Social work with older people: a vision for the future

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Contents

Foreword

This report is jointly badged by a special interest group of eight social work academics engaged in research and teaching in gerontology and gerontological social work (the G8) and The College of Social Work (TCSW). Gerontological social work is social work with older people. G8 members are strongly committed to reinvigorating professional practice and academic interest in social work with older people and their families and to ensuring that this specialist area of social work is defended, developed and invested in.

The report offers a 'vision' of what the G8 sees as the role, aims, and distinctive nature of social work with older people, in what contexts it can be effectively deployed, what evidence there is – both in the UK and internationally – of its effectiveness and what social work with older people's contribution is, and can be, to health, wellbeing and the achievement of social policy goals.

G8 members are all qualified social workers and are as follows:

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The College of Social Work is the centre of excellence for social work, upholding and strengthening professional standards for the benefit of the public. It is an independent membership organisation that aims to provide a strong unified voice for social workers and play a leading role in the development of social work and social policy.

Dedication

This report is dedicated to Professor Olive Stevenson, social worker and academic (born 13 December 1930; died 30 September 2013). Olive's legacy has been as 'the foremost social work educator of her generation, an inspiring lecturer, a prolific scholar and inquiring researcher and committed public servant' (extract from information about her memoir). She was a powerful champion for social work and for the rights of older people and their families.

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4

Social work with older people: a vision for the future

This report offers an academically informed, trustworthy, coherent, and accessible overview of social work with older people: what it is; why we need it; what its aims are; its skill and knowledge base; which populations and contexts it works effectively with and in; and the extent and nature of the evidence base relating to its effectiveness. The report also addresses a range of key issues that impact on, and intersect with, social work with older people and offers a way forward that engages social work with meeting the needs of the growing older population in England (and the wider UK) who need care and/or psychosocial support.

Examples of social work initiatives or services are offered in 'boxes' at relevant points in the report and 'key opportunities' for social work are highlighted at the end of each section or subsection.

The authors not only believe strongly that there is a future for social work with older people but also that it is a necessity for the health and social care economy, professionals and service providers, and most importantly for current and future generations of older people and their families. This report provides a vision – a 'call to arms' – to reinvigorate and re-establish gerontological social work and a rationale for investment in this specialist field before it is lost from the purview of British social work altogether. The views expressed in this report are those of the G8 and are not necessarily shared by The College of Social Work (TCSW).

Specific aims of the report

- To highlight the key issues around ageing, age related ill health and disability, and life course influences on later life outcomes that can be addressed effectively by social workers working with older people.

- To review the current and future roles and contexts in which gerontological social work is, and/or can be, effective and evidence its effectiveness.

- To help build a business case for investing in gerontological social work.

Key definitions

Gerontological social work refers to social work with older people.

The term 'older person' generally refers to people aged 65 years or older. Specific age cohorts are also identified where relevant.

While the report is primarily focused on England, as TCSW's remit is England only, statistics and research evidence often relate to the whole of the UK. Where England only evidence is referred to this is identified.

Executive summary

Section 1: Context

The scope and role of gerontological social work

1. Gerontological social work is specialist social work with older people. It is concerned with maintaining and enhancing the quality of life and wellbeing of older people and their families and with promoting independence, autonomy, and dignity.

2. The main focus of gerontological social workers is on understanding the physical and mental health problems that older people may experience within the context of economic, social and environmental influences. They work with the individual older person, their family and community resources and often facilitate difficult decisions, for example a move to a care home.

3. Gerontological social workers' specialist skills and knowledge include understanding of: the ageing process and models of ageing; health conditions in later life; end of life issues; family carers' needs; the policy and legal frameworks relating to older people and carers; effective management of loss, change and transitions; and the evidence base for interventions in work with older people.

4. Several key drivers underpin the need to invest in gerontological social work:

- The increasing size and diversity of the older population, and in particular the growing numbers of older people with complex long-term conditions. A body of social work expertise to work with those older people and carers who require support from health and social services is vital not only for individual wellbeing, but also for the effectiveness and efficiency of the health and social care economy.

- The linked challenges of policies promoting prevention and provision of comprehensive and personalised support services to older people with complex and/or changing needs.

- Uncertainty about whether the self-directed model of care is an appropriate mechanism to deliver 'personalised care' for very frail older people with

multiple needs. A related challenge is how best to work with older people who are unable, or choose not, to access self-directed care.

- The needs of subgroups of older people whose rights to autonomy and agency are compromised, for example, people with dementia, older people living in poverty, and care home residents.

- Evidence that public sector cuts are placing older people at increased risk of (re)admission to hospital; delayed discharge; preventable care home admission; reduced choice and quality of services and abusive or undignified care.

5. The need for a body of social work expertise to work with those older people who require support from health and social services is vital not only for their individual well being, but also for the effectiveness and efficiency of the health and social care economy.

Ageing in the UK

6. The UK's demographic context represents a primary challenge and opportunity for social work. Increased life expectancy and a growth in the 'oldest old' population means an increased prevalence of ill health and long-term conditions.

7. About a third of family carers in the UK are older people. Older carers are more likely to provide long-term intensive care and have health problems of their own.

8. Most older service users in contact with social workers have complex needs and/or are at the end of life.

9. The older population is increasingly heterogeneous, including: more people living alone; more people with complex health needs remaining at home; higher numbers of black and minority ethnic older people and of lesbian, gay and/or bisexual elders.

10. Despite the overall improvement in the living standards for older people in the UK there is evidence of widening inequalities in relation to income, social class, gender, ethnicity and disability persisting into later life.

Service usage

11. Older people are the largest group of users of the NHS, accounting for approximately 40 per cent of all hospital bed days.

12. Older people account for nearly 60 per cent of local authority spending on social services and it is estimated that over 1.7 million more adults – the majority of whom are older – will need support over the next 20 years.

13. The rise in the older population likely to need social care has coincided with serious reductions in public funding.

Age discrimination

14. There is continuing structural age discrimination in health and social care resource allocation. Age discrimination can intersect with other dimensions of social inequality such as sexism, racism or oppression linked to homosexuality.

15. Social work's anchoring in values of social justice makes it well placed to challenge the persisting age and other types of discrimination embedded in the allocation and delivery of health and social care services.

Welfare policy and social work with older people

16. The 'community care reforms' had a significant impact on social work with adults. Social workers were recast as care managers working within an administrative model of care. This shift eroded many of the traditional roles and tasks of gerontological social work and contributed directly to its loss from frontline practice.

17. By the early 2000s, there was growing evidence that assessment practice was increasingly focused on demonstrating an older person's 'eligibility to receive a service' rather than on 'individual need'. The loss of 'the therapeutic relationship' at the heart of assessment that took account of an older person's strengths, biography and aspirations was also identified. Social work as a service in its own right was increasingly marginalised.

18. Since 2007 the 'personalisation' agenda and the use of personal budgets has been a policy priority. Despite evidence that personal budgets result in

improved outcomes for some adult service users, their benefit to older service users and their carers is unclear. Costs linked to personal budgets for older people may be higher and their psychological health and wellbeing may be lower by comparison with those receiving conventional services.

19. The older people who are most likely to be eligible for support, those with long-term complex needs, are also likely to have the greatest difficulty in managing a personal budget. It is precisely this group who require skilled and knowledgeable input from gerontological social workers.

20. Social workers are trained to think critically about their practice and the wider context in which it is shaped and delivered. They have a key role in highlighting tensions between the realities of older people's lives and narrow interpretations of policies such as 'personalisation' and 'active ageing'.

21. Although policy developments have undermined the role and function of social work, key recent documents identify an ongoing role for social work in supporting people's independence and promoting choice and control. This creates an opportunity for social work to demonstrate its contribution in these areas and the specific value of social work, rather than the broader social care.

22. Welfare policies that are relevant to older people intersect with social work in a complex way. The reform of adult care law proposed in the current Care Bill 2013–14 is intended to simplify and clarify the current labyrinth of 'adult care legislation'. This may give greater scope for social workers to use the law to uphold the rights and interests of older people.

The devolved policy context

23. Devolved political and administrative powers in Scotland, Wales and Northern Ireland have resulted in divergent social policy trajectories with different implications for social work practice. For example, the Welsh Government foregrounds the importance of the relationship between the social worker and the service user for effective assessment. These differing models of practice create opportunities for social workers in England to learn from experience

elsewhere and to advocate for approaches that are most effective in meeting needs sustainably and promoting older people's well being.

Section 2: International evidence base

24. Evidence from North America demonstrates that a concerted coherent plan, effective leadership and core funding are fundamental to any strategic initiative to raise the quality and visibility of gerontological social work and its contribution to the health and wellbeing of older people

25. In the US and Canada gerontological social work is recognised as making a key contribution to addressing the challenges posed by an ageing population at both a macro level (e.g. policy making) and at a micro level (e.g. services for, or interventions with, older people and their carers). This powerfully illuminates the potential role of gerontological social work in a UK context.

26. The Geriatric Social Work Initiative (GSWI) in the US has demonstrated the effectiveness of gerontological social work, particularly in developing policy and in delivering interdisciplinary care and support to older people with dependency needs.

27. International evidence shows that for gerontological social work to be re-established and reinvigorated it must be underpinned by high quality research. The capacity for the gerontological social work community to conduct high quality research, including intervention research, is therefore a primary priority.

28. It is essential that gerontological social workers are appropriately educated and trained to be able to deliver effective interventions. In the US, the GSWI, funded by the Hartford Foundation, has successfully 'gerontologised' social work education. Specific outcomes include: the development of academic 'champions' to teach students and promote gerontological research; specialist doctoral students and programmes; and the creation of core competencies for gerontological social work practice and ageing curriculum.

29. The infusion of ageing content across undergraduate and postgraduate programmes and the development of innovative models of practice learning have consistently demonstrated: an increase in student interest in

gerontological social work; more positive attitudes toward older people; an increase in gerontological skills and knowledge; and an increase in doctoral gerontological research.

Section 3: The contribution of gerontological social work to older people's health and wellbeing

The evidence base

30. Demonstrating social work's contribution to older people's health and wellbeing is fraught with difficulties. These include: the limited investment in gerontological social work research; the merging of social work into other roles with different titles, such as care manager or broker; the difficulty of isolating the specific contribution of social work; and the problems inherent in evaluating interventions in lives which are complex and rapidly changing.

31. There is an urgent need to capture the outcomes of gerontological social work, despite the challenges this poses.

The nature of support provided

32. Social workers are uniquely placed to conduct individualised bio-psycho-social assessments of need that identify and address interconnected physical, psychological, life course and social needs.

33. Social workers undertake the complex and sensitive task of working alongside older people and carers to reach an understanding of their difficulties and help them find ways of managing these to prevent their escalation.

34. Their skills include: developing community resources, connecting older people to appropriate services, and providing a continuous supportive relationship through times of crisis and change. This can make it possible for older people to remain in their own homes and communities for longer, despite increasing frailty.

35. There is evidence that social workers in hospital emergency departments and other interdisciplinary contexts enhance the impact of follow-up care and reduce readmissions of older patients.

36. Social workers have a role in initiating and delivering preventive interventions, to improve older people's quality of life and contribute to longer-term financial savings. Facilitating older people's access to appropriate and timely preventive services can reduce the need for domiciliary support, prevent falls, and delay admission to a care home. It can also provide relief for carers to maintain their health and wellbeing.

37. Social workers' assessment skills, in particular the ability to identify social, psychological and emotional needs and strengths, mean that they are well-equipped to explore goals for re-ablement with service users, to plan how these are best achieved and to review progress and outcomes.

38. Community approaches can mobilise older people's skills, experience and expertise. The development of social enterprises and 'Social Work Practices' may offer new opportunities for social work involvement in innovative community orientated activities.

39. Social workers can make a significant difference to the lives of older people with complex high intensity needs, who may be reluctant to engage with services. Social work skills in building trust, eliciting understanding of the older person's wishes, exploring options and facilitating choice and control are key to positive and sustainable decision making in later life; they also promote autonomy and dignity.

40. Social workers' training in critical analysis, reflection, and decision making equip them for the complex task of protecting vulnerable adults from harm. This role requires understanding of the law, policy and procedures and balancing protection, with the promotion of independence and self-determination.

41. Social work's ability to assess and intervene at the level of informal networks is an important component of 'preventive safeguarding'. Social workers can be instrumental in identifying and ameliorating risk factors for elder abuse such as stress, mental health problems and substance misuse in the lives of family and friends.

42. Social workers' commitment to social justice and advocacy is especially important in contexts involving incapacity and deprivation of liberty.

Older people who are most likely to benefit from social work (and lose most from its absence)

43. Later life is characterised by transitions: in roles, relationships and identities; in environment, living arrangements and social participation. Research shows that social workers have expertise in helping people manage transitions through a combination of practical and emotional support, managing anxieties, and acting as a bridge between settings. Positive transition experiences are less likely to generate further health and social difficulties.

