisen out of 'the crisis in industrial culture'. These new social movements are consciously engaged in critical evaluation of capitalist society and in the creation of alternative models of social organisation at local, national and international levels, as well as trying to reconstruct the world ideologically and to create alternative forms of service provision (Oliver, 1990, p. 13).

He also identifies four characteristics associated with them. These are:

- They tend to be located at the periphery of the traditional political system and sometimes are deliberately marginalized.
- They offer a critical evaluation of society as part of 'a conflict between a declining but still vigorous form of domination and newly emergent forms of opposition'.
- They are concerned with the quality of people's lives as well as materialist needs.
- They tend to focus on issues that cross national boundaries and thus they become internationalist (Oliver, 1990, p. 118 and following).

Participation and empowerment are central philosophies underpinning the new social movements. They are an explicit expression of their concern with a different politics: a participatory politics. This is particularly developed in the disability and community care service users' movements. Shakespeare suggests that it may be more helpful to see the disabled people's movement as a *liberation* movement rather than a new social movement, emphasizing that:

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The democratic approach is not service-centred. It is about much more than having a voice in services, however important that may be. It is concerned with how we are treated and regarded more generally; with the achievement of people's civil rights and equality of opportunity. This is reflected in the three current priorities of the disabled people's movement: for anti-discriminatory legislation, a freedom of information act and the funding and resourcing of organizations controlled by disabled people themselves.

## **Service users and collaborative networking**

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Collaborative networking has not yet figured as a major concept in the theoretical and philosophical discussions of service users' and carers' organizations. Concepts of involvement, empowerment, advocacy, rights, discrimination and oppression have been much more central to debates and developments. Yet networking is actually a central concern and activity of such groups and organizations, in terms of both their support and campaigning activities. A lot of networking goes on among service users and their organizations. There is recognition among such groups of the importance of networking and many efforts are being made to develop new and effective approaches to it. At the same time lack of resources is placing major obstacles in the way of:

- Networking within disability movements.
- Networking between disability movements.
- Regional and national networking.
- International networking.
- Networking between service users and carers (Beresford, 1993).

Any exploration of collaborative and networking skills in community care needs to take account both of the networking needs of service users and carers and the importance of challenging constraints in the way of meeting them.

## **Putting the project together**

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Although debates about networking have developed separately from debates about involving service users and carers, we felt that it was time to begin to develop a more integrated profile of the skills needed for all forms of collaborative work. We even came up with a provisional definition of

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tailed a changed model of statutory practice. Traditionally the 'practitioner' was expected to work out what help the 'client' wanted and provide it, generally from a narrow menu of services provided by their agency, like home help, day services and residential accommodation.

The new model of practice is meant to start from and be much more explicitly led by the needs of the service user. It is framed in terms of the idea of 'care management'. The care manager may now be drawn from a wide range of practitioners, including nurses, social workers, occupational therapists and home care organizers. There are three key components to care management: assessment, creating a 'care package' of support, and review.

This approach has two rationales. First, the aim is to generate more responsive, flexible and imaginative forms of support and move away from the service-led model that has characterized community care and personal social services more generally. Service-led policy and practice meant that service users have often had to fit into services, instead of services matching service users. Second, much more emphasis is to be given to making the most cost-effective use of budgets in order to provide support as efficiently and economically as possible. Budgetary considerations and responsibilities are built into care management, where before they were not seen as part of the duty or role of the community care practitioner.

A problem has quickly emerged with these two objectives. Instead of being complementary, they frequently seem to be at odds with each other. Service agencies and service users' organizations both argue that services frequently seem to be budget-driven rather than needs-led. But the problem of finance taking priority over need is not the only concern raised by service users and their organizations.

They have developed a more fundamental critique of the care management approach to practice. Many are dissatisfied with the terminology and the business model underpinning it. Disabled people's and other service user organizations increasingly reject the notion of 'care'. Care is associated with custody, being controlled and their own lack of control. Many disabled people feel the word has a history which is demeaning and based on an assumption of their dependence. They talk about the way 'care' services medicalize them and treat them as sick or as a problem (Beresford and Croft, 1993a, p. 35).

The use of the term *care management* is another expression of the current fashion for the new business culture in welfare. It may be intended to mean ensuring people get the support they need and overseeing the services they receive. But for many service users it carries different resonances. They dislike the idea of being managed, as if they cannot manage their own lives or as if they were an object to be managed.

It is not only the terminology which service users are questioning. They are also challenging the framework underlying it. They are developing a

different framework for meeting their needs which puts them in the driving seat and means that effectively they become their own care manager. This can be seen in each aspect of the care management process.

Therefore, in assessment, instead of an outside professional deciding what a service user's needs are – which is how it has traditionally been and how it is still often the case as care management is conventionally interpreted – the service user defines their own needs for themselves. Such self-assessment makes possible self-defined needs. The role of the worker here is to support people with information, advocacy and support.

Instead of the care manager putting together a 'care package' for the service user, service users can set up their own self-run support schemes. Already a number of disabled people run their own personal assistance schemes. They put these together themselves or with assistance. They control them, the schemes are accountable to them and they hire and fire workers.

Finally, the service user has the key say in review. Review is explicitly based on their judgement, their criteria and their experience, rather than those of the worker involved.

Clearly such a user-led model of community care has major implications for the role of both the care manager and other community care workers. It means a continuing role, but a different role to that suggested by the terminology, which puts the professional centre stage. Some professional reservations have been raised about this user-led model of care management. Commentators have suggested that some service users would be unable to undertake their own assessment of needs, because of intellectual or other impairment, for example, people suffering from Alzheimer's disease.

Disabled people argue that with suitable support *all* service users can be involved in communicating what they want. Care management can thus be seen as a continuum, from some service users taking the main responsibility for arranging the meeting of their needs, to others being involved as fully as they wish in the process by a practitioner acting on their behalf. So instead of care manager as mediator or arbiter between the service user's needs and the support provided, the care manager becomes a supporter to enable the service user to work out what support they want and how best it could be provided to meet their needs.

## Carers

The concept of 'carer' is also a contested one. It emerged in the 1970s to reflect the work of millions of people, predominantly women, who support disabled, ill, old and distressed people unpaid at home, often without choice or adequate support and with restrictions on their opportunities and rights. Since then there has been an increasing emphasis in government policy on

the role of unpaid carers. Some critics argue that this has extended to substituting their work for public provision.

In the project on which this book draws, we spoke to both service users and carers and sought to identify and distinguish their views and concerns while recognizing that service users may also be carers and carers service users.

As there has been increasing recognition of the role of carers, service users have identified problems with it. A common complaint is that more weight is paid to the views of carers than of service users 'because it's the cheaper option', and that the service system has frequently encouraged carers to speak for service users and failed to distinguish between the two. Disabled people increasingly demand choice in the support they receive instead of having to rely on partners, family or friends as carers. Disabled people are now beginning to question the basic idea of the carer. For example:

Informal carers only exist as an oppressed social group because older and disabled people experience social, economic and political oppression ... These are the factors which create a dependence on unpaid assistance within the family (Morris, 1993).

This clearly has important implications for both community care policy and practice, since it suggests that if the prior needs of disabled people and other service users are met, then the support they receive on the basis of personal relationships and the needs of those offering such support are likely to change. It is also a further reminder of the need for services and practitioners to respect the rights and choices of both service users and of people who offer them support, as well as recognizing the differences between them.

## **The plan**

The different views of service users, carers and workers about community care, as well as the differences in power between them, led us to conceive of the development project in a particular way.

We chose a model which could be described as that of two streams flowing into one another at the final stage. One stream was to consist of work with service users and carers; the other stream was to consist of work with social workers and nurses. The whole process was to culminate in a workshop in which all groups would participate.

This plan was heavily influenced by our concern with ensuring that the process of exploring collaboration culture and collaborative skills was itself a collaborative process.

Keeping work with service users and carers separate initially from work with social workers and nurses was seen as a way of opening up rather than closing down the communication process. It was hoped that it would create opportunities for people to develop their own ideas in their own ways prior to meeting with one another to discuss them. But we recognized that this made the planned workshop session all the more important.

Although it was to consist of a one-off event, the workshop was seen as very significant to the whole project. In particular we anticipated that it would produce three gains:

- 1 Opportunities for the different groups of participants in the project to learn more about one another's perspectives.
- 2 The chance for participants themselves to be able to negotiate and synthesize their different perspectives.
- 3 The possibility of developing a skills profile for community care collectively 'owned' by them all.

Overall, we saw the project as a development project in that we hoped that all those taking part would be able to raise their levels of awareness about collaboration; that service users and carers would become clearer about what it was that they had a right to expect from practitioners; and practitioners might have an opportunity to think more deeply than they otherwise would about the knowledge, values and skills that they brought to their collaborative work and how these might be most effectively developed.

## Summary

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This chapter has looked at the background, aims and early stages of the Collaborative Skills in Community Care Project and in so doing has explored a number of key concepts, such as the relationship between competency, skills and culture. We have also tried to acknowledge the intellectual antecedents of the project and in particular to show how both that broad current of thinking about relationship building, often referred to as networking, and ideas about the involvement of service users and carers, influenced it. Finally, there has been an attempt in this chapter to show how the project was put together and why it assumed the shape it did.



# 3 The community care diaries: a record of collaboration

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## An inter-professional project?

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Although we decided to separate the first phase of our work with service users and carers from our work with practitioners, we did not separate the social workers, community psychiatric nurses, district nurses or managers taking part in the project from one another. In fact, as far as we were concerned, collaboration and a certain kind of inter-professionalism were inextricably entwined and we intended the project to reflect this.

We have not been the only ones to recognize a link between inter-professional work and collaboration. For example:

Since 1985 a number of key organisations have been established whose main aim is to foster collaboration and communication between professionals. ... The aims, objectives and mission statements of all of these organisations bring out as watchwords the three C's: communication, collaboration, and – much more difficult to achieve – co-operation (Spratley and Pietroni, 1994, p. 2).

This link is not confined to collaboration between professionals. The emphasis on communication, collaboration and cooperation so evident in inter-professional work has led to a phenomenon described by Spratley and Pietroni as the 'user centredness' of inter-professional work (Spratley and Pietroni, 1994, p. 17).

And yet, when groups of different professionals come together to discuss skills, they still tend to treat issues such as multi-disciplinary teamwork as if they benefit service users but have little to do with processes by which service users and carers might themselves become part of the team.

We wanted our work with practitioners to be somewhat different. We did not want to encourage them to focus exclusively on their relationships with

one another or other professionals, but to keep in mind the connections between all forms of collaboration. In this way, we hoped to open up the whole question of skills analysis to a broader set of concerns and issues. At the same time we felt we would not be imposing an artificial constraint on their discussions. On the contrary, it seemed to us that so many inter-professional issues also involved relationships with service users and carers that it would be artificial to attempt to separate them.

## Methods

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Our approach was shaped by our overall aims and by some specific concerns. Because we saw our work as akin to stimulating a discussion, we were interested less in collecting data from nurses and social workers than in raising awareness of collaboration and the skills involved in it. But as our central concerns were with 'knowing in practice' (Schon, 1983, p. viii), we did want to ensure that any discussions were grounded in practice realities rather than idealized images. We decided that the best way of proceeding was to focus on day-to-day collaborative practice through a *community care diary* and then to develop ideas about these practices through *discussion groups*.

All participants were asked to keep a community care diary for one month. This chapter is largely concerned with the subject matter contained in the diaries. In the following chapter, however, the focus shifts to the discussion groups which were intended to provide opportunities for participants to learn from one another, make new links and critically evaluate existing practices.

## The practitioners

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Sixteen participants were recruited for the research project. They consisted of social workers employed by one London borough, and nurses employed by a district health authority covering the same area. Some were employed in direct work with service users/patients. Others were employed in management roles. For some, their main area of interest was in the field of mental distress. For others, the professional focus was ageing. Two described themselves as African-Caribbean, one described himself as Asian. Three out of the original 16 were male. One of the white female participants had a visual impairment.

Although we did not contact particular individuals, we quite deliberately sought to make contact with professionals who already had a strong inter-

est in collaborative work and in community care. The demands we then made on their time ensured that only those with high levels of commitment actually saw the whole research process through from start to finish.

## **The introductory workshop**

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All those who expressed an interest in participating in the project were invited to an introductory workshop. This was designed to encourage people to ask questions and to enable them to raise specific concerns prior to making any commitment to the project. It also allowed us to begin engaging at a personal level and in a collaborative way with those with whom we would be working closely later on.

### **Drop-out rate**

One of the original male participants withdrew immediately after the workshop and several others did not fill in their diaries because of work pressures. In all, six diaries were completed and two group interviews and one individual interview were held.

Perhaps rather perversely, we were pleased that some individuals felt able to withdraw from the project immediately after the workshop having realized what it would entail. Those who stayed with the project to the end demonstrated considerable commitment. However, it was disappointing that the six professionals who completed their diaries and attended discussion groups were all white.

## **Reading the community care diaries**

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As the completed diaries were returned to us, we began to read them and identify issues which needed to be followed up in discussion. As we did so, we became increasingly aware that hidden beneath the surface detail of particular meetings or telephone conversations was a critical mass of ideas, attitudes and values strongly influencing behaviour. In what follows we attempt to identify some of the key elements of this critical mass.

To protect confidentiality, the examples which are given correspond to but are not identical with the situations described by the professionals.

## Concepts of need

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Any attempt to develop a profile of skills related to community care has to start with the key concept of 'need'. Perceptions of need are not only important in themselves but also because of their impact on assessment, planning and all subsequent judgements about effectiveness. This applies as much to perceptions about the need for service development or better inter-agency communication or community needs as it does to perceptions of individual needs. The diaries tended to focus on the latter, but other kinds of needs were also mentioned and in every case the kind of assumptions made about them influenced the whole process of assessment and intervention.

### The service-led model

For both social workers and nurses, descriptions of need sometimes took the form of a list of problems relating to specific services in a straightforward one-to-one fashion, such as 'help with cooking and cleaning', or even of formal care or medical services which might be appropriate, such as 'day care' or 'wound treatment'. In these cases, there was often no clear separation between the general concept of need and the more focused concept of 'service requirement'. As the community care reforms have been largely based on precisely this kind of separation between needs assessment and service provision, this seemed to suggest that rather more traditional concepts of assessment were still influential in at least some situations.

The diaries suggested that where there was such a blurring of the distinction between need and service requirement, there was also a very clearly defined problem which helped to shape perceptions of the situation and expectations of the role of the professional, as when, for instance, helping someone to move from an institution into the community. It was almost as if in such situations the social worker or nurse was presented with a ready-made task which they had to perform in a relatively short space of time and this precluded any attempt at comprehensive needs assessment.

While the service-oriented type of assessment was the most limited in terms of scope for professional judgement, it was also, rather paradoxically, the least democratic type of assessment. It seemed to be least informed by any concept of assessment as a process of consulting about issues and options with service users and carers. The impression given was of a process characterized instead by a narrow focus on key tasks or one problem, such as poor housing, which the professional was expected to solve.

Further evidence that the issue of expectations of role was connected with the way in which the concept of need was understood was contained in the way in which statutory responsibilities were identified with the

concept of need, so that, for example, a responsibility to devise a 'Section 117 after-care plan' was offered as a definition of need.

The service-oriented type of assessment was characterized by a very limited concept of the needs of the support network. Where relatives or friends were mentioned it was often in terms of things they would not do for the service user, such as 'daughter and son-in-law do not wish to have father home', rather than in ways which suggested their own needs were being explored.

Broadly speaking, these kind of assessments were dominated by a rather narrowly focused, problem-solving ethos.

## **The collaborative model**

What was noticeable from the diaries was that while a minority of the assessments were dominated by a traditional service-led model, most were characterized by much more holistic approaches to the definition of need. Rather than simply imposing service perspectives these approaches were characterized by a much greater sensitivity to the different ways in which needs were experienced and expressed. At its simplest, this involved a recognition that more than one person in a situation could have needs. In one example of this kind, the needs identified included not just those of a disabled service user who needed help with 'daily activities', but those of his wife who needed to be able to share some of the practical tasks involved, thereby removing what was described as the responsibility of 'physical care' from her.

But this type of approach to assessment also took more complex forms in which there was evidence of a willingness to be very open-minded as to what might constitute need. In one situation need might be defined in terms of 'isolation, housing and financial problems'. In another situation, need was seen in terms of 'medical care and poor quality relationships'. This reflected a concern with persons rather than straightforward problem solving. This enabled skills, attitudes and levels of motivation to be seen from time to time as specific needs.

Sometimes, instead of listing specific needs in a quantitative way, the assessment focused on a key issue and the needs generated by it. One example of this way of thinking about need was enabling people to manage the transition from hospital to community. Here, need was perceived in terms of developing a support network. Interestingly, this linked the kind of needs someone might have in relation to quality of life with those they might have in coping with day-to-day problems in an integrated approach to the analysis of need. Where this approach was adopted it enabled the professionals to step back and think about the connections between all aspects of the situation.

As we read the diaries, it became clear to us that there was a link between holistic, needs-led perspectives and a predisposition to collaborative work. Not only were holistic assessments frequently a product of collaboration but the plans made as a result tended to emphasize the contributions that could be made by a wide range of different individuals and agencies.

### **Collaboration and innovation**

It was noticeable that wherever the emphasis was on service innovation there was a tendency to adopt a needs-led/collaborative approach. While the traditional service-oriented assessment was exclusively concerned with the allocation of existing predetermined services, the collaborative approach was the norm when situations were assessed with a view to developing new kinds of services or new policies.

In one situation need was defined in terms of developing new shared policies to work with offenders who had been given a psychiatric diagnosis. In another situation need was defined in terms of developing shared understandings between different agencies in relation to care management and specific mention was made of the need for better cooperation and communication. This again emphasized the relationship between concepts of need and collaboration culture. A commitment to needs-led thinking seemed to lead naturally to an innovative and developmental orientation to service delivery and one which focused on collaborative initiatives of various kinds.

### **Identifying positives in the situation**

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Community care assessment involves thinking about the relationship between needs and resources in the context of a specific situation (Smale and others, 1993, p. 43). Therefore concepts about resources are every bit as important as concepts of need.

#### **Resources as services**

Frequently, practitioners identified particular services, such as housing or occupational therapy, as resources. At other times these services were represented by and identified with specific individuals, such as a community psychiatric nurse or a disabled employment adviser. Although sometimes the emphasis was more on unpaid assistance than formal services, the same notion of a resource as a fixed set of taken-for-granted services prevailed.

Within this broad definition of resource, there was some variation. For example, sometimes the service was anonymous, at other times it was individualized and personalized. As a result, agencies or professional groupings were sometimes identified as resources while at other times specific friends, family members or professional colleagues were named. Only in a small number of cases were attempts made to identify skills separately as resources. It is perhaps no accident that this occurred mainly in relation to areas of recognized expertise such as counselling rather than in the broad range of more practical supportive activities.

### **Resources as relationships and opportunities**

The diaries showed that sometimes a very different approach was taken to the identification of resources. This more qualitative approach included as resources such things as a history of inter-agency cooperation and multi-disciplinary work, a supportive family and a tightly knit network of friends. It also included relatively intangible things such as 'opportunities' embedded in a situation, such as access to transport. Moreover, the process of mobilizing resources like this was described almost invariably in collaborative terms. The reasons for this were significant.

These resources were not things, they were not fixed or given. They could not be simply 'plugged in'. Rather they were outcomes of certain processes. Inter-agency cooperation would continue to be a resource only if agencies continued to relate well to one another. Families and friends would continue to be supportive only if they were able to get their needs met and if their relationships with one another and those they were supporting continued to be positive. Transport could be accessed only if geographical constraints and other kinds of restrictions were overcome. The process of mobilizing resources like this was inevitably very different from the process of simply asking for services. One of the distinguishing characteristics was that it always involved a process of negotiation leading to a process of collaboration. These were all collaborative resources or resources which emerged through a process of collaborative work.

### **Between two cultures: service-led versus collaborative approaches**

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Overall there were strong indications of a link between concepts of need, the way in which resources were described and the relative significance of collaborative approaches to community care practice.

The characteristic pattern was twofold. Where needs were seen in terms of service requirement there was a tendency to describe resources in somewhat mechanistic terms, either as part of the situation which could be taken for granted or as standard services of some kind which could be introduced into it.

But where, as in the majority of cases, needs were seen more holistically, then the concept of resource was extended more widely to include individuals and agencies with whom there would have to be negotiations about roles and relationships. In general in these situations, much less was taken for granted and a variety of different perspectives were assumed.

In general, assessment was characterized by two major approaches to the question of need and the question of resource: a traditional one associated with concepts of service requirement, and a needs-led, more holistic approach in which negotiation and collaboration formed part of the professional world-view.

It was not surprising to find two very different professional cultures present simultaneously, nor to find these combined in the same individuals. This kind of struggle between the old and the new is exactly what one would expect at a time of 'paradigm change' in professional attitudes and values (Kuhn, 1962). What was more surprising was that there seemed to be no particularly strong connection between professional background and approaches to assessment. Rather, it seemed to be the way in which the situation was perceived which triggered a particular stance towards these issues.

## **Perceptions of complexity**

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As we explored the comments people made in the diaries, it rapidly became clear that the relative dominance of the traditional service culture and the new needs-led collaborative culture in any particular situation was associated with the extent to which a situation was perceived to be 'complex'. This issue of complexity seemed to be a product of two separate but related considerations. Most straightforwardly, it represented a judgement about the need to manage a complex pattern of resources. But, on the other hand, it also represented a judgement about the non-standard or non-routine nature of the needs in question.

In general, where the focus was on a particular narrowly defined problem, assessment seemed to be oriented towards service requirements rather than broader concepts of need and there was little evidence of thinking about the relevance of collaboration except to some extent with the service user. Where situations were judged to be 'complex', on the other hand, then a collaborative approach came to the fore.



There were strong indications that running alongside the traditional, individualistic and problem-centred approach was another set of ideas which were not articulated very clearly but which seemed to recognize that situations were often complex and multi-faceted and could only be understood therefore by including all those involved. There was thus an implicit acknowledgement of the part others were likely to play both in terms of defining the situation and in terms of social support.

Understanding the process by which needs came to be understood as complex in this way was clearly the key to understanding how decisions came to be made about networking and collaboration in general. It was as if professionals asked themselves a number of questions before coming to a decision about complexity and whether or not they were going to spend time developing a collaborative network.

### *Were carers 'coping'?*

In relation to individuals they saw as in need, one of the factors seemed to be the degree to which carers were seen to be able and willing to cope with only minor input from formal services. If they were judged to be coping then it was much less likely that the situation would be perceived as complex and as a result little or no consideration would be given to support and collaboration.

What was being said about caring and its relationship to perceptions of complexity and collaborative work seemed to us to be very important. It seemed to be informed by resource-led rather than needs-led thinking. While there were many situations in which formal services would be inappropriate or intrusive, the concept of coping seemed to function also as a way of rationing scarce resources. It did this in two ways.

First, and most straightforwardly, perceptions of degrees of coping among family and friends could be used to make decisions about services. Whether this way of rationing resources was official policy or not was unclear and may well have been irrelevant given the constraints imposed by a central government administration which took the view that family and friends represented the 'front line' of community care.

Second, the concept of whether carers were coping seemed to be not simply a way of rationing services; it was quite compatible with, for example, a decision to provide a specific service or set of services in accordance with what we have described as the traditional 'service requirement model'. Rather it seemed sometimes to be linked to a view that what made a situation complex and thus requiring of collaboration was the fact that the carers themselves needed support in order to cope.

To some extent this is self-evidently true. Supporting carers involves an objective increase in the complexity of the practice issues. But was it right to

assume that someone who was coping did not need support? It seemed very much as if restricting the notion of 'need for support' to situations where coping was actually breaking down was leading to a reactive crisis-oriented model of community care practice. We were told later on that collaboration required investments of time and energy which were in very short supply and that these kinds of considerations were used to make decisions about priorities. There were therefore clear links between this and the next question.

*Does this situation have a high priority?*

It seemed likely that resource constraints played some part in deciding whether or not to take the time and trouble to develop a collaborative network in a particular situation. As well as the question of whether carers were coping, other factors, such as perceptions of risk and statutory responsibilities, would also inevitably play a part in the process of prioritizing work. At least some of the variation in what was and was not handled collaboratively could be accounted for in this way.

*Were other professionals or other agencies involved?*

Often it was the necessity to consult with other practitioners and other agencies and the need to access resources controlled by others which appeared strongly to influence the decision as to whether a situation was complex enough to be networked.

*Do I have primary responsibility?*

If individual professionals perceived that they had primary responsibility, then they were much more likely to take on the role of networker than if they saw someone else as having primary responsibility. This relationship between networking and primary responsibility seemed to be very significant because it implied that networking was strongly motivated by a concern with and a sense of accountability for outcomes.

Overall, what these questions reveal is that complexity was much less an objective feature of the situations these practitioners dealt with than an alternative approach to them triggered by a series of events which effectively made simple solutions impossible. In other words, as is often the case, these professionals found themselves working in new and creative ways when it was impossible to act in what one might describe as a routine manner.

This finding should come as no surprise. After all, we all of us tend to act routinely until something about the situation forces us to stop and think. In

this context, the contrast between the two very different ways of working that was so characteristic of these practitioners becomes much more understandable.

## **Collaboration and power sharing**

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When we shifted our attention from the very general collaborative issues we have looked at so far to the specific issue of power sharing, the diaries became less informative.

On the one hand, most practitioners showed that they were willing to collaborate with a very wide range of people. In one fairly typical example, this included a service user, hostel staff and a consultant psychiatrist. On the other hand, there was little evidence of the extent to which professionals saw their own power as an issue for negotiation.

While many of the diary entries showed a well-developed awareness of inequality and injustice within society and a willingness to advocate on behalf of those who were oppressed, this awareness did not tend to be extended into an analysis of relationships between community care professionals and service users. There was little explicit reference to power and methods of power sharing with service users.

This did not necessarily mean that power sharing did not happen. It might simply have been unstated. Perhaps it was a 'basic assumption' and was so much a part of the assumptive world of the professionals that it literally went without saying. There was some evidence to support this idea, because the diaries showed that professionals seemed to accept that in general all those who were consulted had the right to influence decision making and many of the references to negotiation with service users, carers and other practitioners could be seen as coded references to power sharing. But, in general, power sharing was very much an implicit rather than explicit goal and was incorporated within an understandable concern with 'getting things done'.

It seemed to us that there might be real differences between this type of professional perspective on issues of power and control and the perspective of service users and carers. We decided to try to clarify some of these issues in the discussion groups.

## **Roles and modes of interaction**

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Fortunately the diaries were clearer in relation to a number of other issues, some of which cast a little more light on the subject of power sharing.

Coordination, mobilization and support emerged as central preoccupations of all the practitioners in relation to networking. When asked to reflect on their roles in relation to other members of the collaborative network, the words 'coordination', 'facilitation' and 'support' were frequently mentioned, often linked to one another, such as 'coordinating a support package'. At other times, more specific phrases were used, such as 'pulling together the network'. Sometimes these phrases were linked to particular goals, such as 'continuity of care' or more immediately 'attempting to improve relationships'.

It was not immediately apparent how much power or authority was vested in these roles. Sometimes the networker seemed to carry considerable informal authority, as when devising and communicating 'daily plans', at other times the role seemed much more of a nurturing one, as when the role was described in terms of 'advice' or 'emotional support'.

The predominant tone was an active one although there were also references to acting as a 'resource' for members of the network.

For the most part these professionals were highly flexible, gearing their roles and modes of interaction to particular circumstances. There was thus considerable evidence of strategic thinking. There were some indications, however, that roles were not always freely chosen, often representing something of a compromise between what professionals would like to have done and what they felt able to do. For example, one professional commented that an inability to maintain contact at the planned level had led to a *de facto* change in her role and the setting of a much less ambitious set of goals for the collaborative network, with a move away from a notion of joint planning towards simply informing one another of developments.

## Negotiation

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There was clearly a relationship between the negotiation process initiated at the assessment stage and the development of collaborative networks. In fact, it was the process of negotiation which provided important clues about network partnerships and the way they revolved not just around the fairly innocuous idea of working together but of doing so in a context of real differences and tensions which might drive them apart. This was because negotiation reflected both the wish to work together and the difficulty in doing so. In many cases, these tensions and the consequent complexity of the negotiations were connected with issues related to risk and compulsion. As far as the practitioners were concerned, the presence of risk made it much more likely that thought would be given to developing a negotiating strategy.

Certain ways of conducting negotiations, particularly those concerned with risk, were seen as more successful than others. For example, there was frequent reference to the need for 'network conferences' as a way of overcoming barriers to effective decision making.

## Relationship work

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One feature of the diaries was the way references to relationship work crept into descriptions in ways which indicated that it was seen as a basic assumption rather than an explicit focus of the work. However, one practitioner explicitly linked quality of support to quality of relationships and another linked the establishment of trust and a certain level of personal familiarity to the whole process of inter-agency work.

While it was clear that practitioners were concerned with maintaining the networks they had helped to develop, it was not clear how much attention was specifically given to the support needs of those involved. There was some evidence of the importance attached to enabling support to be accessed, for example, by putting people in touch with support groups. But the extent to which professionals saw their own role as a supportive one in relation to anything other than direct work with clients was not clear.

Interestingly, where the issues were of a more managerial nature and not linked to the welfare of specific individuals, there was likely to be a more explicit focus on the quality of the links between members of the network. In this sort of network considerable attention was given not just to issues such as good communication but also to the overall development of relationships and mutual support.

## Summary

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In this chapter, we have begun to look at the results of our direct work with community care practitioners. In particular, we have focused on the record of collaborative work contained in the community care diaries that the practitioners' group were asked to keep. One issue that emerged was that many of the practitioners seemed to operate two very different approaches to community care assessment. The co-existence of these service-led and collaborative models led us to describe the situation we found as 'between two cultures'.

Overall, certain themes seemed to influence everything else:

- A sensitivity to and a willingness to respond to the demands of a particular situation.
- Personal credibility.

and

- Attention to communication processes.

These emerged strongly once again in the course of the discussion groups which are the focus of the next chapter.

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# 4 Discussion and reflection

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## Themes and questions

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The next step in our work with the practitioners was to discuss with them some of the implications of what they had written in their diaries. This chapter is concerned with what came out of our meetings. To protect the confidentiality so important in a small project like this one, a commitment was given not to include quotes or to identify individuals. We have respected this while trying to convey a flavour of the discussions.

Altogether, we held three discussion groups. Over the course of these discussions certain themes emerged about collaborative skills and their relationship to collaborative culture. In the following sections we describe these themes in the context of the topics around which they clustered. We begin with assessment as a collaborative activity.

## The assessment process

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### Open minds and open systems

During the very first of the discussion groups, it emerged clearly that assessment was frequently seen as a collaborative activity. Moreover, this group suggested that relationships established at the assessment stage would very often form the context for all subsequent decision making. The word used to describe collaboration in defining need and planning support was 'openness'. The assessment system was seen as open not just in the sense that it involved talking to several different people, but also because it was

rooted in a value system which became quite explicit during the course of the group discussion.

A nurse related openness to the holistic or 'whole person' approach – the need to relate to all aspects of a person's life and to see the connections rather than to be narrowly focused on illness or specific problems. A social worker related openness to the principle of choice, that is the importance of obtaining as much information as possible to enable the service user to make meaningful choices.

The difference in terminology and emphasis reflected differences in professional culture but what was more striking was the complementarity of these values. Subsequent discussion groups confirmed this link between an inter-disciplinary orientation towards openness and commitment to collaborative work. Certainly the practitioners themselves had no difficulty in understanding one another's values and philosophies or relating them to collaborative practices.

### **Building relationships**

All of the discussion groups acknowledged that early on it was not always easy for practitioners to find ways of working with one another or with service users and carers. In so far as a collaborative approach to assessment was seen as hingeing on a process of engagement with others, it was agreed that a key strategy was the development of relationships over a period of time. While, in social work in particular, there is a long tradition of focusing on relationships with service users as a part of the assessment process, it is not always recognized how important the process of relationship building is in relation to the collaborative network as a whole. This point was picked up and developed in the groups.

During the first group, it was emphasized that 'engagement' encompassed relationships between professional groupings and between agencies. In this way, it was stressed, liaison and inter-agency work contributed to the development of the kind of relationships which would make collaborative forms of assessment possible.

### **Task-based roles**

It was during the second group discussion that someone emphasized the importance both of collective decision making in the planning process and the need for clarity about who was doing what. On the face of it, this seemed puzzling. But as discussion progressed it became clear that an important paradox was involved. What was described as 'blurring of role boundaries' had to go hand in hand with what was described as 'clarity



about roles' and it was the group that first described this paradox which offered a resolution of it.

The key seemed to be the relationship between 'blurring' and 'clarity' on the one hand and 'coordination' on the other. What was suggested was that if there is a sufficiently high level of collective responsibility and collective identity, then the consequent blurring of role boundaries would lead to a more informed awareness of where there were real differences in knowledge and skill and a greater ability to make constructive use of them in the work. What was being suggested was, in fact, the need for a move away from stereotypical thinking about roles of the kind exemplified in statements such as:

'because I am a district nurse / social worker I will do this'

or

'because you are a district nurse / social worker, you will do that'.

Instead it was being argued that roles should be linked to a shared understanding of the actual knowledge and skills available to a collaborative network and their relevance to a unique set of circumstances.

As a way of building up shared understandings about knowledge and skills, a social work manager specifically recommended 'shadowing' other practitioners to get a better understanding of the nature of their work; an idea picked up with some enthusiasm by others both in this and subsequent group discussions.

### **Sharing assessment means sharing power and feeling empowered**

The opening up of the assessment and planning process to others was mostly seen as an extension of, rather than a challenge to, professional identity. In other words, there was a noticeable absence of defensiveness on the part of these practitioners about their own expertise. It was acknowledged that this might not be universally true and that where practitioners feel oppressed by their managers they are less likely to undertake the kind of power sharing necessary to the establishment of collaborative modes of assessment.

One person in the first group suggested that even where there was some collaboration with other professions, those practitioners who did not feel empowered by their managers would be unlikely to share power with service users and carers. Other members of the group agreed that to share power we need to feel empowered ourselves. To some extent this turned

conventional wisdom on its head. Professionalism is often seen as antagonistic to empowerment. But here, professional autonomy and a self-confidence were linked to, and even to some extent became prerequisites for, collaboration.

But even if there is a commitment to sharing power and to collaborating with others in an assessment, all three groups felt that certain key skills were needed in order to make these things happen. In particular, it was felt that individual practitioners and managers needed to be skilled communicators, able to adapt their style to a wide range of different circumstances and people. If the groups were engaged in the process of defining a new kind of professionalism, then this was clearly a major component of it.

### **Responsibility, accountability and assessment**

In the second group both a nurse and a social worker said there was a need to recognize that some practitioners had very specific responsibilities and accountabilities which could not simply be negotiated away. This point seemed to support the more general observation that cooperation is likely to be enhanced by a realistic understanding of the concerns and responsibilities of others. Simplistic solutions based on a denial of the facts are not helpful.

During the third group discussion the theme of professional responsibility and its relationship to the assessment process was developed in a new direction. A social worker argued very strongly that one way of exercising professional responsibility was to make a decision as to the most appropriate way to assess a situation. She also pointed out the significance of context. If a referral was made in the context of a ward-round at a hospital it would almost inevitably lead to a multi-disciplinary assessment, whereas if it were made in the social work office or by telephone, then there would need to be more of a choice made.

This highlighted the difference between those collaborative relationships which are constructed on the basis of lack of clarity about responsibility and those which are made as a result of some strategic decision to involve others. It also made it clear that a strategic decision to collaborate is not an abdication of professional responsibility. Rather, it involves a complex series of judgements about who to approach, how to approach them and what their role should be in relation to the assessment process.

### **Multiple perspectives**

The third discussion group saw a social worker arguing for the key importance of two factors: 'respect' for the views / knowledge / expertise of others, combined with an awareness of the importance of ensuring that there is

some level of integration so that services can be delivered in a rational and appropriate way. In making these points she was pointing to a key dilemma about collaboration – how to facilitate and empower others to say what they think, while ensuring that the efforts of the collaborative network are coordinated effectively.

In fact, in discussion it was recognized that a plurality of views can strengthen rather than weaken the collective effort. Different perspectives may represent different aspects of the truth and, just as important, different kinds of needs which have to be addressed in the collective decision-making process. To take a different approach and to seek to ignore awkward opinions is likely to lead to the breakdown of the collaborative network at some future date.

## **Power sharing**

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As far as the first group were concerned power sharing, especially with service users and carers, was something which all of them took for granted, in the sense that they saw it as a routine part of their practice. They saw power sharing as involving two key areas of skill – flexibility and the ability and willingness to share information. A nurse pointed out that being in the community as opposed to an institution was in itself a source of power, while a social worker highlighted one specific empowering strategy, which was to make management aware of the problems being created for service users and carers by lack of resources.

During the second group discussion, the relationship between power sharing and negotiation was explored in more detail. It was suggested that service users had the power to refuse both services and ways of working and this would include the power to reject a collaborative networking approach. A social worker suggested that the use of feedback to inform service users and carers was an empowering strategy. The social work manager pointed out that the new procedures, such as the incorporation of self-assessment into the assessment process, were giving service users more influence than before.

This discussion left us with a sense of frustration. In spite of an obvious commitment to empowerment, or at the very least 'responding to the wishes' of those they worked with, the practitioners found it difficult to identify key issues for practice; and there was almost no reference to the way in which power was manifested in their own relationships with service users and carers. In theory, service users might, for example, have the power to reject services or styles of service delivery, but in practice they might well accept what they were offered for fear of the consequences. We concluded

that a more grounded and realistic discussion about this would be likely to take place during the planned workshop, when service users and carers as well as practitioners would be present.

## **Coordination and the mobilization of resources**

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The way in which this topic was explored in the groups was in terms of a number of more specific issues.

### **Regular contact**

On the question of coordination and mobilization of resources, all the groups agreed that this was an integral aspect of their role as community care practitioners and stressed the importance of regular contact with those with whom they were working. In general there was a commitment to a team approach.

### **Strategies**

Over the course of the group discussions, a number of specific strategies were mentioned as ways of ensuring that resources were effectively mobilized and coordinated.

Ensuring that regular meetings take place between practitioners, carers and service users was mentioned by a nurse, as was the importance of following up arrangements and checking on progress.

One social worker explicitly linked liaison with mobilizing and coordinating resources. She emphasized the importance of prior knowledge of other agencies and an established liaison relationship with them. This also led her to include developing trust and the 'nurturing' of relationships as coordinative skills.

All the groups agreed that poor relationships between health authorities and social services departments hampered their own efforts to mobilize and coordinate resources.

### **The question of lead responsibility**

One issue which emerged in the first and second group discussions particularly strongly was that the practitioners did not always assume that they should be the ones responsible for coordination. But it was also clear that this decision had less to do with professional expertise as such than with the way in which practitioners became involved. If they took lead responsi-

bility early on in the development of a piece of work, this would gradually tend to translate itself into assuming responsibility for overall coordination. If another practitioner took on this lead role, even if the situation were very similar, they would tend to leave coordination to them. This practice might change with the full introduction of new care management practices, but nevertheless drew our attention to the link between roles and processes.

### **Leadership, trust and clarity**

During the third discussion a social worker raised an issue which appeared to be linked to the tricky question of leadership. She felt coordination required someone to have a clear vision of the kind of things that needed to happen. She also emphasized that collaboration should not be an excuse for dumping responsibilities on to others. Trust was important and could only be built if people were frank and honest. She also pointed out that persuading people to get involved in these kinds of collaborative work practices was not easy.

Through discussion certain things were identified as critical ingredients of trust. These included clarity about the nature of the work: not suggesting, for example, that it was simpler or less demanding than it really was, and trying to spell out in a realistic way some of the implications. This was particularly important when working with service users and carers. Clarity about the kind of collaboration envisaged was also critical. It was recognized that there was scope for considerable misunderstanding about roles and relationships and that this kind of misunderstanding could undermine trust. Finally, there was the intangible but vital question of personal credibility. The way one had conducted oneself in the past would always have consequences in the present and the way one conducted oneself in the present would be bound to impact on future relationships. This emphasized how important the time dimension is in this and other aspects of collaborative work, which is always a product of its own history.

### **Close working relationships as an alternative to coordination**

The second discussion group drew attention to the relationship between certain ways of working and the teamwork which was so central to community care philosophy. A nurse said her own experience of the 'care programme approach' had been very positive. This involved identifying a core group of practitioners who would work closely together. In her view this provided the right kind of environment for collaborative practices to develop. She also emphasized the value of joint working, including joint visits to service users with other professionals. There was some general discussion about this which showed that it was not only beneficial to give some

thought to ways of focusing collaborative energies most effectively, but that where there was a sense of being part of an integrated whole the need for day-to-day coordination might be less. In other words, where people were working closely together, coordination – in the sense of explicit management of the work – was unnecessary.

### **Liaison and coordination**

Some of the difficulties that could arise when trying to mobilize resources from other agencies were discussed in all the groups. During the second group discussion, a social work manager and a social worker both independently stressed the importance of liaison in establishing an atmosphere in which other agencies were responsive to requests for services. Emergencies posed particular problems, they felt, because one would not be able to route communication through those individuals one already knew. One solution to some of these problems, they suggested, was to establish closer inter-agency relationships by working towards a 'shared set of objectives'.

## **The management of conflict**

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The groups constantly returned to the theme of conflict and how it might best be managed in a collaborative framework. They focused on this broad area of concern in a number of particular ways.

### **Conflict and the negotiating process**

Issues concerning negotiation and the management of conflict became linked in our discussions. It was generally recognized that where there was actual or potential conflict, negotiating skills played a key role in maintaining and developing the partnership network. During the course of the first discussion group, a social worker suggested that some conflicts could be prevented if attention were paid to possibly contentious issues, such as confidentiality and finance, at an early stage. On the other hand, she also felt that good practice could lead to conflict, as when taking on an advocacy role in relation to another agency. This raised the interesting point that professional consensus should not be bought at the price of 'selling out' the interests of service users. In other words an ability to negotiate on the basis of an explicit conflict was preferable to collusion and, moreover, compatible with a commitment to partnership and collaboration.

The second discussion group emphasized the importance of an ability to negotiate one's way out of overt conflict and out of situations where every-

thing seems very 'stuck'. A social worker argued that negotiating skills were particularly important when there was ambivalence on the part of one or more key players in a situation. The group discussed this and concluded that ambivalence often reflects covert conflict and in turn makes it difficult to generate effective commitment to goals which have apparently been agreed.

Establishing or re-establishing the conditions for collaboration under such circumstances was seen as essential but very challenging. One rule which seemed to emerge from the second group discussion was that where either overt or covert conflict is identified, it needs to be addressed straight away before it gets worse. This was a point made by a number of people but put particularly strongly by a social work manager.

### **Honesty and working with conflict**

Working with conflict is a value-driven activity. In the second discussion group, working with conflict was explicitly linked to a concept of honesty by both a nurse and a social worker. By honesty these practitioners meant something more than simply telling the truth. Through discussion, the group as a whole decided that honesty meant a willingness to confront difficult and possibly conflict-ridden issues directly with those whose trust and confidence was essential to the success of collaborative work.

Honesty involves being able to explore the difficult and conflict-ridden situations which can arise in collaborative work. In particular, the second group made the point that it is very important to be able to make explicit the different perceptions, values or interests which might lie behind conflicts with other professionals or with relatives and carers.

### **Collective responses to conflict**

One issue stressed by a social worker in the second group was the way in which the whole of the collaborative network needs to play a part in resolving differences and conflicts between different members. This was picked up by the group as a whole and developed. Racism was singled out by a nurse as an area of conflict which needed to be resolved collectively, even if it initially seemed to involve only one or two people, and the group as a whole seemed to agree.

This notion of collective responsibility for conflict resolution created some new dilemmas, when it was translated into practice. During the third discussion group, a social worker agreed with it in principle and felt she herself had some responsibility, but was also very unsure when it would be appropriate to intervene in someone else's conflict. This may therefore be one of those principles which people find easy to affirm as a general rule but find much harder to put into practice in a particular situation.

## **Support**

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Although it had not always emerged very clearly from the diaries, there was unanimity in all the discussion groups about the centrality of support to collaborative work.

In the first discussion group some very specific one-to-one forms of support were mentioned, like helping other professionals to cope with death and dying. But the main emphasis was on more general ways of offering support to carers and professional colleagues, which included both emotional support and practical support. In relation to the latter, it was suggested that one key aspect of being supportive was being responsive to requests for help – the implication being that bureaucratic delay was incompatible with a supportive stance.

During the second group discussion, the participants suggested that one small but important ingredient of support was simply recognizing the contributions of others. A social worker felt this was often forgotten by professionals in their dealings with one another. She argued that positively valuing one's own supportive work and being prepared to set time aside for it was vital. A nurse added that listening to people when they wanted to offload their feelings was important and helped them to feel valued.

In the final discussion group the importance of offering support to carers by making time for them was emphasized. A social worker said she often made specific visits to talk to carers rather than trying to see them at the same time as service users.

## **Network conferences**

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Here it is important to give space to something which emerged very strongly in the second discussion group and which does not fit neatly into any one topic area. This is the central place of network conferences in what could be described as 'strategic thinking' in relation to support, conflict resolution and empowerment.

### **As a strategy for support**

As a support strategy, the group emphasized the value of network conferences as part of the professional support system. A social work manager emphasized the similar role played by meetings of the managers' network in which he was involved.



## **As a strategy for conflict resolution**

In terms of conflict resolution, the group agreed network conferences were ways of enabling those holding very different views to begin to empathize with one another's perceptions. It was also suggested that by enabling all those who attended to develop a fuller understanding of differences in their points of view, conferences laid the groundwork for collective decision making which did not marginalize minority viewpoints. If conferences were to succeed as conflict resolution strategies, it was agreed by the group that it was very important to invite, and then to do everything one could to encourage, the attendance of those who may not normally attend conferences but whose views need to be acknowledged if realistic plans are to be made.

## **As a strategy for empowerment**

The group suggested that in relation to empowerment, network conferences could be seen as strategies for increasing the power of service users and / or carers in relation to practitioners. By inviting service users and carers to participate in open processes of decision making, their own views were likely to have more weight than if decisions were made on the telephone or in private discussions between practitioners. A social worker described a practice of holding network conferences in the home of the service user rather than in an office and in this way symbolically giving some power back to them. All agreed that inviting service users and carers to attend was clearly not enough. People needed to be enabled to participate fully and if necessary to challenge the views of professionals there and then.

## **The organizational context of collaboration**

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### **Organizational culture**

In the second and third discussion groups a set of issues emerged in relation to the organizational environment and its impact on networking and collaborative work in general.

There was clearly ambivalence about the role of management. Members of the first group recognized both positive and negative features. They suggested that the organization as a whole can be threatened by the participative, democratic characteristics of collaboration. In particular, they suggested that hierarchical organizations which place a strong emphasis on

containing the flow of information and the processes of decision making within very circumscribed limits can react very negatively to attempts to develop a networking approach. On the other hand, they also saw their organizations as recognizing networking as a way of becoming more effective by creating more and better opportunities for communication and innovation.

The general organizational culture seemed to be the key factor. The group members felt that the most network-friendly organizations were those which could be described as 'task cultures', whereas those which were least network-friendly were more traditional 'role cultures' (Handy, 1981), in which the preoccupation with maintaining power and control led to attempts to reduce or confine the scope of collaboration. All the practitioners were clear about what they wanted from their organizations. They wanted management to set guidelines or frameworks within which they could feel free to operate, but not to interfere with their day-to-day collaborative work.

### **Access to organizational resources**

The second and third discussion groups also focused on that aspect of the organizational environment which related to the scarcity of resources, including resources for networking. All those involved felt that decisions about priorities affected what they were able to do. There was considerable uncertainty about the rationale for these decisions. It seemed to us that this kind of uncertainty was likely to demotivate staff and possibly act as an obstacle to creativity and initiative. Collaboration plainly required good communication between management and those working directly with service users and carers.

## **Networking**

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All the groups were asked to think about the process of developing collaborative networks and, based on their own experiences, the following ideas or definitions emerged:

- Working together towards a common goal, with each person contributing something different.
- Creating a web with a common thread so that all the parts are linked together as a whole, dependent on one another.
- User involvement, shared understanding and contacting people at the right moment.
- Communication, discussion and coordination with various service

providers and users and carers, and the mobilization of resources to address assessed needs in terms of a common goal.

- Inter-agency and intra-agency work.
- A process of partnership in assessment.

Putting all these suggestions together we came up with the following definition of the skills involved in developing collaborative networks:

**Helping to create some kind of purposeful pattern or 'web' of communication and cooperation based on the acknowledgement of difference.**

This concept of the 'web of communication and cooperation' seems to us to embody a very powerful image of collaboration. It draws attention to both the complexity and the strength of the links that bind individuals, groups and organizations together and emphasizes that while there may be many different kinds of strands they are all equally important and all bound together in a strong and purposeful design.

## **Education and training for collaboration**

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Finally we asked participants to think about their own and other's training needs in relation to collaboration.

The message that came through very clearly from the first two discussions was that there was a need to overcome the lack of understanding that different professionals and different agencies had of one another's roles and areas of expertise. At least one practitioner also felt there should be courses available for carers as well as for practitioners. Two specific expectations were mentioned.

First, there should be opportunities for mutual sharing and learning. Second, there should be opportunities for developing a common set of aims and objectives for community care. Neither of these suggested a conventional academic course, and the specific training methods mentioned echoed this need for dialogue rather than instruction. One idea was discussion groups for nurses, social workers and others, perhaps including carers. Another idea was shadowing other practitioners in their workplace situations.

While these comments might indicate an entirely informal and workplace-centred approach, a social worker involved in the final discussion raised doubts about whether this would be sufficient when she pointed to the need for 'structure' and some guarantee of quality and 'common standards'.

## Summary

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In this chapter, we have focused on the practitioners' discussion groups. The message of these groups was clear. Collaboration is linked to an approach which recognizes that needs can only be met by a range of people working together. It is characterized by a commitment to the idea of exploring a range of possibilities and options for change with those, including service users, most closely involved in any given situation.

It seems to require an ability to involve others, particularly carers and service users, in processes of decision making; to communicate appropriately and effectively; to make good assessments drawing on a range of perspectives; to negotiate shared understandings; to manage conflict; to effectively mobilize resources and to be able to give and receive support. In terms of training, the strongest demand seemed to be for multi-disciplinary training, with a strong preference for informal discussion over more formal approaches such as lectures.

What is striking about these findings is the very large area of common ground that appears to exist between nurses and social workers and between mental health specialists and specialists concerned with ageing. There is certainly strong support here for a shared collaboration culture to underpin this type of work. In the next chapter we turn to the perspectives of service users and carers.

# 5 Collaborating with service users and carers

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## The context for service users and carers

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Now is a good time for action to involve and collaborate with service users and carers in community care. The community care reforms provide a catalyst, but a number of other developments also offer a strong basis for reform. These include the growing interest expressed by government in consumer involvement in public services; the new legal requirements for consultation, comment and complaints procedures in community care; and the emergence of powerful movements of disabled people and other recipients of community care services demanding more say and involvement in policy, provision and legislation.

All of this has raised the profile of user involvement in community care planning and provision. Carers, service users and their organizations have become involved in many different ways. People are becoming more involved in their own personal dealings with community care services: for example, by attending meetings affecting them; seeing records kept about them; and making use of complaints procedures. Service users are getting involved in managing existing services and in planning and developing new ones. There are now a growing number of examples of service users being involved in community care planning, standard setting and quality assurance, monitoring and evaluation, staff recruitment and training, designing and placing contracts and running their own user-led services.

However, both service users and carers question how much real say they have achieved in community care. The gains from getting involved are generally limited, while the effort entailed is usually considerable. The consultative forums and committees and the market research exercises which have mushroomed in recent years, and which are the main expressions of

user involvement, are distanced from most people's day-to-day experience of community care practice and services. Their outcomes are also uncertain. Spending constraints seem to have exercised a much more powerful influence on policy and services.

So far service users and carers have not often been asked what skills they think practitioners need to work with them. They may be asked their views of plans, policies and services, but not of the practitioner skills which are at the heart of their experience of community care. Yet who is in a better position to say? This is a question which has guided us both in writing this book and in undertaking the project which informs it. For us a vital logic underpins it. If agencies want to work in a collaborative way with service users and carers, they will need to collaborate with them to find out how best to do so.

## **User involvement in training**

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Perhaps the nearest that service users and carers have so far come to being involved in developing skills for community care has been through their involvement in training for professionals. This involvement takes several forms. It includes service users offering contributions to courses, acting as trainers, providing their own training courses for professionals and producing training materials (Keville, 1992, p. 13; Beresford, 1994).

Clearly training, including in-service training, qualifying and post-qualifying training, is crucial in developing and implementing more participatory and empowering practice in community care (Beresford and Croft, 1993b), and the involvement of service users is central to such training. Yet so far user involvement in community care training is limited and patchy.

It is still much more likely to mean service users or carers offering a one-off slot as outside speakers than being an integrated part of learning. One group of social work students said:

'We've had a limited number of service users. It tends to be isolated people coming in saying "I'm disabled" and not many and not really linked. ... It's tokenism to say what disability is' (Beresford, 1994).

Service users place considerable emphasis on their involvement in training as a means of changing the culture of professional practice. In practice, it is still mostly used to offer an additional perspective to complement the conventional professional ones. So while user involvement in training is likely to have major implications for professional skills, this issue remains undeveloped.

## The involvement of service users and carers in identifying skills

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Policy makers, educators and service providers have so far paid little attention to the contribution service users and carers can make to the identification of appropriate skills for community care practitioners. Service users and carers are not often involved in defining the skills that are needed for agency practice and management. Little systematic attempt seems to have been made to explore this with them. Yet it is a particularly appropriate area of activity for both groups at this crucial stage in the development of community care. This is because of:

- The fundamental changes now taking place in the aims and organization of community care and community care professionals.
- The new priority attached to the perspectives of service users and carers in community care.
- The changed funding arrangements for community care and increased emphasis on budgeting and cost-effectiveness.

Community care service users and their organizations have long urged the need to work 'with' rather than 'on' or 'for' people. A growing body of evidence is emerging from them which highlights the kinds of approaches to the provision of support which they value and prefer. This builds on:

- The development by disabled people of a social model of disability to replace individual and medical models.
- The new emphasis from disabled people's organizations on people's rights as well as their needs.
- The development by disabled people of self-run personal assistance schemes and user-led services.

Colin Barnes highlights the importance of involving service users in the definition of both people's needs and practitioners' skills in his discussion of disabled people and discrimination. He shows that historically 'professionals' perceptions of need are frequently at odds with those defined by disabled people and their organizations and that 'disputes between disabled people and professionals over the form and levels of service considered appropriate are not uncommon'. He concludes that:

Comprehensive assessments of disabled people and their families by professionals remain central to the process of service allocation, and professional power within welfare bureaucracies continues to go unchallenged (Barnes, 1991, pp. 133, 147).

As service users and carers have increasingly expressed their views and a start has been made to seek their views, a growing amount of evidence has emerged that service users' views of health and social services do not necessarily match the professional view (Siddiqui, 1993, p. 13). One study showed that when patients and nurses at a psychiatric hospital were asked which aspects of care they rated most highly, the two groups had very different perceptions. For example:

Patients rated 'drug treatment' and 'being seen at ward rounds or case conferences' in their bottom four items. Nurses placed these in their top four (Sharma, 1992, pp. 20-21).

## **Involving service users and carers in developing skills**

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Two key points emerge from all this for the involvement of service users and carers in developing skills for community care. First, service users and carers are likely to have some mould-breaking things to say about skills for community care. Second, because little has so far been done to explore this, any attempt to do so will have to break new ground. We realized that we would have to start from scratch in the project. But while there is little to build on as far as service users' and carers' views about community care skills are concerned, there is now considerable experience, information and guidance on good practice for involving people to be drawn on.

Not only would involving service users and carers in developing community care skills be new for us. We could expect it to be new for them! We couldn't assume that they would be used to thinking or talking about skills for community care because, as we have seen, it is not something service users or carers have been encouraged to do. Instead the expectation has been that people are the recipients of practice rather than the active partner in or initiator of it.

The emphasis in this part of the project was on developing a collaborative process which offered service users and carers an opportunity to contribute their views on what skills are needed for community care practice. We didn't assume that they would be in a position to discuss what a collaborative practice would or should look like, since, as we have said, this is unlikely to be a discussion most would be familiar with or be able to contribute to on equal terms. The kind of concepts upon which community care is based, like needs and needs-led, commissioning and user involvement, may not be ones which most service users are familiar with or with which they structure their experience. Some of the older people we spoke



to, for example, weren't sure whether they had any experience of community care services because they weren't sure what these were. Our objective was for the project to provide the opportunity for a discussion about skills and collaboration on people's *own* terms. The aim was that this discussion would offer a variety of insights on collaboration, including insights on:

- What skills service users and carers identify for community care.
- What skills service users and carers think practitioners need to work in a collaborative way with them.
- What skills service users and carers think practitioners need to collaborate with service users' and carers' organizations.

This discussion would be of value in its own right, offering service users and carers an opportunity to express and develop their perspectives on skills for community care. It would also be of value in making comparisons with what practitioners said.

## Carrying out the project

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We carried out the project by organizing a series of group discussions with service users and carers locally. We contacted service users' and carers' groups in the area in order to set up the discussions. We wanted to ask people about the kind of skills which they found helpful and unhelpful from their own experience, how they experienced their relationships with practitioners and what skills they thought would be supportive for working in more collaborative and participatory ways.

There were five stages to this work:

- 1 Desk research on existing information on users' and carers' views of skills and collaboration in community care.
- 2 Identifying users' and carers' organizations and groups in the area.
- 3 Making contact with users' and carers' groups, explaining the aims of the project and seeking their involvement.
- 4 Preparing a schedule for use in discussions with users' and carers' groups.
- 5 Undertaking the discussions, tape recording and transcribing them.

We also identified two additional issues which we wanted to address. The first was ensuring the effective participation of black carers and service users. Our experience suggested that specific efforts might need to be made to ensure this happened. The second issue arose from our recognition that there tend to be fewer user groups of older people – one of the groups we

were focusing on in the project – than other groups of community care service users. Because of this it might be necessary to bring some older people together specifically for the project. In the event this was not necessary because there was an active organization of older people in the area, but this is unlikely to be the case in all areas.

We carried out seven group discussions. These were with:

- Users of a daytime service for people with mental distress.
- Two carers' groups in different parts of the area.
- A group of older Asian women, with caring responsibilities.
- Disabled people involved in an organization of disabled people, which included older disabled people.
- Members of a self-advocacy organization of people with mental distress.
- Members of a forum of older people.

We made efforts to involve as diverse a range of groups as possible in a small-scale project. The groups included people who came together as users of a service, people involved in service user self-advocacy groups, people involved in a group with a paid worker and people involved in carers' groups concerned both with offering mutual support and influencing community care policy and practice.

We gave the groups both verbal and written information about the project before the discussions were held. At the discussions, we made clear commitments about confidentiality and feedback and permission was sought and obtained for tape recording and transcription of discussions. All the discussions were recorded and fully transcribed in this way.

We developed a flexible schedule for use in the discussions, drawing on our contact with the groups before carrying out the discussions. The core areas to be covered included:

- People's experience of community care services.
- People's attitudes to community care services.
- The skills they felt service providers need to meet their individual needs as service users and carers.
- The skills they felt service providers need to work with users' and carers' groups.
- Their ideas and suggestions on how these skills might be developed.
- What, if any, problems they saw in working as a group with community care agencies and workers.
- The skills they felt they need as a) individuals and b) a group to work effectively with community care services.

- The relation of skills in community care to other essentials for effective and sensitive services.

The schedule was flexible so that members of groups could introduce particular issues that concerned them and extend discussions about particular areas covered as they wished. We told all the groups about the second phase of the project, where it was planned that service users, carers and workers would have a chance to meet together, exchange views and develop discussion. All the groups expressed an interest in taking part in this meeting.

## **What people said**

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The findings from this part of the project confirmed the value and importance of involving service users and carers in the process of identifying and developing skills for community care. Their views did not necessarily reflect professional expectations and assumptions about what is important for service users and carers. Participants seemed to welcome this chance to offer their views and emphasized the importance of exploring ways of accessing what they said to practitioners and policy makers at local level and beyond.

They had things to say about skills and collaboration whether they were experienced members of users' and carers' groups or individuals whose only contact with services was as users of them. The only difference there seems to be between the two is that the latter often have more difficulty in formulating proposals and demands and would benefit from more support in developing their views and ideas.

## **People's experience of community care**

The people involved in the service users' and carers' groups had between them experience of a very wide range of community care practitioners and services. These included community nurse, home help, community psychiatric nurse, physiotherapist, general practitioner, social worker, community transport and occupational therapist, as well as home chiropody service, day centre, day hospital and counselling service. They didn't only mention designated community care services and practitioners. One carer, for example, spoke of a policewoman who was very helpful to his wife who had a drink problem.

The range of services and practitioners, and the variety of agencies and authorities responsible for them, could lead to problems of coordination:

'The health authority says it's the local authority. The local authority says it's the county authority. The county authority says it's the health authority, so you go round in circles. No one has a pot of money to pay for it really. It's also true that there are a great many different types of organization at different levels, some of whom are competing to provide these social services ... There is a bewildering number of organizations related to doing something in mental health' (Local self-advocacy organization of people with mental distress).

Cuts in one service could result in another collapsing:

'We have one member who has support from a variety of different people, different groups and the one thing she had which wasn't covered by anybody else was a home help who used to come in and do her washing. That was withdrawn because it wasn't an "essential task", but in fact the washing had been done, including all the bandages because she has ulcerated sores, which meant that when the district nurse came along twice a week to replace her dressings there weren't any clean bandages. So from the council's point of view, washing isn't essential. From the health district's it's nothing to do with them. But taking the two services together, if you withdrew one, the other collapsed. So they actually replaced that service. They reinstated it' (Local organization of disabled people).

People reported problems of access to services. As some carers said: 'You don't know the right people to contact, do you?' For the group of older Asian women, the problem was not that they didn't know how to contact services, or what services there were, but actually *getting* services. Increasing charges are also restricting access to services:

'Social workers do not charge, but you need to pay for home help. I used to pay £2.50 per hour. But these days the charges are so high it is better to hire a private one' (Group of older Asian women).

Service users' and carers' experience of community care services and practice was very mixed, both as individuals and as a group. They could never be sure what kind of treatment they would receive or how helpful a practitioner would be. People talked about good and bad experiences and about workers they regarded as really helpful and poor:

'And when you think back, you can't think back sufficiently to get a clear picture of what you went through. It's a nightmare' (Local carers' group).

'Sometimes the home helps can be erratic and not come' (Local organization of older people).

'The social worker was such a source of help to me. I couldn't have done without her' (Local carers' group).

'My neighbour had a home help service every day and a district nurse twice a day. And I would highly recommend what happened with him until he died ... He had marvellous attention' (Local organization of older people).

## **Attitudes to community care**

As a result, people's attitudes to community care practice and provision were mixed, ranging from 'My experience? Diabolical, in just one word' (Local carers' group) to:

'I have found them extremely helpful ... a very, very positive experience' (Local self-advocacy organization of people with mental distress).

'A good professional worker can make all the difference' (Local carers' group).

Clearly service users and carers found some professional practice unhelpful rather than helpful; for example, when unrealistic commitments are made:

'Hospitals promise you the earth. "Oh yes, take them home. That will be fine." This person will be in, that person will be in, and you wait and eventually you cope and you don't bother and they don't turn up and they don't bother' (Local carers' group).

They also expressed a sense that professionals often don't have the appropriate skills:

'Health workers aren't provided with the skills and language to consider people as people ... Workers are stalled from seeing other ways of helping people by the narrowness of their experience and training' (Organization of disabled people).

'They just go by the book. I would say that my doctor, my psychiatrist and my experience of hospitals have all gone by the book ... I went back to my doctor and told her I was very angry with her. She said, "Oh why?" and I said because I needed your help and your only answer was to put me in touch with the duty psychiatrist at the hospital who wanted to admit me. And her answer was she was told I should have been admitted' (Local self-advocacy organization of people with mental distress).

## **Skills for a collaborative approach to community care**

It was when service users and carers discussed skills for community care that it became most apparent how different their world-view was from that of the service system. If anything emphasizes the importance of involving service users and carers in the definition and development of skills, it is this. It doesn't necessarily mean that their views are in conflict with those

conventionally expressed by community care agencies, services, trainers or practitioners. Rather they tended to see things differently – to have different starting points, to frame their ideas differently and perhaps to have different conceptions of what constituted skills.

People's comments and trains of thought didn't always fit neatly with our initial terms of reference, so it was important to be flexible. They raised new themes and issues. Some individuals and groups found it difficult to discuss some of the issues we raised. In order to do justice to the breadth of people's thoughts and ideas it may be helpful first to headline separately the different responses of service users and carers to the key areas we explored, before going on to look at some of these in more detail. Let's begin with the carers' discussions.

## **The skills carers identified**

### *The skills workers need to work with individual carers*

- Patience.
- Understanding and empathy: 'If you've got a very ill patient who is unable to assert themselves ... they can be pushed around a lot.'
- Experience – workers need to know what caring is really like.
- The ability to 'really listen'. If workers listen to what carers say they won't make judgements about them.
- To have information to pass on to carers: 'You need someone with knowledge of where you can get help.'

### *The skills needed by professionals to work with carers' groups*

- Experience or understanding of caring, illness and disability.
- Information and knowledge about local services, benefits, finances, disability and different illnesses.
- The ability not to make judgements or assumptions about people.
- The ability to communicate with each other.

### *The skills carers' groups need in order to work effectively with community care services*

- To be well organized.
- To be clear about what you want.
- To be able to put in writing what you want.
- To be able to maintain your independence as an organization.
- Assertiveness.
- To know the terminology and legislation.

- To be able to think positively at a time when there are not enough services and resources to meet your needs.

### *Additional issues raised by carers*

- Carers have to work very hard.
- Caring affects every aspect of people's lives.
- People may not choose to be a carer.
- Often when you start caring you do not know where to get help.
- Even if you do know where to go to get support, you may find there are not enough services: 'I cared for something like 16 years for my mum without any help.' Some people can't get any help at all.
- Sometimes the services that exist can be very unhelpful for carers. You may have to be very assertive to deal with services.
- Carers really value having a social worker of their own who can help them.

### **Older Asian women's group discussion**

The group of older Asian women did not see themselves as a group either of service users or carers and did not come together on that basis. But they had experience both of providing and receiving support. Their particular experience of community care meant that their response was different from that of the other groups of carers and service users.

- Many women in the group had problems and difficulties that meant that they really needed support. They would like help from community care services.
- The women knew what services there were and how to contact them, but when they contacted social services they were told that because of cuts in services no help was available. They had to struggle on without help.
- It was difficult for women to comment on how services could be made better for them when they had little access to services in the first place.

### **The skills service users identified**

Now let's turn to what service users said about skills for community care.

#### *The skills service providers need to work with service users*

- The ability to treat people with respect as individuals.

- Being able to provide information.
- The ability to listen to what people say.
- Communication skills.
- Being able to help people identify their needs instead of acting as gatekeepers.
- Good networking between services.
- Well-publicized services.

*The skills service providers need to work with service user groups*

- Able to take groups seriously and value them.
- Able to take part in joint discussions with service users' groups.
- Able to develop consultation skills.
- Able to back up groups.
- Able to tell other service users about the groups so they can get involved.
- Able to recognize the discrimination service users face.
- Able to involve service users in training professionals.
- Able to train disabled people as community care workers.
- Able to recognize users' groups' needs for resources.
- Able to provide appropriate information.

*The skills users' groups need to work well with community care professionals*

- Confidence.
- The ability to work in a professional manner: for example, to take minutes accurately, to be able to handle meetings.
- A realistic approach to what's possible.
- Able to put criticisms positively.
- Able to provide appropriate information.
- Able to work with other community organizations.
- Training.

*Additional issues raised by service users*

- The need for adequate resources.
- The need for enough time to make change.
- The need for more people in users' groups. This is linked to resource issues, such as travelling expenses.
- The need for more support services run by voluntary organizations.
- The need for service users and workers to be involved in joint discussions.



## Issues service users and carers raised about community care skills

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While the philosophy of this project was based on involving service users and carers, we were also careful to distinguish between the two. It is important not to confuse one with the other, for they have different perspectives, interests, rights and concerns. Carers have often been used to speak for service users, and this still happens. While this project provided opportunities at all stages for each group to speak for itself and offer its own different account, one of the interesting issues to emerge was how similar – in kind if not in detail – service users' and carers' concerns were about collaboration and skills for community care. We can see this through the three groups of skills that have been identified: those for practitioners to work with individual service users and carers, those to work with their organizations, and those for service users and carers to work with community care practitioners and agencies.

### Skills for working with individual carers and service users

Service users and carers identified a wide range of skills which they felt were needed. There was considerable agreement between the different groups about these skills. They included seeing the individual as a whole person, not as a set of symptoms or problems; treating people as individuals, not as an anonymous group or class; treating people with respect; acknowledging the validity of their experience and views; providing them with full and accessible information; listening to what they say and asking them what they want; recognizing the need to meet them on their own terms and if possible on their own ground, where they would feel more comfortable and relaxed:

'I think perhaps [there is a need for] more of an understanding of old people, to listen more carefully to them' (Local organization of older people).

'I think a lot of it is basic consideration for people ... It is treating people as individuals. Treat them as humans. It's all that sort of thing' (Self-advocacy organization of people with mental distress).

'A simple example. Jane has arthritis and is partially sighted. She is 62. In social services' terms, because of the way the teams are all split up, is she an older person or is she somebody with a sight impairment or is she someone with a mobility impairment? And because the teams are all split up into various groups, it gives you a view that people are split up into these groups and the truth is we aren't!' (Local organization of disabled people).

'They've got to have good listening skills, and I mean really good listening skills because we don't always say to other people what we want to say ... It takes a lot of trust to be able to tell somebody the truth about how you feel and what you really want' (Local carers' organization).

'If you could pick up a phone, phone somewhere and say something is happening, this is happening, what do I do and where can I go for help' (Local carers' organization).

### **Skills for working with service users' and carers' organizations**

We wanted to explore the skills practitioners need to work collaboratively both with individual service users and carers and with their organizations. There were many overlaps in the skills people identified for effective collaboration in both situations. This was particularly true of the carers' groups, where people placed an emphasis on many of the same skills. The skills people highlighted included: providing information, confidence-building, knowledge of resources, listening and having a commitment to service users' and carers' rights, needs and interests:

'People who have time to talk, listen – these are the basic things' (Self-advocacy organization of people with mental distress).

'I thought they needed to listen to what the carer thinks he or she needs: information on what's available in the area such as volunteers, respite care, home helps; not to impose their views on clients – let us say what we want; and to give information on financial matters ... and we need regular visits from the social worker ... it must be a definite commitment to come at that time' (Local carers' group).

A common concern among people who took part in the discussions was the importance of both health and social services taking them *seriously*. There were real worries and fears about tokenism, based on some people's experience. Service users and carers stressed the need to support groups which were independent and under their own control to become established, and then once they were, for practitioners and services actually to listen to what they said and recognize and respond to their continuing need for resources. Such a commitment was seen as essential for effective collaborative working. It was felt to be reflected in consulting people and groups *before* decisions were made rather than afterwards:

'I think the main [skill] is to take the group seriously ... I mean they promised me the CPNs [community psychiatric nurses] will send people along [to the group]; different things are going to happen, but it never happened ... It really annoys you because I'm doing it all and I'm on the helpline and I say anybody

can ring me anytime. You don't want praise for it, but you want some back-up' (Self-advocacy organization of people with mental distress).

'To really communicate with us and other groups and by doing that to develop their consultation skills. ... We're trying to get them to consult us *before* they do things' (Self-advocacy organization of people with mental distress).

'Consultation is a rubbishing word because half the time they've already made up their mind what they're going to do and then they consult you after the act and this is what's happening' (Organization of older people).

## **Skills for service users and carers to work in collaboration with community care agencies**

Service users and carers identified a wide range of skills which they found helpful in working with agencies and professionals. These covered three main areas: skills for personal development, technical competencies and skills for organizing. Mostly these could be gained by experience, by agencies ensuring that accessible information was available and by enhancing people's confidence. One group highlighted the importance of their members' technical skills, which facilitated their effective dealings with health and social services organizations, skills which they felt meant they were highly competent and professional. These skills included being able to provide detailed and accurate minutes, undertake important negotiations and produce businesslike correspondence.

At the same time there was a feeling that service providers should recognize that some groups might not have these skills and that collaboration should not always demand them. Service providers should be sensitive to working in ways which are comfortable for service users' and carers' groups and not expect them to be the mirror-image of other professional groupings. This requires new skills from service providers, both in being sensitive to different ways of doing things and in adopting these different ways themselves in their dealings with service users' and carers' groups:

'We need assertiveness. We need to know the terminology. You have to know the legislation and how the various organizations, shall we say the statutory authorities, interpret the legislation' (Local carers' organization).

'Confidence ... What you do need to have is an effective group of people who've got the confidence to basically deal with professionals ... We've been lucky in the way this group's developed. We've got people with skills like that and people with different skills we've been able to use. We've got the best minute secretary ever' (Self-advocacy organization of people with mental distress).

It was clear from the comments of some of the groups that working with community care agencies could be a difficult, demanding and painful experience. Members of one group said:

'You also have to be practical and realize you can't change the world ... It does take a lot of time to change things ... you've got to have your life as well' (Local organization of disabled people).

All these skills may be needed at a time when people are going through considerable difficulties, with inadequate material and personal support. Some service users and carers seemed to feel a lack of support from practitioners at both a personal level and as members of groups. The kind of skills which they mentioned needing in their personal dealings with services, like assertiveness and being clear about what they wanted, might also be seen as a measure of the shortcomings of professional community care skills.

## Summary

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In this chapter we have begun to look at what service users and carers had to say in the development project about skills for community care. One of the interesting findings that emerged is how often skills and values which might be expected to be taken for granted in qualified practitioners are lacking in their experience. Because of this, service users and carers placed a particular premium on such qualities as respect, reliability and openness. There were some important overlaps here with what practitioners said. Another significant finding was the high degree of similarity between what service users and carers said. The different perspectives, interests and rights of these groups are rightly stressed. But their overlaps and shared concerns, as this emphasizes, are no less important.

