Chapter 1
Social care theory for practice

Introduction

Social Care Theory for Practice is a major component of your HNC in Social Care. You may note that it is worth two credits within the framework of your qualification, and it certainly underpins major concepts in social care. It covers important elements like values, anti-discriminatory practice, legislation, care planning and intervention methods, as well as team work, and is very much focused upon how theory relates to day-to-day work. You may also find that it lends itself to other areas of study, like psychology, social policy or sociology, and hopefully, as you gain experience in workplaces, you will benefit from understanding how theories and class work relate to actual real-life work. It will challenge your thoughts and experiences, help you to analyse your own understanding of the world around you, and hopefully encourage you to consider the nature of your own opinions. This is a challenging area of study; Social Care Theory should enhance your analytical skills and while it may not make you change your mind about some things, it should help you to understand your own views and the views of others.

This chapter aims to explain the main concepts relating to the central themes of the unit in a step-by-step way. However, in any work setting, you should be mindful of individual policies and procedures, team structures and mission statements which relate to some of the areas mentioned.

Certainly, as an area of study, Social Care Theory for Practice is aptly named:

- it aims to help you to understand some of the broad themes in the huge field of social care and equip you with enough underpinning knowledge to practise safely, ethically and responsibly. It will also give you a degree of factual knowledge in relation to theories on teams, management styles and communication. It should also give you an insight into the sometimes daunting area of legislation, covering major Acts which impact upon a social care worker’s role, responsibility and duty.

Social care theory provides ample food for thought.

On completing this unit you should be able to explain how social care values and principles influence practice; understand the care planning process; be aware of a variety of social care intervention models; evaluate and describe types and models of teams and
In this chapter you will learn:

Values and underpinning care principles

Through general discussions and perhaps through prior learning, you may already have quite a fixed idea of what values may mean. We talk a lot about 'respect', 'individuality', 'equality' or 'diversity' in social care. This chapter aims to challenge and unearth a deeper comprehension of values and look at wider social issues which may influence our understanding of what is 'right' or 'wrong', 'good' or 'bad', in Social Care. Values are about ethics, moral dilemmas, challenges and cultural awareness; they reflect our own personal belief systems, backgrounds and socialisation and they can, and probably will, change! You not only have to consider your own value-base, but also the values of those around you – team members, other professionals and people who use services for example. Our first area to consider is very simple – what exactly is a value?

Key terms

Intervention to get involved; to interfere with events or processes

Knowledge awareness and understanding of concepts and facts

Methods a way of doing something, especially systematic

Principle a rule of conduct or expected practice

Process routine way of dealing with something

Skills capacity to do something – demonstrated ability to do something

Values the worth we place upon someone or something

Different values

In our culture, widely speaking, we have many influences placed upon us – some are rather more obvious than others; some we feel we can control or ignore, and others are deep rooted and intrinsic. Generally, in wider society, you may recognise that we value money, possessions, family, friends, status, celebrity, popularity or beauty. The list goes on and on. Equally, in wider society, you may recognise that we do not value deceit, dishonesty, the unemployed, or people with disabilities. It is important to recognise that, at this point, we are considering society in its widest sense – try to put aside your already formed ‘social care’ values and consider how the media portrays certain societal groups, for example. You could pick up a ‘popular’ magazine and look at adverts or articles, counting the number of different social ‘groups’ portrayed. This may help you to grasp the very fluid meaning of values. In simple terms, a value is the worth we place upon something or someone.

Key terms

Ethics moral principles or a recognition of right and wrong

Culture a recognised and shared way of doing things or belief systems common among a group or society

Values, in society, may include a variety of areas like cultural values – respecting dress code, or specific rituals at certain times; personal values – recognising self-esteem and confidence; social values – manners, etiquette, choice of language; ethical values – moral boundaries and a sense of what is right and wrong; spiritual values – a sense of faith or belief. Later we will look at some examples of social care values and demonstrate that indeed, they are often linked together.

Consider this

You are on a rescue mission: a building is ablaze and you know, from officers at the scene, that three people are trapped. You have enough oxygen in your breathing apparatus to enter the inferno only once. The three people trapped are:

- a single, elderly male, who suffers from Alzheimer’s and is already debilitated by chronic emphysema
- an active middle-aged female, who is employed as a specialist heart surgeon and married with two young sons
- a 23-year-old female, who is HIV positive. She is an unemployed single-parent, with a five-year-old daughter.

You can carry only one person out! You have to decide who it is.

1. Who would you rescue?
2. What influenced your decision?
3. Would that decision be popular, obvious, understandable or surprising to others?
4. Do you know agree with that decision?

Of course, this is a very basic exercise, but it should illustrate that values are complex and often difficult to identify; sometimes we act or react in an instinctive way or do things because they ‘feel right’. However, by studying values, you should come to understand their origins and limitations; there are many issues which bring our values into scrutiny.

Personal values

As individuals we are laden with values and opinions, and sometimes also prejudices and stereotypes, as products of our lives, interaction and experiences. It is crucial that we consider how we might influence others and take stock of our own beliefs and by doing this we must consider our own personal viewpoints.

Our personal values also cover a range of areas and can even be contradictory. Within a social group, shared values (positive or negative) may bind people together. Pressure groups, like Greenpeace; or charitable organisations like Save the Children, for example, aim purposefully to capture a particular value base among society. Conversely, extreme movements like the Ku Klux Klan also ‘tap’ into a very different set of values.

Consider this

Thinking about the suggestions of types of power above, can you think of examples where you have come across these? Have you recognised a type of power others may see in yourself or identified a type of power another person has had over you?

Key terms

Culture a recognised and shared way of doing things or belief systems common among a group or society

Values, in society, may include a variety of areas like cultural values – respecting dress code, or specific rituals at certain times; personal values – recognising self-esteem and confidence; social values – manners, etiquette, choice of language; ethical values – moral boundaries and a sense of what is right and wrong; spiritual values – a sense of faith or belief. Later we will look at some examples of social care values and demonstrate that indeed, they are often linked together.

Consider this

You are on a rescue mission: a building is ablaze and you know, from officers at the scene, that three people are trapped. You have enough oxygen in your breathing apparatus to enter the inferno only once. The three people trapped are:

- a single, elderly male, who suffers from Alzheimer’s and is already debilitated by chronic emphysema
- an active middle-aged female, who is employed as a specialist heart surgeon and married with two young sons
- a 23-year-old female, who is HIV positive. She is an unemployed single-parent, with a five-year-old daughter.

You can carry only one person out! You have to decide who it is.

1. Who would you rescue?
2. What influenced your decision?
3. Would that decision be popular, obvious, understandable or surprising to others?
4. Do you know agree with that decision?

Of course, this is a very basic exercise, but it should illustrate that values are complex and often difficult to identify; sometimes we act or react in an instinctive way or do things because they ‘feel right’. However, by studying values, you should come to understand their origins and limitations; there are many issues which bring our values into scrutiny.

Personal values

As individuals we are laden with values and opinions, and sometimes also prejudices and stereotypes, as products of our lives, interaction and experiences. It is crucial that we consider how we might influence others and take stock of our own beliefs and by doing this we must consider our own personal viewpoints.

Our personal values also cover a range of areas and can even be contradictory. Within a social group, shared values (positive or negative) may bind people together. Pressure groups, like Greenpeace; or charitable organisations like Save the Children, for example, aim purposefully to capture a particular value base among society. Conversely, extreme movements like the Ku Klux Klan also ‘tap’ into a very different set of values.
In social care, as a sector, the Regulation of Care (Scotland) Act 2001, led to a clear set of standards being published, and expected of workers. Buying into these standards is non-negotiable, and if we are brutally honest, may pose challenges for some. However, aspiring to those standards, which we look at later, can only safeguard and enhance the care experience to those standards, which we look at later, can only safeguard and enhance the care experience to those standards, which we look at later, can only safeguard and enhance the care experience to those standards, which we look at later, can only safeguard and enhance the care experience to those standards, which we look at later, can only safeguard and enhance the care experience to those standards, which we look at later, can only safeguard and enhance the care experience to those standards, which we look at later, can only safeguard and enhance the care experience to those standards, which we look at later, can only safeguard and enhance the care experience to those standards, which we look at later, can only safeguard and enhance the care experience to those standards, which we look at later, can only safeguard and enhance the care experience. 

Key terms

Prejudice beliefs held about individuals or groups based on an assumption and stereotype – pre-judging someone or a situation without personal insight or knowledge

Ku Klux Klan American organisation proposing white supremacy

Consider this

Quietly consider some of your own values, past or present, and try to be honest. Working in a social care setting are there individuals you may find it more difficult to work with? Why? How might you overcome this potential barrier?

Case study

Considering your prejudice

Look at the following scenarios and, being as honest as you can be, explore your reactions to the situation. In the past would you have reacted differently? Do you feel you have developed a value base since childhood, or through specific life-events? How do you react now to the information in the cases below?

Sammy

You are in primary school and have a strong group of friends you play with – both inside and outside your school time. Sammy is the new boy. He doesn’t support the same football team as you and your friends. He has moved from England and has a different accent. He also lives in a rough part of town, and doesn’t have the same sorts of clothes as you. Some of your friends have started to pick on him. They call him names as he walks past and one of your friends even throws a rock at him during maths class. You go along with your friends although haven’t actually ‘picked’ on him to date.

After class, one of your mates dares you to go over to Sammy and tell him he smells. You feel uncomfortable about this, but your group of friends are all watching. You do as they say, going over to him and shouting at him ‘You smell’ and run away laughing. All your mates think this is brilliant and for a moment you feel strong and accepted. Later, at home, you think again...

Shopping

You are visiting your local shopping centre and have some money to spend on clothes for a night out. In a clothes shop, you are trying to look at some nice tops. The shop is busy, and your temper is beginning to fray. There are two women in front of you with buggies, they are chatting and blocking the aisle. From behind them, you have said ‘Excuse me’, but they just keep chatting. In the end, you get very frustrated and ‘tut’ loudly, barging past. One of the women throws you an unfriendly stare and the other mutters ‘sorry’ in a sarcastic tone. Would you have done the same if the aisle was blocked by a wheelchair user?

The tenement

You live in the top flat of a tenement building. You get on well with all of your neighbours and the close is clean and well kept. There is no security entry on the door, but this has never been a problem. Until now! Over the past few nights gangs of Asian youths have been standing in the close smoking and hanging around. You feel intimidated and usually make sure your door is locked when you get home. One of the downstairs neighbours lives alone and is getting angry. This is particularly bad for him, as his front door is right next to the main entrance. A meeting is called between all residents to discuss what is seen to be a menace. In the end, you decide to get a security intercom fitted in the close, with all residents paying a share. During the meeting, when this was decided, one of your neighbours makes a racially inappropriate claim saying ‘Who wants those kind hanging around anyway?’ You feel uncomfortable with this comment, but are aware that you are sure one of the guys hanging around called you a ‘piece of white trash’ under his breath. You are also aware that there have been racially motivated attacks in the area on previous occasions.