44. Evidence from North America suggests that employing social workers in care homes has various benefits, including advocacy for residents and the monitoring of care quality. This is an untapped opportunity for social work in England.

45. Effective assessment and support for carers of older people – many of whom are older people themselves – is pivotal to reducing or preventing the use of expensive health and social care resources, including institutional care. Research highlights the need for a proactive approach to address difficulties early and prevent the need for costly crisis intervention. Engaging social workers in preventive work with carers is likely to reap considerable therapeutic and financial benefits.

46. Gerontological social workers have specific skills and roles in working with people with dementia and their carers at various stages, including early intervention, diagnosis, support planning and rehabilitation. As this group of people are at high risk of institutional care, interventions that extend the period of community living can achieve significant cost savings as well as enhanced quality of life.

47. The quality of care for older people at the end of their lives is a key concern for gerontological social work. Findings from recent research suggest that social workers are widely seen as best placed to undertake the crucial roles of advocate, navigator, co-ordinator and facilitator, to enable older people to achieve a dignified end.

Section 4: Conclusion and ways forward

48. Gerontological social work has enormous potential to respond to the diverse needs of a growing older population.

49. Social workers have an important *proactive* role to play within community based programmes designed to promote and maintain social engagement, health and wellbeing.

50. The skills of social workers in promoting relationships can maximise opportunities for older people to continue living as part of families and communities as well as offering support to those who are isolated.

51. Expertise in supporting people through change and transition is central to specialist gerontological social work and could be used much more extensively and in a wider range of settings.

52. There is significant scope to develop and extend social work's leadership role in joint working between health and social care.

53. The professional values of social work and its commitment to social justice place it in an ideal position to provide advocacy, uphold older people's rights and prevent and address abuse.

54. To further these agendas and to take forward the development of gerontological social work we propose that three key intersecting areas are addressed: practice, education and research.

55. In terms of practice, there is a pressing need to reverse the increasing disappearance of gerontological social work and, following the example of the US and Canada, to establish it as a recognised and valued resource for current and future generations of older people and their families.

56. There is a parallel need for ageing related subjects and research to be embedded in social work training and education. Developing specialist capacity in teaching is vital if gerontological social work is to be rebuilt.

57. In relation to research, there is little explicit research focused on social work with older people, as distinct from social care. There is a primary need for

investment in research activity, driven by gerontological social work academics and practitioners, to demonstrate the contribution of social work to the wellbeing of older people and to the health and social care economy. Again, there is much to be learned from the successful strategies in North America to rebuild gerontological social work research.

58. Enhancing the lives and wellbeing of older people and their families through specialist, evidence-based gerontological social work is vital to the development of the future social work profession. Timely social work interventions that are responsive to older people's needs and preferences are also cost-effective as they have a significant preventive function in the short and longer term. One of the many challenges for gerontological social work is to demonstrate this incontrovertibly.

Section 1: Context

Section 1 offers a definitional, demographic and policy context for the report.

What is gerontological social work?

Gerontological social work is specialist social work with older people. It is concerned with maintaining and enhancing the quality of life and wellbeing of older people and their families and with promoting independence, autonomy and dignity. Most service users who have contact with social workers have complex needs and/or are at the end of life. In these contexts social work's focus is about providing appropriate care and security and offering direct support to the older person and their family.

For gerontological social workers the core 'skill set' that all social workers possess is supplemented by an additional set of specialist skills as well as specialist knowledge. Gerontological social workers' main focus is on understanding not only the physical and mental health problems older people are at risk of experiencing, but also the influences of socio-political context, economic status and environmental issues too. They work with the individual older person as well as their family and the wider community; many of these situations are characterised by loss, complexity, multiple needs, change and transition. They are often involved in helping to facilitate difficult decisions, for example about an older person moving into a care home.

The kinds of specialist knowledge a gerontological social worker would have include: understanding of the ageing process and models of ageing; health conditions (more) common in later life and primary treatments; end-of-life issues; family carers' profiles and needs; policy and the law regarding older people and carers; social work theory especially around effective management of loss, change and transitions; gerontological research, including evidence about what interventions are effective in work with older people and their carers. Knowledge about local services and the wider community are also important.

What gerontological social workers can achieve, with which groups of older people and their families in which contexts is a subject to which we return in Section 3.

Why do we need gerontological social work in England in the 21st century?

There are a number of key drivers underpinning the critical need to invest in developing gerontological social work in order to meet the existing and future needs of England's elderly population (House of Lords Public Service and Demographic Change Select Committee, 2013; The College of Social Work (TCSW), 2012).

The UK demographic context represents a primary challenge and opportunity for social work. The increasing number of older people with complex long-term conditions and their carers not only requires skilled personalised intervention to assess and meet their needs but also demands a practice which acknowledges the intersecting impact of the life course, long-term physical and/or mental ill health, disadvantage, vulnerability, uncertainty, change, risk, and transition on the wellbeing of older people. Taking account of the needs of families and carers is also vital. That the older population is becoming more diverse and heterogeneous is an additional issue. The need for a body of social work expertise to support and work with this (growing) population is vital for their current and future wellbeing and for the effectiveness and efficiency of the health and social care economy (Holmes *et al.*, 2013).

Recognising the importance of providing comprehensive, personalised support services to older service users and developing responses to the linked policy agendas relating to public health, health inequality, and prevention for older people are important policy issues. Much of the recent policy discourse in England ignores, or barely acknowledges, social services' responsibilities to older people with complex and/or changing needs. A key question is how far the self-directed model of care – constructed as the primary mechanism to deliver 'personalised care' to all those eligible for local authority support – is appropriate for very elderly people with multiple needs. A second question, and one that should be of key concern to social work, is how older people who cannot (or choose not to) make use of personal budgets access assessments of need and appropriate services.

A third issue relates to the needs of specific sub-populations of older people. Social workers have a tradition of working with groups who are marginalised and/or disadvantaged, who are at risk of being excluded from decisions about their care, and whose rights to autonomy and agency are compromised. Older people living

with long-term conditions such as dementia who are 'necessarily dependent' on others for their survival are one such group; care home residents are another; and older people (mainly women) existing on the edges of society due to long-term poverty are a third. These groups are not only growing in number but without access to a specialist social work service will have no professional voice to champion their cause in respect of social justice, foregrounding the relevance of inequality, defend their rights to high quality care, and engage in ways to enhance their opportunities for inclusion.

A fourth issue relates to the widespread concern about the impact of public sector cuts on the wellbeing of older service users and on the quality of their care. A recent survey by The College of Social Work (TCSW) and Age UK suggests that shortfalls in social work (and social care) support to older people is placing them at risk of: (re)admission to hospital and/or delayed discharge; abuse and/or neglect; not coping due to reduced social work time being provided in face-to-face support; reduced choice, quality and quantity of services and their capacity to deliver dignified care; receiving a task-focused, narrow assessment of need; and preventable care home admission (Age UK and TCSW, 2012; TCSW, 2012).

Ageing in the UK

This subsection will outline a number of key dimensions of ageing in the UK to provide context for the rest of the report. These are: the ageing profile of the UK's population; service usage by older people; life course issues; and age discrimination.

Ageing profile of the UK population

The UK – along with its European peers – is an ageing society. Currently, life expectancy is 82 years for women and 80 years for men (Office of National Statistics (ONS), 2011). There are over 10 million[1] older people in the UK (17 per cent of the total), a figure estimated to rise to over 16.4 million by 2033. Of this population, 1.3 million are aged 85 years or over and 12,000 are centenarians (Age UK, 2013).

It is irrefutable that for many older people life expectancy and quality of life has vastly improved since the introduction of the welfare state in the 1940s. A baby born in 2011 is almost eight times more likely to reach 100 than one born in 1931 and men

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[1] Older people means on or above state pension age (currently 65 years for men and 60 years for women).

aged 65 and over can expect to live only the last 7.3 years of their life with a disability; for women the average is 9.4 years (ONS, 2011). However, it is also the case that the prevalence of ill health and long-term conditions increases with advancing age (Age UK, 2013a). A significant proportion of those aged over 75 years have at least one illness or disability that impacts negatively on their quality of life. Amongst older people living in the community, 71 per cent (4 million) have a longstanding illness or disability, with 42 per cent of older men and 46 per cent of older women reporting that their illness has a 'limiting' impact on their lives (Victor, 2010).

Long-term physical conditions that disproportionately affect older people are heart and circulatory diseases particularly strokes, hypertension and coronary heart disease. Arthritis is estimated to affect 47 per cent of older people and osteoporosis about 8 per cent. Sensory impairments and falls are common. Frail older people tend to typically have three or four long-term conditions (British Geriatrics Society, 2010). Currently the number of older people in the UK living with dementia is 820,000; this figure is estimated to rise to over 1.7 million by 2051. Depression affects 22 per cent of older men and 28 per cent of older women living in the community (Knapp and Prince, 2007). In 2010–11 just over 1 million (10 per cent) older people in the UK reported that they were 'always or often lonely' (Women's Royal Voluntary Service, 2013).

There has also been a steady increase in the amount of alcohol consumed by older age groups in recent years (Smith and Foxcroft, 2009). Currently an estimated 1.4 million people aged 65 and over exceed recommended drinking limits; 3 per cent of men and 0.6 per cent of women aged 65–74 are alcohol dependent (Wadd *et al.*, 2011).

UK surveys suggest that there are currently 6.4 million family carers in the UK (Carers UK, 2013). A third of all carers are older and a growing number are very elderly (i.e. aged 75 years or over). Older carers are more likely to share the same household as the cared for person and to disproportionately provide long-term intensive care for a spouse or a (very old) parent/in law. They are also more likely to have health problems of their own. Recent research suggests that older carers

provide £15bn in unpaid care (Age UK, 2010); dementia carers, many of whom are older, also save the UK public purse £8bn every year (Alzheimer's Society, 2012).

It is estimated that approximately 342,000 older people living in private households in the UK are abused each year. If care homes are included this figure rises to 500,000; this is equivalent to about 5 per cent of the total UK older population (O'Keeffe *et al.,* 2007). Very elderly people with co-existing long-term conditions, older women living alone, and people with advanced dementia are at particular risk.

In the future the older population will be increasingly characterised by diversity and heterogeneity, including: more older people living alone, being divorced or never married; increasing numbers of people with complex health needs remaining at home; and a greater number of older people living in poverty. The number of black and minority ethnic people aged 70 years and over is projected to rise from 170,000 in 2006 to 1.9 million in 2051; there is also likely to be an increasing number of lesbian, gay and/or bisexual older people (Age UK, 2013a). Almost certainly there will be growing numbers of older people facing difficult decisions in situations of risk, dependency, uncertainty, and transition – including admission to a care home, loss of a long-term carer, and managing multiple health problems.

Service usage

Older people are the largest group of users of NHS and local authority social services. Whether in an emergency, or helping to manage a long-term condition, the NHS is vital to the lives of many older people. Despite a recent downward trend, those aged over 65 years still account for approximately 40 per cent of all hospital bed days. Almost two thirds of all – both general and acute – hospital beds are occupied by older people at any one time. Up to a quarter of such admissions are of people with dementia. This is one of the reasons – along with complex co-morbidity – that older people's hospital stays are 2.5 times longer than those of younger adults (Age UK, 2013).

Older people currently account for nearly 60 per cent of the £16.1bn spent on social care by local authorities (DH, 2010a). In 2010–11, 60 per cent of the 885,000 adults receiving community based services were aged 65 years and over (Health and Social Care Information Centre, 2011). Local authority support is targeted, through stringent eligibility criteria, on those with the highest levels of need so older service

users are likely to require help with activities of daily living and to have complex health related needs (DH, 2010). It has been estimated that an additional 400,000 older people fund their own community based care (Dilnot Commission, 2011).

At the same time as there has been a reduction in funding for social care, there is a growth in the number of older people needing support. It has been estimated that over 1.7 million more adults, the majority of whom are older, will need care or support over the next 20 years. In parallel, figures from the latest budget survey suggest that a further £800m will be removed from adult social care budgets in 2013–14. This brings the total level of real term spending cuts to £2.68bn since 2011 (Samuel, 2013).

Six per cent of the UK's older population lives in a care home: of these 40 per cent are self-funding (Dening and Milne, 2011). Despite a reduction in the overall proportion of older people entering a care home over the last decade it is likely that this figure will rise as a consequence of the increase in the number of very elderly people with complex long-term conditions and dependency needs. Four fifths of the care home population is estimated to have dementia and two fifths to have depression: key physical health issues include stroke, incontinence and mobility problems (Quince, 2013). Most care home residents are very frail and highly dependent. Having a co-resident carer has a strongly protective effect on care home use: the chance of being admitted to a care home is 20 times higher in people who do *not* have a family carer living with them (Banerjee *et al.,* 2003).

Life course issues

It is now well established that health outcomes in later life are *primarily* a consequence of life course factors rather than age per se and that the determinants of both physical and mental ill health are often located in childhood or early adulthood (Victor, 2010).