# 6 Raising the concerns of service users and carers

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## Concerns expressed by service users and carers

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In addressing the questions we raised about skills and collaboration in community care, service users and carers also identified a number of other related issues which concerned them. They reflect the context of collaboration as well as some of the boundaries that currently limit it. They also open up the discussion beyond conventional professional parameters. It will be helpful to look at these concerns next.

### The relationship of skills for community care and professional and organizational cultures

Service users and carers made a number of references to organizational cultures and traditional professional cultures which were not consistent with more collaborative and participatory approaches to practice in community care. They highlighted that skills for collaboration in community care need to be seen in the broader context of professional cultures and philosophies and that these cultures may need to change, if such skills are to be effectively adopted and developed. Training in new skills on its own would be unlikely to be effective. It needed to be coupled with changes in attitude. Members of the local organization of disabled people said:

'I think in the seventies people were beginning to open up to ideas that maybe people had some sort of right to what was common experience, and isolating and controlling people wasn't the way forward. But you get vast differences in attitudes. Because, for example, if you go to a hospital and talk to hospital people, they're much more into telling you what you can do and what you can't do and treating you very much as a patient. If you go to social services, you're

more likely to bump into someone who is talking to you as a person about what you want to do and how, how you can achieve it and how you can take responsibility.'

## **Issues of resources and agency culture**

The problem of inadequate community care resources, cuts in agency services and budgets were common themes in the discussion. For instance:

'Can we get it absolutely clear from the start that local authorities are providing the services with the resources that are available to them. If more money was coming from central government into localities, more could be done!' (Local organization of older people).

There was an understanding among participants that inadequate resources would limit the nature and quality of services available to them. For them it meant a limit on how often and how long they could see a practitioner, restricted opening hours for valued services and not enough of the services they wanted. They called for increased funding and resources. But while this was seen as important, it was not seen as the only problem. Resources were coupled with an appropriate culture for more empowering and collaborative working. There needed to be change in *both* if community care policy and practice were to be needs-led. There are both resource issues and skills issues; both must be addressed and they need to be given equal priority. Limited resources don't prevent cultural change, even if they may inhibit it. For example:

'There are still resources that social services can call on. There are still innovations that social workers and care managers and so on can bring about. They can be a lot more imaginative in the way they use resources' (Local organization of disabled people).

## **Different agency responses to self-help and self-advocacy groups**

Service users and carers had experience of collective involvement in groups that were concerned with offering mutual support, and in groups concerned with expressing a users' or carers' voice, by offering users' or carers' views and providing feedback to service providers. Some groups serve both purposes. Some are more specifically concerned with the provision of self-help support. One discussion group felt that with the increasing emphasis on user involvement, there was beginning to be some recognition and understanding of the needs and role of self-advocacy groups, with some earmarked funding for them, but that service providers were still often less clear about those of support and self-help groups. As a result,

these could be left unsupported to 'get on with the job', imposing a great strain on their members. Service users and carers thought a good understanding of the aims and needs of such groups would be helpful for more collaborative working:

'I think we're getting two kinds of groups and I think there are important differences. This group is a consumer feedback group ... It is politically fashionable for all government services at the moment to show that they are paying attention to customers: and so the hospital gave us money because they wanted us to do that ... but there are a lot of groups who try to provide a kind of social service – a drop-in centre, a therapeutic centre, a meeting centre – that get nothing at all from social services' (Self-advocacy organization of people with mental distress).

At the same time, groups which are primarily concerned with representing the views of their members and working for change are also increasingly conscious of the need to offer their members support. While self-advocacy groups are trying to draw together the two strands of self-help and action for change, agencies still seem to be drawing a distinction between them. As we have seen, getting involved can be a demanding and stressful experience, particularly for people who are experiencing difficulties. So while groups may have a different emphasis, all are likely to have some concern with providing support, and this needs to be recognized by community care agencies and practitioners. This has implications for skill development to enable practitioners both to be sensitive to and able to support the diversity and changing forms and objectives of self-organizations.

## **Differences between health and social services**

Service users and carers talked about both similarities and differences between health and social services. One difference that was identified with implications for a more collaborative approach to community care was the emphasis on a medical model in health. Some service users found this unhelpful and inconsistent with their equal participation. Such differences in culture and philosophy are likely to have an important bearing on the different learning needs of workers in these two services:

'I think another area that is a problem is health workers. We're saying there's a difference in attitude. Health workers in their training aren't provided with the skills and language to consider people as people. They consider people as patients and cases, so that then they're stalled from seeing other ways of helping people by the narrowness of their experience and training ... In social services, you're more likely to bump into someone who is talking to you as a person ... They speak totally different languages' (Local organization of disabled people).

## **Reconciling the skills for an interpersonal approach with the new budgeting and purchaser arrangements in social services**

The new arrangements for community care will have profound implications for the role and skills of social workers and other social services workers. Care managers will be expected to put together care packages, understand budgets and possibly manage them, as well as making assessments which are needs- rather than service-led. Service users attached considerable importance to social services workers having the skills to negotiate and operate this new care culture effectively.

Training which was centrally concerned with a traditional interpersonal approach to social work would not necessarily offer this. As a result, social workers could be disempowered and ineffective when seeking to deal with the new system. Ultimately this would be detrimental to the interests of service users and carers. They felt there was an urgent need for social services staff to gain the new skills now required if service users' and carers' needs are to be appropriately met:

'... If you imagine being a social worker is a game, they've been trained and run to the game rules. Now they're having another set of rules imposed on them ... Most people aren't trained and even their experience of life which has led them into training isn't to do with budget control, resource control, breaking the bad news to people that they're not going to get what they need ... There's been a great change and very few of them have got experience of management of change, to learn how to cope with radical rethinks' (Local organization of disabled people).

## **Community care services must be accessible for people to be involved in them**

The group of older Asian women weren't getting the services they needed and wanted. Discussion about what skills were needed was undermined by the fact that they did not get a service at all. If they were referred by their general practitioner to a social worker, the social worker frequently did not come. Because women did not get a service, they did not feel it was their responsibility to identify skills. The problem was not lack of knowledge about where to get services, but not being able to get them when they went:

'People say that social workers help out, but I have been ill for the last seven years, no social worker ever came to see me. Even my GP wrote to the social worker but still nobody came round.'

'From time to time officers come to this group and explain to us about the social services, but usually social workers do not help out.'



'It's up to you how you improve these services.'

This group highlighted a vicious circle which affects black people and members of minority ethnic communities more generally. Because they don't receive community care services, or services are inappropriate, they are less likely to be included as part of the discussion to change those services and less likely to see it as something they should be part of. Where this happens, practice and services are likely to develop in a way further and further away from meeting their rights and needs. Because of this it is important to adopt a *pro-active* approach to practice, which encourages practitioners to explore local patterns of needs, instead of a *reactive* approach, based on responding to whatever needs have traditionally come forward.

### **Training for service users and carers as well as service providers**

Service users and carers highlighted the need for the development of new skills among community care practitioners and managers. For example:

'The local authority is closing down a home with 50 people in it. Practitioners need information on how those people can live in the community, like, "What do we do? Who do we contact? Where might funding be available?"' (Local organization of disabled people).

However, they didn't see training needs stopping with service providers. They felt that it was important that resources for training were not solely directed towards professional training. They also identified the need for training for service users and carers and their organizations if they were to collaborate with community care and other services on more equal terms. These included training to increase people's confidence, assertiveness and expectations. Several groups placed an emphasis on confidence-building. Confidence was regarded as important both for individuals as service users and carers and when they were involved in service users' and carers' organizations interacting with providers of community care. As people said, when you are using such services you are likely to be particularly vulnerable and stressed. Your confidence may be at its lowest. Confidence-building is therefore essential:

'Special training in skills, like, for example, going to college and within that college you would be seconded to various organizations ... The reason is because that person could be faced with certain situations and not everybody could handle it' (Users of a daytime service for people with mental distress).

Service users and carers also thought training was needed to develop practical skills. These included skills in communicating, advocacy, resource management, planning, negotiating and dealing with official agencies, as well as knowing where to go to get information, learning how to work together in groups and developing their own ways of doing things. Equal opportunities training was also required, including disability equality and anti-racism training.

### **The centrality of general practitioners**

The comments of service users and carers confirmed the centrality of general practitioners (GPs) in community care, as primary service providers, budget holders and crucial agents for referral. For most people, they were the pivotal figure in their relationship with services. They are the community care profession which people are most likely to be in routine contact with and they have a high profile in the community. Among the large group of older people who took part in the project, they were the service most people had made use of. Yet GPs have been the profession least involved in collaborative developments around the community care reforms.

Their central role in community care puts a particular premium on the development of collaborative skills in the initial and subsequent training of GPs, although there may be many problems in the way of this:

*'I found my GP, my mother's GP, hasn't been at all helpful. He more or less wiped his hands of it.'*

*'My experience is quite the opposite. When John got ill like this, the first thing my GP, who's a wonderful person – a woman – said was you must go to social services and I wouldn't have known about this group or anything other than from my GP in the first place' (Local carers' group).*

*'I found his attitude very dismissive. I know he's got a lot of people to see and I didn't come out with a particularly good feeling. When I saw the CPN (the community psychiatric nurse), the CPN was a lot better' (Users of a daytime service for people with mental distress).*

*'You've got to be in the system ... And if you haven't got a very good GP and if you're not very vocal and you're not as capable as you were, then you don't get into the system and you're left floundering' (Local carers' group).*

## Issues arising from service users and carers

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One of the aims of this project was to enable service users and carers to speak for themselves about skills and collaboration in community care. They were certainly able to do this. Much of what they said may be familiar to practitioners who seek to work closely alongside service users and carers and their organizations. It may be less familiar and more challenging where traditional, more paternalistic approaches to practice and learning persist. It is not our intention to offer a commentary on what service users and carers said or place our own interpretation on it. But we do want to single out for reflection some key issues which emerge from what they said.

### The importance of experience

Service users and carers placed great weight on their first-hand experience. Crucial qualities which they believed practitioners needed to offer appropriate support were the understanding and empathy which came from such experience. While they argued the value of first-hand experience, they did not say it was essential. What many did feel was important, was that where practitioners did not have such experience, they were prepared to learn about it directly from service users and carers. So, for example:

*'What I am saying is for social workers to be in contact with us, to know what we are experiencing ... Each one of us, although we're the same, each of us has different problems and it's only by talking to us that the social workers can understand and go on from there' (Local carers' group).*

Their approach to skills was not based on a crude notion that common-sense experience was everything, but instead seemed to follow from a developing theory which prioritized people's understanding, feelings and subjectivity and which sought to comprehend the nature and detail of these. This might mean a psychiatrist really listening to a service user's experience, or a social worker staying for a length of time with the woman whose husband had Alzheimer's disease and hit people with his walking stick, 'and seen him and had a whack with the stick'.

Service users and carers saw two ways in which skills for collaboration could be developed – through experience and through training. Some placed most emphasis on experience. Some saw training which drew on their experience, and which helped practitioners gain insights into that experience, as offering the way forward:

*'... By involving professionals and carers together in training. We got to understand each other very well. And I think they began to understand some of our*

problems, you know, by the training and the little group work' (Local carers' group).

### **The interrelation of skills and values**

Service users and carers were not just concerned with technical skills, although there seems to be an increasing emphasis on them in community care training and they thought they were important. Carers, for example, wanted practitioners to have a grasp of the kind of practicalities that concerned them, like lifting, forms of medication, and so on.

Service users and carers did not place any emphasis on skills in terms of specific skills for particular areas of practice: for instance, in assessment, review or matching services to individuals. It was as though something more important had to precede this. This was workers' adoption and internalizing of a particular kind of value system and culture in relation to service users and carers. At the heart of this was an explicit valuing of service users and carers.

Service users and carers seemed to have realistic and reasonable expectations of workers. They were generally tolerant of their shortcomings, mistakes and failings. What they were less likely to excuse was being kept in the dark, patronized, ignored, lied to or deceived. They pointed to a different philosophy of practice. Older people stressed the need to have 'respect for old age'. Disabled people argued the importance of appropriate learning: for example, being familiar with a social model of disability.

Skills and values seemed to be closely bound up for service users and carers. What they saw as skills, others might see as values or human qualities: for example, honesty, commitment, candour, patience, tolerance, empathy and reliability – workers providing accurate information or coming when they say they will.

It may be argued that these qualities are preconditions for entry into or qualification in professional training, but the experience of service users and carers suggests that such values and skills cannot be taken for granted in practice. They often seem to be lacking and some service users think they may actually be weakened rather than strengthened by conventional professional training.

Service users and carers seemed to see changed practice values as a prerequisite for developing specific practice skills. This has important implications for a strategy to develop collaborative skills in community care. It also has parallels with the approach service users and carers have adopted in developing their own skills. Their view is that if they are to learn and use practical skills effectively, they must first value themselves and develop their own confidence, self-esteem and assertiveness (Beresford and Croft, 1993b). Similarly if practitioners are to adopt skills to work collaboratively

with service users and carers, they must first learn to value service users and carers.

## Challenging the legacy of training

Training has been presented as the main way in which community care practitioners can improve the way they work with service users and carers. Yet in the view of some service users and carers, professional training actually often seems to *distance* workers from the people they work with and to desensitize them to their own and other people's feelings. As a result some service users felt they were being subjected to an alien philosophy or ideology of 'care' rather than the human understanding, empathy and support – the extended human skills – which they wanted. For example:

'They tell you to do things without understanding why you can't do them or offering help to do them' (Self-advocacy organization of people with mental distress).

'I found the GP's attitude very dismissive. I know he's got a lot of people to see. I didn't come out with a particularly good feeling' (Users of service for people with mental distress).

The distance between professionals and service users has been increased by professional training and recruitment policies which have discriminated against service users. So while the service users and carers we spoke to put a high priority on first-hand experience, this has largely been seen as a minus rather than a plus for professional practice. The implementation of equal opportunities policies to recruit disabled people, psychiatric system survivors and other service users as community care educators, trainers and practitioners offers the most effective way of challenging the depersonalization of practice and the exclusion of service users' experience from it.

## People's different levels of experience and involvement

People involved in the service users' and carers' groups had different backgrounds and degrees of experience in both their individual and collective dealings with community care services. This reflects the general picture. Service users and carers are likely to be at many different stages and have different levels of knowledge and expectations. Some of the people we spoke to had a very thorough understanding of the new arrangements for community care, had been involved in efforts to influence policy development, had sat on joint planning and other planning and participatory structures and had received training on community care and user involvement.

Others did not have this experience and were primarily concerned with their own situation, as well as the general need for change and improved skills if their needs were to be most appropriately met. This meant that participants in the project had very varied levels of experience and understanding of the issues under consideration. This is typified by the contributions of two members of one of the carers' groups:

'We now get invited to virtually anything that's going on, such as there was a discussion about a stroke rehabilitation ward and there was a seminar last Thursday and our national organization was invited to that.'

'My husband, he died three years ago, but he had Alzheimer's. I just didn't know what to do with him and I didn't know about Alzheimer's. I didn't know what it was and when I was with the doctor ... I said to him, what am I going to do? What shall I do now?'

There must be recognition of and value given to the differences in experience and skills which exist both within users' and carers' organizations and between them. Appropriate support should be offered to develop people's understanding and skills, if collaboration is to be effective and not tokenized.

### **Starting with people's personal experience and agendas**

Service users and carers start with their personal agendas and experience. It is generally because of their roles as service users or carers that they become engaged with community care services. Their interest in community care begins there, although it may develop beyond this into collective action and the formulation of collective agendas and demands. Service users and carers are sometimes criticized for their 'personal agendas'. It is important to remember that community care is concerned with the provision of personal services and that people's personal experience and agendas should be valued as the necessary starting point for service provision, planning and delivery. This is not always the case and community care gets lost in organizational, managerial and other structural issues. But it needs to be taken into account both in developing skills and in collaborative working.

### **Learning from doing**

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We had two main aims in our work with service users and carers. We wanted to offer them an opportunity to be involved in the discussion about community care skills and we wanted to find out more about their views and ideas about these skills. Collaboration and involvement weren't just central issues we wanted to explore and develop in the project. They

were also *essential* for carrying it out. If we were to involve service users and carers in the project on equal terms, we would have to be able to collaborate with and involve them effectively. So in its work with service users and carers the project had to draw heavily on such skills itself. This included skills for identifying people to take part in the project, to gain their cooperation, to enter into discussion with them and to maintain their involvement.

Because of this, the process of the project offers some helpful insights into the skills that are needed for collaboration, as do the findings. These reinforce what service users and carers said and adds to their picture. But again, like them in their discussions, we found it difficult to separate skills from values and other issues. Perhaps that is one of the important lessons to learn from this project: that the three are not necessarily divisible. So let's look now at some of the most important lessons that emerged for us in collaborating with service users and carers. But first perhaps we should offer a word of reassurance.

## **Don't be disheartened!**

In this discussion, we have tried to be honest about the demands and difficulties of involving and collaborating with service users and carers. Seeing these problems set out in detail, however, may be offputting and

### **Exercise**

#### **Why should service users want to be involved?**

Statutory community care services are now required to involve service users by law. Agencies are now seeking service users' involvement with more or less enthusiasm. Many seem to think this is an offer service users will find hard to refuse. Most service users do seem to turn it down though. Why should service users want to be involved? After all, it can be a lot of hard work with little to show for it. Try and think of five good reasons why you think service users should want to be involved.

#### **Feedback**

This is the kind of question which gets harder to answer the more carefully you think about it. Initially it seems a very good deal. You'll have a chance to give your views. People will know what you think. You could improve how the service works. But the reality isn't always like that and service users and carers have become increasingly aware of this from bitter experience.

intimidating. We hope not, because this is not our intention. We hope it will be much more a matter of to be forewarned is to be forearmed.

Sometimes when you read accounts of schemes to involve people, the picture is one of unqualified success, with people rushing to take part, no shortage of quotable comments and a massive enthusiasm to stay involved. The truth is usually some distance from that. First, involving people is a hard slog, as will probably already have become clear from this book. That is not because people are not interested or apathetic, or because the workers trying to involve them are necessarily doing it all wrong. Getting involved is still something out of the ordinary for most of us. That is especially so for people who have spent any length of time in the community care service system and have been segregated and disempowered.

But getting involved can be worth it – if it is made worthwhile. Ways of doing this include agencies and professionals:

- Not making decisions until service users have been involved.
- Ensuring that participatory initiatives are properly funded.
- Paying service users' expenses and a fee for their expertise.
- Making the possible outcomes of involvement clear at the outset.
- Giving weight to what service users say.
- Ensuring participation is fun as well as work.
- Giving feedback promptly to service users about what has happened as a result of their involvement.

The crucial thing to remember is that it is the service agency's and practitioner's responsibility to encourage people's involvement, not the responsibility of people to get involved.

Getting involved worries and frightens most people. They wonder, 'What will they ask me? Will I know what to say? Could I get into trouble? Will I do it all wrong?' We should remember that this is just as true for service providers as service users and carers. People have also got many other demands on their life and may be having a struggle just keeping their head above water. So don't expect a massive response and do not devalue a small one. Participation and collaboration are long-term strategies that take many small steps to come to fruition.

## **Involving and collaborating with people**

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Now we will look at some of the lessons we learned from this part of the project. They fall into three major areas, concerned with involving people, collaborating with them and ensuring the equal involvement of black peo-



ple and members of minority ethnic communities. These are three areas of key concern to service users and carers. Hopefully, by setting them out in this way, we will also help readers to take these ideas forward in their own practice, through the practical insights they offer. Let's start with trying to involve people.

## 1 Involving people

### *Making contact with local service users and carers*

The best way of making contact with service users and carers is through their own organizations. In some areas, there are still few user-led groups. In many, there are not user-led groups for all groups of service users, such as older people, disabled people, people with learning difficulties, mental health system survivors and so on. In those cases it is worth looking to regional or national organizations to see if they can put you in touch with local contacts. Generally there are also voluntary organizations, local umbrella organizations and some practitioners who are in touch with individual service users and carers, if not groups, who may be able to provide a starting point.

Ours was a local project. We used several methods to identify and reach service users and carers and would recommend trying as many as possible. They pointed to the value of community development skills in such work. They also highlighted the importance of finding out about and making use of existing information. The methods we used to make contact with people included:

- Drawing on the knowledge of the local authority social services department training officer who was involved in the project.
- Referring to existing information and guides, such as that produced by the social services department about local groups.
- Making contact with people involved in local community care networks.
- Finding out about local service users' groups from people with more general knowledge of service user networks.
- Snowballing – which simply means finding out about other contacts as you go along from those you have already made. It was in this way, through the coordinator of the day service for recipients of mental health services, that contact was made with the self-advocacy organization of people with mental distress.
- Finding out more about local minority ethnic communities by networking with members of these communities, with whom we were already in touch.

Such contacts represent a valuable asset. They are there to be built on for further work, as well as helping to ensure that as wide a range of people as possible can become involved.

### *Clarifying the terms of involvement*

We made careful efforts to explain fully to people the terms on which we were seeking their involvement. When this happens people know what they are taking on and can make an informed judgement about whether they want to be involved. We explained the aims and nature of the process, who was undertaking it and who was funding it. We explained that the project was independent of the local authority and local services. Equally it had no power to effect change in local services. The aim was to bring together people's ideas and experience which would then be available to be fed into local and national discussions, hopefully to influence policy and practice.

We also made clear that strict confidentiality would be observed in the project. No one would be identified by name, unless they wished to be, and what individuals said in groups would remain anonymous and confidential. Groups would not be identified by name without their agreement. People were asked for their permission for discussions to be taped and transcribed. The issue of confidentiality was emphasized to the transcriber. People were promised that they would be kept in touch with what happened.

### *Starting with groups*

Efforts to gain people's views tend to be based on individual interviews or group discussions. We opted for group discussions. We did this because in our experience they ensure greater equality in the relationship, by increasing people's confidence and assertiveness. They ensure a wide range of views and experience, and help discussion to develop as participants interact with each other.

We also thought it was important to involve service users and carers who were involved in existing groups. We did this for two reasons. First, while such groups are often criticized by service providers as 'unrepresentative', they are generally democratically constituted organizations which have clear links to the service users' and carers' movements. Second, such groups have played a central part in the development of service users' and carers' thinking and action and have already been widely involved in debates about community care.

Individual service users and carers may have limited opportunities to reflect on and make sense of their experience of community care. They may

feel they should be grateful for whatever they get. They may not know what else might be possible. While they may have worries and reservations about the way they are treated and the service they receive from community care, they may be reluctant to criticize it and not know how it might be different. People in this position need time and support to think through their feelings about services.

Being involved in a group can make a real difference to individual service users and carers. It means that there are opportunities for people to think through, reflect, discuss, exchange and analyse their thoughts and feelings. This is one of the strengths of the user movement and one of the reasons that people involved find it supportive. You discover how your experience relates to others and find out that your concerns are not strange or remarkable, but shared by other people too. You begin to feel less isolated and more able to work out and express your views. It is important that efforts to involve service users and carers should build on rather than bypass or ignore this experience.

## 2 Collaboration

### *Providing information*

When carers' and users' groups are asked for their help, they need information in clear and straightforward terms so that they have a good idea of what is being asked of them. They generally have very limited resources and many demands on their time. People want to be able to make judgements about whether it is worthwhile to get involved. Generally groups involved in this project wanted information on paper so that they could discuss it with each other informally, or at a meeting. In one case, we made an initial visit to explain the project in more detail, as well as sending information. A small poster was made and put up in the day service for people with mental distress to let people know about the project. In all cases there was discussion on the phone, and information was again given as clearly as possible when we met members of the group.

### *The importance of sensitivity*

Service users and carers are not another set of professionals to be coopted into the traditional community care process. Collaboration means practitioners and services making a cultural shift to include service users and carers, not them having to learn the way practitioners and services work. This means being sensitive to their needs, rights, preferences and concerns. Meet people on *their* terms, in their territory. Recognize their generosity in giving their time, both as individuals and as a group. Try to fit in with their

arrangements. Use language which is accessible, appropriate and not patronizing. Ensure information is provided in accessible formats and meeting places are fully accessible. In our project, for example, some of the discussions were held in the evening. All were held where people wanted them to be held. Some had to fit in with other business that the group needed to discuss, or in one case with people having their lunch.

Where agencies and practitioners are not sure how best to respond appropriately to service users and carers, it is best just to ask. Service users and carers also value acknowledgement of their effort. As they say when it has not happened: 'It costs nothing to say thank you.' As we have said, groups and individuals are at different stages and levels of development. There is no one user or carer voice. All have important things to say. Sensitivity will improve the chances of them all being included and of them all wanting to take part.

### *Encouraging people to develop their own agendas*

Practitioners and service agencies should not expect people to have the same agendas as them, or to be familiar with the issues which they think are important. People know most about their own experience. Often that means their direct experience of services. That is what is important and familiar to them. They will want to talk about their own personal dealings with services and to begin with may find it difficult to talk about more abstract or wider issues.

It was to accommodate this that we used a flexible, semi-structured schedule, with a relatively small number of open-ended questions, and made it clear to participants that they could include what they wanted to in the discussion. People's experience is the heart of the matter. They may have few chances to talk about it, least of all with people involved with community care, so it is important to ensure that they have that opportunity. It is also valuable in its own right and provides vital insights for broader practice and policy issues.

### *Developing trust*

Trust is a prerequisite for effective and enduring collaboration. Agencies and practitioners have to develop a track record of collaboration. Service users' and carers' groups are often cautious, and understandably so. Their experience of user involvement in community care has frequently been negative. Consultations often do not lead to much. It is not often there is a history of positive partnership with community care agencies. Trust is something that practitioners must work to foster and gain. It cannot be taken for

granted. Why should service users or carers trust professionals or services? Do not take it personally if they have reservations.

One of us is a service user. This is important for building trust with service users and enabling their involvement. Service users should be involved in the development of any initiative for collaboration or participation right from the start. Trust can also be gained by being clear about what you want; making limited demands on the limited resources of service users; making clear what gains, if any, there may be for them; and making sure they are fully and quickly recompensed for any expenses they incur.

### *Group work skills*

Group work skills are at a premium in the kind of discussions which our work with service users and carers required. Discussion groups may be small or large. Each requires a different approach and different skills. The smallest discussion in this project was with three people, the largest with more than 50. They were very different, but equally valuable. It is important to value small as well as large discussions. There are many obstacles in the way of people getting involved in such discussions. There are practical problems, like lack of time and opportunity. Many people are also worried or frightened by the idea of taking part in a discussion. It is necessary to ensure that people have a sense of support to encourage them to take part and offer their comments if they want to, without them being placed under any obligation or pressure to participate.

### *Collaboration takes time and effort*

Collaboration is exciting and rewarding, but it is not an easy option. It demands time and effort as well as skill. However much effort and time you expect it to take, it is likely to take more. This is one of the lessons that managers and service providers seem to find hardest to learn.

The discussions which we organized for this project lasted from between half an hour to about an hour and a half. But they all took a lot more time to set up. People needed to have the chance to discuss the idea at a meeting. Groups needed to fit them into their schedule. This is an important part of the process and cannot be rushed. The people we met with were generally very busy, with limited resources, as well as often having other constraints on their time.

Collaboration has to fit in with service users' and carers' timescales and priorities. These are people who are likely to be under pressure, under-resourced and quite probably without paid workers. Groups may meet monthly or perhaps less often. They have to keep their members informed. What time they have together is precious. Making contact is likely to mean

a lot of cold calling, which requires confidence and being clear about what you are doing. Keeping in touch with them is likely to mean a pattern of making numerous phone calls, listening to answerphone messages and having to call back again. Groups may want an initial meeting with the practitioner or agency to sound them out, check out what they think of them and make a group decision. You may have to make a one-off journey, wait while they go through the rest of their agenda and then have just a few minutes to explain what you want. It may feel frustrating. You may feel irritated, especially if you have to do it more than once, but this is what collaboration means if it is to be real rather than rhetorical. It is also a token of the respect which people have a right to expect and another expression of the increasing assertiveness of service users.

### *Feeding back to people*

We undertook to send service users' and carers' groups a copy of the final report of the project when it was produced. We are sending them a copy of this book. We also explained about the second stage planned for the project, which we discuss in the next chapter, when anyone who wished to could come to a meeting where they would meet other service users, carers and practitioners involved in the project. We saw this as an important part of the feedback process. There they would have a chance to learn more about what other people had said and to take forward the discussion together. This project confirmed other experience that participants in such projects greatly value being kept in touch. If you contribute to something, you want to know what has happened and particularly how much notice has been taken of your views and ideas. Letting people you have involved know what is happening is important. It does not matter if there is not much to report, or the news is not good. People want to know what is happening. Otherwise they are unlikely to get involved again.

## **3 Involving black people and members of minority ethnic communities**

Large numbers of people from minority ethnic communities, particularly people from Asian communities, live in the area where the project was located. There is much evidence to suggest that black people and members of other minority ethnic groups are under-represented as users of community care support services. Concern has frequently been raised about the degree to which such services match the needs of minority ethnic communities (Baxter and others, 1990; McCalman, 1990; Gunaratnam, 1992). Ensuring the involvement of black people and members of other minority ethnic groups was identified as a key concern in the first national survey of

user involvement in social services (Croft and Beresford, 1990). Unless specific efforts are made to involve them, all the signs are that they will be inadequately represented in schemes to consult and involve people.

We expected that this would be the case in this project. In the event, while some members of minority ethnic communities took part in the discussions, they did not reflect the numbers of such groups living locally. Members of the discussion groups were predominantly white. For this reason, we made specific additional efforts to involve members of minority communities, particularly members of local Asian communities.

One member of the project team made contact with a local radio station for members of local Asian communities, to pursue the idea of a phone-in to provide wide access for members of Asian communities. It was not possible to pursue this idea because there was no clear response from the station.

We also made contact with a local Asian women's project. One of the groups which met there was a group of older Asian women. With the support of the project and the agreement of the women, a discussion for this project was held at one of their regular meetings. They requested that the facilitator should be a woman and that the discussion should be in Punjabi. Here the help and skills of the translation and interpretation unit of the local authority were invaluable. A woman worker from the unit acted as interpreter at the discussion and the unit then transcribed the discussion into English.

The interpreter spent an hour before the discussion with the English speaking worker from this project, running through the schedule and discussing how to undertake the session. The Punjabi speaker would have liked more preparation time. We had modified the schedule for use in this discussion. Although we had sought to be sensitive to the culture of participants, some of the issues did not make sense to them. It was clear that concepts like 'service user' and 'carer' were not ones with which the women were familiar. It also appeared that members of the group might fall into both categories, while not necessarily seeing themselves as in either.

The inclusion of the group of older Asian women ensured that views from some members of local Asian communities were included in the project, although clearly we should like to have extended this involvement of local minority ethnic communities. It also highlighted the importance of not imposing assumptions about community care and the provision of support upon such groups.

We also made provision to ensure that members of the older Asian women's group could take part in the get-together meeting. The interpreter was again available. She had been briefed so that she would translate the flip charts for Punjabi speakers and interpret during the meeting.

The issues which were raised in this project about the involvement of black people and members of other minority ethnic communities raise in

microcosm the broader issues relating to their involvement and partnership in community care. Major issues emerge about the need for additional funding and support both for specific black and other minority ethnic groups to be able to get together and for service users' and carers' groups in general to be able to reach out effectively to involve minority ethnic communities fully.

## Summary

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This chapter has explored some of the broader concerns about community care expressed by service users and carers in the development project. Many issues for collaborative practice emerge from this discussion, both from what service users and carers said and also from the process and practicalities of involving them. The two are closely interrelated. An inadequate process of participation will qualify what people can say as well as placing restrictions on who is in a position to say something. Once people are admitted to the discussion, their different perspective mean that the terms of the debate are likely to be changed.

Service users' and carers' comments place further emphasis on the interactive nature of collaboration. Collaboration requires understanding, change and new skills from *all* participants. All need support and training to make this possible. It is about much more than changing services and practice. It is also about changing our relationship with them.



# 7 Putting it all together: the get-together meeting

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## From participation to collaboration

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So what can we learn from the project so far? Service users, carers and practitioners were all interested in a collaborative way of working. They were all willing and able to take part in discussing and developing skills for community care. They all had a contribution to make in defining them. But so far these had been separate discussions. While there were important overlaps in what each group said, they had all taken place in isolation.

There had not actually been any collaboration so far, except between us and them. It is one thing to have separate conversations, quite another for there to be a dialogue. Some large questions still hung in the air. Were people's different perspectives reconcilable? Would service users, carers and practitioners be able to talk to each other? Would any agreement be possible? The get-together meeting we planned could provide some answers. It would offer an opportunity for collaboration, a chance to see how well it worked and, hopefully, coming out of the collaboration of service users, carers and practitioners, there would be information on the skills required for community care.

We did have some experience to build on. Two recent projects, in which one of us had been involved, explored related areas. These were:

- *The User Centred Services Project*, which through a series of workshops explored how service users and service providers could 'build bridges' to work together, identifying a range of skills and approaches that could be helpful (User Centred Services Group, 1993).
- *The Towards Managing User-Led Services Project*, which explored a range of issues and skills associated with the involvement of service users

alongside service providers in managing user-led services (Begum and Gillespie-Sells, 1994).

While these did not have the same focus on skills for community care as our project, both were concerned with:

- Drawing on the experience and ideas of service users.
- Developing collaboration between service users and providers.
- Increasing the involvement of service users in community care services.

They offered a helpful basis for the meeting. We started with two aims:

- To feed back, discuss and share ideas and experience within and between the groups of service users, carers and practitioners.
- To try to take discussion about skills for community care forward by enabling the different perspectives of service users, carers and practitioners to come together to explore and define them.

In the event we added an additional aim for the day. During the course of the project, there were signs that there was some local interest in the project beyond the people and groups who were directly involved. Some people in the local social services asked to be kept in touch with what was happening. Others told us about other activities which were taking place locally to involve and consult service users and carers. These were important reminders of the local context of the project and of the fact that not only might its findings be useful locally, but that in the local setting they could also be set alongside other developments and initiatives.

Because of this, we thought it would be helpful if we could find some way of feeding back information emerging from the project directly to local agencies concerned with community care. We decided that this was something we could do at the meeting. We invited four people with key interests in local community care to come to the last part of the meeting so they could listen to the discussion and feed it into their organizations. They offered their views, asked questions and had a chance to meet participants. The representatives were:

- The coordinator of the local association of voluntary community care organizations.
- The older people's adviser at the equal opportunities unit of the local authority.
- A service manager in the social services department responsible for providing services for older people in one part of the borough.

- The manager of the local community mental health team.

In the event all but the last of these was able to take part.

The project wasn't part of the policy formation process of the community care agencies involved. We always made this clear to participants, saying that there were no guarantees that community care agencies would take any notice of what they said. Now at least, though, these agencies would know about it.

## The get-together meeting

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About forty people came to the meeting. There were participants from all the discussion groups, except the older Asian women's group and the users of the day centre for people with mental distress. An interpreter was available on the day for members of the Asian women's group. They had particular problems coming because they had a meeting earlier in the day. It was agreed, however, that the proceedings of the day would be translated and reported back to them to keep them in touch and we did this. Three members of the practitioners' group were able to come. A fourth practitioner, a social worker who was interested in the project but unable to complete the diaries, also contributed to part of the discussions.

It was a lively and positive meeting. Many people spoke. It was not dominated by professionals. People seemed to enjoy it. It was informative. There were differences of opinion within as well as between service users, carers and practitioners, but the atmosphere was friendly and reflected the commitment, thoughtfulness and hard work of participants. One of the managers who came to listen to what people said commented afterwards:

'These kind of meetings are often confrontational. I've been to meetings where there are 200 people and discussion gets down to a couple of people's personal experience which nobody else is interested in. It wasn't like that today.'

We also had some contributions from people who couldn't come to the meeting. One member of the group who used the day centre for people with mental distress wrote, although she said she wouldn't be coming. She said:

'... As a follow-up to the discussion I would remark that one doesn't want sympathy but **IMPORTANTLY** understanding ... Instead of pumping us with tablets (creating more problems) the medical profession would do well to take **TIME TO LISTEN ...**'

Another woman from one of the carers' groups gave her apologies for not coming and said that she would very much like to come, but felt she was a prisoner looking after her husband. She asked if her views could be given at the meeting, which they were:

'There is no care in the community – there aren't enough resources. We don't know who to turn to for what. I battered my head against a wall for six months. Quite by accident I got on to the social worker and things became a lot easier then.'

A word about our use of language might be helpful at this point. Throughout the meeting we used the term 'skill' rather than 'competency', because we wanted to avoid terminology which might exclude some people. However, the term skill should be understood in its broadest sense as a synonym for competency, including 'knowledge' and 'values' as well as 'skill' in the narrower sense of 'ability to do things'. It was in this broader sense that service users, carers and practitioners had tended to use the word throughout the discussions we had.

## **The structure of the meeting**

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The meeting was structured in three parts. This was designed to enable participants to move comfortably from the individual discussions they had already been involved in to working together as an overall group. The three parts were:

- 1 Separate meetings for service users, carers and practitioners. In the meetings of service users and carers, we reported back briefly what people had said in the individual group discussions as a basis for further discussion to be shared with other groups. We asked participants to identify three or four key points they would want to raise for discussion in the large group. This was an opportunity for practitioners, carers and service users to learn what other people in their own situation had said, to share thoughts and views with them, and to begin to take their discussion forward.

It is important for people to have time on their own prior to meeting with other groups. Different groups of people need time apart as well as time together. This allows for their differences, as well as enabling people to discover similarities and overlaps. This is especially important for service users and carers whose relationships with professionals and services are often difficult and unequal. The differences between carers and service users can also be as important as those between service

users and practitioners. That is why we started the meeting with separate discussions. It provided a basis for people to go on to meet with other groups better informed, more familiar with each other and likely to feel more confident.

- 2 The three groups – service users, carers and professionals – came together, with key points from their separate discussions recorded on flip charts. Each group briefly reported on its earlier discussions as a basis for a general discussion.
- 3 The final session focused on identifying skills for community care, building on the discussions which there had already been. This was when we would see if we could find common ground. The outside representatives were present at this part of the meeting to hear what people said and to be available to offer any information they might need.

We will now go on to look at what came out of these linked discussions, beginning with the first: the individual discussions of service users, carers and practitioners.

## What people said at the meeting

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### Part one: The individual discussions

We put flip charts up on the walls which summarized the original discussions that had been held with the service users' and carers' groups and the older Asian women's group, for everyone to be able to see. These were read out, like all other written material produced on the day, so it was accessible to everyone. The written feedback for the community care professionals took the form of handouts. The feedback was all discussed and agreed by the groups concerned. This feedback, from service users, carers and the group of older Asian women, can be seen in full in Chapter Five, where we use it to provide a list of the key points these groups raised in their discussions.

#### *The carers' discussion*

The carers' discussion again reflected the way in which they placed skills in a broader context. The issues they discussed included:

- Lack of resources, particularly the inability of social services to respond to the needs of carers.
- The unreliability of many professionals as a source of accurate information for carers.

- The fact that carers were often left to cope on their own with minimal help. This could be very frightening. It would be helpful if social services made contact every so often, to check that the carer was all right.
- The failure of professionals to communicate effectively with each another. For example, an older woman was discharged from hospital and left at home, unable to go out, because community services were not provided and friends were expected to look after her, although a case conference at the hospital had decided that services were needed.
- The lack of continuity in care between hospital and community services leading to a failure to respond to the totality of need: 'The hospitals see patients as just patients. They forget about the carers and the home. They don't see the person.'
- Long waits for patients in hospital when they are admitted.

These were the key points carers raised for general discussion:

- Workers need to know which services are no longer available as well as those that exist, if they are to provide accurate information.
- Professionals need to communicate properly with one another.
- Voluntary groups (including carers' groups) need to know how to make an alliance with the council, not necessarily a partnership, to maintain independence.
- Workers should have the skill not to assume that, because someone is a friend or a partner, s/he wants to or is able to be a carer.
- Carers need someone (from social services) who is a good listener, who has the power to act, who is an advocate, who will help them become more independent and build up their confidence.
- Carers value contact from a person in social services.
- Workers need to know what is what – all the skills that come with good communication: listening, responding, acting on information, understanding (some people cannot fill in forms, for instance).
- Carers need training to care: training in practical skills. It would help build confidence so they know what they are doing is right and do not have to learn from mistakes.
- Carers need someone they can trust – or they will not have them in their homes.
- Carers can be reluctant. The council can see caring as a cheap option.

Carers again stressed the need for skills on both sides – for both carers and practitioners. Carers also need choices, and practitioners have an important part to play both in acknowledging and enabling this. This choice ranges from choice of practitioner to being able to choose whether or not

they want to be a carer. The complicated organizational structure of community care places a premium on communication skills for practitioners. Carers see an important role for suitably skilled social services practitioners.

### *The service users' discussion*

The service users' discussion highlighted the considerable pressure they felt under both as individuals and as members of self-advocacy organizations. The issues they discussed included the following:

- Rising charges for services mean that people are having to go without them.
- The work done by home care workers has changed without discussion with service users. Instead of doing housework, which people want, they are administering medication, which they do not want them to do.
- The changes in community care have resulted in a decline in skills.
- Home care workers have been required to take on auxiliary nursing responsibilities without adequate training.
- Statutory services need to cooperate more with users' groups.
- Service users' organizations are overstretched and need more financial support.

These were the key points service users raised for general discussion:

- Many people do not go to meetings because they feel nothing comes of them – the meetings are just there to appease them.
- People do also feel they can make a difference.
- Money / resources are of central importance. If government does not provide the money, there is nothing you can do.
- But it isn't just money that's important – it is also the willingness of professionals to act on information from users' groups. Professionals are required by law to consult service users, but service users are reliant on their goodwill for action.
- There is a feeling that the purpose of the new arrangements for community care – to give priority to users' needs – has got lost along the way.
- Service users feel that the voluntary sector is the salt of the earth.

Service users felt that the community care changes had had massive effects, with major repercussions for practitioners' skills. The changes had created additional demands on practitioners and services at the same time as these

were undergoing cuts. There were also changes in services and the roles and skills required of workers were changing, but without taking account of what service users say they want, either individually or in service users' groups.

Service users and carers gave equal priority to a number of issues in their separate discussions. Both emphasized the importance of cooperation and collaboration. Both identified inadequate resources as a block on appropriate services and good practice. They also restated the importance of values and basic human qualities in their definition of skills for community care. Some basic skills, which would be expected of qualified workers – for example, reliability and the provision of accurate information – could not always be taken for granted. Both offer an important reminder of the increasing involvement and centrality of service users' and carers' groups to the development of community care.

### *The practitioners' discussion*

Let's begin with a reminder of what practitioners said. The following summary was the feedback which informed their discussion at the get-together meeting. One point which emerged when comparing diary entries with comments made in the groups was that they did not always convey the same picture. Where they were different, it was always the group or individual interviews which conveyed the picture of more positive and skilful collaborative practice. These are the issues they raised:

- Developing assessment as a collaborative activity, involving service users, carers and other professionals with different perspectives, can offer practitioners a positive alternative to defining needs themselves and then making their own response. This idea of collaboration extends to the whole decision-making process. While there may be a blurring of role boundaries, there will also be greater clarity about roles. This can be resolved by the idea of coordination: a greater collective ownership of the assessment process leads to a more informed awareness of differences within the collaborative network.
- Opening up the assessment and planning process to service users, carers and other professionals can be an extension of, rather than a challenge to, professional identity. This idea may be less developed among practitioners who feel less empowered in relation to other agencies and professionals. To share power we need to feel empowered ourselves. Flexibility and an ability to communicate with a wide range of people are essential aspects of power sharing.
- The ability to negotiate is very important in situations of conflict. It is particularly important where there are not shared values in a collabo-



rative network, resulting in difficulty in engaging people effectively and conflicts between key network members.

- Honesty is a key personal quality in resolving and exploring conflict. It is important to be straightforward and direct. Skills in facing up to conflict and being able to communicate clearly things which are difficult or painful to say are essential. Racism is an area of conflict which needs to be faced up to by everyone involved in a collaborative activity.
- Networking conferences, where people can come together to share their ideas and proposals, are an effective way of resolving conflicting perspectives on assessment and of arriving at solutions. They also empower service users by enabling them to challenge practitioners on a face-to-face basis. It is important to ensure that people who tend to avoid face-to-face interaction are encouraged to attend, as a specific way of addressing conflict within the collaborative network.
- The organization context of professional practice can both inhibit a collaborative way of working, because it is perceived as too empowering and threatening to existing hierarchies, or facilitate it, by setting limits and guidelines for action.
- Collaboration is underpinned by trust; personal relationships which grow and develop over time; and personal knowledge of a range of different services and the roles of those involved. Liaison work could help to develop the quality of relationships between practitioners and this would contribute to people's ability to mobilize and coordinate collaborative networks.
- Collaboration is especially appropriate where needs are complex and can only be met by a range of people working together. Collaboration is also linked with choice and empowerment, because it offers a way of exploring possibilities and options for change with service users. It is also linked with the need to evolve shared understandings in complex situations and, through shared understandings, develop common goals. Collaboration may need to be seen as a value, not just a method of work.
- Practitioners are better able to offer support if they are supported themselves. This support comes with shared objectives and a team approach, which involves being able to listen to and praise others. Confidentiality offers a way of making it safe to undertake more intensively supportive work with each other.
- Getting services for carers, as well as service users, is a key part of the role of practitioners. Sharing information and making skills available to carers are both ways of being supportive. To be supportive it is also necessary to be responsive.
- User involvement, good communication, shared understandings and

being able to get to the right people at the right time, are key issues for practitioners working collaboratively.

- The practice of collaboration is uneven and patchy. This is linked to what priority it receives. Developing collaborative networks takes time, and in a situation of scarce resources this leads to a debate about priorities which involves values as well as resources.
- The key training need is for multi-disciplinary training. Training methods like informal discussion are preferred to more formal methods such as lectures.
- Definitions of collaborative working include:
  - Working together with others for a common goal with each person contributing something different.
  - Creating a web with a common thread so that all the parts are linked together as a whole, dependent on one another.
  - Communication, discussion and coordination with various service providers, including service users and carers, and the mobilization of resources to address assessed needs in terms of a common goal.

A number of new points emerged and others were clarified for the first time in the practitioners' discussion at the get-together day. These included:

- Needs and service and non-service system resources vary from one locality to another. In any area, the attitudes and behaviour of key individuals, like hospital consultants, can either increase or decrease the ease with which collaborative working can be practised. The more resistance there is, the more skills are required.
- Skills in addressing anxieties and enabling others to face up to necessary risks when intervention is not appropriate are very important.
- Organizational definitions of practitioners' roles and tasks impact substantially on people's ability to act as 'key workers'.
- Handling the complexities of responsibility and accountability requires skill.
- While outcomes are often negative, practitioners can still be positive about their skills.
- The ability to work with your own feelings is a very important skill.

Building on this, practitioners raised four central areas of skills as their key points for discussion. These were:

- 1 Communication skills: particularly listening skills. What is a person feeling underneath? Listening to people, responding and acting.

- 2 Teamwork: being able to work well together with other professionals, service users and carers. Being clear about roles and tasks and who is responsible for what.
- 3 Conflict management: being able to work with actual and potential conflict. Addressing conflict rather than avoiding it.
- 4 Handling feelings: the ability to understand and manage your own feelings and to be able to think about them in a professional way.

## Part two: Coming together as a group

People came together again at this stage to begin the process of discussing community care skills with one another. No attempt was made initially to focus discussion exclusively on skills issues. Instead each group was encouraged to address the issues which they wanted to. Each group, in turn, fed back the summaries of past discussions and the key issues which had been picked up so far at the meeting, so that everyone had a picture of where everyone else was.

What followed was a lively and free-ranging discussion. People expressed their feelings, and there were some strong feelings, but this took place in a friendly atmosphere of tolerance and mutual respect. It probably helped to clear the air and enabled people to work well together later on in the meeting. Service users, carers and practitioners all took an active part. These are the main issues they raised:

- It is difficult for both carers and service users to get as many people involved as they want to. They need more people to come forward. Community care agencies could help by paying service users' and carers' representatives when they take part in joint discussions, and offer alternative support to service users so that carers can be involved:

'If carers have to spend out of their own pocket, they can't go' (Carer).

- Service users and carers both said that they need time to themselves. They cannot always be expected to use their spare time for meetings and getting involved. Practitioners and agencies need to be sensitive to this:

'I'm just too damned tired. I just sit down in the afternoon when I don't go shopping and I'm too tired. We all need our own space. I don't think a lot of people take that into account' (Service user).

- A social worker raised the point that workers frequently have to be the bearer of bad news about what *isn't* available when what people

want is services which *are* available. Social workers have no power over cuts. It takes them a long time to understand the day-to-day details of carers' responsibilities:

'We need to understand the frustrations of your day' (Social worker).

- Service users and carers were particularly concerned about the problem of scarce resources and this issue came to dominate the latter part of the discussion. A particular fear was that practitioners would more and more have to 'skimp' to get things done rather than be able to give them proper care and attention. One social worker spoke of demand increasing and 'a battle between quality and quantity'.

The issue of resources was a theme that ran through the whole of this project. It was raised by all three groups of participants. But it never became an excuse for not trying to think things through or make progress on skills. A number of points were made about resources:

- Resources in health and social services were inadequate.
- As well as needing more resources, people needed to work in different ways.
- The inadequacy of resources was undermining improvements in practice and provision which had developed in recent years.
- The cause of the scarcity of resources originated at central rather than local government level.
- Service users' and carers' organizations were inadequately resourced.
- Many service users and carers had to rely on an inadequate income.

### **Part three: Finding common ground about skills**

In the final part of the meeting, when we picked up some of the themes and issues which people had raised so far, we aimed to provide the chance for people to say what skills they thought were needed for community care and for collaboration. At this stage we didn't know whether there was common ground about skills among service users, carers and practitioners. We thought there was, but each group had a different perspective and different experience. We raised the themes as three questions for the group to explore. We began with the issue of resources. We asked:

*What are the skills needed to work effectively in a situation where resources are scarce?*

People said:

- Advocacy: speaking up on behalf of service users and carers.
- The ability to prioritize appropriately and decisively.
- Making time by managing time effectively. Holding on to fundamental issues about your role and purpose and avoiding over-bureaucratizing your work. Put contact with service users and carers first, paperwork second.
- Negotiation skills.
- The ability to make alliances with others in the struggle for resources. This is part of what it means to collaborate effectively.
- Imagination, in making the most of scarce resources and seeking alternatives.
- The ability to develop trust and invest in relationships.

The second theme which we explored was that of *communication*. The importance of good communication had been a consistent feature of the earlier discussions of all three groups – service users, carers and practitioners – and had figured in the feedback and earlier discussion at the meeting. We asked:

*What is good communication and what are the key communication skills?*

People said:

- Skills in listening, responding and acting – not one or two of them, but all three.
- Being able to communicate information reliably and accurately, particularly in relation to the availability and nature of resources.
- Skills in checking understanding, to ensure that communication has been effective and that what you have said has been understood.
- Avoiding ambiguity, lack of clarity or jargon in communication, so that there can be agreement among us about what is meant. Ensuring such shared meaning is important in all communication, both formal and informal, individual and collective, verbal and written, including letters, leaflets and so on.

The third theme people discussed was that of collaboration itself, and, in particular, the skills that are needed for collaboration between practitioners, service users and carers. We asked:

*What makes for collaboration and what are the key skills that are needed?*

People said:

- Handling yourself and other people in such a way as to demonstrate respect:

'If they come into the house with a jumped-up attitude, my back's up. If they talk to me like a person, I'm all right. I've been down that road and I don't like it. It's about respect' (Service user).

- The ability to ensure that collaboration is based on agreed purposes, aims and goals.
- The ability to understand conflict and to maintain respect even when there are honest differences of opinion:

'Professionals must understand conflict between users and carers. Carers feel if they are assertive, they are labelled' (Carer).

- Awareness of the potential for exploitation of carers and service users and the skill to avoid this.

## **The gains of getting together**

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If the discussions which made up the first part of this project suggested that involving service users and carers in defining skills for community care could change the nature of the debate, the get-together meeting confirmed this very clearly. Not only did all participants, service users, carers and practitioners, emphasize and endorse a new pattern of skills, they also pointed to a different understanding of the relationship between skills and resources.

Usually in discussions about community care skills, the availability of resources is either not mentioned or identified as a problem that gets in the way of practising skills as they should be practised. Here the real-life experience of service users and carers kept questions of resources at the top of the agenda. Their involvement made it necessary to relate skills to resources. This made the discussion real. It suggested ways of reconciling the crucial problem in community care of conflicts between needs and resources. So collaboration changed the terms of the debate as well as informing it.

This did not mean that the discussion was concerned with constructing skills 'down to a price' – the last thing that service users or carers would want to see – but rather pursuing skills that were consistent with an environment of short resources. This meant both skills that could be practised with scant resources and skills which would help deal with and challenge short resources.

The meeting showed that service users, carers and practitioners could talk to each other on equal terms, given a supportive, neutral setting. Collaboration is possible. We are not suggesting that there was not and would not be disagreement and conflict. Conflict is part of collaboration; it certainly doesn't rule it out. Collaboration can provide an opportunity to resolve conflict.

There was a surprising amount of consensus among service users, carers and practitioners about the skills needed for community care. They could work together, develop discussion and make progress. They were able to collaborate to come up with concrete proposals for community care skills and collaboration. They could collaborate to produce a set of skills which would be useful in current conditions, agree on them and share ownership of them.

## The process of the meeting

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The process of making it possible for this to happen, however, should not be taken for granted. How well people are able to collaborate is likely to depend on how well the process of collaboration is facilitated as well as on their own experience, skills and values. This was one of the points raised by participants, as well as a belief underpinning our approach to collaboration. We tried to reflect this in the way we organized the get-together meeting.

We wanted this meeting to be a chance for participants in the project to meet each other and to have their say. We were anxious that it should be a positive and enjoyable, informal and informative occasion. Many of the people who took part in the project had little spare time and many pressures and restrictions on them. We wanted the meeting to be a break from that, not to add to it. We therefore placed an emphasis on the *quality* of the meeting. People were welcomed when they arrived and offered a drink, and then after the first two sessions there was a half-hour break with a range of hot and cold drinks, cake and biscuits, and culturally appropriate refreshments. It was a chance to relax and to socialize. We restricted it to a half-day meeting so it would not be too long or tiring for people; they would be more likely to have time for it and be able to fit it in with other arrangements.

People spent some time in the larger group, but after initial introductions they broke up into small groups, which experience shows most people find easier to speak in. This helped break the ice and reflected the emphasis of the meeting on informal discussion. By the time the last session arrived and people were asked what skills they thought were important for working in

more collaborative ways at a time of short resources, many people seemed to feel able to contribute.

We took the view that, as initiators of the meeting, we had to take responsibility for it and ensure it was as positive an experience as possible. But that is not the same as taking control of it. It is helpful to have a suggested structure and programme for the meeting, available for discussion and change. But be flexible. Do not try to predetermine what happens. In this case, a tight ship is likely to be an abandoned ship!

Running such a meeting required a range of overlapping skills. These included:

- Social skills, making it possible for a diverse group of people to feel at ease in what may be unfamiliar surroundings, with people that they may feel anxious or uncertain about.
- Group work skills, supporting people to work together and exchange and develop their views.
- Communication skills, to initiate and encourage discussion in large and small groups and to be sure that participants felt comfortable and able to participate.
- Summarizing skills, to draw together accurately what people said.
- Catering skills, to produce refreshment when it was needed.

To ensure equality at the meeting, we offered a set of ground rules at the beginning for people to discuss, amend and agree. These included:

- Using simple, accessible language without jargon or initials.
- Giving everyone a chance to speak and not interrupting people.
- The right to have a break from the meeting if and whenever people wanted to.
- Not smoking.
- Keeping what people said confidential and not raising or repeating it outside the meeting.

We were made very aware of the importance of language for effective collaboration throughout this project. Using unfamiliar language is excluding. Do not wait for people to challenge you for not being clear, even though people in service users' and carers' groups have increasingly gained the confidence to do this. Instead make a conscious effort to use clearer, simpler language. You'll still get it wrong sometimes, but service users and carers tend to be forgiving if they know practitioners and their agencies are trying to communicate on equal terms.

Language is part of wider issues of access. If information needs to be sent out in advance, it should be produced in accessible formats. Physically



access should include a loop if needed for people with hearing impairments and the availability of interpretation for deaf people and members of minority ethnic groups. If flip charts are used, then it is important that the

## **Exercise**

**How can practitioners ensure that service users are involved on equal terms?**

The get-together meeting raised a lot of issues for us about trying to involve people on equal terms. This is a crucial issue for any collaborative activity that involves service users and carers. User involvement is often seen as a way of helping to ensure equal opportunities by including service users and carers. But all the evidence suggests that the involvement it elicits is likely to be limited and biased, unless participatory initiatives are organized to stop this happening. Service users can expect to be in a minority in unfamiliar circumstances. This is a recipe for inequality. It is likely to be only the most confident and experienced people who come forward and even then they will probably feel at a disadvantage. Try to think of some simple ways in which practitioners and agencies can ensure that service users and carers are involved on more equal terms.

## **Feedback**

The most common problem service users and carers report when they get involved is having their credibility questioned. Are they representative? Who do they speak for? What mandate have they got? Yet the same questions are never asked of the managers and professionals involved alongside them. The crucial starting point in working with service users and carers is for practitioners to have a friendly and positive approach and treat them with respect. There are also many other specific steps they can take to ensure they are involved on more equal terms. These include:

- The adoption of agreed ground rules for meetings to ensure equality for service users and carers.
- Outreach work to involve black people and members of minority ethnic groups.
- Always involving more than one service user or carer so that they are not isolated or tokenized.
- Providing accessible and appropriate information.
- Giving the same weight to what service users and carers say as to the views of professionals.
- Payment for the involvement of service users and carers so that they are not the only people at a meeting who are not being paid to be there.

material on them is accessible to non-readers or visually impaired participants by reading them through. The meeting seemed to work well. Participants put effort into trying to offer ideas and participate in the discussion. They talked to each other and seemed to be enjoying themselves.

Some of the reasons the get-together meeting seemed to work included the following:

- People had some investment in coming. They had already been involved in the discussion in their own groups, so the meeting meant something to them.
- Invitations to come were made throughout the course of the project – at the first group discussions, then by letter and through newsletters and by phone – so invitations were followed up.
- When people got to the meeting, they would see a face that they knew. Service users and carers had already met the people who had undertaken the discussions with them. People were welcomed and introduced to each other.
- Background information on what had happened before was readily available to put things into context.
- The brief of the meeting was quite specific – the skills needed for community care. It is easier to focus on something concrete like this, and it didn't prevent people exploring other, related issues which were of concern to them.
- The people facilitating the meeting were all experienced facilitators. They were able to be flexible, were generally able to keep calm and knew how to deal with conflict, which is essential.
- Service users, carers and practitioners were all genuinely interested in improving services and wanted to be part of positive discussions about change. They all wanted to help.
- There was money for transport and other expenses.

This is the kind of meeting which it may be very difficult to organize if your preference is for certainty! Not until the meeting itself did we know exactly who and how many people would come. Would people come at all? In the event a good number did. This was probably helped by us having made clear offers to people for support for travelling expenses, child care, respite care, and payment for lost earnings, and ensuring that we used a centrally located venue which was accessible for people who used wheelchairs. We also made sure that money was available for expenses on the day so that people would not be out of pocket for any length of time.

Meetings like this may seem unremarkable – unless they go terribly wrong. But they work well in helping people think things through, make contact with each other, gain a better understanding of their different per-

spectives and carry out practical collaborative tasks. But as we have already said more than once, they take a lot of time planning and preparing. It is hard work, but it can be even more rewarding. The meeting provided another example to show that service users, carers and practitioners could collaborate effectively and that there was important common ground among them about skills for community care. This provides a firm foundation to develop a practical model of collaborative practice.

## Summary

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This chapter has focused on the get-together meeting which brought together service users, carers and practitioners to exchange ideas and experience on the topic of skills for community care. It reports the issues which the different groups raised and describes how they were able to find common ground about the skills needed. We see how the different groups were able to work together effectively and identify skills for community care collaboratively. Guidelines are also offered for organizing such collaborative activities, drawing on the experience informing the meeting.

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# 8 What we learned about collaboration

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## The collaborative process

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As the project progressed, we became increasingly aware that the process of our work with service users and carers was drawing attention to issues which all agencies looking to develop collaboration will need to consider if community care is to succeed in being an empowering, responsive and needs-led enterprise rather than simply one which is oppressive, reactive and solely budget-led.

In particular, the development project showed that attempts at involvement are likely to succeed if they engage people's concerns, and if they are clearly focused so that both the purpose of the process and its limits are clearly visible from the start. Moreover, our work with practitioners also showed the advantages of a focused approach to skills analysis and development which starts with 'where practitioners are at', rather than where policy makers and senior management would like them to be.

Looking back, it now seems as if one thing which the project showed was that service users, carers and practitioners can come together by focusing on shared objectives, even if their starting points are very different, provided that the pace of the work is not forced and people feel able to develop their own ideas in their own ways. This is an important point which anyone starting a collaborative piece of work ought to bear in mind.

The project was also collaborative in another sense. It could be seen as a collaborative form of communication which enabled people first to identify and then to discuss key issues with one another. We learnt that people benefited from being facilitated to develop their ideas; that they needed opportunities to engage with one another and form relationships; and that they needed time to explore and then to consolidate new information. We

acknowledge that none of these things may be very new or surprising, but they are nonetheless vital to the success of any collaborative endeavour.

## **Collaboration – the culture**

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Because of the way in which it drew all the different threads of the project together, the get-together meeting provided us with an insight into some of the defining characteristics of what we have described as collaboration culture.

In many ways the culture concept emerging from the workshop was one which had echoes of ideas which emerged earlier on in the project. In particular, it evoked the image of the 'web of cooperation and communication' described by some of the nurses and social workers at an earlier stage. But it was more focused and systematic.

Collaboration is a way of working with other people which is characterized by the following basic assumptions:

- Effective communication is never to be taken for granted. It requires a constant investment of time, energy and thought. This includes spending time listening to and talking to other people, rather than simply making assumptions about them, and it also involves a willingness to think critically about underlying patterns and styles of communication.
- Relationships are valued. This means treating people with respect, being prepared to work at developing trust and recognizing that supporting other people or gaining support for yourself is an integral part of professional work in the field of community care. This is linked to another assumption which is that a strong set of collaborative relationships can deal with conflict in an open and constructive way and may even be further strengthened by the experience.
- Empowerment is an integral part of community care practice. In collaboration culture, all actions are constantly scrutinized for their impact on the position of service users in relation to other members of collaborative networks, and in relation to the power over their lives all too often still wielded by welfare bureaucracies of all kinds in both the state and the independent sector.
- Processes of assessment and planning are shared, open and flexible. This involves a commitment to creativity and a willingness to involve people widely, both in relation to the identification of needs and the accessing of appropriate resources.

- Actively working together with others involves a commitment to shared objectives. This also implies acknowledging responsibilities to others as well as having expectations of them.
- The search for quality is a never-ending one. There will be processes by which both outcomes and ways of working are constantly reviewed, and processes of review will be open to service users, carers and others with whom practitioners are working.

## Constructing the web

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Rather than divide collaboration culture rather arbitrarily into knowledge, values and skills, we have taken the view that it is better to approach it as an integrated whole but to recognize that there are specific skills which may be required to build it. The concept of collaboration as a 'web of communication and cooperation' also suggests a new way of thinking about skills – one linked to the process of constructing the web.

The development project convinced us that, like any other body of skills, collaborative work can be practised at a variety of levels from the most basic to the most complex. This in turn has led us to focus first on some of the basic skills of collaboration.

What follows can be read in two ways. It can be seen as outlining what amounts to a set of guidelines for newly qualified workers. Or alternatively, it can be used as a checklist for more experienced workers who want to ensure that attention has been paid to the basics in any collaborative work they are currently undertaking.

We make this distinction between the full range of collaborative skills and what we describe as collaborative basics partly because this was the distinction made by those who participated in the workshop. It came over particularly strongly from our discussions with service users, for example. But we also make it because it seems to fit in with how we actually learn: not all at once, but gradually and continuously.

## Learning about learning

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In thinking about the process of skill development, we inevitably have to think about learning itself. If human evolution teaches us anything, it is that our success as a species is in large part due to our ability to learn from our experience and to apply this learning in ways which generate new and different kinds of experiences for ourselves and others. This interaction between experience, thought and practice lies at the heart of our humanity

and yet it has taken our formal educational systems a long time to recognize the essentially interactional nature of the learning process, a process in which thought, action and reflection are intertwined in a continuous spiral.

The implications seem to be that:

- Learning about collaboration is likely to be a continuous process and one that nourishes itself, for over a period of time ideas are developed and their consequences experienced, in turn laying the foundation for further learning.
- This process of reflecting on experience, giving it meaning and applying the resulting insights to collaborative practice, requires a shift from a rational scientific model based on seeking to control learning processes to something much more experiential.
- Learning from collaborative experiences is, in large part, dependent on a process of attending to and learning from those you collaborate with: a process which is likely to be educational for them as well.

Putting all these points together, it is not too far-fetched to describe learning about collaboration as rather like the process of learning a new language and, as with any new language, we need to start with the basics.

## **Collaborative credibility**

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All those who have qualified as professionals nevertheless still need to demonstrate what the Central Council for Education and Training in Social Work refer to as 'professional credibility' (Central Council for Education and Training in Social Work, 1990, s.3.5.i). We found in the development project that basic qualities, such as honesty, reliability and an up-to-date knowledge of resources, are valued very highly by the users of services. But we also found that simply possessing a professional qualification was no guarantee of this kind of professional credibility. Moreover, a similar emphasis on honesty, reliability and knowing what one is talking about came over very strongly from the practitioners in the project.

These elements of collaborative credibility are not enough in themselves to make collaboration work, but the evidence from the development project was that without them the process of developing a collaborative relationship will not even get to square one. It should also be emphasized that practitioners need to demonstrate not only that they can be trusted, but that they have the ability to communicate qualities of honesty, reliability and knowledgeability to service users, carers and other practitioners alike. This is a skilled activity which cannot be learnt or demonstrated overnight. It



will inevitably take time, and with any new relationship it will have to be demonstrated all over again.

## **Anti-oppressive values**

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The project showed clearly the importance attached to certain key values by all those who participated in it. Broadly speaking these values could be summed up as a commitment to anti-discriminatory practice on the one hand and empowerment on the other. Professionals, service users and carers all agreed that they expected the nurses, social workers and others with whom they had dealings to be committed to the fight against injustice. There was a feeling among all those who participated in the project that even newly qualified professionals should be able to show that they are aware of injustice and willing to do what they can to oppose it. Although some skills might be missing, all agreed that the key values should be in place.

As with credibility, a commitment to anti-discriminatory practice is something that all those involved in collaborative work need to be able to communicate effectively to others. In other words, one of the preconditions of collaboration is that it is not enough to be committed to anti-racism, anti-sexism, or any other 'ism'. This commitment needs to be demonstrated to others in an active way. Even experienced workers need to remember that there is a continuing need for this in the way that they conduct their relationships and respond to issues. These are the kind of commitments that can never and should never be taken for granted.

A basic understanding of the importance of empowerment and a willingness to act on this understanding are vital components of collaboration which must, if it is to have any meaning, involve sharing power. While newly qualified workers might not be expected to be able to undertake some forms of empowerment, all those involved agreed that it was a fundamental expectation that anyone seeking to form a collaborative working relationship should demonstrate a willingness to share power and on occasion to accept constructive criticism.

## **Teaching and learning about the basics**

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Line managers, training sections and trainers could adopt a number of the strategies listed below. If they do not, practitioners can make use of this list themselves to make what seem to us to be some very reasonable demands:

- All newly qualified community care practitioners should receive a balanced workload which enables them to tackle the relevant issues; and more experienced workers should continue to have the time to reflect on their practice and the encouragement needed to ensure that both collaborative credibility and anti-oppressive values remain fresh and creative elements of practice rather than simply becoming rather tired bits of rhetoric.
- Expectations of newly qualified staff should be pitched at a realistic level. It needs to be recognized that it is just as unreasonable to expect a newly qualified worker to make key decisions on their own about risks to adults as it is about risks to children. But it is also unwise to put even experienced practitioners constantly in the position of having to balance collaborative principles against risk factors without giving them the opportunity to refresh their collaborative practices in less demanding situations.
- Adequate opportunities for supervision must exist so that new professionals are able to engage in a process of recognizing and consolidating their competencies, and more experienced practitioners are enabled to continue to learn by being able to share uncertainties and vulnerabilities.
- Opportunities should be created for peer group support and discussion (equally useful for both newly qualified practitioners and those who are more experienced).
- Specific training on anti-discriminatory practice, user and carer involvement and working with value conflicts should be available to all groups of workers. In relation to user involvement, it would be especially helpful to make use of service user trainers both on conventional courses and as an alternative to them.

## **Training and resources for service users and carers**

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While it is important to make appropriate use of service users and carers as trainers, it is also important to recognize that they may have training needs as well.

Collaboration needs to come from both sides of the welfare counter. Service users and carers need opportunities to develop skills to work with community care services as individuals and organizations, just as community care practitioners need to develop skills to work with them. This study highlighted the training needs of users and carers and their organizations as well as those of practitioners. This needs to be acknowledged in education and training for practitioners. There needs to be recognition developed

in professional training for collaboration that service users and carers will themselves need training and resources.

## Are you ready to move on?

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Evaluating whether you or someone you supervise is ready to move on to more advanced collaborative work, or whether there is a need for further consolidation around the basics, is not an easy or straightforward matter. To help make this slightly less complicated we have made use of the findings from the project to develop a tool which should help to act as a starting point.

It is a *self-evaluation schedule* which is mainly designed for use by the individual practitioner, but it can be used by managers or supervisors or by peer groups. It may also be helpful to service users and carers, and their organizations, who want to evaluate and improve the practice they experience.

For those wishing to develop their skills in collaborative work further, a number of new challenges present themselves. We explore these in the next chapter.

## Summary

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In this chapter we have tried to 'unpack' some of the broad issues raised by the project. We began by acknowledging the way the process in which we were engaged mirrored its subject matter. We then moved on to explore some of the key features of collaboration culture, especially collaborative forms of communication, relationship building, empowerment, assessment and working with other people. Finally we looked at some of those things which we called collaborative 'basics' – that mixture of collaborative credibility and anti-oppressive values and attitudes which forms the bedrock of collaborative practice.

## **Exercise**

### **Basic Skills in Collaborative Work**

#### ***A self-evaluation schedule***

This is not a test. It is a tool for self-evaluation. It is therefore best seen as a way for you to understand your own levels of skill better and to help you to identify staff development targets for yourself.

#### **1 Have you demonstrated 'collaborative credibility' by:**

- a) consistently doing what you say you will do or if unable to do so by explaining why?

**Evidence:** .....

- b) engaging in frank and open discussion with those with whom you are collaborating – especially service users and carers – about uncomfortable, difficult or painful issues?

**Evidence:** .....

- c) having up-to-date knowledge about benefits, legislation and services and the ability to make constructive use of this knowledge?

**Evidence:** .....

- d) showing a willingness to listen to others and to take notice of what they say in all areas of your work including assessment?

**Evidence:** .....

#### **2 Have you consistently challenged discriminatory attitudes and policies when needed and thought critically about your attitudes and actions:**

- a) in direct work with service users and carers?

**Evidence:** .....

- b) with your colleagues?

**Evidence:** .....

c) with other practitioners / agencies?

**Evidence:** .....

**3 Have you sought consistently to empower others by:**

a) finding ways to share power with service users and carers?

**Evidence:** .....

b) challenging policies and practices which prevent service users and carers making their voices heard?

**Evidence:** .....

**4 Have you been able to work with value conflicts by:**

a) helping all those involved to understand the nature and depth of the value conflict?

**Evidence:** .....

b) taking account of actual and potential value conflicts in the process of negotiating and planning with service users, carers or other practitioners?

**Evidence:** .....

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# 9 The skills

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## Building a collaboration culture

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As we saw in the last chapter, the development project helped all those involved to see that there were certain basic principles involved in laying the groundwork for what we have called collaboration culture. Getting the basics right is as important in collaborative work as in anything else and, as we also saw in the last chapter, this is in itself a skilled activity. But the project also showed that a fully fledged collaboration culture requires more than this. It involves:

- Building interpersonal collaborative networks.
- Building inter-organizational and intra-organizational collaborative networks.

Through these activities the key themes of collaboration culture are given substance and meaning.

The interpersonal sphere consists of all those collaborative practices which are concerned with linking between service users, carers and other practitioners in order to develop a collective response to individual rights and needs. For those working with service users and carers on a face-to-face level, whether they are nurses, social workers or occupational therapists, this is inevitably the sphere of collaborative practice with which they are mostly preoccupied.

In contrast, although the inter-organizational and intra-organizational spheres are also concerned to some extent with relationships between individuals, here individuals relate to one another as representatives of groups, services or agencies. Linking is not just between individuals across organi-

zational boundaries but between groups, services and organizations of all kinds in order to improve ways of collectively identifying and responding to community needs. The emphasis is on developing new networked structures, systems and cultures. Community care practitioners may well get involved to some extent in this type of work in relation to service innovation. But for service managers, community care planners, commissioners and those concerned with encouraging and supporting independent service users' and carers' organizations, this type of work is likely to be a major preoccupation.

In what follows, we explore the key skills needed for building a culture of collaboration and locate them in the context of a range of interpersonal and inter / intra-organizational practices. Each area of collaborative skill is linked to a set of exercises to help make the discussion less abstract and to enable practitioners to test out or further develop their own collaborative skills.

## **Skills in collaborative communication**

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### **Improving the quality and flow of communication**

We learnt that when working with individual service users, a whole range of practices can help to improve the general quality of communication and ensure that the right information gets to the right people. These practices include network conferences; regular meetings with service users, citizen advocates and carers; long-term inter-agency liaison; following up written contacts with telephone calls; identifying a core group of named individuals as key workers, and so on. But it is important that thought is given to the appropriateness of whatever is done.

This means that part of the skill lies in the analysis of communication problems as well as the possession of a repertoire of possible solutions to those problems. This takes us back to one of the basic issues dealt with in the last chapter, that of attending to what other people are saying. In itself, it is not enough, but without it analysis is impossible.

The project clarified the point that at an inter / intra-organizational level there is a need to think more strategically about both the flow and the quality of communication. Strategic options include newsletters, inter-agency meetings, and meetings with service users' and carers' groups and organizations. But as with interpersonal communication, the response needs to be an appropriate one. Therefore an ability to attend to what others are saying and to analyse the nature of communication problems is essential.