Social division, on a broader scale, offers us a diversity of values and can often be influenced by class, gender, sexual orientation, religious affiliation, age or ability. However, if our personal value base is that we ‘respect all others’ or ‘like different people’, meeting not so like-minded individuals should not create tension or fragmentation, but be embraced as a positive opportunity. Contrary to this, values like ‘I don’t like gay people’ or ‘disabled people are stupid’ clearly create negative images, thwarting open communication and contributing to negative stereotypes and damaging interpersonal relationships. Quite often, we sense incongruence and, as individuals, tend not to trust people who display it. If we fail to recognise our own values and some of the potential prejudices we may have, we may buy into discriminatory practice and indeed contribute to it (albeit in ignorance).

Activity

Consider the following examples of work situations. How might a worker’s lack of congruence show up in the written account?

Case scenario

Gary has turned up at the hostel shouting and swearing at the locked door – he wants to ‘have it out’ with Stu, who he is calling a ‘liar’.

You are not sure if all of the facts are indeed accurate in the written account Stu prepares. Stu has already expressed doubts over his potential to other staff, saying things like, ‘It won’t be long until he is evicted’. One morning, you go to work on an early shift and indeed, overnight, Gary has been evicted for turning up at the hostel ‘under the influence’. Stu was the nightshift worker responsible for the eviction. You know he has acted defensively towards Gary in the past, and wished him failure, in many ways. You plan to discreetly address this matter with the Manager today. In the meantime, Gary has turned up at the hostel shouting and swearing at the locked door – he wants to ‘have it out’ with Stu, who he is calling a ‘liar’.
So – a value is the worth we place upon something. It may be a monetary worth (for example a house is worth £150,000) but for social care, we focus on the intrinsic worth of individuals. Sometimes this can be known as unconditional positive regard. It is also important to realise that, in social care, ultimately our professional conduct is not negotiable: the National Care Standards clearly communicate in which we should behave and several pieces of legislation guide our actions towards others, and we will move on to consider some of these legal guidelines later.

Central to the concept of values is the issue of self-awareness, and it is important that we consider our own awareness of ourselves. Self-awareness includes recognition of our personality, our strengths and weaknesses, our likes and dislikes and how our lives have been shaped and influenced by our own experiences and the experiences of others. In order to check our own self-awareness, we need to reflect upon our own actions, thoughts and beliefs as well as seeking guidance and feedback from others.

Activity
It can often be challenging to consider our own prejudices or stereotypical views. Often, we may have our own ideas on how we can justify our thoughts and actions. It may be helpful to consider how others you know, such as close family or friends, express views you disagree with; you can then think about views which you have or present, which they may disagree with.

Jot down your thoughts and consider if there are any areas of your own belief system which you may need to be wary of in a social care context.

Some examples have been given in the table below to help you to start this process, but think carefully about any beliefs you have which may clash with the beliefs of others.

<table>
<thead>
<tr>
<th>Person: e.g. my mum thinks...</th>
<th>but I think...</th>
<th>others may see me as...</th>
</tr>
</thead>
<tbody>
<tr>
<td>My mum thinks that all abortions should be outlawed unless two doctors agree that continuing a pregnancy will result in the serious ill-health of the mother</td>
<td>That sometimes an abortion is someone’s only hope. If someone is young or has been raped, I think they may need help and counselling to sort out how they feel. Only under these circumstances, can an abortion be carried out – but only up to a point in pregnancy</td>
<td>Being overly cautious – it is a woman’s individual human right to decide what happens to her body, and her future. Without justification, abortion should be granted, without counsel to women who seek it.</td>
</tr>
<tr>
<td>Euthanasia should never be allowed – whether someone is old or ill, all human life is sacred</td>
<td>Euthanasia should be allowed, for anyone who considers it the only route out of a miserable physical assistance</td>
<td>Being too quick to make such a statement – can parents abort disabled foetuses or disabled people be encouraged to take their life because they may feel they are “useless”?</td>
</tr>
</tbody>
</table>

Prejudice leads to discriminatory practice.

Examples of different beliefs and views

Johari window

A useful tool to enable us to consider the complexities of human interaction and how we can develop self awareness is the Johari window. As the diagram below illustrates, this divides personal awareness into four different types: open, hidden, blind and unknown.

As you can see, there are clear elements which are ‘unknown’ areas as well as blind areas. While these may always exist, your aim is to minimise these in favour of the open/free elements, with the ‘hidden’ element becoming less well hidden through openness and self-awareness.

This model assumes that ongoing disclosure between two parties will lead to openness from both. In Social Care practice, in order to promote fulfilment and potential, it may be necessary to increase your self-awareness, but also to minimise the ‘blanks’ about others. It is not always service-appropriate or desirable to become overly familiar with people who use services; however, in different kinds of services the professional boundary should be drawn according to policies, ethos and level of engagement.
Anti-discriminatory practice

Ultimately, you should engage with people who use services in a professional manner, in a way appropriate to identified boundaries and in a way which promotes anti-discriminatory practice. It is central to your work that you should be seeking to reduce oppression, increase independence and be mindful about not perpetuating discrimination: indeed, challenging stereotypes, sexism, racism, disbabilism and other forms of discrimination are key areas which link directly to your value-base, power-base and your self-awareness.

Key terms

Oppression to keep down or make suffer – to oppress is to exert power over others negatively

While other subject areas like sociology and psychology detail significant related topics like discrimination, socialisation and oppression, it is important to remember that the effects of discrimination and oppression on groups and individuals are far reaching. Those who face discrimination tend to feel a sense of alienation and isolation, have lower self esteem and negative self image as well as lesser social expectations and life-chances. Being aware of your value base and conforming to the standards published goes some way to enabling staff and workers to ensure they are supported to carry out their duties with robust policies and procedures, training and development opportunities and organisational support to combat discrimination, dangerous or exploitative practice. The Codes are specific and clearly define acceptable standards of practice. The broad Codes include:

- protecting the rights and interests of people who use services and carers
- establishing and striving to maintain the trust and confidence of people who use services
- promoting the independence of people who use services and protecting them (as far as possible) from danger or harm
- respecting the rights of people who use services while seeking to ensure their behaviour does not harm themselves or others
- upholding public trust and confidence in social services
- being accountable for the quality of your work and maintaining and improving your knowledge and skills.

Consider this

These Codes may seem simple at a glance, but consider each in turn and identify how each might impact upon everyday practice. What might some of these Codes mean to workers within the social care field?

Codes of Practice

In relation to these care principles are rules, guidelines or conduct standards which demonstrate our values. The Scottish Social Services Council publishes guidelines relating to conduct expectations in their ‘Codes of Practice’ literature. These guidelines promote positive practice across the sector and also empower workers to ensure they are supported to carry out their duties with robust policies and procedures, training and development opportunities and organisational support to combat discrimination, dangerous or exploitative practice. The Codes are specific and clearly define acceptable standards of practice. The broad Codes include:

- protecting the rights and interests of people who use services and carers
- establishing and striving to maintain the trust and confidence of people who use services
- promoting the independence of people who use services and protecting them (as far as possible) from danger or harm
- respecting the rights of people who use services while seeking to ensure their behaviour does not harm themselves or others
- upholding public trust and confidence in social services
- being accountable for the quality of your work and maintaining and improving your knowledge and skills.

Key terms

Self esteem feeling of pride or competence in yourself (or lack of) – how a person feels about themselves

Case study

Codes of Practice in action

Read the scenarios suggested below, then identify the Codes of Practice which you feel have been affected by the practice suggested in each.

Scenario 1: James is supported in his own home every morning for three hours. He is assisted to take a bath in the morning, prepare a breakfast and make sandwiches for lunch, to deal with any correspondence requiring attention and to attend to basic household duties. He has two staff who support him on a rota basis – Margaret (his Key-worker) and Saad (his Support Worker). Yesterday Margaret was running late, she arrived an hour later than usual and did not phone ahead. She brought with her, a pack of pre-packed sandwiches for James’ lunch and said ‘that’ll save a bit of time’. Today she was due, as usual, to arrive at 8am, now it is almost 10am, and there is still no word from her. James has tried to phone Saad but he only gets through to an answering machine. James is becoming worried.

Scenario 2: Rohan has spent a good deal of time in institutional care for severe depression. However, he has now successfully moved from such care, to his own flat. Occasionally he becomes depressed, but his 24-hour staffing support package helps him through ‘his darker’ times and he has a good relationship with all of his staff. During times of depression, Rohan can become isolated and can display self-harming behaviour. He feels he requires stronger intervention from his staff team, but so far they just tell him it is ‘his choice’ and they will support him by leaving him alone to cut himself. Rohan feels ashamed of his actions and one member of staff has already told him he is ‘just an attention seeker’.

Core values

Core values which underpin conduct include dignity, privacy, choice, safety, confidentiality, individuality and access to services based upon individual need. While these suggestions are by no means exhaustive, they are areas which broadly relate to the principles discussed, and it would be hard to imagine a positive care environment which neglects one or more of these values. We shall briefly discuss some of the values mentioned and consider them in a practical context.
Safety
Safety is also an important area to consider – indeed, it touches upon a sense of protection and a sense of risk. We should all have the right to feel safe, both in ourselves and in our environment, and we should feel safe expressing ourselves as individuals and in our hopes for the future. Safety in the workplace then, can be about the ‘nuts and bolts’ of environments like plug and sockets being correctly wired, but can also be about our trust in others not to harm us physically or emotionally. It can be about people who use services feeling secure and recognised for their own qualities and may also be about staff ensuring people are not harmful to themselves (through support arrangements which may tackle difficult issues like addictions or abuse), or others.

Social justice
In addition to the values mentioned above, underpinning many of these is a sense of social justice. As a key theme in Social Care Theory, this relates to some of our earlier discussions in this chapter: a recognition that we inhabit, and indeed make up, a society, a structured collection of values and ethics, norms and values. Social justice is not so much about criminal justice (with which it should not be confused) but more about a sense of obligation in society to look after us all; it indicates that as a society we indeed make up, a society, a structured collection of values and ethics, norms and values. Social justice is not so much about criminal justice (with which it should not be confused) but more about a sense of obligation in society to look after us all; it indicates that as a society we

Choice
Another area we may not always think deeply about is the area of choice. Is choice simply about giving people what they wish for? In reality, in every service, is there an unlimited availability of options and choices? Are choices somehow tempered by other important issues like safety, risk and health? In our lives, are choices limited by circumstances or other factors beyond our control and, in care services, how might we ensure meaningful choices and empowerment remain central to the work we do with people who use services? On the other hand, what might a lack of choice mean to someone? Is it likely to cause some form of disengagement, even hopelessness if the lack of choice is persistent and the role of advocacy (self or otherwise) is central to combating lack of choices for individuals. It is also important that choice be explained to an individual receiving care – i.e. what is meant by that term in the context of their care and how empowerment will be central to the professional relationship; after all, choice without empowerment seems inconsistent and meaningless. Choices are about a whole range of issues and respect preferences and individuality at their core.