A prominent example is that of poverty. The legacy of long-term exposure to poverty and related socio-economic disadvantage is strongly correlated with poor health outcomes, including the onset of long-term illness in 'younger' old age and shorter life expectancy (Moffatt *et al.,* 2012). A female born in Glasgow can expect to live nearly 12 years less than one born in Kensington and Chelsea; the difference for

men is 14 years. The lower the socio-economic status of an older person the more likely it is that they will experience ill health and die prematurely.

In 2011 in England, 1.8 million (16 per cent) older people lived in poverty; of these 1.1 million (9 per cent) lived in severe poverty (Department for Work and Pensions (DWP), 2010). Six million older people were estimated to live in fuel poverty[2] in 2011; in 2009 42 per cent of older people reported that they 'struggled' to afford essential items such as food and fuel (Age UK, 2013a; ICM Research, 2009). Older women, long-term carers and older people from minority ethnic groups are at particular risk of experiencing long-term poverty (Godfrey *et al.,* 2005). A recent report by the Centre for Social Justice (2010) concludes that socio-economically disadvantaged older people face daily challenges in eating healthily, maintaining and developing social networks, and accessing leisure and other activities.

Despite the *overall* improvement in living standards for older people in the UK there is evidence of widening inequalities in relation to income, social class, gender, ethnicity and disability persisting into later life.

Age discrimination
Age discrimination is defined as 'an unjustifiable difference in attitude, response, or treatment based solely on age' (Centre for Policy on Ageing, 2009). Age discrimination can be evidenced in every sphere of life and society and has been identified as having a pernicious impact on older people's wellbeing. Research by Age UK (2012) suggests that 61 per cent of older people in the UK consider that age discrimination 'exists in their daily lives acting as a multilevel barrier to opportunity and inclusion'. It is also common in service settings.

The fact that two thirds of NHS patients are aged 65 and over and yet receive only two fifths of total expenditure suggests the existence of structural discrimination in the allocation of health care resources (Age UK, 2013). Age discrimination also underpins the allocation and nature of medical treatments. For example, the Royal College of Psychiatrists estimates that 85 per cent of older people with depression receive no help at all from the NHS. Of those who do access treatment far more are offered tranquilisers than talking therapies compared to younger adults (Melzer *et al.,*

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[2] A household is defined as being in 'fuel poverty' when it needs to spend 10 per cent or more of its income on fuel.

2012). The fact that a survey identified that a lower proportion of hospital staff 'respected older people's dignity and privacy' in 2013 than in 2011 may also be indicative of ageism in the workplace (ICM Research, 2008; Care Quality Commission, 2013, 2013a).

Evidence of structural discrimination can also be seen in social care. Lack of investment in innovative services for older people and the assumption that older people's needs can be met by 'off-the-peg' packages of practical services are two prominent examples. The very limited involvement of qualified social workers in the needs assessments of, and intervention with, older service users and their families is a prime example of age discrimination (Ray and Phillips, 2012; Ray *et al.,* in press). Age discrimination can intersect with other dimensions of social inequality such as sexism, racism or oppression linked to homosexuality, amplifying its impact and consequences.

Key opportunities

+ Specialist social work expertise can make a major contribution to enhancing the health and social wellbeing of older people with support needs and their family carers.

+ The UK's demographic context represents a primary challenge and opportunity for social work, particularly given the increasing number of older people with long-term conditions living in the community. That the older population is increasingly diverse and heterogeneous is also relevant.

+ Social work intervention can address the intersecting impacts on health and wellbeing of: disadvantages across the life course, chronic physical and/or mental ill health, poverty, vulnerability, uncertainty, change, risk, and transition. In so doing, it can ensure that support for older people is both effective and sustainable.

+ Promoting human rights and challenging social injustice are fundamental to social work. There is increasing need in the current economic and political context for social work to highlight the deleterious impact of public sector cuts on older service users' wellbeing and care and to find creative approaches to minimise their impact.

+ Social workers' specific skills and experience in working with older people who are marginalised and/or disadvantaged afford opportunities for engaging some of the most vulnerable older people whose needs are often rendered invisible.

+ Social work's anchoring in values of social justice also makes it well placed to challenge the persisting age discrimination embedded in the allocation and delivery of health and social care services.

Welfare policy and social work with older people: increasing degrees of separation?

In this section we briefly outline the key policies that are relevant to gerontological social work with particular emphasis on its erosion by successive policy changes in England. It is noteworthy that welfare policies that are relevant to older people and to social work intersect in a complex, direct and indirect, and sometimes opaque way.

The development of care management

For over 20 years, the National Health Service and Community Care Act 1990 has been the primary policy framework underpinning the organisation of care and support for adults with dependency needs (DH, 2001). Following sustained criticism about monolithic and inefficient social services, the 'care management' model was developed with the aims of supporting a 'needs-led' rather than a 'service-driven' approach to care. Assessment, identified as the 'cornerstone' of care management practice, was envisaged to be holistic, empowering and individualised. Cost containment and the allocation of resources to those in 'greatest need' became an explicit and legitimate goal of welfare.

Community care reforms were ideologically wedded to the marketisation of welfare and sought to stimulate the development of services from the independent and voluntary sectors while decreasing the role of local authorities as providers of services. The underpinning policy assumption was that a well-developed market place would drive up standards through competition, thereby keeping costs competitive and enhancing choice for 'consumers' of care (i.e. service users). The degree to which these goals have been achieved has been the subject of considerable debate, with arguments being made by both supporters and detractors.

What is certain is that the 'community care reforms' have had significant implications for social work with adults. Social workers were recast as care managers with primary responsibility for assessing need and brokering care arrangements within an administrative model of care. The imperative to manage finite resources in an increasingly managerialised context has progressively eroded many of the traditional roles and tasks of social workers. This shift has been especially pronounced in social work with older people, reinforcing a widely held view that practice in this arena lacks therapeutic content, is unchallenging, and offers reduced career progression

(Lymbery, 2010). The resultant loss of specialist social work skills with older people is one of the key consequences.

Modernising social services

The Labour government's agenda for improvement in personal social services and health care – the so-called 'modernisation' agenda – was underscored by assumptions that performance could be improved via robust target setting, benchmarking and a change agenda driven by the centre. For example, *The National Service Framework for Older People* (DH, 2001a), sought to give strategic direction to improvements in support and services for older people around eight key 'standards': rooting out age discrimination; person-centred care; intermediate care; general hospital care; stroke; falls; mental health in older people; and the promotion of health and active life in older age. The 'measurement' of how far key goals attached to each of the eight standards were being met by the NHS and local authorities became an embedded aspect of assessing the extent to which policy aims were being achieved. The nature, number and roles of community mental health teams for older people with mental health problems is a prime example of such a goal in relation to the standard on 'mental health and older people' (Lingard and Milne, 2004).

The delivery of personal social services within a care management framework remained a key feature of the 'modernisation agenda'. During the early 2000s there was growing evidence that assessment practice was focusing on demonstrating an older person's 'eligibility to receive a service' rather than on an 'individual need' (Lymbery, 2005; Sullivan, 2009). Additionally, that practice was shifting ever further away from a nuanced relationship-focused activity that took account of an older person's resources, biography and aspirations and towards a time-limited administratively driven activity. Social work as a service *in its own right* was increasingly marginalised.

The personalisation agenda

More recently, the 'personalisation' agenda has been recast in England as the provision of direct payments to people eligible to receive them. Since the late 2000s cash payments in lieu of services have been viewed as the primary mechanisms for people who receive care and support to achieve personalised care, choice and

control and to maintain (or regain) independence (DH, 2010). Personal budgets[3] for people who are eligible for support from social services is a primary policy priority and a core element of the White Paper *Caring for our future: reforming care and support* and the succeeding draft *Care Bill* (DH, 2012; HM Government, 2013).

Although there is evidence that personal budgets result in improved outcomes for some adult service users, such as people with learning disabilities, the ability of older people with high support needs to benefit from them is much more equivocal (Netten *et al.,* 2012). Take-up has been low and it is not clear that personal budgets will be of benefit to older people with long-term and/or complex needs and their carers. Costs relating to personal budgets may also be higher and many older service users prefer to use more trusted conventional services. Few people with dementia are currently offered direct payments and many carers feel that the system is overly complex (Alzheimer's Society, 2013). Recent evidence even suggests that the psychological health and wellbeing of older service users in receipt of personal budgets may be lower than the wellbeing of those in receipt of conventional services (Moran *et al.,* 2013).

The role of social work in the arena of self-directed care is characterised by uncertainty. On the one hand an ongoing role for social work is clearly identified in a number of policy documents. Guidance related to 'Putting People First' states that: 'Social work is focused on supporting independence, promoting choice and control for people facing difficulties due to disability, mental health problems, effects of age and other circumstances' (Putting People First Consortium, 2010: 1). Other sources of evidence indicate that self-directed mechanisms are intended to substitute for social work. The Centre for Workforce Intelligence estimates a decrease in the need for social workers with adults due to the 'introduction of personal budgets' (CWI, 2012: 6).

Paradoxically, those older people who are most likely to be eligible for support from social services are also most likely to have long-term complex needs and be the most reluctant (or unable) to make use of a personal budget. It is precisely this group

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[3] Direct payments are cash payments in lieu of publically funded social care services; these have been in existence since 1997. From 2003, direct payments were supplemented by personal budgets: under this approach, the local authority gives the eligible person an immediate indication of how much money is available to spend on meeting their needs, and then allows them to choose how this money is spent and how much direct control they have over the money itself.

who require highly skilled and knowledgeable specialist social work input to achieve sustainable outcomes (McDonald *et al*., 2010). Practice dominated by administrative procedures is ill-equipped to deliver this goal (Richards, 2000). This is an issue picked up in more detail in Section 3.

There is a related paradox embedded in policy. Most of the aforementioned policy goals – choice, independence, autonomy and self-directed care – are underpinned by the notion of 'active ageing' (Lloyd *et al.,* 2013). While this may be an achievable aspiration for an older person who is relatively fit and has low level support needs, it is much more challenging to consider for someone with advanced dementia and/or who has a number of co-morbid conditions. That active ageing is widely regarded by policy makers as 'the norm rather than the exception' is at odds with the profile of those older people who actually need support from local authorities (Spicker, 2012).

A linked point is one of lack of criticality of the ever-increasing encroachment of the market into – and in place of – social work. That the market model neglects poverty and inequality as defining dimensions of 'need', that it presents service users as independent able-bodied 'consumers', and is antagonistic to the provision of universal welfare provision, positions it as oppositional to the needs, profile and contexts of most older people who are eligible for support from social services (Ferguson, 2007; Glasby, 2012).

Other policy related developments
While we have highlighted the direction of policy travel in so far as it relates to gerontological social work, it is also important to identify key policies that are relevant to the provision of health and social care more widely.

The *National Dementia Strategy* (DH, 2009) is the first national strategy focusing on dementia. It aims to address some of the inadequacies of dementia care and create an overall improvement in the experience of people living with dementia. The strategy currently focuses on, for example, improving care in hospital and in care homes, reducing the use of anti-psychotic medication and improvements in diagnosis, intervention and support for both the person living with dementia and their carers (Alzheimer's Society, 2012). Its goals are underscored and amplified by the 2012 Prime Minister's Dementia Challenge (DH, 2012a).

The Mental Capacity Act 2005 is based on a 'presumption of capacity' and promotes the fundamental importance of human rights. Theoretically at least, the Act offers a pivotal protection to older people with dementia who are commonly deemed to 'lack capacity' and as such are routinely excluded from decisions about their care and treatment. Any decision or act made on behalf of a person who lacks capacity must be done so on the basis of the person's 'best interests' and on the basis of the 'least restrictive option' available. It also needs to be proportionate to the nature and complexity of the specific decision. Deprivation of liberty safeguards form part of the mental capacity legislation and are in place to ensure that a care home or hospital may only deprive a person of their liberty in the best interests of the person when the person is unable to demonstrate capacity to make such a decision themselves.

Family carers provide the majority of community based care and support to relatives with dependency needs, including older people with long-term conditions. A number of separate but intersecting pieces of legislation relate to carers. The Carers and Disabled Children Act 2000 places an explicit duty on local authorities to offer carers an assessment of their own needs. The Carers (Equal Opportunities) Act 2004 places a specific duty on local authorities to consider whether carers wish to take part in paid work or training as part of their assessment. The (updated) *National Strategy for Carers* (DH, 2010) emphasises the importance of: recognising carers' contributions, early identification of carers, supporting carers to stay mentally and physically well, and helping carers to remain in paid work. The 2013–14 *Care Bill* (see below) includes important new rights for carers. All those who consider themselves to have caring responsibilities will be entitled to an 'assessment of need' making it easier for them to receive vital support. It also places a duty on local authorities to make it clear when, and in what circumstances, carers are entitled to support.

The draft White Paper *Caring for our future: reforming care and support* and the draft *Care Bill* (DH, 2012; HM Government, 2013) herald a new era of reforms of health and social care. In addition to the personal budgets issue noted above they have a number of implications for older people with health and social care needs and for local authorities and the NHS.