## **Ensuring all voices are heard**

One issue emerging clearly from the project was that good communication does not consist solely of finding ways to ensure that those who already have a voice can speak more clearly to one another. It is also a matter of enabling those who have previously been ignored or silenced to find a voice and to ensure that others pay attention to it. Good communication is empowering because it creates new opportunities both to speak and to listen. A key skill lies therefore in exploring and then developing new kinds of communication opportunities for those who have previously been silent.

The project emphasized that enabling small organizations and community groups to be heard involves linking communication systems to participatory objectives. In particular it means paying attention to feedback processes at every stage of the decision-making process.

A key skill for practitioners and managers is therefore being able to make involvement an empowering rather than an oppressive practice by ensuring that concepts of effective user involvement and accountability to the community are built into participatory arrangements. This can be done either directly or through lobbying, another skilled activity.

Whatever they do, practitioners and managers need constantly to bear in mind the empowering potential of new opportunities for communication.

## **Reducing conflict through effective communication**

While real conflicts of view – between practitioners and carers, for example – cannot simply be wished away, the project seemed to indicate that when opportunities were created for sharing not just opinions and decisions, but the thinking lying behind them, then it was sometimes possible to reduce conflict and develop a shared understanding. The skills involved here include overcoming one's own feelings and motivating others to overcome theirs sufficiently to begin a process of sharing either on a one-to-one basis or in a group.

At an inter / intra-organizational level one of the key skills is to reduce the potential for confusion and conflict through the use of specific models of communication. Frequently, locating responsibility in named individuals and ensuring everyone knows who these individuals are will be all that is needed. Sometimes, however, it will not be enough for these individuals to be positive and purposeful. Where an agency is about to take on new responsibilities or to give up old ones, opportunities for discussing all the implications openly and honestly may mean investing time in developing more widespread forums for face-to-face discussion between opposite numbers, preferably at a number of different organizational levels, from that of senior management to that of the practitioner.

## **Exercise**

### **Putting communication skills into collaborative practice**

- 1 Identify a situation in which you are involved with other practitioners / service users / carers and in which you feel either or both the quality of communication and the flow of information could be improved. Try to answer the following questions:**

How does the present system work? What are its advantages and disadvantages?

How might the quality of information flowing around this network be improved and what might be achieved as a result of any improvement?

- 2 Identify any individuals or groups who tend to miss out on important information.**

How might the system of communication be changed in order to include rather than exclude them?

Outline the steps you would take to achieve some or all of these changes.

- 3 Identify a situation in which you are involved with other practitioners / service users / carers and in which you feel that some powerful individuals or groups dominate all discussions at the expense of others who are less powerful.**

What are the barriers to participation in the communication network? How might they be overcome?

How might you go about supporting those who are silent to develop a voice?

How might you go about ensuring that others listen to and take note of these new voices?

- 4 Identify a situation in which you are involved with other practitioners / service users / carers and in which conflict is linked to poor communication.**

How might misunderstandings be rectified?

How might you enable conflicting points of view to be heard?

How might the communication system be used to acknowledge and contain conflict rather than to deny and amplify it?

- 5 Identify a situation in which you are involved with other practitioners / service users / carers and in which inappropriate language or style of communication is being used.**

What is it that is inappropriate?

How might you set about trying to ensure that a more appropriate kind of language is used?

## Skills in the use of appropriate language

This could take many different forms, most obviously using an interpreter when there is no common language, but also including forms of direct communication sensitive to the needs of children; open-ended styles of questioning when exploring needs with service users and carers; and knowledgeable but flexible ways of discussing issues with other practitioners. Sometimes the need might simply be to avoid using oppressive jargon. The skills involved here include an ability to analyse situations in terms of dominant linguistic features, which goes beyond the question of whether someone speaks English or not. It also includes an ability to be aware of one's own language and to modify it as appropriate. As with many other communications skills, an ability to use language appropriately is at root an empowering strategy.

Similar issues arise at an inter / intra-organizational level. For example, publishing leaflets in a variety of languages is essential; and when chairing meetings it is important to ensure that if service users and carers are present, language styles include rather than exclude those who are unfamiliar with professional jargon. Although the context might be different, the skills involved are closely related to those already identified for interpersonal work.

## Skills in relationship work

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All collaborative networks are *social* networks. Whether they consist of individuals or organizations, the effectiveness of communication and levels of cooperation will depend on the extent to which all those involved are able to build and manage their relationships successfully.

## **Handling conflict**

The project made it clear that an ability to analyse and manage ambivalence and conflict and its impact on oneself was an important aspect of the process of developing and sustaining community care networks. A key skill seems to be finding ways of making it safe to expose the sources of conflict and discuss them. This does not always resolve conflict but does seem to reduce the destructive power of conflict-laden issues by demonstrating confidence in the strength of relationships.

## **Confronting discrimination**

Serious dilemmas can be posed when one or more of those with whom one is seeking to collaborate demonstrates discriminatory attitudes or behaviour. Sometimes it may be necessary to terminate the collaboration, but during the course of the project we also heard about ways of challenging this kind of behaviour. The critical element here seems to be a collaborative network able collectively to demonstrate its disapproval and having the power to enforce a change in behaviour. A key skill therefore consists of ensuring that anti-discriminatory values are built into the basic assumptions underpinning the collaboration and having the confidence to mobilize support on the basis of these values so that any discriminatory behaviour will be immediately challenged if it appears.

Institutionalized discrimination may be more appropriately addressed at an inter / intra-agency level. Often the problem can be seen as one of lack of responsiveness or accountability, often associated with a lack of any real relationship to certain parts of the community. In the case of a culturally insensitive meals-on-wheels service, for example, involving organizers in direct discussions with service users, friends and relatives and enabling them to access advice about easy-to-prepare recipes might play a part in a successful anti-discriminatory strategy oriented towards changing the relationship between meals-on-wheels and the community.

## **Developing trust**

One of the issues that emerged very strongly from the project was the importance of building and sustaining trust, mutual respect and mutual understanding between the members of a support network. Skills involved here include being able to encourage informal contact between members of the support network, facilitate group discussions, explore opportunities for mutual aid and support and promote joint visits.

At an inter / intra-organizational level, trust also involves planned and regular interaction with opportunities for the kind of collective action which

## Exercise

### Putting relationship skills into collaborative practice

- 1 **Think of a situation in the past where you were trying to work with someone from another agency or a service user or carer and relationships deteriorated because of unresolved conflict.**

If you had the chance to go back to that situation now what might you do differently that would enable the conflict to be addressed in a constructive way?

- 2 **Suppose that another professional with whom you were working closely as part of a collaborative network made a racist, sexist or disablist remark about a service user.**

What would you do?

Would you act alone or with others? If the latter, with whom?

What would be the impact of your response on network relationships?

- 3 **In the course of your work, you are about to embark on a new set of relationships with other practitioners, service users and carers.**

What would help to build trust between all these people?

What would you do first to facilitate this process?

- 4 **Imagine that you yourself needed additional support in your professional role.**

What would you be likely to need support with?

How would you go about identifying potential supporters?

Would you need the help of one or more 'brokers' – if so who?

How would you make contact or, if using a broker, how would the broker do it?

What might best motivate your potential supporters to respond to your needs?

If successful in recruiting supporters, what kind of obligations might you have to them in the future?

leads agencies to develop confidence in one another and the strength of their relationships.

## **Developing support**

The ability to develop personal support networks is a key aspect of collaborative work. This involves all members of a collaborative network either being able directly to meet one another's needs or alternatively helping to ensure that some needs are met in other ways.

Support can mean different things to different people and what is supportive in one situation may not be so in another. But whether support is emotional, practical, oriented to sharing or oriented to campaigning, consideration needs to be given to ways of identifying and recruiting potential supporters. The skills involved include being able to identify sources and patterns of potential as well as actual support, forging links with key figures able to broker support and being able to apply these principles to one's own needs as well as those of others.

It is not usual to think of support at an inter-agency level but it is possible for small voluntary or service users' organizations to be quite isolated and vulnerable when working alongside larger, much more powerful and more effectively resourced organizations, such as social services departments. In these situations finding ways of channelling additional resources to small organizations can be very supportive. This can take the form of making knowledge and expertise available as well as money. The skills involved here are similar to those employed in evaluating more personal support needs. But there is a need to understand that different kinds of organizations may have different kinds of needs.

The best way of exploring what is meant by competency in the mobilization of support is to think what it might imply if you were to attempt to recruit additional support for yourself.

## **Skills in empowerment**

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### **Advocacy**

One of the findings from the project was the importance attached to a willingness and an ability to speak up for service users and carers in a credible and effective way. The skills involved include being able to present well-prepared, well-argued and comprehensive assessments which link community care needs to the rights of individuals to exercise choice and control over their own lives (see Skills in assessment and planning, p. 143). But they go wider than this, as well.

At an inter / intra-agency level, an ability to lobby for changes in the way in which health and social services are planned and delivered so as to pay more attention to the question of 'rights' was widely seen as a key advocacy skill and one which would make the notion of 'user-led' services more meaningful than it sometimes is.

### **Involving service users and carers in defining and assuring quality**

Individual service users may have been given formal rights to complain, but the project showed that they often sought a more active role in relation to service quality. For care managers, in particular, it was clear that safeguarding quality meant working with service users and carers to develop 'care packages' which reflected a real concern with quality of life as well as quality of care in a traditional sense. This, in turn, meant that it was important to maintain an active concern with rights and choices, as well as perceived dependency needs. The skills involved include having the ability to work together with service users and carers to develop creative and life-enhancing plans for support, and to challenge service providers who continue to approach their task on the basis of a lowest common denominator service.

At an inter / intra-organizational level the project showed that there were still too few opportunities for service users, carers and their organizations or other community groups to make an impact on the increasingly important processes by which quality standards were defined and quality assurance systems implemented. Key skills therefore include the ability to support service users and carers to develop their own priorities in discussion with one another and to have regular and reliable opportunities to communicate with community care agencies about these priorities. In these ways involvement becomes an integral part of the whole quality system rather than a tokenistic afterthought.

### **Promoting responsiveness**

At an interpersonal level this focuses on ensuring that all those involved in supporting individuals are prepared to respond positively to the needs and wishes of service users and carers. It involves having the skill to challenge other practitioners who seem to be unreasonably rigid in their approach. But it also involves being able to enable other practitioners to explore ways in which they might overcome real obstacles to their responsiveness, including bureaucratic and resource constraints.

At a broader, inter-organizational level, structural constraints on responsiveness need to be challenged. This involves being able to act as a cultural

innovator promoting new organizational values. Pursuing this within one's own organization may be important but it is unlikely to be enough. Service users need to be assured that all the agencies they deal with share the same kind of values in relation to responsiveness. So there is a need to be able to deploy these skills in the context of inter-organizational forums. To be

## **Exercise**

### **Putting empowerment skills into collaborative practice**

#### **1 Assuming that in your workplace opportunities for advocacy arise quite frequently:**

Are there any opportunities for advocacy which you think you might have missed recently?

Why might opportunities for advocacy be missed in this way?

Think of ways in which advocacy might be undertaken without disempowering service users.

#### **2 Assuming that you have some responsibilities in relation to quality assurance in your organization:**

How might service users be involved more thoroughly than at present in setting and monitoring service standards?

What issues might need to be addressed to ensure that this happens?

#### **3 In what ways could your organization be made more flexible and responsive to the needs and wishes of service users and carers?**

What problems might need to be overcome first?

How would you set about tackling these problems bearing in mind your position within your organization?

#### **4 Thinking of the individual service users or service users' groups that you have contact with:**

How might you go about discovering their training needs?

How might the use of service user trainers become an integral part of staff development?



successful in this, practitioners, including managers, will need to have the skill to develop alliances with service users' and carers' organizations.

## **Facilitating training for service users and carers**

The project demonstrated there is an unmet need for training among service users and carers. At an interpersonal level this may mean simply being willing and knowing how to share community care knowledge and skills with others, especially service users and carers. Sharing skills helps to demystify professionalism and to give service users and carers more sense of involvement and control. It is a reciprocal process. So practitioners may stand to learn something new as well! It may also mean helping service users and carers to contact one another so as to form 'action learning sets' or groups which enable knowledge and skills to be shared and developed.

At an inter-organizational level, the issues and therefore the skills are more likely to focus on finding ways of channelling resources to service users' and carers' groups and creating new learning opportunities for them.

## **Skills in assessment and planning**

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### **Engagement**

The project confirmed the truth of the traditional wisdom that effective assessment and planning depends on an ability to engage with other people. But in the context of community care this means that assessors have to have the ability to empathize with and relate to a very wide range of people without losing their primary concern with the needs of the service user.

At the level of inter-agency planning / commissioning / purchasing, engagement is equally important. All the key stakeholders, including service users' and carers' organizations, have to feel an integral part of the process. If they feel marginalized or excluded, any plans that emerge will suffer from a lack of support and commitment. Engaging with organizations at this level means paying real attention to their views and acknowledging that a certain level of conflict is likely to occur without allowing this to inhibit the development of relationships.

### **Needs, risks and opportunities**

The project showed that a collaborative approach to community care involves a shift away from a traditional concept of assessment, often dominated by concepts of risk, towards one in which the creation of new *opportu-*

nities for improving the quality of life is a central objective and the characteristic process is one of continuous dialogue with service users, carers and other practitioners.

The skills involved in opportunity assessment and opportunity planning include an ability to collaborate with others and especially service users in analysing both existing patterns of interaction and evaluating the potential of new forms of life-enhancing support. This again reinforces the critical importance of an ability to attend to what other people are saying.

At a wider level, the shift from a concept of risk to a concept of opportunity has radical implications for community care planning. It involves focusing not on certain standardized notions of need and their relationship to existing services, but on the kind of opportunities which would improve the overall level of support and quality of life of individuals and groups drawn from a diverse set of local cultures and family structures. At the same time, profiling services will have to give way to auditing community resources in a much more flexible and creative way. The skills involved in this would have to include the ability to engage with and take notice of a wide range of service users', carers' and other groups, alongside powerful vested interests, such as social services departments and health authorities and representatives of the emerging independent sector.

### **Awareness of multiple perspectives**

It is inevitable that any system which involves talking to service users, carers or other practitioners will generate a situation in which individual assessors will have to take account of multiple perspectives. The key skills here are concerned with enabling people to express their views and then deciding not that some are right and others are wrong, but that they will all embody some part of the truth of the situation. This will enable conflicts of view to be handled sensitively.

If the aim is to develop an inter-organizational rather than a purely interpersonal collaboration, then this issue takes on a new kind of meaning. It is a question of understanding that building a concept of need at this broader level cannot be separated from the aims and objectives of different organizations and how these relate to the interests of various groupings across the whole field of community care. Concepts of 'community need', therefore, need to be sensitive to the politics of community care.

### **Creativity**

Almost by definition, the concept of opportunity planning requires creativity. At a time when guidelines and detailed procedures of one kind or another are threatening to reduce human services to a series of mechanical

tasks, to talk about creativity may seem hopelessly out of touch with reality. But we would argue that the whole concept of a needs-led service is meaningless if imagination and innovation are not placed at the centre of community care practice. Some might argue that it is almost a contradiction in terms to talk about skills in creativity but it is clear that an ability to respond to the demands of a situation in a fresh way, untrammelled by what sometimes passes for traditional wisdom, will be of great importance. It also needs to be recognized that opening up fuller and more open-ended discussions with service users and carers will enable them to be creative in their thinking as well. This will in turn reinforce the creativity of assessors.

At an inter / intra-agency level, creativity is also important. After all, although it will be possible to learn from what has been done elsewhere, specific issues thrown up by a particular client group, a particular locality

## **Exercise**

### **Putting assessment and planning skills into collaborative practice**

- 1 Whether you are a purchaser or a provider you are likely to be concerned with some aspects of assessment and planning.**

How might you start to involve a broad range of people in a collaborative approach to the assessment task?

How might this process be made manageable and service users assured that their needs, rights and wishes remain uppermost in your mind?

- 2 Traditional assessments often focus on the question of risk.**

How might you ensure that in future your own assessments or those undertaken by others give more weight to opportunities for life enhancement?

- 3 How might a number of very different views about needs contribute to an integrated assessment? How might you go about setting up a process which could achieve this?**

- 4 Under pressure of work it is often difficult to be imaginative in relation to assessment and planning.**

As an exercise try to think of five different ways in which the same set of individual or community needs could be met. To make this more interesting you might like to limit the contribution of standard services to a minor role in four out of the five!

or a particular blend of local groups and agencies, in principle add up to both a need and a recipe for innovative thinking.

## **Skills in collaborative working**

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### **Clarifying goals, roles and tasks**

Almost all collaborative working arrangements have to overcome a series of hurdles before they can begin to be effective. The development project showed that misunderstandings and false conceptions of one another's roles are commonplace. It is therefore essential for the success of any collaborative venture that attention is given at the outset to clarifying goals, roles and tasks. This should not be seen as a once and for all event, but something which is constantly reviewed. Sometimes it may be useful to formalize this understanding as it exists at any one time and commit it to writing. But it is important that clarity does not lead to rigidity or demarcation disputes. The purpose of clarifying key collaborative issues is not to produce a set of job descriptions. Rather, it is to develop a set of shared basic assumptions around which the collaboration can grow organically. The skills involved in this include an ability to think in a task-oriented way, and to combine maximum flexibility about who does what with maximum clarity about any decisions made.

Contracts are often useful ways of enabling those who intend working together to clarify the terms of their relationships. Inter-organizational work is no exception. Increasingly, purchasers, providers, service users and carers will need to come together around shared understandings about the range of support services that could be available to care managers. Working towards legally binding contracts should not mean that broader issues are lost sight of. It is important that people are not rushed into commitments before they feel ready. There is a skill involved in facilitating an open-ended phase of exploration of possibilities as well as a skill in judging the best moment to conclude negotiations and sign a contract.

### *Handling multiple accountability*

Multi-disciplinary and inter-agency collaboration, and collaboration between professionals and service users and carers, all raise questions of accountability.

The project helped everyone involved to see that agreements about accountability must be made meaningful to all those involved. In particular, service users, carers and other community care practitioners need to be

aware of what kinds of rights they have to information, consultation and participation in decision making. There are skills involved in translating notions of multiple accountability from the rhetorical to the practice dimension, by paying close attention to the needs and sometimes conflicting interests of all those involved and being able to work together to develop the system of accountability.

At an inter-organizational level, community care will not work unless attempts are made to thrash out issues of confidentiality, professional autonomy, line management responsibilities, the purchaser/provider split and service user involvement in such a way as to provide a useful framework of accountability for practitioners. The skills involved here will include an ability to negotiate between the competing claims of particular notions of accountability.

## Coordination

Collaboration is intimately connected with coordination. At the level of the care package, the framework for coordination is laid by early negotiations about roles, goals and tasks. But while this might set the overall strategy, there is still a need for day-to-day coordination, if only to ensure that small problems do not become large ones and any conflicts are dealt with at an early stage.

Having said this, there is a tension between the concept of authority inherent in the notion of coordination and the participative principles of collaboration. Care managers and others will need to be able to find ways of managing this tension. Sometimes this might be done by enabling service users themselves to act as coordinators. But even if this is not the case, coordinators need to have the ability to give some tangible expression to the principle that the power of collaborative coordination is derived entirely from the collaborative network itself and its collective wish to accomplish its tasks effectively.

Similar issues arise at a broader level. It may be difficult for various groups and agencies to collaborate effectively unless one agency or group takes on responsibility for coordinating the multi-agency effort. Those taking on roles like this as representatives of their organizations will need to have skills in chairing meetings and, from time to time if conflict emerges, skills as conciliators as well.

The question of power and accountability may in some ways be more easily resolved at this level, but there will still be a need for skills in clarifying the extent to which the coordinator is simply acting for the collaborative network as a whole rather than in his or her own right. Moreover, while coordinators can reduce democracy, they can also enhance it. It is the larger, more powerful agencies which may feel most constrained, and

## **Exercise**

### **Putting skills in collaborative working into collaborative practice**

#### **1 In your day-to-day collaborative work:**

What kind of issues cause the most confusion and what could be done to prevent this kind of confusion arising in the future?

What might be the advantages and disadvantages associated with a written contract?

#### **2 Negotiation is a process. It can be divided into three stages: exploration, discussion and decision making.**

How would you apply this model to your own work?

#### **3 Identify a situation in which you are working with more than one other person. Divide a sheet of paper into as many columns as there are individuals or groups involved in the collaborative network.**

In each column write down the kind of responsibilities that you feel you have to the individuals or groups concerned.

What are the similarities?

What are the differences?

Then write down in each column the kind of responsibilities that you believe these individuals or groups have to you.

What are the similarities?

What are the differences?

What conclusions do you draw about accountability?

#### **4 How might the concept of a network conference be applied to some of the problems of coordination that you currently face?**

#### **5 How would you chair a network conference so as to ensure that all those involved felt they were participating in the decision-making process?**

the smaller community organizations most empowered, by effective inter-agency coordination.

## **Skills in review and evaluation**

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### **Performance indicators**

As already indicated in the earlier discussion about quality assurance, the project emphasized the need for consultation to underpin any attempt to develop yardsticks by which to judge the extent a support network was succeeding in its aims. If there is no consensus on positive or negative indicators, it is very difficult to see how evaluation can take place. This will involve skills in facilitating dialogue on broad issues connected with quality of life objectives, while at the same time focusing attention on the link between these and specific indicators.

At the inter-organizational level it will also be necessary to establish agreements on the expected outcomes of collaboration. Here again it is important that the indicators genuinely reflect the process of meeting needs and not the internal requirements of agencies.

### **Review processes**

Planned review meetings or network conferences in which careful preparation has been made for the involvement of service users and carers as well as practitioners must lie at the base of any process of reviewing the effectiveness of care packages. Being able to set up and facilitate these meetings is a key collaborative skill.

Reviewing inter-agency planning systems also involves skilled facilitation, especially when it comes to giving due weight to the experiences of service users and carers and ensuring that all members of any review committee are fully aware of these experiences.

### **Monitoring**

Concepts of review and evaluation are largely meaningless unless there is a reliable way of monitoring what is going on. This process of monitoring developments needs to involve all those who are in collaboration with one another. At an interpersonal level this may mean that skills are needed to ensure that feedback is continuous and that information is conveyed in a clear and readily understandable form.

At an inter-organizational level, for example when monitoring hospital discharge arrangements, ensuring continuous, clear and accessible feedback may require skills in developing and maintaining appropriate information systems and computer databases. But it will also require skills in opening up these issues to discussion and collective decision making.

### **Self-criticism**

One of the issues which emerged quite strongly from the project was something which is often ignored in discussions about evaluation, and that is the ability to step back and be critical about one's own practice from time to time. Sometimes stubbornness or pride can interfere with the work.

At an interpersonal level this requires an ability to reflect, to consider alternatives and to accept that someone else may be right when you are wrong.

At an inter / intra-organizational level it requires an ability to step beyond the traditional perspectives associated with your own service or agency and to consider changing practices, even if they are well established and all your colleagues feel comfortable with them.

### **Exercise**

#### **Putting review and evaluation skills into collaborative practice**

- 1 Devise a consultation process which would enable you to work with other practitioners, carers and service users to identify some key performance indicators for the community care work in which you are all involved.**
- 2 In your own field of work, what kind of review processes might best express the principles of openness and participation so important to collaborative work while also ensuring an effective outcome?**
- 3 How might you go about planning a monitoring system with other practitioners, carers and service users? How might the views of others influence the kind of information collected and the way it is communicated to others?**
- 4 How might you build opportunities for reflection into your everyday practice, and how might you provide opportunities for others to feed back to you their views about your practice on a regular basis?**



## Summary

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In this chapter we have focused on the pattern of skills associated with collaboration which the project suggests all community care practitioners, regardless of professional background, will need to have or to develop. We have identified skills in communication, relationship work, empowerment, assessment and planning, collaborative working and review and evaluation as critical components of this skills profile and suggested some exercises which could be used to facilitate the process of skill development.

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# Conclusion

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## Collaboration – a way of transforming welfare

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Throughout this book we believe we have conveyed one message above all others – a simple, but at the same time potentially revolutionary, message. It is that working with other people is not just a different way of delivering traditional welfare services. If taken seriously, it is a way of transforming the nature of welfare systems. This might seem like a far-fetched claim. But the experiences on which this book is based have convinced us that collaboration involves a much deeper and more transformative set of relationships than is usually conveyed by terms such as ‘inter-agency work’ or ‘participation’.

As a result, although this book has been about skills and the process of skill development, it has also been about culture and the process of culture change. We coined the term ‘collaboration culture’ to draw attention to this and to differentiate our subject matter from that of the all-pervasive ‘contract culture’ of community care.

As some service users reminded us at an early stage of the development project, the process of developing this new culture is not something that can be postponed. Collaboration is not a luxury. In as complex and interdependent a system as community care has become, collaboration is *essential* if things are not to fall apart.

We began by looking at the collaborative principle in community care and explored its links with a user-driven rather than budget-driven philosophy. We then moved on to the core of the argument, an account of a project concerned with analysing and developing collaborative skills for community care practice, which involved service users, carers, nurses and social workers and which took as its starting point the interrelationship between collaborative skills and collaboration culture.

This entailed finding out more about some of the skills needed for community care practice, while at the same time exploring the overall characteristics of collaborative work and the implications for the future development of community care systems and services.

## **Key lessons for collaboration**

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From the project, we drew a number of key lessons about both the new culture and the skills required to build it.

Collaboration needs to permeate community care practices, influencing them at every stage. It is not just a way of organizing service delivery. It is also a way of identifying needs and resources – a ‘holistic’ or ‘open’ approach to assessment characterized by multiple perspectives and multiple accountabilities.

Collaborative systems need to be open in another sense as well. They need to be known about and accessible to all sections of the community. This implies a pro-active rather than a reactive form of community care in which being ‘close to the community’ is a guiding principle.

Thinking collaboratively entails thinking strategically about ways of working with and supporting both individual service users and carers and their local and national groups and organizations. This challenges all concerned to think about the way in which collaboration involves sharing power as well as responsibility.

Collaboration can only exist if negotiation is for real and there is a genuine willingness to adapt roles and relationships to shifting patterns of need.

This raises the question of basic collaborative values. It was made clear to us that collaboration involves a certain kind of value system, characterized by honesty, commitment and reliability. It also involves rediscovering the central significance of the personal dimension in community care. This is not personal in any psycho-pathological sense and we are not arguing for more psychotherapy. Rather the need is to develop and maintain through personal relationships a strong focus on service users’ and carers’ experiences and the impact of collaboration on the quality of those experiences. This should be the case whether dealing with an individual and his or her problems, or the needs of a whole community.

But all this takes time. Whether building up relationships with service users and carers or with other practitioners, the project showed us we cannot expect results overnight.

One point brought home to us by our work was that it is no use developing a concept of collaboration which is out of tune with reality. The starting point for collaboration has to be a recognition of the scarcity of resources,

and it has to be seen as a process of working together both to make the most effective use of those scarce resources and sometimes to challenge the systems by which resources are allocated.

## Collaboration culture

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Overall, collaboration involves a complex interdependency – a ‘web’ of communication and cooperation linking community care networks together.

Collaboration culture is what holds this web together. It can be seen in terms of communication processes, relationship issues, empowerment, ways of undertaking assessment and planning, processes of working together and approaches to review and evaluation. But all these form part of a coherent whole and rest upon a foundation of collaborative credibility and anti-oppressive practice.

Individual professionals cannot by themselves be expected to develop collaborative networks. This is demanding work which has to be facilitated by managers. This brings into focus the organizational dimension of collaboration. Collaboration is as much an organizational culture as it is a practitioner culture. It seems that the organizational culture of collaboration is one associated with high levels of autonomy and a facilitative rather than overly controlling style of management. It is clear that some agencies seem to be much further along the road in this than others!

We have identified collaborative skills in relation to the whole spectrum of practice, including communication, relationship work, empowerment, assessment and planning, working together and reviewing and evaluating effectiveness. One distinctive feature of these skills is that they are all closely related to the core of what we have called collaboration culture. As such they could be seen as core collaborative skills.

Another feature of these skills is that they are almost all concerned with the process of developing collaborative networks. This focus on process has been quite deliberate, partly to redress the balance of discussion about skills which seems almost always nowadays to focus narrowly and exclusively on outcomes and partly because everyone agrees that collaboration is desirable, but it is the process of developing collaboration which throws up all the difficult questions concerning change, conflict, identity and role – questions which we felt we needed to address.

## **A collaborative approach to developing skills**

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We began the project in the spirit of trying to move away from rigid concepts of skill towards more fluid accounts of practice which link issues, values and ways of doing things together. In our view, skills analysis should not be like butterfly collecting and this is particularly so in the field of community care where innovation is so important and what exists today may not be what exists tomorrow. Now that we are at the end of the project, we feel that what we have had to say about the process of skill development is as important as what we have been able to say about collaborative skills themselves.

We are convinced that collaborative skills can only be developed in a collaborative way. This implies that the process of developing new community care skills and refining old ones should be open and participative rather than closed and didactic. Traditional boundaries between professions and between practitioners and service users need constantly to be questioned, and there needs to be a real commitment both to sharing skills and to taking notice of and learning from others if progress is to be made.

The project had a number of valuable practical outcomes. For example, it led us to try to develop a new form of post-graduate inter-professional education and training in community care. This has in itself been a major collaborative challenge involving negotiation between two different university departments, several professional bodies, a number of local social services departments, some National Health Service trusts and a regional health authority.

But for us, the most important outcome of the project was the creation of a new perspective on collaboration, one that does not separate inter-professional and inter-agency work from work with service users and carers, but sees all these things as connected with one another as part of a collaborative approach to community care practice.

Community care can sometimes feel very complex, confusing and even contradictory. While not wishing to oversimplify or deny the real ethical dilemmas associated with it, we feel we have shown that collaboration can help to clarify as well as confuse; that it has to be a value-driven exercise, not simply an attempt to solve technical puzzles or achieve advantages for one's own agency or profession; and that it opens the door to a new kind of culture from which all those involved in community care may benefit.

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## Towards a Comparative Analysis of Collaboration

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### Introduction

The development of community care in the UK has been bedevilled by the problem of collaboration. Debates about it have been going on since well before the passing of the NHS and Community Care Act in 1990 and show every sign of becoming more, rather than less, intense. For British social workers, these debates are of more than passing interest. Not only are they actively involved in community care, they often find themselves occupying precisely those commissioning and care management roles which are charged with the responsibility for ensuring that the diverse interest groups of the community care system, including service users and carers, work together with one another equitably and effectively.

More generally, the way in which social work has become inextricably interwoven with co-ordination, networking, inter-agency work, brokerage and all the other collaborative community care practices (Trevillion, 1992) make it likely that the future of British social work will depend on its ability to re-invent itself as a collaborative profession. Yet attempts to move towards the fundamental transformation of roles and skills implied by this are constantly frustrated by the difficulty managers and practitioners have in thinking and talking about collaboration. This article explores the ways in which we currently talk about the 'problem of collaboration' in the UK and

argues that our approaches are both intellectually and politically flawed and too narrow to be useful. It suggests that a broader comparative European perspective would create a more adequate account of the 'problem of collaboration' linking it to questions about how it is that we should respond to individual need whilst pursuing the goals of social integration and social inclusiveness and that this should form the basis of the long-awaited transformation of social work itself into a collaborative profession.

### The problem with the problems

There has been relatively little debate about the nature of collaboration. Most commentators seem prepared to accept relatively common sense definitions focusing on the process of 'working together' (Cmn 849, p.19, s.3). Some attempts have been made to open up debates about this (Beresford and Trevillion 1995, pp.5-23). But in general, attention has been focused less on collaboration itself and more on why it is that collaboration has been so difficult to achieve, especially collaboration between health and social care agencies.

Within the UK three dominant ways of trying to understand this 'problem of collaboration' have emerged in recent years: as a consequence of 'lack of guidance', as a result of 'unclear boundaries' between health and social care and as a product of

'cultural differences' between key professions and organisations.

These ways of talking about the problem have permeated our thinking to such an extent that they are rarely subjected to the kind of scrutiny which any attempt to systematically relate cause and effect in the field of collaboration ought to receive.

## Deconstructing the dominant discourses

### *i. 'Lack of guidance'*

It has been suggested that one of the biggest obstacles to the successful implementation of the collaborative objectives of community care policy has been a lack of guidance from central government. Hudson comments that there has been a lack of specific guidance on how to achieve collaboration except in terms of a constant repetition of the need to construct relationships on the basis of a clear distinction between 'health care' and 'social care' (Hudson, 1992, p.23). The inadequacy of this has been shown by the fact it has turned out to be more of a recipe for 'passing the buck' than a recipe for partnership. We can see this in relation to Henwood's description of the fiasco surrounding the attempt to define financial responsibility for nursing home placements (Henwood, 1992).

Without denying that there is a 'lack of guidance' in some key areas, this view of the 'problem of collaboration' is partial, at best and misleading, at worst. One could compare it to the situation of the child who has just purchased a model aeroplane in kit form but finds that there are no instructions on how to put it together. The problem of collaboration is reduced to a problem of information. But this is an inappropriate way of thinking about collaborative difficulties. It seems to assume that if those involved were given effective instructions they could put all the pieces of the system together and it would work. But there is no evidence that such a master plan does or could exist. Belief that it does becomes a matter of faith rather than science, closing off discussion where there should be open-ended debate.

But an even more serious criticism of this way of talking about the problem is that it turns people into objects. Those actually trying to collaborate are deemed to be helpless victims of circumstance - their attempts to empower themselves and construct meaningful relationships with one

another, appear to be devalued, even dismissed, out of hand. The model is also highly mechanistic. The assumption is that there is a formula - a set of guidelines - which will activate the collaborative machine, but unless it is known, nothing can be done. This is highly authoritarian approach based on the belief that there is one - albeit secret and mysterious - model of collaboration to which everything and everyone should conform.

This way of talking about the 'problem of collaboration' implicitly seeks to make a case not just for more information but for highly centralised direction and control of the kind which is usually associated with the proponents of a command economy rather than a 'mixed economy of welfare'! Not only is this not compatible with the concepts of pluralism usually associated with community care or the political values of liberal democracy, in practical terms is it conceivable that members of the community whether professional or non-professional would simply accept someone else's idea about how they should relate to one another or be prepared to simply wait to be told what to do? This might work in Plato's Republic but not in 1990s Britain.

### *ii. 'Unclear boundaries'*

The concept of collaborative problems as problems of inadequate 'guidance' - and this needs to be distinguished from problems of inadequate communication - is closely linked to another common view of the problem which links collaborative difficulties with the characteristics of organisational and sectoral boundaries. Henwood, for example, describes failures in collaboration between local authority social services and district and regional health authorities in the following terms:

"The hazy boundary and disputed no-mans land between health and social care was always going to be the Achilles' heel of the community care reforms" (Henwood, 1992, p.28).

This account of the problem tends to focus on the idea that as Robert Frost puts it. "good fences make good neighbours". Somewhat paradoxically, those who focus on the boundary issue seem to take the view that collaborative problems are a product of insufficient differentiation and that the solution to the problem lies in clearer (and more exclusive) definitions of professional and organisational roles and tasks. Even if we put to one side the obvious

paradox of seeking to discover solutions to problems of collaboration by enforcing separation, there is another problem. This kind of strategy is only likely to work if there is a vision to which everyone subscribes and which will act as the basis for an effective division of labour. But those who talk about the problem of collaboration in this way are largely silent about this vision or the consequence of its absence - that different groups and individuals are driven by different visions of the future.

These large areas of silence limit the way in which collaborative issues can be talked about. Accounts focus simply on areas of confusion or ambiguity. Other aspects of the 'problem of collaboration' are simply ignored or taken for granted. There is a lack of curiosity both about the relationship between specific events and the meanings ascribed to them by those involved. Rather than looking for fresh insights, the search is only for other examples of confusion.

One casualty of this approach is the concept of 'collaborative strategy'. If the solution to collaborative problems lies in the separation of roles and tasks, the whole notion of a 'collaborative strategy' becomes rather meaningless. All that is required is for individuals to act in accordance with an agreed template of tasks and roles.

As with the 'lack of guidance' discourse, the 'unclear boundaries' concept looks towards collaborative solutions based on centralised and centralising government initiatives. Interestingly, both these ways of talking imply that separation is the key to collaboration. This reduces the problem of co-operation and co-ordination to that of an effective division of labour. This may have some superficial attractions but, as Durkheim reminds us, complex forms of the division of labour in the absence of over-arching values tend towards anomie (Durkheim 1952) and anomie - the absence of any identification with a wider community - is precisely the problem that collaboration is in many ways designed to tackle.

In the absence of a set of community values, schemes based on the rigid separation of roles and tasks inevitably drift back towards institutional regimes in their attempts to counteract entropy and anomie, and this may be why we are now seeing the emergence of 'institutions in the community' (Collins, 1989).

### *Cultural Differences*

Unlike the other two definitions of the problem, this acknowledges that collaboration is more than separation. And that if there is to be 'coherence' in the market place, there needs to be some kind of communication between the two key players - health and social services - as to what should be commissioned or purchased. So those recommending 'joint commissioning' as a solution to collaboration recognise that significant 'cultural differences' between health and social services have to be reconciled before it can happen (Knapp, Wistow and Jones 1992 p.30).

Those who take this view argue that the major task is to overcome differences of values, language and indeed perceptions of the problem so that common purchasing strategies can be devised. Moreover there is a clear recognition in the White Paper and elsewhere that right through health and social services there will be a need for dialogue to support and develop these shared strategies.

Whilst the cultural argument seems to be couched in much more collaborative terms than the other arguments, it is in some ways supportive of them. Higher levels of mutual understanding will, it is presumed, lead to more effective separation of health and social care and help to fill the information gap by providing a clear framework of guidance within which to operate.

In this way of talking about the 'problem of collaboration', the question of culture becomes a question not of holistic patterns or underlying logics, but rather one of irrational/anachronistic attitudes which are a barrier to the implementation by management of more effective forms of the division of labour. This is intrinsically conservative as higher levels of 'mutual understanding' will inevitably lead to a squeezing out of deviant practices and a consolidation of traditional roles. This might make life simpler. It will certainly make community care easier to manage. But will it not also tend to militate against the flexibility and innovation which are often seen as key elements of the move towards user-led services?

Flexibility and innovation always create difficulties for organisational systems developed to promote older and more established practices. And yet collaboration, in the broadest sense, depends on precisely these qualities. If 'mutual understanding'



is to be obtained at the price of discouraging genuinely collaborative practices, then it may not be such a desirable goal after all! A genuinely 'collaborative culture' will not be created by such an instrumental and bureaucratic approach to the culture question (Beresford & Trevillion, 1995, p.15).

### The narrowness of the debate

We have allowed our understandings of the 'problem' to be overly influenced by the ideology of the market. Community care policy in the UK is very much a child of 1980s Thatcherism and this has led to a situation where the problem of collaboration has been defined simply as : how to make the market work? But five years after the passing of the NHS and Community Care Act, it is not enough simply to assert that market management and collaboration are one and the same thing. Establishing optimum market conditions may or may not be compatible with collaboration which involves much more than simply creating a framework for competition.

Ideology is only part of the problem, however. The fundamental problem with the approaches we have looked at so far is not that they are wrong, but rather that they mistake the part for the whole. It is not that there is not enough guidance, or that there are not problems in distinguishing between health and social care or that nurses and social workers do not understand one another. On the contrary, these problems are real ones. But if we are to understand the 'problem of collaboration' more fully and in particular, if we are to make general theoretical or descriptive statements about it, we need to find a new and much more holistic way of talking about it.

### Comparison: a way of re-setting the problem

Comparative approaches have been strikingly absent from discussions about collaboration and community care. But arguably it is only through the process of comparison that it will be possible to discover the new and more holistic perspectives which are needed if we are to make progress in developing a framework for thinking about collaboration.

This is not to say, of course, that there are no difficulties with the comparative approach. For

example, a description of the problem of collaboration drawn from exclusively American material is unlikely to be helpful to colleagues in Denmark because of the enormous gulf separating the 'welfare regimes' of these countries (Jamieson, 1991). Similar points could be made even within an exclusively European context where social policy, *Sozialpolitik* and *politique sociale* all represent very different contexts within which to understand debates about collaboration (Jones, 1985).

But there are continuities as well as discontinuities, and some of these provide the basis for meaningful comparison. Britain is not the only country to be concerned about finding ways of integrating service delivery systems in a 'community context'. Community care in the broadest sense is a world-wide rather than an exclusively British phenomenon. This trend away from the institution and towards the community has been noted by the World Health Organisation and has given rise to a search for new welfare rationales. This search for alternative rationales has been called a 'search for coherence' in the idea of welfare outside the ready-made institutional structures of hospitals or traditional long-term residential accommodation (Jones 1988). It is this trans-national 'search for coherence' that provides the essential framework for a comparative analysis of collaboration, enabling us to talk about differences and similarities in a meaningful way.

### Collaboration and the relationship between social solidarity and institutional welfare

For comparative purposes, collaboration is best thought of, not in terms of health and social care or purchasers and providers or even social workers and service users, but in relation to a 'search for coherence' dominated by the need to find some way of balancing systematic responses to individual human need with the broader goals of strengthening community life.

Paul Spicker has argued that the British tradition of social policy can be differentiated from the continental European tradition in terms of its overriding preoccupation with questions of state responses to individual need and its neglect of those broader questions relating to the role of social policy in promoting social integration. He describes this in terms of an opposition between 'institutional welfare' on the one hand and

'solidarity' on the other (Spicker, 1991, pp. 17-27). Whilst recognising that there is a British tradition of thinking about 'citizenship', 'reciprocity' and 'community' (Spicker, 1991, p. 21), he correctly perceives that these rhetorical formulations have tended to have little impact on service delivery. The difficulties experienced by those seeking to practice 'community social work' in the 1980's within service contexts dominated by 'institutional welfare' is in many ways a case study of the failure of commitments to social integration to make the transition from rhetoric to practice.

But there is a danger of taking this opposition too far. It tends to distort and idealise European systems while overlooking the conflicts and contradictions in the British system.

There is plenty of evidence of a continental tradition of 'institutional welfare' every bit as bureaucratic and reactive as that of Britain. For example, in Germany the sheer inflexibility of the *Sozialdienst* together with the virtual 'cartel' of the large private and voluntary organisations or '*Verein*' creates a provider-led system obliging any older person seeking domiciliary care to first obtain a medical 'passport' if they are to avoid the stigma of means testing (Lorenz, 1994a, pp. 150-160). This produces a "neo-corporatism which in practice negates the pluralism it seems to enshrine" (Lorenz, 1994a, p. 161). Perhaps more significantly the system generates a form of 'social closure' (Giddens, 1993, p. 221) which militates against the principles of inclusiveness inherent in the idea of 'social solidarity.'

Within Britain, it is also clear that there have been times when social integration has been an explicit goal of social policy. Both the Beveridge inspired reforms which ushered in the Welfare State and the 1968 Seebohm Report which led to the establishment of Social Services departments were arguably as strongly influenced by the goal of social integration as they were by concerns with meeting individual need.

Rather, the major difference between the British and many European systems of social welfare is twofold. Firstly, in the UK talk about social integration is usually accompanied by other conflicting messages about 'dependency' so that appeals to community concepts are often associated with alternatives to State Welfare rather than new ways of linking State Welfare to the active building of communities.

Secondly, there is in Britain no profession or institutional structure capable of translating talk about social integration into every-day structures, systems and practices. Although social work intermittently sees itself as oriented to communities as well as individuals, in practical terms its remit is really very narrow. In contrast, in Europe, the social work profession is both more diverse and more inclusive of a wider range of community interventions. In both France and Germany, for example there is a well developed tradition of social pedagogy oriented to the re-education of society as a whole and in particular to the goal of "helping individuals to become truly members of society, to fully realise their social nature" (Lorenz, 1994a, p. 151). Added to this, there is in Germany, in particular, a career path linking social work with individuals and families to positions with broad responsibilities for social planning. In Germany planners are usually social workers.

It is not so much that continental social workers are collaborative whereas British social workers are not, or that continental European welfare systems are more collaborative than British ones. As we shall see, neither of these things is necessarily true. Rather, it is that the availability of a language of social solidarity makes it easier for social workers in Germany, Sweden, France and elsewhere than in Britain to identify problems of collaboration as problems of social integration as well as problems of meeting individual human need.

The British welfare system issues regular appeals to the values of family and community, but in the absence of a clear idea of what this might mean, as well as the means by which it might be delivered, its practices tend to focus on 'institutional welfare'. But this may now have to change in ways which will have major implications for British social work.

Largely because of the policy of community care, British social workers are having to develop a practice whereby they can relate the process of identifying and meeting individual need with the process of promoting social solidarity, where before they had merely to deploy a rhetoric of community whilst acting in accordance with the requirements of 'institutional welfare'. From a comparative perspective, this is the key characteristic of the collaborative challenge in the UK. As a 'collaborative profession', social work will need to do more than simply adopt new institutional welfare systems in the way it has to

date. As it works alongside others to create new patterns of linkage between different individuals, groups and organisations, it must rethink its relationship to those questions of 'social solidarity' and 'social inclusiveness' which it had until recently almost forgotten about it in its pursuit of reactive crisis management.

British social workers also need to bear in mind that, if collaboration is a search for a new kind of community coherence, it cannot be an emotionally neutral, purely cognitive exercise. Collaboration is not just about systems. At its best, the search for new kinds of community rationales and community linkages is also a search for community experiences and inevitably raises questions about the relationship between collaborative practices and the pursuit of the affective goals associated with social integration and social solidarity. Social workers concerned with promoting collaboration will always be working at both an intellectual and an emotional level. This is something else we may have forgotten about in the UK but which a comparative framework brings once more to the fore.

### Collaboration and perceptions of crisis

The relationship between community experiences and collaborative practices draws attention to the way in which collaborative policies or movements are associated with moments when the divergence between rhetorical commitments to social inclusiveness and the recurring tendency towards the institutionalisation of social welfare becomes obvious and unacceptable, and new kinds of community experiences and forms of life are explored. This is true right across Europe. We can see for example that in Germany, dissatisfaction with the established welfare system has given rise to a wide range of 'alternative' social projects often rooted in broad social movements. One feature of these 'self-help' projects has been a wish to transcend the conventional barriers between different sectors and to establish new forms of collaborative social practice.

"...through their co-ordinating function the boundaries between volunteer, self-help groups, neighbourhood initiatives and established charities dissolve" (Lorenz, 1994b, p. 114).

From a British perspective what is striking about these 'alternatives' is the way they serve to re-focus attention on the twin principles of

individualised responses to social need and the idea of social work as a process of social integration which are fundamental to the German welfare system and closely associated with Article 28 of the Basic Law. They do so not by seeking a return to something which has been lost, but rather by re-inventing the idea of welfare so that what had become a non-sense once more became meaningful.

### Common problems

But comparison not only indicates that there might be a trans-national framework for thinking about collaboration, relating to the somewhat abstract ideas associated with meeting needs and establishing more effective forms of social integration. There are also some substantive issues connected with the search for alternative community rationales and experiences which crop up time and time again, albeit in very different contexts.

For example, on the face of it, there is little in common between the collaborative issues raised by the British commissioning and care management system, the German '*Sozialisation*' (Jamieson, 1991) and the French '*circonscription* team' (Henderson and Scott, 1985). But they all raise fundamental questions related to the search for 'community coherence' such as the problem of medical and professional dominance, the problem of standardised solutions to complex human needs, the impact of vested interests on patterns of care and support and the difficulties experienced by individuals and communities in influencing the nature and pattern of service delivery.

This draws attention to a key point about the problem of collaboration. Whereas, in the past, in both in The UK and in continental Europe the question of social integration could be subsumed in the more traditional question of maintaining the social order, the decline of institutional practices and the growing difficulty experienced throughout Europe of making adequate responses to human need through established systems of welfare means that the question of social integration has become linked to the search for alternative, more sensitive and more inclusive ways of meeting need and new systems by which all those involved in this process can relate to one another.

The point of comparison then, is not to reduce a range of very different collaborative problems to

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'search' for a pattern of welfare which will meet individual human need whilst simultaneously strengthening the links between different sections of society and counteracting social marginalisation. It has been further argued that this pattern of welfare should not be something purely abstract and philosophical, but rather something rooted in the way in which people interact with one another in the day-to-day process of delivering community care in a collaborative way.

Is there a distinctive European-wide social work response to problems of collaboration? In so far as these problems are all very different, if this question is taken to mean is there a distinctive set of social work interventions that would be appropriate in all these situations, the simple answer is no. But if the question is reformulated so we focus on ways of thinking about collaboration, then the answer might be yes.

For social workers everywhere, collaboration is the process of opening up and maintaining a new social space within which new welfare rationales can be operationalised. The problems they face in trying to do this, however, will often be very different. In the UK the challenge is focused on ways of combating social marginalisation and fostering the values of cooperation in a context dominated by institutional and market forces.

This suggests that in the UK, at least, what we might be looking for is a way of thinking about collaboration as a process of building networks of support capable of delivering 'community coherence' by helping to both meet individual human need and create more inclusive forms of linkage between service users, carers, professionals and others (Beresford & Trevillion, 1995). It may also be more important that these networks make sense and feel right to service users than that they feel comfortable to professionals or are compatible with traditional concepts of role and task or are easy to manage. By focusing attention on the importance of the community dimension, comparative perspectives on collaboration make it much more likely that this will happen.

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# Talking About Collaboration

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*Abstract: The identification of a dominant narrative associated with collaboration in community care is followed by an analysis of this as a 'language game'. This kind of 'talk' is then contrasted with that associated with an alternative language game focused on interactional and experiential issues. A research project using this approach is described and certain characteristic features of the new style of working emerging in at least some community care teams are revealed. Attention is drawn to the dissonance that is being generated between collaborative rhetoric and team practices.*

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## Introduction

In recent years, there has been a remarkable convergence of opinion in relation to community care. Whatever their disagreements on other aspects of the policy, almost everyone involved now seems to agree that collaboration is critical to its success. But for some at least there is often a wide gap between collaborative rhetoric and experience. For example, it has been pointed out that "exhortations to organisations, professionals and other producer interests to work together more closely and effectively litter the policy landscape" and yet despite this the reality is "all too often a jumble of services fractionalised by professional, cultural and organisational boundaries and tiers of governance" (Webb 1991: 229).

One way of understanding this 'gap' is in terms of language. In what follows, collaborative talk is analysed as a certain kind of 'language game' (Wittgenstein, 1975) with its own rules and characteristics. This is contrasted with the picture that emerges from an exploration of a different 'language game' focusing on how individuals and groups interact on a day-to-day basis in the field of community care.

## Standard Collaborative Talk

Our Standard Collaborative Talk (SCT) embodies some of the most powerful themes of Western European culture, such as rationality, order and

progress, with which it appears difficult to argue. I would suggest that the way we talk about collaboration is governed by a 'narrative' (Lyotard, 1985) which goes something like this...

Collaboration is inevitable although difficult to achieve. It represents progress and the triumph of science. In particular as the nature of welfare itself changes, particularly in the context of primary and community care, inter-agency and inter-professional contact and communication will increase. This will lead inexorably to the breakdown of traditional notions of team and the development of new forms of multi-disciplinary teamwork and new forms of professional identity.

It is generally to be expected that, as contact between agencies increases, liaison across agency and disciplinary boundaries will also occupy an increasingly important role among professionals. At an individual level increased personal contact will encourage liaison initiatives to develop. Higher levels of liaison will encourage more and closer partnerships to be developed. One of the driving forces in this process will be the requirement to provide needs-led services. This will mean that services will become increasingly and seamlessly integrated. To facilitate this process of organisational and service integration, new mediating or brokering roles will develop. Individuals will act on behalf of their team/agency colleagues to help organisations draw closer to one another and work more effectively to provide integrated services. There will be a general move

away from short-term problem solving towards long-term strategic work.

SCT is, more than anything else, talk about multi-agency 'teamwork'. Within the context of this kind of talk, the multi-disciplinary or multi-agency 'team' occupies a special and privileged position as the site where the collaborative narrative finds form in practice. Therefore the multi-agency team is the obvious place in which to subject SCT to critical analysis.

According to SCT, multi-agency teamwork is supposed to evolve through evolutionary stages. Communication leads to cooperation, cooperation leads to coordination, coordination leads to federation and finally the process of team building leads to total merger (see for example Payne, 1986). But does this whole way of talking about collaboration and teamwork bear any relationship to the experiences of those involved?

## Researching Collaboration

The power of the collaborative narrative and the ease with which it is possible to slip into SCT creates an immediate barrier to any alternative description of inter-agency interactions. In order to overcome this barrier we need first to invent a new 'language game'. This is what we tried to do in a recent study.

Between November 1993 and January 1995 we looked at two social work teams in an inner London borough, one specialising in mental health work, and the other in HIV. Using a new kind of artificial language game, Specific Interactional Talk (SIT) we tried to compare what we found there with what we have come to associate with SCT.

## Specific Interactional Talk

In contrast to the rhetorical nature of SCT, Specific Interactional Talk (SIT) focuses on patterns of interactions. In our research we made use of numbers, visual images and other devices which enhanced the specificity and 'concreteness' of our talk.

The SIT method made use of network

analysis. However, rather than trying to map actual social interactions, in the hope of discovering some objective truth not tied to the subjectivities of participants, we set out to enable these subjects to map their own experiences over an eight week period. SIT was simply the conversations we had with them about the results of this mapping process. SIT was a process of talking about and representing interactional experiences, talking about these representations with research participants and using these conversations to discuss issues such as role and team identification.

Eventually, we were able to configure the inter-agency contacts of every member of each team. In doing so, subjective quantitative data, for example about perceptions of frequency of inter-professional contacts were linked with subjective qualitative material, for instance, about attitudes and concepts of role associated with these contacts.

SIT was at the heart of the project, but was supplemented by observations of intra-team interaction and interviews conducted with team leaders. Interactional approaches are, at root, ways of making sense of the texture of professional lifestyles. We felt that they were, therefore, one way of enabling those with whom we were working, to represent their day-to-day experience of collaboration without needing to use the language of SCT. The SIT method was also a process of building an alternative language.

Each individual participant was interviewed and all claimed interactions other than those with clients were recorded on a 'network wheel'. This consisted of three concentric circles with each sector representing a particular frequency of contact:

- the outer circle represented low frequency contact, i.e. one contact over the eight week time period. This approximates to contact that is less frequent than once a month;
- the middle circle represented medium frequency contact, i.e. 2-7 contacts over the time period which approximates to contact that is at least monthly but is less than weekly;

- the centre circle represented high frequency contact, i.e. at least 8 contacts during the same time period. That approximates to contact that is at least on a frequency of once per week.

During these interviews workers were asked structured open-ended questions, around a number of indices for each contact. They were asked to describe the ways in which contacts were utilised in a professional capacity; how long they had been established and who initiated them. Workers were also asked to describe the type and quality of relationship they had with each contact, to identify those which had been interacted with on a face-to-face basis, and then to identify other ways in which contact had been made.

Once interaction patterns were plotted on the network wheel, it was possible to explore associations between these patterns and questions of role. These issues were discussed with each worker in turn. Participants were asked to identify the team(s) of which they felt themselves to be members. Multiple and overlapping team identifications were represented as Venn Diagrams. In this way we developed with the participants our own kind of 'language game'.

### **The New Working Style**

SIT provides evidence of change in the area of what could be called working style, but not the kind of change assumed by SCT. There was a perception of a significant level of inter-agency and inter-disciplinary working in both teams suggested a movement away from traditional team structures. But in striking contrast to the language of SCT there was little reference in any of our SIT discussions to anything which would support the idea that 'new style' collaborative teams (Webb, 1975), new forms of multi-disciplinary working (Ovretveit, 1993) or new forms of professional identity, were emerging in association with this high level of inter-agency and interprofessional work. Rather, the dominant working style was characterised by a number of features not normally mentioned in SCT.

### **Multi-Disciplinary Contexts Rather Than Multi-Disciplinary Roles**

There was little agreement about the kind of roles associated with multi-disciplinary work. HIV team members tended to describe the need to work with others at various stages of the intervention cycle and therefore classified multi-disciplinary roles as working with others around referral, assessment, review, etc. MH Team members, on the other hand, saw multi-disciplinary roles as emerging not in terms of the intervention process but in terms of the various aspects of their specialist role, for example, 'ASW within hospital', 'working as part of ward team', etc. This suggests that multi-disciplinary work is not as integrated or cohesive as it appears within SCT.

What was also clear was that interprofessional and inter-agency working did not produce new roles. Rather, there were inter-agency or interprofessional contexts in which traditional roles were deployed. Seeing oneself as part of an interprofessional team did not necessarily lead to the formation of a new professional identity or sense of role.

### **Networks Rather than Teamwork**

SIT indicated not only a lack of consensus about team-working across agency boundaries, but also of fragmentation in relation to all aspects of team working - a fragmentation in which the theme of instrumentality appeared to play a major part. In SCT there is a tendency to assume that when individuals develop links with members of other teams the teams themselves draw more closely together and improve their relationships. In many ways the actions of individuals are seen as part of the 'evolutionary' process by which collaborative arrangements are developed at a team level. But in the context of SIT, we found no evidence of any link between personal networks and team networks, nor between multiple team identifications and improved inter-agency or inter-team working. Individuals identified with up to four separate teams simultaneously. This seems to indicate a move away from traditional team-working but it does not imply a move towards the kind of federated structures described by Payne and others.



Rather than an expansion of the concept of team so that it becomes more inclusive, we seem to be seeing what amounts to a disintegration of the whole team concept. This becomes clear when we look at the way affiliations are described within SIT. There are strong indications that the team concept no longer brings together the instrumental and expressive elements which have traditionally been its strength.

With the Mental Health workers two forms of identification exist - with the MH social work team and with the individual's consultant-centred multi-disciplinary mental health team. Identification with the former was always significantly associated with instrumentality ( $\chi^2 = 15.66, p < 0.001$  where  $DF=1$ ). In other words membership of the social work team was seen mainly as a way of getting certain kinds of tasks accomplished. It was not seen as a source of support or a focus of shared loyalty.

The position was rather different with the HIV team members where the professionals tended to identify with a core group of people in the social work team. This was not, however, associated with any need to get things done ( $\chi^2 = 0.49$  where  $DF=1$ ). On the contrary, members looked elsewhere to get things done and saw their core team mainly as a source of support. In this respect core identification was significantly different from what we could call peripheral team identification, that is, identification with personnel from other agencies. Peripheral identification was significantly based around instrumental relationships ( $\chi^2 = 8.04, p < 0.01$  where  $DF=1$ ) and especially around 'instrumental partnerships' ( $\chi^2 = 4.32, p < 0.05$ , where  $DF=1$ ).

In both cases the link between accomplishing tasks and mutual support/loyalty appeared to have broken down. It is difficult to see how in this context a proliferation of team identities is conducive to collaboration. Rather, it seems to be more a way of describing a tendency towards role fragmentation. Multiple identifications suggest not the postulated move towards integrated partnership systems of collaboration but rather a fragmented and individualised sense of professional identity.

## The Marginality of Liaison and the Instrumentality of Partnership

While 'liaison' and 'partnership' can be distinguished from 'teamwork', they are often linked together in SCT. Thus, for example 'liaison' is seen as the initial stage of 'team building' and 'partnership' is seen as helping to create links between teams, outside individuals and agencies, to encourage a more inclusive concept of 'collaboration' linking teams into broader 'community networks'. Overall, the narrative conveyed by SCT is one in which, as inter-agency interaction increases, so too does the incidence of 'liaison' and 'partnership' as well as 'teamwork'. In contrast, the social workers in both the Mental Health team and the HIV team produced an account through SIT which was almost the reverse.

People who had the highest number of different contacts with individuals and groups in other agencies, not surprisingly tended to have higher absolute numbers of liaison links than others ( $r = 0.73, p < 0.05$  where  $N=11$ ). There was also, however, a highly significant correlation between high numbers of different contacts and the use of these contacts to achieve short term instrumental goals ( $r = 0.87, p < 0.01$  where  $N = 11$ ). It seemed that the greater the number of different contacts made by professionals within the teams, the smaller the proportion of these which were actually associated with liaison activities. One might think that those with the highest level of interaction with other agencies and professions would be those most likely to invest in liaison work of some kind. In fact the opposite was true. There was an inverse relationship between the proportion of total workload devoted to liaison and the level of inter-agency work.

This cannot be accounted for simply in terms of different definitions of 'liaison'. Whilst some variation was inevitable, all participants distinguished between short-term client and task related interaction, and longer-term relationship oriented interaction, with only the latter being identified as liaison. We are therefore forced to conclude that there seems to be no reason to assume that contact with other agencies - even high levels of contact with other agencies - will

necessarily create the kind of context in which 'liaison' will develop. As 'liaison' is often seen as the first stage of multi-agency team building, this has considerable implications for many of our ideas about collaborative teamwork.

This was not the only surprising finding in relation to liaison. SCT tends to blur the distinction between 'liaison' and 'partnership', so that they become almost synonymous. But within the context of SIT it emerged that 'liaison' and 'partnership' are conceived of in different ways by professionals and that their relationship is complex. For our research participants, rather than being related to 'liaison', 'partnership', at least in practice, is seen as a property of instrumental interactions ( $\chi^2 = 36.72$ ,  $p < 0.001$  where  $DF=1$ ), with contacts associated with higher frequencies of interaction ( $\chi^2 = 36.96$ ,  $p < 0.001$  where  $DF=2$ ), which are relatively enduring ( $\chi^2 = 63.80$ ,  $p < 0.001$  where  $DF=2$ ). The term 'partnership' was therefore used to describe relationships associated with professional problem-solving, where the recurrence of the problem(s) rather than the quality of the relationship was the defining characteristic. Unlike 'liaison', 'partnership' had an exclusively interpersonal rather than an inter-agency frame of reference.

Through SIT, 'partners' emerge simply as individuals with whom one often does business. Although 'partnerships' for all their limitations were an important element of the dominant working style, the same was not true of 'liaison'. Liaison was associated with both lower frequency interactions ( $\chi^2 = 46.72$ ,  $p < 0.001$  where  $DF=2$ ), and with contacts of a shorter duration ( $\chi^2 = 59.32$ ,  $p < 0.001$  where  $DF=2$ ). Far from occupying a key role in the multi-agency situations we explored, 'liaison' emerges as marginal compared to other professional roles. It accounts for only 14.3% of contacts - a figure consistent across both teams. In terms of time spent, the figure would be so small as to be almost insignificant.

Liaison appeared to create proportionately fewer partnerships than other types of interaction. For example, in the HIV team 37.7% of all contacts were judged by the professionals to be

partnerships as opposed to only 25.4% of liaison contacts. Similarly, in the Mental Health team 62.4% of contacts were judged to be partnerships whilst only 55.4% of liaison contacts were so judged. Overall, liaison was not associated with contacts judged to be partnerships ( $\chi^2 = 3.53$  where  $DF=1$ ).

## What Does SIT Tell Us about Collaboration?

It is impossible to say how typical these teams are in the pattern of their inter-agency activity. What we can say is that a picture emerges of multiple professional identities and team affiliations. However, there is little or no emotional investment in these multiple identities, an overwhelmingly short-term, instrumental approach to 'collaborative' relationships, a radical individualisation of work, and negligible evidence of any link between individual networks and relationships between teams.

SCT stresses progressive integration and rationalisation of services and systems. SIT reveals a progressive disintegration and the disappearance of those over-arching rationales by which individuals might make sense of their work. Moreover, it suggests that in multi-professional and multi-agency situations, individuals may be experiencing a radical dissonance between their beliefs about what should be happening (in terms of received ideas) and their day to day reality - a dissonance which SIT helps to articulate.

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# The Globalisation of European Social Work

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## Introduction

Throughout the post-war period, European social work has been strongly influenced by 'global' processes, but as the nature of these processes has changed, so too has their impact on European social work and European social workers. Broadly speaking, it was as a result of a *globalisation of the first-wave* that European social work developed many of its traditions. Now, a subsequent *globalisation of the second-wave* associated with post-modernist welfare philosophies and post-Fordist patterns of welfare provision is having a fundamental impact on the very nature of European social work. In this article, it will be suggested that globalisation is not only reducing the resources available for social work and reshaping social work organisations (Dominelli & Hoogvelt, 1996), but that it is also creating new patterns of work and accountability and profoundly reshaping the fundamental values and philosophies upon which modern European social work has been built.

## Definitions

This article is not primarily concerned with the theory of globalisation. But anyone making use of a term as nebulous as 'globalisation' has a responsibility to define it clearly.

The seminal work on this subject is probably by Wallerstein, who argued that the expansion of the capitalist world economy has given rise to a single "world system" (Wallerstein, 1974). In recent years it has become common to discuss the properties of this world system in terms of the process of globalisation. Moreover, even those who might not want to go so far as to agree with Wallerstein (that there is a single world system or that we are in a position to say something meaningful about it) have used the concept of globalisation to refer to powerful transnational processes of one kind or another. While particular concepts of globalisation continue to be the subject of heated debate (e.g. Hirst & Ormerod, 1996), it does at least seem reasonable to use the term to refer to the increasingly and incontestably

interconnected nature of the modern world. One of the most succinct definitions based on the notion of interconnectedness comes from Robertson:

"Globalisation as a concept refers both to the compression of the world and the intensification of consciousness of the world."

(Robertson, 1992, p.8)

'Globalisation' is therefore here taken to embrace *both* the objective social, economic and technological changes associated with the dismantling of national and regional barriers to trade and communication *and* the subjective shifts in consciousness associated with the growth of global concerns and global sensibilities. For social workers, it seems particularly important to note this mixed subjective/objective set of characteristics, because 'globalisation' will have significance for them to the extent that it directly impacts upon the way in which their practice is organised, understood and actively experienced on a day-to-day basis.

## Globalisation - the first wave

Social work is a genuinely transnational phenomenon because it emerged out of the movement of ideas and individuals across national frontiers. Although this movement of individuals and ideas across national frontiers can be traced back to the founding of the International Committee for Schools of Social Work in 1928 (Lorenz, 1994), it became even more marked in the period following the traumatic upheavals of the Second World War. It is widely recognised that all forms of social work in Europe have been influenced by the transatlantic passage of Austrian psychoanalysis which eventually led to the transformation of one of its branches into social casework. But the historical context of this movement, backwards and forwards between Europe and America, has received much less recognition.

All over Europe, the history of post-war social work can be traced back to the years between 1945 and 1950 when it is possible to argue that much of

Europe was influenced by a shared philosophy of the social responsibilities of the democratic state owing much to American and to a lesser extent British models. The revival of German social work after the war was closely linked to the establishment of a new Basic Law in 1949, enshrining both democracy and social responsibility. The establishment of the welfare state in the UK in 1946 created a new framework for the personal social services, in which social rights were linked to democratic ideals. In turn the British welfare state model exercised a profound influence on the development of its Norwegian counterpart in the 1940s (Forsund, 1989) where the growth of social work was very closely linked to the post-war period of national reconstruction (Tutvedt, 1991). Many professional associations can also be traced back to this period. Everywhere, democratic principles were linked to the development of social work ideals and it was perhaps not only in Germany that one could argue that social workers were engaged in the process of "rebuilding civil society" (Lorenz, 1994. p.76).

It is possible to trace much of what has helped to generate a shared professional identity for European social workers to this period of post-war globalisation. Certainly, the emergence of a strong sense of optimism about the potential contribution of social work to the building of a better world - so evident in the British context even as late as the 1960s and early 1970s (e.g. Seebom, 1968) - appears to be linked to this pan-European process of post-war reconstruction. More specifically, post-war globalisation made it possible for new ideas about methods of working to flow relatively easily across national frontiers even if they were taken up in a number of different ways in different countries. International conferences facilitated this process and many of those who wrote about particular social work methods, rightly or wrongly, imagined that they were writing for an international audience. To give just one example of this, in the Foreword to a best-selling British book on family therapy, the authors state:

"We believe that our approach is readily applicable to work with families in other countries." (Masson & O'Byrne, 1984)

Then, as now, the globalisation process involved a double movement - both a movement between European nations but also a movement across the Atlantic from the United States to Europe as a whole. For European social workers there is a strong sense in which the process of post-war

globalisation could be described as a process of 'Americanisation', in that the three core social work methods - casework, community work and group work - were largely imported from the United States; although it needs to be acknowledged that the development of these methods owed much to the work of eminent German Jewish social workers forced to leave Europe for the United States in the 1930s (Lorenz, 1994). The new European social work movement began to grow around this American core. There are many differences between national social work cultures within Europe, e.g. the existence of a distinctive social pedagogue tradition in much of continental Europe which has no parallel in the UK. However, social workers from all parts of Europe have no difficulty in recognising their links with one another. This shared sense of identity is arguably as much a product of the 'Americanisation' of Europe in the post-war period as it is of any specifically European initiative.

This spread of ideas still continues. As numerous letters and articles in *Social Work in Europe* show (e.g. Jack, 1996), social work is even now a relatively youthful creature in many parts of central and eastern Europe. Moreover, it is one which appears to be spreading along with other aspects of western European/American culture from pop music to the market economy.

The globalisation of the first wave was strongly rooted in a modernist epistemology involving a belief in progress, science, the possibility of individual freedom, the existence of rights and entitlements and - within the European context especially - a broader commitment to notions of social justice, social integration and the social dimension of citizenship which can be traced back to the French Revolution (Spicker, 1991). It was this modernist link to 'fundamental' or 'universal' principles, both in terms of individual psychology and the nature of the relationship between the individual and society (Bowers, 1950), which gave the modern social work movement much of its apparent power and attractiveness to individuals and groups brought up in the context of often highly insular and specific traditions of social welfare, e.g. Bismarckian corporatism, Swedish collectivism and the curious British mix of charity and welfare statism.

Modernist principles formed the core around which the dominant schools of European social

work developed in the post-war period. A relatively small canon of works (Freudian, Kleinian, Rogerian or Marxist) were seen as holding the answer to a wide range of personal and social problems provided that the appropriate theories were applied correctly by appropriately trained experts. By identifying social work practice with an exclusive body of knowledge and skill, social work was defined as a profession and, even now, its claims to professional status continue to be linked to these modernist/scientific claims to expertise.

Post-war globalisation also ensured that social work became increasingly embedded within what are sometimes called 'Fordist' organisations. There was in this period (approximately 1945-1980) a general European-wide trend towards locating social work in large-scale bureaucratic organisations, a trend justified by references to 'modernisation' as in the Seebohm reforms of the early 1970s that created the new monolithic Social Services Departments so closely identified, ever since, with British social work. While the nature of these large bureaucratic organisations and the role of social workers within them varied widely from country to country, developments in countries such as Germany, Ireland and Scandinavia suggest that it would be reasonable to describe the globalisation of the first wave as closely associated with the bureaucratisation of European social work (Cannan, Berry & Lyons, 1992). Social work organisations, and the systems of welfare associated with them, came in this way to resemble Fordist organisations of the kind described by Giddens (1993).

Social work has often seen itself as in conflict with its own 'welfare bureaucracy' (Leonard, 1975), but, in truth, the relationship has been an essentially complementary one in which social workers by the use of their 'discretionary' powers enable those bureaucratic systems to be flexible enough to meet individual need (Campbell, 1978). This is not something unique to the British experience. It is a striking feature, for example, of the way in which Swedish social workers describe their role, as well (Trevillion & Green, 1996).

The twin principles of modernity and Fordism formed the context in which social work developed and flourished in the countries of the European Union in the period following the Second World War, during what I have called the globalisation of the first wave.

## Globalisation - the second wave

Whereas the globalisation of the first wave was associated with an increase in free trade, this was limited by the continuing role of the nation state and the broadly Keynesian belief that governments could and should intervene in the workings of the market. Social work grew up after the Second World War as an intrinsic part of this Keynesian interventionism which in continental Europe meshed neatly with the collectivist traditions of Scandinavia, the *étatist* traditions of France and the corporatist traditions of Germany.

The globalisation of the second wave is very different. Far from constraining markets within frameworks of social responsibility, it is associated with the emergence of international market forces so powerful that few national governments can resist them. Globalisation now refers to the process by which more and more of what goes on in individual countries is shaped by global flows of money and, in particular, investment. This process is not linked to any specific institutions nor to any specific set of social and political principles other than those associated with the market itself. It appears to have little connection with any traditional political morality, let alone concepts of democracy or social responsibility. If anything, it is antagonistic to social responsibility because this always leads to increased social costs. It seeks out low tax, low cost areas of production and is indifferent to universalist concepts of human rights associated with the globalisation of the first wave.

If the epistemology of the first wave of globalisation was modernist that of the second wave appears to be profoundly post-modern. Left to itself, it subverts all absolute values and puts in their place a distinctive landscape of desire - a 'consumer society' which has been defined by Baudrillard as a

"new and specific mode of socialisation related to the rise of new productive forces and the monopolistic restructuration of a high output economic system." (Baudrillard, 1988. p.49)

## Cutting back on social welfare in Europe

We are all familiar with the effects of global 'restructuration' on the European monetary system and European economic policy, but it is also having a profound effect on social policy.

Throughout Europe, welfare spending is being targeted and policies which seek to constrain market forces in the name of social responsibility are under attack, in the name of the consumer, not least by the government of the United Kingdom.

Even if 'cost cutting' were the only effect of globalisation on social work in Europe, its effects would still be very profound. 'Cost-cutting' produces a search for cheaper alternatives to expensive social work, encourages self-help rather than state help and creates more stress for social workers as they seek to meet individual need with fewer and fewer resources at their disposal.

France is currently racked with industrial disputes which have a number of causes but one precipitating factor is the government's intention to reduce the growth in public expenditure and to open up the welfare system to market forces. The political commitment to 'convergence' on the conditions laid down in the Maastricht treaty for monetary union is fuelling this political project but it also expresses a wish on the part of the political elite in France to restructure French society and economy so as to achieve a more 'global' kind of competitiveness.

It is impossible to say how this will impact on French social work but it seems unlikely that there will be no impact. If it is fundamental features of the 'global market' environment which have been driving changes in the UK, then 'deregulation' in France may set in motion a comparable set of trends.

In Germany, such trends have already begun to influence certain kinds of services, especially those for older people where there has been an increasing 'market orientation' in recent years (Lorenz, 1994).

In Sweden, the so-called 'Swedish model' has been in a state of crisis for some years as it becomes increasingly evident that the 'cradle to the grave' philosophy of state welfare is no longer able to meet need as comprehensively as envisaged in the 1982 Social Services Law (SOL). What Olsson describes as the dominant *étatist* model (Olsson, 1987) is now under severe strain and it is in the sphere of personal social services where these cracks are showing - most for reasons which will be familiar to British social workers. There has been a process of 'cost shunting' from health to social care with responsibility for those

recently discharged from hospital moving to the local *Kommun* which has been forced against all its traditions to look towards the informal caring sector and the private sector for solutions (Gould, 1993).