Conclusion
It may seem that this section of the social care theory chapter has actually posed more questions than it has offered answers – and that can only be a good thing. In changing times, it is important that the ability to question and remain flexible is central to your practice as you change and grow as a person. It is important that this flexibility is not boundless however, and standards of conduct are fixed to a degree through Codes of Practice. It is hoped that you can now reflect upon your own values with more certainty and can show a degree of self-awareness that will enhance your practice and your own learning throughout your studies and beyond.

The care planning process
Having considered values and also identified the Standards of Care expected through legislation, we will now consider a major vehicle for the delivery of a service, namely the Care Plan.

The care plan
Care Plans can go by many names – such as Personal Files, Development Plans, Person-Centred Guides – and they come in many forms: in pictures and photos, in graphics and text, in binders, in discreet diaries, in mammoth texts or in electronic files. Do not worry. In essence the Care Plan, by whatever name, and whatever format, is essentially a contract. It is hoped that this flexibility is not boundless however, and standards of conduct are fixed to a degree through Codes of Practice. It is hoped that you can now reflect upon your own values with more certainty and can show a degree of self-awareness that will enhance your practice and your own learning throughout your studies and beyond.

Key terms
Social justice the distribution of advantages and disadvantages in society

Consider this
Care Plans have certainly changed over the years. Having briefly summarised what they are above, take a few moments to consider what they are not. An example of what they are not might be – a diary of a person’s every move… Can you think of some other examples?

We have already considered (in the previous section of this chapter) some areas relating to values and self-awareness but to recap, values in practice can mean partnership arrangements where the client and the social carer/worker function together through problem-solving processes; the partnership is about increasing independence, self-determination and opportunities for choice. It is not about the worker reforming or changing people. Each person is unique with an inherent dignity that is to be respected; diversity and variety among individuals is to be welcomed and encouraged. This partnership is about establishing a link between individuals and their environment and not about moving an individual or the environment towards an ideal model.
Consider this

Years ago, institutions often catered for an individual's every need (whether to their benefit or detriment). For example, large institutions or asylums often had on-site laundries, kitchens, dentists, nurses, doctors, hairdressers and even power stations. What else can you find out about institutions in the past?

Activity

Think about the house or flat you have just left today – is it clean? Is it tidy? Is it well decorated/organised/spotless? Are your clothes ironed and neatly stored? If you have one, is your garden immaculate with pretty flower borders and mowed grass? The chances are it may not be – if you were to go home right now, to find someone filling out a care plan based on your accommodation, and what they find in it, what conclusions might they come to?

With these principles in mind, it is quite obvious that one of the main communication tools (i.e. the Care Plan) is an important and central method of carrying forward the actual momentum of support.

Care plan information

While different organisations have very different types of paperwork and recording procedures, a general overview of the type of information contained within a care plan might include the following:

- medical conditions, allergies and factual information on contact numbers, next of kin and such
- areas of daily living which the individual can expect support with
- the duration and frequency of that support
- any communication issues which are relevant and current
- any team members involved in support and their role (i.e. Keyworker)
- any other special needs relevant to the individual receiving care.

It is unlikely that any one organisation will deliver every aspect of care – so perhaps external agency information would be included in care plans; this might include the GP, pharmacist, community nurse and any informal support networks. Indeed, reviews of care plans can often involve a wide range of others – from relatives and friends, to professional advocates and specialist services.

How might care provision have changed now? What ‘mixed economy of care’ exists to ensure appropriate services?

Formal care often differs from informal care, in its contractual nature. By this, we mean that formal care relates to an agreement or contract stipulating the responsibilities of agencies, individuals and others in a support ‘package’. Informal care, although absolutely vital, is more likely to be non-contracted support carried out by partners, children and family members, or friends. Professional teams must be clear about exactly who is responsible for what and when. Contracts have to show accountability, cost and quality assurance and it is a very real fact that, as a service, the contractual element of providing care is very much a legal issue. Employers and their employees face very real consequences if their care is seen to be less than what has been agreed, either in terms of time or quality. While Care Plans serve a communicative function, you should be aware that they can be viewed as legal documents which are central to investigations or complaints, should the situation arise. Care Plans mean lots of things to different people, but whatever form the actual Plan takes, the general model of care Planning is given below.

The planning cycle

Rational planning is central to the Care Plan – so eliminating emotive language, discriminatory language or leading information is vital. A successful Care Plan needs to be structured, clear, organised and often methodical. Of course, feelings, intuition or opinion should not be excluded; but a good Care Plan should identify what is factual, what is conjecture and what is belief. It is often beneficial to seek information from a variety of sources, not least from the person who uses services themselves, in terms of content, style, colour or format and while an individual may be responsible for collating and presenting information, it is highly unlikely that only one individual’s opinion or perception should make up the bulk of the Plan’s content. In terms of the formality of Care Planning as a process, there are recognisable, identifiable stages to Care Planning.

Institutions in the past provided very different types of care.

Assessment

This involves gathering information about the person who uses services and assessing their needs in relation to that information; the assessment of needs should also be mindful of the organisation’s role in meeting those needs.
Consider this

Another way of thinking about the complexities of Care Planning is to consider these examples:

- an individual with a 24-hour support package may identify the need for daytime occupation – a college course for example – the Care organisation may not directly provide a college course, but may be able to facilitate and support the individual to access one
- another individual may receive two hours support a day to cover mealtimes – their needs available to use.

Activity

Needs can be broadly grouped into the SPECC range:
- S stands for Social
- P stands for Physical
- E stands for Emotional
- C stands for Cognitive and the final
- C stands for cultural.

Think of the needs (under each of the SPECC headings) after reading the case study below (please be aware there are other groupings of needs available to use).

Case study

Janet

Janet is a 40-year-old single mother of three children. She moved to Scotland from England three years ago, to escape an abusive relationship. Her three children are all at secondary school and there has been concern expressed from the school about their personal hygiene and general well-being. Janet is devoted to her children, but after a particularly violent incident with her past partner, she suffers mild memory loss. While her children support her as much as they can, Janet sometimes struggles to budget well, and can become confused by routine tasks; she has missed appointments and meetings with the school on two occasions. She has also come close to causing a fire in the home while cooking.

She lives in a small estate and has a 3-bedroomed house. The neighbourhood is quiet, but Janet doesn’t know the neighbours very well and has no relatives nearby.

Janet is a heavy smoker, but doesn’t suffer from any physical illnesses she is aware of. Janet is very frail, and obviously prioritises her children when it comes to spending money! She doesn’t have many clothes, and she is underweight, and doesn’t seem to have a balanced diet. She drinks lots of fizzy juice and relies upon quick microwave food for herself.

Janet hasn’t been in another relationship since she left her last partner, and has low self esteem and seems to lack confidence. Although there has been no contact from her ex-partner, she is anxious that he will find the family and also feels guilty that her children have had ‘so much to endure’.

Janet is not in employment and always wanted to learn more about beauty and alternative therapy. Her children are old enough to allow her some time to study at night classes but Janet feels unsure about how to proceed with her aspirations.

Understanding assessment

In the past, assessment has been more closely linked with a medical model of care and can seem to start from the premise that there is something ‘wrong’ which needs to be fixed. This is not necessarily the case; assessment can be far more than the traditional medical stance might imply – it is not about being judgemental about someone’s needs but about assessing a situation. People assess things differently, and have different perceptions, so it is always vital to enter into partnership with the client throughout the process; assessment is not about finding solutions or right answers. More mundanely, it might be about filling in forms and discussing the content of these forms or chasing basic information – it is always about communication and interaction and sometimes it can be surprising and revealing!

Consider this

Needs can often be confused with wants. We may not all be in agreement about what is a need. For example, a balanced diet may be a physical need, but should that be of a pleasant and varied nature? If we say it should, is it acceptable that we include champagne and truffles in our menu? Should we be providing or making provision for diets which offer someone the opportunity to eat fine cuisine in restaurants every night, or to buy basic produce at a local supermarket?

Bradshaw identified a way of looking at needs in his ‘Taxonomy’ – he identified the following kinds of needs:

- Normative need
- Felt need
- Expressed need
- Comparative need.

Normative need relates to the ‘norm’ of usual expectations in society at large – needs can be defined as those which relate to general standards. For example, a house which is damp, unheated and has an outside toilet may not be seen as adequate by ‘normal’ standards.
Felt need relates to an individual’s personal sense of need. If people feel they need something, that might one way of defining the need. ‘I need to make some new friends’ may be a valid identification of social needs.

Expressed need: people can often feel a need, which they don’t openly express. People may feel very vulnerable and lonely, but don’t admit to this. Equally, people may express that they need something but which is not the actual solution to the underlying need. An example of this would be ‘I need a cigarette to calm me down’ – actually having this need expressed does not address the underlying need to feel calmer.

Comparative need relates to needs being identified in the context of comparing situations – using the earlier example of acceptable housing standards, would poor housing in Britain be the same as housing standards in poverty-stricken regions of India or Africa?

In reality, social care works within a framework which relates to budgets and generally agreed standards of living – often linked to social structures such as benefits payments, public housing standards or educational opportunities and attainment.

It is likely that, at some point in your studies, you will be expected to show your understanding and awareness of how needs relate to practice through the tool of assessment and planning of Care.

Goal setting

This may involve a process of identifying minor steps in a bigger plan, or it may be deciding on broad targets for care and prioritising those targets. For many people who use services, support is not seen as a static intervention. Many organisations ultimately hope their services are reduced or redundant, as individual’s independence grows. With this in mind, there may be small steps taken at the goal-setting stage to identify and promote the independence and autonomy of the person who uses services or simply enhancing their circle of social opportunities or broadening their experiences.

Planning, the process by which agreed actions are written down, is central to the ‘working’ of the care plan itself. Goals should, therefore, be SMART (Specific, Measurable, Achievable, Relevant, Time-based – see below); the goals should be realistic, and discussed with the person who uses services and all the relevant professionals involved in a package of care.