The proposals in the White Paper, as presented in the *Care Bill* 2013, bring together existing care and support legislation into a new, set of laws. It focuses on wellbeing, prevention, carers' rights, choice and personalisation. Specific issues of relevance include:

- Family carers will have greater access to assessments of need and should be better supported.

- There should be improved clarity around eligibility of care provided by local authorities, i.e. a national set of criteria, with a national minimum threshold.

- The establishment of Health Education England will have implications for care workforce training.

- The Care Quality Commission (CQC) will be enabled to develop an Ofsted style ratings system for care services.

- An element of continuity of care; if a service user moves between local authority areas service users will have their care provided in the new area, at the same level, until a reassessment takes place.

- The Bill will allow for the cap on how much individuals pay for their social care (as recommended by the Dilnot review of long-term care funding) and deferred payments for social care will be allowed. This may mean that fewer older people will be obliged to sell their home to pay for care, especially long-term care, at least in their lifetime (DH, 2012; HM Government, 2013).

Changes introduced by the Health and Social Care Act 2012 are also relevant and include the following:

- The National Institute for Health and Care Excellence (NICE) is now legally responsible for developing quality standards and guidance for social care; it has recently published quality standards for people living with dementia (NICE, 2013).

- Greater responsibility for public health has been transferred to local authorities and it is now the responsibility of local Health and Wellbeing Boards to oversee and develop this.

- Clinically led commissioning is a substantive change to the way health services are commissioned. Local Clinical Commissioning Groups will now directly commission services for their populations.

Two other important overarching points need to be made about the relationship between social work and policy development over the last 25 years. Firstly, a persistent policy emphasis on 'social care' has rendered – almost – invisible the roles and contribution of social workers, especially those working with marginalised groups such as vulnerable older people and their carers. That social workers have failed to capture their contribution to older people's wellbeing in a way that appeals to policy makers is a factor (see Section 3 for detailed coverage of this issue) but by no means the full story. Economic imperatives, coupled with an emphasis on self-care, self-funding, reliance on the 'family' and 'community' and withdrawal of state-funded care from the majority of vulnerable adults 'in need' are the primary drivers. Secondly, the infrastructure of social care, including social work, is being further challenged by (additional) economic austerity. The immense pressures on resource-constrained local authorities threaten to erode the existing limited role social workers have in working with older people. The consequences of this are profoundly negative and far-reaching: this is an issue we return to later in the report.

The devolved policy context

Over the last 20 years the process of political decision making in the United Kingdom (UK) has undergone a period of significant change. This is largely due to the decentralisation of political and administrative powers to the devolved legislatures of Scotland, Wales and Northern Ireland. One of the main drivers of devolution was to bring powers in relation to key public service areas, including health and social care, closer to the citizen so that local factors were better recognised in decision making. However, since devolved administrations are judged by the differences they create in policy as a means of justifying their existence, it is unsurprising that divergent social policy trajectories have emerged across the UK with a different set of implications for social work in each jurisdiction.

A useful example of this is the 'personalisation' agenda. In Scotland, the national strategy on self-directed support (SDS) describes personalisation as the 'support individuals and families have after making an informed choice on how their personal

budget (PB) is used to meet the outcomes they have agreed'. Scotland's Self-Directed Support Bill, which is expected to come into effect in Spring 2014, attempts to make it easier for people to arrange self-directed support and offers clarification on eligibility for PBs. In Northern Ireland, the concept of personalisation represented a shift in emphasis towards person-centred planning, choice and control, and self-directed care and support. However, The Carers and Direct Payments Act (Northern Ireland) 2002 does not mandate the offer of direct payments (as in England, Wales and Scotland). Unlike other jurisdictions within the UK, Northern Ireland has had a system of integrated health and social care with five regional Trusts responsible for the provision of these services. In Wales, the Welsh Government considered personalisation as a label that had: 'become too closely associated with a market-led model of consumer choice' and recognised the importance of individually tailored care services but ostensibly rejected a market-led approach that they considered would place an unwelcome and unmanageable burden and responsibility for finding appropriate services onto individuals (Welsh Assembly Government, 2011).

However the new Social Services and Well-being (Wales) Bill – expected to be implemented early in 2016 – explicitly commits to encouraging the take-up of 'personalised services' which is predominantly conceptualised as being delivered by direct payments. This Bill intends to bring together a range of existing duties into one single power for local authorities; it also provides clarity about what support and services the public are legally entitled to. The Welsh Government believes that the process of assessment should be underpinned by a strong relationship between social workers and service users and, where appropriate, their family and/or carer. The implementation of 'co-production' as a model can be seen through centrally funded programmes such as the Wales wide 'Developing Evidence Enriched Practice' (DEEP) programme. This programme is being developed and implemented by the All Wales Academic Social Care Research Collaboration (ASCC) with partners including Swansea, Cardiff and Bangor Universities and the Welsh Government's National Institute for Social Care and Health Research. This approach builds upon evidence-based and informed practice developed elsewhere by national agencies with an interest in social work and social care workforce development and uses research evidence alongside other forms of evidence such as organisational knowledge to enrich decision making. Research evidence, user and carer voices,

and practitioner skills and knowledge are accorded equal status within this model (Gerrish *et al.*, 2011; Nutley *et al.*, 2007).

Key opportunities

+ Welfare policies that are relevant to older people and to social work intersect in a complex and often opaque way. The reform of adult care law in the Care Bill 2013–14 intends to simplify and clarify the current labyrinth of 'adult care legislation', thus making the legal responsibilities of local authorities and the rights of service users more transparent. This gives greater scope for social workers to use the law as a tool to uphold the rights and interests of older people.

+ Although recent policy developments have challenged the fundamental role and function of social work, key documents clearly identify an ongoing role for social work, namely supporting people's independence and promoting choice and control. This creates an opportunity and an imperative for social work to demonstrate its contribution in these areas. This includes identifying the specific value of *social work*, rather than the more broadly defined social care. Opportunities for social work to work effectively with healthcare colleagues and services are also significant.

+ Social workers are trained to think critically about their practice and the wider context in which it is shaped and delivered. They have a key role in highlighting tensions between the realities of older people's lives and narrow interpretations of accepted policy discourses, such as 'personalisation' and 'active ageing'.

+ Social workers are educated in a range of methods and approaches. The policy focus on achieving person-centred outcomes creates the potential for them to invoke a variety of means to achieve individually focused outcomes for older people, especially those who cannot, or choose not to, make use of a self-directed budget. Advocating for the right of this population to access good quality care, identifying what quality means from older people's perspectives, and ensuring that this is delivered are related roles.

+ Devolved political and administrative powers in Scotland, Wales and Northern Ireland have resulted in divergent social policy trajectories with different implications for social work practice. For example, the Welsh Government foregrounds the importance of the relationship between the social worker and the service user in effective assessment. These differing emergent models of practice create opportunities for social workers in England to learn from experience elsewhere and to harness this evidence to advocate for approaches that seem most effective in promoting older people's wellbeing.

Section 2: International evidence base

Drawing on the prominent implications of the United Nations (UN) Madrid International Plan of Action on Aging (MIPAA) (2002), the International Federation of Social Work (IFSW) launched its own 'International Policy on Ageing and Older Persons' in 2009. This policy acknowledges social work's strategic position, around the globe, to enable the full social integration of older people. Broadly speaking, this includes the promotion of their social, economic and intellectual contributions and strategic macro and micro level advocacy to tackle any social conditions that hinder security, health and well being (Hokenstad and Roberts, 2011). Unfortunately, limited evidence is available to provide us with a thorough understanding of how nations received, or have responded to, IFSW's policy.

The exception is in North America where high profile gerontological social work initiatives have raised the visibility of gerontological social work practice. Strategic developments have included championing gerontological social work (and interdisciplinary) education, increasing social work's capacity to conduct high quality gerontological research, evaluating social work practice to begin to capture evidence of effectiveness (including cost-effectiveness), and cultivating opportunities for knowledge transfer and mobilisation. At the foundation of this work is partnership building – among universities and communities, gerontological practitioners and professional associations, interdisciplinary researchers (e.g. medicine and technology) and older people and family carers. Although North American approaches to social work and welfare delivery are unlike those in England, there are messages that are relevant for invigorating gerontological social work here and building its capacity to respond to the needs of an ageing population.

Gerontological social work initiatives in North America
United States

Since the late 1990s several parallel and multifaceted initiatives have developed in the US to increase the capacity of social work to meet the needs of an ageing population. For the most part, these initiatives have been funded and led by various professional, inter-professional, academic and other charitable and independent arrangements. Since an early emphasis on strengthening education, the initiatives have expanded to include the development of evidence and the transfer of usable

knowledge to practice settings. The economic evaluation of gerontological social work practice has begun to receive prominence more recently (Rizzo and Rowe, 2006; Frick and Kunz, 2008).

The Council on Social Work Education (CSWE)[4] was the first host of the Geriatric Social Work Initiative (GSWI) in 1998 to strengthen ageing and gerontology education in social work. With funds from the John A. Hartford Foundation,[5] the CSWE first focused on faculty development, and then expanded their work to strengthen social work programmes through enriching curricula to address ageing and older people. This work culminated in 2004 with the development of the National Centre for Gerontological Social Work Education (CSWE Gero-Ed Centre) and work has continued in areas such student recruitment, creative mechanisms to develop student interest in older people and specialisation programmes at the postgraduate level.

To date, the total investment from the Hartford Foundation has been approximately $65m (Aging Times, 2008). This includes the expansion of the GWSI to include: (a) the Hartford Partnership Program for Aging Education (HPPAE) affiliated with the New York Academy of Medicine (NYAM),[6] (b) the Hartford Scholars Program, and (c) the Hartford Doctoral Scholars Program. These programmes have virtually transformed or 'gerontologised' social work education in the US by training academic champions to teach students and engage in research, recruiting future leaders through the promotion of doctoral studies, the creation of core competencies for gerontological practice (see Box 1), and developing ageing curriculum and practice learning opportunities through various university and community partnerships (GSWI, 2013; Damron-Rodriguez, 2006, 2009). The core competencies, for example, are used to specifically guide and evaluate curricula development and practice education.

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[4] The CSWE is the sole accrediting agency for social work education in the US.
[5] The Hartford Foundation was established in 1929 with a bequest from the Hartford brothers (former Chief Executives of the Great Atlantic and Pacific Tea Company) to improve the health of older Americans. One of the key strategies for the Foundation is to fund programmes aimed enhancing geriatric expertise in healthcare settings. Advancing medical, nursing and social work education has been at the core of this strategy.
[6] Founded in 1847, the NYAM is an independent non-profit institute that addresses health through education, research, advocacy and prevention.

Box 1: Geriatric social work competency scale (II)

I. VALUES, ETHICS, AND THEORETICAL PERSPECTIVES
1. Assess and address values and biases regarding aging.
2. Respect and promote older adult clients' right to dignity and self-determination.
3. Apply ethical principles to decisions on behalf of all older clients with special attention to those who have limited decisional capacity.
4. Respect diversity among older adult clients, families, and professionals (e.g. class, race, ethnicity, gender and sexual orientation).
5. Address the cultural, spiritual, and ethnic values and beliefs of older adults and families.
6. Relate concepts and theories of aging to social work practice (e.g. cohorts, normal aging, and life course perspective).
7. Relate social work perspectives and related theories to practice with older adults (e.g. person-in-environment, social justice).
8. Identify issues related to loss, changes and transitions over their life cycle in designing interventions.
9. Support persons and families dealing with end-of-life issues related to dying, death, and bereavement.
10. Understand the perspective and values of social work in relation to working effectively with other disciplines in geriatric interdisciplinary practice.

II. ASSESSMENT
1. Use empathy and sensitive interviewing skills to engage older clients in identifying their strengths and problems.
2. Adapt interviewing methods to potential sensory, language, and cognitive limitations of the older adult.
3. Conduct a comprehensive geriatric assessment (bio-psychosocial evaluation).
4. Ascertain health status and assess physical functioning (e.g. ADLs and IADLs) of older clients.
5. Assess cognitive functioning and mental health status of older clients (e.g. depression, dementia).
6. Assess social functioning (e.g. social skills, social activity level) and social support of older clients.
7. Assess caregivers' needs and level of stress.
8. Administer and interpret standardized assessment and diagnostic tools that are appropriate for use with older adults (e.g. depression scale, Mini-Mental Status Exam).
9. Develop clear, timely, and appropriate service plans with measureable objectives for older adults.
10. Re-evaluate and adjust service plans for older adults on a continuing basis.