More generally, we know that throughout Europe (in Holland, Italy, Spain and elsewhere, as well as in the countries we have already mentioned) there is an intense preoccupation with the perception that the costs of welfare can no longer be sustained without explicit prioritisation or rationing. This is producing a new emphasis on what in the UK would be called 'value for money' right across Europe and regardless of the 'welfare regimes' dominant in particular countries as epitomised in the recent international conference *Hard Choices in Health Care* (Trevillion, 1996a).

The recent discovery that pension costs throughout the European Union are unsustainable and may be incompatible with monetary union only adds fuel to the fire.

These changes are pervasive and not dependent on specific ideologies or even welfare regimes. Almost everywhere social workers are concerned about the effects of diminished resources. This includes social workers from countries who have actively embraced free market philosophy and those where there continues to be a deep attachment to corporatism or collectivism. For example, social workers in Sweden (the home of collectivism) and in London (the capital of deregulation and privatisation) appear to have very similar concerns in this regard (Trevillion & Green, 1996).

### New organisational forms

However, the impact of globalisation goes far beyond simple cost-cutting. The Nation State - so central to the post-war project of social reconstruction - is itself changing. Under the impact of global forces there is a process of

"hollowing out of the State associated with the shift from Keynesian *government* to post-Fordist *governance* associated with a movement towards a complex 'partnership' between official, para-statal, and non-governmental organisations in the management of economic and social relations. "

(Jessop, 1996.p.176)

More specifically, as the nature of the State changes so do its tasks and this is beginning to

have a major influence on the shape and the culture of State social welfare organisations throughout Europe.

Paradoxically, globalisation seems to make organisations smaller rather than larger (Naisbitt, 1994). The telecommunications revolution and the spread of capitalist markets together with the international division of labour combine to create a 'global village' in which small, flexible and responsive organisations appear to have a distinct competitive advantage over large bureaucratic corporations. Moreover, it is also argued that the internal structure of organisations will change, moving from full-time to part-time employment linked to a tendency to contract in work wherever possible and the development of an organisation consisting of a small core of full-time workers and a large periphery of contracted-in and part-time staff (Handy, 1990). This is usually given a positive connotation, linked to arguments for 'telework', flexibility, portfolio employment, etc. and used to argue that globalisation is an empowering process through which individuals will find fulfilment and personal freedom. It is even claimed that through these kinds of processes men and women will become more equal!

### Changes in the organisation of social work

The impact of globalisation on organisations may not always be benign and in relation to social work organisations there is increasing evidence that such changes, especially perhaps if they are implemented too quickly, can lead to disorientation, alienation and loss of professional identity. We need to recognise that, within the UK public sector, globalisation is coming to mean the literal disappearance, not only of large organisations, but also the disappearance with them of job security, predictability and long-term strategic planning, together with the marginalisation of equal opportunities.

In Britain, the progressive deregulation of the welfare environment has opened up new forms of contractual relationship and new patterns of linkage between traditionally separate sectors of welfare - voluntary, statutory and private. Organisations have got smaller and whereas the links between the component parts of organisations have become looser, so the possibilities for linkages across sectorial and organisational boundaries have increased. As part and parcel of the shift from Fordist government to

post-Fordist governance, welfare has itself become a product which is produced through the operation and interplay of complex and inter-locking 'partnerships' or networks. It has become more individualised and less predictable and, in so far as social workers are reconstituting their practice along the lines of these networks, it seems likely that social work too will become a more networked and open-ended process. This can produce new opportunities but also new dangers.

While compression and fragmentation create new opportunities for partnership and collaboration and can generate higher levels of creativity, there is a danger of producing almost the opposite effect as well. Relationships may cease to be valued because they become market commodities along with the services themselves; the emphasis may shift towards short-term advantage rather than long-term mutual gain producing a situation from which nobody benefits in the long run. One way of putting this is to say that compression and fragmentation create opportunities for both 'win-win' games and 'lose-lose' games. While it is probably not possible to predict which kind of game will become dominant in a particular welfare culture, it does seem likely that the shift from institutional to networked modes of welfare will produce a concomitant shift in the way in which social workers define and manage their tasks and relationships. This, in turn, may have important implications for the identity of social work itself (Trevillion, 1996b).

### Governance in action: network practices in London and Stockholm

It would be a mistake to see the impact of globalisation as confined only to countries governed by parties committed to explicitly liberal and free market policies. Even without any apparent ideological thrust towards deregulation, organisations are changing in response to the problem of scarcity; the degree of convergence around the new organisational values of 'intelligence, information and ideas' is striking. For example, whereas much of the literature on Swedish social policy emphasises the small role played by voluntary or 'third sector' organisations, on a recent research visit to Stockholm I was struck by the way in which such organisations now seemed to have moved centre stage, at least in some areas of work. For example, a team of *kurators* (medical social workers) based in a north Stockholm hospital spoke to us of the very active



role played by an organisation called *Noah's Ark* which seemed to act as an umbrella group for the voluntary or third sector. Later on we had a chance to meet a representative of this organisation, who confirmed the importance of the link with the *kurators*. Moreover, it became clear to us that this was only one of many links between the *kurators* and a range of other agencies.

Meeting with the *kurators* and the members of this network showed how far working practices, in at least one Swedish team, had moved away from classic collectivism or indeed conventional teamwork, towards more open-ended ways of working with broadly based welfare networks. While some of this was clearly linked to notions of 'good practice', resource constraints and the need to explore cheaper alternatives to state services were also playing a part, alongside a change in the structure of the organisation associated with a move away from standardised bureaucratic structures. In this respect, Swedish workers appeared to be as much influenced by the new global organisational values as those in London.

The effects of all this on social work practice are however, very complex. In London the effect of the shift seems to be that social workers have become more individualised, more entrepreneurial and more instrumental as well as more networked in their practice (Trevillion, 1996b). In Sweden, the effect may be to create a new notion of the 'co-operative social worker' looking to explore ways of overcoming bureaucratic boundaries in order to meet individual need and investing strongly in cross-sectorial relationships (Trevillion & Green, 1996).

However different they might be, the tendency towards an increasingly networked model of service delivery was evident in both Stockholm and London. But with the rise of the virtual organisation comes the question of accountability. Social workers operating in networks or virtual organisations are not easy to manage in conventional ways. They become 'self managers' or they look to processes of interactive learning as substitutes for management. Where the network generates effective mutual support, as in Sweden, this kind of autonomy may be experienced positively and valued for its own sake, but where the network is highly instrumental and not especially supportive, as in London, then autonomy may come to seem more like being lonely or neglected (Trevillion 1996b).

## Globalisation and the European Union

The creation of a single European market open to the global marketplace has created a pressure in many member states for a coordinated move towards a 'Social Europe'. It is inevitable that in so far as there is a pressure towards agreement on a European framework of law and policy it will be oriented towards addressing the consequences of the single market. In other words, within Europe, there is an additional factor pushing towards a Europe-wide globalisation of social work and that is the drive towards economic and monetary convergence within the European Union. It is commonly assumed that this will take the form of seeking to counterbalance the market with a new range of social rights which are legally enforceable because

"the dynamics of creating a single market have made it increasingly difficult to exclude social issues from the EU agenda."

(Leibfried & Pierson, 1995. p.44)

However, this is by no means certain.

The Maastricht convergence criteria are in many ways starkly opposed to the principles of the Social Protocol and there are as many pressures leading towards a deregulatory social policy as a regulatory social policy in the future. Some, for example, are arguing for what has been described as 'neo-voluntarism' which if it was adopted by the European Union would mark a major break with its corporatist traditions (Streeck, 1995). All one can say with any certainty is that the search for common solutions to common problems will intensify.

In so far as the European Union mediates between member countries and the restructuring of world markets it could be seen as, in part, an agent of globalisation even without any shift towards 'neo-voluntarism'.

One noticeable feature of recent developments is that the European economy is now based on continuing high levels of unemployment. This is a direct consequence of globalisation and by itself creates a number of common issues for social workers to deal with throughout the European Union.

One other very important issue closely linked to global processes but defined by the European

Union is the growth of a 'Fortress Europe' mentality whereby the Union increasingly functions as a collective defence against what is seen as the 'threat' of asylum seekers, refugees and others seeking to gain entry to it. The rise of global economics and global politics has seen more and more of humanity on the move. Impoverished and oppressed as a direct result of globalisation, some from Eastern Europe, Asia, Africa and elsewhere inevitably turn towards the European Union.

Throughout Europe, social workers are becoming increasingly preoccupied by issues raised by these processes and in many ways it could be said that the need to develop an effective practice response is actively reshaping European social work from Hammersmith to Stockholm and Paris.

Social work was born at a time when racism, unemployment and poverty were thought to have been banished forever. It now has to re-invent itself in a world where these things not only happen but are becoming increasingly commonplace. These developments are taking place at a Europe-wide level and are closely linked to the direction taken by the European Union.

### Global values and philosophies

One might argue that even if contemporary social work operates in a global/market environment, its culture continues to be informed by other non-market values and goals and this is likely to reduce the impact of global forces. But this ignores the fact that what are seen as enduring or fundamental social work values are themselves a product of globalisation, albeit the very different globalisation of the post-war period. We know that social work is open to global shifts and movements in its philosophy/ideology. If we see this in terms of a global communication network disseminating new ideas to which national and regional systems of welfare are receptive, one interesting fact to note is that there has been a subtle shift in the nature of the messages about social work travelling along or through the global network. Over the past twenty years we have seen a reduction in global 'messages' emphasising quasi-clinical/medical expertise and a philosophy of social engineering of a kind compatible with Fordist/modernist welfare structures and programmes, and an increase in global messages emphasising 'involvement', 'empowerment' and 'choice'.

The paradox here is that as professional ideas originating in one place become more and more accessible to social workers in other parts of the world, it becomes less and less likely that these will be universalist in the sense that modernist welfare ideals are universal. The new ideas currently circulating around the globe encourage social workers to listen to others, be flexible, respect differences and be modest about their own role and knowledge. This not only has the potential to generate a new kind of social work 'culture' (Beresford & Trevillion, 1995); it may also increasingly relativise the theoretical base of social work and in the absence of specific claims to expertise, it may not be possible to sustain orthodox notions of professionalism.

In support of this, we know that in the UK at least there has been both a proliferation and diversification of social work theories and on the part of many qualified social workers a general drift towards pragmatism and away from theory altogether. One recent study suggested that as many as eighty different theories were being taught on professional courses in the UK while at the same time suggesting that many social workers were 'out of touch' with theories of any kind (Marsh & Triseliotis, 1996).

In so far as social work identity in the post-war years was linked to a notion of 'expertise' and this in turn was linked to a belief in an ordered system of professional knowledge, it seems likely that the new post-modern and post-Fordist social work is much less securely anchored in a specific epistemology than was the case with its predecessor.

### Conclusion: social work in transition

Social work is a product of globalisation. But if the globalisation of the first wave established what have come to be seen as its 'traditions', the globalisation of the second wave has challenged these traditions and created new uncertainties as well as new opportunities and challenges.

At the moment, social work in Europe appears to be going through a process of transition as it moves from Fordist certainties to post-Fordist ambiguities. We can see this in the way in which certain kinds of transitional discourses have become dominant. For example, transitional between the old globalism of social engineering and the new globalism of networks and markets is

the discourse of decarceration and community care. Decarceration and community care can be seen as harking back, on the one hand, to notions of social engineering through its association with the goal of improving society, eradicating prejudice, etc. and looking forward, on the other, to a new more open-ended welfare system in which individuals negotiate their own needs and services and in which patterns of welfare are increasingly individualised.

The UK, North America, Sweden, Germany and many other countries have been strongly influenced by the transitional discourse of normalisation, decarceration and community care (Trevillion, 1996c). While this transitional discourse can be accommodated to the ideals of social citizenship characteristic of the post-war phase of globalisation, it remains to be seen how easily a profession so strongly rooted in modernism and Fordism will respond to the new discourses of welfare which are likely to emerge during the next few years.

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## New Concepts of Intervention in the French Judicial Field

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### Abstract

*New methods of psychological intervention have recently emerged in the French legal field, especially concerning mediation proceedings within family and criminal domains. Mediation within the criminal domain has become a popular option in France's campaign against juvenile delinquency, and represents an intermediate step between prosecution and dropping the case. In addition, due to an increasing divorce rate in France, family mediation is also increasingly sought as an alternative to costly and lengthy legal battles created when couples seek marital separation. This article reviews the nature, benefits and consequences of mediation within criminal and family legal proceedings, and discusses the important psychological features of this process.*

Human justice cannot actually decide between good and evil. It can only limit conflicts and avoid an unending series of individual disputes within a given society. In this way, legal justice is by nature imperfect but can work very effectively in many fields when adapted to norms and conditions of particular societies. The norms and conditions of French society are changing, especially with regard to marriage, the traditional family, and the treatment of juvenile delinquents. In the areas of both juvenile delinquency and family law, classic French judicial practices are no longer sufficient to deal with the range or frequency of problems experienced by the population. In order to address the changing needs within these domains, the French courts have turned increasingly to psychological intervention and, specifically, to mediation.

### Juvenile criminal mediation

Over the past ten years, an important observation has been made in the field of juvenile criminal

justice: the practice of bringing young people before traditional courts often has a paradoxical effect and can strengthen delinquent tendencies. As the immediate incarceration of minors was found to be counterproductive, new approaches to dealing with juvenile delinquency were urgently needed. A current and popular solution in France is to impose 'reparative measures' on the delinquent minor. In this way, the minor avoids serving a prison or jail term while at the same time gaining another chance to 'repair' past harms and to live in society in a constructive way.

Recent studies (e.g. Hollin, 1990; 1992) that have discussed the issue of offender treatment have made the distinction between two types of preventative measures that help break the repetitive cycle of delinquency: primary prevention (before the first offence), and secondary prevention (after the first offence). Mediation and reparation measures can be understood as one form of secondary prevention. The general concept of preventative measures is consistent with the theory of societal vulnerability (Walgrave, 1992; Van Welzenis, 1993) and views the young offender's self-image as playing a crucial role in his or her chances of avoiding further criminal acts. The overall goal is to help young delinquents steer clear of other individuals (i.e. other criminals) who may have a negative effect on the juvenile's self-image and who may encourage future criminal behaviour (Panseri, 1993). In this way, reparation measures are designed to help the juvenile avoid the damaging effects of punishment and social stigmatisation.

### *Historical roots of reparation-mediation*

The French Order of February 2, 1945 paved the road for the development of reparation-mediation programmes by giving preference to educational solutions to juvenile delinquency over penal ones. This order reflected the choice of French society to

# The co-operation concept in a team of Swedish social workers

## Applying grid and group to studies of community care

*Steve Trevillion and David Green*

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### INTRODUCTION

The influential Griffiths report defined community care in terms of enabling people 'to live normal lives in community settings' (Griffiths 1988: 3.1, 5). For those involved, like ourselves, in what has become the massive industry of community care policy and practice, it is easy to lose sight of the simple but deeply radical shift involved in supporting individuals in the community rather than seeking to remove them from it. Any system which aims to 'design and arrange the provision of care and support in line with people's needs' (Griffiths 1988: 3.4, 5) is going to be very different from one which simply seeks to slot 'problem individuals' into a range of preordained services frequently provided only within highly stigmatized institutional contexts.

While more has been written about community care than any other twentieth-century welfare policy initiative, some of its most basic features are still under-researched. In particular, although almost every kind of financial, organizational and even interpersonal feature of community care has been the subject of government sponsored research, there has been little attempt to find out what it means to those actively involved, and to society as a whole. Ten years after the publication of the Griffiths report in the UK, this chapter is an attempt to develop an anthropology of community care and thereby, reinsert the question of meaning at the centre of the community care debate.

Our subject is 'collaboration', or the process of working together with others to assess need and deliver services. We see this as important because community care is utterly dependent upon the development of new collaborative cultures in place of the old institutional ones and it is here, also, in the exploration of cultural creativity, that we think anthropology has much to offer.

To date, the problem is not that anthropology has had no influence on research into collaboration, but rather, that an unacknowledged nineteenth-century anthropology has continued to distort our perceptions of the subject. We begin, then, with a critique of the nineteenth-century assumptions underlying current approaches to collaboration and move on to develop a new framework for thinking about the meaning of community care in general and 'collabora-

tion' in particular. This consists largely of a reinterpretation of Mary Douglas' work on 'grid and group' applied to the analysis of the shift from institutional to community care. We use this framework to illuminate an ethnographic account of the process of 'co-operation' as it was described to us by a group of Swedish *kurators* and members of their 'co-operative network' in the course of a short-term but intensive period of fieldwork in Stockholm in 1996.

## COMMUNITY CARE: NINETEENTH-CENTURY MODELS AND TWENTIETH-CENTURY PRACTICES

For anyone aware of the history of anthropology, one of the most striking features of the current debate about community care is its implicit endorsement of discredited nineteenth-century ideas about the development and spread of cultural practices. Much of the debate about community care appears to revolve around a set of paradigms virtually indistinguishable from those associated with nineteenth-century 'evolutionism' and 'diffusionism'. These need to be challenged before we can begin to mark out a terrain in which anthropology can help us to understand this important development in twentieth-century social welfare policy and practice.

'Evolutionism' has been described as the desire 'to arrange the peoples and social institutions of the world in an evolutionary series, from a theoretical primordial man to the civilised human being of mid-nineteenth century Europe' (Leinhardt 1966: 8). 'Diffusionism' has generally been associated with the ideas of Clark Wissler and the *Kulturkreis* school who held that cultural artefacts of all kinds have diffused outwards from a relatively small number of innovative 'culture centres'. Although long abandoned by anthropologists these simplistic cultural models continue to exercise a strong influence on the way in which community care is represented.

Who would now defend Morgan's division of history into three stages: *savagery*, *barbarism* and *civilization*? Many years ago such ideas were condemned as 'unhistorical' and 'unscientific' (Leinhardt 1966: 12). And yet, community care is usually described simply as a reaction to and against the inefficiency and barbarism of the 'great confinement' (Foucault 1973: 38–64) of marginalized populations in 'total institutions' (Goffman 1968: 13–22), a feature of prewar social policy across Europe. For example, in a recent book on care management, the authors, while trying to locate community care within an historical context, end by declaring that it is a 'happy combination of sound economics . . . and common humanity' (Orme and Glastonbury 1993: 10).

In the UK and within the context of this kind of discourse, successful community care initiatives are frequently represented as tokens of or signposts to an idealized communitarian future (Benn 1982). In contrast, the divisive features of institutionalization are seen as distasteful relics of the past – either morally flawed (Wagner 1988) or 'unfit' to survive because they are found wanting by the Audit Commission on one or more forms of quality measurement (Audit

Commission 1992). The Audit Commission makes direct use of the concept of 'fitness' in its work and regularly declares institutions or policies 'unfit' in relation to the tests of 'efficiency' and 'effectiveness'. In recent years it has applied this approach directly to the evaluation of inter-agency arrangements particularly those intended to generate co-ordination between health and social care organizations (Audit Commission 1992: 10–12). Studies of collaboration have in this way become dominated by a neo-Darwinian paradigm.

Diffusionism, too, is alive and well in social policy, particularly in the relatively new field of comparative social policy where, all too often, ideas and policies are seen as spreading across continents or around the globe mainly as a result of their inherent superiority. This is reminiscent of the way that the *Kulturkreis* theorists saw superior cultures exporting their ideas to inferior ones.

There is a tendency to see the spread of community care practices as merely the inevitable result of the adoption of morally superior and more professionally advanced theories and concepts generated by a small number of innovative welfare cultures, most frequently Anglo-American ones. This ignores the fact that where diffusion does take place, it is often dysfunctional, testifying to the power of ideology rather than to the superiority of ideas. For example, within the UK, many of the problems of community care in the period since the passing of the NHS and Community Care Act in 1990 can be traced back to the slavish adoption of American case management models developed to solve different problems in a different context (see Griffiths 1988), while more relevant European models and experiences were largely ignored.

What these tendencies have in common is a belief in a relationship between community care and progress which is not only highly questionable in its own right but also tends to prevent us from asking many of the most interesting questions about community care. In particular, by convincing us that the spread of ideas about community care is historically inevitable, they prevent us from inquiring into the way in which community care emerges in the context of individuals and groups trying to make sense of their relationship to one another in a rapidly changing, local, national and global environment, in which 'traditional' solutions to welfare problems no longer seem to work or to be desirable. This is the context in which we should be thinking about the vexed question of collaboration.

The ways in which the collaborative ideals of the NHS and Community Care Act have failed to materialize have by now been exhaustively documented (e.g. Hudson 1992). In part, the failure to find a solution to this long-standing problem may be connected with the way in which studies of collaboration have been dominated by a specific 'narrative' of progress (Trevillion 1996a: 96). In some cases, efforts have even been made to arrange 'types' of collaboration or inter-agency partnership into an explicit evolutionary series. So it is alleged that communication is the earliest stage of a process which leads inexorably through co-operation to co-ordination and finally, at the apex of the evolutionary pyramid, to total merger (Payne 1986).

But what we now know is that there is an enormous gap between this kind of 'talk' and the ways in which individuals and groups actually go about the process of building community care networks and making sense of what they are doing. If we are interested in exploring these processes, we would do better to think in terms of cultural creativity rather than narrow cultural determinism and to make use of a very different kind of anthropology to understand both the nature of community care and the processes associated with collaboration.

## **THE COLLAPSE OF THE INSTITUTIONAL GRID**

Welfare systems are undergoing massive levels of change and nineteenth-century anthropology cannot help us to see what is going on. Drawing on the work of Douglas and Turner on ritual boundaries, spaces and categories, and Goffman and Foucault on total institutions and disciplinary regimes, we can identify a whole range of issues which have little or nothing to do with either evolution or diffusion. One of the most obvious of these is the shift from a mode of social and cultural practice generating segregated, marginalized, medicalized and controlled living spaces (such as asylums and hospitals) to one associated with the progressive removal of the physical and symbolic boundaries separating these spaces from other, more 'normal' ones (Wagner 1988). In short, an anthropological perspective suggests that community care is, in part, concerned with what could be called 'the normalization of space'.

The same point could be made in relation to time and power relations. For example, in community care individuals will be able to choose when they have breakfast or even whether they have breakfast at all. They will have control over their own daily routines in ways which are impossible in an institutional environment (Seed and Kaye 1994). This restructuring of space and time is therefore directly related to the empowerment of individuals and families, and the dismantling of institutional systems of power and control (Collins 1989).

Community care can consequently be defined in anthropological terms as *a process of restructuring time, space and power relations*. But unless we want to repeat the evolutionist error of assuming that change is unilinear it is important that we view this process of restructuring in a more complex and open-ended way than we might otherwise do. Mary Douglas' work on 'grid and group' (Douglas 1973: 77–92) makes it possible for us to begin to do this. The concept of 'grid and group' was inspired by Bernstein's concept of restricted and elaborated codes, but in Douglas' hands it became a powerful tool for thinking about types of control systems linking cosmological characteristics with degrees of conformity.

At its most basic, grid and group analysis involves four quadrants generated by two pairs of oppositions. One axis consists of the opposition between a completely shared public system of classification and a completely private system of classification. The other axis consists of an opposition between a situation where the group has total power over the individual and one where this group



pressure is completely absent and the individual is able to exert pressure on others him/herself (Douglas 1973: 84).

By adapting this matrix to our own purposes, we can create a model which both describes the process of cultural change associated with community care and which allows us to map different kinds of community care systems in a comparative manner (Fig. 1).

The bottom right quadrant is largely irrelevant to our present discussion and is applicable only to those societies where there is no legitimate authority and no commitment to welfare but only a militarily strong and self-seeking tyrant or dominant elite: Mobuto's Zaïre springs to mind. The bottom left-hand quadrant describes an extreme form of market dominated welfare in which everything is for sale but there is no shared system of values.

We are principally concerned with the two upper quadrants. Community care implies some common values, although, in some cases, the level of shared classification may be very minimal. Community care lies above the horizontal line but always closer to it than institutional care. If institutional care is associated with a welfare culture characterized by strong grid and strong group structures, both rejecting and oppressing those who do not match up to the demands of conventional behaviour, then community care is associated with a movement away from this towards a welfare culture in which there is a high level of social change, and in which norms and values are constantly renegotiated.

Thinking in these terms enables us to see more clearly why the process of delivering community care has proved to be so troublesome. Much can be explained in terms of the difficulty of imposing any values, including those of community care, in the context of a relatively weak grid. Moreover, it is easy to see how attempts to do so tend to swing the cultural system back towards strong grid and the kind of institutional controls which are antithetical to community care. Community care therefore relies upon the maintenance of a classificatory grid strong enough to make new policies and practices widely acceptable, but not so strong as to undermine the flexibility of systems and the empowerment of individuals which are critical to its identity.

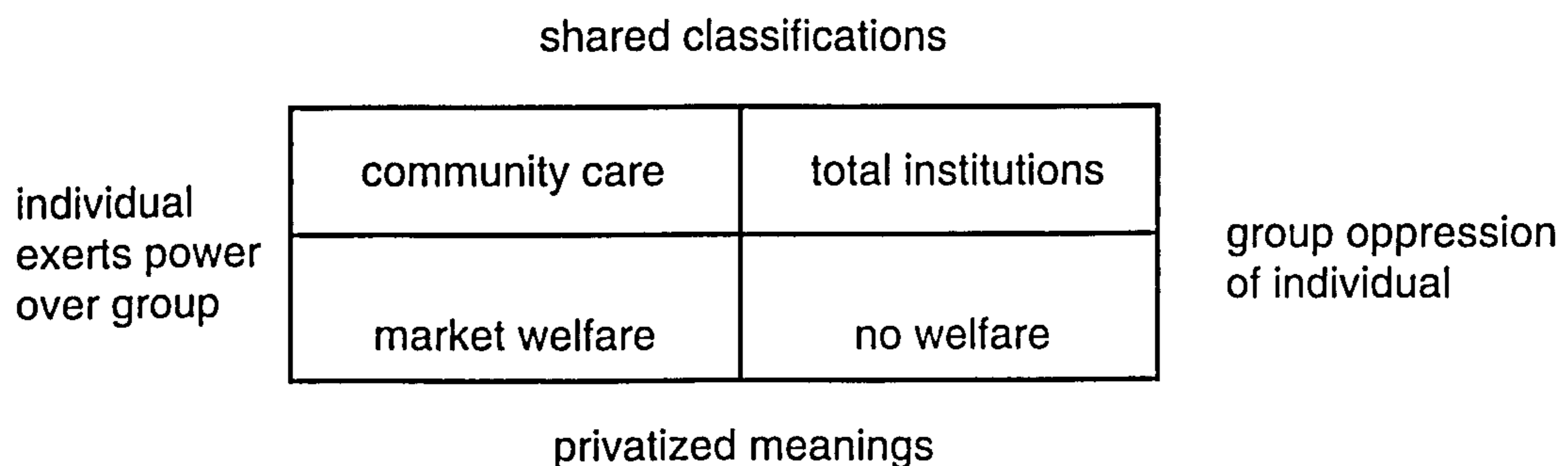


Figure 1 A grid and group analysis of welfare systems

For any society, this is a risky enterprise. A complete fragmentation and privatization of meanings can only be averted if new kinds of cultural strategies are developed to reinvent some kind of consensus about meanings, goals, etc. In the new cultural conditions associated with community care, a public classificatory system can no longer simply be imposed on groups and individuals.

This is the context in which we need to understand the current preoccupation with the problem of 'collaboration'. 'Collaboration', or the process of working across organizational, professional or role boundaries, emerges in anthropological terms as a reconfiguration and reinvention of the classificatory grid associated with a shift in power from the large-scale corporate group to smaller and less formal groups and networks. This puts us in the position of being able to explore both the process by which rigid classificatory boundaries are dissolved and the responses to it by which new forms of 'connectedness' (Bott 1971) are generated between individuals and groups previously separated from one another by the strength of the institutional grid.

Another way of putting this is that, as we move from the top of the institutional quadrant to the bottom of the community care quadrant, we also move from social situations dominated by highly organized and enduring social groups, which impose patterns of social interaction on their members, to ones characterized by relatively open-ended, fluid social networks whose existence is constantly being negotiated and renegotiated. From this perspective, *collaboration is nothing less than the process by which social reality is negotiated in and through community care networks of various kinds.*

A range of possible collaborative configurations are conceivable, from those involving a minimal commitment; to shared norms and values and minimal interference in individual or agency autonomy; to those involving much higher levels of sharing and mutual responsibility. However, as it is impossible to conceive of the development of new classifications without subverting old ones, collaboration can also be seen, in anthropological terms, as a *transgressive* cultural practice, apparently undermining accepted boundaries and identities in its search for new ways of thinking about and practising welfare.

Interestingly, community care in general, and collaboration in particular, has emerged as a laboratory of cultural innovation in which attempts to dissolve and rebuild the world of welfare are constantly going on. In this context, it is time we began to ask how these 'experiments' are being conducted in different countries and to identify where on the continuum of cultural configurations they lie. This is not so much an orthodox comparative project as a way of exploring collaborative cultures which may be very different to one's own, and the process begins to fill in the top left-hand quadrant with good quality ethnographic data. This is likely to raise some interesting issues and questions. For example, some forms of collaboration will be close to the boundary of the vertical axis indicating major differences in levels of power and control, while others will be close to the horizontal axis indicating a highly privatized and individualized set of arrangements.

But it is difficult to see how a highly privatized and individualistic world view

is compatible with the kind of social relationships that make collaboration possible. Collaborative cultures lying in the bottom left-hand corner of the community care quadrant might therefore be taken as the outer limit of collaboration. Likewise, collaborative cultures lying near the top right corner of the quadrant might be seen as containing so many quasi-institutional control features that they also constitute the limit of collaboration. In contrast, one might expect the most 'successful' examples of collaboration to be found near the centre of the quadrant, where there is a commitment to building a shared world view combined with opportunities for participative interaction.

One useful way of analysing some of these differences is in terms of the extent to which 'connectedness' or high levels of mutual interaction exist and are associated with an 'imagined community' of 'carers' (Anderson 1983). In such a situation, the networks to which the individual belongs represent to that person a meaningful collective entity regardless of the lack of formal group or organizational boundaries.

Collaboration cultures where there is little evidence of an 'imagined community' are likely to lie in the bottom left-hand corner of the community care quadrant. But in the centre and towards the right of the quadrant, one would expect any tendency towards diversification and fragmentation to be counteracted by a commitment to an 'imagined community' within which to negotiate shared meanings that bind individuals and groups to one another on a voluntary basis. If we are interested in applying anthropology to the development of social policy, it seems clear that any examples of collaboration which can be located in the centre/right of the community care quadrant are likely to be of considerable interest.

## **BACKGROUND**

For many years we had been working on various aspects of the question of collaboration, often through detailed discussions with individual practitioners. But we had become critical of many aspects of contemporary British approaches to collaboration and wanted to see if alternative approaches were being developed elsewhere.

Why Sweden? The choice of Stockholm was partly opportunistic. We would have been prepared to work with professionals from any of the European Union countries. But the literature on Sweden made us aware that some of the issues associated with the transition from a state welfare culture to more complex and negotiated patterns of welfare would be very likely to be present. One significant factor was the way the Swedish literature demonstrated a strong awareness of and commitment to the ideas and principles most frequently associated with community care at an international level. For example, official literature describes the Swedish Social Services Act in terms of 'the holistic view, normalisation, continuity, flexibility and a local focus' (National Board of Health and Welfare 1992: 27).

## COLLABORATION IN THE UK

We do not propose to describe the British situation in detail. It has been exhaustively documented elsewhere. As British researchers familiar with this system, however, we took with us a certain assumption about the nature of collaborative problems and solutions which in retrospect can be seen as only one of the realignments of grid/group relations made possible by the collapse of institutional welfare.

There is a widespread concern about the problem of collaboration in the UK. One interesting feature of the debate has been that, on the whole, in so far as solutions have been proposed, they have been structural solutions – ways of organizing relationships around tasks and outcomes. The problem is often seen as one of imposing order onto chaos. The collaborative space, in other words, is most frequently seen as one which needs to be rationalized and organized (Trevillion 1996b: 11–14). All this seems to be linked to a tendency to assume that collaborative problems are best dealt with in ‘structural’ ways. Implicitly, this defines the problem of working together as a problem of social order and it defines collaborative solutions in terms of strategies for imposing social order. This, in turn, reveals a tendency to resurrect institutionalized control systems in an attempt to solve the problem of collaboration.

Our own research with social workers in London emphasized to us the way in which collaborative initiatives had often failed to generate communities at a team level. This, in our view, is closely connected with the highly fragmented and instrumental characteristics of British community care systems. While there are plenty of examples of individual good practice, in our experience many attempts at collaboration are located either in the bottom left-hand corner or the top right-hand corner of the community care quadrant.

We had found that in a context of scarce resources and demanding management, many British social workers had chosen not to invest in potentially difficult cross-boundary relationships or in the future of collaborative enterprises. Inevitably, we carried these thoughts and assumptions with us, even while we hoped to experience something different in Sweden.

## EARLY CONTACTS

This project grew out of contacts made at the University of Stockholm and especially with Thomas Lindstein, Dean of the School of Social Work. Through him we were put in touch with the National Board of Health and Welfare and through them we made contact with a team of *kurators* or hospital social workers based in a large suburban hospital in Stockholm and specializing in the field of HIV. Without the enthusiasm of the *kurators* themselves, the project would never have begun, but the part played by others in enabling the key research relationships to be formed also needs to be recognized. It is probably true to say that the setting up of the project mirrored its subject matter in

that it was, itself, a good example of networking and collaboration, in this case across national frontiers.

## METHODS

To some extent, we have found that all qualitative research with professionals has to be seen as a form of action research, in that individuals and groups will only devote time and energy to projects which appear to them to have some practical benefit. Sometimes, the insistence on short-term practical outcomes can make exploratory research very difficult to negotiate. However, early on, we realized that the *kurators* valued the opportunity to reflect on their collaborative practices in an open-ended way, and so, although they were keen to make use of the research process, we did not find ourselves having to work to any agenda other than those of exploration and reflection.

Our fieldwork techniques had to be very intensive as we only had four sessions, spread over three days, in which to complete data collection. We were limited not only by financial constraints, and these were real enough, but also by the need to minimize the level of disruption to the lives of the busy professionals with whom we were working. For these reasons, long-term participant observation was never a realistic option. Instead, we decided to make use of a range of qualitative methods which would ensure that we made optimum use of the time available. We used a combination of network analysis (Scott 1991), case studies and semi-structured interviewing conducted with groups rather than individuals (Glaser and Strauss 1968). Most of the work was done on a face-to-face basis, but we asked the *kurators* beforehand to complete some simple forms detailing their interactions with others over a two-week period. This gave us important clues as to some of the characteristic patterns of interaction and informed the kind of questions we decided to ask on arrival in Stockholm.

The team we worked with consisted of three social work trained *kurators* who worked in a specialist HIV unit in a large hospital in Stockholm. Swedish *kurators* are medical social workers, frequently but not always based in hospital settings, employed by the *landsting* or county rather than the *kommun* or local authority (as would be the case in the UK). We worked with this team intensively over a period of four days, and what follows is an account both of our work and the encounter between British and Swedish perspectives on collaboration.

The fieldwork process began with a general and wide-ranging group interview with the *kurators*. This provided important data on attitudes, roles and practices. The second session was devoted to case studies presented by each member of the *kurators'* team. This enabled us to link general themes to specific practices, and to gain key insights into collaborative problems and dilemmas as well as successes.

The third session took the form of a network meeting which involved the *kurators* and a number of key individuals in their HIV community care networks. We used network analysis at the beginning of the sessions, asking participants to

complete a simple record of interactions with others in the room and then developed this activity into a group discussion. One important feature of this interview was the way it directly addressed patterns and styles of collaboration. The final session consisted of a further group interview with the *kurators*, which sought clarification, contextualization and initial feedback.

## **PHILOSOPHY OF THE *KURATORS***

On our first day together we began by asking some basic questions about structures, systems and values. It was the discussion about 'values', however, which proved to be most interesting. 'Values' occupy a key place in professional thinking in the UK but in continental Europe the professional emphasis is frequently on 'theory' or 'knowledge'. The Swedish *kurators* saw 'values' as so general as to be meaningless. They did, however, recognize that a general 'philosophy' of care was important and so we eventually settled on the idea of working on a 'statement of philosophy' instead of a list of 'values'. This 'statement of philosophy' contained many clues as to the way in which collaboration was conceived.

### **1 Helping people to help themselves**

The *kurators* described this in terms of helping people 'to fish', but that 'instead of one doing it for them, they do it for themselves. But then, of course, as they become sicker, we do more of the fishing for them.'

### **2 Respect for differences and respect for the uniqueness of individuals**

For the *kurators*, 'respect' included both an awareness of the validity of different lifestyles ('having respect for each person's individuality') and an awareness of the inequality often underlying 'difference' ('that you can have very different resources in life and you try to react to that in the way you try to help').

### **3 Supporting and involving families and carers**

It was important to the *kurators* that they tried to locate their clients in family networks even if these families were not especially supportive.

We also have a strategy . . . to involve persons around the patient, the network, even if, maybe, it's a theoretical network; but talking about the family, trying to get the family to come together with the patient here at the hospital, talking to the doctor, talking to us.

#### **4 Non-discriminatory practice**

This was seen as a team or group responsibility, as well as an individual value: 'we know where the professional boundaries are and we have group pressure to keep those boundaries. If someone is slipping . . . there is always someone to step in'.

#### **5 Normalization**

This was defined both in terms of 'mainstreaming' or the idea that 'the ordinary type of organizations should be able to deal with HIV' and in terms of 'being included in society'. It was thus closely linked to another general principle – 'inclusiveness'.

#### **6 Inclusiveness**

This was seen in terms of enabling individuals with HIV to gain access to mainstream services, that they

shouldn't be put out to specialized organizations. . . . You shouldn't have to travel from one side of the city to another, you should be able to use the school that is closest so that they [the children] can play with their friends.

#### **7 Social education**

This was both a value and an activity which struck us as quite distinctive. We felt that education was taken much more seriously as a professional responsibility than would have been the case in the UK:

We often go out talking to different people . . . if we feel there is discrimination and our clients are being discriminated against, we talk to groups, bosses or whatever's necessary. At the moment we have a little premature baby at the children's ward and they have never had that and the mother now is going to go there . . . and so they have questions about the kinds of precautions they should take.

#### **8 Overcoming isolation by building social support networks**

The *kurators* saw themselves as working to locate individuals within society and specific support networks, 'to help people find people who they can talk to, family members, good friends, even at work, if that's possible. We don't help people to isolate themselves.'

## 9 Individualization of support initiatives

The principle that ‘people are not the same – they have different backgrounds’ and are in ‘need of individual support’ was important because it showed how seriously the *kurators* took the community care principle of flexibility, which in the UK would have been related to the concept of a ‘needs-led’ service.

### STATE, SOCIETY AND COMMUNITY

As the *kurators* themselves tended not to prioritize any one of these statements over others, it is rather artificial for us to do so, and yet we were very struck by the strong commitment they felt to the principles of social inclusion. For them, these entailed both social support and the right to lead a life without experiencing prejudice and discrimination. If this is linked to the obvious importance attached to the question of choice and the negotiation of care needs on an individual basis, it is clear that this statement of philosophy places the *kurators*’ model of practice firmly within the community care quadrant of our matrix, where little is imposed, much is negotiable, and yet there is a strong commitment to achieving a shared classification system.

Whilst most of these ‘philosophical’ principles were very familiar to us as ‘values’, it was noticeable that words such as ‘community’ and even ‘citizenship’, which would have been ubiquitous in the UK, were avoided. In fact, in the literal sense, there was no exact equivalent to the British concept of ‘community care’. Rather the emphasis was on more specific ideas. This may have been because, in contrast to the British social workers, they did not see their work in this area as linked to a radical legal/policy shift, or even to a specific organizational or managerial objective.

There was also a more profound reluctance to adopt the idea of ‘community’ as something separate from the state or society as a whole. This is reflected in the Swedish language which likewise does not clearly distinguish between these ideas.

This is how you use it [community] and they use it very much in the States as well. Everywhere ‘community’, ‘community’. The thing is . . . we don’t talk about that in that way here. We talk more about the *samhälle* in the bigger picture.

*Samhälle* was defined as ‘the state or the political community’. ‘It is too big in that way, but that’s what we say,’ said one *kurator*.

When talking about the local level the *kurators* preferred to talk in terms of local networks rather than local communities. This reminded us, as Britons, of the way we tend to define ‘community’ in opposition to ‘the state’ and how this split permeates social policy. When we put this to the *kurators* they made it very clear that this was alien to their way of thinking. ‘I don’t think that is something



that is opposite – “community” as opposite to “the state”. I don’t think that we think like that’, said one. ‘We mix it all up. It’s all the state in a way, the society’, said another. One suggested

That is typically Swedish really because we think of the state and society as the same word. We have a tradition in Sweden that the society is responsible for the individual and we don’t always talk about the state. It’s both the state and the other levels.

From this we drew a rather paradoxical conclusion. Whereas in the UK there is considerable talk about ‘community’ there is very little sense of any belief in specific communities of care either real or imaginary. On the other hand, in Sweden there is a reluctance to use the term ‘community’ because of its specific connotations. However, as we shall see more clearly later on, there is evidence of a considerable interest in ‘communities’, if these are defined as specific inter-agency or inter-professional groups or networks with which individuals closely identify, and which represent core professional meanings and aspirations. This preference for small-scale, flexible and interpersonal social relations over and above more generalized and abstract social constructs is, again, consistent with a form of practice which belongs in the community care quadrant.

### **SAMVERKA OR CO-OPERATION**

The idea of ‘collaboration’ was recognized and they were obviously more comfortable with the term than with the concept of ‘community’, but the *kurators* nevertheless preferred to use the term ‘co-operation’ as a more accurate translation of the Swedish word *samverka* which literally means ‘working together’. This preference for ‘co-operation’ rather than ‘collaboration’ turned out to be very significant.

‘Co-operation’ could only exist when certain, quite demanding, conditions were met. In particular, it seemed that where roles and philosophies diverged too much it was seen as preferable to abandon ‘co-operation’ rather than to continue simply because there might be some administrative advantage. This point seemed to be reached most frequently in relation to the tension between care and control. The *kurators* clearly experienced an internal conflict between the philosophy of social support and empowerment to which they were committed, and their more controlling roles especially in relation to ‘contact tracing’ and the enforcement of codes of responsible sexual behaviour. And yet, they seemed able to manage this except when they felt this delicate balance to be put under pressure by external forces such as their relationships with the Regional Medical Officers (RMOs) who had direct responsibility for the imprisonment of persistently sexually irresponsible individuals carrying the HIV virus. The relationships between *kurators* and RMOs seemed to constitute something of an outer limit for co-operation because sometimes the emphasis by the RMOs on

the exercise of legal authority seemed to make continued co-operation impossible, and restricted the discussions *kurators* felt they could have.

In the UK, collaboration is not always seen in terms of a very close working relationship, let alone a meeting of minds. In the Swedish situation co-operation made more demands on those participating, especially in terms of what in the UK would be called 'core values'.

Some other co-operative relationships were also seen as very difficult to manage but for reasons associated less with values and more with money. For example, relationships with the *kommun* were seen as quite conflictual at times. The question of housing responsibility was identified as a potential flashpoint in the relationship between *kurators* and their *kommun* counterparts as well as in the relationship between officials of different *kommuns*.

It's a struggle between the county (including the *kurators*) and the municipality (*kommun*) because of money. There is sometimes a struggle over who should pay. . . . If someone is ready to leave the hospital but can't go directly home . . . there can be a struggle about money. Stockholm's divided into different municipalities. . . . [One client] had his address in one but was going to move to the one next to it. So these two social welfare officers were bouncing back and forth with him, who was going to give him his money.

Nevertheless, co-operation with the *kommun* still survived. This may have been partly because the kind of market pressures so evident in the UK were not as evident in the Swedish situation. There seemed to be an important distinction in the minds of the *kurators* between problems which make co-operation difficult (such as arguments about financial responsibility) and problems which make it inappropriate (control versus care). We felt that *samverka* lay at the heart of the *kurators'* inter-agency and inter-professional practice. It epitomized both their commitment to developing close working relationships with others and a willingness to negotiate openly the terms of these relationships, provided that a common set of principles could be established. All of this indicated that *samverka* should be regarded as a strategy located firmly in the centre of the top left-hand, community care, quadrant.

## CO-OPERATION WITH THE 'THIRD SECTOR'

Whereas much of the literature on Swedish social policy emphasizes the small role played by voluntary or 'third sector' organizations, we were struck by the significant role played by some of these. An organization called Noah's Ark seemed to act as an umbrella group for the voluntary or third sector and constantly recurred in descriptions of co-operative working. The traditional complementary role of voluntary agencies seemed to be increasingly combined with a newer role of substituting for state services from the *kommun*.

This change was felt by the *kurators* to be forcing them to pay more attention to how they presented situations to external bodies, whereas in the past they would not have needed to do this. As one put it:

Over the years, I have had to increase my skills in the sense of being nice, able to joke with people and making them like me in a way . . . that has always been the social worker's role but over the last years I have found that I have had to put more emphasis on seducing them.

The fact that *samverka* was practised with the 'third sector' as well as with other more traditional state bodies added weight to our growing conviction that, at the philosophical level at least, the *kurators* were engaged in a process of community care.

### THE ROLES OF THE *KURATORS*

When we spoke about roles, the *kurators* emphasized both social work and counselling. Although there was some ambiguity about the terms *kurator*, counsellor and social worker, there was considerable clarity about the part played by the team in the work of the unit. The *kurators* felt they provided continuity of care, and this emphasis on continuity and the long-term perspective was an important key to understanding the co-operative/collaborative model. 'With HIV patients you never lose responsibility, but that's a rather special situation in hospital care because usually you treat the patient . . . and after that you let go. . . . With HIV patients we follow all the way.'

The *kurators* emphasized three key roles: psycho-social support, research and development work, and contact tracing. Whilst psycho-social support might be seen as synonymous with what in the UK is called 'care management', it did not involve purchasing and it did not imply a set of activities designed to set up a particular 'package of care'. It was a much more fluid and flexible way of conceptualizing support work and did not prioritize co-ordination over other issues or separate service delivery from assessment of need. It was also clear that this flexible supportive role was legitimated by legislation and current policy. It was also interesting to note the emphasis on research and development. 'Of course, besides, we do research. . . . We are always thinking about how we can improve our way of working. Mostly all social workers involved in HIV work have this research aspect in the Stockholm area.'

Few social workers we have spoken to in London attach any real significance to research and development. It was clear that what was meant by research in Sweden was less formal research and more reflecting on and improving practice. But even in this form it is difficult to find echoes of this in the British material. Individual British workers are, of course, committed to improving their practice but do not describe this as a major role. Again, the emphasis on long-term development in Sweden suggested a much longer time perspective than is usual in the

UK and was to constitute another clue as to the model of collaboration/co-operation.

This orientation to social education suggested that any tendency towards moral relativism or the privatization of meanings would be resisted by the *kurators*. They expressed commitment to establishing a strong common, if still negotiated, set of principles. This showed that they were not infinitely flexible in their philosophy and suggested that their community care practice should be located some distance from the bottom of the community care quadrant.

## **OUTCOMES AND PROCESSES**

The *kurators* found it difficult to talk about their work in terms of precise goals. They sometimes emphasized prevention, but otherwise talked simply about the need to ensure that clients were 'satisfied' with services. One expressed their goals as being 'A combination, maybe, between psycho-social support of a high standard and the patient's confidence and satisfaction, because I think that they are really connected to each other. Without the confidence, it is very difficult to have good support.'

We were told that 'the prevention goal does not necessarily have anything to do with the patient being satisfied'. 'Satisfaction' seems to have much more to do with the way relationships are being conducted and the elusive quality of confidence than it does with the UK concept of consumerism, with its emphasis on service standards and specifications. This also suggested another difference. In the British situation roles have tended to become increasingly identified with specific service outcomes, such as assessment, construction of care packages, reviews, etc. Specific outcome 'talk' of this kind was not a feature of the *kurators*' discourse and they did not connect it with their roles.

The emphasis on process seemed to be at one with the strong value placed on negotiating the relationships underlying *samverka* and again seemed to indicate that the philosophy of the *kurators* was consistent with the kind of ideas which one might expect from a practice system located at the centre of the community care quadrant.

## **CASE STUDIES OF SAMVERKA**

The case studies we looked at highlighted a number of new issues. They showed the extent to which questions of social exclusion were bound up not only with HIV but also with issues of race and culture, since most of them dealt with situations involving relatively marginalized and disadvantaged racial and cultural minorities. Therefore the co-operative and inclusive approaches adopted meant all had to address issues of trust and confidence.

One feature of the co-operative patterns described was that very few of them drew upon formal strategic links although, when asked, it was suggested that these had been created at an earlier stage. Rather, the links made tended to

assume a context of co-operation which evidently stemmed from other factors. Moreover, most of the links made were created in partnership with service users. There was little sense of services being organized for people and so the relationships in question almost always included the client. They were always triangular, rarely dyadic.

Although support was a major aim it was rarely operationalized in terms of 'plugging' people into existing networks or services. The pattern was frequently of effecting introductions and then allowing clients to pace the way they engaged with new social contacts, as described in the following exchange:

KURATOR: I don't know how it happened but she started in a support group. I don't know when exactly . . . and it meant a lot to her seeing how other people behaved in these situations. It enabled her to inform her family and friends about being infected with HIV.

RESEARCHER: That sounds like a very important moment.

KURATOR: Definitely but I don't know how that happened really.

RESEARCHER: You didn't organize that.

KURATOR: No I didn't, but I was really happy about it. . . . It can feel that you're talking to a wall for two years and suddenly they do something.

None of this would have been possible in a situation where services had to be purchased as there would have been a pressure for a much clearer definition of the support network at a much earlier stage, rather than just allowing it to develop at the pace of the client.

Another interesting contrast was in the use of network conferences. In the UK these are generally associated with reactive problem solving and constitute an extension of the co-ordinative role of the care manager. The Swedish *kurators*, on the other hand, spoke of this in terms of creating new possibilities for dialogue, and focused less on solving service delivery problems and more on enabling the client to benefit from a variety of perspectives. There was also an acceptance that a number of planned and unregulated interactive possibilities might emerge from such meetings, and that this might have a positive if unspecified impact on the client's situation. Again, we were struck by the open-ended and flexible approach adopted. For example, we heard about a conference being used in connection with some bereavement work:

I really appreciate this, that the social welfare office (*kommun*), the woman [female social worker] there was sympathetic and really professional. She took the initiative to arrange a social network meeting where she invited the boy [son of the dead woman], the new family, the teacher, the child psychologist, the grandfather, people from the social welfare office, and me. So we were sitting all bunched, discussing what had happened and taped it. Her idea was that the son would have something to take with him. It [the conference] had the possibility of

explaining some things because they [the family] wanted to blame the Spanish man who had infected the woman. So I could really say that that was not how it was. And the boy was there. That was really a nice experience. It was a good way of finishing work with this family.

The *kurator* went on to emphasize that 'the motivation of the social worker was to give something to the boy, to show him how many people were engaged with him'.

In at least one case we heard about educational activities designed to reduce prejudice and discrimination. These activities were only possible because of the co-operation of key people but they were clearly of a challenging rather than collusive nature. They were however, clearly part of a co-operative stance designed to effect normalization. This suggested that some conflictual strategies were employed to further the co-operative approach. Although apparently paradoxical, this seemed to us to be quite consistent.

Almost all the collaborative interventions described were open-ended and oriented towards the long term. They could best be described as springing from an orientation to co-operative processes rather than collaborative structures. One *kurator* described an experience as useful 'because I learned to wait and not be in a hurry in the process. I think we have learned to step back for a while and let people find their own way. There isn't any other way, really.'

This was only possible because of the existence of a well-defined, established network of professionals, which had an enduring existence outside any formal pattern of meetings. We gained the impression of a co-operative stance linked less to problem solving than to a process of attempting the integration of individuals within society. But clearly the existence of a network of professionals was very important to this goal. The question for us was: what was holding it together? We could find little evidence of formal links.

## **THE HIV NETWORK OR 'HIV WORLD'**

The network members with whom we worked included psychologists, nurses, home care organizers and a representative of the 'third sector' from the Noah's Ark organization. Given that community care rests upon the ability of informal and negotiable social networks of all kinds not only to deliver services in a reliable way but also to generate a shared set of classifications, we attached considerable importance to understanding the social glue that held *samverka* together.

While we could find little evidence of formal links, the fact that it was possible to meet with so many busy people occupying key positions was in itself a clue as to what held the network together – something which might best be described as generalized or *transferable trust*. We benefited enormously from this as researchers, and it was clearly a key component of the co-operative stance adopted by the network as a whole.

When asked to reflect on what it was that held their network together, its members identified a number of factors. These included: trust, reciprocity, familiarity and shared history/biography, opportunities for informal social interaction, which extended to socializing with one another outside the work context, and a strong sense of individual professional identity, which meant there was little confusion about who should take responsibility for what.

We explored these, in turn.

## **1 Trust**

This was exemplified for us in two statements made by different members of the network:

If I want something for my patient, how can I explain his situation? How colourful can I make the picture? If I know the person who is at the other end, I can make that picture colourful and if that person trusts me, he or she also knows that I tell the truth. I am not painting things up to get more things for him or her. I'm trusted as a person, so, of course, the fact that I know a person affects what my patient gets or doesn't get.

I think there is some kind of ground trust to people in this room and to people in HIV care in Stockholm because I think we share a lot of common ideas about this type of care. Sometimes we may . . . not meet as much as we ought to do and maybe we have thoughts that we could do this in another way than that person is doing it, but I think there is a trust that people do the best they can and that they want the best for our common patients.

## **2 Reciprocity**

This was linked to trust as in the belief and expectation that help offered would always be repaid.

PERSON 1: I think it's very good. I know that I can trust her (pointing). I know that if I want something then I always get it. And I hope that's reciprocated.

PERSON 2: Yes.

## **3 Shared history/biography**

It was very obvious to us that the network had a shared history, as if the life courses of those involved had criss-crossed one another many times and influenced one another's development in certain ways.

Maybe it is because the world of HIV care in Stockholm is rather small. We are not so many persons. We really know each other rather well, at least the people I have spoken to over the years. I can understand that it is not very easy to come as a new person in this world because people know each other from many years back but I also think that you benefit from it, from just the fact that we know each other so well in the units and we know this trust is there.

This quotation also provides a very clear clue about the strong identification with an imagined community – the ‘HIV world’ of Stockholm. This is possibly linked to a wider identification with the global ‘HIV world’.

#### **4 Informal socializing**

This was, in part, what kept alive the sense of shared history. One member of the network said:

There is specifically one woman . . . we have met over the years at conferences, different meetings, so when I meet her in the street we kind of hug each other, you know. We meet in private and we have this kind of contact.

Another member of the network added:

I think its because I meet B so often. So I have got to know her and her colleagues at Noah’s Ark so well because I am there almost once a week with some patient or just to go up for a coffee and to have a talk.

#### **5 Clarity about responsibility**

The sense of mutual understanding was very strong but seemed to be promoted almost entirely by the depth of the relationship rather than any formal agreements about roles and responsibilities. In fact, they seemed mystified by the question.

PERSON 1: In the system, I think we know each other so well that we usually know who’s responsible for what. If we don’t know we have ways of finding out by talking to someone who knows.

PERSON 2: I wouldn’t say that we have particular meetings just to discuss who is in charge of what, what is that person’s function.



## 6 The view from the HIV world

When asked to reflect on what was shared in terms of professional philosophy, a number of orientations, or what in the British context would be called 'values', emerged characteristic of the whole network. Of these, the most striking was the holistic approach which valued the person. This was linked to a tendency to reject medical models in favour of social models and to see the person rather than the infection as their core interest. One quotation seems to sum this up:

From my perspective, one very important 'value' is really to try to get people . . . to realize that people with HIV are human beings and more than a virus, and I think that is very much forgotten. . . . To understand people with HIV, I think that you have to understand the personality and the person's life history . . . not only respect but looking at the whole person.

In many respects this would have been very familiar to UK workers. However, the fact that these values were embodied in a network of people interacting with one another on a regular basis served to differentiate this situation from the British one.

The network then discussed recent changes in Swedish welfare and society, and it was acknowledged that UK-style conflict and confusion was growing in other fields but that HIV was to some extent still protected by its history, although we were also warned not to take away too rose-tinted a view.

Sometimes I think that the organization or the institution has a big HIV infection . . . there's lots of fights, there's lots of struggle and a lot of killing – psychologically – and we behave just like the virus. I think it's also important that we bring forward that we do have problems.

Interestingly, it was also acknowledged that in some respects scarcity had generated more imaginative and innovative solutions to co-operation, with more opportunities for working together and a greater role for the 'third sector':

because the security also made us a bit lazy and maybe we didn't use our heads in the way that we could, so what's happening is that we have to use our heads more, that we have to find other ways.

## CO-OPERATION AND SOCIAL INCLUSION

A clear view about co-operation emerged out of our final discussions with the *kurators*. One feature of the collaborative/co-operative model developed by the Swedish network was that it was oriented to *process* rather than *structure*. The

*kurators* saw co-operation not as a response to fragmentation or disintegration but rather as a way of making orderly but potentially unresponsive social institutions receptive to the needs of people with HIV. The whole orientation was towards social inclusion, the provision of choice and the creation of opportunities. This process of *opening up* the social structure was facilitated by a web of co-operative relationships through which these opportunities were created.

In contrast to the UK situation, with which we were familiar, the dynamism in these relationships sprang out of professional concerns rather than specific managerial initiatives. Management was important but collaborative initiatives were professional rather than managerial. The reason for this was clear. If the issue of 'co-operation' is seen in terms of the need to work with others across a range of organizational and sectoral boundaries to make services more responsive and flexible, standardized management-driven approaches of the kind dominant in the UK would not be considered relevant or appropriate to the nature of the issue. Underlying this was a much stronger belief in the role of the individual, and a much greater emphasis on the role of discretionary professional judgements, than is possible or acceptable in the UK.

Conversely, it might be argued that one of the weaknesses of the Swedish model of co-operation is that its strong reliance on a meeting of minds and the very existence of an imagined community or 'HIV world' makes it difficult to accommodate serious conflicts and philosophical differences.

## CONCLUSION

We have argued that 'collaboration' emerges in anthropological terms as a reconfiguration and reinvention of the classificatory grid associated with a shift in power from the large-scale corporate group to smaller, informal groups and networks. We have looked in some detail at the way in which the model of 'co-operation' has been developed in one Swedish social work team, as a particular response to what is, arguably, a global cultural problem.

The Swedish model of co-operation is rooted in a concern with a shared philosophy and is not only strongly oriented to the importance of relationships but also premised on a specific concept, the 'HIV world', which constitutes both a tangible social network and an imaginary community, or point of reference, which allows the practice of *samverka* to be securely anchored in what would otherwise be a very difficult and conflict laden environment.

Finally, this comparative exploration of co-operation/collaboration shows the potential of anthropological models for illuminating some of the more complex socio-cultural areas of community care, in particular the ways in which collaboration culture is being constructed on a day-to-day basis through the interactions of those most closely involved in the definition of 'need' and the provision of services.

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## 7 Social Interaction Theory and Social Work

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### Introduction: Looking for a Theory

Whereas, doctors or lawyers can look to a specific discipline as the basis of their practice- medicine in the case of doctors and law/jurisprudence in the case of lawyers- the same cannot be said of social workers. Whilst social work usually claims to have a theoretical base, this frequently turns out to be a mixture of theories drawn from sociology, psychology, etc. The search for an authentic social work theory goes on, but in answer to the question: «what is social work»? it is still the case that we generally describe what it is that social workers do rather than trying to define the discipline itself, whereas a psychologist asked the same question would first of all define the discipline –«the science of the mind» – before moving on to show how the discipline can be applied to solving human problems.

In the UK, despair at ever solving this conundrum has fuelled the «competency» based approach which has, in turn led to an attempt to define social work in terms of «six core competences» (CCETSW, 1995, pp. 11–12). This, not only, turns knowledge acquisition into a «black box» but represents a purely pragmatic approach to theory itself with major implications for the nature of social work research which becomes increasingly preoccupied with developing ever more ingenious ways of measuring or evaluating the «outcomes» associated with the acquisition of the competences.

If this was simply a way of applying the Popperian «falsifiability criterion» (Popper, 1972) to social work, it might have some value. But in general, what is evaluated is not a particular hypothesis, but, a particular programme or set of interventions. As result, we do not learn much about social work from these evaluation exercises. In fact, social work theory, in this way, effectively disappears. Theory becomes anything which apparently «works». As the subject fragments into ever more narrowly defined specialisms, this tendency towards pragmatism increases, so that for many practitioners and even some academics the very idea of a body of common theory underlying social work, may now seem strange or quixotic.

Now, in criticising this I don't want to be seen as arguing for a return to grand metaphysical speculation under the guise of social work theory or even the resurrection of Freudian or Marxist dogmas. Far from it. In fact, I believe that social work theory can only now be constructed on the basis of «common sense» by which I mean that it can only be developed by paying close attention to how it is talked about in everyday speech. This kind of Wittgensteinian approach (Wittgenstein, 1953) has the great merit of clarifying meaning by clarifying how we use certain words.

## Social Work and Talk About Social Problems

What seems to worry most social work theorists is that in lay conversations or in the media, social work, is seen, not as a unified body of knowledge and expertise, but rather, as something associated with certain kinds of problem solving activities. Social workers protect children-or fail to protect them, they take people into psychiatric hospitals – or refuse to do so. They provide «packages of care» – or don't! Time and again, the most commonly used statements about social work link it to certain undeniably important and often anxiety laden processes of problem identification and problem solving. From a linguistic point of view, «social work» is most frequently encountered as a TERM used in a STATEMENT about PROBLEM SOLVING. Conventionally, as social workers, we want to distance ourselves from this. We say we don't want to be seen as simply there to solve problems and, in any case, we say we facilitate others to solve their own problems. But nevertheless, people persist in linking social work to a problem solving process, so that, whereas, there appears to be little inclination to concede to it a specific expertise there is a strong impulse to concede to it A SPECIFIC POSITION IN RELATION TO PROCESSES OF SOCIAL ACTION LINKED TO THE ATTEMPT TO SOLVE SOCIAL PROBLEMS.

The problems this creates are obvious and well rehearsed, especially in connection with the creation of expectations that the profession cannot fulfil and the consequent disillusionment with social work itself (Davies, 1981, pp 3-4). But, I would suggest, that in this insistence on locating social work WITHIN PARTICULAR CHAINS OF SOCIAL ACTION, there are some clues to the nature of social work and social work theory.

My own approach today, is to start with these «common sense» formulations rather than to reject them, out of hand, and to suggest that

rather than looking for an alternative way of defining social work, we should accept that social work is an activity which will always be associated with complex process of social interaction, frequently bound up with chains of decision making. This brings me to my next point, which is that THESE CHAINS OF INTERACTION AND DECISION MAKING EFFECTIVELY BIND SOCIAL WORK IN A VERY FUNDAMENTAL WAY TO THE SOCIAL SITUATIONS OF WHICH IT IS A PART.

### Social Work Theory as a Theory of Embodied/ Embedded Practice

Social workers, to my mind, are quite rightly seen by most people as deeply INVOLVED in situations WITH their clients rather than as specialists called upon to exercise some peculiar expertise and then depart. To be so bound up in situations seems to many people to disqualify social work from consideration as a serious profession. But this is to assume that social work and therefore social work theory would be more authentic or genuine or real if it were more disembodied than it is, more external and more objective than it can ever be. But this is curiously old fashioned. We know that the whole trend of social theory is towards the recognition that theory is embodied in subjects and that abstraction often comes at the price of reification. Social work theory must certainly be a theory of an embodied practice but this does not make it any less of a theory. In some ways it could be an advantage as the subject comes without many of the pretensions to objectivity associated with many branches of psychology, for example.

If we follow this line of thought along, for a moment, it should be clear that if social work has a base of theory it must be associated not only with embodiment but also with its highly embedded position within a mesh of social relationships in conditions of crisis or change. In other words, my first proposition is that SOCIAL WORK THEORY IS A THEORY ABOUT THE RELATIONSHIP OF THE SOCIAL WORKER TO A MATRIX OF SOCIAL RELATIONS OF THIS KIND. Social workers may use other theories such as those of child development and may need knowledge of the law, etc. but these are not social work theories. In other words these theories may inform but do not guide social work practice itself, even though they are used by social workers. My second proposition is that THE MINIMUM REQUIREMENT OF A SOCIAL WORK THEORY IS THAT IT SHOULD

ALLOW THE SOCIAL WORKER TO ENCOMPASS AND MAKE EXPLICIT THE CONCRETE SET OF SOCIAL RELATIONS OF WHICH HE OR SHE IS A PART AND THEN TO ACT ON THE BASIS OF THIS UNDERSTANDING. It should not result in an abstract or partial vision but rather enable the worker to holistically grasp the situation as a whole while continuing to act and to be involved.

This may not seem like a very startling or original observation but its implications are quite radical. Let us start with the concept of «the social work process», which I take to be at the root of almost every social work theory.

### A New Look at Process

While there is scope for identifying process with traditional psycho-analytic thinking, this is not the only option. Moreover we have to remember that the processes with which social work is implicated are many and various and not all of them fit comfortably within a client /social worker dyad of the kind favoured by psycho-analytic thinking. My own preference would be to see process in terms of the real conditions of practice which consist usually of a complex web or mesh of social interactions . This suggests to me a third proposition which is that A THEORY OF SOCIAL WORK PROCESS IS ONE WHICH FOCUSES ON SHIFTS IN THE KALEIDOSCOPIC PATTERN OF THESE RELATIONAL WEBS. This brings me to my fourth proposition: SOCIAL WORK THEORY HAS TO BE AN INTERACTIONAL THEORY. Curiously, however, until recently there was little or no interest among social workers in many of the major schools of social interaction theory. Indeed some of them continue to be virtually unknown to social workers.

Traditionally, social work processes have been described in terms of psycho-dynamic concepts such as «projection» and «transference» or in terms of «functional/dysfunctional systems» or in terms of individuals acting in accordance with strictly group interests, e.g.. analyses of race, class and gender. While all of these could claim with some justification to be theories of social interaction, they tend either to locate social worker/client interactions in a social vacuum or resort to some form of determinism in their attempts to describe chains of social action. While not going so far as to say that they are wrong I would argue that they are inadequate because THEY DO NOT ENCOMPASS A SUFFICIENT LEVEL OF INDETERMINACY OR COMPLEXITY. Unlike these theories, those which

focus mainly on social interaction are based upon a simple metaphor and that is that social life can be thought of as a certain type of game. Game theory has developed along a number of parallel tracks. Let us look at each in turn.

### Market Games

This theory originates within economics rather than sociology and analyses human interdependencies of all kinds. It sets itself the basic task of explaining interdependency in terms of interactions between individuals which are aimed at «value maximisation and cost minimisation» (Jordan, 1996, p. 42). For social workers the key elements are those concerned with the strategies of rational goal oriented actors seeking to maximise their rewards and minimise their costs within social games constituted according to market principles. While undoubtedly crude, this model comes into its own in certain kinds of situations, particularly those characterised by interactions based on competition for scarce resource. As, increasingly, social workers take on the role of rationers and gatekeepers, this approach can help to illuminate aspects of the economics of social work. Without criticising the theory, however, it seems clear that it cannot account for forms of interdependency which are not conditioned by these factors and an over reliance on it might run the risk of seriously distorting our understanding of interdependency.

### Self-Other Games

Mead was concerned with the question of how we learn to behave correctly, i.e. how the process of socialisation actually works. He argued that we learn to be members of society through our interactions with others. He went on to suggest that most of these key interactional processes could be thought of as «games» through which we learn by our encounters with the «other» what is expected of us and how others will see us if we behave in particular ways (Mead, 1934).

This offers a rich account of the learning process but is principally concerned with the way in which social order is constructed and maintained. It tells us little about the struggle to meet needs or indeed about conflicts between self and other. It assumes a consensus and so can describe almost all the types of interaction with which social workers are concerned



merely as deviance or distortion in the learning process. It also has the disadvantage of being limited largely to dyadic interactions or to constructs such as roles which are the symbolic ordering of routine social interactions between self and other linked to the idea of the generalised other. If we are interested in three or four person interactions and we are concerned with non-routine or relatively unpredictable situations and courses of action then symbolic interactionism is of little value. As a theory it seems to lack the ability to take adequate account of change, conflict and creativity.

## Social Games and Social Forms

Simmel argued that society consists of a web of patterned interactions. It was Simmel's key insight that the tensions, conflicts and coalitions between individuals and social groups produced a certain kind of logic or set of social «forms» which could be described in geometrical terms. These «forms» were not pre-ordained but rather arose out of particular kinds of situations, frequently those in which relations were characterised by differential levels of power and control. Social forms were, in other words, forms of interdependency. Moreover he suggested that in a context of interdependency and within the constraints imposed by the form, individuals and groups pursued strategies which in turn fed back into the nature of the form (Coser, 1971, pp. 177-216). From Simmel we can take the ideas of form and strategy. Social life becomes a complex game in which the rules cannot be finally separated from the players or the moves. His most interesting contributions focus on the logic of group relations and in particular the difference in the strategies available to members of dyads and triads, together with his account of power as a reciprocal interaction between subordinate and dominant individuals or groups.

## Systemic Games

Using Von Neumann's mathematical theories of games as a starting point Gregory Bateson went on to suggest that a whole range of different types of game were possible and that different types of social system constituted different types of «game». The main feature of this approach to social interaction is that it is concerned not with the socialisation process but

societies go about reproducing their essential characteristics over time and in diverse ways (Bateson, 1973).

From the point of view of social work, the main advantages of Bateson's approach are that it focuses on the characteristics of systems and the role of game players in maintaining certain kinds of systems. However, unlike Simmel's theory of «forms» it requires a separation between rules and game playing and tends always towards looking for explanations for continuity rather than change. It has been very influential not least in terms of family therapy and systems work and its best known explanation is that of the «double bind» and its role in the maintenance of a schizophrenic system. From Bateson's systems approach we can take the concern with tracking specific sequences of action and reaction and the pattern of these chains and their relationship to one another, specifically the idea of interactive sequences as communication games.

### Power Games

Building upon Simmel's work on interdependency, Elias developed a theory of social goals which began to relate micro-and macro aspects of interaction together in a coherent way.

At its simplest, Elias asks us to think of sequences of action and response in contexts of interdependency as games, frequently power games or contests. This focus on power and control allows Elias to see that frequently we lose control of the game we are in not to the others involved but to the game itself. As complexity increases, we also lose our sense of what the game is. As interdependency increases this impersonal element becomes more and more important (Elias, 1978, pp. 71-103). This is a powerful description of an experience common to both social workers and clients. If it is a fundamental goal of social work to empower those who feel oppressed then it is important to recognise that it is the diffusion of power as much as its consolidation which oppresses. The theory of «emergent» properties offers a way for social workers to think about problems of power and control in relation to questions of complexity and helpfully indicates THAT HELPING OURSELVES AND OTHERS TO UNDERSTAND COMPLEX SITUATIONS CAN BE EMPOWERING.

## Instrumental and Expressive Aspects of Gaming

All the approaches described above make some reference to both goal orientation and meaning construction. But whereas, symbolic interactionism sees goals merely as the pretext or trigger for symbolic learning and market theory sees meaning as important only in so far as it contributes to the shaping of individual goals and collective demands, the approaches associated with Simmel, Elias and Bateson attempt to address both. The main difference being that whereas Bateson and the later family therapy tradition argue for an essentially circular concept of meaning as something derived from fixed patterns of action and reaction, the approach opened up by Simmel does not rely upon reified notions of rule or types of society. It seems to suggest that we can apprehend social action as a creative and open-ended game in which the actors are constrained by the rules but through their actions they can change those rules and in which individual strategies and the forms in which they are embedded constantly generate new patterns of social meaning. Actions are therefore both goal oriented and symbolic whilst remaining essentially creative.

This formulation of the relationship between social interaction, meaning and the relationship between the individual and the broader social context seems to me to be very promising and to lend itself exceptionally well to a framework of social work theory. However, something is still missing...

## Sociometry and Network Analysis

Although the concepts of game, strategy, interdependency and power games have considerable value in their own right, for social workers, something vital is still missing and that is a theory which would allow them to:

- 1 map out specific configurations rather than relying on general metaphors
- 2 think about the impact of relationships upon goals as well as goals upon relationships
- 3 explore the relationship between interaction patterns, social experience and definitions of need.
- 4 understand the relationship between social games and the processes by which individuals and groups mobilise support and take collective action.

This is where social network theory appears to be particularly helpful. The work of Barnes (1954), Bott (1971), Mitchell (1969) and others

showed how people use their relationships both to further their own interests and as sources of personal practical and psychological support. This links with the work of Moreno on «sociometry» and his attempt to describe social situations in terms of «attraction» and «repulsion» patterns (Moreno 1978). Significantly, Epstein (1969) showed how a communication network can mark out and reinforce social boundaries. In recent years social network theorists have used this body of ideas to develop new accounts of social action and social support (e.g. Garbarino, 1986).

Social network theory forms the bridge which allows many of the general truths of social interaction theory to be understood in terms of patterns of relationships and processes of mobilisation. It is more than just an assessment tool (Seed, 1990), it has led to the development of new methods of doing social work such as networking (Trevillion, 1992, pp. 1-21).

### Conclusion: A New «Theory» for Social Work?

The perspectives identified here constitute a rich mine of concepts and explanatory constructs which can help social workers to explore motivation, interdependency and social process—all issues critical to their practice. However, it is also clear that without some clearer organisation of concepts they may be reluctant to do so or fail to use concepts appropriately. What is offered is then less of a new theory and more an attempt to organise a range of concepts drawn from the sources I have identified and to orient this theory to questions of assessment, intervention and evaluation.

If it can be effectively developed from the sketch that I have produced here, social interaction theory can have a major impact on social work theory. In principle it offers social workers new ways of understanding social situations and practice contexts in terms of «social forms», emergent properties, network patterns, games and strategies.