Implementing care

Linked to the previous goals, the implementation stage identifies the nuts and bolts of support. This part of the process instructs and records how goals may be met and who/how delivery of support is achieved. In implementing care and in readiness for the next phase of evaluation ad review SMART can be applied. SMART goals are those which are:

- Specific
- Measurable
- Achievable
- Realistic
- Time-framed

Evaluation and review

As a point of reflection, this may be a chance to consider what has been achieved through the current Plan. At this review stage, the opinions of others may be sought in terms of changes to be made to the assessment of need at a given point in time – this then leads to a re-evaluation of the status quo and, typically, amendments to the Care Plan, as the cycle continues.

Negotiation is a central part of the planning process and views and opinions should always be sought – relatives, partners and people who use services may all hold a stake in this process.

Consider this

Earlier in the chapter we considered values. How might values influence the Care Plan process? Whose values maybe relevant and why?

Person-centred planning

In addition to the more general cycle of care planning already discussed, other specific planning tools have emerged in recent years; for example Person-centred Planning or Essential Lifestyle Planning. Innovative in its approach, certain methods used in Person-centred Planning have become embedded in general planning work; however, as a tool, there are several useful concepts which are worthy of particular recognition.

Key themes often associated with Person-centred Planning include the following.

Circles of Support

Developed in Canada, the UK first started to become aware of this in the mid-1980s. Simply put, a circle of support is a group of people who help another person achieve their desired outcomes or goals. This is not about being a paid member of staff or team, but about valuing an individual enough to ‘freely’ offer support. Such a relationship negates issues of power or authority and all parties can experience a great deal of satisfaction and achievement from being part of the circle.

Paths

Paths often focus upon an individual’s ultimate goal and work back from there – unlike more traditional methods of Care Planning, this allows the achievement to be the focus, so working back through potential barriers rather than moving from the ‘here’ to the ‘future’ and anticipating difficulties along the way.

Essential Lifestyle Plan

This is simply a version or tool of person-centred planning. Like more traditional Care Planning there are various stages of progress but a typical recording of an Essential Lifestyle Plan may include the following sections or processes:

- the administration section
- who owns the plan, when was it done, who added to the plan
- the person’s section.

This is an introduction to the person upon whom the plan is based, including ‘good things about me’ and positive things others see. This part usually identifies what is important to the person in terms of order i.e. most important, second in importance and third in importance to produce distinct listed information.

Person-centred planning has features which move away from more ‘traditional’ medical models of care, as summarised below (adapted from Person centred care planning, Miller and Gibb, 2007).

| Clinical labelling of people | Seeing the whole person |
| Professionals being in charge | Sharing power |
| Professionals inviting people in | Person choosing who attends meetings |
| Meeting in offices at times to suit service | Meeting in venues chosen by person who uses services |
| Meetings being ‘chaired’ by professionals | Facilitators co-ordinating meeting |
| Not asking what the person wants | Encouraging the person to dream |
| Writing notes of meeting | Drawing/graphics to illustrate points |
| Filing plans away | Giving the plan to the person |
| Professionals putting the plan into action | All team members having some responsibility for the plan and its implementation |

Person-centred planning has moved away from the medical model of care.

Activity

Consider your own life – can you map out the things and people that are important to you? Can you order them, to help you to identify your own ‘essential life plan’?

The support section

This details what others need to know in order to provide the focus individual with a healthy and safe experience, to work out what they want and what is important to them. Various sections can be added here, such as communication.
information or important medical details. Where there is a conflict between the focus individual and the planner, health and safety must prevail and details should be sensitively included in the plan, acknowledging the focus individual’s reticence or discomfort.

The action section
Issues to work out are included here – perhaps a list of questions might be included which still have to be answered. Also in this section, it is noted who is doing what to maintain the individual’s health, safety and chosen lifestyle. What needs to change is noted, as well as what does not need to change.

The main focus of this person centred approach is to consider someone’s needs in terms of their perspective and not from a service or specialist perspective alone.

Systems approach
Another form of care planning is known as the Systems Approach – this has come from work conducted by Pincus and Minahan in 1973. As a model for social work, this approach is useful to examine in a wider context and as an approach to identifying a range of needs and services designed to build-up a package of care. It recognises that people in society depend upon systems generally and that social work must therefore, recognise and evaluate these systems in the context of meeting needs.

Pincus and Minahan argue that there are three kinds of systems which may help people:

- informal or natural systems such as friends, family, neighbours, peers
- formal systems such as community groups or trade unions, clubs or community services/centres
- societal systems such as schools, hospitals, benefit agencies and so on.

It is also important to recognise that such systems can sometimes hinder people’s development and realisation of potential. Pro-actively, as care workers, being aware of the impact of such systems on an individual’s need helps the planning of care to be recognised as complex and not only about the individual in the ‘here and now’.

The work of Pincus and Minahan therefore progresses to recognise that individuals experiencing problems may not be able to utilise help through these systems for a range of reasons:

- perhaps the system does not exist for them
- the system may not have sufficient resources
- the system may be inappropriate
- individuals may not know about or wish to use a system
- different systems may conflict with each other/the individual.

Case study
Sharon
Sharon is an 18-year-old lone parent. She lives in a council house which is very damp, with her two sons aged three months and 2 years. Her mother is an intravenous drug user and has led a chaotic lifestyle for several years. Sharon herself has experienced social work intervention as she grew up, spending extended spells of her childhood in various foster homes. Sharon keeps in regular contact with her mother, who lives a few streets away, but is reluctant to allow her children access to their grandmother. Sharon’s father has never been a part of her life and she does not know much about him.

The estate where Sharon lives has a ‘bad’ reputation – there is a high volume of lone parents living in the area and crime is increasingly a problem in the neighbourhood. Sharon is not in employment and has no contact with the father of her children; nor does she desire contact at this point. Her youngest child has been in and out of hospital with chest infections and she is receiving support from her local community centre, which welcomes her and her children to the crèche held twice a week. Sharon is keen to consider her future and would like to take up a college place next year when her youngest child is older – she hopes to become a hairdresser at some point. Sharon has recently been diagnosed with depression and is keen to ‘take stock’ of her life.

1. Consider this case study and try to identify the systems contained within the scenario.
2. Which are beneficial to the individual?
3. Which systems may hinder the individual?

The Systems Approach is keen to fully assess an individual, family or group in the context of their environment and community. It recognises that systemic influences are direct and indirect – for example, someone’s location, age, gender and background can and does influence where they are now and where they see themselves. The current systems may be functioning in harmony or at odds, or simply not functioning at all; and in order to assess an individual we should consider issues such as their self-image, attitudes, values and beliefs about themselves and their current position. We should then consider looking at the family – is there a system here and, if so, is it contributing well or not so well? What social networks are around at present and how do these influence the individual and what environmental systems are available or apparent?

The work is complex and can be time-consuming, but it certainly encourages a holistic approach to care planning. Four further systems are then identified to explain the working relationships around delivery of solutions to meet need(s):

- change agent – professionals (for example a social worker) who can help a client bring about change
- client system – individuals, groups or families and communities who seek support
- target system – people who the change agent is trying to target in order to meet aims (Client and Target Systems may or may not be the same)
- action system – people with whom the change agent may work to achieve its aim. (Again, the client, target and action systems may or may not be the same.)

Consider this
All of the language used here, about systems and agents and so on, may seem confusing. Identify the systems/agent in the scenario below to illustrate the theory.

David is six years old and is on the Child Protection Register. He has been referred to Social services from both his GP and his school. His father is known to Probation and Addiction Services locally and Social Workers are keen that the family take up parenting classes and a respite ‘babysitting’ service. David’s attendance at school has recently become erratic; he has been to the local Accident and Emergency Department on four separate occasions in the last six months – presenting with a variety of cuts and on two occasions broken bones. He is generally pale and quite withdrawn and, developmentally, his language skills seem to be below the expectations for a child of his age.

Use the grid below to guide you.

| Change agent |
| Client system |
| Target system |
| Action system |

The Systems approach may use four further systems as shown.

As stated in Social Work Practice – an Introduction by Victoria Coulshed and Joan Orme ‘Assessment is an ongoing process, in which the client participates, the purpose of which is to understand people in relation to their environment...’
Anti-discriminatory practice

Positive care planning, following a variety of methods or models, should reflect the principles of choice, empowerment and risk taking. The design and development of a care plan should also promote anti-discriminatory practice and promote fulfilment and potential.

How might anti-discriminatory practice evidence itself in a Care Plan?

As a record of work, to a degree, a Care Plan is a powerful document. It contains important and private information and builds a picture of someone's needs and support. It reflects practice and agreements of work. By picking up such a document, an Inspector or Commissioner is able to glean a 'flavour' of a service.

Activity

Imagine you are a member of the Care Commission and you are asked to visit a local Care Home to report upon standards of service. What kind of things might you look out for in a Care Plan? What types of language do you expect to see?

Consider the following list of words and phrases – circle those which you think suggest positive practice and then consider those which may give you cause for concern.

<table>
<thead>
<tr>
<th>Need</th>
<th>Bored</th>
<th>Same as usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opportunity</td>
<td>Empowered</td>
<td>Made an enquiry</td>
</tr>
<tr>
<td>Given choices</td>
<td>Considered</td>
<td>Conflict</td>
</tr>
<tr>
<td>Disagreed</td>
<td>Did not allow</td>
<td>Attention seeking</td>
</tr>
<tr>
<td>Hoped</td>
<td>Gave out money</td>
<td>I listened to him</td>
</tr>
<tr>
<td>Phoned</td>
<td>Will ask</td>
<td>Told</td>
</tr>
<tr>
<td>Same everyday</td>
<td>Going out</td>
<td>Ate all food</td>
</tr>
<tr>
<td>As usual</td>
<td>Invited friends</td>
<td>shouted</td>
</tr>
<tr>
<td>Happy</td>
<td>Complained</td>
<td>Listened</td>
</tr>
<tr>
<td>Referred</td>
<td>Ended</td>
<td>reviewed</td>
</tr>
</tbody>
</table>

Identify the positive and negative language.

A discriminatory workforce, or individual, is likely to use (however inadvertently) discriminatory language. If a care plan is written in a way which suggests poor practice, concerns over actual practice may be raised.

As we have touched upon earlier, values are implicit in care plans – some of those values include:

- empowerment
- right to self-determination
- promoting independence
- protection from harm and abuse
- social justice.

People who use services can be vulnerable for a variety of reasons, and the very fact that they receive care may indicate that vulnerability, however temporary. Promoting positive care planning ultimately promotes anti-discriminatory practice. It is essential, throughout any care plan, that the focus remains with the person who uses services.