III.	INTERVENTION

1. Establish rapport and maintain an effective working relationship with older adults and family members.
2. Enhance the coping capacities and mental health of older persons through a variety of therapy modalities (e.g. supportive, psychodynamic).
3. Utilize group interventions with older adults and their families (e.g. bereavement groups, reminiscence groups).
4. Mediate situations with angry or hostile older adults and/or family members.
5. Assist caregivers to reduce their stress levels and maintain their own mental and physical health.
6. Provide social work case management to link elders and their families to resources and services.
7. Use educational strategies to provide older persons and their families with information related to wellness and disease management (e.g. Alzheimer's disease, end-of-life care).
8. Apply skills in termination of work with older adults and their families.
9. Advocate on behalf of clients with agencies and other professionals to help elders obtain quality services.
10. Adhere to laws and public policies related to older adults (e.g. elder abuse reporting, legal guardianship, advance directives).

IV.	AGING SERVICES, PROGRAMS, AND POLICIES

1. Provide outreach to older adults and their families to ensure appropriate use of the service continuum.
2. Adapt organizational policies, procedures, and resources to facilitate the provision of services to diverse older adults and their family caregivers.
3. Identify and develop strategies to address service gaps, fragmentation, discrimination, and barriers that impact older persons.
4. Include older adults in planning and designing programs.
5. Develop program budgets that take into account diverse sources of financial support for the older population.
6. Evaluate the effectiveness of practice and programs in achieving intended outcomes for older adults.
7. Apply evaluation and research findings to improve practice and program outcomes.
8. Advocate and organise with the service providers, community organizations, policymakers and the public to meet the needs and issues of a growing population.
9. Identify the availability of resources and resource systems for older adults and their families.
10. Assess and address any negative impacts of social and health care policies on practice with historically disadvantaged populations.

V.	LEADERSHIP IN THE PRACTICE ENVIRONMENT OF AGING

1. Assess 'self-in-relation' in order to motivate yourself and others including trainees, students and staff toward mutual, meaningful achievement of a focused goal or committed standard of practice.
2. Create a shared organizational mission, vision, values and policies responding to ever changing service systems in order to promote coordinated, optimal services for older persons.
3. Analyze historical and current local, state, national policies from a global human rights perspective in order to inform action related to an identified social problem and/or program for older adults for the purpose of creating change.
4. Plan strategically to reach measurable objectives in program, organizational, or community development for older adults.
5. Administer programs and organizations from strengths perspective to maximize and sustain human resource (staff and volunteers) and fiscal resources for effectively service older adults.

6. Build collaborations across disciplines and the service spectrum to assess access, continuity, and reduce gaps in services to older adults.
7. Manage individual (personal) and multi-stakeholder (interpersonal) processes at the community, interagency, and intra-agency levels in order to inspire, leverage power, and resources to optimize services for older adults.
8. Communicate to public audiences and policy makers through multiple media including writing synthesis reports and legislative statements and orally presenting the mission and outcomes of the services of an organization or for diverse client group(s).
9. Advocate with and for older adults and their families for building age friendly community capacity (including the use of technology) and enhance the contribution of older persons.
10. Promote use of research (including evidence-based practice) to evaluate and enhance the effectiveness of social work practice and aging related services.

Very recently, the Hartford Foundation provided another $1.35m to create the new Hartford/Gerontological Society of America (GSA) National Centre on Gerontological Social Work Excellence.[7] The National Centre's three objectives are to further the development of social work research leaders to advance evidence-base knowledge, mobilise the GSWI alumni network (over 200 doctoral scholars and faculty fellows) to influence policy and practice, and create five Hartford Academic Centres of Excellence in Geriatric Social Work in higher education (GSA, 2013).[8] The Academic Centres of Excellence are expected to expand GSWI's work by, for example, providing leadership in social work education, including the expansion of partnerships with organisations delivering services to older people, engaging in interdisciplinary research collaborations, and creating and evaluating models of knowledge translation to practice and policy.

As previously mentioned, a variety of these initiatives are closely aligned with NYAM. The NYAM's Social Work Leadership Institute (SWLI) mandate is to develop programmes and policies that promote social work intervention (Rosenfeld *et al.*, 2008), and one of its priorities is the care of older people through leadership, policy advocacy and research and evidence building (SWLI, 2013). Its Leadership Academy in Aging is aimed at working with deans and directors of social work education programmes to advance educational models that will benefit the health

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[7] The GSA is an interdisciplinary organisation for research, education and practice in the field of ageing. It fosters collaboration among scientists (biological, social, psychological, behavioural), policy makers and health and social care professionals.
[8] At the time of writing, two Academic Centres of Excellence have been announced – Boston College and the University of Michigan.

and care of older people. A specific policy programme brings together individuals to address models of care to improve health and social care delivery to older people through a National Coalition on Care Co-ordination (N3C).

A recent success was the publication of a report on evidence of effective care co-ordination models for older people with multiple chronic conditions and functional limitations (Eldercare Workforce Alliance and N3C, 2013). The key elements of all effective models were identified as person- and family-centred care, team-based care and evidence-based management. One example is the Care Transitions Intervention programme (CTI) (Coleman *et al.*, 2006) as described in Box 2 below.

Box 2

Care Transitions Intervention (CTI): A person-centred intervention designed to improve the quality and contain costs for patients with complex care needs as they transition across care settings.

Evidence: Intervention patients had lower 90-day rehospitalisation rates and lower hospital costs at 180 days post discharge.

Target patients: Individuals being discharged from the hospital with a diagnosis of stroke, heart failure, coronary artery disease, cardiac arrhythmias, COPD, diabetes, spinal stenosis, hip fracture, peripheral vascular disease, deep venous thrombosis, and pulmonary embolism.

Staffing: A transition coach, which can be a social worker, registered nurse or occupational therapist. Each transition coach has a caseload of approximately 40 patients.

Duration: 30 days post hospital discharge.

Focus: Continuity of care by helping family maintain a personal health record, understand how and when to obtain timely follow-up care, coach patients to ask the right questions of their care providers, help patients increase self-care skills (medication management, increased awareness of chronic illness symptoms, recognizing 'red flags' and warning signs and how to respond); initial home visit (48 to 72 hours post hospital discharge), and three follow-up calls 30 days post discharge home.

Additionally, its research and evidence building programme maintains an online searchable evidence-based database on ageing care (EDAC) (link in Box 3 below).[9]

Box 3

http://www.nyam.org/social-work-leadership-institute-v2/publications-and-resources/edac/
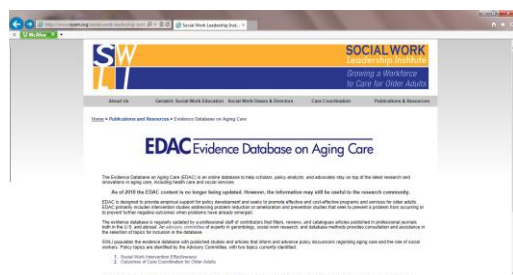
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[9] According to the EDAC website, the database has not been update since 2010. It would appear that funding issues may be at the source of this problem.

In terms of effective gerontological social work interventions the following example in Box 4 offers a strong one (further examples are identified in Table 1 later in this section).

Box 4

Zvi Gellis, University of Pennsylvania and Hartford Faculty Scholar, is an expert in geriatric mental health and has extensively researched depression and homebound older people.

Late life depression is associated with functional decline and increased health care utilisation. However, screening older people for depression is not common. Brief and effective psychosocial interventions are necessary to improve quality of life in older people and reduce reliance on healthcare services. Problem solving therapy (PST) has been repeatedly demonstrated as an effective intervention for depression, easily adapted to accommodate the needs of people with co-morbid physical health problems who are housebound.

Six weekly one-hour sessions are delivered by clinical social workers: educational sessions about depression, daily life stressors and management of physical health problems; three types of problem solving for daily living; and planning for pleasurable activities.

Randomised control trials repeatedly demonstrate significant immediate positive effects of PST. PST is low cost and practical, and can be delivered alongside medication intervention. Larger trials are currently being run to explore effectiveness in ethnic minority groups and longer-term impact of PST. This work is supported by the National Institute of Mental Health's strategy for *Psychosocial Intervention Research in Late Life Mental Health Disorders.*

(Gellis *et al.*, 2007; Gellis and Kenaley, 2008; Gellis and Bruce, 2010)

Canada

Like colleagues in the neighbouring US, social work in Canada is also closely aligned to health care delivery; interdisciplinary responses to the needs of an ageing population are also familiar. The key initiative in Canada resembles work in the US, but on a much smaller scale.

The National Initiative for the Care of the Elderly (NICE) was formed in 2005 by the University of Toronto's School of Social Work. With five-year funding from the Canadian Government's Networks of Centres of Excellence (NCE)[10] programme,

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[10] NCE funds academic-led large virtual research centres that bring together partners from academia, industry, government and the non-profit sector. Networks are supported to undertake research and

NICE formed to promote evidence-based interdisciplinary gerontological practice. Its three overarching goals include: (a) to help close the gap between evidence-based research and actual practice; (b) to improve the training of existing practitioners, geriatric educational curricula and student interest in geriatric care; and (c) to effect positive policy changes for the care of older people (NICE, 2013).

Specific to evidence-based practice, NICE formed several themed working groups (e.g. dementia care, end-of-life care, elder abuse, mental health) made up of academic scholars, practitioners and older people. The working groups have been responsible for reviewing and critiquing existing evidence to create evidence-informed tools for use by practitioners in a range of practice settings. These 'user friendly' assessment and intervention pocket tools (paper or digital) are now sold and the funds used to further the NICE agenda. Box 5 provides an example of an evidence-based elder abuse screening tool being promoted by NICE.

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development and engage with 'community receptors' to accelerate the translation of knowledge to practice.

Box 5

Indicators of Abuse (IOA)
The IOA checklist signals mistreatment of seniors. The IOA also helps sensitize the practitioner to important abuse issues. The IOA is practical for busy practitioners and useful in training intervenors and volunteers in cases of abuse to recognize the signs of abuse. The IOA is a summary of abuse high-risk signals. It is not, however, a substitute for becoming knowledgeable about abuse signs through education.

Caregiver and Care Receiver Indicators of Abuse
Indicators of abuse are listed on the next two panels, in order of importance*. After a 2-3 hour home assessment (or other intensive assessment), rate each of the following items on a scale of 0-4. Do not omit any items. Rate according to your current opinion.

*The majority of the most important indicators are the caregiver ones.

Caregiver

___Has behaviour problems
___Is financially dependent
___Has mental/emotional difficulties
___Has alcohol/substance abuse problem
___Has unrealistic expectations
___Lacks an understanding of medical condition
___Caregiving reluctancy
___Has marital/family conflict
___Has poor current relationship
___Caregiving inexperience
___Is a blamer
___Had poor past relationship

Care Receiver

___Has been abused in the past
___Has marital/family conflict
___Lack of understanding of medical condition
___Is socially isolated
___Lacks social support
___Has behaviour problems
___Is financially dependent
___Has unrealistic expectations
___Has alcohol/medication problems
___Has poor current relationship
___Has suspicious falls/injuries
___Has mental/emotional difficulties
___Is a blamer
___Is emotionally dependent
___No regular doctor

Caregiver age___years
Caregiver and care receiver kinship:
___Spouse/partner
___Non-spouse/non-partner

Scale
Estimated extent of the problem:

0	= non-existent	4	= yes/severe
1	= slight	00	= not applicable
2	= moderate	000	= don't know
3	= probably/severe		

Total sum of the ratings for all items (range 0– 108)

Interpreting Results
The abuse indicators are listed in rough order of importance. In general, the caregiver indicators carry more weight than care-receiver indicators. However, it is the total list of indicators together that signal abuse. Thus, the higher the total score, the more likely it is that abuse is occurring. The total score close to 16 and higher are suggestive of abuse. Total scores of 4 or less indicated that there probably is no abuse. Each indicator that is rated by the interviewer as being between 1 and 4 on the scale should be explored clinically. However, each individual indicator does not, by itself, indicate abuse.

Original source: Reis M. and Nahmiah D. (1998) Validation of the Indicators of Abuse (IOA) Screen. *The Gerontologist*, 38(4) pp.471-480.

With further funds from Health Canada, NICE with colleagues from the Geriatric Education Recruitment Initiative (GERI),[11] developed inter-professional core competencies to complement those developed by the Canadian Geriatrics Society, Canadian Academy of Geriatric Psychiatrists and the Canadian Gerontological Nursing Association. Like in the US, the core competencies are used as goals or outcome measures for education and training. NICE also delivers, usually in collaboration with other organisations and professional associations, a range of interdisciplinary educational programmes – many of which are delivered online.

NICE has subsequently become a non-profit charitable organisation. Partnerships with other organisations and academic institutions have also been critical to sustain its developments – and key partners, among others, include the Canadian Social Work Association, the Canadian Association of Gerontology, and the John A. Hartford Foundation. With further funds from NCE and the International Development Research Centre (a Canadian Crown Corporation), NICE formed an international arm to extend its collaborations globally (GSWI, 2013).

The impact of the initiatives

The vast majority of the initiatives in the US have undergone thorough evaluation. Overall, the outcomes have been very impressive and are widely published in the literature. NICE in Canada is currently evaluating the impact of their tools in practice (NICE, 2013).