But the theory also suggests that this type of knowledge can only be gained with the help of others, as positions within a social game inevitably conceal the nature of the game from those playing it. The knowledge offered by social interaction theory is not objective in that it resides outside those involved but is rather inter-subjective knowledge. This inter-subjectivity is the conceptual counterpart of the web of interdependency

in which those involved find themselves. It is in this web of interdependency that not only the individuals but also the theory is literally embedded

INVOLVING OTHERS IN DECISION MAKING IS THEREFORE FOR SOCIAL WORKERS NOT MERELY DESIRABLE FOR ETHICAL REASONS, WITHIN THIS FRAMEWORK OF THEORY, IT BECOMES A PRECONDITION FOR THE FORMATION OF VALID SOCIAL WORK KNOWLEDGE AND A PREREQUISITE FOR SOCIAL WORK INTERVENTION. In other words, social interaction theory re-defines the social work task as one of involving key figures in a problem situation in a process of SHARED ELUCIDATION OF GAMES, FORMS AND STRATEGIES SO AS TO REVEAL OPPORTUNITIES, CONSTRAINTS AND MEANINGS MORE EXPLICITLY. Moreover, one could go further. If social needs and social problems can be understood as certain kinds of configurations or modes of interdependency operating at both micro and macro-levels, then social work is part of the process by which those involved change their modes of interdependency through individual or collective action. Moreover, according to this theory, the position of the worker is not a neutral one. He or she joins (even if they don't want to) and becomes part of the social process. His or her strategies enter the total field of strategies alongside everyone else's and contribute to the overall pattern of interdependency for good or ill.

This does not imply any one method of social work. As a general orientation it is as appropriate for working with groups or communities as with individuals or families. However, it does imply a shift away from simplistic treatment models as well as simplistic advocacy models. It requires a much more inclusive, reflexive and interactive orientation in which interventions are seen as moves which subtly alter the nature of the social game and in which the professional game is seen as a characteristic spiral of intersubjective discovery with the consequence that new opportunities for action are constantly revealed and new questions raised about assumptions, motivations and goals.

Earlier on, I argued that the minimum requirement of a social work theory is that it should allow the social worker to encompass and make explicit the concrete set of social relations of which he or she is a part and then to act on the basis of this understanding and that social work theory will be that which permits or enables the kind of relational and reflexive statements to be made by social workers to themselves and others which clarify risks and opportunities and which lead to actions which help to

solve social problems. I would suggest that the theory I have outlined goes at least some way towards meeting these criteria.

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NETWORKING AND  
COMMUNITY  
PARTNERSHIP

*To Rachel and Phillip*



# Networking and Community Partnership

Steve Trevillion

**Ashgate**  

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**ARENA**

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# Introduction

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The first edition of this book was published in 1992 as *Caring in the Community: a networking approach to community partnership*. This edition has been thoroughly revised and rewritten in the light of recent research. The new title reflects a stronger emphasis on the concept of networking than was present in the initial text and the overall aims and objectives are:

- to develop a general theory of networking,
- to define the practice components of networking,
- to explore specific networking tasks and roles,
- to analyse the impact of networking on particular fields of social welfare practice, and
- to identify key issues for teaching and learning about networking.

The book has been written for a mixed readership and the hope is that welfare practitioners and their managers will find as much of value in it as students, academics and policy makers. The author is a former social worker but networking is an interdisciplinary field and what has been written is not just for social workers but also for community workers, health promoters, community psychiatric nurses and anyone else interested in networks and networking.

The term 'networking' has become almost as familiar to social services practitioners, managers and policy makers in the 1990s as the term 'genericism' was to the post-Seebohm generation in the 1970s. Thirty years ago, genericism was closely associated with the idea of a 'unified social services department': a large publicly owned and controlled organisation with a single director, directly accountable to local politicians and aiming to offer access through 'one door' to a wide range of in-house services for



## 2 *Networking and Community Partnership*

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individuals and families needing help (Seebohm Committee, 1968). In contrast, networking is closely associated with the development of a very different vision of social welfare.

In the 1990s, it is no longer assumed that social services departments can meet 'need' through the provision of a relatively standardised set of services. Instead, the solution to individual and family problems is increasingly seen as dependent on the linking together of a wide range of different kinds of organisations – private, public and voluntary – each providing some specialist contribution and the whole requiring coordination and strategic alliances rather than traditional management and administration. The term 'virtual organisation' has been coined to describe some of the more radical attempts to build new kinds of welfare structures betwixt and between conventional welfare institutions (Statham, 1996, p.10)

A number of specific changes have encouraged this trend. These include the National Health Service and Community Care Act (1990), especially perhaps the introduction of 'care management' with its emphasis on the coordination of complex 'care packages' and 'joint commissioning' based on the idea of a strategic partnership between health and social services (McBrien, 1996), the new emphasis on primary care teams (Jones, 1992) and the introduction of health and education 'action zones' (Peck and Poxton, 1998). Some of these changes have been driven forward by governments committed to market ideologies and various versions of communitarianism (Etzioni, 1995); some have been generated by grassroots social movements (Brandon, 1995).

All of these developments have been accompanied by endless calls for those involved with assessing need and planning or delivering services, whether for communities as a whole or for specific individuals, to network with one another outside conventional organisational structures and systems so as to develop new types of partnership transcending sectoral boundaries and linking planners, purchasers, providers and users of services with one another and with communities as a whole. So closely identified has networking become with this broad vision of partnership that it is impossible to discuss it in isolation from the emergence of that vision.

While the partnership concept was originally used in a limited way to indicate that 'clients are fellow citizens' (British Association of Social Workers, 1980) and therefore entitled to be treated with respect by professional social workers, in recent years it has become identified with the much bigger idea that social services themselves should be seen as a product of a wide ranging social partnership (Etzioni, 1995; Hutton, 1997). As a result, what was once identified with particular areas of social policy such as child care and community care now seems to have permeated the fabric of policy making in local as well as central government. To take just one example of

this, the London Borough of Croydon has described its anti-poverty strategy as one which is explicitly based on the partnership principle: 'To improve the quality of life and opportunities for groups and individuals across the Borough by working in partnership with other public bodies, the private sector, voluntary organisations, community groups and other agencies' (Croydon Strategic Projects, 1997).

This is not a purely local or national phenomenon. Within the broader European context, the 'New Community Partnership' designed to embrace local people, local government and local business in an integrated fashion (Macfarlane and Laville, 1992) is but one of the attempts currently being made to revive civil society and social solidarity in the European Union. But unless something is done to enable these ever more ambitious partnership structures to fulfil their promises of mutual understanding and joint decision making, there is a danger that the sheer complexity of roles, tasks and relationships characteristic of the new welfare partnerships, already exacerbated by the impact of globalisation and deregulation (Trevillion, 1996a, p.100), may lead only to higher levels of confusion, poorer decisions and a downward spiral in the level of service quality. It is here, where vision and rhetoric have to be translated into practice, that networking can be located. However, networking, like partnership, is not immune to the dangers of inflated expectations and so it is important to establish a reliable definition before going any further.

## **Problems of definition**

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Of genericism, it has been said that 'from the very beginning there was controversy as to what this term actually meant and what form its application in practice might take' (Challis, 1990, p.40). Unfortunately, much the same, it seems, could be said about networking. Some have suggested that networking is inextricably linked to the introduction of social care markets and the development of new kinds of relationships between organisations (Laming, 1989, p.19). Others have suggested that networking is a way of injecting more analytic rigor into 'post-Griffiths case management' (Sharkey, 1989, p.391) by taking into account issues such as size and density of social networks. On the other hand, Payne has argued that almost any kind of 'linking' work can be described as networking (Payne, 1993). At the same time, and under the influence of popular versions of management theory, networking has also become identified with the use of informal social contacts as a route to securing information, influence and career advancement.

#### 4 *Networking and Community Partnership*

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While there is nothing wrong with the development of particular versions of any theory in order to suit particular circumstances or to solve particular problems, the sheer variety of ideas about networking and the vagueness of the ways in which these ideas have been expressed is a cause for concern. The history of social welfare is littered with ideas which were once fashionable but which were found wanting when hard questions were asked of them. The problems associated with defining 'genericism' contributed to its collapse in the face of demands for specialist expertise, and the claims of 'community social work' (Barclay, 1982) were made to look very shallow as soon as the concept of 'community' began to be subjected to critical scrutiny. Social welfare may now be organised on network principles, but this, in itself, is not a theory of networking. At best, it is one of the issues which such a theory needs to explain.

The first problem which arises is the need to ensure that any definition of networking is broad enough to encompass the diversity of networking practices without degenerating into vacuous generalisations about 'partnership' and 'community'. At the very least, any definition of networking has to be broad enough to include such activities as the chairing of network conferences, inter-agency networking, the coordination of complex support networks and the mobilisation of activist networks for campaign purposes without becoming meaningless.

A secondary problem is that many of the skills and practices associated with networking often resemble those associated with other well-established psychosocial theories, methods and techniques. For example, chairing a network conference involves assembling a particular network in one place at one time. Superficially, this appears to make it very difficult to clearly separate network conferencing from groupwork.

The solution to the problem of diversity is to build into any definition of networking the one feature which is not only shared by all the examples given but is also a key aspect of all the new welfare 'partnerships': boundaries and boundary crossing. These boundaries might reflect entrenched assumptions about the roles of service providers and service users or be more straightforwardly organisational or professional or, in the case of activist networks, a product of both geographical and social distance and the isolating effects of discrimination and disadvantage. Sometimes all these boundaries might be present simultaneously. Networking involves crossing boundaries like this by way of new patterns of linkage rather than seeking to dissolve or abolish the boundaries themselves.

While any social network can be described as 'a specific set of linkages' (Mitchell, 1969, p.2) those links which networkers seek to forge tend to have much stronger cross-boundary characteristics than those which tend to arise spontaneously between friends and families. This has implications for the

kind of networks or 'sets' with which networking is concerned. Inasmuch as networking is concerned with cross-boundary linkages, it is also concerned with cross-boundary sets characterised by internal differentiation.

The second problem, the overlap between networking and other methods of psychosocial intervention, arises only if we seek to explain networking in terms of some essential and distinctive core of therapeutic techniques. Networking has much in common with community work, counselling and groupwork, but this does not make it the same as any or all of these. What makes networking distinctive is its concern with the building of patterns of social interaction which try to combine possibilities of collective action with respect for difference. This is inherent in the cross-boundary character of the 'sets' with which it is concerned. Any of these are characterised as much by their internal differences as by their commonalities and this preoccupation with the 'linkages' which manage the tension between difference and similarity remains, whether networkers make use of family systems techniques, groupwork or community development.

While attempts to manipulate social ties could be seen as amoral, the theory of networking which is developed in this book is based on the core values of choice, empowerment and partnership. These lie well within the mainstream of much of the thinking behind contemporary social welfare policy and practice. What is distinctive to networking is the way they permeate its most fundamental structural characteristics.

Almost every facet of current social policy embraces the concept of 'choice'. Even if this sometimes becomes almost facile, the concept of choice is rooted in a concern with the dignity and worth of individuals, regardless of their circumstances, age or level of disability (Wagner, 1988). While groups, organisations or even traditional communities can all deprive individuals of choice, networks tend to safeguard it. In part, this is because individuals actively choose to join social networks (Bott, 1971, p.222). But it is also because, in consequence, networks themselves are defined by the choices of those involved. Social networks grow, diminish or change as a result of the choices which are made and networking makes it possible for individuals and groups to have choices that would otherwise not exist by opening up new relationship opportunities.

'Empowerment' is an elusive concept (Baistow, 1995) but, if we assume that it consists of a mixture of access to information, access to practical and emotional support, an opportunity to define oneself rather than to be dependent on the identities imposed by others and active participation in decisions which affect one's life, then networking can be described as empowering. Having opted into a network, one can gain access to information, emotional and practical support and, in some circumstances at least, an opportunity to define oneself in new and more autonomous ways. Some

networks can be made more 'inclusive' and other networks can be developed to challenge injustices or to demand new kinds of social rights. Fundamentally, networking is empowering because it enables individuals and groups to gain control over their environment.

The concept of 'partnership' has been heavily criticised (Morris, 1993). It is no panacea and can lead to attempts to substitute heady rhetoric for practical help. But as a value it is difficult to see how any social welfare practice can ignore it, if only because the 'ultimate moral basis' of citizenship is the web of reciprocal relationships – the community (Jordan, 1990, p.70). In that sense we are all partners, all the time. But partnership is more than this. It also expresses the important paradox that it is possible to come together with others while remaining different. Partnership of one kind or another is therefore integral to all the cross-boundary linkages with which networking is concerned.

Drawing together all these characteristics, it is possible to produce a working definition of networking:

Networking is the development and/or maintenance of any set of cross-boundary linkages designed to promote choice and empowerment which enables its constituent individuals, groups or organisations to work with one another for common purposes without merging their identities.

Much of this book will be concerned with exploring this definition in more detail and analysing its implications in an attempt to develop a theory of networking

### **Theory and research strategies**

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Networking can be called a 'theory' only insofar as it contains some models of and for practice. Model building in the social sciences is fraught with difficulty and controversy (Blaikie, 1993, pp.168–97) and practice theorists have the additional problem that they are frequently attempting, not to describe or explain some identifiable, pre-existing social phenomenon, but rather to develop a model of intervention which will enable skilled practitioners to help to solve social problems of one kind or another. They are concerned with generating knowledge of and for action and, in relation to networking, the epistemological requirements of these action models are particularly demanding.

Networking involves theorising or hypothesising about patterns of linkage, the meanings ascribed to the linkages by those involved and the engaged or participant position of the networker. This creates a situation in

which it might appear that networking is drawn simultaneously towards 'retroductive research strategies' whereby models are developed to explain observed regularities, 'abductive research strategies' whereby accounts are based on the concepts of social actors and the various engaged or committed stances associated with feminism, and 'emancipatory research' (ibid., p.162-97). In fact, networking is not particularly eclectic. It has a distinctive epistemology and ontology, but it is one which is characterised by a process of making connections between multiple viewpoints and perceptions.

As a practice theory, networking can be broadly conceived of in terms of social constructionism, in that it is focused on the way in which particular social realities are constructed by social actors through the interactive sequences in which they are involved. At the same time, and unlike what has been termed 'strict constructionism', networking theory is not purely relativistic (Sarbin and Kitsuse, 1994, pp.12-16). It adopts a 'contextual ontology' in which the analysis of the ways individuals experience and make sense of their interactions with others is based on the assumption that there is such a process of interaction going on.

Networking is also strongly reflexive. The research projects on which this book is based provided opportunities for discussion in which there was no attempt to privilege one truth as against another, only to require that some kind of consensus emerge. These group discussions approximated to the conditions of an 'ideal speech situation' of the kind associated with Critical Theory (Blaikie, 1993, p.213). The search for 'rational consensus' is a distinctive feature of the contextual constructionism of networking. Both as a theory and as a practice, it is associated with situations in which linked individuals and groups are asked to reflect upon their common sense constructions in the light of other 'contextual' information about their interactions and interdependencies. In that this creates numerous opportunities for positive feedback effects, networking could also be said to share aspects of the 'circular epistemology' characteristic of family therapy and other systems theories (Hoffman, 1981, pp.5-9).

## **Methodologies, research techniques and data sets**

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The raw material of networking is social interaction and this book draws heavily on those theories, methodologies and techniques associated with the analysis of social interaction and interdependency. While the evidence on which this book is based was gathered using a variety of different research methods, including action research and case studies, the consistent focus on data associated with social interaction has led to a bias towards

those techniques which have been developed for the analysis of social networks. The relationship between social network analysis and networking is explored in detail in Chapters 1 and 2. Here, the aim is to examine the type of network evidence used in the book and, in particular, the relationship between research methodologies, techniques and data sets.

The book contains a number of distinct data sets associated with particular projects. There are 'action research' data drawn from The West London Project, British 'case study' material from the North London Project, 'ethnographic case study' material from Sweden and 'historical' data consisting of case material drawn from personal experience. What the data sets have in common is that they consist of accounts of social interaction.

The techniques employed to gather the data included diaries (Seed, 1990), exploratory semi-structured interviewing of individuals and groups (Glaser and Strauss, 1968), narrative accounts (Gergen, 1995) and network analysis (Scott, 1992). The techniques used to analyse the data included participatory group methods (Beresford and Trevillion, 1995), thematic analysis or 'qualitative content analysis' (Berelson, 1952, pp.114-34), network wheels (Scott, 1992), grid and group analysis (Douglas, 1973) and, in relation to the 'historical' material in particular, the testing of conjectural models.

All the data sets incorporate multiple perspectives and viewpoints, but they do so in rather different ways. The West London and Swedish Projects analysed or interpreted many of the data collectively in the participative context of 'ideal speech communities' (Habermas, 1972), allowing both for different interpretations and for attempts to transcend these differences. The North London Project relied more on a formal triangulation between different sources of data as a way of handling the question of 'difference'. Finally, the case notes contain alternative views about problems obtained from those directly involved.

### **The West London Project, 1992-3**

Funded by the Central Council for Education and Training for Social Work, this project aimed to identify collaborative skills. It was directed jointly by Peter Beresford and myself and conducted in partnership with a local health authority and a local authority social services department. It brought together health and social work professionals, service users and carers specialising in mental health work and work with older people. Although the focus of the project was the development of a community care skills profile, it soon became clear that this profile had to be located within a broader concept of 'culture' and the secondary aim of the project was to identify the characteristics of this 'culture of collaboration'. Fieldwork began in the summer of 1992 and extended until early 1993. The first phase of the project

consisted of exploratory workshops. These were then followed by a series of user and carer group meetings and a parallel process of work with health and social work practitioners and managers.

For four weeks the professionals kept a community care diary, originally piloted with social work students, in which they noted details of their interactions with others and the way they responded to particular situations. The diaries were then subjected to a thematic analysis and a series of prompts devised for a number of group discussions. From these discussions general issues were identified and brought to a final workshop session involving all research participants when the various service user and carer groups, together with the professionals, were able to work towards a consensus around the question of skills.

The results of this project were published as *Developing Skills for Community Care: A collaborative approach* (Beresford and Trevillion, 1995). As well as contributing to an understanding of collaborative skills, the project showed that it was possible to research patterns of social interaction in the context of the planning and delivery of community care services and to link network data with opportunities for reflection on networking practices. This led directly to the next project.

### **The North London Project, 1993–4**

This project was conducted in a different part of London and was focused, not on skills, but rather on a comparison between two social work teams within the same local authority social services department. The aim was to develop an account of the extent to which the rhetoric of partnership and collaboration was accompanied by purposeful linking between these teams and other teams and organisations and also to discover whether networking activity was associated with the development of new roles. It was funded by the local authority in question and by development research money provided by the Higher Education Funding Council for England and Wales.

While the choice of the local authority was partly related to factors external to the research topic, such as common membership of a Diploma in Social Work training programme, it was also related to a shared interest in exploring the implications of cross-boundary working in the aftermath of the 1990 NHS and Community Care Act. The two teams were chosen specifically because of their declared interest in the implications of cross-boundary working. Some attempt to achieve continuity with the West London Project was made, in that one of the teams selected was a specialist mental health (MH) team. The other team was exclusively concerned with HIV. While this represented the inclusion of a new client group focus, the advantages of inter-team



comparison and the opportunity to incorporate work in an area which was widely seen as in the vanguard of community care developments were seen as outweighing any potential methodological disadvantages.

Planning began in the autumn of 1993 and the fieldwork phase lasted from January to May 1994. The methodology was negotiated with the participants. Senior and team managers within the local authority expressed a clear preference for an approach based on interviews over and above what they saw as the potentially time-consuming nature of diary keeping and group meetings. But it was not only for this reason that a new methodology was employed. Unlike the West London Project, which brought together a range of individuals from different agencies and teams with service users and carers, the North London Project was essentially a 'case study' (Robson, 1993, p.5) but where it differed from orthodox case study work was in its definition of the 'phenomenon' or 'situation' as certain kinds of routine activity undertaken by team members. The focus was not on the team, itself, as in Goffman's classic study (Goffman, 1971, pp.83-108), but rather on the relationship between external interactions and team functioning.

To begin with, the two team leaders were interviewed. Team leaders were seen as occupying a strategic role in the new decentralised structures becoming commonplace within local authority social services (Challis, 1990) and the assumption was that the team leaders would be able to offer particular insights into the relationship between their teams and the wider organisation, although all of this evidence had to be framed or 'bracketed off' in terms of the likely impact of their role and status on their perceptions.

The next stage consisted of individual interviews with both sets of team members, based on a semi-structured schedule. The focus was on gathering qualitative and quantitative data on network interactions which could be analysed in terms of a network wheel (Scott, 1992). This part of the project was designed to elicit information about roles, concepts of 'team' and the characteristics of cross-boundary linkages.

The data on roles and role sets were gathered in an exploratory manner using the terms and categories used by the individual respondents. Each respondent was identified by a simple code, such as HIV1 or MH1. No attempt was made to standardise these role categories, partly because different members of a single team were involved in very different activities. However, the use of some terms as synonyms was generally obvious enough to permit some standardisation of analytic categories at a later stage. These classificatory data were then used to create a number of boxes which were then filled in with data about interpersonal interactions.

Having accomplished this, it then became possible to explore qualitatively the way in which role and activities were classified and to locate particular linkages within the framework of perceived roles, thereby creat-

ing a series of role-based network 'sets'. It also became possible to develop a quantitative model of the overall pattern of linkages or 'personal professional network' of each respondent by extracting cumulative data on particular individuals from the whole range of role boxes in which those specific individuals were located by the research participants. This, in turn, made it possible to compare and contrast 'personal professional networks' both within teams and between teams and to look for evidence of any shared or collective team networks and the kind of activities which might be helping to develop these.

Some of the results of this project were published in 'Talking about collaboration' (Trevillion, 1996a). As well as showing how different reality and rhetoric might be in the field of community care, the project also contributed some important insights to the overall programme of research on networking. These included raising awareness about the sheer complexity of roles and relationships in contemporary social welfare organisations, highlighting the problematic status of the team concept in the new welfare networks and emphasising the difficulties which might be encountered in trying to develop new strategic cross-boundary linking roles.

### The Swedish Project, 1995-6

The aim of this project was to conduct exploratory research on collaboration/cooperation outside the UK as a pilot project for a broader comparative European study of this subject. While the aim was to use anthropological techniques in order to develop alternative conceptions of cross-boundary working, a central concern was with the way ideas about cooperation could be related to and made sense of in tandem with an exploration of patterns and modes of network interaction.

The modest amount of time and money at our disposal led us to focus on a model which could be described as a short-term/intensive ethnographic case study which had links with some of the participatory methods pioneered in applied anthropology/development studies and referred to there as Rapid Rural Appraisal (Cornwell, 1992, pp.12). A relatively extended period of preparation led up to a short but intensive and highly structured four days of fieldwork in Stockholm with a group of HIV specialist *kurators* (medical social workers) in May 1996.

As part of the preparatory phase, the *kurators* were asked to complete summary diaries containing details of their movements and interactions. These diaries were then used to frame the areas for discussion and exploration during the fieldwork phase of the project.

The fieldwork techniques consisted of semi-structured group interviewing with the *kurators*, presentation and discussion of case narratives drawn

from the *kurators'* own experiences and a group discussion with the *kurators* and members of their professional network. The project generated a body of material which was published as 'The Co-operation Concept in a Team of Swedish Social Workers' (Trevillion and Green, 1998). The major finding was that, while some of the same forces were evidently at work in both the UK and Sweden in relation to collaboration/cooperation, the models developed by teams in London and Stockholm were very different. In particular, the emphasis on teams and relationships in Stockholm differentiated the *kurators'* approach to cooperation from the more individualistic, instrumental and outcome-oriented approach to collaboration found in the London teams. The contribution of the project to the overall programme of work on networking lay principally in the way it suggested that it might be possible to map various approaches to inter-agency and interprofessional linking work in a comparative manner.

### **The case notes, 1980–86**

Throughout the text, reference is made to specific cases or situations in which I have been involved either as a social worker or as a supervisor/line manager. Ethical and legal constraints preclude any direct use of original documentation, and names and other distinguishing details have been altered to preserve anonymity, but, as far as possible, the authenticity of these professional experiences has been preserved.

Some element of retrospective reorganisation of material is almost inevitable when trying to present personal experiences some years after the events described, but my justification for using this material in the book is twofold. The case notes predate the development of any theory of networking and are significant not only because they represent the raw material from which the theory developed but also because they have continued to offer me opportunities for testing and modifying concepts and models of networking.

With historical material of this kind, the process of testing models and hypotheses cannot be undertaken experimentally. What can be done, however, is to explore the material in a critical manner to see whether the model which best fits the situation being described is one consistent with the general theoretical position of networking and/or which suggests that the theory needs to be developed further. This is similar to Bernal's idea of 'plausibility' which he invokes as an alternative to positivistic conceptions of proof in historical enquiry (Bernal, 1991).

## **Organisation of the book**

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The layout of the book reflects the logic of the argument by moving from questions of general theory to specific practice implications. Chapters 1 and 2 are concerned with basic theory. Chapters 3, 4 and 5 explore assessment, brokerage and inter-agency work. Chapters 6, 7 and 8 look at the impact of networking on care management, empowerment and work with children and families. Chapter 9 considers the implications of a shift towards networking for the education and training of social welfare professionals, while Chapter 10 offers a brief conclusion.

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# 1 Social welfare and social networks

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People are hardly aware of the problem created by the possibility that hundreds, thousands, millions of people may have some relationship to each other and be dependent on each other, although this may well happen in the modern world. Despite this general lack of awareness, the wide span of dependencies and interdependencies which now bind people together are among the most elementary aspects of human life. (Elias, 1978, p.100)

## Complexity

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Modern social welfare has become increasingly 'complex' (Hall, 1995). Whether one looks at structures or systems, the picture is much the same. At the structural level, it has become apparent that even one of its sectors, such as the independent sector, may contain such a diverse set of organisations that it is impossible to generalise about it (Taylor et al., 1995). At the systemic level, the delivery of health and social care services is now characterised by unprecedented degrees of complexity associated with 'the varying roles, responsibilities, resources and traditions of the many agencies involved' (Gostick, 1997, p.193).

The implications for individuals working within these complex structures and systems are significant. The following portrait is based on an analysis of the social network of one of those who took part in the North London Project, a psychiatric social worker in a large teaching hospital:

While Sweden and the UK have different welfare systems and the specific problems posed by the move towards complexity may also be different, many of the new challenges faced by social welfare practitioners in both countries centre on the question of building and maintaining cross-boundary relationships in a context of change: challenges for which their own organisations may have few answers.

Traditional welfare organisations have a number of strengths. They provide those who work in them with a clear sense of role and task, decision making takes place within clear structures of accountability, and standardisation of services ensures both a broad public understanding of what the organisation does and a certain level of equity in terms of service provision. A defence could certainly be made of the postwar British National Health Service and the post-Seebohm local authority social services department on these kinds of grounds. But, although well adapted to a world of limited expectations and relative stability, these kinds of organisations have shown themselves to be poorly suited to the complexities of a new welfare environment characterised not only by markets and the drive towards social partnership but also by the effects of rapid social and economic change (Statham, 1996).

## **The social network concept**

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Although many claims have been made for the power of social networks to solve social problems (Speck and Attneave, 1973; Maguire, 1983), at root the social network concept is a way of understanding complexity. 'The concept of social network paves the way to an understanding of the linkages existing between different institutional spheres and between different systems of groups and categories' (Srinivas and Beteille, 1964, p.165). Because it encompasses complex patterns of interaction and multiple viewpoints or 'normative frameworks' (Mitchell, 1969, pp.47-9) the social network concept can help social welfare practitioners to make sense of their cross-boundary working environment. It has to be acknowledged, however, that the term 'network' can, itself, be confusing because it has a number of meanings.

The word can be used as a 'metaphor' to refer to any kind of general and unspecified interconnectedness in society (Mitchell, 1969, p.1). This can be helpful, if the aim is to simply emphasise the complexity of our interdependencies. But it can easily lead to a 'rose-tinted' view of reality (Bulmer, 1987, pp.137-8). The move away from 'community social work' to narrow specialism and market-driven forms of care management focusing

on 'cost containment' (Phillipson, 1992, p.122) can, in part, be traced back to the disillusionment with the language of network and community which surfaced in the late 1980s and was associated with the celebration of individualism (Wilding, 1992, pp.10–11).

So as to avoid, once again, getting drawn into endless debates about 'community' or 'neighbourhood spirit' (Abrams, 1980), we should probably avoid using the term 'social network' as a metaphor altogether. There are a number of alternative approaches, all of which build on the original insight that it is possible to describe social life in terms of specific 'social fields' (Barnes, 1954, p.43). Mitchell defined a social network as 'a specific set of linkages among a defined set of persons' (Mitchell, 1969, p.2) More recently, it has been defined as a 'perspective' which 'encompasses theories, methods and applications that are expressed in terms of relational concepts or processes' (Wasserman and Faust, 1994, p.4) and which has four key elements:

- individual social actors are viewed as interdependent;
- linkages between social actors are seen to direct the flow of material and non-material resources;
- the network environment is seen in terms of opportunities and constraints on individual action;
- lasting patterns of relations can be thought of as structures.

One might want to add that relations between groups or organisations as well as between individuals can be modelled in network terms.

Many different kinds of social issues can be explored using social network perspectives. These range from studies of inequalities in resource distribution to explorations of patterns of influence. For those working in the social welfare field, the approach also offers important new insights into areas such as risk analysis. This can be illustrated through an example.

Figure 1.1 represents a 'social field', 'set' or 'network' of the kind described by Barnes, Mitchell and others. At first sight, it looks rather schematic and abstract. Nevertheless, it is possible to see that A, B, C, D, E, F, G and H are all interacting in a particular way with one another. C, for example is interacting with A, B, D and E but not with F, G, and H. Moreover, A and B are interacting only with C and not with each other. F and C have no contact with each other but both have contact with E and D. As soon as we make the example less abstract, some of the advantages of the network perspective become more evident.

Let us suppose that the social field to which Figure 1.1 refers is an extended family network and that A, B, C, D, E, F, G and H are all separate households and that G is a nuclear family unit – the Godstones – consisting



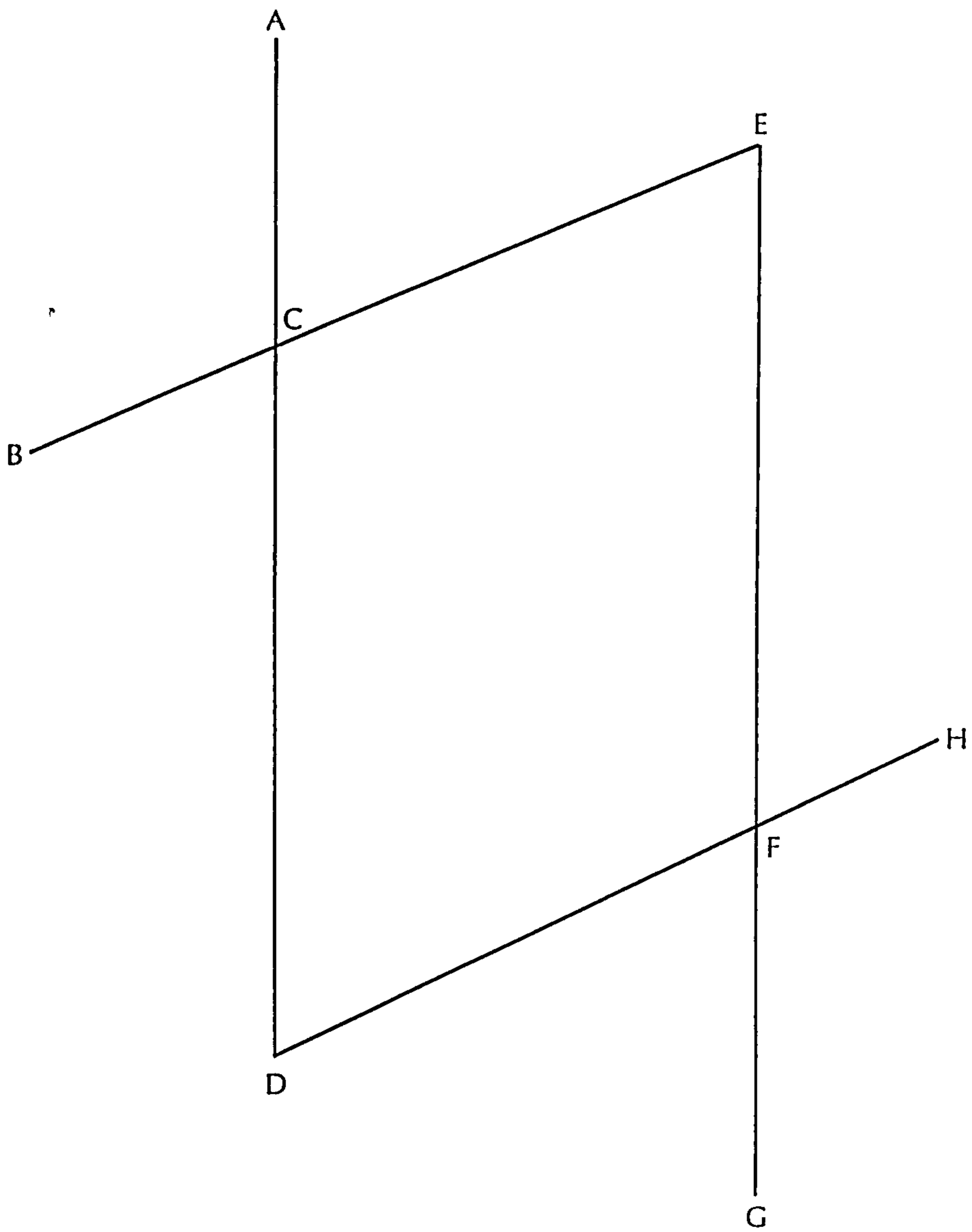


Figure 1.1 A social network

of Mr Godstone, his wife Jean Godstone and their daughter Emma Godstone. There are indications that Emma has been sexually abused by Mr Godstone. If there has been abuse then the relative isolation of the Godstone family

might turn out to be a key factor in having enabled it to remain undetected. The only contact the family have with their relatives is Jean Godstone's regular trips to see her mother Louise Farmer ( F on the diagram). But Emma rarely accompanies her mother on these trips. There is no contact with neighbours and Emma's withdrawn behaviour at school has prevented her from making any close friends.

If we put all this together, it becomes clear how the position of the Godstones within their extended family network has reduced any informal surveillance by other family members to a minimum and has effectively blocked Emma's access to informal help and advice. In other words, the pattern of network interaction increases the exploitative patriarchal power of Mr Godstone and makes Emma extremely vulnerable, and this needs to be recognised by any social workers who become involved with the family.

This example shows that the process of mapping a social network can generate information about the relationship between risk, vulnerability and support which lie at the heart, not only of social work but also of other professions such as health visiting and community psychiatric nursing. The techniques associated with eliciting this kind of information about 'the social landscape of people's lives' (Seed, 1990, p.11) can be used by social welfare practitioners as follows:

- to take account of the impact of social change on social networks,
- to define network boundaries,
- to analyse 'connectedness' or 'density',
- to identify links between needs and resources,
- to identify brokers and brokerage networks,
- to analyse the exclusionary or empowering potential of social networks,
- to understand types of exchange and degrees of reciprocity, and
- to locate the potential for social support within social networks.

### **Taking account of social change**

If social life in general and social welfare practice in particular have become more complex it is not only because the pace of change has quickened but because society has become much more differentiated and pluralistic. One consequence of this is that it becomes harder and harder for people to identify exclusively with particular closed social groups (Durkheim, 1933). In such a context, concepts such as 'family' or 'group' which presume shared norms and values can often seem anachronistic, unhelpful and even oppressive, because they are associated with an attempt to impose an artificial level of uniformity on a fluid and rapidly changing social situation.

Unlike 'family', 'group' or 'system', the social network concept makes no assumptions and seeks to impose no particular order upon events. Rather, it simply describes what is, which may often be something very different from a closed group or conventional family unit: 'In network formation ... only some, not all of the component individuals have social relationships with one another. In a network, the component external units do not make up a larger social whole; they are not surrounded by a common boundary' (Bott, 1957, pp.58-9). So the social network concept gives us a way of describing a whole range of relatively fluid and informal social phenomena (Srinivas and Beteille, 1964, p.166) which may be of great significance for those working in a rapidly changing society such as our own in which traditional institutions may no longer provide the frameworks within which people lead their lives.

The continuing movement away from traditional patterns of family life (Robertson-Elliot, 1986, pp.34-72) provides a good example of the way network analysis can help us to respond to change. The concept of 'the family' as an integrated social group may well be adequate for work with a relatively isolated nuclear family household, but if the parents divorce, remarry and form new 'reconstituted' families (ibid., pp.134-76), the resulting pattern of relationships will be a network rather than a group (Rands, 1988, p.128). Moreover, it may well be a network in which different individuals have very different relationships with one another.

The children of divorced parents may continue to see both of them, but the parents may cease to have any but the most minimal contact with each other. As a result, children and parents may have very different concepts of what constitutes their 'family'. If there were a social worker or health visitor involved, they would need to recognise that the family – at least as far as the children are concerned – is not a household (either of a traditional or reconstituted kind) but rather a network of relationships running across household boundaries.

### **Defining network boundaries**

Any assessment which needs to develop a picture of the 'social environment' can make use of network analysis. However, one obvious problem is that social interaction has no beginning and no end. Social networks do not present themselves to us in a ready-made form. Rather, the 'social environment' has to be actively constructed by placing a particular boundary around the network (Wasserman and Faust, 1994, pp.30-31). In some situations, it may be more appropriate to start with a predefined 'set' or collectivity of some kind (Mayer, 1962), whereas in other cases we may want to start with one individual or group and work outwards (Mitchell, 1969), being pre-

pared to define the boundary flexibly in terms of some measure of social distance rather than any shared characteristics.

Although community work aspires to community empowerment, in many cases the starting point is a problem defined by those living outside a particular geographical 'community' or 'community of interest'. From a social network perspective, this leads to a 'nominalist' or external definition of the boundary around a 'set' as opposed to a 'realist' or internal definition of that boundary (Laumann *et al.*, 1989). Sometimes the community work response to the nominalist/realist dilemma is to focus on specific 'communities of interest'. Again, from a social network perspective, this divides an original 'set' into a series of 'sub-sets' related to various 'minority' groups, for example sub-sets based on race, gender or employment status. But insofar as these categories continue to reflect external criteria rather than subjective perceptions, some problems are still likely to remain. The 'communities' which exist in the mind of a community worker may continue to correspond very inadequately to the reality of what has been called the 'subjective network' (Srinivas and Beteille, 1964, p.166) or the way in which individuals experience their own networks and may indeed seriously distort the nature of this experience.

Adopting a 'realist' approach generates other problems, many of them associated with the need to show that there is some connection between a particular network and its concerns, on the one hand, and a publically recognised issue or problem, on the other. As a result of these difficulties, community workers often move between 'nominalist' and 'realist' boundaries in the way they define network and community.

When we are interested in the support which is available to particular individuals, we invariably focus on their 'personal network' (Mitchell, 1969). A care management assessment is a good example. The health of an elderly person might suddenly deteriorate, leading that person to request additional help from the local authority social services department. A care manager would only be able to make an assessment by interviewing both the client and those members of the personal network already actively involved, bearing in mind that the best way of supporting the client might be through supporting those members of the personal network acting as carers. But there are other people involved as well, and one of the difficulties with the personal network approach is that it is not immediately apparent how we distinguish between those we need to talk to and those whose views may be less relevant.

Although it is easy to begin exploring relationships using this approach, the sheer number of links that could be included in the network soon makes it unmanageable. One way forward is to distinguish between key relationships and those which are less significant, on the basis of how direct

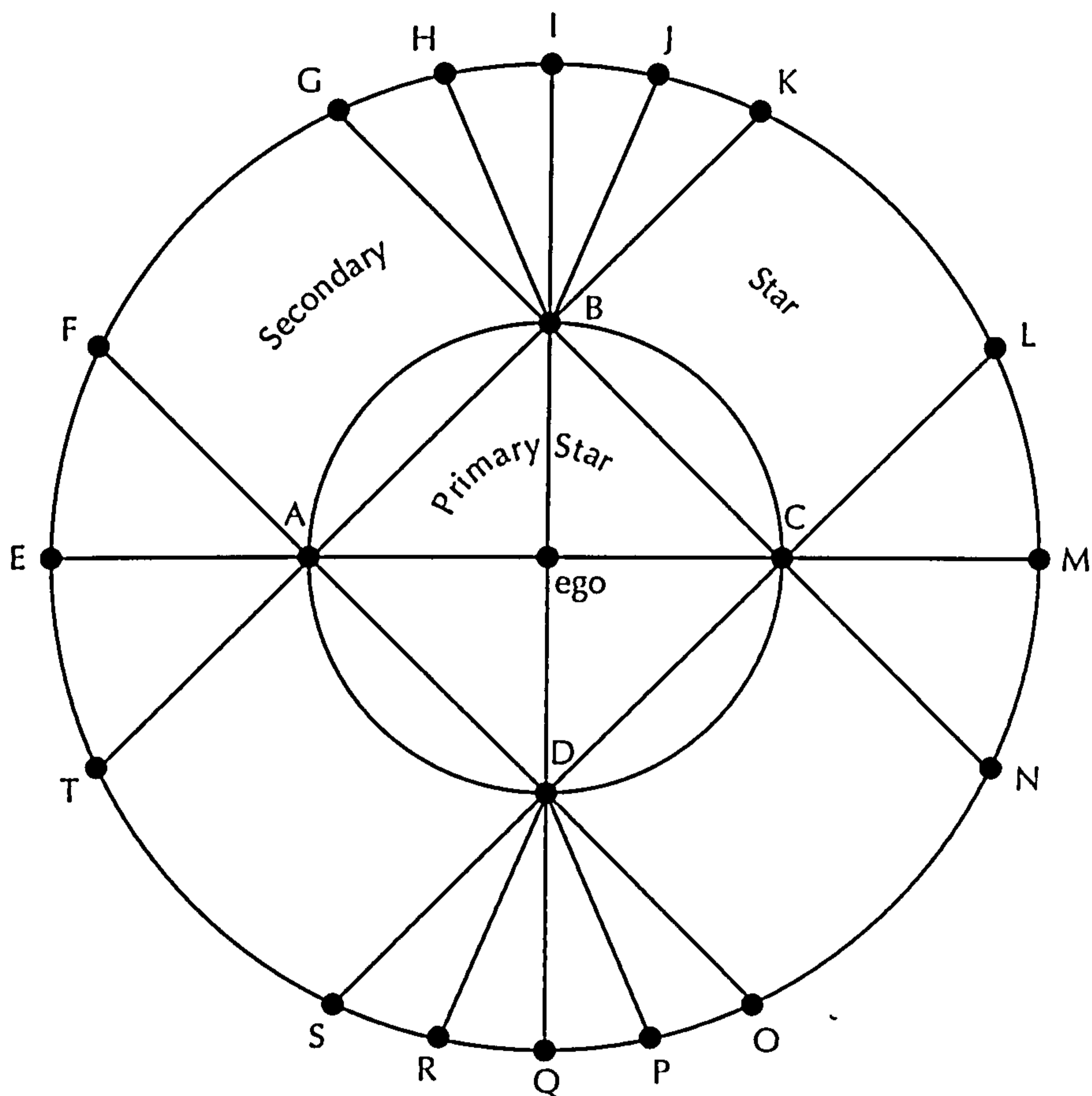


Figure 1.2 Primary and secondary 'stars'

or indirect the interactions are (Barnes, 1969, pp.58-72). The full set of individuals linked directly to that person is the primary network or *primary star*. The full set of individuals linked to the primary star is the secondary network or *secondary star* and the full set of individuals linked to the secondary network is the *tertiary star*. The relevance of the primary star is obvious, but whether or not parts of the secondary star are relevant will depend on an analysis of the situation. In general, only researchers using snowball sampling techniques (Goodman, 1961) will be interested in all the links associated with all three 'stars'.

In the example, some parts of the secondary star (the carers network) might be significant because of their influence on the carers and their future

actions. On the other hand, it seems safe to conclude that members of the tertiary star are so distant, both from the carers and from the person for whom they are caring that they can be ignored. The relationship between primary and secondary stars is illustrated in Figure 1.2.

In network terms, the process of supporting carers focuses on the complex interplay between the primary and secondary stars. It may not always be easy to predict the effect of changes in the secondary star on the primary star. Moreover, another complication is that, while it might seem that a personal network approach avoids the problems of choosing between 'nominalist' and 'realist' definitions of 'sets' and 'sub-sets', this is only true with very simple networks. As soon as a care manager becomes interested in the *secondary star*, it is likely that the complexity of interaction will be such that he or she will want to start selecting particular patterns or sets of links to focus upon, based on some understanding of the key issues or problems.

### **Analysing 'connectedness' or 'density'**

Unless there is a significant degree of interaction between people, we cannot say that they are 'partners'. The social network approach enables us to gauge the amount of 'interdependency' or 'connectedness' in a social field which is a measure of this basic element of partnership. 'Connectedness' (other authors use the term 'density') has been defined by Bott as 'the extent to which the people known by a family [or individual/group] know and meet one another independently of the family' (Bott, 1971, p.59). This enables us to distinguish between 'close-knit networks' and 'loose-knit' networks (*ibid.*). Figures 1.3 and 1.4 illustrate both types of network. A social network may be relatively 'loose-knit' simply because there has been no history of contact or communication. This is often the case with 'loose-knit' networks of professionals.

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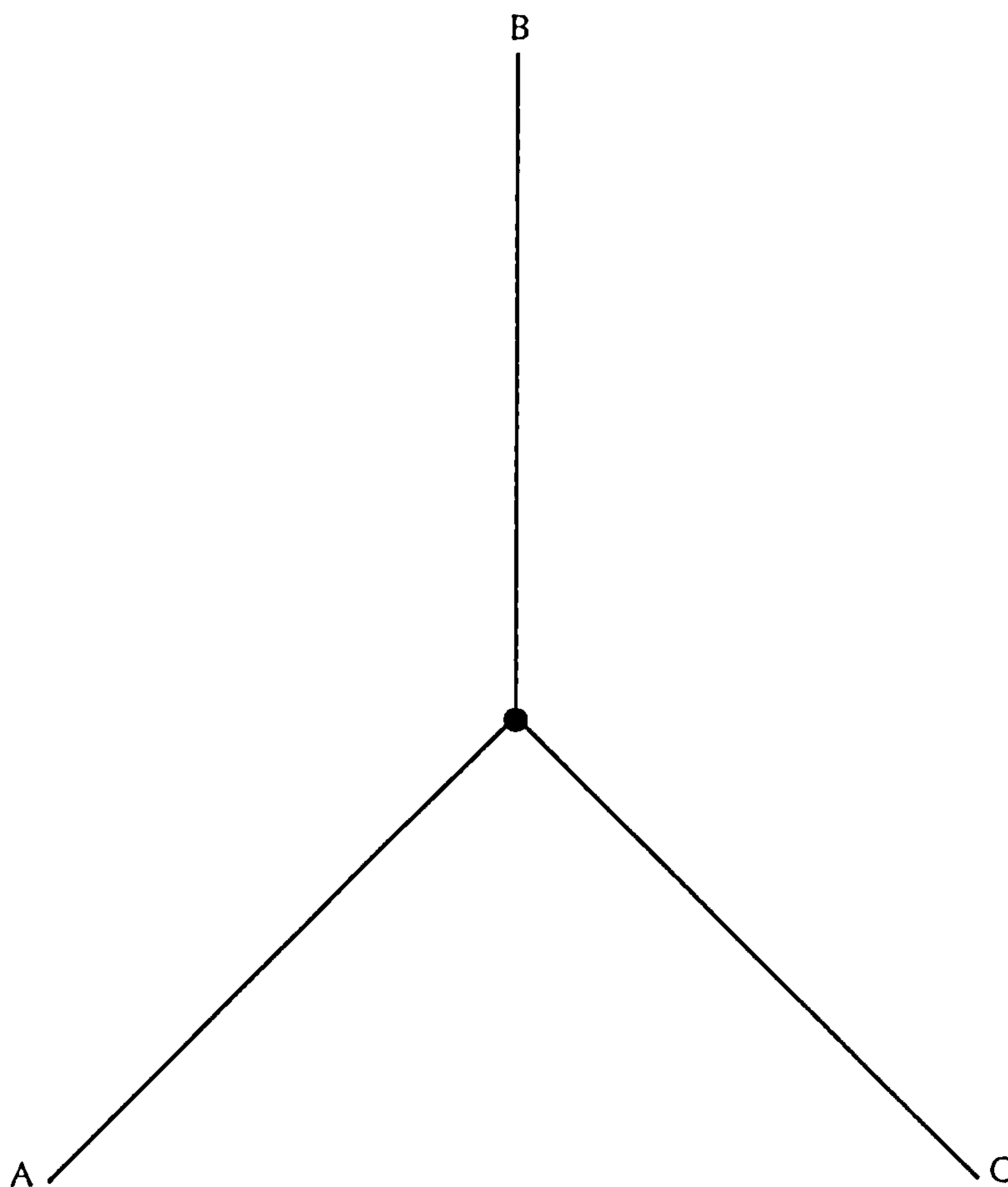
In 1985 I was working as a senior social worker in South London. The departure of a colleague meant that I assumed responsibility for the supervision of a complex child care case and this, in turn, led to an invitation to a 'professionals meeting' at a nearby family centre which was to include educational psychologists, residential social workers, teachers and others, as well as myself and the social worker I was supervising.

Although it was a large family, my initial response to the sheer number and range of professionals present was one of surprise. It also quickly became obvious that those present barely knew one another and had little sense of working together to help a particular family, albeit one in which

the children were separated from one another and/or their parents. Although many of the professionals had been working skilfully with particular members of the family for many years, some of them had never met before and had little idea of what others were doing or whether what they were doing was compatible with what was going on with other members of the family.

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While it is possible to argue that good work was accomplished in this situation without the need for any improvement in patterns of professional



**Figure 1.3** A loose-knit network

She was part of a large group of social workers, some of whom she rarely saw because they spent much of their time elsewhere. Although she was employed by a local authority, she spent most of her working hours with health professionals who were directly responsible to a National Health Service Trust. Her main role was the 'resettlement' of those leaving hospital. She had links with a voluntary agency which was largely responsible for many of the practical tasks associated with the 'resettlement' process. She also had links with a group of Community Psychiatric Nurses, a specialist housing association, the staff of two local hostels and members of the local authority Housing Department.

Within the hospital, she had to maintain relationships with the interdisciplinary teams on a number of different wards and to cultivate relationships with consultant psychiatrists. Apart from these face-to-face contacts, she was constantly in telephone contact with a number of specialist advisory workers in the field of welfare rights, one of whom worked for the local authority, while others worked for a variety of voluntary organisations. She readily acknowledged that the success of her work depended more on informal processes and personal relationships than any formal organisational structures and, when asked to which 'team' she belonged, she found it very difficult to give a straightforward answer.

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In this example the experience of complexity is associated with a high level of cross-boundary work, a diverse range of 'partners' and a multiplicity of team identities (Trevillion, 1996a, pp.98-9). This is not just a UK phenomenon. One *kurator* (hospital social worker) who took part in the Swedish Project spoke about the way in which her job had become less bureaucratic and predictable and more interesting and innovative, but also, at the same time, more anxiety provoking:

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because the security also made us a bit lazy and maybe we didn't use our heads in the way that we could, so what's happening is that we have to use our heads more, that we have to find other ways... I think that in this country we are not adjusted to this yet. I think we are going to find another way of dealing with things. Today, we don't know where to go for the next step. We are rather insecure, I think.

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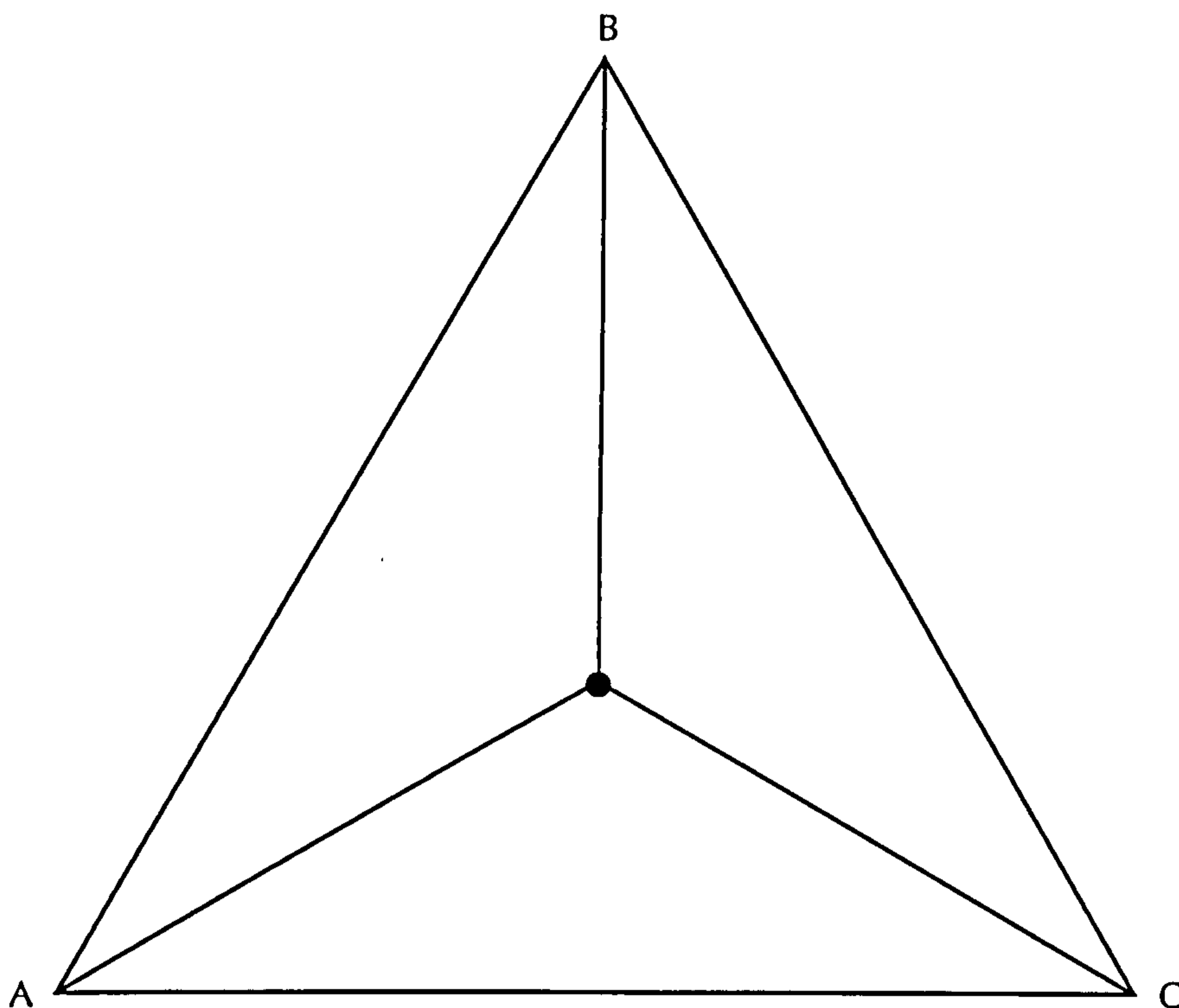
communication, it was only after this meeting that a coherent therapeutic strategy began to emerge, partly as a result of pressure from myself and the social worker whom I was supervising. Perhaps even more significantly, it is hard to see how a network characterised by such poor levels of communication and coordination could have discharged its responsibilities effectively in relation to child protection.

Often clients find the lack of contact between different professionals quite baffling: 'Why don't you talk to one another?', they quite reasonably ask. The consequences of not 'talking to one another' vary from duplication of effort to dramatic and sometimes dangerous gaps in service provision. Moreover, only by reviewing with the service user the pattern of services as a whole can one get any idea of their impact on the life of the service user.

Sometimes too much 'connectedness' can be a problem, as with some residential homes, where the staff identify very strongly with the home and with each other and discourage contact between residents and outsiders. This is likely to reduce the capacity for healthy self-criticism and increase the acceptance of bad practice, including in extreme cases human rights abuses. Moreover, it is not consistent with 'normalisation' philosophy or the idea that residential care should be a form of 'community care' (Wagner, 1988)

Sometimes it may be important to explore the interplay between different levels of 'connectedness' within a network. A community worker may discover that people living in one low-rise part of an estate may have much more contact with one another than people living in blocks of high-rise flats. He or she may also discover that those living in the low-rise dwellings have secured most of the official positions on the Tenants Association and often seem to speak for the rest of the estate without consulting them. Here the relative 'close-knittedness' of one part of the estate is a problem for the Estate as a whole, which can only be resolved if the community worker can enable the rest of the estate to interact more closely with one another and challenge the position of what amounts to a dominant clique by participating more fully in the Tenants Association.

An alternative way of thinking about 'connectedness' is the concept of 'holes' in the network mesh where there is relatively little social interaction going on. In a highly interdependent social field there will be few 'holes' in the network mesh (Barnes, 1954, p.44). Conversely, the larger the number and size of holes in the mesh, the smaller the degree of 'connectedness' in the network. While this may simply mean that the whole network is very 'loose-knit', it may also be apparent that the 'holes' are present in particular places only. This kind of analysis can show that some individuals or groups are only tenuously linked to what is otherwise a well integrated social network.



**Figure 1.4** A close-knit network

The presence of holes in a particular mesh of relationships should always alert us to the possibility of social marginalisation and social exclusion. So a 'hole' around a disabled or mentally ill person living 'in the community' may reflect the systematic rejection by that community of the individual concerned. On the other hand, lack of contact with neighbours may be freely chosen and reflect not social exclusion but something very different. Where a particular family chooses to distance itself from others in the street or neighbourhood because it sees itself as belonging to a higher social class, the hole in the network mesh around them is what they have created and is a measure of their ability to exercise social power.

### **From needs to resources**

Meeting need is not always a matter of introducing new resources into a situation. It may be better to think sometimes about enabling individuals to gain access to resources which already exist. But in this connection it is

useful to bear in mind the number of 'steps' or intermediaries required to get from one part of a network to another (Mitchell, 1969, pp.12–19). As the number of 'steps' increases, so too does social distance. Where there are too many 'steps' involved, it may not be realistic to expect people to meet their own needs unaided. The process of taking a series of 'steps' has been described as a 'walk' (Wasserman and Faust, 1994, pp.105–8), but where the distance between one part of a network and another is too great it may preclude any kind of 'walking'. Being aware of this may help to focus attention on the need to reduce the number of 'steps' to a manageable number. Where the process of gaining access to resources involves overcoming significant boundaries rather than simply reducing the number of 'steps', some form of 'brokerage' may be necessary.

### **Brokers and brokerage networks**

A social network is an exchange system and its linkages are conduits for the flow of information and resources of all kinds. In many situations these flows are obstructed by the boundaries between one network and another. Those able to control the flow of information or resources across these boundaries and from one network to another are in a potentially influential position in relation to patterns of exchange, and many definitions of brokers and brokerage networks emphasise this aspect of their role. 'Brokers introduce men with power to men seeking its use who are willing to give favours in return for it' (Kettering, 1986, p.4). Networks held together in this way by brokers have been described as 'brokerage networks' and brokers themselves have sometimes been described as 'expert network specialists' in recognition of the skills that they deploy (Rodman and Courts, 1983, p.20).

Within the social welfare field, the concept of 'brokerage' has been used to describe a range of professional or quasi-professional linking and coordinating activities such as service brokerage (Brandon, 1995) and ways of handling key worker responsibilities under the care programme approach (Dube, 1994). The emphasis here is less on power and control and more on the use of brokerage skills to enable information and practical help to flow across otherwise impenetrable barriers of bureaucracy. However, it would be a mistake to think that only professionals can be brokers.

Some brokers can be seen as 'gatekeepers' controlling access to a 'range' of network contacts. In these cases, establishing a relationship with them is vital (Henderson and Thomas, 1987, p.153). A social work team moving into a new patch office in an area traditionally suspicious of the local authority might begin to win acceptance by establishing links with key figures who could act as 'brokers'. Sometimes, these kind of links can have a more specific function, as well.

In 1982 I was a member of a social work team which wanted to offer advice, information and counselling services to homeless young people living in temporary accommodation. These young people were not willing to contact us directly. In the case of the older ones, this was based partly on lack of information about the services they might get from a social worker and also on a feeling that social workers would not understand or be sympathetic to their problems. In the case of the younger ones, this avoidance of social workers was additionally based on a fear that they might be forcibly sent home or 'taken into care' if they asked for help.

Faced with this problem, we decided to make use of our contacts with youth workers in a local 'drop in' centre and staff at a local hostel, asking them to disseminate information about services and encourage young people to make direct contact on the understanding that social workers would always seek to work with young people in trouble rather than force them to go home or to come into care, unless there was really no alternative. On the basis of this understanding the youth workers and hostel staff were willing to act as go-betweens, mediating between the team and local young people.

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Looking back on this experience now, it seems to me that the social workers made use of a brokerage strategy, but did not themselves take on the brokerage role. Rather, by encouraging the drop-in staff to act as 'brokers', the social workers were able to ensure that channels of communication were opened up between the social work team and local young people.

### Exclusionary and empowering networks

Analysis of the 'composition' (Rands, 1988, p.129) of a network sometimes reveals that certain categories of people are being excluded from it. To take a hypothetical example, a drop-in centre for unemployed people might decide to advertise itself by informal 'word of mouth', a method which might appear to have worked very well until the organisers realise that there are no black unemployed people using the centre. Given the high rates of local black unemployment, this can only be explained by the racism of the drop-in centre's informal network.

Similar implicit exclusionary devices, whether based on race, class or gender, are common, particularly in those networks where membership provides access to wealth, power or prestige. One might call such a network an *exclusionary network* because of its concern with narrowly defined membership criteria. The quintessential example of such an exclusionary

network is the so-called 'old boy network' which operates to ensure that preferment in a whole range of situations goes to white, male, upper-class members of the network.

Empowering networks, like exclusionary networks, may be for certain sorts of people only, but there the similarity ends. A women's support network may exclude men in order to 'raise consciousness' and encourage assertiveness among its members. The exclusion of men is not an attempt to maintain privilege but, in contrast, an attempt to facilitate the kind of personal development which could lead to a challenge to the exclusionary practices associated with the 'old boy network', among others.

If we are serious about partnership and empowerment, we ourselves need to share power (Adams, 1990, pp.132-3), but this does not mean that empowerment is necessarily always a 'zero sum game'. A social network approach to the analysis of power and oppression focuses as much on ways of facilitating access to sources of power by reducing 'steps', creating 'walks' and removing dysfunctional boundaries as on the power differential between professionals and non-professionals.

Even amongst the relatively powerless, some may be more powerful than others, and one of the dangers confronting empowering networks of any kind is that energy which should be used challenging oppression can be used to maintain the position of a small clique. Where an ostensibly empowering network becomes dominated by a clique, it may resemble an exclusionary network and oppress those on whose behalf it may claim to speak. Professionals hoping to facilitate the development of empowering networks need to be aware of these issues because an empowering network should be empowering for everyone.

Creating new social pathways or 'walks' linking disadvantaged individuals to educational and vocational opportunities of various kinds can also be a way of developing networks of empowerment. A good example of this is the way in which social work education based in the universities can forge links with individuals and groups in disadvantaged and minority communities by setting up access courses in local colleges and linking up with key brokers capable of representing the university to these communities and these communities to the university. Brunel University has had such links for many years and it is obvious to all those involved that they help to enable members of some of the poorest and most disadvantaged groups in London not only to advance their own careers but also to act as role models for others who may follow in their footsteps.

## Exchange and degrees of reciprocity

It has been suggested that 'mutual exchanges' lie at the heart of a healthy social network (Garbarino, 1986, p.35) and there are many examples of networks which do appear to function on the basis of reciprocity: for example, friendship networks. However, there are also many networks which are characterised by various degrees of 'directedness' or relative lack of reciprocity (Mitchell, 1969, pp.24-6) and complete reciprocity may not always be desirable if it prevents some people taking an initiative on behalf of others. The presence of 'natural neighbours' or 'help givers' on whom others are dependent appears, for example, to be crucial to the development of at least some neighbourhood networks (Collins and Pancoast, 1976, p.21).

But although 'directedness' may be of some use in the short term, in the long term it can lead to instability. 'Natural neighbours' may fall ill or move away, perhaps partly to escape the stress of taking on too much responsibility. Even where total reciprocity may not be a realistic aim, as when very dependent people are being cared for intensively by family friends or neighbours, opportunities for carers to meet and support one another (Trevillion, 1988, pp.302-7) should be explored as ways of strengthening these informal caring networks. Some element of reciprocity is essential to any partnership.

In practice, it is difficult objectively to evaluate the level of reciprocity in an exchange. Although some extraordinarily complicated statistical models have been developed to try to measure reciprocity, even the most sophisticated of these have been found to generate information which is potentially 'misleading' (Wasserman and Faust, 1994, pp.500-55). In most cases allowing the members of the network to evaluate their own exchanges is likely to be much more effective and reliable, simply because, when people do this, they are likely to take all aspects of their interactions into account and not just the more tangible ones. Therefore issues such as the extent to which all views are listened to or the extent to which everyone shares equally in decision making may be as important as the extent to which everyone is contributing equal amounts of time or practical assistance in determining whether people feel that they are in a genuine partnership with one another. Reciprocity may turn out to be inseparable from democracy.

## The social support network

'Support' is one of those words which can be used too loosely. The main danger of this is that we can assume 'support' is present when it is not. Network analysis offers a way of thinking more precisely about 'social

support', whether our focus is child care planning, care management or the care programme approach. In particular, it can prevent us from making hasty judgements about the 'supportiveness' or otherwise of relationships. While it is now widely accepted that all of us have a 'support system' which is embedded in our relationships (Caplan, 1974, pp.1-40), a social network perspective enables us to go further. Garbarino, for example, defines the social support network as 'a set of interconnected relationships among a group of people that provides enduring patterns of nurturance (in any or all forms) and provides contingent re-inforcement for efforts to cope with life on a day to day basis' (Garbarino, 1983, p.5). This suggests that support cannot easily be reduced to any one feature of a social network but is rather dependent on the interplay of all its characteristics. In particular, Garbarino draws our attention to the link between the support which is available to individuals and patterns of interaction.

More recently, Clare Wenger has tried to create a typology of social support networks based on the idea that 'support network type is highly predictive of outcomes in a wide range of areas of life' (Wenger, 1994, p.2). She has focused on older people but her typology is probably applicable much more widely. There is not the space here to do full justice to her work, but she argues quite convincingly that network types reflect different levels of involvement of people in the locality, with family and friends and with the wider community, and that network types are correlated to patterns of service requests (*ibid.*, pp.3-4). Wenger's work shows conclusively that, when trying to analyse support, we need to look at the network, as a whole, rather than focusing on one or two 'supportive' relationships.

## **Two arguments against network analysis**

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Two problems emerge at this point, which need to be dealt with. One is of a general theoretical nature, the other relates more directly to using social network perspectives to solve practical problems. Without wishing to oversimplify a sophisticated technical argument, the theoretical objection to network analysis can be reduced to the following propositions: (1) the only genuine forms of network explanation are those which focus entirely on the connections between people and make no reference to the behaviour of individuals and by implication their values, internal motivations and conscious choices; and (2) genuine network explanations which meet the criteria outlined in the first proposition have little or no value because all the interesting or important issues can be described by making use of alternative explanations based on the behaviour of key social actors (Dowding, 1995).

Now the strength of the criticism contained in the second proposition is dependent on the truth of the first proposition. But, far from being a convincing picture of network analysis, the suggestion that authentic network explanations make no reference to individual social actors or effectively write people 'out of the script' is at odds with some of the most basic statements which have been made about social networks by those who invented the concept.

While it is true that the literature on social networks is full of technical jargon which uses terms like 'clusterability' (Wasserman and Faust, 1994, p.233), it is also notable for its concern with individuals as active agents. Bott, in particular, emphasised the importance of 'choice' in the construction of social networks (Bott, 1971, pp.103–222). Misunderstanding of this arises because network analysis does not recognise that there is an absolute distinction between the social and psychological domains. If the network is seen as the 'primary social world' of the individual (ibid., p.159), then it is through network experiences that the sense of self and the wider universe of meanings or 'cognitive social structure' (Wasserman and Faust, 1994, pp.51–2) is created. This does not mean that individuals are seen as automatons, but rather that their individuality is seen as embedded in social processes and in particular network processes.

It cannot be denied that some writers do seem to have fallen prey to an excessive 'formalism' (Dowding, 1995, p.158). They have lost touch with the fundamental objectives of the social network approach and have substituted technical expertise for the sociological imagination and, thereby, given network analysis a bad name. *But network analysis ought to be concerned with interdependency, interaction and social process and as such it should enable us to explore more, rather than less, fully the ways in which individuals and groups think about and act towards one another.*

The second problem can be summed up as follows. It may be possible to describe the interactions and interdependencies of individuals and groups by the use of various social network techniques. It may also be possible to show that a knowledge of social networks can help social welfare practitioners to be more effective. But it is not clear that an understanding of social networks necessarily leads to a distinctive networking practice. To make the leap from network analysis to networking requires a new kind of practice theory which draws upon social network principles but which can be framed in terms of actions and processes. This is the subject of the next chapter.



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## 2 Networking: a theory for practice

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### Research, development and practice

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Networking is part of the broader contemporary search for 'a culture in which common humanity and the instinct to collaborate are allowed to flower' (Hutton, 1997, p.65). This does not mean that all networks are necessarily a force for good, but, provided two important conditions are met, the process of establishing cross-boundary linkages is one of the ways in which the collaborative vision can be turned into a practical reality. The first of these conditions relates to values, the second to knowledge. Networking is a value-driven activity. What this means is that great care must be taken to ensure that any patterns of linkage which are actively encouraged or helped to grow are compatible with the principles of participation and power sharing underlying the concepts of 'collaboration' and 'stakeholding'. Armed with a few ideas about social networks and a commitment to building the 'New Jerusalem' of a 'stakeholding' society, it is easy to do more harm than good. Powerful cliques may become more powerful and manipulative individuals can inadvertently be presented with even more opportunities to promote their own interests. Networking must therefore also be a knowledge-driven activity.

Social welfare has seen more than its fair share of fads, fashions and ideologies masquerading as practices. All those involved, including service users, are by now rightly suspicious of the claims of any new practice to be able to deliver what it promises. It is time to spell out the relationship between research, development and practice in relation to networking.

The previous chapter focused on applied social network analysis. At its best, this 'incorporates an understanding of the client's world from the

client's point of view' (Seed, 1990, p.9), but while networking is concerned with assessment, it is also concerned with intervention. It is much less concerned with mapping techniques than network analysis and its link with social network theory is of a different kind. Networkers see in network theory both a new language for thinking and talking about social interaction and a set of radical insights into how individuals and social groups can relate to one another outside conventional institutional structures, and networking emerges as a practice with five key characteristics which can be seen both as objectives and as processes:

- the restructuring of the interpersonal domain,
- building communities,
- promoting flexibility and informality,
- maximising communication possibilities, and
- mobilising action sets.

Each relates to a well-established feature of social networks and draws on this to generate models of practice rather in the way that groupwork theory was developed from an analysis of social groups (Spratt, 1958, pp.182–200). So these characteristics of networking are 'relational' in the same way that network analysis is 'relational' (Wasserman and Faust, 1994, p.6), but the shift from network analysis to networking generates a number of new research and development questions closely associated with these practice objectives.

- How can issues associated with meaning, identity and self-worth be addressed through social network interventions?
- What are 'communities' in the field of social welfare and how can they be developed or promoted through social network interventions?
- How can relatively rigid institutional/bureaucratic social welfare systems be made more flexible and informal through social network interventions?
- How do we analyse and go about maximising the potential for appropriate and effective communication in a social network?
- How do we mobilise and maintain 'action sets' in the field of social welfare?

This chapter will look, in turn, at each of the five key characteristics of networking and the associated research questions.

## Restructuring the interpersonal domain

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Social networks are the 'personal order of society' (Mitchell, 1969, p.10) and networking is relationship work. In the last resort, it is not agencies which interact with one another, but people representing agencies. But this kind of relationship work involves working in a systematic way with the connections between feelings about self and others and the characteristics of the particular social networks in which those feelings are embedded. In particular, the restructuring of the interpersonal domain involves *developing respectfulness, promoting reflexivity, encouraging reciprocity and enabling connectedness*. Each of these will be looked at, in turn.

### Developing respectfulness

In the course of the West London Project, carers and service users were asked: What makes for collaboration and what are the key skills needed? The answer was lengthy and included many different types of personal qualities and skills. But the very first thing on the list was 'respect'. This was summed up by a service user: 'If they come into the house with a jumped up attitude, my back's up. If they talk to me like a person, I'm all right. I've been down that road and I don't like it. It's about respect' (Beresford and Trevillion, 1995, pp 115-16). 'The road' that is referred to here is not an isolated thoughtless comment or even a lack of sensitivity. It is a particular way of linking with someone which actively disempowers that person and makes it impossible to move on to establish any kind of partnership.

Much has been written on this subject from almost every angle, including that of the right of all disabled people, however 'different', to be valued for what they are (Morris, 1991). But the West London project made it clear that, from a 'relational' perspective, the process of developing respectfulness involves actively circulating and making available to a network as a whole the multiplicity of views, opinions and potential contributions which are contained separately within its component units, without seeking to privilege professional perspectives. This is the 'road' of respect and it is intimately connected with reflexivity.

### Promoting reflexivity

Any attempt to work directly with social interaction – the raw material of human interdependency – requires of us that we be able and willing to take account of the way in which we ourselves are perceived and related to in

the way in which we work. Competence in this area of work involves that most difficult of all tasks, genuinely listening to and responding to what other people have to say. The West London Project emphasised the way in which working with others depends on a willingness to be 'open'.

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As part of the project, nurses and social workers met in a series of discussion groups and several points relating to 'openness' quickly emerged. First it was emphasised by one of the groups that the way interprofessional relationships were handled at the assessment stage tended to shape the pattern of decision-making and if individuals were seen as having closed minds or fixed views it was extremely difficult to generate an atmosphere of collaboration. The group then went on to specifically connect this quality of 'openness' with the capacity of network participants to engage with one another and with the task.

It was as if the process of building links across professional and organisational boundaries could only take place if there was a collective letting go of fixed assumptions, a desire to listen to what others might say and a willingness to contemplate making changes in one's own practices. Another group picked up this theme and developed it further by suggesting that the process of achieving clarity about tasks and roles in a collaborative network could only be achieved if there was a 'blurring' of traditional roles.

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An important part of being 'open' is being willing to take seriously other people's perceptions about you or your agency. This can be quite painful, but it is vital that the realities of the situation are acknowledged, however painful, uncomfortable or challenging and however much they may delay cherished policies and plans. Some of my own project/case notes demonstrate this quite vividly.