Miller and Gibb (2007) identify ten points of good practice in assessment and care planning. These are:

1. A firm value base underpins respect and dignity of every individual and promotion of choice, rights, empowerment and protection.
2. The person who uses services should be at the centre of the process – the plan is with, and not of, the person who uses services. The plan should be an agreement and highlight areas of disagreement sensitively.
3. Good communication is needed, including listening
4. The plan should be ongoing and never be regarded as finished and complete.
5. It is important to be needs led and not service led. 'needs led' means focusing upon the 'whole' examination of need and how they relate; 'service led' means the service leading the identified needs. An example of this would be someone who is depressed requires counselling, but a service led agreement may not prioritise the counselling because resources are few and far between
6. Accurate, up-to-date information is needed; if something is opinion, it should be identified as such.
7. Labelling, stereotyping or scapegoating a person is not acceptable – if an individual's behaviour is described as 'attention seeking' it can lead to a negative image of that behaviour.
8. The care plan should be specific about responsibilities (who does what) and outline rights.
9. It should have built-in evaluation processes and time-frames.
10. It is important to emphasise that there is no one 'right' care plan; there are no absolutes and care planning can be as individual as the person upon whom it focuses.

Relevant legislation and policy

While individual employers will have their own particular policies and procedures, there are several items of legislation that are relevant to the care planning process and which play a role in promoting positive care.

This legislation includes the following:

- Regulation of Care (Scotland) Act 2001
- Data Protection Act 1998
- NHS and Community Care Act 1990
- Mental Health Care and Treatment (Scotland) Act 2003
- Adults with Incapacity Act (Scotland) 2000
- Community Care and Health (Scotland) Act 2002.

While Social Policy as a subject covers many of these Acts in more detail, some will be mentioned here in the context of anti-discriminatory and positive practice. Not all have been given in detail in this chapter.

Regulation of Care (Scotland) Act 2001

This piece of legislation is responsible for some major changes in Scotland's care provision. The Act sets up two important bodies: the Care Commission (The Scottish Commission for the Regulation of Care) and the Scottish Social Services Council.

The Commission, broadly, is responsible for the inspection and registration of care services and identifies those services which then adhere to the National Care Standards – if a service fails to meet, or fails to comply with standards, they can lose their registration or face penalties under this Law. The Care Commission also has the power and duty to inspect and regulate services and Inspectors have the power to insist on changes to a service if standards are not met. Ultimately, should a service fail to comply with recommendations, or if the quality of that service is found to be substandard, the service can be closed down. Care standards are based upon six principles (as discussed earlier in the chapter) and these are:

- dignity
- privacy
- choice
- safety
- realising potential
- equality and diversity.

It is vital that care plans relate to and echo these fundamental standards and principles.

Data Protection Act 1998

This Act relates to the lawful collection of personal information. Care plans often contain information of a highly personal and confidential nature. Personal data includes factual information like date of birth, telephone number and bank details and this Act relates to information stored electronically and manually. All data held on a person has to be up to date and accurate, and it must be kept safely to prevent loss, damage or unauthorised access or use of the information. A copy of information can be requested via Subject Access Request, but care plans, usually, should hold information the person who uses services is aware of. Individuals, under the Act, have the right to:

- know if you, or someone else, is processing information about them
- know what that information is and why it is being processed and who has access to the information
- receive a copy of personal information about them
- know about the sources of the information.
Methods and models of social care practice

In this section, we will consider some of the methods of intervention available to social care workers. We will also discover some of the skills required for working with others and consider some interventions or useful skills available in challenging situations. The theory of intervention can seem to be very separate, and they are seen as distinct theories academically; however, in practice, you are likely to soon recognise that several interventions can be used; although perhaps not in their entirety.

Methods of intervention

On pages xxx and xxx, we touched upon Systems theory and Person centred planning – these are not only useful concepts linked to care planning, but can be viewed as models which workers can adopt when supporting a person who uses services. There is a framework of an approach, a way of looking at a situation, contained within these theories. In addition to models of working with others, there are also methods which can be adopted. For example, a basic model of care planning may be to Assess, Intervene and Review – this being a very simple framework upon which to build complex arrangements for agreeing support.

Just as this is an example of a framework for care planning, other theoretical frameworks exist which attempt to structure and identify specific areas of practice. While these models do not claim to represent social work solutions in a ‘parcel’, they help us to consider and understand some methods of dealing with others/situations. Equally true, is the fact that no one theory, method or model is likely to contain a solution to an individual’s support needs – but they allow us to be aware of a range of possible interventions and practice which may be useful. No one intervention is likely to be a perfect fit for supporting others, but bits of some may be useful and, at least, help us to consider solutions more broadly. While the different approaches may be called something distinct, elements of each are often used in practice.

In considering potential assessments in your HNC, it is likely that you will be expected to identify and describe a theoretical framework, and apply that framework to practice with an evaluation. Some of the approaches to social work we will consider include:

- psychodynamics
- psychosocial casework
- behavioural social work.

These are not specifically models of intervention in themselves, but rather large backdrops/ theoretical influences on approaching social work/care practice. Much has been written on such theories, and here we will just briefly outline the main points of each.

Psychodynamics

You may come across this approach as you study psychology as part of your HNC. Broadly speaking, psychodynamics is a school of thought attributed, most commonly, to Sigmund Freud. Just as Freud’s personality model reflects the conflict between the Id and the Superego, with the regulatory Ego caught in the middle, so society and the individual are seen as conflicting extremes. The individual in crisis is at the centre.
### Activity

In the table below are some examples of conflicts which may precipitate social care or social work involvement – how might social workers/carers intervene?

<table>
<thead>
<tr>
<th>Situation</th>
<th>Suggested intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>A young child is not encouraged to attend school so therefore misses most classes.</td>
<td></td>
</tr>
<tr>
<td>A father expresses sexual interest in his children, by using inappropriate language around and about them – this may not involve direct action at this point, but does suggest unusual boundaries in relationships.</td>
<td></td>
</tr>
<tr>
<td>An elderly man, suffering from dementia, wanders the streets in his pyjamas late at night</td>
<td></td>
</tr>
<tr>
<td>A 13-year-old girl is addicted to alcohol and is sexually active – already she has a sexually transmitted infection and has had a miscarriage.</td>
<td></td>
</tr>
<tr>
<td>After an accident, a 20-year-old man is unable to control his body below his neck – he cannot move or eat independently and his ‘old’ life seems unattainable.</td>
<td></td>
</tr>
<tr>
<td>A young, single father struggles to care for his two children. He loves them dearly, but the house is a mess; bills don’t get paid and he cannot cope with all of the demands placed upon him.</td>
<td></td>
</tr>
</tbody>
</table>

---

### Case study

#### An example of conflict

Aidan is seven years old and has been diagnosed with ADHD. He sometimes becomes very agitated in social situations and has been displaying inappropriate behaviour towards other children – hitting out at them or shouting at them. He finds sleeping difficult, so is often tired and grumpy. At other times, he is full of energy and finds it hard to concentrate upon school work in class situations. He can display socially inappropriate behaviour, by snatching food at snack times, eating very quickly and then trying to take other’s food. Aidan is quite a big boy, so he is physically intimidating other students by using threatening gestures at times. To date he has been included in mainstream school classes, but his social worker has been asked to attend a school meeting to address his needs and identify additional support required, to ensure minimal disruption to the school, classmates and to encourage his success at school.

1. What behaviour may Aidan display that will contradict the ‘normal’ rules of school?
2. How might the school be able to offer a more appropriate environment?
3. How might Aidan’s social worker work with him to encourage more useful behaviour and to develop a stronger sense of self?

Intervention is seen in terms of strengthening the Ego in such circumstances to enable the individual to deal with their social and personal situation in a healthy way. When we consider ego strengths, we do not do so in a fixed manner – if someone’s ego can deal with reality, their ability to present as mature, rational, clear and balanced individuals is clear. Conversely, if defence mechanisms are used and the ego is weakened, an individual may be seen to be confused, in denial, needy or impulsive. This approach helps the individual to react to their situation in a positive way or a more useful way. Often, a social carer cannot make an environmental problem just disappear – the individual receiving care has to accept their situation and deal with it differently or think about it differently. If this is achieved then the stress and difficulties faced by the individual might make their health, life and interactions easier and more appropriate.

#### Psychosocial casework

A step beyond psychodynamics, this approach is linked to the work and writing of Erikson. As the title suggests, psycho (of the mind) meets social (environment) in this approach. It recognises that the individual’s psychology may have to alter but goes a little further – recognising the importance of the social structures around in setting the scene for behaviour. Social work practice need not only look at an individual’s Id and personality, but also at the wider social scene. Altering the social and family situations around a person who uses services may have just as much impact as making mental adjustments. Also of importance in this approach are theories of psychosexual development. Psychosocial casework often aims to identify at what stage a person who uses services may be ‘caught in’, which can help to explain current behaviours, attitudes or difficulties. In this context, an individual’s current presentation and difficulties may be linked to Freud or Erikson’s stages of development.

#### Case study

**A psychosocial approach to Jim**

Jim is in his early 40s and is a single dad to Cath, aged nine. He was happily married and employed two years ago, living in a beautiful village near the coast. He was happy and content, and looking forward to watching his child grow up. One day, he returned from work to find his wife had left him for another man. He lost his job and his house, as the family home had to be sold, and he was left ‘homeless’. His daughter begged to stay with him, and this was agreed. However, the divorce arrangements are still not finalised and this is a source of great stress. Jim also has been forced to move into a Glasgow city-centre, high-rise scheme. He is on floor 34 of a block of flats and his neighbours seem to be mainly younger mums. The
Loose dogs also roam the corridors, leaving their mess behind them. Whereas his daughter used to attend a small rural school, she now walks to the nearby primary through dirty streets, where she has already been asked if she wants any drugs. Jim is unable to work as he has to look after his daughter and his wife is using this as evidence that he is incapable of supporting her. Jim has no savings and is receiving basic benefits. He gave all of his belongings, household goods and savings to his wife when they separated. He still loves his wife and is very hurt by her actions and by her growing animosity towards him, and more recently, his daughter (who visits during school holidays).

Jim's mental health is faltering; he has panic attacks and recently visited his GP where he was immediately given some anti-depressants and told to get a repeat prescription. Jim has no friends or family nearby, and devotes all of his energy to his child.

1. What psychological factors may be affecting Jim at this time? Think about the losses he has faced and changes he has encountered – how may his self-esteem be affected?

2. What social factors are affecting him at present? Think about his environment and his concerns over his daughter and try to consider what may be sources of stress and de-motivation for him.

3. What could a worker bring to the situation using the psychodynamic approach?

### Behavioural social work

Behavioural practice recognises, in the context of social care, that thoughts, attitudes and feelings are a result of a range of past and present influences; in practical terms, the use of behavioural social work may not be entirely neat when compared to Skinner's initial behaviourist theories, but this approach does allow us to contextualise an individual's present condition or situation.