Very briefly, early studies demonstrated an absence of ageing content in social work education programmes and few practice learning opportunities in settings working with older people. The infusion of ageing content across undergraduate and postgraduate programmes and the development of innovative models of practice learning have consistently demonstrated an increase in student interest in gerontological social work, more positive attitudes toward older people, and an increase in gerontological skill and knowledge (Lee *et al.*, 2009; Dorfman *et al.*, 2007; Adler, 2006; Volland and Berkman, 2004). Higher rates of gerontological practice on graduation have also been noted (Lee *et al.*, 2009).

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[11] GERI involves professional organisations working together to improve recruitment in geriatric medicine, nursing and social work.

In terms of gerontological social work leaders, over 200 doctoral students and social work faculty scholars have been funded and supported to conduct gerontological research (GSWI, 2013). It is worth noting here that the impact of the initiatives on intervention research and policy and practice will be better understood in the near future as their evaluation is typically demonstrated over the longer term (Frick and Kunz, 2008). In any case, the doctoral students and social work faculty scholars are also well positioned within the GSA community and its profile is continuing to rise. Further, the recent creation (2013–14) of Centres of Excellence will, no doubt, contribute to the expansion of high quality research for translation into practice and policy.

Gerontological social work intervention: outcomes in North America

'Conducting research with older people will continue to be challenged by the complex multidimensionality of the problems they face. With multiple conditions, multiple providers, and multiple interacting treatments, the study of older adults is never simple. They may simultaneously confront significant physiological, psychological, and social impairments, and measuring outcomes of treatment activities may require an array of measures across multiple domains during both the assessment process and after the intervention.' (Berkman, 2011, online)

It would appear that the evidence base for gerontological social work in North America is growing in both quantity and quality, but the picture is a complex one. First, there have been advancements in ageing research and gerontological theory overall which is influencing all research (Berkman, 2011). Second, gerontological social work researchers are often part of the interdisciplinary research team studying interdisciplinary practice. The outcomes, in this instance, are interdisciplinary measures of effectiveness rather than simply those of social work. Third, the formal evaluation of an intervention, including economic, (i.e. cost-effectiveness or cost-benefit analysis) usually lies within broader economic, political, social and cultural agendas, which undoubtedly impacts on the nature of the research, the findings and their dissemination (Frick and Kunz, 2008). In the US in particular, much of the gerontological social work research has aligned itself with broader policy developments, agendas within the GSA community and the setting of research

priorities by the social work community. For example, Burnette and colleagues (2003)[12] conducted a Delphi study on setting priorities for gerontological research. The priorities identified by the expert panellists of researchers and practitioners were then considered in relation to those identified by the US National Research Council and the National Institute on Aging to ensure compatibility and draw out social work's contribution to other research agendas. Box 6 outlines the overall priorities for gerontological social work research.

Box 6

Intervention research
1. Developing and testing psychosocial interventions across populations and conditions
2. Developing and testing ethnically sensitive assessment and interventions
3. Developing psychosocial outcome measures
4. Developing and testing psychosocial and ecological interventions for cognitive and mental disorders

Housing and living arrangements
5. Maximizing housing-living arrangement options for aging in place
6. Transitions and adjustments across care settings and environments

Service delivery
7. Coordination and integration of health, mental health and social service systems
8. Utilization and barriers to health, mental health and social services
9. Interface between informal and formal care
10. Service use by ethnic elders

Detection and assessment
11. Determining needs of ethnically diverse elders

Family caregiving
12. Effective services to family caregivers
13. Understanding specific caregiver population

Health–mental health
14. Chronic illness, disability and rehabilitation – QOL and psychosocial wellbeing
15. Detection, assessment and treatment of late life depression

Workforce
16. Recruitment and education of professional workforce for an aging population

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[12] Raveis et al. (2010) is another example.

The purpose in this section is to present a snapshot of a very small selection of the specific gerontological social work evidence on effectiveness from North America; offering a thorough critique of their quality and/or methods is outside the remit of this report. It is important to note that the tendency in this research literature is to look at the effectiveness of the intervention and then link the outcomes with other cost measures (e.g. a discharge home following emergency room visit saves an estimated amount of money based on per day rate for an inpatient bed). Specific cost-effectiveness studies are more difficult to find, but this is by no means unique to gerontological social work. It is also the case in many complex multidimensional arenas including in child protection, mental health, and in health care more widely. Public health interventions – for example on obesity – also routinely struggle to find hard evidence of their impact.

The following examples of effective gerontological social work interventions are drawn from a number of sources and are selected given their potential for application in England:

Table 1

Social work intervention	Outcomes	Investigators
Geriatric depression, social support and rehabilitation service utilisation	Evidence of environment and psychosocial factors that have detrimental effects on morbidity and service utilisation.	Horowitz et al., 2003 and 2005
Geriatric depression and brief problem solving therapy (See Box 4 for details)	Demonstrated effectiveness of brief problem solving therapy at home.	Gellis *et al.*, 2007; Gellis and Kenaley, 2008; Gellis and Bruce, 2010
Empowerment intervention for Black African carers	Positive caregiving outcomes.	Chadiha *et al.*, 2003 and 2004
Carer support groups	Lower overall outpatient costs compared to non-intervention group, improvement in one of the following - quality of life, physical function or health status - for carer or care recipient.	Toseland and Smith, 2006
Social work support services and care	Significant improvements in medical utilisation with cost savings.	Claiborne, 2006

co-ordination for stroke patients		
Social work services in hospital accident and emergency services	More expedited community referrals and decreased demands on hospital services.	Ponto and Berg, 1992
Geriatric evaluation and management services	Reduced hospital admissions, reduced nursing home placements, improvements in quality of life and quality of health outcomes.	Engelhardt *et al.*, 1996; Boult *et al.*, 1998; Burns *et al.*, 2000
Discharge planning from hospital to home	Increased patient satisfaction, improvements in quality of life and readmission rates.	Preyde *et al.*, 2009 and 2011
Motivational interviewing and behavioural change with older people with acute and chronic illness	Improvements in physical activity, diet, cholesterol, blood pressure and glycaemic control, and increased smoking cessation.	Cummings *et al.*, 2009

Key opportunities

+ Evidence from North America demonstrates that a concerted coherent plan, effective leadership and some core funding are fundamental to any strategic initiative to raise the quality and visibility of gerontological social work and identify its contribution to the health and wellbeing of older people

+ In both the US and Canada gerontological social work is recognised as making a key contribution to addressing the challenges posed by an ageing population *and* to responding to those challenges. Its contribution is evidenced at both a macro level (e.g. policy making), and at a micro level (e.g. services for, or interventions with, older people and their carers). This provides a powerful illustration of the potential role of gerontological social work in a UK context.

+ The Geriatric Social Work Initiative (GSWI) in the US has unmistakably demonstrated the effectiveness of gerontological social work, particularly in developing policy and in delivering interdisciplinary care and support to older people with dependency needs.

+ For gerontological social work to be re-established and reinvigorated it must be underpinned by high quality research; the capacity for the gerontological social work community to conduct high quality research, including intervention research, is a primary priority.

+ It is also an a priori requirement that gerontological social workers have specialist skills and knowledge; they need to be appropriately educated and trained to be able to deliver effective interventions.

+ GSWI (US) and the National Initiative for the Care of the Elderly (Canada) have learned that effective gerontological social work practice is reliant on highly skilled practitioners who can use research evidence in their work.

Section 3: The contribution of gerontological social work to older people's health and wellbeing

Demonstrating social work's value and effectiveness in the lives of older people is not an easy task. This is not because social work is not valuable and effective but because clear evidence is hard to find. This is for a number of reasons. Firstly, research into the process and outcomes of gerontological social work has been limited. This is partly because of a lack of interest and commitment to social work with older people by practitioners, educators and research funders (Richards *et al.*, 2013). Second, as identified in Section 1, social work roles have increasingly been broken down into related roles with a number of different titles: these include 'care manager', 'broker', 'social care practitioner', and 'approved mental health professional'. Even when research studies capture the professional role that these practitioners perform, it is difficult, if not impossible, to extract the contribution of social work itself. Thirdly, the lives of the people with whom social workers work are complex and dynamic, affected by many constantly changing variables. Evaluating the effectiveness of social work interventions in a context that shifts in shape and form during the period of intervention presents a considerable challenge. Social work is an activity that is often hidden from direct view but is there nevertheless.

Despite such challenges, detailed engagement with social work research and practice initiatives reveals both the current and potential contribution of social work to improving the health, wellbeing and quality of life of older people and to the more effective use of health and social care resources. In this section of the report, we consider social work's contribution – both actual and potential – from two perspectives:

> 1. The nature of the support provided. Social work encompasses an increasingly diverse set of roles and tasks, undertaken in a variety of settings. We summarise some key areas in which social work does, or can, contribute to the wellbeing of older people. These include: assessment and support planning; prevention, early intervention and re-ablement; community social work; safeguarding and risk management; and advocacy.

> 2. The particular subgroups of older people who become 'service users' of social work and who stand to gain most from it (and lose most from its

absence). As highlighted in Section 1, the category of 'older people' is expanding and potentially spans five decades of life, with differences not only in age, gender, ethnicity, religion, sexual orientation, social class, income and life experiences but also in the difficulties faced in later life. Social work has a particular contribution to make in promoting the wellbeing of older people facing specific challenges. These include: older people undergoing transitions; older people undertaking significant caring responsibilities; older people with dementia; and older people at the end of life.

The nature of support provided

Assessment and support planning

In collaboration with older people and their families, gerontological social workers conduct bio-psycho-social assessments to identify and address inter-connected physical, psychological, life course, and social factors that affect health, wellbeing and need. A bio-psycho-social approach is fundamental to social work practice and provides an essential basis for working with older people who are in the process of managing the transitions, change and loss (often) associated with later life. Developing a collaborative understanding of needs and identifying ways to maximise the social and psychological resilience of older people and their families is a highly skilled task and one that is key to supporting quality of life and to the well-targeted and effective use of resources (Richards, 2000). A particular challenge is the increasing number of frail older people who access emergency health and social care services and are at risk of unnecessary hospital admission and inappropriate care, e.g. premature admission to care home. Multidisciplinary teams, including social workers, have an essential role to play in assessing the needs of this high-risk group to improve the quality, outcomes and efficiency of the care provided (Banerjee and Conroy, 2012). Social workers based in emergency departments in hospitals not only provide information, advocacy and emotional support for older people who are frequent users of emergency health care, but also improve access to social and health care services. There is some indication that this improves follow-up care and reduces the number of future admissions, although this does depend on an adequate infrastructure of care services being in place to address the complex and intertwined needs experienced by this particular group of older service users (McLeod and Olsson, 2006; McLeod *et al.*, 2003).

Following on from assessment is the role of designing and organising support packages tailored to the needs of older service users and their families. In England, since the introduction of personal budgets, this is normally undertaken by a 'support broker', which means that social workers now only undertake this role in the most complex cases. Engaging with the key policy objectives of choice and control (discussed in Section 1) for service users with high levels of need who are increasingly remaining in their own homes, presents a number of challenges. That recent research suggests that older people receiving care in their own homes are significantly less likely to feel 'in control' of their daily lives than older residents of care homes or extra care housing underscores this challenge (Callaghan and Towers, 2013). There is a related challenge linked to mistrust of 'the care system'. Research with older people aged 80 years or over who have experienced more than two emergency hospital admissions in the previous five years identified a reluctance to engage with services, even when they needed them and knew about them. Reasons included lack of trust of professionals, dissatisfaction or frustration with existing services, and concerns that care services would undermine their independence (Themessl-Huber *et al.*, 2007). These findings have implications not only for the funding, delivery and monitoring of services for older people living at home but also for the process of developing trusted and appropriate support packages for older people with high level needs. Gerontological social workers, equipped with specialist communication and engagement skills, are well placed to engage vulnerable older service users, with issues of choice, control, autonomy and aspiration embedded within the processes of assessment and support package development (Hardy *et al.*, 1999). Many users in this context will have sensory or cognitive impairments and are likely to be very frail and 'necessarily dependent' on others for their survival; some will also have a family carer.

Prevention, early intervention and re-ablement
The Marmot Review (Commission on the Social Determinants of Health, 2010), which focused on the issue of health inequalities across the life course, argued that such inequalities were preventable and that tackling them was a matter of social justice. The review identified a number of key areas for intervention to reduce inequalities. These included: maximising control and capabilities for people across the life course including later life; ensuring a healthy standard of living for everyone;

developing and sustaining communities; and strengthening the role and impact of initiatives that focus on preventing ill health and disadvantage. Subsequently, the Select Committee on Public Service and Demographic Change, in their report *Ready for Ageing* (House of Lords Public Service and Demographic Change Select Committee, 2013) highlighted the vital importance of supporting prevention, health promotion and positive management of long-term conditions in older age.