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In 1982, I was working in a neighbourhood-based social work team heavily influenced by the then new ideas of community social work and community care. Having decided that it would be a good idea to emulate successes elsewhere in the country, and to establish teams of social workers and home helps working closely together, two of us arranged a meeting with the home care manager to discuss the idea. She also seemed keen and feeling decidedly optimistic we arranged to meet all the home helps working in

our social work 'patch'. However, it soon became apparent that the meeting was not going according to plan. Nobody wanted to discuss ways of working more closely together. Rather, the meeting was used as an opportunity to vent years of pent up anger and frustration about their experiences with social workers. The level of distrust and suspicion in the room was so palpable that we had little choice but to recognise that we could not put any new service plans into operation until we had managed to resolve more fundamental problems.

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If we had thought more deeply about the issues, we could have predicted that this might happen. We could then have focused less on defending ourselves and more on the important task of starting to build an atmosphere of 'openness'. In the event, the encounter forced us to think about how trust and credibility could be established and how we ourselves could act differently, in the future.

The fact that we had made the effort to come and talk to the home help group on their territory demonstrated 'respect' and, in spite of the initial hostility (or perhaps because of it), we were able to establish good working relationships characterised by what could be described as a 'blurring' of traditional roles and the development of new consultation and support structures which set in motion a process of change which started to influence others as well. Reflexivity is infectious. If one person starts to act in an open and reflexive manner, others may also become more open to personal and professional change.

### Encouraging reciprocity and facilitating connectedness

The subjects of reciprocity and connectedness are best presented in tandem, as it is rarely possible to work with one without working with the other. The Swedish Project painted a vivid picture of a health and social care network referred to by the participants as the 'HIV World', which was characterised by a high level of informal socialising, a strong sense of a shared history and a quality of trust rooted in an expectation that one could ask for help on the assumption that at some future time one could also be asked to give something back. The following is an excerpt from a network meeting in which a brief dialogue takes place between a *kurator* (hospital social worker) and a representative of a voluntary organisation, followed by a statement about the 'HIV World' from another *kurator*.

*Kurator 1:* I know that I can trust her (pointing). I know that if I want something then I always get it. And I hope that's reciprocated.

*Voluntary organisation representative:* Yes.

*Kurator 2:* Maybe it is because the world of HIV care in Stockholm is rather small. We are not so many persons. We really know each other rather well, at least the people I have spoken to over the years.

The second kurator then goes on to identify a potential problem with the pattern of connectedness and the basis on which reciprocal exchanges are organised within this rather circumscribed and close-knit 'social world':

I can understand that it is not very easy to come as a new person into this world because people know each other from many years back.

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One only has to think, for example, of the problems posed for networks like the 'HIV World' by the demands of service user groups for full involvement, or the impact of those with a different cultural background or set of expectations about how people should relate to one another, to see that successful networking is often a delicate balancing act by which people are encouraged to develop existing relationships while being open also to new ones and by which isolation and fragmentation are avoided without taking away the possibility of articulating different kinds of perspectives.

## **Building communities**

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### **Collective identities**

One of the difficulties posed by the concept of 'community' is that it tends to be opposed absolutely to both the values of individualism and the everyday social roles which tend to differentiate us from one another. So Plant, writing about community experiences, describes the process of joining a community as one by which people bring 'themselves', in the 'totality of their social roles' (Plant, 1974, p.16). But networkers are much more likely to be involved with the more ambiguous processes that take place in what could be called 'task communities'.

Any set of cross-boundary linkages in which the boundaries consist of more than simply geography or social distance can be thought of as a potential 'task community'. Members of a 'task community' may have little in common, other than a need to work with one another, but they still need to develop a sense of shared identity, however tentative, and the networker has to find ways of enabling a sense of collective identity to be constructed alongside other, often more powerful or more permanent, allegiances.

With interprofessional networks it is often necessary to encourage some letting go of traditional roles and relationships in order to build a 'task community'. The North London Project suggested that the difficulties the two social work teams had in this respect were associated with the absence of innovatory thinking about roles and tasks. Although there was plenty of evidence of multiple team identification linked to multiple role identification, there was no evidence for the development of new network-based roles such as brokerage, only a proliferation and fragmentation of more traditional roles (Trevillion, 1996a). However, this should not be taken as an argument for weak forms of professional identification. The evidence from the Swedish Project suggests that a strong sense of who one is and what one can contribute can actually help to promote a strong sense of collective identity between professionals.

Strong identities are not necessarily 'conservative' identities. Those of the professional workers in the North London Project appeared to be both weak and traditional and if the identities of the Swedish *kurators* were robust it was because they had been developed in the context of an overall vision of how the network could contribute to the care and support of those living with and affected by HIV in Stockholm. They were not the result of trying to defend traditional claims to expertise (Trevillion and Green, 1998, p.115). Sometimes, paradoxically, it is the effort to resolve conflicts and difference which can promote shared identities.

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In the course of the West London Project, the interprofessional discussion groups explored the relationship between conflict and collaboration. One group came to the conclusion that making potential conflicts explicit at an early stage made it more likely that there would be fewer conflicts later on. Another group took this further and argued that 'honesty' was an essential basis for any partnership and that any honest relationship had to acknowledge potential conflict. It was pointed out that, when a network gets 'stuck' in its decision making, it is frequently because of unacknowledged conflict and that finding ways of helping people to own up to their conflicts and differences might help the network to move on to more open and construc-



tive debate. The same group suggested that certain conflicts, although they might originate between two individuals or organisations, should be regarded as the business of a whole network and it was apparent that this group saw dealing as a network with a network problem as a way of generating a sense of collective identity. The discussion indicated these 'network conflicts' were likely to be connected with issues associated with core values such as 'racial equality'.

It is not easy, however for networks to tackle issues collectively and, while a third discussion group had no difficulty in agreeing to the principle, its members were uneasy about how they would actually put the principle into practice.

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## Empowerment

Health and social work practitioners are often very unclear about the meaning of the term 'empowerment' and how it influences their practice. This was the subject the interprofessional groups in West London Project found it most difficult to discuss (Beresford and Trevillion, 1995, pp.57-8). In part this may be because it has often been assumed that empowerment consists of simply letting relatively powerless service users and carers make decisions on their own. But this is to mistake cause and effect. It is not the absence of 'disabling professionals' which generates 'enabling and empowerment' (Hadley *et al.*, 1987, p.10). On the contrary, simply leaving service users to make their own decisions unaided may be actively disempowering, unless people already have access to all the information they need and have developed a high level of self-confidence. It may be more appropriate to think of empowerment in terms of opportunities for participation. In the West London Project, the topic of empowerment only came alive when the groups discussed particular participatory strategies:

A social worker described a practice of holding network conferences in the home of the service user rather than in an office and in this way symbolically giving some power back to them. All agreed that inviting service users and carers to attend was clearly not enough. People needed to be enabled to participate fully and if necessary to challenge the views of professionals there and then. (Beresford and Trevillion, 1995, p.63)

There are many different forms of empowerment, but building a 'task community' implies some move towards shared 'ownership' of meetings and decisions.

## Enabling mutual support

'Mutual aid' or mutual support lies at the heart of any community process (Hadley *et al.*, 1987, p.11). In any community partnership members need to be able turn to one another for help and support. 'Task communities' face particular problems in relation to this. Care management networks may include a number of different carers who may not have had any experience of mutual support. Moreover, the presence of a number of different professionals in the network may also make it very difficult to expect the network to function automatically as a 'social support network'.

During the 1980s I was involved with a large number of network conferences which led me to conclude that the process of building a support system is intimately connected with the practical business of sharing responsibility and the symbolic activity of sitting down with other people as a new kind of collective entity with a shared identity and shared aims. The following which I wrote at the end of this period focuses on carers, but could apply equally to isolated professionals or home helps and sums up these links between community support and community identity in what I would now call a 'task community':

Loss of self-esteem is linked to an overwhelming and undifferentiated sense of responsibility amongst carers. The isolation of carers and the ambivalent support available to them can be counteracted by the physical structure of a network conference. Seated in a circle, perhaps for the first time, the caring network is made visible to itself as a group of people each with a contribution to make. Within the problem solving context of the conference carers can identify and negotiate appropriate, limited and complementary roles. As these roles become more clearly defined the conference becomes more interdependent and more aware of its common boundary and purpose. In turn, this growing awareness helps individuals to internalise a sense of their role as carers and to resist feelings of total responsibility and powerlessness. (Trevillion, 1988, p.303)

Overall, enabling task communities to evolve consists of enabling people to feel a part of something positive and empowering with which they can identify, through which they feel they can enhance their own choices and the choices available to others and by which they can feel supported or offer support to others.

## **Promoting flexibility and informality**

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Conventionally, networks have been classified as belonging to either 'informal' or 'formal' types (Barclay, 1982, p.xiii) with the possibility of a third mixed or 'interwoven' type combining lay and professional care (Bayley, 1978, p.31). But all community partnerships need to be informal even if they only involve other agencies or other professionals and we can help to promote informality by our own attitudes.

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When I was a senior social worker in South London I had responsibility for a case involving two children who were at risk of sexual abuse. After realising that my own child protection responsibilities and the probation service's befriending and after-care responsibilities overlapped in the area of marital counselling, I undertook several joint visits with a female probation officer to help the parents talk through their relationship with one another and whether or not they wanted it to continue – an informal conciliation service.

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Institutionalised and routinised responses to client need, in which every agency focuses on its own conception of its responsibilities, allow certain unpopular tasks to be avoided by assuming that someone else will do them. As soon as professionals start relating to each other across institutional boundaries, it becomes much more difficult to avoid shared responsibility and professional roles have to be adapted in a much more thoroughgoing fashion to the task. By seizing opportunities for collaborative work, we put ourselves and others in the position of having to negotiate our roles in the context of a particular piece of work. In doing so, we set ourselves the kind of challenge which is likely to stimulate creativity in ourselves and in our partners and lead to a greater collective 'ownership' of the task.

In these and other ways, networking can build on and develop the potential for informality implicit in any social network and informality can also be linked to empowerment. The Swedish Project showed how an informal style of work can be seen as part of a strategy for 'opening up' the social structure by making social institutions more responsive to relatively powerless individuals and groups (Trevillion and Green, 1998, p.118).

## **Maximising communication possibilities**

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### **Communication networks**

A communication network is best seen as a pattern of linkages which promotes information flows. It can be a way of translating an abstract right to information into something real and practically useful. In the UK, for example, the 1989 Children Act makes it obligatory for social workers to provide more information than ever before to children and families. But such is the complexity of some of this information that it is only likely to be effectively transmitted if all those concerned with caring for children cooperate with one another to create the kind of linkages which enable people to listen to one another. Only when such an atmosphere is created can we say that a communication network exists. A communication network can, however, do more than this. It can convey requests for help and offers of help from 'person to person' (Srinivas and Beteille, 1964, p.168) thereby forming an essential part of the structure of mutual support.

### **Working with closed and open circuits**

Communication networks exist along a continuum from relatively 'closed circuits' to relatively 'open circuits' (Srinivas and Beteille, 1964, p.167). All patterns of network communication have their advantages and disadvantages. In encouraging certain patterns of communication to evolve, networkers always need to bear in mind the purpose of the partnership.

Closed-circuit partnerships are able to transmit information to every part of the network quite speedily because the high level of 'connectedness' ensures that individuals probably hear the message from several different people simultaneously. At the same time, the wide range of transmitters should act as a self-correcting device ensuring a minimum of distortion in the message. If distortions do occur, it may be relatively easy to 'broadcast' new 'correct' versions of the message. In the case of a communication network focused on a child 'in need', it is likely that a 'close-knit' and closed circuit of communication would best serve the interests of the child and those of the partnership as a whole, enabling the social worker to ensure that parents and others do not miss out on key bits of information.

A closed circuit of communication may also be a very helpful way of establishing a shared awareness of neighbourhood issues. This is not only relevant for social workers or community workers. It has been suggested, for example, that health visitors wanting to know what is going on in their local areas should speak to as many people as possible by 'dropping in' on

other agencies, attending community forums, inviting people for lunch and so on (Drennan, 1988, pp.114–17).

Where confidentiality is an issue, for example when a person has an HIV diagnosis, or where someone has disclosed a history of sexual abuse, communication should always be organised on closed-circuit principles and governed by clear network agreements about the flow of sensitive information.

Messages passed through an open circuit are likely to be broadcast more quickly and more widely than messages passed through a closed circuit. Open circuits are more appropriate where the aim is to spread a message to as many people as possible. An example of networking to create such an open circuit of communication is the work done by those working in community health education (Gaitley and Seed, 1989, pp.19–27). Rather than focusing on developing a tightly interwoven partnership, community health educators try to forge links with a wide range of individuals and groups. In this way, not only is the health message transmitted widely, it is also varied to suit the needs of different networks.

Community workers have sought to disseminate information by direct 'street' contact with drug users in the hope that at least some of them in turn will pass on advice to other drug users. Efforts have also been made both in Glasgow and in London to reach out to resistant heterosexual networks by making information available at football matches and again hoping that the staff and supporters networks will act as a transmission system for health advice.

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I attended two such events at the Queens Park Rangers stadium in London in 1994 and 1997 and also spoke to one of the community workers responsible for organising the liaison between the football club and the local authority social services department community health teams. What was noticeable about both these events was the use of a wide range of different forms of communication, all focusing on the same kind of safe sex message, from stalls and stickers to broadcasts over the loudspeaker system at half-time and the use of photographs, newspaper articles and so on, as ways of following up and reinforcing the message in the weeks after the football match. As the community worker made clear to me, the success of ventures like this depends on the building of a strong partnership between supporters clubs, football club directors, councillors and local authority staff.

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One feature of all these community health education strategies is that they attempt to use informal networks as channels of communication instead of the advertising campaigns which often seem to create more problems than they solve (Wiseman, 1989, pp.211–12).

### **Managing the messages**

The identity of the initial 'transmitter' – the point at which the message enters the 'communication network' – can be of considerable importance. If he or she is relatively peripheral, having only a few links to other members of the network, it may take a long time for the message to circulate. It may even get lost altogether. If, on the other hand, a message enters the network through a 'central figure' (Collins and Pancoast, 1976, p.21), the message may circulate much more quickly and effectively, as the following example drawn from my experiences as a social worker in South London demonstrates.

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Responding to a request for a support group for all those involved in visiting elderly people on a local council estate, I called a meeting of these 'good neighbours'. I assumed that the best person to 'spread the word' about this was the chair of the tenants association who I knew visited some elderly people herself. I could not have been more mistaken. On the day of the meeting, very few people were present. The TA chair in fact knew only one other 'good neighbour' and was not the best person to ask. After the meeting I discovered that one of the social services department's own home helps who lived locally knew most of those involved in the visiting scheme and, when she was asked to encourage people to come to the next meeting, most of them duly turned up.

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Networks tend to spread rather than direct information. Nevertheless, provided the number of intermediaries is kept to a minimum, messages can be passed through a network to particular individuals.

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On one occasion, I urgently needed to speak to the mother of a child in care who had been avoiding contact with both the child and myself. As a last resort, I decided to try to convey the need for a meeting through an inter-

mediary, the child's grandmother. Although attempts to make direct contact had failed, I reasoned that the grandmother might reinforce rather than simply pass on the message. The strategy worked on that occasion, although it subsequently failed.

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Looking back on this now, it seems likely that the first attempt worked only because of the relationship that existed between the grandmother and the mother of the child. When that relationship deteriorated, the strategy became useless.

### **Information is power**

Communication networks are rarely homogeneous. There are always features which differentiate one bit of the network from another. In particular, whether or not one has access to 'gossip' may indicate whether one is a network insider or a network outsider (Epstein, 1969, pp.121-5). Although a social network may disseminate relatively neutral information quite widely, the really important bits of information may only circulate within a small 'inner circle'. This often seems to happen in those 'interwoven' networks of social care in which professionals, volunteers, relatives and others try to collaborate with one another to help a particular individual. This is a kind of professional 'gossiping network': a clique set apart by access to a set of private understandings from which clients, carers and others are excluded. This type of situation makes a nonsense of any talk of empowerment and yet, because the power of the professionals is so dependent on the control of information, securing an agreement to spread information more widely can be very empowering.

Communication patterns can reveal themselves in a variety of ways and network analysis can help us to understand the clues which are offered to us and lay the foundations for communication networking. A community partnership is often only as effective as its communication network. There is no one ideal pattern of communication and both 'open circuits' and 'closed circuits' have their place. But it is important that we are able to facilitate the pattern of communication that is most appropriate for a particular community partnership and that we ourselves understand how to link up with and communicate along existing channels.

What must be emphasised, however, is that communication does not exist in a vacuum. Communication networking is as much about building trust and credibility and challenging the control of information by powerful cliques and groupings as it is about any 'technical' processes.

## Mobilising action sets

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An ability to do things together is inseparable from the partnership concept. This can take the form of mobilising support for an individual or action on behalf of a group. That part of a social network which is mobilised for specific purposes like this can be described as an action set. 'An action set may be looked upon as an aspect of the personal [or group/organisational] network isolated in terms of a specific short-term instrumentally defined interactional content' (Mitchell, 1969, p.40).

Mobilising 'responses to adversity' (Barclay, 1982, p.xiii) or transforming social networks into action sets, cannot always be left to that nebulous creature 'the community'. Ways often need to be found of helping those involved to work actively together. This is what is sometimes referred to as 'interweaving' (Bayley, 1978, p.31). Action sets of all kinds frequently need to be coordinated, whether they are composed of professionals, volunteers or service users. Coordination is the key to case management, but it is also a vital ingredient of community action, the formation of self-advocacy networks or cooperation between agencies in order to meet the needs of 'children in need'. As such, it usually has to be a part of any action set strategy. It should not be assumed that coordination requires a single coordinator or that the individual or group asking for help or inviting the assistance/participation of others is always the coordinator of the action set; for example, the Swedish Project showed that a very effective pattern of mobilisation can exist based purely on mutual support and an intuitive grasp of how those involved should work together.

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At a meeting of the HIV network which referred to itself as 'the HIV world of Stockholm' it became clear that there was such a high level of trust and interpersonal responsiveness that it was very difficult to identify any particular coordinating roles, although there was plenty of evidence of what was referred to as *samverka* or 'cooperation'. The network members themselves identified the following as the glue which held the network together and to some extent took the place of formal coordination: 'trust', 'reciprocity', 'familiarity', including a sense of shared history, 'informal socialising' and a strong sense of individual 'professional identity'.

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It may be that the difference between an action set able to coordinate itself and one requiring the services of a specific coordinator is related to the



difference between one recruited from those already known to one another and one based on a newly created 'brokerage network' (Srinivas and Beteille, 1964) where the process of mobilisation involves creating links between quite distinct networks and the role of the broker is critical. Brokerage and coordination may therefore be closely associated with one another.

Liaison can sometimes appear to be remarkably marginal to the process of mobilising resources. The results of the North London Project suggested that in some situations there can be no relationship at all between the practical business of obtaining resources for clients and the more nebulous activities which were described as 'liaison' (Trevillion, 1996a, pp.99-100). In contrast, the Swedish Project identified relatively few formal liaison activities but a strong link between informal networking and the creation of a mobilisation potential. There is evidence from the Swedish Project that informal networking seems capable of generating trust even between potential partners who may never have met and the presence of trust seems to be the critical element in ensuring that requests for help emanating from one part of a network are met with a positive response from other parts of the network (Trevillion and Green, 1998, p.114).

At the inter-agency level, it has been suggested that establishing partnerships in the context of Health Action Zones may enable system redesign to take place, ensuring that the mobilisation of inter-agency resources is made more effective (Peck and Poxton, 1998, p.11). However, it will be important to ensure that health issues are 'owned' by the whole network, or we may find that, by marginalising the involvement of certain organisations, the issues associated with them also become marginalised and the work of the whole partnership becomes distorted. This has been the experience of Area Child Protection Committees (Sanders *et al.*, 1997) and the same thing could happen to Health Action Zones.

Mobilisation of network resources can mean many things. It may involve actively brokering a 'care package' or it may mean simply helping potential activists to get in touch and stay in touch with one another, so that they are in a position to work together when they need to do so. Overall, it means thinking and planning ahead and investing in the future.

## **The role of the networker in the network**

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So far this account of networking as a practice theory has focused largely on activities and processes. But to what extent is networking a distinctive practice role? A networker does not have a role in the sense that a doctor, lawyer or psychotherapist has a role. Nobody is employed as a networker

and nobody, when asked to name their profession or occupation, is likely to say 'networker'. Networking is always a process which someone engages in as part of another role. Care managers can be networkers but so can community workers and nobody can be a networker if they do not have some other role compatible with networking.

But although networking is not a conventional role, it certainly has some role implications. This should already be clear from the way in which these activities have been described. A care manager who networks behaves in a very different kind of way from one who simply packages care through formal purchasing and contracting mechanisms. A community worker who networks behaves very differently from one who works only with formally constituted community organisations. Moreover, those who work with a networker tend to develop a different set of expectations about how he or she will relate to them than they would otherwise do.

Networking tends to create a new kind of social environment. If it is successful, it develops a much higher quality/quantity of cross-boundary linkage between organisations and institutions than previously existed and these new kinds of relations will tend to change the overall pattern of roles associated with these 'sets', including the role of the networker. If the networker is replaced by someone else, that person will inherit a very different set of role-based expectations as a result of the networker's activities. For all these reasons it is possible to talk about a networking role, provided the peculiarities of the role are acknowledged.

It may be easier to take on a networking role if the networker occupies a relatively powerful position in a social network, but networking itself tends to equalise power relations because it operates horizontally across and between organisational, professional and sectoral boundaries. It can therefore be defined in terms of its flattening effects on status differences and, for this reason, it may of course be resisted by those seeking to preserve the status quo. Associated with this is the important point that networking is not a management role, although it may help a network to manage complex relationships. Some of these points may become clearer in the next chapter, which discusses networking in relation to the assessment task.

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# 3 Assessment: a networking approach

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## Linking the micro to the macro

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Network assessment is a form of 'community assessment', but, unlike most examples of 'community assessment', it emphasises the continuity of the links between the individual and the community without either denying important differences between individuals or relegating the 'community' to the status merely of background information.

By the 1970s, 'community assessments' were commonplace in social work, community work and various branches of nursing (Reinhardt and Quinn, 1973, pp.174–5) and yet attempts to develop a community approach to the assessment task have been dogged by the problem of satisfactorily linking the micro-world of the individual and the macro-world of politics, economics and the environment. One example of this is community care, where it is now widely recognised that there needs to be a shift towards 'needs-based planning' linking together individual and collective definitions of need in an integrated way (Bibbington and Tarvey, 1996, p.3).

But the models of 'community assessment' which have been developed have tended to focus on collective as opposed to individual need. One attempt to recognise the diversity of 'communities' is the 'needs auditing' approach associated with the Institute for Public Policy Research: 'a needs audit seeks to identify and highlight these differences, to attempt to reconcile them where possible, and to negotiate a consensus about problems and priorities' (Percy-Smith and Sanderson, 1992, p.43). But no amount of discussion or even active community participation can overcome the fact that there are differences between the way in which 'needs' are manifested and experienced at different social levels, as well as connections. This should be

the starting point for any 'community assessment' and it is one of the strengths of the situational approach associated with networking.

The networking approach to 'community assessment' always starts with a specific situation of some kind. There is no requirement to operate with a simplistic opposition between individual and community needs or resources. Rather, the concept of 'need' is related to network patterns and the position of individuals, families or groups within these. Network assessments are always 'community assessments', not because they focus on collective as opposed to individual need, but because both needs and resources can be defined in terms of network structure. Differences of scale can be respected, but connections between needs at different levels can also be made by exploring the relationship between personal and other types of network as they nest within one another. In other words, the network concept enables the most personal of problems to be seen in community terms and the most political of questions to be seen partly in terms of interpersonal interaction.

It has been suggested that social workers and others should see society as a complex network and that this will enable them to 'cut across traditional categories such as casework and community development based as they have been on the reification of the individual and community respectively' (Lane, 1997, p.334). There is no need to abandon the concepts of 'the individual' and 'the community' altogether, but by relating these traditional concepts to social networks of varying shapes, sizes and complexity it is possible to define the assessment task in quite a new way which does indeed 'cut across the traditional categories' of 'casework and community development'.

## **Negotiating an assessment partnership**

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One feature of networking, which it shares with community profiling, is that assessment is not something which is done to others but something which is always undertaken in partnership with others. For networkers, the partnership principle is as much a feature of the process of assessment as it is of the goals of assessment. This does not mean that networkers do not formulate their own ideas about situations, but it does mean that they are always prepared to negotiate about them, and the very first thing that needs to be negotiated is the assessment partnership itself. Negotiating the assessment partnership involves gaining access to the network, defining the network and legitimating the network (getting permission to operate as a partnership) and these processes often take the form of a number of distinct activities:

- identifying and negotiating with community gatekeepers (access),
- identifying and negotiating a focus and a field (definition), and
- identifying and negotiating 'roadblocks' (legitimation).

## **Community gatekeepers**

Under some circumstances, community gatekeepers may act as 'middlemen' or, presumably, middlewomen (Rodman and Courts, 1983). They may use their central position within their own networks to act as mediators between what could be seen as a 'sub-culture' and the world of social welfare professionals.

Professionals need community contacts and some contacts will be more useful than others. The specific question which social workers or other professionals always need to address is: who are the gatekeepers? Who are the people who have it in their power to block communication with important sections of the community but who could provide community access? Whoever they are, creating the conditions for effective assessment work will involve identifying an exchange of some kind in which the needs of the gatekeepers are met at the same time as the conditions for an assessment partnership are created. Here is one example.

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Home helps who live in the area in which they also work can be seen as community gatekeepers. But they are often also useful mediators between social services departments, on the one hand, and local residents on the other. I was involved in developing home help/social worker liaison projects in two different local authorities in the 1980s. These projects attempted to provide a context in which social workers could relate to home helps as neighbourhood brokers. Social workers made themselves available when home helps came to the office and in this way developed a network of contacts with a number of key home helps.

Social workers gave advice and information about social security benefits, sheltered housing and other 'practical' issues and also offered consultation and support with more complex and stressful situations. Home helps, for their part, alerted social workers to particular issues and problems. Slowly but surely – and without having, at first, to do more than meet home helps – the social workers involved in the liaison were able to become part of the communication network linking the home helps to a large number of vulnerable people and those involved with supporting them, in one way or another.

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This illustrates an important truth about networking, in general, and assessment partnerships, in particular. Long-term mutual benefits are rarely sufficient, in themselves, to create the conditions for partnership. Without losing sight of the long term, immediate attention needs to be paid to the subjective needs of those involved. Where those concerned are gatekeepers, it is absolutely critical that their needs are correctly identified.

In the above example, it seems likely that, because home helps themselves felt helped, they were able to work more effectively. The negotiation process, handled appropriately, ushers in a 'virtuous circle' in which positive responses to the needs of gatekeepers make it more and more likely that they will cooperate in ensuring a constant flow of increasingly useful information. Sometimes the gatekeeper will be a carer, sometimes another professional; sometimes there will be more than one gatekeeper. But across a whole range of situations, from inter-agency work to case management, it seems as if assessment is dependent upon an ability to negotiate with community gatekeepers/mediators.

### **Focus and field**

For networkers, the individual is always part of a social field of some kind. This immediately seems to suggest that the focus is a social field as well, but this would be a false conclusion to draw. The only occasions when the focus is likely to be a network are when networking is undertaken within, and on behalf of, a closed group of some kind.

In a residential home for older people, the officer-in-charge might network with and on behalf of all the residents to facilitate new patterns of living involving more cooperation and collective activity. So long as the work was entirely focused on the residents as a whole and their relationships with one another, we could say that the focus was the network. One could say the same for any sub-groups set up for particular purposes, such as reminiscence groups. For the most part, this kind of activity is best described as groupwork rather than networking. However, even in this area of work, field and focus may overlap, rather than being absolutely identified with one another.

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One project in which I was involved included both residents of a particular home and some older people living in the surrounding area. The aim of the project was to collectively explore memories and the project was established as a result of networking across the residential home/community boundary. It was not this, however, which created the distinction between

field and focus, but rather the need to involve a number of professional and non-professional brokers in the bringing together of these older people, as a group. The field therefore included a wide range of people who were not the focus of the work, but there to facilitate the work.

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In other situations, the difference between field and focus is even more obvious. There might be a need to network on behalf of the specific interests of specific groups of residents – not against the interests of others, but rather to challenge disadvantage and discrimination within a home. For example, the isolated position of black elders within a predominantly white home might lead the officer-in-charge to network on their behalf.

Networking would be undertaken with the residents as a whole but on behalf of black residents. It might still be appropriate to see the residents, as a whole, as a partnership, because they would all need to be involved in any anti-racist initiatives, but the primary focus of concern and commitment would at this time be the black residents. If the work involved challenging racist stereotypes or confronting individual residents with the unacceptable nature of their behaviour, this distinction between client and community partnership would become very obvious.

Another circumstance which might create a distinction between focus and field would be the need to break down barriers between the home and the rest of the community. This means paying attention to the links residents had with family and friends (Douglas, 1986 p.131) and the new relationships that might be established with people living outside the home in terms of shared interests of one kind or another.

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One particularly dynamic and progressive officer in charge of a home in South London worked closely with me on ways of implementing these kinds of ideas during the 1980s. She constantly 'scanned' the local environment for opportunities to develop links with a wide range of individuals and organisations outside the home, in order to facilitate the growth of an overlapping set of networks drawing the neighbourhood into the home and drawing the residents into the wider social space of the neighbourhood.

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Differentiating between the concepts of focus and field solves one problem but creates another one. If the focus is not the field or, to be precise, is



only part of the field, how do we go about identifying those others who might be considered part of the field? Identifying the focus enables us to identify the field. In chapter 1, it was pointed out that a personal network can be analysed in terms of 'primary', 'secondary' or 'tertiary' stars. The field will normally include at least some of the first, if not the second or third of these 'stars'. But it may also include others, not yet involved, including professionals or official agencies of one kind or another. Initial discussions will soon highlight those who want, or need, to be involved in any partnership activity. In this way, the assessment partnership is recruited from the field. One way of thinking about this is that the core of the assessment partnership is likely to be an action set capable of mobilising its efforts on behalf of the focus around which it has formed.

This can be illustrated with reference to the styles of work pioneered with people living with and affected by HIV and AIDS, where the concepts of field and focus turn out to be highly compatible with the model of 'flexible, augmentative social care planning' in which all 'social legal, health and interpersonal networks' are included (Gaitley and Seed, 1989, p.14) and which is supposed to enable social workers, nurses and others to grasp the pattern or 'gestalt' of the total situation (ibid., p.15).

The following is based on an account relayed to me by the social worker. The details have been changed to protect confidentiality.

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John is about to leave hospital, having partially recovered from a serious infection. He is able to move around with some difficulty, but is breathless and easily tired. He wants to return home to his flat on a council estate where he lives alone. A former lover and some friends might be prepared to offer limited support but there is little likelihood of family support as there has been no contact between him and his family since they discovered he was gay ten years before. Although some attempt could be made to reinvolve the family, it seems likely that much of the care needed will have to come from statutory and voluntary organisations. John is closely involved in the process of defining who should be involved as partners in the assessment process but, on the whole, accepts the advice he receives from the social worker.

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In this case the assessment is undertaken in partnership with those who are likely to play a part in the 'care package' which John will need. Volunteers, a district nurse, the general practitioner, a home help organiser, an

occupational therapist and a housing officer could all be worked with as an assessment partnership and much may depend on an effective inter-agency network to which managers will need to contribute. Links between health and social services are likely to be particularly important.

The concept of the assessment field is open enough to include a number of individuals, groups or agencies who may be prepared to participate as informants, but who may not want or need to be involved at a later stage. We therefore need to keep in mind a distinction between the eventual action set, mobilised to meet the needs of an individual or group, and the broader field. Nevertheless, involving people as partners at the assessment stage may make it much more likely that they will stay involved.

Awareness of many of these issues appears to be quite widespread, particularly within the area of HIV work. Whereas the previous example was based on material from London, the Swedish *kurators* pointed out that 'we also have a strategy ... to involve persons around the patient, the network, even if, maybe, it's a theoretical network'.

These examples illustrate what can happen when there is little or no conflict between social worker and service user about the choice of partners, but what if there were such a conflict and it was not possible to resolve it? The answer has to be that, if service users do not give permission for other people to be approached with a view to contributing to the assessment process, then, in the absence of any issues which might override it – child abuse, evidence of mental illness and so on – this has to be respected. This may be particularly relevant in relation to work with people living with HIV and AIDS.

### **Identifying and negotiating roadblocks**

When someone outside the context of the existing assessment partnership intervenes to block its work, the assessment process is brought to a halt as if the road ahead were blocked. When this happens, we need to follow the trail of resistance back to its source and reorient the framework of assessment so that it takes account of this resistance.

An attempt by social workers to liaise with district nurses or health visitors to explore joint staffing of 'family advice sessions' at a local community centre may initially meet with an enthusiastic response, but, as some of the implications begin to emerge, the health workers may become much less enthusiastic. Communication becomes increasingly awkward and meetings less and less productive. It turns out that a number of senior managers are not happy about the project and are effectively blocking it. The nurses and health visitors will therefore not be able to participate in the assessment exercise unless they get 'permission' from their seniors to do so.

Communication will continue to be muffled unless the social workers and their managers succeed in negotiating 'permission' for discussions to continue with the relevant health service managers. This 'permission' might only be granted if they themselves are involved in some of the meetings and then it might be possible to openly discuss any concerns they might have without these acting as a general block on all communication. An assessment partnership must be inclusive of all those who might have an interest in its work and the power either to advance or to block it.

Sometimes assessment may become blocked simply because some people feel they cannot express their true feelings or their real needs. To deal with situations like this, a social worker will need to attend to implicit, as well as explicit, messages.

Many carers may feel that they have little choice but to care for aged and infirm parents, spouses and children. When asked directly, they might well say that they want to continue caring for their dependent relative. But anyone seeking to put together an appropriate 'care package' in such a situation who simply took this at face value and did not pay attention to 'process' clues such as tiredness, frustration, anger or depression would be likely to miss an important part of the message, that part which says, 'I feel exhausted, trapped, devalued and unhelped by everyone, including you!' Messages like this are silenced because they are in conflict with assumptions about the way carers ought to feel in our 'patriarchal' society (Gittins, 1985, p.131) and this has been reflected in the way professionals have ignored the needs of carers (Hicks, 1988).

## **How does an assessment partnership work?**

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It is impossible to lay down hard-and-fast rules about situations as varied as those described in this book, but the networking approach to assessment can be characterised in two ways:

- as a process of integrating diverse perspectives to produce one multi-dimensional picture which can form the basis of any collective action undertaken by the partnership;
- as a process of continual feedback which constantly deconstructs and reconstructs the network picture, either by filling in the assessment 'gaps' or by transforming the network picture entirely.

The feedback process raises individual and collective awareness and one consequence is that the networking approach to assessment is educational.

When people begin to build up a picture of how things are now, and how they might be different in the future, they are educating and empowering themselves. But surely, different viewpoints imply conflict? Can there be an assessment partnership if some of the partners are in conflict with one another? The answer is 'yes', and the assessment might be all the better as a result.

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As a social worker in West London in the 1980s, I once had a client, an elderly woman living alone, who was gradually withdrawing from responsibility for her own life. I felt, rightly or wrongly, that those involved with her had to do everything possible to reverse this process. Another social worker involved in the assessment partnership disagreed with me vehemently, feeling, rightly or wrongly, that decline was irreversible and that we should collectively assume responsibility for the client's welfare. As a result, the way in which 'facts' were interpreted was open to constant challenge.

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Because neither of us was in a position to impose our views on others involved in the situation, and because we were both committed to the partnership, we were both exposed to pressure from other members of the partnership to compromise and to explore the middle ground. The partnership not only survived the conflict, but ensured that the assessment and planning process was undertaken from a much more realistic perspective than would have been possible if either I or the other social worker had had sole responsibility for the assessment.

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## **Gathering and analysing information**

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Having established the conditions for assessment through negotiation, it is time to move on to the next stage, which involves the assessment process itself. What kind of information do we need? Network assessments require both 'hard', or relatively objective, information and 'soft', relatively subjective, information.

'Hard' information covers anything which might help us to understand how the characteristics of a particular network mesh together with the likely effects of particular interventions upon it. We are therefore likely to

be interested in such things as the pattern of interaction, the frequency of interaction, the role of brokers in linking together different parts of the network mesh, the way information flows around the system and whether or not 'action sets' exist. But as we are interested in facilitating community partnership, we are also likely to be interested in working out how specific interventions on our part might help to promote patterns of partnership in all these areas.

'Soft' information is just as important as 'hard' information. When the assessment task involves 'joining' an existing social network, we may think of the networker as a 'controlled participant observer' (Moreno, 1978, p.109) experiencing all the currents of thought and feeling flowing through that network. This kind of 'soft' or process knowledge is an example of the reflexivity associated with networking and often plays a significant role in assessing what needs to be done to create an assessment partnership. It is likely that many views and experiences effectively silenced by feelings of powerlessness will only be discovered through reflecting on 'process'

The five-dimensional model of community assessment incorporates the following:

- interpersonal and interactional data,
- community data,
- information about the flexibility and responsiveness of systems,
- information about communication patterns, and
- data on mobilisation potential.

### **Gathering and making sense of interpersonal and interactional data**

Social fields of various kinds contain large amounts of information and, by analysing the way in which individuals link with one another, we can begin to understand the forms of interdependency which characterise a particular social field. How should we go about gathering this kind of data? A number of techniques are available, some designed for in-depth work, others to produce rapid results.

#### *Network diaries*

These come in many different shapes and sizes, but should enable individuals to keep track of who they interact with, how, why, what their various relationships mean to them and, ideally, provide some space to enable those involved to consider alternative or additional contacts (Beresford and Trevillion, 1995, pp.39–52). Whatever form the diary takes, it

is vital that the diary-keeping process includes some opportunity for those keeping these records to discuss and reflect on what they are producing. Diaries can provide excellent raw material for further groupwork sessions (ibid., 1995, pp.53–66).

The main benefit of the diary approach is that it provides very detailed and specific data, together with opportunities for reflective discussion about relationship needs and opportunities. One weakness, however, is that, unless all key members of a network are simultaneously keeping diaries, the picture of interpersonal relationships which will be built up will inevitably correspond to the subjective perceptions of the diary keeper. This may be acceptable if that is our main interest, but it may lead to important information about other issues, such as constraints on caring or parenting, being missed out or only loosely described. The main drawback of the method, however, is that in my experience it takes a minimum of three or four weeks to generate meaningful data. Where there is a pressing need for intervention, a network diary is unlikely to be the most appropriate assessment tool.

### *Network questionnaires*

This method of network assessment involves making use of a standardised checklist of questions designed to reveal information about the quantity and quality of interpersonal links. All the data which can be obtained through a diary in an indirect way can, at least in principle, be obtained through a questionnaire directly and in a fraction of the time required for diary keeping.

Questionnaires can generate a mass of data (Trevillion, 1996a). Unfortunately, like diaries, questionnaires have to be administered simultaneously to several members of a network in order to overcome the problems of selectivity of data outlined above. A more fundamental problem is that use of a questionnaire can appear disrespectful and, even in a research context, does not provide many opportunities for individuals to reflect on the significance of their relationships. The lack of time for thought and reflection can also shift the balance of power rather too far towards the interviewer and away from the interviewee.

All these problems can be overcome in a research or development project, but may be more intractable in practice. In addition, the very lack of time which militates against diary keeping might be thought to make for an atmosphere which is decidedly un conducive to an emotionally neutral survey of network relationships. If there is an element of urgency, there may also be so much pressure for intervention at a practical or emotional level that it is difficult to see how satisfactory answers can be obtained.

### *Network tracking*

Network tracking does not require any materials other than a blank sheet of paper and can be incorporated in a standard professional interview. It simply involves following up all relationship data with some characteristic questions. (How often do you see X? When did you last see X? Who is X closest to?) It is often appropriate and helpful to build in reflexive questions. (How do you feel about your relationship with X/ How would you change your relationship with X?) If possible, those using this method should try to explore unmet needs both in terms of existing relationships and in terms of imagined relationships.

Excursions into fantasy, often prefaced by a comment such as 'How would you like your relationships to be different? can generate sometimes startling insights into the gap between the way relationships are ordered and how individuals would like their needs to be met. Even if time is pressing, helpful data on social fields can be generated in this way, often by single interviews. If there are opportunities to meet and work with individuals named by the client or other initial respondent, even richer and more multi-faceted assessments can be produced.

### **Gathering and making sense of community data**

In the previous chapter, the community dimension of networking was discussed in terms of the overlapping categories of identity, power and social support. These form the basis of this aspect of the assessment process.

#### *Identity*

Where individuals or groups feel alone with their problems, even though they may have access to material resources, it may well reflect problems with the social field. As the kind of information we are interested in relates to specific social fields rather than philosophy or politics, it will normally be more effective to find ways of asking questions about identity in the context of specific relationships or patterns of social interaction, such as 'Do you find that you identify with X and Y?' or 'Do you feel you have something in common with X or Y?'

The information yielded by diaries, questionnaires or other techniques for recording interaction patterns can be used to generate these kinds of questions in follow-up interviews.

Of course, there are many issues of identity which have less to do with patterns of social interaction than with personal memories or strongly felt political or religious beliefs. These 'psychological networks' or 'imagined

communities' (Anderson, 1983) should always be taken account of in any assessment, but constitute a subject of their own which is only loosely connected with networking. The contrast between the 'psychological' and 'interactive' network may, however, be very revealing and informative.

### *Power*

From a networking perspective, it is important that empowerment is seen not as a zero sum game in which power is transferred from one person to another. This traditional way of thinking is based too literally on Weber's discovery that power is relational. Rather, we need to see empowerment in more creative terms as a qualitative shift in the relationship between individuals and the social environment such that they feel they can 'make a difference'. From this point of view, any assessment of power in social fields should take the form of exploring what kind of opportunities exist for positive feedback loops which would enable individuals engaged in forms of social action to experience themselves as being able to 'make a difference'. The aim would not be simply to measure degrees of empowerment, but also to explore the potential for creating new pathways linking disempowered individuals and groups to sources of social power.

As with identity, abstract questioning about power is unlikely to deliver interesting answers. Usually, it will be more appropriate to explore the subjective meaning given to specific action sequences and to evaluate them with other members of the assessment partnership in terms of 'making a difference'. One way of doing this is through the use of *hypotheticals*. A hypothetical is simply an imaginary situation. In this case, a hypothetical could be used to explore by a process of question and answer whether a new pattern of linkages would 'make a difference' and open up new opportunities to the disempowered individual or group.

### *Mutual support*

It is unwise to assume that close-knit patterns of social interaction always generate social support. But, on the other hand, loose-knit social fields are far less likely to be associated with social support than close-knit ones. Therefore, in any effort to try and gauge the degree of mutual support in a social field, it is normally helpful to have some overall measure of 'connectedness'. This can be done by making use of the interaction data already gathered through diaries, questionnaires or 'network tracking'. Having established this, it is then necessary to explore in more depth the degree to which key individuals actually experience their relationships as supportive and the degree to which they conceive of support not simply in terms of



specific individuals but in terms of collective processes. This kind of data is only likely to emerge in the context of a process of reflection upon 'connectedness' which it is not always easy to justify or explain when time is short and needs are pressing. Therefore it will normally be more effective to link this process to particular events. Individuals can be asked whom they find most supportive and in what ways that support is actually made tangible. They can also be asked if there had been any occasions when they were able to reciprocate that support.

If the answers to these questions seem to reveal an absence of supportive community relationships, the assessment should focus on ways of generating increased levels of support. In this connection, use could also be made of hypotheticals and, if so, it will probably be practical to integrate work on support with work on empowerment. In any case, the connections between the different aspects of community are such that it would be unwise to regard them as mutually exclusive categories.

### **Flexibility and responsiveness**

Discovering the extent to which a social field incorporates flexibility, informality and responsiveness may start with accounts of personal experiences, but should also extend into a form of critical path analysis which involves wide ranging discussions.

#### *Critical path analysis for networkers*

At root, this approach is concerned with tracking an issue or problem across the organisational landscape, taking particular note of what happens at the boundary between different organisations. But, whereas conventional critical path analysis focuses solely on what happens to the issue or problem, the real aim of this assessment exercise is to discover information about structures and systems. In order to do this effectively, the assessment partnership should ideally include members of the various organisations involved, especially if the behaviour of these organisations is deemed to be of continuing interest. Positive indicators might include speed of organisational response, openness of the organisation to lateral or peer contact and communication, willingness to engage in informal as well as formal discussions and communications, and so on.

As always, with networking the aim is to move rapidly from assessment to intervention, and any problems identified should lead on to the development of particular networking strategies designed to overcome them.

## **Information about communication patterns**

Communication is almost as varied as life itself, but to point this out is not particularly helpful unless some attempt is made to provide tools which can render this complexity intelligible. On the other hand, the subject of communication seems also to lend itself to a kind of lazy overgeneralisation. It is almost too easy to blame 'communication problems' for any failures in the social welfare system and doing so seems to make it harder to identify the real issues.

The social network approach tries to overcome these difficulties by focusing on some key characteristics of the communication network and using this as a way of gaining information about communication patterns and processes. In Chapter 2, it was argued that it was important to know whether a communication circuit was 'closed' or 'open' and where the barriers to communication flows actually lay. Building on this, it is possible to see that information about communication networks can be obtained from the following:

- exploring the overall shape or pattern of communication, noting the relationship between this and specific patterns of access to and exclusion from information;
- exploring the specific characteristics of specific (dyadic) communication linkages;
- exploring the relationship between overall communication patterns and communication content; and
- exploring the relationship between the characteristics of a particular linkage and communication content.

All the data on interaction collected through diaries, questionnaires or network tracking can provide information on communication networks. However, obtaining a holistic picture may be very difficult unless some attempt is made to obtain information from a variety of sources.

In general, networkers should try to encourage an experimental approach to communication issues among members of the assessment partnership as they seek to move from the assessment stage into the planning process. Use could be made of a hypothetical to explore whether or not it would be helpful to reorganise the way all involved communicated with one another. If it could be shown that new patterns or styles of communication created new opportunities for individual service users, this process of 'experimentation' could be quite a powerful mechanism for promoting change, especially if the whole process were conducted in a network conference or some other face-to-face setting.

## **Gathering information on mobilisation potential**

Networking is a very practical activity. We are interested not only in who knows who, but also in the extent to which individuals and groups can call upon others for assistance. Moreover, the assessment process focuses not only on what is but also on what could be. An individual may currently be unable to call on many people for help, but under some circumstances this might change. Networkers pose the question: under what circumstances or conditions might an existing social network be transformed into an action set? Analysing mobilisation patterns and mobilisation potential is an important part of the assessment process.

Sometimes all that is required is to observe closely what is already happening. If a mobilisation process is under way, all that is needed is to ensure that you understand how it works and who is involved. This may not always be straightforward, but attention to the issues already outlined in this book should be sufficient to enable patterns and processes to be charted. However, in many cases, the fact that help has been sought from a professional indicates that mobilisation processes have been relatively ineffective. In such a situation, the networker needs to understand mobilisation issues while very little mobilisation appears to be going on. In such a situation, use can be made of hypotheticals which focus on specified changes in the social network.

For example, an isolated former psychiatric patient may be very lonely and may tell his or her social worker that his response to his feelings of rejection by the wider community will be to stay home alone, drinking and watching television. However, if a hypothetical change in his situation were introduced to him, such as closer coordination between the mental health services and his family or ways in which former inmates of the same psychiatric hospital could contact one another, he might then be encouraged to explore his reactions to this changed situation and new mobilisation strategies might emerge as a result.

## **Avoiding mechanistic approaches**

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For the sake of convenience, the various aspects of assessment have been presented separately, but it would be quite wrong to give the reader the impression that these activities can be carried on in isolation from one another. The networking approach to assessment is an integrated one, through which knowledge and understanding of one issue is connected with another. Nor would I like anyone reading this chapter to believe that

networking consists simply of using one or other of the assessment tools I have briefly described. With the possible exception of network diaries, none of them is available in a complete form, for use 'off the peg'. My hope is that practitioners may use the descriptions I have given of ways of assessing networks as a spur to their own creativity, rather than as a model to be rigidly or mechanistically copied.

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# 4 Community brokers

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## Brokering task communities

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Networkers can be found in a wide range of settings, taking part in a wide range of activities, but whatever the context of their work they will frequently be found acting as brokers: brokers of people, brokers of information and brokers of resources. Inasmuch as all forms of networking are concerned with forging links across boundaries, it could be argued that all forms of networking are a kind of brokerage. However, this ignores the strategic role played by brokers. Those networks which can be defined as 'complex' or 'brokerage networks' come into being and depend for their continued existence on specific brokers (Eisenstadt and Roniger, 1980, p.43). While many people can actively participate in cross-boundary work to the benefit of a particular network, brokers are significant in situations where the network relies upon the strategic linking work of a particular individual, organisation or group.

We are concerned here only with forms of brokerage which are relevant to the field of social welfare. So as to distinguish this type of brokerage from that which is concerned with political manipulation and ways of 'circumventing formal structures' (Komito, 1992, p.140) the term 'community brokerage' will be used to describe the strategic linking work which is associated with the development of community partnerships and the building of 'task communities'.

This type of linking work has been compared to the way a spider builds a web. The West London Project asked a number of different interprofessional groups to contribute to a general definition of strategic linking work. One of the most striking comments made was that it was like building 'a web'.

This was later elaborated on and became 'creating a web with a common thread so that all the parts are linked together as a whole, dependent on one another' (Beresford and Trevillion, 1995, p.64).

While this is a memorable image and it conveys the notion of interdependency very well, it tends to imply that the community broker is rather like a spider spinning his or her web. Apart from its slightly sinister overtones, this image exaggerates the power of the community broker. A spider creates its own web but a community broker simply connects existing organisations/networks/services with one another. He or she may supply some strategic threads, but the raw materials of the web are there already. The best examples of community brokerage may lead to the development of some dazzlingly complex networks, but the expertise of the community broker lies in the process of making connections.

Community brokerage is perhaps therefore more appropriately defined as the process of making and maintaining the strategic links on which complex networks of separate individuals groups or organisations depend for their continued existence. The role of the community broker has a number of components, each of which can be seen as a role or role set: brokering change, promoting network education, encouraging power sharing and facilitating network reflexivity.

### **Brokering change**

Brokering change involves making change by forging new kinds of links. All the most significant features of brokering change can be present when working with those who are already involved in a situation, but not in any form of contact or communication with one another, as in the following case study dating from the 1980s.

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Henrietta Plowden was a woman of 84 who lived alone in sheltered accommodation. She had Alzheimer's Disease and would not allow anyone except her daughter-in-law to shop, clean or cook for her. Although the situation had remained relatively stable for some time, it was at considerable cost to the emotional and physical well-being of her daughter-in-law. However, some months after assuming responsibility for coordinating the few services which played any part in supporting this elderly woman, I became aware that a 'crisis' was looming in the shape of the very reasonable desire of the daughter-in-law to go away on holiday for two weeks with her immediate family and so I called a 'network conference'.

Although conscious of the possible risks to Henrietta Plowden, my feeling was that this 'crisis' might be an opportunity to establish a more equitable and effective partnership. I therefore approached the conference with the intention of exploring whether it might not be possible to involve the home help, a volunteer visitor and the warden of the sheltered housing scheme much more closely than in the past.

The idea was to use the conference as a vehicle for bringing together the various parties in a way which would enable her pattern of support to be renegotiated and enable her daughter-in-law to feel that she was not responsible for everything to do with her welfare. The aim was to solve both the immediate 'crisis' precipitated by the daughter-in-law's holiday and the longer-term problems relating to the overconcentration of care in one part of the network, by facilitating the development of a more 'interwoven' network.

But having a strategy and seizing an opportunity are not enough. There also needs to be a clear plan of action. This is never easy to develop when all involved are very worried and when there is no previous history of successful partnership and collaboration. In this case, there were the added problems of enabling the daughter-in-law to feel she could trust the professionals to take more responsibility and persuading her to accept help from 'strangers'. Eventually, the following plan was designed.

The daughter-in-law was to be accompanied by the home help – whom the client normally only allowed to make a cup of tea – on several visits to her mother-in-law prior to going on holiday. By sharing tasks with the daughter-in-law on these visits, the home help might be accepted as a substitute by the client in the daughter-in-law's absence. On her return, the daughter-in-law was not to resume all her previous tasks but, rather, only some of them. If successful, a similar procedure was to be used to introduce other underused helpers and to enable them to play a fuller part in supporting Henrietta Plowden.

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Looking back on this process now, it seems as if I was taking on the role of brokering change by establishing new strategic links between those who had previously had little to do with one another. Inasmuch as those links could not have been developed by anyone else at that point, the resulting complex network could be seen as continuing to depend to a considerable extent on the way in which those links were constantly nurtured by my own brokering activities, either within the conference or outside it. The case therefore fits well with the model outlined at the beginning of the chapter.



Looked at in more detail, it is possible to see that the brokering of network change involved two distinct sub-roles, problem solving and change legitimation. The first was associated with network analysis and change management, whereas the second was associated with the process of achieving a mandate for change from the stakeholders

### *Problem solving/network analysis*

Network problem solving involves engaging the network in the process of assessing both problems and solutions and putting problem-solving ideas into practice through the development of new patterns of linkage. As well as channelling new resources into a situation, this may take the form of reorganising the pattern of existing resources. In this case, time was spent ensuring that everybody had a good grasp of the pattern of daily and weekly interaction, including the number and type of tasks for which individuals were responsible, how often certain tasks had to be performed and the qualitative features of particular interactions such as the intensity of emotion associated with them (likely to be in inverse proportion to the ease with which they could be transferred to somebody else).

### *Problem solving/managing change*

However strong the case for change, the experience of it, which always involves loss, can be overwhelming (Toffler, 1971, pp.28–51) and resistance to change is often born out of this fear of drowning in it and losing control. Here it was possible to work towards change while anticipating resistance to it both from Henrietta Plowden and, perhaps less obviously, from other members of the caring network, including the daughter-in-law.

Although Henrietta Plowden, her daughter-in-law and the home help were all asked to make changes in the way they related to one another, nobody was asked to make so many changes that they were likely to feel they had lost control of the pace of change. The sharing of tasks rather than simply insisting that one person hand over responsibility to another also seems to have made a major contribution to the change management process.

### *Legitimizing change: achieving a mandate for change from the stakeholders*

In any situation, change will be resisted if it is seen as counter to the interests or wishes of those who are most closely involved. All those with a stake in a situation should ideally be brought into the process of discussing

possible changes before they are implemented, so as to ensure that well intentioned interventions are not immediately undermined or rejected by key stakeholders. Just because change is on a small scale and involves individuals rather than organisations, this does not mean that there are no 'stakeholders'.

Here all the key players, including Henrietta Plowden, had a 'stake' in the outcome. For the daughter-in-law, her role as carer was at issue and she was concerned to protect her role while also reducing the scale of her responsibilities. For the home help and the home care organiser, what was at stake was justifying their use of time on this particular client and whether they were using their skills and resources in an appropriate way. For Henrietta Plowden, what was at issue was all her fears about herself and her future, while for me, as the social worker, what was at stake was achieving a viable care plan in line with the needs and expectations of everyone involved, while also respecting the needs, wishes and sensitivities of the client.

The process of achieving a mandate had to be an inclusive one and, in this case, the choice of a network conference seems to have facilitated this. While it may not be necessary always to hold such a conference, in this situation it is difficult to see how the process of achieving a mandate from all those involved could otherwise have occurred. The term 'mandate' should not be taken to imply that a formal declaration is necessary in every situation. However, what is needed is for the broker to achieve an explicit consensus, not only about the wisdom of specific plans, but also about the whole direction of the change process. This involves some discussion of underlying values and philosophy as well as practical details. More than anything else, as this case demonstrates, it is the process of achieving a mandate which secures a network partnership and the network conference therefore seems to have played a pivotal role both in achieving a mandate for change and in securing a supportive partnership.

Sometimes the process of legitimating change can go badly wrong, undermining the whole brokerage strategy, as in the following example, drawn from the period when I was working as a senior social worker in the 1980s.

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A child protection conference was called following a perceived deterioration in the quality of care being given to a child. The conference decided on a plan which entailed a major change of role for the family aide who had been involved for some time in an informal and 'supportive' manner. This family aide was asked to explain to the parents that she would be focusing much more on surveillance and much less on general befriending than in

the past. This might have been justified and probably was, but unfortunately, the family aide, who also worked for the home care service as a home help, did not realise that she might be expected to undertake this kind of work. As a result, she did not do as she was asked and when it became clear that no obvious change of role had occurred, it emerged that she had never felt happy with a decision which had been taken at a meeting in which she felt she had no power to either express her views or to believe that notice would be taken of them.

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This kind of passive subversion of decisions to which everyone has apparently 'agreed' but which some network partners feel they nevertheless cannot support in practice, is in fact quite common and represents a failure of the mandating process, which leads inexorably to a breakdown, not only of particular plans, but also, frequently, of the network itself. In my experience, while powerful dissenting voices make their views known quite clearly and explicitly, the least powerful members of a network partnership may not say anything, but rather act out their unhappiness through a process of quiet subversion.

In situations like this, individuals or groups may have their own very strong views about the nature of their 'contract' with the rest of the network. An effort needs to be made to involve relatively powerless but distinctly unhappy members of a network partnership in a process of careful renegotiation, rather than ignoring them just because they have not actively opposed the plans supported by the more dominant members of the partnership.

### **Network education**

Community brokerage can be seen as an educational role. During the initial stages of the development of a complex network, this educational role tends to take the form of developing network awareness. During the later stages it may take the form of developing action learning sets.

#### *Developing network awareness*

The process of linking individuals, groups or organisations with one another requires that some attention be given to shared awareness. When this does not take place, attempts to pursue joint action tend to founder.

It may seem that all those agencies involved in child sexual abuse work in a particular area would benefit from the formation of a multidisciplinary

'team' and a new network might be created consisting of police, paediatricians, psychologists and social workers. However, it may quickly emerge that all the members of this 'team' were approaching their work with different perceptions, priorities and different values. Such a network plainly needs to develop some shared understandings before it can do any useful work. This may require translation or interpreting skills.

### *Network interpretation*

Those who speak different languages sometimes need an interpreter in order to communicate, but it is not just differences of language which sometimes lead to mutual incomprehension. Whenever we attempt to reach out to others who may not see the world in the way that we do, we may fail to communicate even though we might appear to be using the same language. It is always much easier to stereotype or caricature other people than it is make the effort to understand practices which may, at first, appear strange or mystifying. But unless someone takes the risk of trying to comprehend and then to help others to understand, it will not be possible for a community partnership to be built and this is as true of inter-agency relationships as it is of other relationships.

There are two stages involved in the process of inter-agency interpreting. The first stage is the 'ethnographic stage', in which the community broker meets and talks to the different network participants. In the case of inter-agency brokerage, this is ideally linked to a phase of 'participant observation' or unstructured time spent in the different organisational cultures. The aim is to develop one's own awareness of different perceptions, values and priorities. The second stage is the 'lingua franca stage' in which the broker actively helps the agencies to understand one another.

The relations between local authority social work teams and small voluntary organisations are often difficult because contacts are too superficial to promote a real understanding of each other's work. The model proposed here might help to overcome this kind of impasse. It might reveal to a statutory social work team that the lack of clear policy or line management accountability complained of by them in relation to a small voluntary organisation might give that organisation a flexibility and willingness to experiment which could be invaluable in setting up imaginative 'packages of care'. Simultaneously, the small voluntary organisation might discover that the 'bureaucracy' of the statutory social work team is associated with a capacity to deliver reliable and predictable services on a long-term basis that they are unable to match.

### *Developing action learning sets*

Although it is likely that the community broker will continue to be needed for the lifetime of any complex social welfare network, it may be possible to develop the broker's educational role from that of spreading general knowledge and awareness into more focused activity in which the responsibility for learning shifts from the broker to members of the network themselves. Certain kinds of social networks can provide opportunities for mutual learning and therefore community partnerships can be seen as what have been described in other contexts as 'action learning sets' or informal peer-based learning networks (Gay, 1983).

The role of the community broker is to help organise these 'action learning sets' and to support the learning process which, if successful, is likely to enable network members to find new ways of thinking about their collective endeavours.

### **Power sharing**

Brokerage can lead to an accumulation of power in the hands of the 'broker'. In some situations it may even be 'a step on the road to political power' (Kettering, 1986, p.55). But in a social work context, any unnecessary accumulation of power by professionals is counterproductive and certainly unlikely to facilitate the empowerment of clients who may have a 'history of powerlessness and enforced passivity' (Rose and Black, 1985, p.82). An essential community brokerage skill is therefore the ability to counteract this tendency by using one's own position as an intermediary to open up channels of communication for others, rather than to continue to monopolise communication.

Inter-agency liaisons which are conducted on a one-to-one basis have a potential to exclude other members of the organisations involved from participation. Combining regular one-to-one communication with occasional larger-scale meetings between a range of agency representatives can be helpful in preventing 'broker' monopolisation of the liaisons developing.

At the inter-agency level, the broker agency should see its liaisons as an opportunity to introduce other agencies to one another, rather than seeking to channel all inter-agency communication through itself. Fundamentally, there is a need to develop the attitude that brokerage is about opening up contact and communication.

When trying to build networks of support around individual service users, the issue of power is even more central. For example, care managers may inadvertently oppress both service users and carers if they monopolise

channels of communication and fail to enable people to build their own patterns of 'connectedness' with one another.

Although it was argued at the beginning of this chapter that community brokerage is associated with complex networks which are dependent on the efforts of the broker for their continued existence, the role can be discharged in an empowering way if the emphasis moves away from control and into ways of helping people to obtain the resources they need. There is some support for this rather paradoxical role from the general sociological/social anthropological literature on brokers which emphasises that those who use brokers can be very proactive and to some extent can be seen as in control of the brokerage situation (Komito, 1992).

### **Facilitating network reflexivity**

Brokers need to stay involved with the networks they have helped to set up, if only to monitor the continued viability of the linkages which bind it together as a 'task community'. All complex networks have a tendency towards entropy and fragmentation. It is important that networkers operating in situations like this 'take the temperature' of the network on a regular basis. The only reliable way of doing so is to ensure that the pattern of linkages includes a number of feedback loops between the broker and the brokerage network. These can be either formal or informal, but they must be robust enough to ensure that the broker receives reliable information. For their part, brokers need to be willing to recognise that there are problems and this is not always easy, particularly as, in some cases, the broker may have put a lot of time and energy into arranging for the birth of a new network and may not want to recognise that his or her 'baby' is in trouble. This process of 'taking the temperature' of the network lies at the root of network reflexivity because community brokers cannot help to spread awareness if they, themselves, are out of touch with what is going on because they do not want to face up to the truth.

### **Linking action sets**

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So far, we have concerned ourselves only with those aspects of community brokerage which relate to the creation, or continued growth, of specific complex networks. But the concept of community brokerage is much broader than this and extends to the development and management of links between 'action sets' or even between more broadly based inter-agency networks.

One of the curious features of the development of links between action sets is that they may often be haphazard or even entirely accidental by-products of other types of networking. Whereas all the other types of networks we have looked at have been purposeful, there comes a point when network dynamics can take over. In order to understand the reasons for this, we need to go back to social network theory. Social networks tend to consist of links which are multiplex rather than single stranded (Mitchell, 1969, p.4). This is almost inevitable where the number of possible links is finite. What this means for community brokerage in particular is that, as more and more community partnerships are created, they tend increasingly to overlap with one another. This has two major consequences. One is that certain key individuals become ever more closely linked with one another, and the other is that action sets, many of which will be brokerage networks, will themselves become increasingly enmeshed with one another.

This process is almost unavoidable and may have many benefits, but it would be wise to remember that one unfortunate result may be that individuals start to feel that they have lost control to rather nebulous external forces. However, one way in which individuals and organisations can empower themselves is to seek to take advantage of this process by consciously setting out to develop a series of networks, linked by brokerage, within which community partnerships may support one another. At its simplest, this type of brokerage involves single chains developed in a linear fashion, supporting a number of interrelated initiatives and overlapping networks.

### **Brokering single network chains**

The following hypothetical case study is based on my own experiences as a social worker in West London .

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A local health visitor and a locality-based social worker work with each other on complex child care cases concerning a number of homeless families temporarily living within the neighbourhood. Although they find that they often approach their work in a different way, they value each other's contributions and begin to explore the possibility of an inter-agency liaison to promote collaborative work. When they discuss this idea with their managers, they get a positive response, but it seems also that, as the major shared concern would be homeless families, the liaison should cover all those health visitors and social workers who work with this client group, many of whom live outside the boundaries of the original 'patch'.

Eventually, a number of local liaisons are started but all those involved also meet as a special interest group on a regular basis. Members of this special interest group then begin to work together on projects, one of which is the development of new crèche/playgroup facilities in some of the hotels and hostels being used to house homeless families. This project meets with an enthusiastic response from some homeless families who involve themselves in it and, over time, a number of other activities are generated.

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The process of building a chain of linked networks of this kind can be seen as a process of discovery, in which the links between issues are revealed and personal and political strategies are combined. A whole range of feedback possibilities then arise, through which the issues dealt with by one partnership can inform the work done by another. In this example, the health visitor and social worker may well encourage individual clients to participate in the play space campaign or in general campaigns about homelessness, while at the same time cooperating closely in their more individualised supportive work.

Network chains like this develop incrementally over time, but in ways which allow those involved to stay in control of the overall process through their brokerage activities.

### **Brokering multiple network chains**

Like single chains, multiple chains consist of a number of different networks and activities held together by brokerage. Unlike them, however, multiple chains do not focus on a single issue or even set of issues, but rather characteristically involve forging links between partners who may be of value to one another across a wide range of issues. Some of the best examples of this come from the heyday of patch or neighbourhood social work. I was once a member of a team in the 1980s which held regular 'patch lunches' to which many local groups and agencies were invited. The explicit purpose of these 'lunches' was to encourage more links to be made and the team in this way saw itself as brokering a neighbourhood-wide set of partnerships.

### **Brokering the inter-agency partnership system**

Many contemporary welfare activities depend on the existence of well organised and clearly articulated partnership systems. But if such systems are



to work, it is vital that all those involved have some awareness of their relationship to them. This means that the partnership system as a whole needs to be brokered. Brokering the partnership system is essentially a matter of ensuring that the parts facilitate the whole and the whole facilitates the parts. Unlike the progressive and incremental processes associated with developing network chains, this requires a more planned approach in which all aspects of the system are brokered simultaneously.

Ensuring that the partnership system works is becoming increasingly important as social policy puts an increasing emphasis on communication, cooperation and collaboration between professionals, service users, families and others. It is this emphasis which is revolutionising services for both adults and children. As far as the latter are concerned, it is clear that services to 'children in need' and their families will entail effective inter-agency collaboration, for example between housing and social services departments and between different local authorities. The issues are even clearer in relation to services for adults.

### **Community care: a case for systems brokerage**

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The care management system which is the centrepiece of the government's community care policy cannot exist in isolation. The case management partnership needs to be supported by a complex partnership system. To some extent, the need for 'a fully integrated system which is geared to the support of the care management process' is already recognised (DOH/SSI, 1991a, p.66). But, whilst it has been acknowledged that community care is not yet a 'seamless service' (DOH/SSI, 1991b, p.21), it has not yet been fully appreciated that the process of integrating 'information systems, 'service planning', 'service contracting', 'quality assurance', service monitoring', 'management support' and 'training' (DOH/SSI, 1991a, p.66) cannot be separated from general issues of coordination and collaboration. In other words, we need to see the community care system, as a whole, as a partnership system.

Those involved in planning accessible information services will need to be involved in discussions with libraries, advice centres, health centres and other community facilities, but they will also need to have links with social workers and others involved with service users, carers and their representatives and self-advocacy groups. They will also need to feed back to all those involved with service delivery as to whether the information which is provided is adequate or, indeed, whether it seriously misrepresents the reality of what is on offer!

The choices available to service users and their carers will be very dependent upon the ability of agencies to collaborate with one another on service developments. But these developments will not be effective unless they address, in a relevant way, the needs which are uncovered through the care management process. Developmental units will thus need good links with care managers, service providers and service users/carers. Developmental work will need to feed into service contracting arrangements and if, as seems likely, 'service menus' are put together, not by individual care managers but by others, the links between these three divisions will be of great significance.

All parts of the community care system need to be 'quality assured'. This means that the criteria set for specific bits of the system need to complement one another and there needs to be a way of ensuring that all those involved in all parts of the system feed back to one another. Therefore service monitoring cannot just consist of specific input/output measures (DOH/SSI, 1991a, pp.69-70). It also has to consist of ways of evaluating the part played by the service in the overall community care system. This can only be done if information is shared and discussions are opened up through a quality assurance partnership.

Management support cannot just mean the direct support of workers. It has also to mean that managers liaise with their opposite numbers in other units, divisions or agencies while simultaneously building supportive structures for their own workers. Training has to draw upon the experiences of care managers, service providers, service users and their carers and has to be linked to the processes of service development in order to ensure that it is relevant and useful.

Increasingly, all those involved with the development of community care will have to look towards models of partnership in order to develop 'plural, yet integrated, systems of care management' (DOH/SSI, 1991a, p.74). There has been an increasing recognition that the development of a 'seamless' community care service will depend in large part on the effectiveness of 'lead managers' (DOH/SSI, 1991b, p.22), but in order to really grasp partnership opportunities these 'lead managers' should be allowed to operate not just as inter-agency negotiators but as brokers facilitating and coordinating a number of wide-ranging partnerships between service users, carers, professionals and agencies in order to create the kind of culture within which case management and service delivery can be effective.

Community care is not unique. We need to recognise that partnership systems of all kinds will grow in importance in future years and as they do so they will raise questions of coordination and integration which can only be addressed if there are specific individuals who are enabled to conceive their role in networking terms. This raises interesting questions not just

about community care but also about the whole nature of management in the new social services world. If managers are to be networkers, this suggests that the key management task may increasingly be the management of the negotiating process.

## **Community brokerage in practice**

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Given everything that has been said about the way in which the delivery of present-day social welfare services depends on various types of brokerage, the reader might be forgiven for thinking that what has been described is a common feature of practice. But the findings of the North London Project suggest that its presence should not be taken for granted. In a letter to those participating, the project defined brokerage very generally as 'the activity of going between different agencies or professional groups with the aim of bringing them closer together' and went on to emphasise that it was 'less concerned with "one off" forms of brokerage which are specifically concerned with the delivery of services' than with more general roles.

In the event, although the project found plenty of evidence for partnership and liaison, there was little evidence of the kind of activity which could be called systems brokerage. One reason for this was that individual practitioners tended to develop very personalised and individualised networks which were not available to other members of their own organisations. Another, more deep-seated, reason might be the difficulty many of those taking part had in perceiving the benefits of anything which did not produce immediate and identifiable outcomes. Helping other organisations to work more effectively with one another falls, almost by definition, outside this conceptual framework (Trevillion, 1996a).

Even where there is a strong belief in the value of 'cooperation', brokerage activities are often designed to ensure that specific individuals receive an appropriate range of services, rather than establishing new links between different agencies (Trevillion and Green, 1998). To the extent that I have found evidence of a willingness to invest in long-term relationship building between teams and organisations, the focus has almost always been on the links an individual or team could build for itself, rather than on the construction of a set of linkages between the different participants. Where these links have developed it has been by accident and without any real planning.

In network terms, what appears to be happening is that a loose-knit network is put together, focused on a particular individual or team, and

which may have little durability as a result. While systems brokerage is the logical extension of other forms of brokerage, there appear to be significant barriers to its development. While it is not possible to investigate these barriers in depth here, their presence needs to be acknowledged and, if networking is to fully realise its potential, they need to be overcome.

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# 5 Inter-agency networking

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## The problem of collaboration

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Inter-agency work has long been seen as the key to primary health care (Kleizkowski *et al.*, 1984, p.16). More recently, it has been mooted that this should also encompass strategic linkages between health and social care (Duggan, 1995). Arguments for a multi-agency approach have been made for even longer in relation to child protection (Maher, 1987, pp.145-7) and whole areas of policy making such as community care and child care have now become linked to the ability of the health, housing and social services to work together (Lewis and Glennerster, 1996, p.165; DOH, 1991, s.1.8). Even urban regeneration has come to be seen as dependent on the existence of a 'networking organisation' (Macfarlane and Lavelle, 1992, p.111).

But there is always a danger not only of proposing inadequate or inappropriate solutions, but of misunderstanding the nature of the problem of collaboration. The recent literature on the 'health and social care divide' tends to assume that the problem of collaboration consists either of inadequate or insufficient guidance from central government, unclear agency and professional boundaries leading to role confusion or persistent cultural differences generating constant conflict and misunderstanding between health and social services. While these ideas may appear to be superficially attractive, they lead to 'top down' solutions which often make the problem worse (Trevillion, 1996b, pp.11-14).

The plea for more guidance tends to lead to requests for more centralised direction and control. The focus on boundary maintenance may lead to a clearer division of labour, but it does nothing to encourage individuals or organisations to question their assumptions or explore new ways of work-

ing together. Finally, the concept of cultural differences tends to define the problem of collaboration as irrational resistance to progress and this in turn suggests 'solutions' which often consist of management seeking to impose new organisational and professional values from the top down. While managers and policy makers need to define the overall aims and create an enabling context for inter-agency work, their efforts may be self-defeating if they lead to rigid and stereotypical forms of the division of professional labour and only partially successful attempts to force people to change their values and beliefs. While good organisation and effective administration will always be essential, if these are to be delivered through interorganisational networks then more attention will need to be paid to network processes than has hitherto been the case.

Contrary to much of the received wisdom on the subject (for example, Payne 1986b), inter-agency collaboration is much less about the way in which organisations gradually merge into one another to create new organisations than it is about the restructuring of organisational life itself on network principles. Some of this has already been touched on, but if we are witnessing the birth of new, open-ended, social networks criss-crossing the spaces between organisations and creating a new interorganisational space characterised by new patterns of 'connectedness' (Statham, 1996), this is the context in which we should be discussing inter-agency work.

In the general context of networking in which there is always a strong emphasis on making links across organisational boundaries, how easy is it to separate inter-agency work from any other type of networking? One of the most commonly used definitions of inter-agency work stresses that it should involve 'joint initiatives' (Hall, 1988, p.82). But what exactly is a 'joint initiative' and how can this be defined so as to avoid the trap of making inter-agency work synonymous with almost any example of networking? It seems right to insist that inter-agency work must be focused on more than a particular short-term problem of service delivery. On the other hand, given the criticisms already made about an overreliance on 'top down' decision making, it also seems appropriate to define 'joint' or collective 'initiatives' in such a way that practitioners as well as managers can be seen to play an active part.