Behavioural social work, very loosely, recognises that we respond and behave in certain ways because of a range of factors. These factors include: trial-and-error, instinctual responses, learned responses and thinking about how to respond as individuals (cognitive learning). Useful, this approach can be directed towards assisting a person who uses services with a specific problem or particular issue. For example, this type of approach gives rise to some commonly used social care practices like reward schemes or the ABC approach. The ABC approach recognises that we may actually encourage or invite certain behaviours without realising it and it forces us to look at a situation in a more analytical way.

### Case study: Using ABC

Every Tuesday morning Marie encourages John, her person who uses services, to have a bath. The rest of the week, he chooses to shower, but his care plan has been amended to include a bath to allow him to receive treatment for his dry skin condition. John requires some physical support to get in and out of the bath. No hoist is used, but Marie gently supports him as he steps in and out.

Other staff members have also supported John to have a bath, and there have been no problems. However, when Marie does it, John tries to lash out at her and grabs at her. This is potentially a problem given the confines of the bathroom, the health and safety implications in terms of slip and trip hazards, and is also leading Marie to lose self-confidence in her ability to work with John. Usually they get on with no problems whatsoever, and John speaks highly of Marie as a worker.

The sequence of events leading to this unusual display of behaviour is examined.

By considering the broad approach you may take towards a person who uses services, or a particular situation, you can focus your support in different ways. It is also worth considering that not all clients or people who use services can express complex communication or language, which can mean that accessing details of their psychological state or history may be very difficult or impossible.

### Crisis intervention

Another social work approach is crisis intervention. Crisis intervention recognises, within it, the usefulness of some types of interaction – like life-space work or gentle teaching, and these are explained further in this section. While these are not only useful for crisis intervention they are a way of assisting individuals through a period of upset or change.

While we have considered broad approaches to tackling someone's needs, some situations (rather than some people) lend themselves to specific types of work. Crisis intervention should not be confused with dealing with an emergency: an emergency situation may well be life-threatening and short-lived. A crisis is something a bit different. Gerald Caplan defined crisis as an upset in a 'steady state' or loss of equilibrium. He recognised a crisis as a response to a serious stressful event.

There are different kinds of crisis, which we may all face at different points in our life. These types of crisis include:

- Developmental – where transitions between different stages of life create stress. Dying might be an example here. Another might be moving from childhood to adulthood.
- Situational or accidental – specific life events or situations create a crisis for an individual like job loss or loss through divorce.
- Complex – These examples are less likely to be seen as the normal ‘everyday experiences’ and might include becoming a victim of assault or other crime, severe mental illness, or physical illness, or post-traumatic stress syndrome.
Crisis can be seen as a perceived threat, a loss or a challenge. It is important to recognise that the crises refer not only to actual threats, but to imagined ones too – the threat can be physical or psychological; loss might be about losing health, a limb or others but can also be about losing direction or feeling isolated and empty.

Looked at positively, this approach recognises that a crisis is a new opportunity to learn and progress; it can be a time to try new methods of solving problems or to discover new strengths.

Case study
Siraq

Siraq was a healthy young man, who enjoyed an active social life. He was looking forward to university when he was involved in a motorbike accident. He was hospitalised immediately after the crash, was in a coma for some time, and awoke to discover he had lost his right leg below the knee. His rehabilitation was a slow and painful one, and while his family were supportive, he began to lose touch with friends and his girlfriend during his time in hospital. He missed his final exams for university, and the whole experience had left him feeling isolated, depressed and hopeless. He also suffered some scarring to his face and body, which he was assured, would fade in time. He was allowed to go home after several weeks of therapy, agreeing to continue physiotherapy for the coming months. However, Siraq now feels anxious about returning to university when he was involved in a motorbike accident.

2. How might Siraq be offered support?

Case study
Katy

Katy is a worker in a busy day centre for adults with learning disabilities; she works two days a week, between 9.30 and 5pm. She greets people who use services at the door of the service before organising the groups and activities for the day. Usually, Katy will work with people who use services in the kitchen area, baking and encouraging food hygiene skills.

Case study
Daniel

Daniel works in a nursing home for elderly residents. For an hour each afternoon, the residents are encouraged to use the common sitting room to get together, chat, play games or watch television. During this time, Daniel often organizes a quiz to stimulate the residents. Two particular residents, Charles and May, do not seem to get along very well. During quiz times, Daniel has noticed that May shouts out answers if Charles has been asked to answer. Charles finds this very frustrating and has responded by shouting and swearing at May. Recently, he has even refused to take part because of ‘that woman!’ The care team have thought about ways to help this situation and another staff member has agreed to sit alongside May to assist with her quiz answers. When it becomes apparent that she is about to interrupt Charles, the worker intervenes and gently reminds May to ‘keep her answers to herself’ until the results are put in. By redirecting May from shouting out, May has been persuaded not to give out her answers, and has even been rewarded by coming first in the quiz on two occasions. Charles feels he has an opportunity to respond and interact independently, and the tension seems to have passed, for now.

1. How is gentle teaching being used here?

2. What may be the experience of crisis for the people in this scenario?

Life-space work

Life-space work is specifically about using a crisis to gain new opportunities. By supporting someone in a crisis, the worker recognizes (and helps the person who uses services to recognize) that growth, insight and change are all positive elements of their situation. Interviews or meetings can be set up to explore the situation, reflecting on what happened and acknowledging the individual’s emotional pain or confusion. By discussing feelings early on in the process, it is hoped that there is more clarity of thought in later discussion, where some solutions can be found. Midway through the process, there can be more discussion on what the real areas of change need to be; the worker can encourage the individual to identify the most urgent problems which seem to block progress in the ‘here and now’. If there is missing information about past events, it is fine to revisit them here, but hopefully the Intervention is not about total reflection or counselling, but about ultimately moving forward and progressing while acknowledging, while not dwelling upon, emotional issues. By working together, the social worker acts as a kind of role model in attempting to solve problems; encouraging change in thinking, feeling and action.

Gentle teaching

Gentle teaching may also be used to encourage someone in crisis. This approach is often used where an individual is unable to use complex language to express themselves as they might, or where there are poor opportunities to reward the individual with praise or insight. It may be necessary to use several tools of intervention, in a planned and agreed way. Over a short period of time, we may use ignoring/interrupting, redirecting and rewarding as tools of communication and assistance. Indeed, when we are faced with behaviour we find difficult or challenging to manage, some of these techniques are useful.

Some examples of crisis intervention and the associated practice of gentle teaching or life space work may be found in the case studies which follow.
Task-centred work

Another model of intervention is Task-centred work. This model realises that open-ended work may be less effective than specific, small-step approaches to tackling issues for a person who uses services. In 1969, research conducted by Reid and Shyne set up two systems of intervention in a voluntary child welfare agency in America. Two contrasting care options were offered; one being the more traditional open-ended approach lasting around 18 months, the other being a series of 8 interviews in Planned Short-Term Treatment. Upon evaluating the services offered, it was found that those on the short, structured route improved more than those on the more traditional route! Analysis of the results gave several potential reasons for these findings – including a lack of confidence in clients who had enduring intervention, perhaps a degree of learned helplessness becoming apparent, or evolving dependency upon services. Researchers in the UK began to look into task-centred work during the 1970s and 1980s which gave rise to the implementation and development of Task-centred work in the UK.

Task-centred work deals with eight main areas which are:
- interpersonal conflict
- dissatisfaction with social relations
- difficulties in role performance
- problems with formal organisations
- problems of social transition
- behavioural problems
- reactive emotional distress
- inadequate resources.

Consider this

Consider the headings above, can you identify an example for each?

For example, problems with formal organisations may mean children or parents who are in conflict with schools.

Furthermore there are distinct phases and steps to use when helping people who use services to achieve their goals:
- problem exploration
- agreement
- formulation of an objective
- achieving the Task(s)
- termination.

The emphasis of this model is to allow the client to choose the areas or tasks most appropriate to their situation. Solving these concerns focuses on their input and achieving, over agreed timelines, what small steps are necessary. The worker and the client jointly visit the priorities identified by the individual, on-going assessment recognises the completion of these small-scale tasks until the ‘whole’ has been resolved.

Case study

Jock

Jock lives in his own tenancy and is visited by his support team three times a day to get support with cooking and household chores. Jock is a lively character who has spent most of his life in hospital, but he now enjoys an active social life and is well known in the community. He has a great sense of humour, has an ‘eye for the ladies’ and goes fishing with a neighbour once a month. He also goes to the bookies every Saturday for a one pound bet.

He can neglect to keep his flat tidy, and has little experience of living on his own. Before being placed in hospital, Jock lived with his mother who did all of the housework and cooking. While in hospital, little was done to encourage his independent living skills and this is now a major area of support for him. At teatime, staff support Jock to assist with food preparation and to do any dishes from the day. Jock really does not appreciate having to do the dishes, and not only hides dirty cups and plates in the cupboard under the sink, but can become quite outspoken when prompted to either wash the dishes or dry them and put them away. After tea, staff have agreed that he will share the responsibility of cleaning up plates and utensils – one party will wash, the other will dry.

More recently, when one of his support staff asked him what he preferred to do, he stormed out of the house, saying he was ‘off to the pub’. At his evening visit, the staff member agreed that they would share the washing up; if Jock did 10 minutes of supervised cleaning, the staff would finish it off, leaving him only the washing machine to switch on after the dishes. The Care Plan reflects this new approach with a view to reducing the staff intervention time, on dishes, by two minutes every month. Staff have also agreed that the racing results be put on the radio at this time, to redirect attention from the chores alone. If this is not available on any given day, then Jock’s favourite music will be played while doing the dishes. So far, Jock seems happier with this arrangement.
Another important approach to supporting individuals, families or groups is counselling. While more depth will be given to the topic of counselling in the Interpersonal Skills chapter (page xxx) it is worth mentioning here as a type of support.

The term counselling is frequently used today and has many different meanings and connotations. In different settings, counselling means different things; for example in education, it is often linked to guidance or helping someone to find a course or a job. In medical settings, or in the military, to be ‘counselled’ may mean you have been told what to do. Debt counselling is a term often used to describe advice services which help people to manage their finances and budget accordingly. Counselling in some services might be about advice or information. Overall, counselling usually links itself to some form of helpful activity or discussion. The British Association for Counselling (1991) considers ‘...the task of counselling is to give the client an opportunity to explore, discover and clarify ways of living more resourcefully and towards greater well being.’

Counselling skills

The task of counselling can help another person to explore thoughts and feelings to reach a clearer understanding or make appropriate decisions and take appropriate action. Whatever the outcome of counselling, it is important to recognise the role of counselling – as a set of skills enabling practice. An effective helper will demonstrate a set of values and skills which are beneficial to communication, which might include:

- active listening
- patience
- positive regard
- confidentiality
- congruence
- acceptance.