There is therefore a potential mandate for social workers to engage with tackling health inequalities associated with later life. However, as noted in Section 1, since the community care reforms of the 1990s, social work and social care resources have increasingly been targeted on older people with the highest level of need. While fiscal imperatives to reduce welfare spending have driven this process, focusing resources exclusively on those 'in greatest need' has taken resources away from investment in prevention of ill health or dependency. Spending on crisis or reactive services has been at the expense of developing preventive services that delay or reduce high level needs from worsening or developing in the first place. Tackling this 'vicious circle', recognised by the Audit Commission (1997), has been a recurrent policy objective, including in the White Paper, *Caring for our future: reforming care and support* (Department of Health, 2012; HM Government, 2012a).

Evaluation of the Partnership for Older People Projects (POPPs) has demonstrated benefits from preventive interventions (see Box 7). These include improvements in older people's quality of life and better local working relationships as well as longer-term financial savings. The projects involved a range of professionals including social workers.

Box 7

Partnership for Older People Projects were funded by the Department of Health to develop services for older people, aimed at promoting their health, wellbeing and independence and preventing or delaying their need for higher intensity or institutional care. There were 146 projects, run across 29 English local authority areas from 2006 to 2009. Approximately two thirds (64 per cent) of the overall spending was on 'community facing' projects aimed at reducing social isolation and promoting a healthy life, while around one third (36 per cent) was 'hospital facing', directed at avoiding hospital admission or effecting speedier discharge. It was found that hospital overnight stays reduced by almost half (47 per cent) and use of Accident and Emergency departments by almost a third (29 per cent). This was estimated to represent a cost reduction of £2,166 per person, with the biggest savings generated from projects focused on hospital discharge (Windle *et al.*, pp.7-8, 2009).

Social work is concerned with the connection between individuals and their family, social and neighbourhood environments and – at more intensive levels of need – with supporting people across transitions between community and institutional settings. Social workers have particular skills in working in partnership with older people themselves and with other professionals and organisations and in mobilising community resources (Ray and Phillips, 2012). There is therefore considerable potential for them to contribute to both 'community-facing' and 'hospital-facing' preventive initiatives. For example, it is often assumed that the step from assessment of 'low level' need to providing a link to services is unproblematic. However, research shows that older people often try to minimise difficulties and relate stories that construct themselves as independent and resilient (Clarke and Bennett, 2013). Social workers are uniquely equipped to undertake the skilled and sensitive task of working alongside an older person to reach an understanding of the difficulties they are facing and to help them find ways (that suit them) of managing these to prevent their escalation. This is a nuanced and demanding activity that rests (often) on the development of empathy and an appreciation of the range and types of informal and formal support available (Richards, 2000). These are core social work skills.

Allen and Glasby (2013) consider the evidence for preventive approaches for older people, defined as 'preventing or reducing need for health and social care services' (p.3). These include promoting healthy lifestyles, the provision of housing adaptations, equipment in the home and telecare. Older people's needs may be complex, calling for different interventions and approaches. As part of their role in carrying out holistic person-centred assessments, social workers can identify and work with older people to address difficulties that may contribute to health problems, such as tackling the social isolation and loneliness that may trigger depression and alcohol misuse. Facilitating older people's access to appropriate and timely preventive services can reduce the need for home care support, prevent falls, delay admission to care homes; it can also provide relief for carers, thus helping them to maintain their own health and wellbeing (Allen and Glasby, 2013).

One of the 'top' prevention strategies employed in local authorities is re-ablement (Allen and Miller, 2012). This approach focuses on helping older people to learn or regain daily living skills often post hospital discharge. Most re-ablement services are

not targeted on older people with a specific condition although some services are specialised, e.g. people with dementia. In some authorities all older people eligible to receive support from their local authority are required to engage with re-ablement services when they first access social care services. In terms of evidence of its impact, it seems that data gathering in local authorities may focus on 'reductions in the social care package required rather than meeting the older person's outcomes' (Allen and Miller, 2012 p.3). Although re-ablement may not be effective in these narrow terms, there is evidence that it does lead to improved quality of life for service users (see Box 8).

Box 8

One large-scale study investigated the longer-term impacts of re-ablement compared with a traditional home care service. In the 12-month study period, there were no net cost savings to health and social care. Although there was a decrease in social care use following re-ablement (60 per cent lower than the cost for the group receiving traditional service), these reduced costs were offset by the increased costs of the re-ablement service itself. There was no difference in costs of health services. However, users of the re-ablement service had improved health and social care-related quality of life compared with users of the traditional services (Glendinning *et al.*, 2011).

Critical junctures affecting the success of re-ablement appear to be the assessment before re-ablement begins (Glendinning *et al.*, 2011) and assessment at the point of handover to longer-term support (Institute of Research and Innovation in Social Services (IRISS), 2011). Social workers' skills in holistic assessment and their ability to understand and intervene within wider family and community contexts render them particularly well placed to explore with service users their goals for re-ablement, plan with them how these can best be achieved and review progress and outcomes. In this context, social work's ability to identify and respond to social, psychological and emotional needs is critical. For example, a study on decision making around long-term care concluded that a key factor in admission to a care home was loss of confidence, rather than functional problems in daily living, especially for older people living alone (Taylor and Donnelly, 2006). Successful re-ablement is about sustaining and building strengths and resilience on all levels – physical, social and emotional – and when delivered in a timely manner has the capacity to delay or even prevent admission to long-term care. Again this is a core social work skill.

Social work has to date been unable to demonstrate its effectiveness in relation to preventive approaches because its focus is increasingly restricted to high intensity needs and situations of significant risk. The social work role in 'prevention' is too often constructed as about minimising or preventing service use rather than proactively working alongside people to help them find better (in terms of both quality of life and cost measures) ways of managing their difficulties. A local authority respondent in one study felt that financial cuts had meant that the aim of prevention was to ensure that people 'didn't end up at their door in the first place' (Brookes *et al.*, 2013 p.6). A major shift of focus is required if social work is to play its part in ensuring that services designed to prevent low level or moderate difficulties worsening and delay (or prevent) the use of more intensive services and enhance quality of life fulfil their potential (Wistow *et al.*, 2003).

Community social work

Community work was a key part of social work education and practice in the 1960s and 1970s and a community focus continued into the 1980s with the creation of neighbourhood social work. However the advent of care management in the 1990s shifted the focus away from addressing needs at the level of local communities to individuals 'in need' (Smith, 2006). More recently, interest in building social capital and strengths-based approaches has refocused attention on responding to social difficulties by working with, and within, communities. Social workers combine knowledge of community resources, skills in interagency working, and engaging people who are socially invisible or excluded with specific skills in building the capacities and confidence of others.

An example of a community work approach with older people is described by Bowers *et al.* (2013) in a Joseph Rowntree Foundation project, 'Not a one-way street'. The project started from several key premises: the majority of older people, including many with high support needs, fall outside of stringent eligibility criteria; the support provided by councils is largely restricted to intensive home or residential care; older people are often unaware of support that may be available; and there is a lack of understanding of the potential of schemes based on mutual support and reciprocity. Bowers and colleagues found that approaches based on mutual support and reciprocity generated extensive benefits to older people with high support needs, their families and communities and the wider service system (see Box 9).

Box 9: Not a one-way street: summary of benefits and outcomes

Benefits/outcomes for individuals
• Relationships: companionship; supportive and nurturing, long-term relationships; avoidance of loneliness
• Practical and emotional support through crises, loss and major life events
• Use and development of skills, interests and knowledge
• Feelings of being valued and valuable
• Financial gain/income
• Physical, mental and emotional health benefits
• Avoiding hospital admissions and moves to residential care
• Shared cultural, spiritual and belief systems

Benefits/outcomes for families and personal networks
• Being supported to age well 'in place', retaining friendships, relationships and networks
• Being supported to live within a reliable and supportive environment
• Safe and supportive arrangements/relationships that supplement dispersed family connections and support
• An alternative to and support to cope with the complexities of family attitudes and dynamics

Benefits/outcomes for local neighbourhoods (wider society)
• Stronger community cohesion as a result of bringing people together at a very local level
• Better connected individuals in local neighbourhoods, improving community wellbeing and health
• Individuals recognise their contribution, and the benefits of giving
• Organised networks ensure balance of giving and support

Cost-effectiveness for services and the wider system
• Effective use of scarce housing resources
• Cheaper and more effective ways of providing care
• People are motivated to get involved in other work
• Other agencies are encouraged to adopt similar approaches based on mutuality and reciprocity (adapted from Bowers *et al.,* 2013 p.20).

Key ingredients of the different schemes included: an 'asset-based' approach in which project leaders uncovered and mobilised older people's skills, experience and expertise; small-scale and locally based initiatives; and ownership of the scheme within the community itself. An important finding was that older people could be supported to 'stay put in difficult times' (p.42) when their needs increased or they experienced a crisis.

Developing community resources, connecting older people to services when these are needed and providing a continuous supportive relationship through times of change can make it possible for older people to remain within their homes and communities despite increasing difficulties. Over time, this way of working also

challenges negative individual and social attitudes towards older people with high support needs (Bowers *et al.*, 2013). While projects such as 'Not a one-way street' are necessarily small-scale and localised, there is scope for their integration within mainstream services and for social workers to play a key role in this initiative. The creation of social enterprises and of social work practices for adults offers opportunities for learning and development building on innovative development such as these (Teater and Baldwin, 2012).

Safeguarding and risk management

A review of evidence from a number of studies indicates that older people are the main recipients of adult safeguarding, with older women and people in care homes among those at highest risk of abuse (Institute of Public Care (IPC), 2013). A survey of people aged 66 and over in private households found that 2.6 per cent reported experiencing mistreatment (defined as physical, psychological, sexual or financial abuse and neglect) involving a family member, close friend or care worker during the past year; this figure increased to 4 per cent when incidents involving neighbours and acquaintances were included (O'Keeffe *et al.*, 2007). As the survey excluded older people with advanced dementia and people in care homes, these figures are likely to significantly underestimate the overall prevalence of mistreatment among older people. The survey also noted that the prevalence of mistreatment increased with declining health status and that men over 85 were more likely than 'younger' older men to experience financial abuse while women aged 85 and over were more likely to experience neglect. These studies emphasise the particular vulnerability to mistreatment of older people in advanced old age and in poor health.

Protecting vulnerable adults from harm is a challenging area of practice, requiring social workers to operate in a vortex of different policies and procedures, such as adult safeguarding, personalisation, mental capacity, 'best interests' decisions, deprivation of liberty, as well as potentially conflicting values, such as protection, promotion of independence and self-determination (Mitchell *et al.*, 2012). This demands not only sound legal knowledge and a solid foundation in professional values, but also a capacity for critical reflection in 'conditions of uncertainty' (Gardner *et al.*, 2006). While procedures provide an overall framework for action, ambiguous situations require the exercise of professional judgement (Preston-Shoot and Wigley, 2002). Social workers' training and skills in critical analysis, reflection and decision

making equip them well for this task, while their value base of upholding rights and promoting social justice provides a springboard from which to advocate for vulnerable people in situations involving incapacity and deprivation of liberty (Boyle, 2009). Recent research that explored social work assessments of decision-specific 'mental capacity' with people with dementia, found that social workers with a rights-based orientation were able to support older people to articulate their preferences and advocate for them to retain their chosen lifestyles, even in contentious circumstances (McDonald, 2010).

The social work role in safeguarding is often reactive in response to suspected mistreatment. Social work's proactive role of working with people at an earlier stage to identify acceptable and unacceptable risks and find ways of managing these before a crisis point is reached is often not realised. Early intervention can help with developing a trusting relationship, the importance of which is underlined by research suggesting that older people may conceal risks because of fears that this will jeopardise their independence and that such fears are borne out by what happens in practice (Mitchell *et al.*, 2012). Biographical research with older people and their families provides further insight into the processes by which older people seek to balance reduction of risk with maintaining independence (Bornat and Bytheway, 2010).

Social work's ability to assess and intervene at the level of informal networks is an important component of 'preventive safeguarding'. The risk of mistreatment may be increased by difficulties, such as stress, mental health problems or substance use, in the lives of family members, friends and neighbours (Choi and Mayer, 2000). Social work's 'think family' remit generates opportunities for these factors in the lives of significant others to be identified and addressed (Morris *et al.*, 2008). Social workers can also be instrumental in educating older people, whose use of services or reliance on others may expose them to different types of risk, to recognise and act to prevent mistreatment (such as financial abuse) (Faulkner and Sweeney, 2011).

Advocacy

As noted in Section 1, ageist stereotyping and discrimination are widespread not only in society generally but also in health and social care settings (Centre for Policy on Ageing, 2009). Discriminatory attitudes and behaviour have been identified as key

factors contributing to the undignified care and abuse of vulnerable older people in care settings (Baillie and Matiti, 2013). A commitment to empowering disadvantaged and marginalised service users is at the heart of social work practice, so advocating for service users is a specific role social workers adopt, especially in interdisciplinary and inter-agency contexts such as healthcare settings and supported housing. As practitioners who are attuned to mechanisms of marginalisation and stigmatisation and equipped with skills to challenge them, there is a clear rationale for increased involvement by social workers in both acute and long-term care settings for older people. Advocacy has a particular role in supporting people living with dementia, as a growing body of research points to the adverse effects, including heightened anxiety and social withdrawal, of negative stereotypes on people with this condition (Scholl and Sabat, 2008).