Inter-agency work might be expected to have two distinct outcomes, both of which need to be incorporated into any definition of inter-agency networking. There needs to be some process of collective decision making, but there also needs to be a discernible impact on the relationship between the participating organisations. This produces the following definition:

Inter-agency networking is the development and maintenance of a system of interorganisational linkage characterised by collective decision making and a set

of positive feedback relationships between the internal structure, systems and values of participating organisations and the interorganisational network of which they are all members.

This suggests that it is possible to distinguish conceptually between the inter-agency network and the agencies themselves. This may seem curious, but in practice this separation is easy to observe as the set of inter-agency linkages is usually managed by a relatively small set of key individuals drawn from the participating organisations.

### **Take your partners?**

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Many inter-agency partnerships are based upon a shared interest and involvement with a particular client group. Community mental handicap teams, for example, operate as multidisciplinary networks of social workers, nurses, psychologists, speech therapists and so on, seeking to coordinate service delivery (Humphreys and McGrath, 1986). But the process of deciding which agencies to link up with is not always straightforward. Should only specialist organisations be included, or should more general welfare organisations which devote a considerable amount of time to the client group also be invited to participate? Should user groups be included, and how might the interests of families and carers best be represented?

Even relatively narrowly defined client groups may raise issues like this. The joint planning teams set up as a forum to discuss issues relating to the care of people with HIV and AIDS were meant to include representatives from health and social services, but also representatives from voluntary organisations. But which ones? No clear answers to this question were ever devised and the membership of joint planning teams varied as a result.

The purchaser/provider split associated with the NHS and Community Care Act has created new kinds of problems for inter-agency work. This can be seen in relation to the difficulties now being encountered with 'joint commissioning'. It has been widely assumed that relations between the commissioning partners (health and social services) and the service providers can be governed purely by market-led considerations and detailed contractual arrangements, but this can lead to problems, for example, in relation to hospital discharge arrangements, about which complaints have multiplied in recent years. According to an Age Concern spokesperson:

Health purchasers are not based in hospitals and as a result communication between purchasers and providers is often poor. Trusts don't purchase services



so, unless collaboration is good, service users may not get the district nurse they need or equipment such as incontinence supplies. (*Community Care*, 1997, p.19)

Partnership clearly needs to extend across the purchaser/provider divide, but if there is an attempt to do this, it is again not always clear who should be included and who excluded. Moreover, the range and diversity of provider organisations (Taylor *et al.*, 1995) may pose problems for any attempt to impose a common set of expectations on all partners. If this were not enough, there can be conflicts between the demands of the joint commissioning partnership and the broader partnership embracing both purchasers and providers.

The need to involve service users and local communities at the planning and commissioning stage also raises some difficult questions. Should all those living in a particular local or health authority area have some say in these matters? As this is likely to prove impossible, should the emphasis be on those currently using services? The latter may simplify the process of identifying partners, but if one of the problems is the low level of service delivery to certain parts of the community such as black and ethnic minority groups, then focusing exclusively on existing service user groups might make matters worse.

Choosing a locality focus does not always resolve these difficulties either. What of agencies equally active in more than one locality? As each agency is likely to define its geographical boundaries somewhat differently, which definition should be adopted as the boundary of the inter-agency network? Sometimes, differences of organisational culture ensure that these issues remain unresolved.

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When I worked in a neighbourhood-based social work team in London I found that health service representatives persisted in treating what I saw as an inter-agency 'patch' network, with a number of different partners, as a link between the health service and the local authority as a whole, which effectively ignored not only other neighbourhood-based organisations but also the local social work team.

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The introduction of Health Action Zones is an attempt to solve these problems by 'developing locality commissioning' in wide-ranging partnerships within a common, clearly defined geographical territory (Peck and Poxton, 1998, p.7).

In addition to the key agencies responsible for implementing collective decisions, there will also be a wider network of stakeholders. This poses a problem which is not just practical but also ethical and philosophical, because the stakeholder argument is essentially a moral and political one. In principle, it suggests that all those who have a 'stake' in the outcome of a decision should be involved in making that decision. Does this mean that any inter-agency network should also include representatives of the stakeholder network? It may complicate decision making but also add to the legitimacy and acceptability of decision making.

The West London Project showed that a wide range of stakeholders could come together to make decisions and, according to its co-director, the London Health Partnership appears similarly to have found little difficulty in working with a mixed service agency and stakeholder network:

Work with local partnerships begins with a burning local issue, such as how to improve hospital discharge, how to stop lonely deaths, or how to avoid last year's winter bed crisis. First, we engage stakeholders who bring together people representing the whole community of interest around their burning issue.

Then the LHP designs custom-made conferences which allow local players to find common ground they are prepared to work for. Participants range from those at the top to those at the bottom of organisations and great care is taken to ensure they are not just the usual suspects. The events take place over two or three days and generate a range of actions by local people. These are different in each place. After this, we look at the implementation and learning how to sustain the changes. (*Community Care*, 1997, p.21)

Linking stakeholder and service agency networks can be successful provided that the process is carefully managed and attention is paid to the creation of a consensus. The fact that irreconcilable differences are not mentioned suggests that, perhaps, areas of 'common ground' will always be found if there is enough commitment to finding them.

## Brokers and representatives

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As we saw in Chapter 4, there are many examples of inter-agency networks which depend on specific brokers. Community care is a notable example of what I have called 'systems brokerage'. However, not all inter-agency networks fall into this category. Brokers tend to be associated with those initiatives where a particular agency is primarily responsible for the success of an initiative. In the case of community care, local authorities have been identified as the 'lead agency' and it is therefore not surprising to find that

they sometimes take on the role of 'systems broker'. However, even within the broad context of community care, some issues are likely to be driven forward by other agencies as much as by social services departments.

A close look at the work of the London Health Partnership shows that issues such as hospital discharge may be a matter of such grave concern to so many organisations that it would be false to describe the process of establishing a partnership as dependent on one particular agency acting as a broker. All those involved actively seek to represent their issues and concerns. The reality is that everyone is active and everyone networks with everyone else. Networks like this might be best described as representative networks, in that each agency is actively represented and the representatives as a whole manage the partnership system.

As with any other kind of networking, inter-agency networking operates at a number of different levels simultaneously and what follows applies equally to those networks based on specific brokers and those consisting of linked representatives.

### **The interpersonal network within an inter-agency network**

Inter-agency links are too easily seen in depersonalised terms. All the inter-agency projects in which I have been involved have relied on a relatively small number of committed individuals as well as the broader support of their respective organisations. These include GP/social worker liaisons undertaken in the period 1981-3, a network of local organisations supporting the work of a community interpreting service during the same period, a forum for agencies representing the interests of older people in the period 1984-6, a broad-based patch network representing ten different local agencies who met regularly for a 'patch lunch' at a community centre in the period 1984-5 and, more recently, a large Diploma in Social Work Programme network consisting of more than 20 statutory and voluntary organisations from all over London. Although all of these networks have been very different, they have all shared this feature of conducting organisational business in an informal manner through individuals who have often got to know one another very well.

In some situations, the potential sensitivity of some inter-agency linkages may mean that all communication needs to be channelled through specific individuals nominated by participating agencies. When setting up GP/social work liaisons as a neighbourhood social worker, I found that even the most welcoming and interested GPs insisted on channelling all their communications through specific named individuals. Thereafter, these liaisons seemed to work best when there were regular meetings between the named social workers and the GPs. Looking back on this now, it seems to

me that the key issue here was trust. Because networking takes place outside established procedures, it involves an element of risk taking and, in a situation where trust may in any case be very fragile (Hunter and Wistow, 1987, p.140) and there is always a danger of 'inter-professional demarcation disputes' breaking out (Hill, 1982, p.73), these risks only become acceptable if bonds of personal trust can be developed.

The same principles appear to apply at higher management levels.

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In the course of a group discussion which formed part of the West London Project, a social services manager talked about a network of managers from different agencies which he attended on a regular basis. He made a point of emphasising that one of the most important elements in the success of this venture was the way it had enabled personal relationships to flourish. As a result, where issues could be routed in a predictable way through named managers, problems could generally be solved with a minimum of conflict. However, this led him to express concern about how well the inter-agency system could deal with emergencies. Unpredictable situations which obliged individuals who did not know one another to solve problems quite often produced conflicts and tensions and in these situations the inter-agency liaison network seemed to be of little help.

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Where inter-agency work is successful, it seems to demonstrate that it is not agencies which relate to one another but people representing agencies. Where large-scale bureaucratic organisations are concerned, a constant and skilled brokerage effort is frequently needed to prevent the breakdown of the inter-agency network. Helping staff to manage their inter-agency relationships has been compared with the work of marriage guidance counsellors: 'Those lucky managers charged with running joint health and social services projects have, like counsellors from Relate, beavered away behind the scenes, working for a nearly perfect marriage where staff from both sides strive together to offer clients a seamless service' (*Community Care*, 1997, p. 19).

### **The inter-agency network as a 'task community'**

One of the aims of inter-agency networking is to generate a sense of collective commitment to collective decisions. This is not easy.

In one case, a social worker whom I was supervising gained the rather passive agreement of her team to undertake liaison work with the home care team. Having successfully negotiated an opportunity for social workers to meet specific home helps by appointment at a fixed time of the week, she was dismayed to discover that few social workers were willing to make use of this opportunity. It needed much subsequent work and continual 'reminders' to her colleagues to increase the number making use of the new liaison possibilities.

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This kind of problem occurs when the interpersonal nature of the decision-making network leads to the development of an inter-agency clique out of touch with the feelings of the colleagues they are supposed to represent. This creates a tension between the tendency for the members of a strongly committed decision-making or representative network to become closely identified with one another and the dangers this poses of a split between inter-agency structures and the participating organisations.

As any inter-agency network has to be judged by the results it achieves, these kinds of problems need to be taken seriously and we should avoid assuming that an effective and well organised 'task community' is always a very close-knit structure. Some degree of 'connectedness' is essential, but an overly 'dense' inter-agency network may prove to be counterproductive if it excludes others. One answer to these kinds of problems is to ensure that everybody in an organisation gets a chance to participate in an inter-agency network.

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The neighbourhood social work team in which I worked in the period 1981-4 was involved with other similar teams from the same local authority in regular meetings to learn from one another's experiences and to undertake shared 'policy' making. The meeting rotated through the different patch offices and was very much a collective responsibility.

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This is an example of a close-knit inter-agency network which managed to avoid the problem of cliques by including everybody. However, this kind of solution is only possible on a very small scale.

One of the tests of an effective task community is external to the service agencies themselves and that is the extent to which the community is open to the wider stakeholder network discussed earlier on and to particular service users. An inter-agency 'community' cannot be said to exist if service users, the 'citizens' of that 'community' are excluded from it. Therefore structures need to be developed for opening out inter-agency links to user involvement, and not just on agency terms. As Croft and Beresford remind us, people want 'more control over their own lives' and this involves playing a genuine role in the inter-agency decision-making process, a process which involves moving from a preoccupation with 'personal troubles to collective policy' (Croft and Beresford, 1989, p.16).

## **Flexibility and accountability**

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There is a conflict between the bureaucratic mode of organisation and inter-agency networking. A classical bureaucracy encourages vertical communication up and down the various management levels and this has an impact on the transmission of information (Weber, 1978, pp.956-1005). Few organisations correspond precisely to this ideal type. Local authorities for example, are, influenced strongly by non-bureaucratic factors such as local politics, and yet there is a tendency towards bureaucracy in most large organisations. The concept of a 'networking organisation' is probably as much of an ideal type as the concept of a 'bureaucracy'. Few organisations correspond precisely to the expectations one might have of a 'networking organisation' and yet, where networking is found, it tends to encourage horizontal communication across organisational boundaries rather than vertical communication within organisational boundaries. Where bureaucracy and networking coexist (as they usually do) this tension can cause problems.

Networking undermines bureaucratic power and it calls into question rules or assumptions which have never before been called into question and which have helped to define organisational 'culture' (Schein, 1985). In doing so, it can create an institutional 'backlash'. One of the interprofessional discussion groups which were a feature of the West London Project discussed this issue in some depth.

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Almost all members of the group felt that managers could feel threatened by the 'participative' and 'democratic' characteristics of inter-agency networking and they related this to the fact that all their organisations were

still quite hierarchical. But there was also a general acknowledgement that their organisations recognised that networking could be helpful. On the whole they tended to the view that their organisations were becoming more 'network-friendly' than in the past but that more traditional attitudes still survived. This group also identified somewhat inadvertently one of the key problems for organisations seeking to become more 'network-friendly'.

This group, which did not include any managers, were unanimous in their view that the best managers were those who simply set a broad context and resource framework and then left workers to do what they thought most appropriate in relation to inter-agency work.

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But if, by definition, inter-agency work is work done on behalf of one's own agency, it is not clear how this kind of individualised decision making could possibly deliver a genuine inter-agency arrangement. These comments suggest a lack of clarity about the difference between interprofessional collaboration on problems of service delivery and interorganisational linkage.

There is an echo of this theme in the results of the North London Project. In some ways these seemed to represent the ideal situation described by the professionals in the other project. Interprofessional linkages were highly individualised and there was little or no sense of management interference in the way these relationships were conducted, but the result was a lack of interorganisational linkages even at a team level (Trevillion, 1996a, p.98).

While flexibility and informality are the hallmarks of inter-agency networking, achieving them at the expense of organisational fragmentation is clearly counterproductive, as there appears to be little point in developing linkages between organisations if these organisations cannot make corporate decisions. There has to be accountability and there has to be some measure of control. How is this to be achieved?

In part, the answer may be to focus as much on intra-agency linkages as on inter-agency linkages and to ensure that, however informal the style of work, there are clear channels of communication and accountability within the teams, sections and organisations that networkers represent. If parts of a particular organisation become so closely engaged with other organisations that they start to develop new interorganisational identities then this needs to be formally acknowledged and linked to new mechanisms capable of delivering effective communication and accountability, perhaps by adopting some of the procedures and processes associated with stakeholder networks.

## **Networking the communication system**

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In some respects, it is very artificial to try to separate a discussion about inter-agency communication networks from the debates about appropriate types of linkage and ways of using linkages to promote shared or collaborative working. In a sense, an effective communication network is simply one which enables these kind of inter-agency processes to occur. In addition, much of what has already been said about promoting network awareness and acting as an 'interpreter' applies as much to inter-agency work as to any other kind of networking and community brokerage. But it is probably worth taking the risk of sounding repetitive to state clearly that inter-agency cooperation cannot flourish unless there is a shared understanding of key issues.

A social services department may be seeking to implement a policy of removing suspected abusers rather than their victims from households in which abuse has taken place. But to do this they need cooperation from the housing department. If the issue is seen as giving abusers priority over other people on the housing waiting list, it is likely that there will be considerable resistance to the idea both from the housing department and from those housing associations which specialise in accommodation for single people.

Prior to any formal request for cooperation with a policy of removing abusers, representatives of all these agencies should meet to explore the issues together and formulate a policy to which they could all feel committed. This process will probably be much more effective if incest survivors or mothers desperate to keep their children out of care have some opportunity for participating in these discussions and making their views known.

It is often a specific issue like this which, because it cannot be resolved easily, leads agencies to invest time in their relationships with one another. In doing so, they often discover a number of other issues which can be talked about informally. Communication channels set up to discuss the issue of rehousing abusers can also be used for discussing the position of homeless families in particular hotels, or elderly people who become homeless as a result of family disputes. If the discussions extend to the position of people recently discharged from psychiatric hospital and placed in bed and breakfast hotels, the partnership might invite representatives of the health authority to join. In this way the communication network might continue to grow and evolve over time.

There is no one ideal pattern of inter-agency communication, but, on the basis of all the issues which have so far been raised, it would seem as if networkers trying to develop appropriate channels of communication should ensure the following:



- the flow of information across the interorganisational interface is managed by a relatively small number of people who know one another well;
- information flowing through these inter-agency information brokers is transmitted to and from a range of clearly identified strategically positioned individuals and groups within the broker/representative's own agency;
- communication links between service agency and stakeholder networks are established and maintained, and these links are fully integrated with consultative and decision-making systems;
- the growth of the communication network is paced appropriately over time.

## **Mobilising resources**

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An inter-agency action set is a network of agencies involved in some form of collaboration. Almost always, these same agencies will have established liaison relationships with one another. In order to understand the inter-agency action set process, we need to understand the relationship between liaison and collaboration and, as a first step, we need to define our terms.

The words 'liaison' and 'collaboration' are sometimes used interchangeably, as if they had the same meaning, but it is probably best to see them as referring to different aspects of inter-agency partnership. It has been argued that they refer to different degrees or levels of partnership. In this view, organisations can be seen as moving through a number of 'stages' in their relationship with one another from 'communication', through 'cooperation' and 'coordination' to 'federation' (Payne, 1986b, p.75). But this model is questionable because a high level of organisational integration, perhaps rather surprisingly, does not in itself seem necessarily to produce an effective mobilisation of inter-agency resources.

The work of Community Mental Handicap Teams (CMHTs), in at least some areas, appears to have been undermined by the lack of understanding and ability to work together of the NHS and local authority social services (Humphreys and McGrath, 1986, pp.21-7) even though the teams themselves were organisationally integrated, corresponding to Payne's concept of a 'federative stage' of development. The CMHT experience suggests that, rather than seeing liaison and collaboration as different 'stages' or 'levels' of networking, it may be better to see liaison as embodying the continuity of contact between agencies which is essential to the success of collaborative initiatives. In terms of network theory, liaison

can then be thought of in terms of the development of action set 'potential', and collaboration as the process of mobilising an action set. Likewise effective network communication may not be simply the first stage of community partnership but rather the process which underpins the future of the relationship as well.

This may help us to distinguish between genuine liaison and activities which may be described as such but which do not create action set potential. The North London Project provides some good examples of this difference between rhetoric and reality.

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John Smith is a HIV social worker. He is based in a social services department team but has a lot of contact with health professionals and medical charities. Superficially, his involvement in inter-agency work appears to be impressive. Not only does he have a large number of inter-agency contacts but he also clearly identifies liaison with other agencies as a key role. In fact he has intensive contact with ten organisations and, of the ten areas of activity into which he divides his work, two specifically relate to liaison work. But, if we explore these liaison activities in more depth, a number of less reassuring features emerge. Not one of the ten organisations with whom he has most frequent contact figures in his liaison activities. Even more surprisingly, none of those individuals with whom he has the most intensive contact actively participates in his liaison work.

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What is notable about this is not the relatively low level of interactions devoted exclusively to liaison but the lack of any obvious relationship between liaison and mainstream service delivery work. When statistical tests were applied to these features at a team level, they confirmed this impression of the marginality of liaison (Trevillion, 1996a, pp.99–100). While it would be very rash to conclude that John Smith, or even his team, is in some way a typical example of contemporary inter-agency work, what this piece of research does show is that it is very easy to be misled by appearances and to assume that activities which are described as 'liaison' actually make a difference to service delivery, when the opposite may be true.

## **Inter-agency 'rules' and 'contracts'**

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The history of the CMHTs and of joint planning and joint finance (Hunter and Wistow, 1987, pp.110-56) suggests that local authorities and health authorities may not be able to work well with each other in the absence of clear 'partnership contracts'. Underlying this, perhaps, is the problem of joint 'ownership'. Liaison links can be used to work out the basis of a future collaboration. The issues which the partnership contract will need to address will depend on the nature of the collaboration.

A contract for an inter-agency project such as a CMHT will need to pay attention to issues such as accountability and line management responsibilities, the resources which will be committed to the project by the various agencies, the proportion of time to be devoted to service delivery, as opposed to developmental work, and confidentiality. The purpose of such a contract is to support workers and give them the confidence to develop new ways of working, rather than to impose a new bureaucracy, and it is important that this principle is respected, otherwise the contract will be disabling rather than enabling. But contracts like this can never be negotiated once and for all.

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I remember from my own experience the case of an inter-agency 'rule' which obliged social workers to inform health visitors of any child care concerns or of any new families with young children moving into the area. This rule was constantly flouted by social workers. The health visitors communicated their concern but nothing happened. Discussion within the social work team revealed that people were either unfamiliar with this 'rule' or unhappy about it because it appeared to conflict with the professional 'rules' about confidentiality. Eventually a new inter-agency code of conduct was negotiated which took account of confidentiality and which was respected.

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Where inter-agency collaboration is to be directed more towards strategic planning than to a specific project, the contract will need to address a different set of issues. A community care planning partnership may need to involve a social services department, a housing department, a health authority, a number of voluntary organisations, service users and carers. In order to do business with one another they will need to develop a shared

understanding of issues such as the roles they are expecting one another to play and the power of the partnership to make decisions which will be binding on all its members.

One of the secrets of developing and then maintaining an effective inter-agency action set is coordination. But the most appropriate way of coordinating a particular inter-agency partnership will depend on the situation. One issue is the size of the network. If it is not too big, it may be a good idea to call a network meeting. If a liaison relationship between social workers, community workers, a tenants' association and a local church-based group revealed a need for a new youth club on an estate where territorial rivalries effectively made other clubs inaccessible to local young people, a network meeting might enable the partnership to begin work on a campaign to persuade others that a new club was absolutely essential.

The meeting could divide key tasks between different agencies. The community workers might gather and collate evidence of the need and present it to officers and members of the local authority. The social workers might write their own reports, commenting on the need for preventative services on an estate with high rates of juvenile crime and on young people being 'looked after' or coming into 'care'. The church-based group and the tenants' association might contact the local media and persuade them to run stories about the lives of local youngsters and lobby local politicians about the strength of feeling on the estate in support of the campaign. Some network members might seek to broaden the base of the campaign by involving local young people themselves, the police and the probation service. Subsequent meetings could review strategy and develop the campaign as it went along.

Sometimes the inter-agency network will be too complex to enable mobilisation of resources to be undertaken through a single planning meeting. The development of a mental health resource centre might need to be undertaken by a number of specialist groups, each one concerned with a particular service. For example, the drop-in centre might be developed by community psychiatric nurses, a volunteer organiser and social workers from local patch teams together with service users, whereas advice and information services might need to be developed by the Citizens' Advice Bureau and community workers. In a situation like this, it might be advisable to appoint an overall network coordinator who would act as a broker 'interweaving' the different groups into a viable whole. But network coordinators are not managers and if they possess authority it is only because all those involved are prepared to vest some authority in them.

## **A way forward?**

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This chapter has drawn attention to a number of problems and difficulties as well as a number of key principles. We have seen, for example, that patterns of interaction between individuals from different agencies can occur without producing any inter-agency collaboration. It may not be possible to say whether the results will be good or bad, but what is obvious is that such networks will develop without any overall sense of strategic direction and may carry all those involved, including the users of services, off into uncharted and potentially dangerous territory.

Inter-agency work has to be carried out on behalf of an organisation, not an individual, and it must be oriented towards achieving the strategic objectives of individual organisations, not the whims and fancies of individuals, however creative they might be. This implies careful attention to the way in which patterns of communication are organised, clear structures of accountability and the appropriate use of contracts, as well as the encouragement of creativity and informality. This is not an easy combination for any organisation or set of organisations to deliver and so it is not surprising that the problem of collaboration has proved so difficult to solve. Nevertheless, networking perspectives provide a framework with which to guide practitioners and managers in this difficult area.

# 6 Care management revisited

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## The alchemists of welfare

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Care management was developed many years ago in the USA and Canada, where it is still known as 'case management'. By the early 1980s, its two key characteristics had already been identified. Austin had described it as 'a mechanism for linking and coordinating segments of a service delivery system (within a single agency or involving several providers)' (Austin, 1983, p.16). This captures the way in which case or care management is an attempt to ensure that services are delivered in an integrated fashion and that diversity and complexity do not lead to fragmentation, inefficiency and confusion. Meanwhile Steinberg and Carter had coined the now familiar term 'service' or 'care packages' and emphasised that these 'packages' had to be developed on the basis of an understanding of the needs of particular individuals (Steinberg and Carter, 1984, p.xi), thereby capturing one of the key paradoxes of case or care management, the attempt to define individual need in holistic terms while seeking to meet it through a variety of highly differentiated specialist services.

Putting these two early definitions together, we can see that care management is less a technical or mechanistic device than it is an aspiration. It aspires to an ideal world in which 'real' need is both understood and met in holistic terms, but it operates in a far from perfect everyday world of rival professions, organisational conflict and scarcity of resources. Care packaging or service coordination is the way in which care management tries to reconcile what is ultimately irreconcilable. As a result, care management is, perhaps, doomed to perpetually frustrate all those involved with it because its aims can never be finally realised. This does not mean, however, that it

should be dismissed as a failure. The mediaeval alchemists may have been wrong to believe that 'base' metals could be transformed into gold, but their failures laid the basis of modern chemistry. Likewise, care managers can be seen as the alchemists of modern welfare, constantly seeking to transform inadequate resources and inappropriate services into the philosopher's stone of a genuinely needs-led service. The philosopher's stone, of course, lies forever beyond their grasp, but it will be the contention of this chapter that, if they base their work on networking principles, they will frequently discover quite new and unexpectedly successful ways of working with complex situations.

## **Care management in practice**

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The early years of care management in the UK were characterised by a high level of confusion as to what it actually was (Lewis and Glennerster, 1996) but, as some of this early confusion has receded, a number of more distinct problems have begun to emerge. Some are related to inter-agency work, some are related to problems of empowerment, some are related to the shortage of resources for community care, in particular, and social care, in general; but there is one problem which goes to the heart of care management and that is its apparent failure to deliver a genuinely needs-led community care system.

Although the philosophy of care management is that a person should receive a unique blend of services reflecting his or her own unique needs, there is considerable evidence of a tendency to standardise both services and procedures. Suggesting that 'the introduction of assessment and care management has not benefited people with learning disabilities', Smith argues that this is rooted in the drive towards uniformity: 'Most authorities have been obsessed with creating uniform procedures to meet the needs of all client groups and particularly elderly people. In doing this they have lost some of the unique features needed to meet the individual needs of people with learning disabilities (Smith, 1995, p.7). In general, it seems that individuals are still made to fit services, rather than the other way around. Dipping into Greek mythology to make this point, Ritchie suggests that 'the tradition of tailoring in services owes more to Procrustes than to Savile Row' (Ritchie, 1994, p.133). While no system of welfare can hope to operate fairly and equitably without reference to some common standards, and individual claims will always need to be considered within the broader context of public priorities, these concerns go deeper.

One of the three key aims of the community care legislation was to 'give people a greater individual say in how they live their lives and the services

they need to help them to do so' (Cm 849, s.1.8) and this was supposed to lead to 'services that respond flexibly and sensitively to the needs of individuals and their 'carers' (ibid., s.1.10). But care management, in practice, is now frequently accused of leading to an 'increase in bureaucracy' which appears to have accompanied the new procedures to the extent that 'the formalisation of procedures threatens to change the nature of social work practice' (Lewis *et al.*, 1997, p. 22). Rather than achieving a flowering of creativity, care management has, all too frequently, it seems, led to a move away from a professional culture and towards a 'managerial culture' (Lewis and Glennerster, 1996, p.143). And so it is argued that care management is implicated in turning activities at one time shaped by professional judgement into a '(semi) mechanical process' involving 'production line' techniques 'de-skilling' workers and turning them into 'slavish followers of protocols, devised not by themselves as part of a culture of good practice, but as set by those who want to control them as they themselves are controlled' (Simic, 1995, pp.13-14).

The increasing recognition that there is a problem associated with the tendency towards standardisation rather than individualisation has created a new orthodoxy which regards care management as irreconcilably oppose to social work and indeed any kind of person-centred human service activity. Simic speaks for many when he writes: 'The interpersonal features of practice that many associated with social work are disappearing in deadline and throughput dominated practice' (ibid., p.12). This is a powerful argument, persuasively put and while it is not the fundamental 'linking' and 'coordinating' principles of care management which are responsible for the general move towards market competition, contract-based relationships and the refusal of central government to take any responsibility for defining the relationship between 'rights', 'needs' and services in conditions of scarcity (Trevillion, 1996d), there must now be serious doubt about the extent to which current models of care management can refocus attention on the relationships with service users, carers and other professionals which are supposed to underpin both the assessment process (CM 849, ss.3.2.4-3.2.6) and the process of care planning (ibid., s.3.3.1). This is exemplified by the problems associated with operationalising the idea of 'partnership'.

### The gap between rhetoric and reality

As part of the North London Project, 11 social workers, the entire membership of two teams of social workers/care managers (six members of a specialist HIV team and five members of a mental health team), were interviewed and asked what the concept of 'partnership' meant to them. The aim of this was not to be able to generalise about care managers' attitudes



but rather to compare attitudes and practices within the context of a particular organisation at a particular time.

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Ten of the responses demonstrated a strong awareness of the relationship base of effective partnership arrangements. Themes such as 'trust' and 'mutual understanding' were present in almost all the responses. Even the one respondent who was sceptical about partnership acknowledged that an effort had to be made to develop good working relationships. However, when these general statements were compared with the statements which the same people made about specific 'partnerships', the gap between rhetoric and reality was striking.

There was little evidence in the study of any deliberate attempt to develop relationships and it was hard to avoid the conclusion that in practice the term 'partnership' was defined on the basis of three features which had little or nothing to do with the themes of 'trust' or 'mutual understanding' which were such a feature of the general definitions they had given. These were instrumentality (there was a strong association between problem solving and partnership), intensity (high frequencies of interaction were positively associated with partnership) and durability (the concept of partnership was only applied to relatively long-term relationships).

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It is hard for care managers to practise what they preach. While these care managers were involved with networks of service providers, this did not mean that attention was being given to developing or sustaining patterns of linkage. The result was that, in contrast to initial assessment and the process of putting together 'care packages', opportunities for actively working alongside others were very limited. In some respects, the situation seemed to exemplify Simic's point about 'throughput dominated practice'.

Some of the reasons for this may have been quite local. The comments made by one of the team leaders seemed to suggest that the fragmentation of work at the care management level was duplicated throughout the organisation, with very little attention being paid to support and coordination. However, the 'fit' between this picture and that of some of the general comments which have been made about care management by its critics is too close to ignore. Is this kind of pattern inevitable or is a fresh relationship-oriented approach possible?

## A Fresh Approach?

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We have known for many years that the 'packaging' of care is dependent on an ability to work with clients and 'informal carers' (Steinberg and Carter, 1984, pp.25-6) as well as with representatives of other agencies. In fact, the relationship tradition in care management goes back to the 'interweaving' strategies advocated originally in the 1968 Seebohm Report and subsequently elaborated upon in the 1982 Barclay Report under the rubric of 'community social work'. It has also been known for some time that the careful stitching together of relationships and the work needed to ensure that those relationships remain robust and enduring are critically dependent on 'face-to-face' communication and negotiation with clients and carers (Bayley, 1973, pp.316-17).

As these principles are so well established and as care managers themselves often appear to subscribe to them, why has it proved so difficult to incorporate them successfully in care management practice? Part of the problem may lie with the concept of 'need' itself. While in some respects need is central to any form of care management, controversies and misunderstandings about what is meant by this term have tended to devalue the language of need to such an extent that it now appears either to embrace almost anything or to be associated with the way 'eligibility criteria' restrict access to a specified restricted range of health and social care services. Without jettisoning the idea of need altogether, it may now be time to re-evaluate it in the broader context of 'quality of life'.

It has been argued by some commentators that 'quality of life encompasses well-being in terms of both the inner self and the environment' and that plans based on a concern with 'quality of life' tend in any case to have better outcomes than those developed on the basis of other, more restricted criteria (Seed and Kaye, 1994, p.31). One of the other advantages it has is that it tends to focus less on the way in which specific needs can be met by specific services and more on the way a whole complex of linked issues, activities, services and relationships can contribute to 'well-being'. If one of the concerns about care management is with the way in which it has in some places been associated with a turning away from relationships, locating assessment, care planning and coordination within a 'quality of life' framework might help it to break away from the debilitating short-termism which has marred the early years of its development in the UK.

Some of the weaknesses of the dominant models of care management go back to its inception. The case management pioneers were so preoccupied with counteracting fragmentation that they oversimplified the relationship between control and coherence. Because of their concern with finding ways

of taming the power of individual service providers and enforcing overall integration on behalf of the client, they neglected the problem of the overly powerful care manager and, even more fundamentally, they failed to explore the difference between setting up a resource system to enable specific services to be channelled to a relatively passive recipient and developing a network of potential resources to be actively deployed by the service user. By making a shift now, away from the former and towards the latter, we would also be making a shift away from the management of care services and towards a way of working closely with individuals to achieve an improved 'quality of life' by the active deployment of appropriate resources which might not always be formal services. This is a move away from conventional care management to what could be called 'brokering social support'.

It could be argued that this would still raise the same problems of finite resources and potentially unlimited demand as care management. As far as it goes, this is true. The concept of 'quality of life' does not create new resources (although it might lead to a more imaginative deployment of existing resources). However, what the concept does is to move the debate away from ways of restricting access to services by narrow 'eligibility criteria'. It focuses attention on the kind of rights which individuals in a society have to a way of life which is compatible with their status as citizens. This issue is explored in more depth in the next chapter, but the model of brokering social support which is proposed here would be dependent for its successful implementation on a willingness to move to a more clearly rights-based approach to social welfare.

### **Network approaches**

There is some evidence that social network approaches are beginning to influence practice, albeit in a relatively intuitive way. For example, certain network themes kept recurring in the diaries which were kept by social workers/care managers as part of the West London Project.

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Some key words such as 'support', 'facilitation' and 'co-ordination' were mentioned frequently. Some diaries also used specific phrases such 'pulling together the network' and mention was made of a perceived connection between the quality of relationships in a support network and the effectiveness of the support provided.

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While it was clear that those taking part in the West London Project often operated to tight deadlines and with a very short-term approach to problem solving, it was also clear that they sometimes acted quite differently. This can be understood in terms of the way in which they sometimes linked flexible and holistic approaches to definitions of 'need' with a willingness to think in network terms (Beresford and Trevillion, 1995, pp.43-4). However, the analysis can be taken a step further.

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When operating in this particular mode or mind set, the care managers focused on network strengths ('a supportive family') and network opportunities ('access to transport') rather than problems and 'needs' and implicit within this was a concept of 'quality of life' even if this new language was not used by care managers themselves.

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One of the advantages of trying to make these relational perspectives explicit is that it becomes possible to redefine care management as a certain kind of community brokerage.

### **Brokering support through the interpersonal domain**

This aspect of brokering social support focuses on the way in which individual members of a support network are linked with one another and the impact of this on respect, reflexivity, reciprocity and 'connectedness'. The following case study is based on work undertaken by myself in the period 1982-3, which predates the community care reforms. It contains no references to purchasing, but it does contain many relational features which can be analysed in terms of the concept of 'brokerage'.

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Emily Francombe is an 87-year-old woman. She lives alone in a bed-sit owned by a housing association. She is rather confused and very suspicious of others. She is convinced her neighbours are plotting against her and sometimes directly accuses them of this. Her mental and physical health continue to deteriorate until she stops paying her rent, regularly loses her pension book and sometimes goes without food for some days.

Having sent a representative to call on Emily Francombe who has not been allowed into the flat, the housing association make a referral to the social

services department and a duty social worker tries to visit. She is also unsuccessful. Visits by other social workers and community psychiatric nurses fare no better. After each of these visits Emily Francombe complains to the neighbours who in their turn complain to the authorities, who respond by attempting to visit, which starts the cycle up, all over again. Things only start to improve when it is agreed that only one social worker should visit and that the housing association should cease trying to gain access to the flat. Eventually, this social worker gains access to the bed-sit and after several months manages to persuade her to accept a home help three times a week.

However, although Emily Francombe allows the home help to visit, she will not allow her to do any cleaning, only some minimal shopping; and if the home help is ill or on holiday, she refuses to allow any other home help into the flat. The social worker continues to visit but only every couple of weeks. When he does so, he becomes acutely aware of the additional anxieties generated by his presence and is forced to conclude that the day-to-day monitoring of the situation is, in any case, almost entirely dependent on the home help.

The general practitioner, social worker and community psychiatric nurse all agree that the home help should continue to visit Emily Francombe in spite of the limitations placed on her. But the home help has to cope with an enormous amount of stress as a result of these visits. Sometimes this elderly woman refuses to allow her into the bed-sit; sometimes she allows her in but cross-questions her about her movements; sometimes she subjects her to long lists of complaints about her neighbours and, because of her short-term memory loss, she almost always asks her the same questions over and over again. If the home help is to be enabled to continue her work she, herself, will need some help. The social worker decides that there is little point in visiting more frequently himself. Instead, he offers to see the home help for a regular consultation session, designed to provide the kind of additional support and assistance which would enable her to continue.

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At first sight, it appears that the concept of 'quality of life' has little relevance here. However, the priorities of the professionals were determined by a willingness to try to find ways of helping Emily Francombe to lead the kind of life that she wanted and in that sense the whole strategy was predicated on a philosophy of 'choice'. Overall, this case study suggests that professional skills can sometimes be more effectively deployed supporting those doing the caring than in direct work.

At the outset, there is little sense of respectfulness. Emily Francombe feels intimidated by what to her appear to be confusing and suspicious

encounters with various mysterious figures claiming some kind of official legitimacy. The neighbours feel intimidated by her and the professionals almost inevitably start to see her as a source of frustration and irritation, rather than as a very anxious and frightened person needing skilled help. While the interventions described above could all be described in traditional casework terms, it is also clear that this is a network crisis which is in danger of precipitating an urgent admission to hospital or residential care and that this is avoided by what could be called interpersonal brokerage.

Very few resources or care services are involved here. The work focuses on the way in which the linkages between key individuals are developed. As these linkages are reconceptualised and reorganised, there is a steady increase in 'respectfulness'. The social worker contributes to this by empathising with Emily Francombe's distress and seeking to reduce the disturbing and unpredictable aspects of her encounters with others to a minimum. Another way in which he does so is by recognising the very skilled work undertaken by the home help and creating a new kind of linkage between the two of them. In practical terms, this involves two strategic shifts in the network pattern. Regular consultation meetings between home help and social worker become a feature of the case and, at the same time, direct contact between the social worker and Emily Francombe is reduced to a minimum. These two changes are closely associated with one another as increased personal support for the home help is combined with an attempt to stop undermining her work by continuing to develop a separate relationship with someone who finds most social contacts very difficult to understand or accept.

There is another aspect of respect which is implicit in the case description but which should be made explicit. In order for the strategy of consultation to succeed, the potentially difficult relationship between the home help organiser and the social worker had to be carefully negotiated, so as to ensure that the line management responsibilities of the former did not conflict with the consultative role of the latter.

If we look at the sequence of events, it is clear that the decisions which help to promote respect are only made possible by reflexivity. These changes of direction are the result of considerable thought and reflection and each time they involve doing something unexpected. The first key decision involves allocating the case to one particular worker so as to break the spiral of numerous unknown professionals calling on Emily Francombe. The second turning point involves what, at first sight, looks like moving in an entirely different direction, quite inconsistent with the original decision to allocate the case to a named worker. Again, it might have been easy for a care manager who had worked hard to gain initial access to the flat to have persisted indefinitely with attempts to build a relationship with this elderly

woman. Taking the decision to entrust direct work to the home help and focus on supporting her required a willingness to look afresh at the needs of the situation. Interpersonal brokerage therefore involves the ability to step back from the network process and to think about links and linkages in terms which are both strategic and empathic.

With someone as frail and confused as Emily Francombe, reciprocity may seem rather fanciful, but that is not to say it is completely absent from the network as a whole. The housing association agree to refrain from taking any action and to focus on supporting the neighbours. The neighbours are willing to contact the social worker if they are concerned about any problems, provided they feel someone is trying to help her. The home help is willing to undertake emotionally exhausting work, provided she receives help and advice from the social worker. The home help organiser is willing to accept a new and more demanding set of responsibilities for her service, provided the social worker maintains regular contact with the home help. The social worker maintains responsibility for the handling of the case, provided he continues to get a flow of accurate information from the home help. Even Emily Francombe appears willing to allow a certain level of what she regards as 'intrusive' behaviour, provided she feels she knows the key individual well and believes that her visitors are there to help her to live the kind of life that she wants to live. Through this 'bargain', she continues to maintain a measure of control and, possibly, self-respect.

Whereas, at the beginning, all the key actors are relatively isolated from one another, relationships have by the end of our account become much more organised. Emily Francombe has regular contact with a home help who is supported both by her own supervisor and by a social work consultant. The consultant is in regular contact with both the housing association representative and the neighbours and both of these see the home help regularly. In fact, the neighbours generally speak to the home help at least once a week. But it is not just the level of 'connectedness' or 'density' of network ties which is important but the way in which the particular pattern of connectedness organises the network and helps to ensure that support is available in appropriate ways from appropriate people at appropriate times.

### **Brokering care communities**

A care management partnership is a good example of a 'task community'. But if those who are involved in caring for someone are to establish themselves as a 'community', they sometimes need to meet on a face-to-face basis. This is particularly so when the stresses and strains of caring lead those involved to feel frustrated and angry with one another and to search for someone to blame. All this projection of bad feelings around the net-

work is a sure sign that the support system has become overloaded with anxiety and that its members need to be helped to come together not only to make new plans but to enable individual members to feel part of a collective effort – a 'care community' which will look after all its members and not only the service user.

This is the process of network conferencing. It has for some time been recognised that network conferences are an important care management tool (Steinberg and Carter, 1984, p.23). However, they should not only be seen as a way of working with the informal network to enhance self-sufficiency. In an earlier work, I described conferencing as 'a way of structuring time and structuring relationships in order to enable the network system to move out of a position of crisis' (Trevillion, 1988, p.302). This can be illustrated by looking now in more detail at one of the cases referred to then.

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Jean Jackson was a 75-year-old woman cared for by her niece, a home help, her general practitioner and the staff of a psychogeriatric day centre. For some time this network was able to care adequately for her without any outside intervention. But I became involved after a series of increasingly anxious telephone calls which make it clear that members of the support network felt unable to cope with what they perceived to be a rapidly deteriorating situation. This message was couched in terms of a request for an assessment under the terms of the Mental Health Act.

The consultant psychiatrist confirmed that Jean Jackson was suffering from Alzheimer's Disease but could not confirm that her mental state was deteriorating rapidly, so an emergency admission to hospital appeared to be inappropriate. A network conference was called to which all the carers and a number of managers were invited, with the purpose of assessing the nature of the perceived crisis. Although there was considerable initial opposition to this strategy from some members of the network who felt that we should be acting rather than 'wasting time' talking, anxiety levels began to drop almost as soon as a network conference was scheduled. So much so, that the conference itself was almost an anti-climax.

When we met, it became apparent that all the carers, both professional and non-professional felt rather isolated from one another. An opportunity to meet helped them to begin sharing with each other and with the social worker some of their frustrations and anxieties. The situation was no longer perceived as a crisis but as a long-term problem and from then on the way the case was handled reflected this.

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Network conferencing demonstrates how the dynamics of the 'social support system' are as much a part of the 'care package' as the separate services. This particular conference began to build new mutual support mechanisms where before there had been none. It also began to clarify the boundaries of responsibility for every member of the conference so that caring became a more manageable and less personally oppressive activity. Perhaps most importantly, conferencing the problem, rather than admitting Jean Jackson to a psychiatric ward, counteracted the sense of personal failure felt by all those concerned and substituted for it a sense of collective strength.

If we look at this as an example of the brokering of a care community, it is possible to see that the way the level of 'connectedness' is developed and even the promise or hope of more 'connectedness' exercise a profound influence on the course of events. By promoting the ideas of mutual support and collective identity and responsibility, the social worker was able to reduce anxieties to manageable levels.

But even a 'task community' should incorporate opportunities for empowerment, and managing power relationships in a conference setting can be hazardous. While conferences can promote participation, it is not always possible to involve service users in them. Jean Jackson was not directly involved in the conference process herself and this decision could certainly be defended on the grounds that, for someone with severe Alzheimer's Disease or any other form of senile dementia, what may be intended as an empowering experience could simply be disorienting and frightening. However, more thought could perhaps have been given to the possibility of a two-stage process in which Jean Jackson could have met a small sub-group of people known to her and able to reassure her.

All the challenges associated with building communities in the modern age are present in the microcosm of the care management system. In particular, care managers are constantly faced with the need to find ways of enabling linkages to grow between individuals and groups who may find it very difficult to communicate, let alone develop a sense of shared purpose or collective identity. And yet, in spite of the problems, the success or failure of care management can often be gauged by the extent to which all those involved in the care management system are willing to recognise the importance of their relationships with one another and prepared to submerge differences, at least temporarily, for the benefit of all and in particular the service user.

Acknowledging this is to recognise that the brokering of social support involves brokering communities.

### Brokering flexibility and informality

The intrinsic flexibility of the network conference process can lead to some very unorthodox developments. In one case, I recall a network conference taking place in the bedroom of a young woman whose combination of mental and physical problems confined her to bed much of the time. However, the role of the social support broker in generating flexibility and informality is not confined to the choice of location for network conferences.

The brokering of social support is dependent on the context in which it is practised. Moreover, effective case management depends upon an ability to be responsive to the demands of a situation rather than to impose a fixed formula of care upon it. Therefore it is probably best to see case management as embracing a continuum of caring partnerships rather than seeing it as a single activity. At one end of the case management continuum are those situations where the informal network is in difficulty but might, with advice, information and support from a case manager, be able to cope. But even here the relationships between those involved and their feelings about themselves and what they are doing may need to be explored as well. People may not want or need formal services, but they may feel overwhelmed with anxiety and/or feelings of guilt that they are not doing more. A real service can be performed simply by listening to carers and confirming that there is nothing more that they can do.

There are many examples of 'interwoven' networks consisting of 'informal' and 'formal' components where the aim is to enhance informal structures. An example might be the family of a young woman with learning difficulties and severe behavioural problems. Although the young woman cannot be left alone, the family may be able to continue caring for her with regular respite care and night 'sitters' coordinated by the case manager. An informal and flexible style on the part of the worker is particularly important when trying to build or hold together an 'interwoven' network.

But at root the brokering of social support is about informality because it is concerned with the 'quality of life'. Although it is usually argued that care management should be concerned only with specific care problems, even the most restricted definitions of care management have to make reference to the part played by the 'structure of living' or largely self-sustaining patterns of informal network support embedded in everyday social interactions (Bayley, 1973, p.316). For those seeking to broker social support more explicitly, the need to get alongside service users, in what one could call 'life-style' decisions, is even more obvious and this cannot be done except in an informal manner. Day has suggested a way forward for this type of work, based on the idea of networking 'opportunities'. He has suggested that different kinds of

support network provide different kinds of 'opportunities' and, in relation to a study of people with learning difficulties, has divided these into a 'segregated' type and a type of network that allows the handicapped person access to the 'non-handicapped world' (Day, 1988, p.277). The implication of this is that all those involved in 'normalisation' work are to some extent involved in care management and that residential workers as well as fieldworkers could therefore lay claim to a role in this.

Decisions taken in this way can involve risk taking. The quality of life paradigm in general and the location of service planning and provision within a concept of brokering social support inevitably leads to some risks being taken in pursuit of 'quality of life' objectives. Service users may feel that some risks may be worth running if they improve the quality of life! However, this cannot be taken as an invitation for those employed as care managers to abdicate their responsibilities. Rather, what is needed is for lifestyle benefits to be weighed against risks and for decisions to be made in an informed way, preferably with the participation of all the members of the 'task community' that brokers will have helped to create.

It could be argued that there is still a risk that informality may lead care managers to be irresponsible in relation to their own organisations, if not towards their clients. But if the accountability of care managers is located within the broader framework of 'stakeholder networks' and inter-agency agreements of the kind which were described in the previous chapter, it should be clear that informality and flexibility can be compatible with broader roles and responsibilities. It may even be that attending to broader responsibilities implies high levels of flexibility because it implies high levels of responsiveness.

### **Brokering information**

A care management system is a communication system. In an ideal world, the appropriate kind of information is transmitted from care managers to service providers, from one service provider to another and from service users to both service providers and case managers. But for this to work there needs to be a shared set of understandings enabling confidentiality to be respected at the same time as those involved are open and frank with one another and able to communicate in a language which all can understand. Anyone with practice experience in this area will recognise how demanding these apparently straightforward criteria really are. One way of looking at the problem of communication in care management systems is to draw a comparison with the world of computers.

Frequently we find that different parts of the same organisation have invested in very different kinds of computing systems. So long as there is

very little need for the different parts of the organisation to communicate with one another, this incompatibility may not matter. In particular, if the organisation is organised on bureaucratic and hierarchical principles, all communication will be controlled by those at the apex of a number of quite distinct organisational pyramids. But if the organisational structure and culture changes, and suddenly all kinds of people throughout the organisation need to send data backwards and forwards, the problem of incompatibility becomes a major organisational headache. This is when organisations call upon the services of specialists, who set up new computer networks by making it possible for previously incompatible systems to 'speak' to one another.

This is exactly the problem faced by those organisations and professions seeking to come together in new social support systems. In order to establish an appropriate set of communication possibilities, the links between the different parts of the system need to be 're-engineered'. Here the computing metaphor ends. Computer hardware will not solve problems based on misconceptions, lack of trust or straightforward unfamiliarity. It is often relationships which need to be rethought and re-engineered, rather than technical systems. Also it is important to recognise that, unlike computers, human interaction needs to be constantly networked if it is to facilitate the kind of communication needed for effective care management. In particular, constant attention needs to be given to boundary issues so that core differences are respected and different strengths preserved while avoiding the need for defensive posturing and obstructive rivalries.

Interpersonal communication is a series of information exchanges between individuals. The social support network is therefore an exchange system in which information is passed from one person to another in the expectation that all those who give information will also receive it. The most effective care management systems are frequently those which benefit from a 'virtuous circle' in which the quality of mutual understanding improves over time as a direct consequence of the process of exchanging information and where mutually satisfying information exchanges generate ever deeper levels of trust, mutual confidence and mutual support. In other words, people are more likely to listen to one another in the future if they feel that information has not been kept from them in the past. Communication, in this way, feeds back directly into the process of developing and sustaining task communities.

### **Brokering care management action sets**

Like orthodox care management, the brokering of social support is primarily a mobilisation strategy and the networks it helps to create and maintain

are primarily 'action sets'. Sometimes people act as if care management consisted of simply asking people to deliver a particular service or, if necessary, persuading them to do so. But the process is often concerned less with persuading people to do things than with persuading them to do them together. An example dating from 1982, when I was the social worker, may help to illustrate this.

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Anna Winkler, an 85-year-old woman of central European origins, lives alone in a flat which is badly in need of major repairs. She lived with a female friend for many years. Since her friend died, she has become depressed and withdrawn. She ventures out less and less and, by the time a social worker becomes involved, her increasing frailty is beginning to make it very difficult for her to continue living on her own. She is initially reluctant to have a home help or to see anyone other than the social worker. At first, it appears she is totally isolated, but, although she is alienated from her family and has few friends, it becomes clear that certain other people are interested in her welfare.

For some years she has had intermittent contact with a small voluntary organisation and someone from this organisation is very willing to be involved in the future. Likewise, her general practitioner is concerned about her and keen to help as much as he can. Someone who works in the garage opposite her flat buys her a newspaper a couple of times a week and, like the others, is interested in her future welfare. The problem here is therefore not mobilising support. That seems to be surprisingly easy. As the case develops, it becomes clear that the problem is persuading these potential helpers to coordinate their efforts.

A network conference takes place. Although the mechanic does not attend, the meeting is able to do some useful work. However, conflicts of opinion emerge almost as soon as the meeting begins and there is a possibility that no consensus will be reached and no plans made. In the event a plan does emerge. The mechanic (contacted outside the conference) agrees to ensure that he sees Anna Winkler whenever he delivers the daily newspaper and to contact the social worker if she does not appear when he knocks. The general practitioner and the welfare worker from the voluntary agency agree to continue to visit once a month but on a new pattern, so that she will see one of them at least once every two weeks. The social worker arranges to visit every two weeks but never on the same week as either the general practitioner or the welfare worker. In this way the partnership is able to develop an initial set of services which consist of a daily 'early warning' system and weekly contact with everyone else.

As time passes, it becomes possible to introduce new services, such as a district nurse and a home help and, after patient negotiation with Anna Winkler, to arrange for her to attend a day centre on a weekly basis. But new services are only introduced at a pace which is determined by Anna Winkler herself and in ways which fit in with the existing 'package'.

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How was the problem of internal conflict solved? The deadlock was broken by the realisation that the key to making progress was to recognise that those present were unwilling to sacrifice their individual opinions and individual autonomy and that, to enable them to think more collectively, it was necessary to persuade them to feel that, by giving up some of their autonomy and therefore some of their (theoretical) individual power, they were gaining some (actual) collective power.

## **Community brokerage and care management**

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The model which has been outlined in this chapter can be seen as an alternative to care management or it can be seen as an attempt to return to the basic principles of linking and coordination which may have been lost sight of in the development of the 'mixed economy of care'. Much of what has been described is already present in care managers' practices in an implicit form, but a conscious shift towards 'quality of life' considerations, combined with a systematic adoption of brokerage principles, might help to restore morale and help to show that the process of organising social support need not be just a cover for cutting costs and reducing services.

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# 7 Working together for empowerment

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Oppression often involves disregarding the rights of an individual or group and is thus the denial of citizenship. (Thompson, 1993, p.31)

This chapter is about the contribution that networking by professionals can make to the processes by which oppressed people can increase their 'involvement' in society and thereby reclaim their status as 'citizens' (Beresford and Croft, 1993). The aim is to show how social workers, nurses, community workers and others can help to dismantle barriers to citizenship through practical network activity. Networking is not the only, or even the most important, way in which these barriers can be dismantled, but professionals can apply some of the network principles that oppressed people have themselves discovered to their own work so as to maximise the potential for empowerment even in the most unpromising of situations.

The chapter looks first at self-organised or self-help networks based on a 'community of interest' and then moves on to consider the implications for professional social welfare workers.

## Networking and communities of interest

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The term 'community of interest' can be used to describe a wide range of 'networks of relationships' and the 'allegiances' associated with them (Barclay, 1982, pp.xiii-xviii). But here it will be used in a more restricted sense to mean a social network which develops around an awareness of oppression. It should not be confused with either the formal community organisations which are the focus of much of the community development



literature or those 'communities' which benefit from the work of such organisations (Wiewel and Gills, 1995).

Networks of this kind are not mutually exclusive. They are constructed on the basis of particular aspects of social identity which are neither natural nor immutable. 'So any group of people with shared concerns/ideas/experiences are a community and we are all part of several communities at the same time' (Macfarlane and Laville, 1992, p.22). As new issues or needs are discovered, so too new 'communities' arise and, however well organised they may later become, many of these 'communities' emerge first of all as relatively informal networks; for example, it has been argued that the 'typical community-based AIDS service organisation was a voluntary, not-for-profit, non-sectarian, free-standing organisation that started as a support group' (Alperin and Richie, 1989, p.166).

Often the spur to network formation is a strong sense of a need to join others to resist some specific act of oppression. The 'web of women' created, sustained and mobilised at Greenham Common cruise missile base in the 1980s as an act of collective resistance to what was perceived as patriarchal warmongering and nuclear genocide is a good example of this. The image of the web was the symbol of the Greenham Common Peace Women. It was also the symbol of the national and international feminist network of sympathisers and activists which sustained the Peace Camp and which enabled a relatively small and often quite vulnerable group of 'campers' to be transformed at times into a massive demonstration by women capable of encircling the base.

Although it is the campaigning potential of networks like this which is their most obviously 'empowering' feature, this campaigning potential rests upon a number of other, less obvious, network characteristics. Dalrymple and Burke's 'first level' of empowerment is the 'level of feeling' (Dalrymple and Burke, 1995, p.51). If it is true that any community of interest has to reach this level before it can develop any further, the most fundamental aspect of empowerment is the sense of solidarity which can be created by linking up with others. Empowerment is therefore intimately related to what have been called 'lateral relations' (Foucault, 1979, p.238). This principle was established many years ago by pioneering feminists, but it has only more recently been explicitly connected with network development (Dominelli, 1990, p.47).

But empowerment is not only a question of feeling better about oneself. As the example of Greenham Common shows, communities of interest mediate between the personal and the political. Another example of this comes from the history of the social movement of disabled people. The social model of disability – a new and challenging way of thinking about disabled identity in relation to discrimination and disadvantage – was de-

veloped by disabled people alongside campaigns for disability rights (Barnes and Mercer, 1995).

Networking within and between communities of interest is an important topic in its own right; but for professional social welfare workers, the question is: to what extent can those aspects of empowerment which are related to patterns of linkage between individuals and groups be translated into their own work, especially as the kind of 'partnerships' with which professionals are involved are, in many ways, quite different from 'communities of interest'?

## **Community empowerment and community partnership**

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To some extent, all communities could be said to be 'partnerships', in that they all contain some element of diversity. But where this diversity includes linkages between professional social welfare organisations and oppressed people, the 'partnership' will always retain some important internal boundaries which cannot be dissolved by reference to 'common interests' and which will remain, however successfully individuals and groups work together.

It is important not to lose sight of the significance of the lay/professional boundary even where professional involvement appears to be minimal or purely facilitative, as in the case of some forms of otherwise 'autonomous' self-help (Adams, 1990, pp.26-36). This makes for a problematic relationship between partnership and empowerment which reveals itself even in the arena of community development which has always been closely associated with participation and empowerment. While it has been pointed out that professionals can help by 'building groups and networks to promote long-term solutions to people's powerlessness' (Edwards, 1988, p.39), it has also been argued that partnership can be 'disempowering for communities and especially for the most disadvantaged and socially excluded groups within communities' (Mayo, 1997, p.3).

This shows that the problems of partnership cannot be blamed entirely on the fact that 'practice skills are insufficiently developed' (Marsh and Fisher, 1992, p.9); for example, it is not always easy to tell if some of the ambitious attempts to develop 'partnerships in regeneration' now being pioneered in areas like Deptford in South London (Centre for Urban and Community Research, 1997, p.64) actually succeed in reaching out to the most oppressed sections of those communities, or whether they collude with existing power structures. At a time when people are looking towards

'partnership' as a miracle cure for urban problems, as reflected in the development of Health Action Zones, it is worth reminding ourselves that, at its worst, it may amount to a takeover of local communities by business interests (*Guardian*, 5 May 1998).

What is clear, however, is that questions of empowerment have to be integral to debates about partnership, rather than constituting a rather apologetic afterthought. Although there has been a widespread recognition of the need to involve carers and service users in planning appropriate training for those who need to find ways of 'working together' (DOH, 1993, s.2.10), it has rarely been acknowledged that collaboration itself has to be based on a collectively owned and controlled vision of social welfare (Beresford and Trevillion, 1995). One of the most important implications of this is that it involves moving away from generalised ideas about 'partnership' which can be open to abuse and which, in any case, tend to be used far too loosely to be of value, and towards a model of the 'collaborative network'.

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As part of a large workshop, The West London Project asked a group of health and social care practitioners to explore the idea of collaboration in relation to specific patterns or sets of linkages running between service users, carers and a range of different professionals. Their responses showed that they wanted to see networks of this kind as lying at the centre of the whole community care process. In particular, they stressed that a greater sense of 'collective ownership' of assessment and planning brings with it a more informed awareness of the different perspectives of network participants and that this in turn helps to generate a sense of empowerment.

They were also careful to point out that, far from leading to a loss of confidence or professional identity, it was much easier to empower others if one felt empowered oneself. Empowerment was seen not as a separate skill or activity but as intimately associated with certain patterns of communication and a flexible approach to problem solving. The group then went on to specifically link empowerment to the process of exploring options for change through networks in which service users and carers were full participants

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The key issues in relation to empowerment seem to lie at the interface between interpersonal issues and community issues. Networking has been described as placing 'a particular value on inter-personal relationships and informal networks as crucial elements of a community's capacity to involve

people in decision-making and to take collective action' (Gilchrist, 1997, p.100).

Some follow-up research on an anti-racist festival in Bristol involving a number of different groups discovered that informal one-to-one relationships had effectively 'underpinned the organisation with credibility, accountability and mutual understanding which continues to operate within and across more formal structures, even though the Anti-Racist alliance itself has ceased to exist' (ibid., p.103). The strength of these relationships was based on trust, respect and reciprocity (ibid., pp.104-7) which confirms that the interpersonal issues introduced in Chapter 2 of the present volume are as important for community participation and empowerment as for any other type of networking.

But interpersonal relationships have themselves to be constructed in an empowering manner. Links should be chosen by people themselves and not imposed on them by professionals.

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The West London Project involved a number of service user and carer groups in discussions about community care. However, one of the groups did not fit into any of the standard categories. Asian women only agreed to participate if they could do so on their own terms. They refused to categorise themselves as 'service users' or 'carers' and wanted to be seen as women belonging to a particular community who both gave and received help. They saw what they had in common as more important than what separated them. Having an opportunity to link up with one another and thereby obtain a 'voice' in the project was recognised by them as an empowering experience, but they made it clear that, had they been forced to divide into 'service users' and 'carers' like the predominantly white groups, the whole experience would have been oppressive.

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In this particular collaborative network, the component units were groups representing particular views and interests. But although the collaboration was formally one between groups rather than individuals, if the individuals in any of these groups had felt unhappy with the way in which the groups were defined then the basis of the collaboration would have been compromised. This experience appears to confirm a fundamental principle about empowerment, which is that people need to feel that the specificity of their own experience has been acknowledged in the way that they link up with others.

## **Service brokerage and advocacy**

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Within the social welfare field and away from the area of community development, the empowerment issue that has attracted most attention is the way service systems tend to reinforce professional power at the expense of those who use services, and there is no doubt that many service users feel that the way social workers and other professionals behave can make it more, rather than less, difficult for people to feel in control of their lives. 'Service users have not on the whole experienced their relationships with social workers as empowering. We have tended to view social workers as controlling, pathologising, victim-blaming, out of touch with our lives' (Wallcraft, 1996, p.39).

This is a structural problem which some have seen as requiring a different kind of approach to the basis on which services are organised and delivered. Unfortunately, little attention has been paid by these theorists to the way in which empowerment might be connected with network patterns and processes.

Service brokerage is a model of collaboration in which a professional is employed by a service user to act as a consultant and to purchase services on their behalf. It has some features in common with conventional UK patterns of care management, including the emphasis on purchasing service, but its proponents argue strongly that 'the fundamental advantage of service brokerage lies in the de-clientising of systems' (Brandon, 1995, pp.9-10). What seems to be meant by this is the liberating effect of having services paid for and controlled by those acting for service users.

The claims of service brokerage to be an empowering practice rest mainly on the extent to which it can transform the balance of power between professionals and service users. We do not have enough practical experience of service brokerage in the UK to draw firm conclusions about this. In the absence of firm evidence either way, all that can be said at this stage is that the proponents of service brokerage may be underestimating the power that can lie in knowledge and expertise even when it is not connected with a cash nexus. But an even more serious shortcoming may be the lack of attention given to wider patterns of relationship. If services are organised on a strictly contractual basis and managed on behalf of the service user by the service broker, it is not clear how relations between individual service providers and service users will be affected. Certainly, there seems little reason to believe that attempts to build a network on a set of strictly market principles will develop collaborative relationships, and without such a pattern of linkages it is not clear how securely empowerment can be embedded in the service system.

Another approach to empowerment which has been developed is associated with the idea of advocacy. While 'citizen advocacy', 'peer advocacy' and 'collective advocacy' tend to exclude professionals (Brandon *et al.*, 1995), there are examples of social workers and community workers working with networks of service users in order to promote these forms of advocacy (Croft and Beresford, 1990). Without disagreeing that there is a place for those employed as social workers or care managers to get involved in this kind of work (Brandon, 1995) or with the principle that advocacy is a useful and empowering activity, it is still possible to question the extent to which it changes the fundamental characteristics of the service delivery system. If the services which are obtained by advocates are delivered in conventional ways, it is hard to see how the overall service network could be described as 'collaborative'.

### **'Inclusiveness' and 'social education' as networking strategies**

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It may be helpful to explore briefly the issue of empowerment in a broader European context. This shows that it is possible to develop approaches which are more consistent with the idea of linking empowerment to patterns of linkage than those represented by service brokerage or advocacy and which do not require major changes in patterns of funding. The Swedish Project showed that networking strategies based on 'inclusiveness' and 'social education' can be undertaken as part of normal professional practice by hospital-based social workers.

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These *kurators* saw 'inclusiveness' as closely linked to 'normalisation' which in their case took the form of a strong opposition to specialised services which might actively prevent those with HIV from using services normally available to other Swedish citizens: 'You shouldn't have to travel from one side of the city to another, you should be able to use the school that is closest so that they [the children] can play with their friends'.

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Even if specialised services were being offered by a voluntary organisation or self-help group, these social workers would have been against them, on principle, if they had the effect of marginalising or stigmatising their

clients. They preferred to enable people to use mainstream services and this was justified by reference to the wider objective of facilitating active participation in mainstream Swedish society. The project also showed that it is possible to think about these patterns of linkage in a wider framework, where empowerment is related, not only to the quality of the relationships within a particular network, but to the location of that network in society as a whole.

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The Swedish *kurators* were concerned not just with the quality and orientation of linkages and relationships in the service network but also with the inclusionary or exclusionary attributes of other relationships important to service users. This meant that, if they became aware of prejudice and discrimination within the situations to which their clients were exposed, they felt that it was part of their responsibility to meet those concerned and to engage in a process of social education. Typically, this would not directly involve the service user but it would challenge discriminatory attitudes and practices and therefore do something to redress the balance of power in favour of service users, enhancing their long-term ability to participate in society: 'We often go out talking to different people ... if we feel there is discrimination and our clients are being discriminated against, we talk to groups, bosses or whatever's necessary.'

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Developing collaborative linkages involves changing the relationship between service users and professionals and addressing the kind of problems which service brokerage and advocacy theorists have identified with conventional service planning and delivery systems. But it also involves attending to the patterns of linkage associated with service delivery and other social networks. It is a matter not just of attending to the quality of relationships within these networks but also of ensuring that the kind of links which people have are consistent with the broader principles of community participation.

## **Empowerment and community brokerage**

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Ensuring that 'task communities' based on collaborative networks are empowering involves solving some of the problems associated with the com-

plexity of these 'communities'. This almost always requires some form of community brokerage. On a large scale, 'New Community Partnerships', which have been defined as 'the bringing together of a single community for joint action and the bringing together of different communities that have a shared interest in tackling local problems' (Macfarlane and Laville, 1992, p.22) appear to need a 'strong networking organisation' capable of building a community 'movement' (ibid., p.111). At the other extreme, even relatively small carers' networks may require some kind of community brokerage in the early stages of their formation and possibly in the longer term as well. This is because people may not automatically identify with one another.

Grant and Wenger suggest that, in the case of one carers' network, a certain kind of supportive connectedness, which they call 'interdependency', was needed to establish an awareness of network commonality. Working together in the same scheme for the care of elderly people led to an 'interdependency' among the helpers, frequent contact and consequent opportunities for helping one another (Grant and Wenger, 1983, pp.45-7). This suggests that the fostering of 'interdependency' may be seen as an empowering strategy in its own right, perhaps linked to the growth of what has been described as 'mutuality' (Holman, 1993, p.52) or a feeling of community.

The potential of this may not have yet been fully realised. The diaries kept by professionals involved in the West London Project indicate that, apart from references to network conferences, which are dealt with in the next section, little attempt was made to develop interdependencies. In most cases the practitioners identified a role for themselves which could be described in terms of brokerage, ensuring that a wide range of services were contacted on behalf of clients and even drawn into sometimes very sophisticated networks of service delivery. However, although this type of brokerage may have been empowering, in that it enabled service users to use a wide range of supportive services, it did not always generate the degree of 'connectedness' which is associated with a collaborative network.

## **Making changes**

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One of the tests which one might want to apply to any claim about empowerment is whether it has led to some identifiable change in the position of those who have been experiencing discrimination and disadvantage. But when we come to think of care management, a care programme approach or other small-scale aspects of social welfare activity, it may not be immedi-



ately obvious how social welfare workers principally concerned with service planning and provision can become involved with broader change processes as part of an overall commitment to empowerment.

One idea which has emerged is the possibility of breaking down some of the barriers between professionals and service users in the belief that this will have tangible benefits. Some feel that the needs of black disabled people will never be effectively met unless there is a greater involvement of black workers in care management. 'If Black workers do not have care management responsibility it may be difficult for them to design and negotiate a package of provision which challenges racism and empowers a Black Disabled person' (Begum *et al.*, 1994, p.148). Such a strategy not only connects the care manager and the service user in a different way, it also strengthens the collective position of that community.

The needs of Black Disabled people are not particularly specialised or complex. Nevertheless to date many large scale statutory organisations have failed to address the concerns and requirements of Black Disabled people. Therefore organisations run by Black Disabled people, Black community groups and/or Disabled people may be in a better position to take a much more pro-active role in the care management process. (Ibid., p.150)

One of the problems about discussing empowerment in relation to more specific changes is that social welfare professionals usually become involved in situations which are already changing and which may often be in crisis. As some kind of change is almost inevitable, it is difficult to evaluate the effectiveness of networking simply by comparing an actual outcome with one or more possible outcomes some of which might conceivably have been even more empowering. Instead, it may be better to look at identifiable shifts in patterns and processes of decision making which can be related to shifts in the pattern of power and control. The West London Project generated a number of examples of these shifts associated with network conferences.

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One of the interprofessional discussion groups felt strongly that network conferences were a particularly empowering type of networking strategy. The group associated this with the way network conferences set up modes of face-to-face communication between a wide range of participants, regardless of their status or power. In addition, one of the diaries completed by a mental health social worker, taking part in the project, focused on the way in which a planned process of after-care and 'rehabilitation' under

the terms of the 1983 Mental Health Act was managed by a network conference consisting of the client himself, a community psychiatric nurse, a consultant psychiatrist, certain key relatives and the social worker who also chaired the conference. This structure allowed all those involved to contribute to the 'care plan' and led to 'collective ownership' of decisions. It was successful enough for the social worker to describe her role simply as 'facilitative'. There were times when the social worker needed to intervene directly but on the whole she was able to describe her role with the client as 'supportive'.

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It could certainly be argued that some other approach might have produced a more empowering outcome, but there was a discernible shift in the pattern of power and control in favour of the client. At the least, it seems likely that the conference process was able to bind the network very effectively together so that nobody was allowed to exert control in an unaccountable way from a position which could not be scrutinised by the other participants. The continued participation of both the consultant psychiatrist and the client and their willingness to talk directly to one another on a regular basis also indicates that the conference process was seen as fair and equitable, whatever its outcome might have been.

The particular outcome of the conference process in this case was a successful transition from hospital to hostel. But even if the overall strategy had run into problems, significant changes associated with empowerment could still have been identified. From being compulsorily detained as a hospital inmate the client had moved into a new kind of relationship with those in the after-care network. He had become a partner in a process where he had a voice in the decisions which were being made, even if his was not necessarily the decisive voice. If we go back to the original connections made between citizenship and empowerment, it is hard to resist the conclusion that the conference process enhanced this man's citizenship status by locking network relationships into a collaborative modality which continued for the whole period of after-care support and supervision.

My own experience of chairing network conferences over a period of five years supports this conclusion about the empowering implications of the processes involved. The tendency towards higher and higher levels of 'connectedness' contributes to the development of a sense of 'community' among the conference members which also acts as a very effective constraint on unilateral action. However, it is important not to overstate the degree to which conference members identify with one another. A network conference is a 'task community' which may share certain aims and objec-

tives but which is characterised by continuing and important differences between its members. The case for the empowering potential of such a conference does not rest on its ability to eradicate these differences but rather on its capacity to provide frameworks within which those differences can be acknowledged and collaboration can flourish.

## **A field approach to empowerment**

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Whether we focus on particular activities such as social education or particular processes like conferencing, this chapter has drawn attention to the relationship between empowerment and the internal and external characteristics of particular 'social fields'. In general, it has been argued that, although professional social workers or nurses rarely work with 'communities of interest', they can see the networks with which they are involved as potentially empowering and they can try to consciously influence patterns of linkage so as to share power and to create the kind of opportunities for groups and individuals which can combat discrimination and disadvantage.

## 8 Networking with children and families

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Work with children and families has become identified with 'law and order' issues and therefore presents a challenge to any way of working based on social network principles. But the tide may be turning. 'In all countries of the European Community, there is an increasing recognition that it is impossible to help children effectively without taking into account their origins, family networks and cultural environments' (Colton and Hellinckx, 1994, p.565). In the UK, the passing of the Children Act in 1989 was associated with the introduction of the idea of 'partnership practice'. 'The Act implies not only a degree of flexibility in how support services might be delivered but also a different relationship between the providers of services and their users' (Butler and Roberts, 1997, p.91). While much attention has been given to the more formal implications of this, including a significant shift in the legal context, the main thrust of the Act was to encourage social workers to explore more informal ways of supporting families. It is therefore timely to consider the possible contribution of network-oriented approaches to the general support of families and, in particular, the detection, prevention and treatment of child abuse.

### Network assembly

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The earliest – and in some ways still the most radical – of the network approaches to family support was 'network assembly', a branch of family therapy. The essential insight of network assembly was that the pattern of relationships in a family network is like a shifting kaleidoscope which can move from a 'malfunctioning' pattern to a more supportive one (Speck and

Attneave, 1973, p.6). Network assembly makes a number of far-reaching claims which include 'resocialisation' of the nuclear family unit within the broader family network, 'demystification' of the network and the removal of pathological network 'secrets' and 'collusions' by the power of what has been called the 'network effect' (ibid., pp.15-16). The 'network effect' is essentially a collective experience which Speck and Attneave describe in semi-mystical terms as 're-tribalisation': the rediscovery of a 'vital element of relationship and pattern that has been lost' (ibid., p.7).

There are few recorded examples of network assembly in the UK, but in the USA it has been more widely used, often in situations where the identified patient has been diagnosed as mentally ill or seriously 'disturbed' in some way and the immediate family do not feel able to cope. The explanation for its relative unpopularity in the UK probably resides in the time-consuming nature of the logistical task, the complexities involved in handling sessions involving large numbers of people and the fear of losing control of the whole process, as much as in the professional apathy noted by Ballard and Rosser (1979).

Beneath the hyperbole and romanticism of network assembly lie valuable insights about the nature of social support and the dynamics of network change. It has drawn attention to the problems which arise within isolated nuclear family units and the possibility of helping such families to relocate themselves within a 'community' of some kind. However, the assumption that support can only be found in a revival of the extended kinship network could be dangerous. What might the effect be of a network assembly on a young girl whose 'disturbed' behaviour may be an attempt to communicate the sexual abuse she had suffered within her extended family?