While counselling in its purest form goes beyond advice giving, guidance and befriending, it is important that boundaries are recognised when it is undertaken. Counselling requires that the person who uses services should feel empowered, should have a sense of self awareness and understanding and also that the process should be about gains which are recognisable and enduring.

Rogers is an important figure in the approach and use of counselling. Rogers devised a person-centred approach model which recognises that individuals are responsible for themselves and will grow and develop as they work through obstacles – as they are the true experts on themselves.

Rogers identified four main qualities which are needed by workers in the counselling process. These are:

- Empathy – ensuring the client feels secure, understood and accepted by understanding the client’s viewpoint.
- Genuineness – being open and trustworthy, not playing a role in counselling.
- Non-judgemental acceptance – suspending criticisms and reactions to views expressed which may conflict with a worker’s own views and beliefs.
- Warmth – non-threatening and welcoming experience where an atmosphere of trust can develop.

In addition to work by Rogers, Egan also contributed to the understanding of counselling through his Three Stage Model of Counselling. The three stages are represented below.
Whatever different models you may use, it is important that the counselling skills are identified through reflection on practice and self-evaluation.

**Activity**

Think about counselling and some of the skills we have mentioned. Try to identify any of your own strengths and weaknesses using the following list of questions as a prompt.

Are you able to:

- control your own emotions in difficult situations?
- relax – control a tremor in your voice or have awareness of breathing patterns?
- listen to what someone is saying without appearing bored or pre-occupied?
- reflect back to someone what they have just said without feeling uncomfortable?
- listen to someone else’s problems without wanting to share your own?
- let someone finish what they are saying without interrupting or fidgeting?
- contemplate a conversation and analyse its content?
- organise goal setting and time keeping?
- accept people’s desire to talk about a topic you are bored with or have little interest in?
- accept people at face value without making judgements?

Simply considering this brief activity may already alert you to some of the skills required in counselling situations – it isn’t just about talking!

**Advocacy**

Closely linked to counselling, and enforced more and more through legislation, is the use of advocacy. Whereas counselling requires the person who uses services to undertake a series of complex communications with a worker, advocacy is about standing up for and talking on behalf of another. Advocacy enables an individual, for a variety of reasons, to be represented in meetings, care plan reviews or when dealing with agencies. An advocate is someone who communicates with a person who uses services and/or their families and friends to represent that individual or ensure their rights are upheld. This may require a degree of interpretation, depending upon the skills and abilities of the person who uses services, and may indeed bring the worker into conflict with others; but it is increasingly recognised as important in safeguarding individual rights.

**Conclusion**

We have considered a range of interventions useful to the social care context, and there are many additional sources of information available to you. Hopefully you have gained a basic insight into some of the forms of intervention, which will allow you to pursue specific models and methods appropriate to your client group and course demands. You may also, through work placements, be given the opportunity to take part in contemporary training in marketed and recognised intervention strategies. Examples of these may include CALM, TCI and SCIPrUK training. These opportunities will allow you further insight into the theories covered here and, in some instances, practical interventions used in specialised settings. Further details on individual psychological theories can be found in the Psychology chapter of this book; and there are more details concerning counselling and interpersonal skills in the Interpersonal Skills chapter. Remember, it is likely that you will be expected to demonstrate a theoretical knowledge of interventions and methods, as well as applying them in your placement, as part of your HNC assessment programme.

**Effective team working**

The final area of study for Social Care Theory is that of teamwork. In context, this unit has covered important areas like values, Codes of Practice, Care Planning and Methods of Intervention. It is, therefore, important that the final area of learning is in relation to teams.

**What is a team?**

Teams are certainly talked about a lot in class work and in practice – but what do you think being a team is about? Often in social care, people may not work in an obvious team setting; workers may work one to one with a client for the majority of their time, or carry quite a distinct and seemingly individual caseload. Even if you don’t work in a traditional team; that is, in a group situation working with others at the same time, the relevance of teams cannot be disputed.

On one level there is the team created by an organisation’s identity and structure, but there is also the team element in working alongside, and with, other agencies, as well as more obvious team work side-to-side with people in similar posts to you. We will look more closely at all of these factors throughout this section and also consider some of the many theories relevant to analysing and understanding teams.

Teams, therefore, rely upon the group process to problem solve, communicate and deliver services; but does that mean they are always affective?

**Consider this**

Think about teams you may have been part of; this may include work teams or other kinds of teams like clubs, or sports teams. Does working together always prove to be effective? Is working as a group quite simple and easy? What can go wrong in a team situation?

You have probably thought about all sorts of examples for this exercise. Certainly, teams are useful at achieving a great deal, but they can go through various periods of greater or lesser effectiveness. Woodcock (1979) identified some characteristics of effective teams, some of which are given below:

- appropriate leadership
- clear roles
- commitment to the team
- well-organised team procedures
- positive relationships
- time spent on developing individuals.

Also the organisation employing workers might be a large one, covering a lot of services in a variety of places. You can see that there are likely to be a range of factors influencing any team and contributing to that team’s identity and role.

To generalise, a team can be seen as a group of individuals sharing a common goal or purpose.

Teams are usually characterised by:<br>
- individuals sharing goals<br>- a requirement for working, not independently, but interdependently (relying on one another to an extent)<br>- a shared commitment to working on group activities<br>- accountability to each other and/or management. </br>

Teams, therefore, rely upon the group process to problem solve, communicate and deliver services; but does that mean that they are always affective?
Activity
From the brief list above, consider how each of the effective team characteristics could be achieved, and how they may be difficult to achieve. You can use the grid below to start you off, but try to add some more examples of your own.

<table>
<thead>
<tr>
<th>Woodcock's characteristic</th>
<th>Working well</th>
<th>Working not so well</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate leadership</td>
<td>Clear roles within team and clear leadership roles. Procedures for supervision and appraisal of staff.</td>
<td>Frequent changes of leadership team. Lack of recognition of roles. Lack of pro-active action from leadership members.</td>
</tr>
<tr>
<td>Clear roles</td>
<td>Realistic and reviewed job descriptions. Procedure for identifying roles and communication between team members on expectations.</td>
<td>Some team members do some tasks, some do all tasks and some do very little with no clear recognition of poor or strong practice. Weak leadership and lack of flexibility among team members.</td>
</tr>
<tr>
<td>Positive relationships</td>
<td>Open and professional manner. Clear boundaries around roles and relationships. Inclusive staff attitude. Sense of enthusiasm in workplace with opportunity for peer mentoring if needed. Supportive team members who take responsibility for team spirit.</td>
<td>Individuals losing professionalism and concentrating upon personal relationships. Divisions within team based on various factors like roles, friendships or even gender/age.</td>
</tr>
<tr>
<td>Time spent on developing individuals</td>
<td>Recognition and sharing of positive practice and group's responsibility not only for success but also recognising weaknesses. Planned and timed training and development opportunities equally available to all staff. Procedures available for individual appraisal and accountability.</td>
<td>Poor training opportunities or opportunities being given to some, but not all staff. Lack of feedback on progress in post and little interest in personal development. Little or no supervision. Weak debriefing in stressful situations. Little time given for team meetings or peer mentoring.</td>
</tr>
</tbody>
</table>

Some characteristics of effective teams (after Woodcock, 1979).

Team development
Teams are not simply born overnight, and they will go through various stages of development throughout their existence. They also have to respond to various forces – sick leave, changes in staffing or leadership, expansion, reduction, role changes. There are many factors which prohibit or maximise an effective team at any given time. While any individual cannot fix a team alone, it is important to be aware of some of these factors in order to clarify expectations of teams. One of the better known theories relating to team development and change is that devised by Tuckman (1977). Tuckman's Stages of Group Development was not written with social care in mind, but is relevant to teams in most circumstances or industries. Tuckman identified five stages that groups go through to develop. These are:
- forming
- storming
- norming
- performing
- ending (or adjourning).

Each of these stages represents a sequence of development for the team and, indeed, Tuckman recognised that in many ways, the five stages are cyclical. Any given team will progress through each stage at its own pace and each stage may last for a different period of time. Members must be prepared to move on to the following stage, or move from the existing stage, before development can occur. It is also recognised that outside factors, or the 'forces' mentioned above, may also shift a group from one stage to another (either positively or negatively!).

Forming
As the title suggests, this first stage is about the formation of the group. At this stage people are keen to know a bit more about each other and to understand the roles and expectations placed upon them; bonds may appear between members of the team which may later become cliques. Members are keen to move towards their goals and each other with the expectation and need for clear and guidance from leaders/managers. The group relies upon safe, predictable and comfortable behaviour to an extent.

Storming
This stage is characterised by conflict and competition. This may be evident not only in ability or focus to achieve goals, but in personal relationships between team members. Some individuals may dominate at the expense of others. Cliques may now form and there is a sense of vying for position within the group. Some individuals may have to be more flexible and need for clear and guidance from leaders/managers. The group relies upon safe, predictable and comfortable behaviour to an extent.

Norming
With the storm of the second stage passing, team members are more comfortable within the team and seem more able to acknowledge each other's contributions. Problem solving becomes easier, and members are willing to question each other and negotiate or change preconceived ideas rather than blaming each other. Creativity is at a high level and there seems to be an increased sense of belonging. Cliques are dissolved and shared ideas flow freely. While all this positive behaviour is good, one downside is that members may become over-protective of the harmony and resist change or overt challenge. Members may become fearful of further turmoil or a lack of harmony and become overly complacent.

Performing
Not all groups reach this stage – some may be yo-yoing between earlier stages. At this point, there is a balance struck between clarity of roles and inclusive team membership and questioning preconceptions and challenging each other. True interdependence occurs among professional roles and there is a sense of loyalty and identity within the team. The emphasis is on achievement and creativity; challenge is not feared and experimental problem solving is attempted. Team members can confidently work alone, alongside each other, as sub groups or as a whole.

Ending or adjourning
Disengagement from relationships may occur. Individuals, after a time, may feel they need to move on to develop and tasks may no longer require completion to the same extent. This can create apprehension among members and anxieties may increase. Some theorists even call this stage mourning and deforming!
**Activity**

Think about the description of the team below and try to apply various examples from Tuckman’s stages to it.

‘My name is Alison and I have just started a new job as a manager of a 24-hour residential home for six men with learning disabilities. These men have lived here for over ten years and share a large house on the main street of a small Scottish town. I came to this management post from another leadership post in a similar organisation. My last post was in mental health services so I am looking forward to the new challenges ahead."

‘I only just met some of the team last week, on a brief induction visit. They didn’t seem very friendly to me – they know I don’t come from the same small town as them and I think a couple of them had a problem with the promoted post but didn’t get it. They are all older than me and have worked here for years – I think they must see me as a young do-gooder from the city."