## **Family group conferences**

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In recent years an alternative has emerged to the focus on pathological or dysfunctional families associated with family therapy. Building on some aspects of network assembly, the family group conference approach places great store by two complementary values. The first of these is the concept of 'family competence', the belief that families can act rationally and constructively rather than simply acting out their problems. The second is the concept of 'reciprocity', the idea that families should be seen as including the extended family and other parts of the community and that the whole should constitute a gigantic exchange system (Hudson *et al.*, 1996, p.3).

One feature of this approach is the key role played by 'coordinators' who observe a strictly independent and yet pivotal position within the systems

set up by the conference process (*ibid.*, p.7). As with many other early examples of networking, the origins of this approach lay in the response of welfare agencies to the challenge of working with neglected minority groups. In this case, it was the need to find innovative ways of working with the family and clan systems of the New Zealand Maori. Placing responsibility back with families and communities was a recognition of cultural realities in New Zealand but also a product of a wish to create a new 'partnership between the State and the community' (Hassell, 1996, pp.18–19).

Family group conference coordinators have sought to 'challenge child welfare thinking that focuses on the individual failings of care givers and, as a result, can promote a communal sense of responsibility for child and family well-being' (Pennell and Burford, 1996, p.207). Because they alone make decisions about who should be present or who should be excluded from conferences, in New Zealand, at any rate, coordinators can exercise considerable power (Connolly, 1994, p.91). In spite, or perhaps because of this, it has been argued that family group conferences can be 'a concrete means of empowering families to make their own decisions and find their own solutions' (*ibid.*, p.100).

The weaknesses of this approach are similar to those of the original network assembly school of family therapy in that the concept of 'coordination' implies a pre-existing family and community resource system which can be mobilised effectively. Also, while it is in many ways more realistic than network assembly, it is also less influenced by network or 'relational' perspectives.

None of this means that constructive use cannot be made of elements of both the network assembly and family group conference approaches. We just need to make fewer assumptions about families and communities. Work with families easily becomes entangled with the worker's assumptions about how family members should relate to one another. However, there is no need for networking strategies to be over-influenced by these normative expectations. In fact, one of the strengths of the network approach should be its flexibility. This means that networking can be used to challenge the assumptions and perspectives of the extended family network as well as to encourage it to take more responsibility.

One of the practice examples provided by the *kurators* who took part in the Swedish Project was of a meeting which could be described as a 'network assembly' or as a 'family group conference' but, in fact, did not fit easily into either of these categories. The meeting was focused on the needs of a child whose mother had just died of AIDS. The *kurator* who described it started by saying that she was only one of the participants and the idea for the meeting came from another social worker. She then went on to talk about both the process and the outcome.

She took the initiative to arrange a social network meeting where she invited the boy, the new [foster/adoptive] family, the teacher, the child psychologist, the grandfather, people from the social welfare office, and me. So we were sitting all bunched, discussing what had happened and taped it. Her idea was that the son would have something to take with him. It [the conference] had the possibility of explaining some things because they [the family] wanted to blame the Spanish man who had infected the woman. So I could really say that was not how it was. And the boy was there. That was really a nice experience. It was a good way of finishing with this family.

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What is noticeable about this account is that there is no emphasis on anything like the 'retribalisation' associated with network assembly, or even any attempt to generate the kind of collective sense of responsibility associated with family group conferences. Rather, the aim seems to be to set up a situation wherein the boy can listen to a variety of different perspectives about the death of his mother and thereby counterbalance the views of his grandparents with those of others, not related to the mother, who took a much wider and less punitive view.

Even one example of this kind is enough to suggest that social networks can have therapeutic effects without these having to be associated with the aim of recreating an extended family or kinship-based 'community', and social networks can collectively support an individual in difficulty without needing always to take on specific responsibilities for problem solving. Similarly, networking relies less upon concepts of 'family' or even traditional ideas about 'community' and 'neighbourhood' than upon more flexible concepts of supportive interaction and communication. It is much less concerned with normative expectations about how people should act than with the processes of social interaction and how these can be worked with on behalf of children and those who are important to them.

## **The networking approach to work with children**

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The networking approach to work with children and families draws on much the same body of theory as that of any other kind of networking. It is concerned with the interpersonal domain and its association with personal networks, the importance of building and maintaining communities, pro-

moting flexibility and informality, developing effective communication networks and mobilising resources to meet need. As in many other areas of networking practice, those involved in working with children and families will often take on the role of 'community broker', actively linking together and helping to integrate diverse social networks. However, the distinctive focus of their work raises specific issues which are unique to it.

In one short chapter it is not possible to do justice to all the different ways in which networking can be used to benefit children and young people in our society. I have chosen to look only at those types of work most closely associated with child protection, in the belief that this is where the case for a social network approach needs to be argued most convincingly.

### **Investigating child abuse**

An investigation of suspected child abuse could be seen as an attempt to discover whether or not a child's personal network is an abusive field – a field of relationships in which abuse has been able to or could flourish. This is not just a question of the general level of family support, although this may tell us something about the probability of abuse (Garbarino, 1976, pp.178–85). We need to know whether there are specific risk factors present in a child's personal network, and just as important as any risk analysis is the need to know which parts of that personal network could contribute to a protective partnership alongside appropriate professionals.

Investigation can therefore be thought of in network terms as the development of a certain kind of communication network. To be effective, this has to ensure that, by one means or another, all relevant information can be made available at or through a child protection conference. One pre-conference strategy which I found useful both as a social worker and as a conference chairperson was to devote some time to ensuring that messages which might otherwise be too weak to get through to the conference because they were being transmitted from relatively powerless, marginal or unconventional sources might need to be boosted by the equivalent of a 'relay' in a telecommunications system. Individual professionals such as teachers or youth workers could be encouraged to take on this 'relay' function, or alternatively the investigating social worker could make direct contact and thereby ensure that the information reached the conference.

As a communication network like this rests on interpersonal linkages which may initially be tentative or non-existent, it will usually fall to the social worker involved to act as a broker by personally mediating between the various sub-sets. Handling this role effectively depends on establishing conditions of trust and confidence in the context of a tense and often highly suspicious and defensive atmosphere.



It has already been argued that a social network approach moves us away from standardised notions of the family. The implications of this are far-reaching. In terms of child abuse, the social network perspective does not make assumptions about the location of abuse, protection or support, as we can never know in advance where these lie; for example, in relation to the latter, there are strong suggestions that the strengths of black women and their ability to protect their own children have often been ignored by white social workers who have tended to make stereotypical assumptions about black families (Jones and Butt, 1995).

In addition to parents, teachers, members of the extended family, neighbours and fathers of school friends, even social workers may be potential abusers. In one situation in which I was involved as a social worker, it was discovered that a piano teacher was sexually abusing a number of children who went to him for lessons. In situations like this, parents may be the key members of a protective partnership and this may be so, even if the abuse has occurred within the family, as when it is revealed that a grandfather or uncle has been sexually abusing a child and the parents take action to prevent any further abuse occurring.

Because so much is unpredictable, it is vital that child protection workers retain a high degree of flexibility and open-mindedness in the way they conceptualise the nature of the abusive system. Having used interpersonal skills in an open-minded way to establish a communication network capable both of generating sufficient information and of relaying it to a central point in the decision-making process, the next step is to mobilise the child protection network.

### **Community protection**

Making support and protection available to children is as important as the detection of abuse. More genuine security for a child can be provided in this way than by dramatic but intermittent interventions by social workers, paediatricians, the police or anyone else. It is here that networking has, perhaps, most to offer to those involved with working with children at risk of abuse. Networking encourages a preventative approach to the question of child abuse by focusing attention on the significance of a child's personal social network.

The likelihood of abuse is increased if children do not have a range of independent contacts with others who can exercise some informal surveillance and, if necessary, intervene to protect children or inform child protection agencies. The networking approach is then partly a matter of reducing abusive opportunities and partly a matter of enabling children to have people to whom they can turn if abuse does occur or if they are frightened

it might occur. More frequent contact between children and protective members of their informal personal network can often help, as can regular contact with a known and trusted professional worker. Facilitating the growth of new relationships by introducing children to clubs or projects where they will make friends and meet responsible adults can also help to prevent abuse occurring.

In other situations, parents may be able to offer little protection because they are too implicated in the abuse themselves. Then the protective partnership may have to be based on other members of the extended family, neighbours or even the parents of the child's friends. But it may be possible to include in the protective partnership one of the parents, even if the other is the abuser.

Wherever possible, children themselves should be fully involved. Any changes in who they see, how often or where they see them, must fit into their own sense of who and what is significant. Failure to attend to the child's eye view can lead to the child undermining the very measures which are supposed to protect him or her. In the case of sexual abuse, if a known paedophile is the only person to take an interest in a child it will probably not be possible to prevent contact unless the child's needs are recognised and work is done with the child to develop other relationships which could meet those needs.

It is probably helpful to distinguish between a broader protective network and a specific child protection 'action set'. The latter is likely to be recruited from the former but may differ from other parts of it by being more directly involved in the conference process and in implementing conference decisions.

### **Network abuse**

One of the most extreme examples of a destructive and oppressive network is one linked to the organised sexual exploitation of children. It has been alleged, but not proved, that some of this exploitation involves 'ritual abuse' (La Fontaine, 1994), but in all cases the abusive network may be able to create its own very powerful legitimating norms which can silence children (Furniss, 1991, pp.329-30) and militate against any of the abusers 'breaking ranks' and providing information about what is going on. Anyone involved in the abusive network who may want to 'confess' is likely to come under extreme pressure from other members of the network not to do so, in case they are in turn implicated.

There are therefore powerful mechanisms keeping an abusive network intact. Ignoring the existence of the abusive network and concentrating on an individual abuser and victim may leave this source of oppression un-

touched and reduce the chances of helping even known victims, let alone unknown ones, and do little to protect future victims of the network.

In this connection, it may be that networking has something to offer. Direct work with the abusive network as a whole is neither possible nor appropriate, but work with all those who have experienced abuse and their families – a network of the abused – can help to encourage children to talk about their experiences (Furniss, 1991, pp.329–30). Such an approach might be seen as an attempt to establish an empowering network capable of challenging the oppressive power of the abusive network.

Another complementary approach might be to attempt to work with individual abusers to encourage them to talk about the abusive network. This would amount to an indirect network assessment. If an abuser is showing signs of wanting to cooperate, it may be possible to gain some information about how the network operates. The aim of such an indirect assessment would be, in the first instance, to discover ways of counteracting the pressures towards secrecy emanating from the network and to challenge the role the network might play in the abuser's own defensiveness and refusal to take responsibility. If abusers do tend to have weak ego strength and a consequent tendency to avoid reality (*ibid.*, p. 34) then this can only add to the power the abusive network has over the individual abuser. A knowledge of how conventional and respectable networks maintain their own norms, communicate informally and mark their boundaries with secrets might be used to understand and ultimately counteract this power.

Networking may also play a part in the preventative work undertaken with abusers. At least two factors maintaining abusive behaviour could be connected with the relationship between the sexual abuser and his social network. Fear of losing his network of family and friends may prevent an abuser from fully accepting what he has done and in prison abusers may find that the only people willing to accept them are other abusers who collude with one another in denying the seriousness of what they have done. In prison, the segregation and persecution of 'sex offenders' of all kinds may reinforce the solidarity of these collusive networks and lead them to cling even more firmly to the idea that they are victims rather than perpetrators. Although reliable information on this subject is notoriously difficult to discover, the high levels of reoffending characteristic of convicted sex offenders (Finkelhor and Associates, 1986, (pp.130–223) might be explicable in network terms.

To counteract the tendency for sexual abusers to form isolated and collusive networks, an analysis of how these networks could be normalised through desegregation in the prison system would be beneficial both to 'sex offenders' and to society as a whole. Although a much more thorough study of this question is needed before specific networking strategies could

be recommended, work with other inmates and prison officers on the role 'sex offender' mythology has in maintaining defensive macho norms in the rest of prison could be enlightening.

In relation to abusive networks, networking is the mirror image of its usual self. The aim is to loosen ties rather than strengthen them. However, this sort of work needs to go hand-in-hand with the building of empowering networks for those who have been abused themselves or directly affected by abuse. There is a need to encourage the development of new social networks, either in prison or out of it, which could enable 'sex offenders' to help one another to resist their own inclinations and, perhaps, pressure from others to once more get involved in sexual abuse, either as individuals or as members of a network. There is also a need for professionals to stay in closer contact with 'sex offenders' on their release from prison than is often the case, to offer a mix of practical advice and support and to monitor their behaviour. These strategies would help to build a preventative community partnership.

## **The professional network**

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Certain groups of professionals are invariably involved in child protection issues. The police, paediatricians, social workers, health visitors, teachers and others form a professional child protection network. There is a need to work closely together and yet the high anxiety levels associated with this type of work can make it very difficult to foster trust and cooperation (Furniss, 1991, pp.59–113). In particular, the combination of interprofessional and inter-agency partnership and the requirement to work closely with parents creates a very challenging environment for effective decision making (Iwaniec, 1995, p.120).

All too often, conflicts which might be manageable in another context prove to be unmanageable in relation to child protection. For example, the breakdown in the relationship between the police and the local authority in Cleveland seems to have been a major factor in the collapse of public confidence in child protection services in that county. There have been numerous occasions when, as a key worker in a child abuse case, I found myself in conflict with other social workers, health visitors or teachers. The lesson I continually learnt as a practising social worker was that collaboration in such a controversial and painful area of decision making as child abuse does not work unless the ground has been prepared by some form of inter-agency work. Sometimes the results of even the most elementary liaison activities can be dramatic.

When I was working as a social worker in South London in the 1980s, the head teacher of a local primary school began to exasperate my colleagues by her tendency to overreact to indications of possible child abuse. Numerous, inappropriate conferences were called which not only wasted valuable professional time but also damaged the confidence of parents in education, health and social services. A regular meeting between a social work team manager and the head teacher was able to resolve this problem very quickly. It transpired that opportunities for an explicit discussion about the range of services provided by the local authority, combined with the implicit emotional support provided by regular meetings and the possibility this opened up of discussing concerns about individual children at an early stage, quickly reduced the flow of inappropriate conferences to zero.

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However, not all conflicts between organisations are irrational. Scott has suggested that inter-agency disputes often centre on practical resource questions, preferred legal options and 'domain disputes' or arguments about who should be responsible (Scott, 1997, pp.77-9). Liaison by itself may not be able to prevent such conflicts occurring from time to time, but it will generate the kind of trust and credibility which enable conflicts to be resolved.

### **Conferencing**

Inter-agency networking may pave the way to better mutual understanding between professionals, but there is also a need for the orchestration of child protection services around the needs of particular children in the conference setting itself. To this end, it may be helpful to think of a child protection conference as a network conference with the chair as a broker who has a responsibility for facilitating service planning as well as decision making.

Child protection conferences can be seen as a vehicle for involving parents and other people who might be important to the child in the process of decision making. As far as parents are concerned, inviting them to attend conferences and to participate in service planning creates opportunities for negotiating the part they will be expected to play. Both my own experience as a social worker in the early 1980s who helped to establish parental involvement as a norm and the more recent research on this subject (Marsh and Fisher, 1992, p.27) seem to point in the same direction. Parental attendance at child protection conferences and subsequent planning meetings can

be a significant form of parental participation. It may also lead to better decisions even if it promotes conflict and dissension, as recent research about child protection suggests that consensus does not necessarily lead to good decisions (Kelly and Milner, 1996) and this in turn suggests that effective teamwork is not the same as 'groupthink'.

The implication is that enabling those with less power and influence to voice their concerns may lead to less conformism but also better and less risky decision making. Therefore an emphasis on participative and empowering processes may help to ensure that conferences do not become dominated by 'groupthink'.

### **Parental networks**

The parents of abused children often feel very alone with their problems. Fear of other people's reactions may prevent them from talking about their feelings and experiences. Various attempts have been made to facilitate the development of support networks for abusive or potentially abusive parents (Starr, 1982, pp.46-9) and in my experience family centres can perform an invaluable function by introducing these families to one another. Providing opportunities for this to happen could be seen as networking to promote the development of a community of interest among these parents.

Where parents have felt themselves to be the victims of an injustice, they have sometimes been able to use their links with each other to launch a campaign for an inquiry, as in the case of the Cleveland inquiry into sexual abuse investigations in the county. This kind of activity is an important check on professional power and should be encouraged rather than discouraged by social workers, whatever the rights and wrongs of the particular case. If there is a concern, as in Cleveland, that only one part of the case is being put then the response should be to provide opportunities for other 'communities of interest' such as incest survivors to mobilise themselves. In this way it may be possible to ensure that inquiries and subsequent reviews of policy take all points of view into account.

### **Networking the child protection system**

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So far, we have looked at some examples of the kind of networking activity which can be systematically developed in relation to child protection issues. Child abuse acts as the focal point around which all this networking activity is generated and any one worker could be in touch with a number of separate community partnerships simultaneously. Together, all these part-

nerships form an interdependent whole which involves a very wide range of people and helps to relocate child abuse as a community problem, rather than thinking of it simply as a family problem. In some ways the broad-based nature of this responsibility is symbolised by existence within the UK of inter-agency Area Child Protection Committees. These are intended to bring together all the key community stakeholders in a single forum. However, there appear to be real problems in generating any sense of collective 'ownership' of these committees, which tend to be dominated by those organisations most actively concerned with investigation and statutory intervention. This leads inexorably to the marginalisation of those organisations which could make the most effective contribution to debates about prevention and ways of helping the child victims of abuse ( Sanders *et al.*, 1997).

### **'Looking after' children**

The possible contribution of networking to child protection work extends beyond the 'gates' of the care system. It can, for example, play a significant part in helping children when they are not living at home but are likely to do so again, in the near future. For some time it has been clear that, when a child leaves home and enters the care system, 'insufficient attention is given to the exploration of kin and neighbourhood networks as potential sources of support' (Packman, 1986, p.203). A networking approach would try to help the child sustain these relationships and, moreover, involve those who demonstrate a commitment to the child in the process of child care planning. Future protective partnerships may depend on this kind of work.

# 9 Teaching and learning

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## Professional education

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Since 1993 I have been involved in teaching networking to groups of social work and health promotion students and I have become increasingly convinced that it can help the 'caring professions' to develop new ways of thinking about social welfare and new skills to enable them to put these ideas into practice.

### A new language

A few years ago I wrote of collaboration that 'we have to find a new, softer, more malleable kind of language to describe these new working relationships – a language of process rather than structure, a language of mediation and permeability rather than one of rigid boundaries and territorial defensiveness' (Trevillion, 1996c, p.67). I then went on to suggest that a new language of this kind was needed not just to describe what was already happening but also to enable welfare practitioners to participate in the process of 'constantly breaking down and re-inventing welfare in collaboration with service users, carers and other professionals in an unpredictable post-welfare state world' (ibid.).

Nothing that I have seen or heard of since I wrote those words has changed my mind. If anything, the issue of language which I was then relating specifically to developments in community care has become central to developments in health, child care and urban regeneration, all of which, as we have seen, are beginning to focus on ways of thinking about links and linking which take their practitioners beyond the domain of traditional professional discourse.



## **New skills**

It was the West London Project which helped to draw attention to the issue of language and it also led to the creation of a new skills profile. Again, although this profile was developed with specific reference to collaboration in community care (Beresford and Trevillion, 1995, pp.133–51), much of it now seems even more widely applicable, especially as it not difficult to relate these skills to the five key characteristics of networking identified in Chapter 2:

- interpersonal skills (such as building trust),
- community-building skills (such as empowerment),
- communication skills (such as use of appropriate language),
- skills in promoting flexibility and informality (such as creativity) and
- mobilisation skills (such as co-ordination).

Cross-cutting these there are community assessment skills and community brokerage skills.

The project emphasised the overlapping and mutually supportive nature of these skills zones, rather than their separation from one another (*ibid.*, pp.123–32). This is congruent with the idea that social networks are holistic entities, even though they may be described in different kinds of ways or have different aspects.

There was no evidence from the research project of any major differences in either the language or the skills needed by different professional groups, which is not to say that these skills might not need to be applied to very different kinds of social problems. In general, any differences between the educational needs of different professional groups are more obvious at basic professional, qualifying level than they are at more advanced levels. Those who think of development in terms of a process of increasing differentiation might find this surprising, but confident and experienced practitioners who are sure of their own identity and skills will always find it easier to focus on what they have in common with other professionals than those who have not yet developed a basic professional identity. This is not to argue against interprofessionalism at a qualifying level, but only to recognise that it can be a more central feature of professional education at a post-qualifying level.

## **Basic professional training**

At this level, there will be differences between the kind of programmes required by, for example, health promoters and social workers. These should

not be exaggerated, but they are real. In a sense, the educational task at this level is quite a paradoxical one, which could be summed up as developing a strong professional identity which can equip the newly qualified practitioner to operate successfully in an interprofessional world consisting of complex and shifting networks of partnership. It may be helpful to spell out the implications of this by continuing to use health promotion and social work as examples.

### Health promotion

Health promotion has recently been defined as 'action and intervention to support and enhance people's health' (Katz and Peberdy, 1997, p.3). This opens up the topic to a much wider range of concerns than simply the traditional concept of health education, and in particular it focuses attention on the relationship between health promotion and the process of working together with a range of individuals and community groups. As a result, networking has come to be regarded as one of the skills which 'competent' health promoters need to acquire. 'Networking is clearly central to health promotion work across professional settings to share information, improve coordination, to gain support and feel valued' (Delaney, 1996, pp.27-8). My own experience of working with groups of health promoters has led me to focus on two key learning objectives:

- how to convey messages about health and illness through social networks and
- how to promote 'well-being' through active networking.

The first objective is straightforward enough. It focuses on the relationship between networking and the traditional health promotion task of effective communication. But the second may require some explanation. According to the World Health Organisation, health can be defined in terms of 'well-being' and 'well-being' in turn can be defined in social as well as biological terms. Helping individuals and groups to exploit opportunities to improve their quality of life has a direct impact on well-being and therefore health. This kind of work therefore focuses on ways of brokering new health-related resources and opportunities and can be specifically related to the goals of 'community participation' and 'empowerment' (Scrivin and Orme, 1996, p.12).

The content of the curriculum will reflect these concerns, but also draw on general networking theory. So, for example, inter-agency work and collaboration will be important, but the focus will be on ways of putting into practice the concept of 'healthy alliances' (Douglas, 1998) which has under-

pinned government policy since the publication of *Working Together for Better Health* in 1993 (DOH, 1993) and which argues that the goal of building a healthy community depends, in part, on establishing effective interprofessional and inter-agency networks (Delaney, 1996, pp.27–8).

## **Social work**

In the UK, basic professional training in social work is governed by the regulations and requirements of the Diploma in Social Work (Dip SW). These have recently been revised but have, continuously, since their inception, been based on the notion of developing professional 'competence'. Any programme of organised professional learning which seeks to obtain validation by the professional body, the Central Council for Education and Training in Social Work (CCETSW) has to define its learning objectives in terms of the definitions of competence laid down in the Dip SW, and networking is no exception. But although the rules and requirements contain precise definitions of particular areas of knowledge, skill and values needed for professional social work, they do not contain an overarching definition of social work. In part, this reflects the recent history of UK social work, which has been one of diversification and specialisation. As social work becomes increasingly absorbed into the broader concept of social care, this identity crisis is likely to get worse. For a wide-ranging definition of the roles and tasks of the profession, it is necessary to go back to the Barclay Report, which defines social work as 'community social work':

By this we mean formal social work which, starting from problems affecting an individual or group and the responsibilities and resources of social services departments and voluntary organisations, seeks to tap into, support, enable and underpin the local networks of formal and informal relationships which constitute our basic definition of community, and also the strengths of a client's community of interest. (Barclay, 1982, p.xvii)

Although many might reject this definition as in any way relevant to the challenges of present-day social work, it still forms a helpful basis upon which educators can build, enabling them to focus on specific areas of competence without losing sight of the whole picture of what professional development should be seeking to achieve. In particular, it focuses the attention of educators on the need for social workers to learn how to work with a wide range of different social networks in the spirit of community partnership.

Of course, there are some very specific issues to explore in the context of particular social work specialisms: for example, the interface between

networking and care management or working with multidisciplinary child protection teams. It could be argued that the importance of the specialisms is such that there are as many different types of education and training in networking as there are pathways to the Dip SW. However, this does not mean that a more 'generic' type of programme is not also possible, focusing on the core issues identified in the Barclay Report and of value to child care and community care specialists alike. A general or introductory course or module in networking at Dip SW level might take as its starting point five key learning objectives which relate to a wide range of competences.

- How to undertake social work assessments of social networks?
- How to undertake social work in partnership with social networks?
- How to make social work interventions in social networks?
- How to evaluate the impact of social work interventions on social networks?
- How to network within and between organisations?

All of these, of course, connect strongly with the general networking issues explored in previous chapters, but they will also be strongly influenced by the fact that it is social workers who are involved. To reiterate, the core skills of networking are interprofessional, but the kinds of problems or issues which have to be faced and the expectations of network partners will both be strongly influenced by professional roles and identities.

## **Ways of building basic professional competence**

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There is much about networking that can be learned from books. After all, this book is intended to communicate ideas to students and practitioners as well as academics. But there are limits to what can be learnt from the printed word. Learning about networking involves exploring ways of interacting with other people and this cannot be done on one's own, however good the book.

Although new technology can help people to gain access to information through a variety of different media, even the most interactive opportunities offered by internet web sites and discussion groups cannot fully take the place of three-dimensional learning methods such as sculptures, which are particularly useful for networking. While formal lectures may often be very helpful ways of introducing basic theory and key concepts, they are not a particularly effective way of helping individuals to work their way through

practice dilemmas of various kinds, and this is often the only way in which practice knowledge, values and skills are really developed. Broadly speaking, I have found three methods to be effective: problem setting and solving, sculpting and network diagrams.

### **Problem setting and problem solving**

Typically, this involves either distributing a fairly detailed case study or asking students to identify some problems in their own practice and then setting a number of tasks for them to work through. Health promotion students have used this exercise to explore problems ranging from sexual health to nutrition.

#### *Exercise*

As a health promoter, what kind of networks might you be trying to build to facilitate your work? Remember, social networks are patterns of contact and communication involving separate individuals, groups or organisations brought together around a common concern of some kind. It may be helpful to think of this in terms of the following:

- Who might be included in these networks and why?
- How will those involved work together?
- What kind of work they will do together?
- How might aims and objectives be clarified through negotiation?

Bear in mind: (a) interpersonal links and relationships, (b) community building, (c) flexibility and informality, (d) communication, and (e) mobilisation.

What kind of difficulties might arise in putting your ideas into practice? How might these difficulties be overcome?

### **Sculpting**

I have mainly used sculpting to enable groups of students to explore the complex dynamics of social fields and the interplay between subjective (individual) perceptions and emotions and objective (holistic) issues. Sculpting works best with groups of at least ten students and can involve up to 20 students at a time. It can be used either in the context of a workshop or in a more conventional classroom situation. However, it is quite time consuming, so I would not advise attempting to use it unless at least an hour and a half is available for the exercise. What follows is a summary of a sculpting

exercise used in the course of a one-day workshop with groups of social work students.

### *Exercise*

All participants were divided into three groups and given information about a particular 'life event' (anything from a serious road accident to the birth of a child with severe learning difficulties) and asked to explore its consequences in network terms, one aspect of which involved creating a sculpt:

Group A: the informal network of family and friends (one has a card telling them that they are 'Ego').

Group B: the professional network.

Group C: consultation group observer/advisors.

The sculpting process starts with Ego organising the members of Group A into a pattern expressing the patterns of social interaction and social support as he or she perceives it, prior to the 'life event'. When the process is complete, members of the group are asked to comment on their positions and how they feel. Some usually say, at this point, that they want to change their positions, either to make their perceptions of their linkages more explicit or to modify the tableau created by Ego.

The next stage involves sculpting the impact and aftermath of the 'life event' and usually involves significant change in the overall pattern of linkages. Group A is joined by Group B, who take up positions in the sculpt in accordance with their professional roles and their pre-existing relationships to other members of Group B. All those in the new tableau are asked to comment on their positions, links and relationships and this exploratory process is coordinated by the observer/advisors who question each member of the tableau in turn. This concludes the 'assessment stage' of the sculpt.

The sculpt then moves into a series of experimental moves by the observer/advisors perhaps assisted by a consultation group. As a result of this, a networking strategy usually emerges to which all members of the sculpt are asked to contribute. One key issue is discovering what it is that would motivate particular key individuals to change their patterns of interaction with others. Sometime it is helpful to finish with a tableau representing the ideal outcome of the strategy in terms of new links and new patterns of 'connectedness'. But it is also important to enable the group to identify new problems or possible blocks on further development.

## Network diagrams

I have used network diagrams with both health promotion and social work students, in combination with problem setting and solving and with sculptures. They can also be used as a form of 'homework' or distance learning, provided the material available to students is sufficiently rich and detailed. The main value of network diagrams lies in their capacity to focus attention on the need to analyse situations in a holistic way, taking account of the total pattern of interaction. I deliberately refrain from providing students with a lot of technical advice about ways of constructing these diagrams. They are asked, instead, to discover their own visual language. This never fails to produce striking and imaginative work.

Diagrams can be used either to simply help students to map out case material in a visual form or to give them a set of visual tools with which to analyse case material and to explore networking strategies. The major problem with the second approach is that drawing lines on a piece of paper can lead students to lose contact with reality, so they are required to justify lines on the paper through an accompanying written text which demonstrates not only *how* interaction can change, but why the individuals and groups concerned should *want* to change the way they are interacting with one another.

## Specialist work

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Most modern education and training in the field of social welfare moves from a general or common base of professional knowledge, values and skill to a more specialist orientation in its final stages. This process of increasing specialisation has become particularly noticeable in the field of social care and social work. In 1992, I developed a module on networking and care management which has since been available to all Dip SW students, but has mostly been taken by those specialising in community care. Over the years, it has become increasingly specialised.

While the module makes use of all the teaching methods described above, it focuses on helping students to acquire the knowledge, values and skills associated with a networking approach to care management of the kind described in Chapter 6. The structure of the module reflects this focus by setting networking in the context of a philosophy of community care associated with ideas such as normalisation, empowerment and participation and showing how care management can be approached from a network perspective. As the module has grown in popularity, it has had to move

away from a small-group approach to one making increasing use of workshop sessions and exercises, but it continues to make use of care management material drawn from placement experiences and to combine this with more formal inputs on assessment and network conferences.

### **Postqualifying and advanced work**

Networking can be undertaken at a number of levels of increasing complexity. At a postqualifying or advanced level, I have generally found interprofessional education and training to be the most appropriate setting for the development of networking skills and what has been elsewhere described as 'the culture of collaboration' (Beresford and Trevillion, 1995, pp.25–38). At this level, all the material can be drawn from practice with a focus on long-term developmental issues, and techniques which allow practitioners to record and then subsequently analyse their practice are particularly useful. Network diaries, already referred to as assessment tools, are very useful means not only of gathering information but also of making it possible for practitioners to analyse and reflect upon this information in a creative way (*ibid.*, pp.39–66).

The role of educators or trainers in a situation like this is much more like that of a consultant or mentor than a teacher. Also, at this level, the distinction between education and training, on the one hand, and research, on the other, is blurred, because everybody is involved in a search for new understandings which can be applied to the further development of practice (*ibid.*).

### **Education and participation**

Finally, the participative ethos of networking extends to the educational sphere. 'While it is important to make appropriate use of service users and carers as trainers, it is also important to recognise that they may have training needs as well' (Beresford and Trevillion, 1995, p.128). Working on a development project with users and carers made it very clear to me that ways needed to be found of offering opportunities to learn about networking to them, as well. As this kind of work develops it will, undoubtedly, give rise to new kinds of learning objectives and new kinds of teaching and learning strategies.



# 10 Conclusion

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Chapter 1 of this book began with an analysis of the problem of complexity in social welfare, and it is to this theme that we now return. In some respects, everything that has been written here is an attempt to provide managers and practitioners with a survivor's guide to complexity. But, while recognising that a world of multiple accountabilities and multiple viewpoints is a potentially confusing or even frightening place to find oneself, an attempt has also been made to show that the spaces in between conventional welfare structures and systems can become a source of energy and creativity if one has some way of making sense of what is going on in this unfamiliar environment. To this end, the emphasis throughout has been on developing a coherent body of theory and showing how it can be used to map the contours of good practice in a range of welfare settings characterised by networks, brokers and gatekeepers, rather than ready-made systems of service delivery.

There has been no attempt to catalogue all the activities to which networking skills can be applied. Rather, the approach taken has been to explore the relationship between social network principles, networking processes and the roles and tasks associated with cross-boundary work and the development of what have been called 'task communities'. Ultimately, perhaps, networking is a state of mind rather than any one type of activity. It exists only insofar as network practitioners attend to the patterns and processes of the various social fields with which they are engaged and only for so long as they keep alive the values of choice and empowerment which must continuously inform their modes of interaction with others and their broad strategic thinking.

The first chapter introduced the social network concept and showed how it could be used as a framework to enable managers and practitioners to

think about social situations in terms of issues such as boundary definition, 'connectedness', reciprocity and support. But by the end of that chapter it was already clear that orthodox network analysis was of limited value to social welfare practitioners who needed to know, not only how patterns of interdependency might be analysed, but also how to actively intervene in these patterns on the basis of a clear set of values.

In order to respond to this problem, Chapter 2 was devoted to developing a general theory of networking by showing how 'relational perspectives' could be translated into the elements of a new practice theory which encompassed the interpersonal and the community domains, the process of what could be called the *informalisation* of welfare, the opening up of communication possibilities and the mobilisation of 'action sets'. On the basis of these considerations, the role of the networker was then defined in terms of network or 'set' transformation.

But at this point it could be argued that all that had really been accomplished was to elaborate on the original hypothesis, albeit with some supporting empirical data. Practice theories need to be tested in as many ways as possible in order to ensure that they are robust enough to claim credibility as theories. So in Chapter 3 the theory was used to construct a model of assessment which included ways of establishing an assessment partnership and some techniques for gathering and analysing network information. This showed that it was not only possible to describe particular social problems in network terms but that 'raw data' could be transformed into useful information about matters such as the impact of patterns of interaction on perceptions and emotions, the relationship between 'connectedness' and community and the location of boundary problems, communication blocks and barriers to the mobilisation of network resources.

Having shown that networking principles could be used to construct a model of assessment, there was then a shift of focus back towards the more general question of role, in part because it was not possible to tackle the question of intervention before looking again at the question of role. While the diversity of networking practices made it difficult to generalise, it was suggested that networking often took the form of 'brokerage' and a particular term, 'community brokerage', was coined to describe this. The whole of Chapter 4 was devoted to the role of the community broker, with a particular emphasis on the relationship between this type of brokerage and the creation of the characteristic 'task communities' of modern social welfare.

The next part of the book sought to take the argument further by examining how networking concepts could generate models of intervention. Two fields of practice were selected for this in Chapters 5 and 6: inter-agency work and care management. In relation to inter-agency work, the intervention model was built around a concept of the collaborative network. In

relation to care management, the intervention model was based on the concept of brokering social support.

Chapter 7 was concerned with the broad theme of empowerment, rather than any particular field of social welfare practice, and tried to show how it was integral to the whole range of intervention models, whereas Chapter 8 set itself the challenge of showing how networking could contribute to child protection work. Given the emphasis of this latter area of practice on formal legal and administrative intervention, this chapter could be seen as setting a particularly stringent test for the relevance of network models based on inclusion, mutual support and informality.

Chapter 9 looked at the ways in which networking could be taught and learnt, with particular reference to the professions of health promotion and social work.

## Implications

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Having established that it is possible to develop models of assessment and intervention based on a general theory of networking, what are the implications? The implications for practitioners have already been explored, but there are other, less obvious, implications as well. In particular, there are implications for managers, communities and policy makers which need to be, at least briefly, touched upon.

For managers, the major implication of a wholesale move towards networking principles is probably the extent to which they can find ways of transforming their organisations into what practitioners in the West London Project referred to as 'network-friendly' organisations, without feeling that they have abdicated their responsibilities or encouraged unacceptable risk taking. While the North London Project showed that organisations can fragment and lose their sense of direction, a broader analysis of network patterns and possibilities has shown that it is possible to combine networking with good management if individual creativity and initiative is contained within clear inter-agency agreements and wider stakeholder networks. It may therefore be that managers need to focus far more than in the past on developing these kinds of interlocking frameworks in order to ensure that creativity and accountability go hand-in-hand.

For communities, the implications of networking likewise involve both risks and opportunities. The risks are similar to those that face managers: a loss of democratic accountability and a set of service structures which are not easy of access and which are incomprehensible to all but a few network 'insiders'. But the answer to this problem is for all involved to work hard

on creating new structures of participation and democratic control. Once again, these are likely to take the form of both wider stakeholder networks and opportunities to participate as service users and carers in the structures of decision making associated with the new networked welfare systems.

For policy makers, the major issue is likely to be the extent to which a vision of a wide-ranging social partnership could be undermined by a failure to appreciate that networking initiatives can only work in a legal and policy context which facilitates dialogue and collaborative ventures. Policies which encourage market competition and the protection of market advantage may not contribute to the creation of a 'network-friendly' environment. Likewise, policies which focus solely on risk reduction and the avoidance of 'scandal' may not sit well with those that focus on the long-term welfare of individuals and communities and the promotion of a social policy agenda based on citizenship and the concept of 'quality of life'.

## Questions

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This book is not intended as the final word about networking. A number of important questions still remain unanswered. Some of these relate to debates about 'effectiveness', others to debates about power and control.

While it is easy to show that it is more effective for people to work with one another rather than against one another (how could it be otherwise, especially when the outcome measures are defined in collaborative terms), it is not so easy to specify how, under any particular set of conditions, one networking strategy might be more effective than another or, indeed, some other type of approach altogether.

One reason for this is the complexity of the subject matter. There is not much that can be done about this. Networking is a strategic response to complexity and there would appear to be little point in developing techniques for evaluating effectiveness which cannot be applied when the situation in question becomes complicated. Another reason may be that we do not yet understand enough about developmental processes in cross-boundary work. If we could predict how social networks move from one stage or state to another, we might be able to show how particular network interventions usher in these changes. But there may be more profound philosophical/ethical difficulties as well.

Effectiveness in this context has to be compatible with the sharing of power and control, the creation of more opportunities and therefore, almost inevitably, more unpredictability. Devising appropriate outcome measures in situations where a multiplicity of outcomes may be not only possible but

desirable will not be easy. There will always be a danger of distorting the process of the work simply in order to ensure that it can be fitted into an overly rigid evaluative template. This would be an abuse of power which would be incompatible with the value system which, it has been proposed, should be integral to the networking approach. On the other hand, too loose a framework may make it impossible to say anything meaningful about what 'works' and what does not. Simplistic outcome measures are always likely to be inappropriate in relation to networking. This is not to say that more sophisticated techniques cannot be devised with networking in mind, but only that some regard needs to be had to the problems associated with complexity and participation when such techniques are being devised.

Themes of power and control have permeated this book and one chapter was devoted to the subject of empowerment. However, some uneasy questions remain which need further exploration. While it is possible to show that networking can be used to empower individuals and groups and to develop more authentic forms of partnership, there is a conundrum about power at the heart of networking for which there appear, as yet, to be few wholly satisfying answers. The conundrum is this: while networkers aim to share power and encourage maximum participation in decision making, they can succeed in these aims only insofar as they are able to exercise influence and thereby effect change. Rather than denying that there is some power associated with networking, there is a need to explore how this kind of power can not only coexist with empowerment but actually help to promote it.

Much work remains to be done, but the direction and, more important, the spirit of the enterprise is clear. Whereas theories like psychoanalysis or Marxism make sweeping claims about human nature, the laws of the mind or the laws of history, networking remains cheerfully agnostic on these matters. It requires no great leap of faith, only a stubborn belief in the ability of people to find strength, purpose and power in and through their relationships with others. While it would be foolish to pretend that all human problems can be solved by social networks, 'relational' perspectives open up a range of perhaps uniquely flexible, open-ended, supportive and empowering strategies which are well suited to the demands of our time.

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# **ON BEING A SOCIAL WORKER: GLOBALIZATION AND THE NEW SUBJECTIVITIES**

Steve Trevillion

## **Introduction**

Some might argue, that individuals no longer matter in organisations dominated by 'managerialism' and that we should not waste our time on explorations of subjectivity when there are more important matters to be addressed. However, in many respects, individuals have never been more important. As welfare organisations, like other organisations, become increasingly 'complex', it is also becoming clear that if we are to understand how they operate and why they act in the ways they do, we need to consider the motivations and strategies of those that work in them (Hall 1995). It is impossible to do this if we do not also have some way of understanding what those concerned think about themselves and their work.

This is a preliminary sketch for a new model of 'professional' social work subjectivity. The distinctive feature of this model is that it draws on the concept of culture to re-situate this topic within the 'interdependencies' of practice and links the process of being a social worker with the new 'complexities' of organisational life in an era of globalization.

While people have been asking, 'what is it like to be a social worker?', for almost as long as they have been asking, 'what is social work?', the attempt here, is to inject a fresh note into what might otherwise seem a rather familiar debate, by making use of a number of key concepts such as 'culture', 'figuration', 'network' and 'technology' which owe more to the work of social scientists such as Simmel, Elias and Barnes than to the

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rather inward looking traditions of mainstream social work theory but which can help to bridge the gap between the inner and outer worlds of social work.

## **Subjectivity**

The conventional distinction between 'subject' and 'object' has been brought into question by a wide range of thinkers who have rejected 'Cartesian Dualism' (Sutcliffe 1968,p.21) in favour of alternative perspectives which stress the connections between these categories. But while most Freudians and Marxists have tended to retain a concept of the natural or essential self however damaged by early childhood experiences or distorted by the effects of ideology, postmodern philosophers and psychologists have gone much further down the road of problematising subjectivity. Some have even suggested that there is ultimately no difference between subject and object (Baudrillard 1981) and many would agree with Foucault that subjectivity is socially and historically contingent so that over time 'new forms of subjectivity have arisen' as an integral part of the process of social change (Foucault 1982, p.216).

While rejecting the cultural determinism implicit in some of this recent work, a view of subjectivity as embedded in a particular time and place, makes it possible to see the question of professional subjectivity in a new way. In particular, it opens up the possibility of thinking about the 'sense and sensibility' of contemporary social workers in terms of broader changes in the world of social welfare. Rather than seeking to establish essential truths about how social workers think, we might begin to enquire about the ways in which social and organisational change is influencing or re-shaping the subjectivity of social workers.

## **Complexity and globalization**

Of all the forces which might be considered to have contributed to the 'complexity' of organisational life, the most talked about and discussed must be that of globalization. In recent years, the subject of 'globalization' has attracted an enormous amount of interest from journalists and politicians as well as from academics. It has proved difficult to define in a satisfactory way, although there appears to be some agreement that while it can be described as a process of 'increased international economic interdependence' (Memedovic, Kuyvenhoven and Molle 1998, p.3), it consists in part, too of political and managerial ideologies and trends. Perhaps one of the most succinct descriptions of globalization emphasises its mixed or pluralistic characteristics by suggesting that it consists of a set of enabling factors (associated with economic and technological developments) combined with specific 'government policies' and 'corporate strategies' (Van Liemt 1998,p.238).

But whatever the difficulties in coming up with a precise definition of globalization, there can be little doubt that the whole complex of economic/technological, political and organisational changes which go by this name have had a major impact on organisational life and in particular working conditions and employment practices.

Within Europe, the public sector as well as the private sector has been increasingly exposed to the new emphasis on 'quality, productivity and flexibility' (Van Liemt 1998, p.241). Phrases like 'Total Quality Management' and trends toward the casualisation and fragmentation of the work force have become all too familiar to those employed by welfare organisations throughout the European Union, in spite of attempts to 'soften the blow' of these changes through employment protection measures such as the 'Agreement on Social Policy' appended to the 1992 Maastricht Treaty (Van Liemt 1998, pp.242-246).

Any survey of recent developments in social policy throughout the European Union could hardly fail to note many of the distinctive characteristics of globalization

(Trevillion 1997). These include 'deregulation' in France, the increasing 'market orientation' of services for older people in Germany (Lorenz, 1994, p. 164), the 'crisis' in the 'Swedish model' of welfare (Olsson 1987) which is leading to a upsurge of interest in the private sector as a provider of care service (Gould, 1993, pp 197-198) and of course the continued growth of the 'mixed economy of care' in the UK (Griffiths 1988). To this might also be added the debates raging in Holland, Italy, Spain and elsewhere about the costs of health care (Trevillion 1996a).

At the same time, and again throughout the European Union, we have seen the rise of new forms of partnership and collaboration. These include the joint commissioning structures developed in the UK for linking health and social care agencies together in the strategic planning of community care (Lewis and Glennerster 1996) and the 'New Community Partnerships' designed to generate links between community groups, local government and local business and which can be found in almost all European countries (Macfarlane and Laville 1992). 'Private/public partnerships' of these kinds simultaneously face in two distinct directions. On the one hand, they can be seen as ways of opening up bureaucratic systems to market forces. On the other hand, they can also be seen as attempts to counter-act the excesses of commercialisation and marketisation by re-emphasising social and community values and promoting social inclusion. Therefore, in their own way, these partnerships are as much a feature of the complexities of globalization as deregulation and free trade.

While it is perfectly possible to describe all these developments separately and without reference to globalization, to do so would be to ignore the relationships they exhibit between the 'enabling' forces of the market place, government policies designed to promote greater 'flexibility' and the rise of new organisational forms and managerial strategies oriented towards the 'mantra' of 'quality, productivity and flexibility'. As these are precisely the elements which most commentators associate with

globalization, there is a very strong case for looking at their combined impact on individuals, teams and networks, even if they cannot all be reduced to the same cause.

How is the new complexity associated with globalisation and its organisational implications affecting the ways in which social workers think about themselves and the world of social welfare? To ask this question is to seek to explore the relationship between globalization and changes in the warp and weft of their everyday experience. To put this another way, is there a particular culture associated with globalization which all social workers could be said to share?

### **World system-world culture?**

At the heart of the globalization concept is the idea of a 'world system' (Wallerstein 1974). It has now become commonplace to associate this with an increasing integration and convergence of social, political and economic systems and the creation of an international culture often described in terms of pop music, Coca-Cola and Nike trainers. While some have regretted the passing of distinctive national and regional identities, there has been a tendency to assume that this just another chapter in the evolution of human society. Globalization has in this way been linked to the 'narrative' of social progress. The implication has usually been that the development of a world culture opens up new opportunities and possibilities for individuals.

Those who have tried to justify linking globalization to social progress have usually focused on the cultural implications of the new communication systems associated with micro-technology. For example, Robertson argues that 'globalization as a concept refers both to the compression of the world and the intensification of consciousness of the world' (Robertson, 1992, p.8). From this, we get the idea of the 'global village' as the telecommunications revolution and the spread of capitalist markets together with the international division of labour allegedly combine to create small, flexible and

responsive organisations and networks which have a distinct evolutionary advantage over the large corporations. This is a persuasive image of ever greater degrees of individual freedom and creativity in the workplace as well as outside it.

But the paradoxical nature of the 'global village' concept has been noted even by its proponents. This 'global paradox' is usually described purely in economic terms- as the world economy grows so too does the tendency for organisations to get smaller (Naisbitt, 1994). But this economic/organisational paradox contains a second cultural one, which it is less amenable to the tenets of 'progress theory'. As organisations become smaller and potentially more diverse in terms of their orientation to particular specialist niches in the world market, they also come to resemble one another more and more in terms of their internal characteristics. So, tendencies towards pluralism and self-expression can be matched by tendencies towards a degree of conformism which is usually associated with the allegedly defunct mass production culture of the Fordist age!

We also need to be cautious about accepting other features of 'global culture' at face value. The much vaunted 'flexibility' is frequently accompanied by 'fragmentation' (Van Liemt 1998, p.245) which is not just a question of 'downsizing'. For example, for many, within the public sector in the UK, globalization is coming to mean the 'literal disappearance not only of large organisations but also the disappearance with them of job security, predictability and long-term strategic planning together with the marginalisation of equal opportunities' (Trevillion 1997, p.5). Whatever the advantages of the new markets and private/public partnerships, these personal losses are also inscribed in global culture.

All of this, should make us question whether there is a single global culture associated with globalization. Economic 'convergence' does not necessarily imply a convergence of meanings and experiences, even between closely related organisations. It may well



be that different social workers in different organisations in different countries may be having very different experiences, all as a result of globalization. While globalization as a phenomenon clearly has cultural implications and therefore an impact on individual social workers and their view of themselves and the world, it is not at all clear that concepts such as 'compression' 'intensification' , 'global villages', 'global paradoxes' or even 'convergence', on their own, really help us to understand very much about these implications. In relation to social work, it may therefore be better to use these ideas in a more limited way, as tools to further our understanding of the diffusion of some key ideas and the re-configuration of working relationships. It is possible to illustrate this through the application of Robertson's concepts of 'intensification' and 'compression'.

### **Global values in social work?**

Where studies of professional culture exist, they tend to support the idea that there has been a growth in universal social work values (Walls, 1994 pp.218-224). These values are 'global' in two distinct ways; first, because they are universalistic in nature and second, because they have shown an ability to take hold amongst groups of professionals in many different countries. One example is the move away from institutional care towards various versions of community care in the UK, North America, Sweden, Germany and elsewhere. This has been accompanied by a considerable interest in a number of associated universalistic values such as choice, integrity, 'normalisation' and user involvement and participation.

This global discourse of values may not translate readily into a common set of policies, structures or services- hardly surprising given the range of 'welfare regimes', political ideologies and levels of prosperity even within Europe. But, at the very least, Robertson's concept of 'intensification' provides a framework with which to begin thinking about the way in which some key professional ideas have been able to cross national borders. By itself, however, this is hardly sufficient to demonstrate the

existence of a world-wide social work culture. For this, we would need to point to more than a few shared values.

### **Overcoming traditional barriers in social work?**

In social welfare, the term 'compression' refers less to the reduction of geographical distance than to the opening up of new forms of contractual relationship and new patterns of linkage between traditionally separate sectors of welfare- voluntary, statutory and private. This process has undoubtedly gathered pace in recent years and effectively changed the nature of welfare as a social space by making it a more and more interdependent one. Computers and telecommunications have played their part in this and every new initiative seems to reinforce the trend.

These new kinds of welfare networks have not necessarily expanded 'choice' but they have changed the nature of practice, not only in the UK but in other parts of Europe, as well and as a result they have helped to change professional subjectivity, as well. For example, in the UK, the new Health Action Zones are likely to involve a wide ranging process of what has been described as 'system re-design' (Peck and Poxton 1998,p.11) involving social workers and others in fashioning new kinds of links with different types of organisations. These kind of processes must have an impact on culture and subjectivity as they entail major changes in roles and responsibilities. But beyond, suggesting a greater awareness of interdependency, it is not clear what form this impact, is taking.

To take this exploration of the relationship between the subjectivity of social workers and the globalization process any further, we plainly need to draw on other ways of thinking about social work culture/cultures in a global context. The most obvious place to look for such models is the longstanding debate about the meaning of social work professionalism. However, as we shall see although this debate about professionalism

and professional 'culture' contains many interesting ideas, it is not all clear that it contains much of value in relation to exploring any 'new forms of subjectivity' associated with globalization.

### **Roles, tasks and 'professional' culture**

One of the things that differentiates debates about the social work profession from that of other professions is the focus on heterogeneous concepts of task rather than homogeneous concepts of expertise. Many years ago, Martin Davies argued that 'there is no such thing as the social work task' (Davies 1981, p.3) and the dominant trend since then has been to define social work not in terms of one holistic identity but rather in terms of a number of complex and overlapping 'roles and tasks' (Barclay 1982). But this leaves a hole where the subject ought to be. Awareness of this problem explains the almost fetishistic attachment to statements about 'core values' in the contemporary social work literature, as it these, which are used to provide a foundation for what might otherwise be a rather shapeless aggregation of loosely associated activities.

### **Values**

In focusing on 'values' as the key to understanding the way in which professional roles and tasks relate to professional identity, social work theorists have, in this context of epistemological insecurity, almost inevitably resorted to a Parsonian functionalism in which values serve to integrate a complex and diverse set of roles and activities. This almost inevitably produces highly conservative accounts of the relationship between subjectivity and social work practice- a discourse in which an unchanging, core of integrative and defining values acts as a brake on change and pulls the practice system constantly back into homeostasis. It is simply not clear how such a theory can accommodate change, least of all the kind of fundamental change which is associated with globalization.

One other feature of the focus on 'values' is that they have been regarded as something which is acquired through education and training, whereas in contrast, the process of working as a social worker is often seen in terms of a challenge to 'professional values'. In the UK, the introduction of care management and other social welfare practices which appear to have a new kind of value base has precipitated a spate of articles on the conflict between professionalism and the nature of day-to-day experiences (Simic 1995). Whatever the rights and wrongs associated with these issues, this focus on values generates a platonic image of professionalism as something timeless and essential, separate from or even opposed to the everyday and contingent world of practice. This is all very well. But if it is change in which we are interested, platonic definitions of professionalism provide little help.

## **Competences**

When we move away from values and into debates about knowledge and skills, we seem to move even further away from any notion of what it means to be a contemporary social worker. Even in their own limited terms, statements linking any one profession to an exclusive body of knowledge and skill are problematic.

Although it might seem obvious that 'a person who is described as competent in an occupation or profession is considered to have a repertoire of skills, knowledge and understanding which he or she can apply in a range of contexts and organisations.' (Jones and Joss, 1995, p.15), we also know 'how difficult it is to find an agreed set of characteristics which distinguish the professions from other occupational areas' (ibid, p.16). In the case of social work with its commitment to inclusive definitions and its orientation to task performance, the problems are particularly acute. For example, how do we distinguish between social work and other social care occupations and what is the difference between a social worker care manager and an occupational therapy care

manager? These kind of questions can easily turn into an obsessive type of academic pedantry which has little connection with the concerns of those engaged in day-to-day social work practice.

The response within social work has been to largely abandon holistic definitions in favour of lists of competences. This tendency to *objectify* professionalism by looking to the things that social workers do, has perhaps now been taken to its logical conclusion with the creation of a competency based model of education and training by the Central Council for Education and Training of Social Workers (CCETSW 1989). Here the definition offered of professionalism is that of overall competence in all the defining areas of knowledge, skills and values. There is, however, a curious coda to this as one of the areas of competency is professional development itself! This highlights the difficulty encountered in trying to comprehensively define professional subjectivity through outcome measures and shows that even a competency based model may be forced to recognise that there is more to professionalism than a bundle of specific competencies.

Models like this are designed to tell us what practitioners need to know to perform a specific range of tasks. They do not tell us anything about how individuals adapt to or make sense of change, nor do they locate the subject within a particular culture except in so far as the culture is represented by 'occupational standards' derived from an analysis of the tasks which need to be performed .

## **Reflectivity**

An alternative to the dominant behavioural model is that which is often described as the 'reflective' or 'hermeneutic approach' approach. Rather than trying to objectify the professional subject this concerns itself with both social and intra- psychic processes and cognitions generated by the experience of doing and talking about social work.

Drawing on the more general work of Schon and the communicative rationality model of Habermas, the emphasis is on 'reflective practice' and constant dialogue with others as a way of making subjectivity more explicit and less divisive. Yelloly and Henkel argue that this answers the need for a practice model showing how 'the way the world without is inextricably intertwined with the world within' (Yelloly and Henkel 1995,p 9).

This hermeneutic 'turn' is helpful in once more focusing attention on the active role of the professional subject. But reflection by itself does not provide us with an altogether adequate concept of subjectivity. This is partly because it tends to exaggerate the role of individual agency and to reduce the role of structure to little more than a loose context within which 'professional identity' can be constructed and reconstructed by individuals. Moreover, as the principal concern is with communication in a context of difference, the approach has relatively little to say about the way different subjectivities are constructed, in the first place.

Without entering into a major philosophical debate about the nature of the social domain, I simply wish, at this stage to point out that the questions we need to ask about social work subjectivity, at this moment, are at least as much to do with structure as agency. The challenges to social work as profession are being shaped by major social upheavals which at their most obvious take the form of new policy objectives, organisational structures and legal requirements.

The reflective approach can certainly help us to understand how specific social workers in specific situations go about 'making sense' but it has little to say about general predispositions or cognitive maps, let alone questions about the relationship between professional belief systems, professional styles, images of others or types of intervention.

## **Beyond professionalism: social work and the new welfare organisations**

There have been attempts to suggest that the 'new organisations' still need professionals who can be relied upon to operate according to agreed codes of conduct and to agreed standards but even those holding to this view, have been forced to acknowledge the tensions between professionalism and the neo-liberalism associated with a market ethos (Broadbent, Dietrich and Roberts 1997). To this one might add, that there are also tensions between traditional professionalism and the demands for increased accountability associated with at least some of the new organisations, especially those that involve collaborative partnerships of one kind or another (Finn 1996). If we put these problems alongside the more fundamental questions already raised about our understanding of professionalism and the culture of professional social work, it becomes clear that we simply do not have a vocabulary with which to explore the questions about culture raised by the globalization debate and which might enable us to grasp the elusive patterns of subjectivity emerging among contemporary European social workers as day by day, they *internalise* (Best and Kellner, 1991, pp50-51) the 'social processes' of globalization. However we look at it, there is a need to explore the culture of social work in a different way.

### **Social work, subjectivity and culture**

To attempt to make use of concepts of culture to answer questions about subjectivity may seem unremarkable to anthropologists or sociologists, but what is so striking about the literature on social workers, is the way in which debates about culture have been marginalised. In general, culture is seen, not as something which social workers have, so much, as something to which they need to be 'sensitive'. So, for many years, we have had 'ethnically sensitive social work' and 'multi-cultural' social work. But as well as being of sometimes doubtful value in the anti-racist struggle (Dominelli 1988), these concepts tell us little about social work as a culture. This problem extends to the

literature on professionalism, itself. Part of the problem with the 'professional' models that we have analysed is that although they may present themselves as accounts of professional culture, they tend to make little or no use of the culture concept, itself. This might go back to the essentialism characteristic of the professional project and the relativism associated with the idea of culture. Professionals of any kind, including social workers, may hesitate to embrace the culture concept because to do so, could render problematic the attempt to anchor professional legitimacy in statements about the defining or essential features of their profession.

In so far as the concept of 'professional culture' does play a significant part in debates, it tends to do so only in as a way of explaining resistance to change as in debates about interprofessionalism, collaboration and organisational change. In these debates, culture signifies a kind of defensive and ultimately irrational professional defensiveness (Trevillion 1996b). With few exceptions (Beresford and Trevillion 1995) the culture concept is rarely used in a positive way to describe new ways of thinking about practice let alone, new ways of thinking about social workers as subjects.

To some extent, as we have seen, the explanation for this resides in the way in which the problem of social work subjectivity has been articulated over the years, especially in the Anglo-American tradition. The concept of subjectivity has either, been explored on a case by case basis or, has been assimilated to the concept of professional roles and tasks, neither of which have been seen in cultural terms. Instead, what will now be proposed is a cultural model of organisational subjectivity which focuses on the interplay between patterns of social interaction and those concepts of what it means to be a social worker which are acted out in practice on a day-to-day basis.

**The cultural construction of the social work subject**



One major obstacle to the use of the culture concept is the number of different definitions of culture which have been coined, most of which are plainly unsuitable or unhelpful because they have been designed to explain traditional, relatively closed and unchanging social systems or tend to reify the concept, so that individual subjects become little more than representatives of The Culture. One exception to this, is the concept of culture as an 'emergent' property of social interaction which is associated with Simmel and Norbert Elias. This can help us to explore the way in which social workers as subjects are actively involved in the making of a culture which, in turn, defines their subjectivity.

Simmel was the first person to argue that society consisted of a web of social interactions. Building upon Simmel's work on interdependency, Elias began to relate individual subjects to a concept of 'figuration' which he defined loosely as a specific pattern of 'interdependent individuals' who are involved together in some kind of activity. In doing so, he self-consciously tried to create an image of culture which was actively constituted by individuals, rather than external to them and through which individuals developed their sense of identity (Elias 1978, p.15).

Elias pointed out that we are so deeply embedded in social process, that we are literally carried along by our social networks. This provides us with a way of defining subjectivity which avoids both psychological reductionism and sociological determinism. The subject is located in 'the processes and structures of interweaving' and the 'figurations' formed by the actions of interdependent people'(Elias,1978,p103). The benefit of this kind of thinking is that it provides a framework by which to relate changes in social work subjectivity to the increasing complexity of organisational life and the curious cultural paradoxes generated by globalization. More specifically, we can relate subjectivity to social welfare "figurations" consisting of characteristic patterns of interaction with service users, other professionals, employers, etc. without over generalising. For the first time we have a cultural paradigm which avoids focusing

on the individual professional in isolation or standards of task performance or the specificities of particular casework relationships.

Another reason why the 'figuration' concept is so helpful in the professional arena, is that it can be used to explain professional subjectivity in a context of complex interdependency without reifying the notion of culture or 'professionalism' or implying that it is static or timeless. The idea that any one 'figuration' exists within a 'figurational flow' (Elias 1978,p.164) is quite a powerful one. It enables us to locate particular contingent patterns of thinking/feeling within the context of equally contingent patterns of interaction and interdependency which can nevertheless, be related to one another in time and linked back to economic and political developments.

The 'figuration' concept also contains an analysis of the relationship between culture and power. As interdependency increases, so does complexity and power appears, to those involved, to pass from individuals to the pattern of interdependency or 'figuration', itself (Elias, 1978, pp.71-103). Of course, for social workers, this is not a recent phenomenon. Social work has always involved complex 'figurations' and social workers have probably always felt that power has in some way slipped away from them to legal and organisational systems of one kind or another. The relationship between social workers as subjects and their social worlds has therefore always been profoundly cultural in . What may have changed, however, are the patterns of social interaction and therefore the 'figurations' within which the social work subject is situated and which mould his or her sense of self and relationship to others.

Intensification, compression, convergence, downsizing and the move towards complex partnership arrangements and inter-organizational networks can all be seen as major transformations of the social work figuration and globalization, itself could be seen as a dynamic factor influencing the direction of the 'figurational flow'.

One consequence of thinking about subjectivity in this way is that it becomes impossible to limit the discussion to the idea of being a member of a profession or even being a member of a team or organisation. Elias encourages us to link one pattern of 'interdependency' with another. We are forced to think about subjectivity in the context of networks of social relations which flow across all conventional boundaries'...a functional relationship which stretches right across the world' (Elias1978,p103).

This generates a new kind of approach which links the study of subjectivity to the sociology of knowledge in an integrated way: But it is not just a question of 'how do people [in this case social workers] perceive and conceptualise the changing and growing webs of interdependence in which they find themselves bound up' (Mennell,1974,p.84). It is also a question of how the 'figuration' influences the way they see themselves.

Unfortunately, the concept of a 'web of interdependency' is so fluid and open that it is very difficult to define figurations in ways which are specific enough to be related to specific aspects of subjectivity. This might not matter much if we were concerned only with generalities but if we want to pursue particular lines of inquiry about the relationship between subjectivity, social work practice and social interaction we need some way of focusing on a particular zone of social interaction which can be related systematically to the experience of being a social worker. In particular, for our present purposes, we need a way of doing this which also captures some of the key issues around globalization at the level of social interaction as well as culture. The answer may be to link subjectivity, social interaction and figuration together through the concept of 'technology'.

**New technology, new relationships and new subjectivities**

We generally do not think of social work as a 'technology'. This is because we associate this word with complex mechanical devices which are not relevant to social work. However, even if we put to one side the way in which technological hardware has become incorporated into social work through computers, telecommunications and complex electronic accounting processes, this failure to consider the idea of 'technology' as relevant is based on a fundamental misconception about the nature of both technology and social work.

We now know that technology should be seen as *a pattern of social relations* associated with the need to operate a particular technical system.\* If the study of technology is the sociological study of the way in which social relations are constructed and reconstructed through the innovation process, then thinking of the social work process as a 'technological' process enables us to link practice innovation to changes in the social work subject as networks of social work relations are re-ordered, and re-conceptualised.

So, a new technology of social care involves a cultural shift of potentially considerable magnitude which can, nevertheless, be mapped out, in some detail, by exploring the innovation process in terms of the changing social fields, patterns of linkage, interdependency, etc. generated by those involved as they seek to achieve personal, professional and organisational goals within the new social worlds, they are, themselves, helping to create by their actions and interactions. It involves a movement from one type of 'figuration' to another and both helps us to understand the dynamics lying behind this and provides us with a way of focusing on specific patterns of social interaction .

One implication of this is that we cannot separate the question of the subjectivity of social workers from the structural question of how the landscape of interpersonal and

inter-organisational relationships is being actively constructed and reconstructed around the demands of the new systems of social care in which social work is embedded? The study of subjectivity becomes part of the study of the new technologies of social work/social care.

I want to focus on one example of innovation and to explore this in terms of the relationship between patterns of social interaction, culture and subjectivity.

### **Collaboration and re-figuration**

We are most likely to find evidence of globalization where we can find new patterns of work, an exposure to market forces and policy objectives related to global shifts in the arena of values. In the UK the question of collaboration in community enshrines policy objectives with a global resonance and a commissioning and care management process which has opened up social work practice to market pressures. It therefore corresponds quite neatly to the models of globalization put forward by various theorists such as Van Liemt in that it combines 'enabling' economic and technological shifts with 'government policies' and 'corporate strategies' (Van Liemt 1998,p.238).

The interest in promoting collaboration between different 'stakeholder' groups in the sphere of community care also provides us with a ready made context within which to explore the organisational complexity which is a feature of globalization, especially as there are strong suggestions that collaboration itself, is directly related to globalization. It is widely seen by management theorists as an 'antidote to [market generated] turbulence' and as a way for newly linked organisations to 'gain appreciation of their interdependence' (Gay 1996,p.58).

All of this, adds up to a strong argument in favour of identifying collaborative arrangements as innovative 'figurations' characteristic of the globalization process. To add weight to this, it has recently been recognised that collaboration produces new organisations. 'When groups and organisations begin to embrace collaborative processes to engage in intra or inter-organisational strategies management and change, they are in essence, inventing a new type of organisation' (Finn 1996,p.152). Can these new 'figurations' be linked to a particular technology of social care?

### **Community care: a new technology of social care**

Right across Europe and indeed beyond there has been a shift from the older technology of institutional care to the new technology of community care. The old technology structured social work relationships in terms of highly organised and prescribed networks of care and control. It is now well established that the 'total institution' imposed a fixed structure of interaction on professionals, residents and their families alike (Goffman,1968). But this structure of institutionalised relations could be described in my terms as an *institutional technology of social care*. Over time, and especially during the period of post-war reconstruction, this *institutional technology* became linked to a broader range of *bureaucratic technologies* characteristic of social care all over Europe (Cannan, Berry and Lyons,1992, pp.47-70).

*Institutional/bureaucratic technologies* are related to Fordist welfare structures but community care technologies are related to the emergence of post-Fordist welfare structures. Therefore, some of the fundamental conditions under which welfare is constructed and delivered have changed, giving rise, not only to a new managerialism and 'technocratisation' (Dominelli and Hoogvelt, 1996), but also new organisational forms. With the decline of traditional Fordist welfare organisations, the conventional team is disappearing to be replaced by more complex and open-ended networks of co-operation and collaboration. These new 'figurations' can be seen as networks of

relationships organised around the technology of community care. In the UK this would involve such structured activities as hospital discharge arrangements, assessment, care planning, purchasing, the interweaving of formal and informal care, etc. We would therefore expect that these new networked organisations/technologies might be the crucible from which new identities would begin to emerge and there is some evidence of this.

A seminal experience for me has been the opportunity to study new social care networks in both London and Stockholm and the way in which individual social workers conceptualise their identity in the context of these new 'figurations'.

### **From teams to networks**

The 'team' concept occupies a central place in the construction of social work subjectivity. Throughout Europe, most social workers expect to work in teams and teamwork is a highly prized. However, the new collaborative organisations based on networks are beginning to shift professional subjectivity away from its location within the traditional team and into a very different kind of inter-organisational roles and relationships. However, the differences between the culture of these new organisations may be as important as the similarities.

The tendency towards an increasingly networked model of service delivery was evident in both Stockholm and London. But whereas, in London, the effect of the shift to community care has been to make social workers become more entrepreneurial and more instrumental as well as more networked in their practice, in Sweden, the effect has been to create a new notion of the 'co-operative social worker' looking to explore ways of overcoming bureaucratic boundaries in order to meet individual need and investing strongly in cross-sectoral relationships (Trevillion and Green 1998).

From a very detailed analysis of network roles and relationships what emerged from our London study of community care networks was a picture of multiple professional identities and team affiliations but with little or no emotional investment in these multiple identities, an overwhelmingly short-term instrumental approach to 'collaborative' relationships and a radical individualisation of work with little or no evidence of any linkage between individual networks and relationships between teams (Trevillion, 1996c).

Whereas the precepts of 'global awareness' might lead one to expect the forging of a new kind of interdisciplinary identity, we found little or no evidence of any attempt to create a new integrated kind of community care professionalism. Multiple identities remained multiple identities and this was associated with a lack of emotional investment in attempts to connect these different 'figurations' (Elias, 1978, p. 103). In turn, this was associated with an overwhelmingly short-term instrumental approach to what seemed to be 'collaborative' relationships and a radical individualisation of work with little or no evidence of any linkage between individual networks and relationships between teams. One could call this an *entrepreneurial culture*, characterised by a highly personalised but relatively impersonal work strategy and mode of interaction with others generating a number of very loosely connected loose-knit networks.

The Swedish network was associated with much higher levels of connectedness than the UK networks. While individual and person-centred networks were important in both countries there was a much higher degree of overlap between network systems in Stockholm than in London. The emphasis on relationships and mutual understanding was much higher in Sweden and while goal attainment was clearly important in both countries, it was only in London that this was translated into an instrumental attitude to network relationships. The Swedish practice culture could be described one where



there was a strong sense of a common network culture being constructed but on the basis of negotiation and with only a slight hint of pressure to conform.

When we met with representatives of the new collaborative organisation in Stockholm, one of the talking points was what it was that held this complex structure together.

The answers we were given included trust, reciprocity, familiarity, and shared history/biography and opportunities for informal social interaction which extended to socialising outside the work context (Trevillion and Green 1998). Overall, we could call this a *relationship culture*, characterised by a close-knit network of strong personal affiliations.

What this brief comparison shows is that new forms of 'connectedness' are becoming a characteristic feature of community care 'technology'. The nature of this shift is quite marked in that it includes a movement away from the highly organised and prescriptive structures of conventional teamwork to more flexible, multi-agency patterns of collaboration and

co-operation. Comparing UK and Swedish social workers also shows that a wide range of network possibilities and cultures can exist in the new environments currently being shaped by globalization. Entrepreneurial cultures and relationship cultures are two of the possible 'figurations' or patterns of interdependency characteristic of the 'new organisations' and each has its own type of subjectivity.

### **Researching changes in professional subjectivity**

So far, the argument has been that concepts of culture and technology can help to re-situate subjectivity in the context of globalization. But it could easily be pointed out that the generalisations so far produced, provide only a limited picture of the mind-set of contemporary social workers. This is true. "Subjectivity" has to be situated within 'culture', but the two are not identical.

While most of the literature on culture tends to assume that individuals grow up within a particular culture and develop their sense of who they are through a process of extended socialisation we cannot assume that this is the case with any kind of organisational culture. In particular, concepts of professional role, certain key values and expectations are likely to have been acquired prior to entering a particular organisation and certainly prior to engaging in the kind of collaborative work involved in creating the 'new organisations' associated with globalization.

Human beings are defined by their memories as much as by their contemporary experiences and no account of subjectivity which misses out this dimension can hope to be complete. Given the impossibility of factoring into any model, the diversity of biographies to be found in just one group of social workers, this makes the quest for an account of subjectivity appear to be foolhardy, at best.

However, there is no need to attempt to produce a comprehensive definition of subjectivity. The aim here is much more limited. I have been trying to explore the shifts in subjectivity associated with the 'new organisations' and to explore these shifts in the context of cultures of interdependency. This is still a difficult task, but, nevertheless a manageable one.

The model taking shape is one in which the patterns of interdependency corresponding to a particular culture are represented in network terms and onto which the concept of the professional self is then mapped.

In relation to the two social work cultures that have just been described, this model would generate a series of statements about the general tendency of those within the culture to behave towards other people in particular ways. I have given some indication of the kind of statements that could be made about subjectivity in an

'entrepreneurial culture' and subjectivity in a 'relationship culture'. Much more work on applying this model needs to be done before one could claim to be doing more than 'scratching the surface' of the question of subjectivity. nevertheless, I believe a start has been made.

### **Conclusion: the way forward**

Globalization can be defined in many different ways and has many different kinds of consequences. However, one way in which all its different aspects come together, is through the way it changes the patterns of 'interdependency' within and between organisations. As far as social welfare organisations are concerned, the impact of globalization has been felt not only through changes in managerial style and approach and the increasing role of markets and quasi-markets, but also in the pattern of everyday relationships.

In order to grasp the way social worker's currently experience their relationships with others and thus their own roles and identities we need to develop an account of the new subjectivities associated with globalization. The problem that has been identified, however, is that none of the traditional ways of thinking about professionalism and professional identity appear to be capable of generating adequate descriptions of what appears to be going on in contemporary European social work. In an attempt to solve this problem, a new model of subjectivity has been proposed based on the concepts culture and technology. The result is a cultural model of subjectivity which is at the same time, attuned to global processes and global systems, yet, sceptical of rhetorical visions based on universal values and experiences. This model contains a view of the social worker as one whose subjectivity is constituted, at least partly, in and by the concrete interweaving and interdependencies of day-to-day social interaction and

which is not synonymous with highly normative public pronouncements about professional identity or values.

In pursuing this line an argument has been made for an interactional 'turn' in studies of professionalism in social work and a more coherent attempt to connect the study of the professional subject with studies of social change and broader socio-economic and organisational debates.

Whilst the idea of globalization opens up an exciting new field for comparative European analyses, it simultaneously creates awkward if not insoluble problems in relation to research methodology which cannot be solved by conventional research methodologies. Rather, what it suggests is the possibility of a systematic and comparative study of the relationship between felt experience, culture, technology and social network which would seek to explore the different 'figurations' and subjectivities emerging in the context of globalization.

\* This idea, to which I am indebted, was first proposed by Professor Stephen Woolgar during the course of his 1997 Brunel Innovation Lecture 'A New Theory of Innovation'.

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