‘One lady was really nice though and I think her name was Max. She introduced me to one of the people who use services there and he was really bubbly and friendly. He even gave me a big hug to say hello, but one of the staff shouted him over as I tried to chat. She told me he must sit back down for lunch as he had previously been shouted at. ‘

‘Anyway, Max says she is an acting team leader and is very happy to have some “new blood” in her office. She is doing a chiropodist appointment coming up and they mustn’t be late.

‘Anyway, Max says she is an acting team leader and is very happy to have some “new blood” in her office. She is doing a chiropodist appointment coming up and they mustn’t be late.

**Belbin’s team roles**

Another theorist who has contributed to our understanding of teams is Dr Meredith Belbin. Belbin did not look so much at the transitional phases a team may go through, but at the individual team members. Belbin identified team roles and, in doing so, recognised that a team requires a group of characteristics to be present in members. Belbin defined a team role as ‘a tendency to behave, contribute and interrelate with others in a particular way’. Belbin explains individual behaviour in terms of how the right combination can influence the team’s success.

Belbin presents nine broad Team Roles covering the type of behaviour each plays in a team setting. These roles include, among others:

- **the Plant** – someone who is creative, perhaps a bit quirky and who creatively problem-solves
- **the Teamworker** – co-operative and diplomatic, this role involves supporting the team and fostering a team spirit; however the individual can seem indecisive if isolated
- **the Shaper** – this role involves being challenging and potentially directive in driving the team towards outcomes and activities
- **the Specialist** – a strength of the Specialist is that they are single minded, seek out knowledge and can be technical and informative. In some instances, however, this role can lead to quite narrow contributions.

There are many articles and websites which further explain Belbin’s work and while there is limited capacity to go into detail here, Belbin’s work is generally useful and highly regarded. Considering only the roles mentioned above, you may already begin to form an idea of the consequences of teams missing some of these roles. Generally, teams require a balance of roles and Belbin is not the only theorist to consider this.

**Benne and Sheets’ classification of group behaviour**

Benne and Sheets classify typical group behaviours into three broad headings:

<table>
<thead>
<tr>
<th>Task-oriented behaviour</th>
<th>Individualistic behaviour</th>
<th>Team maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeking information</td>
<td>Attacking, Blocking, Defending own position</td>
<td>Encouraging behaviour, Harmonising, Expressing group feelings, Setting standards</td>
</tr>
<tr>
<td>Coordinating, Recording, Evaluating</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These types of behaviours are not roles taken on board by group members, but are types of behaviours which can be displayed by any team member at any time. It is clear that task and team maintenance behaviours are more desirable than individualistic behaviours.

**Consider this**

Can you think of any circumstances where either you, or colleagues around you, have displayed some of the behaviours mentioned above?

**Teams and leadership**

While much of what we have considered so far focuses on team members, it has to be recognised that teams require a degree of leadership and management. The nature of leadership is seen as crucial in ensuring that goals and tasks are completed. Leadership includes motivating others, ensuring individuals feel supported and ensuring clarity exists in terms of roles and outcomes. Leadership as a term can mean many things and most commonly, we may suppose leadership comes from management. While this may not necessarily be the case in all circumstances, leadership implies a sense of authority and accountability. Leadership may be seen as a role specific to a job, role modelling and achieving effective performance from others.

**Consider this**

What would you expect from a leader of a team? What would you expect from a manager of a team? Are there differences and similarities?

**Leadership styles**

A leader may be formally appointed, imposed on a team, chosen informally or simply emerge naturally. Leaders should be aware, not only of their own role, but of the impact their own role has on others. There are three classic types of leadership styles:

- **autocratic**
- **laissez-faire**
- **democratic**

The _autocratic_ leader dominates team members; things are done under pressure and there is a clear hierarchy of leadership. While this may be seen as an outdated, uncomfortable approach to achieving goals, there may be times when it is entirely appropriate. Urgent action may be called for, or a team may need to get to grips with poor performance. A team may be in a state of dysfunction, so a short-sharp autocratic response may jolt things along nicely!
The laissez-faire leader prefers to allow the team to sort things out for themselves; shying away from out-and-out authority. This does not necessarily mean that the leader is neglecting to lead, but rather the leader allows teams to own and potentially sort out any issues for themselves. The downside to this is that teams may flounder without very clear leadership. A laissez-faire leader may be seen as ineffective as they do not openly use authority in a way that people may expect. Again, there are some situations where this approach can be appropriate and effective. Highly motivated, skilled and enthusiastic workers who are confident and capable may welcome the opportunity to self-direct. A team may feel empowered of they are given space and time to tackle issues for themselves, without being 'told what to do’.

The democratic approach involves a leader consulting and including others in decisions and tasks. Such a leader encourages participation, but does not become too distant from the team. Democratic leaders can be seen as being unsure of their roles and afraid of using authority. If issues are important and need to be resolved quickly, individuals might find consultation and group decision making frustratingly slow and laborious.

Motivation theories

When considering teams and leaders and managers, the motivation of all involved in service delivery is a huge factor. This is one area which is also well-researched and documented in team analysis. A motivational theory is simply a framework of understanding why people do the things they do. In relation to team motivation, such theories consider what motivates workers. In a lifetime of employment, it is important that motivation is not ignored – if someone is not motivated to do a job, the chances are they won’t, or that they may well do it badly.

Consider this

What motivates you towards studying for social care?
What motivates you to get up in the morning?

Scientific management

EW. Taylor (1856-1915) looked at what motivates men and women to work – given the conditions of the 19th century; he concluded that the main motivator for any worker was money! His ideas became known as ‘Scientific Management’. Taylor’s theorising concluded that people do not like work, and that money was the most important factor inducing people to work hard. While this may seem like quite a drastic interpretation of motivation in the workplace, think about the type of industries which offer cash incentives to productive workers, or bonus payments for achieving targets. In Social Care, it is a fair assumption that getting rich is not a major motivator. Therefore, there must be something else at play.

Herzberg’s motivators and hygiene factors

Fredrick Herzberg carried out a survey in the 1950s to try to establish, among a group of engineers and accountants, what aspects of their work they found highly satisfying and which they found dissatisfying. Herzberg referred to these as two factors: ‘motivators’ and ‘hygiene factors’. The motivators were positives which people identified as being positive factors, the hygiene factors being those people were not satisfied with. (He used the term hygiene to mean those factors which are required to maintain the organisation but which are not in themselves satisfiers.)

Examples of Herzberg’s ‘hygiene’ needs (or maintenance factors) in the workplace are:

• policy
• relationship with supervisor
• work conditions
• salary
• company car
• status
• security
• relationship with subordinates
• personal life.

Herzberg’s research identified that true motivators were other completely different factors, such as:

• achievement
• recognition
• work itself
• responsibility
• advancement.

This may seem quite obvious to some, but Herzberg’s work was important – it showed that people’s sense of satisfaction and dissatisfaction within a workplace were not just opposites; that those things which motivated people and created enthusiasm and ‘settled’ staff were not the opposite of those which depressed and demotivated staff.

Factors which motivate social care workers.

Activity

The grid below illustrates some of the factors which are seen to motivate workers – can you identify ways in which a Social Care career may meet some of these positive factors? There are some suggestions already made to help you start.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement</td>
<td>making a difference to someone’s life</td>
</tr>
<tr>
<td>Recognition</td>
<td>being told by a person who uses services they enjoyed your company</td>
</tr>
<tr>
<td>Work itself</td>
<td>enjoying the company of a person who uses services</td>
</tr>
<tr>
<td>Responsibility</td>
<td>arranging a review for a person who uses services</td>
</tr>
<tr>
<td>Advancement</td>
<td>moving from a sessional worker’s post to a full time worker</td>
</tr>
</tbody>
</table>

Theory X/Theory Y

Another motivation theory is McGregor’s Theory X/Theory Y proposal. This model focuses not only on what motivates individuals, but also at what motivates approaches to managing people. The work of McGregor rests on two contrasting assumptions. Theory X states that an individual needs to be coerced, and almost threatened with punishment, to be motivated towards achieving goals. According to Theory X, the average worker is lazy, avoids work if they can, and doesn’t want to do any more than needed. Employees have no motivation for themselves, have no ambition and require close supervision and control.

Theory Y, on the other hand, recognises that an organisation’s view of people is altogether different. Theory Y recognises that people are productive, are self-motivated and are naturally ambitious. Rewards for achievement generate activity and commitment from employees and, if given freedom, individuals will increase their productivity.
The acceptance of one of these theories leads to a particular management strategy. Theory Y is seen as encouraging teams and organisations to reduce conflict and differentiation, which in turn raises morale and productivity/success/service. Leaders should adopt a supportive, rather than directional, approach. Ultimately, by providing a positive work environment and ethos, an organisation can encourage each individual to feel that the organisational goals are his or her own goals – in social care, when considering Values, it makes sense that these are shared, positive and believed values, rather than imposed and directed ones.

**Goals**

Finally, we will consider goals and their importance in forming cohesive teams. Organisations should have clear goals identified – this helps to define activities and roles and gives a clear identity to a group. Goals can be identified as formal and individual or informal. Ideally, as mentioned before in this section, an organisation and the people working within it should hold very similar views. First we will consider formal goals.

**Formal goals**

Formal goals:
- focus the attention of members on appropriate and productive behaviour
- providing motivation and reward
- they give an indication of what the organisation is like (for example a mission statement)
- they form a basis of action plans/strategic plans/team development
- they are basis for procedures and organisational objectives.

**Individual/Informal goals**

Individual or informal goals:
- different people will experience different motivation
- individual goals may differ from person to person
- individual goals may differ from organisational goals.

If individual and organisational goals are very different, conflict may result. In a conflict situation, performance is likely to be affected and individuals may become disillusioned. Where personal and organisational goals are compatible, organisations are more effective. Overall, an organisation requires informal and formal goals to be similar or, at least, compatible so that individuals can satisfy their own needs as well as meeting the needs of the service.

**Conclusion**

Teams and their success are often central to the success of organisations. The success of an organisation often reflects the success of people who use services, and in social care that is of the utmost importance. Teamwork, collaboration and joint working are all key aspects of a Social Carer’s professional role, and it is useful to be aware of some of the concepts and theories relating to teamwork to equip and enable you to progress your career. By considering, however briefly, some of the better known theories, you are more able to understand some of the dynamics of a team and some of the motivational factors which influence the performance of groups at any point. By being aware of roles and expectations, there is an increased likelihood that any future team issues will be understood from a more objective point of view. Working with others is not always easy, but understanding some of the reasons for conflicts or changes may just ease the process a little!