Key opportunities

+ There is an urgent need to capture the outcomes of gerontological social work despite the challenges this poses.

+ Social workers are uniquely placed to conduct individualised bio-psycho-social assessments of need that identify and address inter-connected physical, psychological, life course, and social needs.

+ Social workers are skilled to undertake the complex and sensitive task of working alongside an older person – and their carer – to reach an understanding of their difficulties and help them find ways of managing these to prevent their escalation.

+ Their skills include: developing community resources, connecting older people to services when needed, and providing a continuous supportive relationship through times of crisis and change. This can make it possible for older people to remain in their own homes and communities for longer, despite increasing frailty.

+ There is evidence that social workers in hospital emergency departments and in interdisciplinary contexts enhance the impact of follow-up care and reduce readmissions of older patients.

+ Social workers' skills in holistic assessment and, in particular, the ability to identify and respond to social, psychological and emotional needs mean that they are well equipped to explore goals for re-ablement with service users, to plan how these are best achieved and to review progress and outcomes.

+ The development of social enterprises and 'social work practices' may offer new opportunities for social work involvement in innovative community orientated activities.

+ Social workers can make a significant difference to the lives of older people with complex high intensity needs, for example, using their expertise in building trust, in enabling vulnerable people to articulate their wishes and in designing sustainable support packages in collaboration with older service users and their families.

+ Social workers' training and skills in critical analysis, reflection, and decision making equip them well for the complex task of protecting vulnerable adults from harm. This role requires understanding of the law, policy and procedures and to balance a number of values - including protection, promotion of independence, and self-determination - whilst ensuring that the older person's views are fully taken into account.

+ Social workers have a specific commitment to social justice and advocacy which is especially important in contexts involving incapacity and deprivation of liberty.

Older people who are most likely to benefit from social work (and lose most from its absence)

Older people undergoing transitions

Old age is a life stage filled with experiences of transition – in roles, relationships and identities, in environment, living arrangements and social participation. Research shows that social workers have expertise in helping people manage transitions through a combination of practical and emotional support, managing anxieties, and acting as a bridge between settings (Asquith, *et al.*, 2005). Managing the transition from one setting to another, such as discharge from hospital or moving into a care home or extra care housing, is a distinct challenge for many older people.

The disorienting impact of life events, such as a crisis admission to hospital or a diagnosis of dementia, can be compounded by failures in communication, planning and support by the services concerned (Ellins *et al.*, 2012). The combination of physical, psychological and social factors impacting on the interaction between the older person and their environment makes this a complex area for decision making. Eliciting an understanding of personal biography, and specifically of the older person's experience of home and of daily routine, is key to clarifying this complexity and requires a skilful approach to assessment and communication (Dwyer, 2005; Peace *et al.*, 2011). Understanding of the older person within their environment, harnessed to a detailed knowledge of resources, enables an exploration of possible options with the older person and their family. Exploring options is an essential step in enabling the older person to exercise choice and control over how specific needs can be met. Evidence from a research review on housing with care schemes suggests that there is also a role for social work in developing solutions to problems for older people and care providers within these settings (Manthorpe and Samsi, 2012). In North America, where care homes routinely employ social workers, research has revealed that they provide a range of services including helping with the choice of home, advocating for the older person, and monitoring quality of care (Kaplan and Berkman, 2011).

Older people who are carers

Effective support for carers of older people is pivotal to reducing or preventing the use of expensive health and social care resources. For example, a critical factor in the decision to enter institutional care is the ability of family members to continue

caring (Taylor and Donnelly, 2006). As noted in Section 1, the chance of being admitted to a care home is 20 times higher in people who do *not* have a family carer living with them (Banerjee *et al.*, 2003). Supporting carers is also cost-effective in terms of promoting the health and wellbeing of carers themselves and may enable them to continue to care for longer (if they wish to). There are high rates of anxiety and depression among intensive carers of frail older people (Aggar *et al.*, 2011); this is particularly the case for carers of people with dementia, carers who have health problems of their own, and those on low incomes (Bradshaw *et al.*, 2013).

A third of all carers in the UK are older and three quarters of all carers of older people are *other* older people (see Box 10). Most often they are caring for a partner/spouse or relative of similar age, or they are caring for a disabled son or daughter; they are nearly always co-resident (Age UK, 2010). Caring in later life is particularly challenging as it tends to be more intimate, involving personal care tasks such as bathing, and intensive, as caring for someone with a long-term condition such as dementia demands caring for many hours a week. Older carers may also have health problems of their own which are often exacerbated by caring responsibilities and tasks. They often find it more difficult to attend health-related appointments, address their own healthcare needs, or gain access to health and social care services to which they are entitled in their own right. The demands of caring often lead to social isolation, which in turn can have a negative impact on older carers' mental health (Age UK, 2010). Older carers are also less likely than younger carers to seek help from services or to identify as a 'carer'.

Box 10: Older carers

= Of around six million people providing unpaid care in the UK, three million of these were aged over 50, providing more than £15bn in care each year. (These were 2001 figures so will have increased further.)

= In England in 2010, there were 959,836 people aged over 65 providing unpaid care to a partner, family member or other person. Of these, approximately 66 per cent were aged 65–74; 29 per cent aged 75–84; and 5 per cent aged 85 and over.

= A quarter of all carers aged over 75 were providing intensive support of 50 or more hours of care each week.

= Compared with younger carers, older carers: care for shorter periods; are more likely to provide intimate personal care and heavy nursing tasks associated with terminal care; and to be caring for a husband, wife or partner.

= The specific needs of older carers are not necessarily met by present service provision.

Adapted from Age UK (2010) p.5

As many care relationships involving older people are reciprocal it may be helpful to conceptualise the context as a caring 'network' or 'system', in which each person's ability to both give and receive support is acknowledged (Bowey and McGlaughlin, 2007). Viewing a relationship as uni-dimensional (i.e. as a 'carer' and 'cared for' person) may not reflect the reality, particularly from the perspective of those involved in the relationship (Lloyd, 2003). There is evidence that assessing the needs of the dyad (or family/system) jointly provides an effective and sustainable basis for care delivery (Gridley *et al.*, 2012). An approach to assessment that understands relationships within a systems framework is a core social work skill, as is the exploration of sensitive issues, such as the carer's feelings about caring. Research has found that carer anxiety and depression are increased if the carer feels resentment about their caring responsibilities (Aggar *et al.*, 2011). As with older service users, older carers may be inclined to present a positive picture and only disclose the extent of the difficulties once a trusting relationship is established (McGarry and Arthur, 2001). Social work skills in forming relationships and undertaking comprehensive and sensitive assessments in partnership with older

people and their carers have significant potential to ensure sustainable and effective support over the longer-term.

A number of research studies with older carers highlight the need for ongoing support for older carers so that a proactive approach can be taken to address difficulties (Age UK, 2010). One study with carers between the ages of 76 and 92 concluded: 'Many carers in the present study were frequently caring under difficult circumstances, and many were caring alone without any formal support or service provision. For some of these carers their first encounter with formal services will be in response to the breakdown of an already fragile home situation' (McGarry and Arthur, 2001 p.188). Another study with older people over the age of 70 years who were caring for an adult with learning disabilities, identifies their reluctance to engage in planning for the future. It highlights the need for proactive and ongoing support to help people to consider long-term options, rather than waiting until a crisis occurs and an emergency response is required (Bowey and McGlaughlin, 2007). Crisis responses are likely to be more costly of resources, more intensive and prolonged, and have more negative outcomes for the people involved. Engaging social workers in preventive work with carers to anticipate future needs is likely to reap considerable therapeutic and financial benefits.

Older people with dementia

The prevalence of dementia increases with age; from around six per cent of individuals aged 65 and above estimated to have dementia, to around 30 per cent for those in their eighties (Luengo-Fernandez *et al.*, 2010). The increasing number of 'older' older people means that there will be more people with dementia requiring social work support in the future. Currently approximately two thirds of people with dementia in the UK live in the community (Alzheimer's Society UK, 2013), although there is no reliable information about how many of these receive social services support. In addition to the critical role of supporting carers just discussed – three quarters of people with dementia are supported by family carers – there are a number of specific dimensions to the social work role in relationship to working with people with dementia. We only have space to explore a few of these but they do offer a flavour of social work's actual and potential capacity in this arena.

Early intervention with people with dementia is hampered by delay, vagueness and euphemisms encountered in giving diagnoses (Bamford *et al.*, 2004). The revised Dementia Strategy in the UK identifies 'good quality early diagnosis and intervention' as a priority area (Department of Health, 2010 p.10). Social workers can contribute to this priority by referring older people for specialist assessment at an early stage and by helping clinicians to sensitively but clearly communicate a dementia diagnosis. Their core professional values and skills, including genuineness, respect, and empathy, equip social workers well for this role. Receiving a dementia diagnosis is a significant social and psychological event in the lives of those affected (Milne, 2010), so working with older people and their carers in the period following diagnosis is particularly important. The changes associated with dementia can trigger difficult emotions, such as anger, fear, anxiety, and sadness, yet people with dementia often have no opportunity to explore or make sense of their feelings (Phinney, 2008). Social workers can help individuals to explore what having a dementia diagnosis means in the context of their lives and identities (Manthorpe and Iliffe, 2005).

Translating the goals of 'personalisation' as defined by current policy, which is rooted in notions of responsibility, active citizenship and the prevention of dependency, is an important and challenging aspect of social work with people with dementia. Despite specific barriers that limit access to personal budgets by people with dementia (Kinnaird and Fearnley, 2010), evidence shows that some people with dementia and their carers *can* benefit from direct payments and personal budgets *if* they are given adequate support (Lakey and Saunders, 2011). Social workers have a key role in facilitating the involvement of people with dementia in assessment and support planning processes. Older people who are deemed unable to make a specific decision about their care may still manage, with help, to contribute to assessment by communicating their needs, preferences and views (Westius *et al.*, 2010). However, this is time-consuming, challenging and skilled work that requires a supportive organisational culture. As noted in Section 1, it is important to ensure that older people who do not wish to make use of a personal budget are not 'forced' to do so. There is some evidence that older people with dementia and their carers would rather have the expert services of a gerontological social worker to support them in assessment and designing a care package and do not want to have to manage a personal budget (Manthorpe and Samsi, 2012; Moran *et al.*, 2013).

A further social work role with people with dementia is in relation to rehabilitation and support. There is growing evidence of the benefits of rehabilitation for people with dementia (Mountain, 2005). For example, forms of cognitive rehabilitation, while not a remedy for memory loss and cognitive impairment, can nevertheless help people with dementia to maintain wellbeing and quality of life (Clare, 2005). Understanding how individuals see themselves and their lives provides the basis for personalised interventions that reduce agitation and improve emotional wellbeing (Cohen-Mansfield *et al.*, 2006). Social work can, for example, link people with dementia with opportunities to engage in creative self-expression thought the arts, to improve self-esteem, emotional wellbeing and social relationships (Lee and Adams, 2011). As dementia is a progressive condition, effective support involves helping people to manage change. Research by Aminzadeh *et al.* (2009) highlights the potential to support people with dementia through change by bolstering their psychological and emotional resilience.

Older people at the end of life

The vast majority of people dying in the UK are older. In 2010, 62 per cent of female deaths were of women aged 80 or over, 91 per cent when deaths of women aged 60 or over are included. The corresponding figures for male deaths are 43 per cent and 85 per cent (ONS, 2012). The quality of care for older people at the end of their lives is, therefore, a critical issue for health and social services and for gerontological social work.

People dying in old age often experience inequality and neglect, compared with people dying earlier in the life course – the so called 'disadvantaged dying' (Seymour *et al.*, 2005). Many factors contribute to this situation. A fundamental issue is that older people are likely to have intersecting co-morbid chronic conditions leading to protracted decline and unpredictable death. This uncertain trajectory, termed the 'ambiguous dying syndrome' (Bern-Klug, 2004), does not fit well with current models of palliative care, primarily developed in settings for people with terminal cancer (Gott and Ingleton, 2011). Typically, palliative care provision is conditional on a terminal diagnosis and specific prognosis. As professionals often fail to recognise that frail older people are in the dying phase of life, older people are at particular risk of dying with their end-of-life care needs unnoticed and unaddressed (Holloway, 2009). These needs may be physical (including pain relief), psychological, social and

spiritual. Older people with dementia are at particular risk of dying with their needs neglected, as are older people who live alone (Rolls *et al.*, 2010). The core values, principles and skills of social work mean that social workers are well equipped to support and advocate for dying older people and their families through every stage of the end-of-life care pathway from initial discussions, assessment and care planning through to bereavement care (National End of Life Care Programme/College of Social Work, 2012). Findings from recent research suggest that social workers are widely viewed as best placed to undertake the crucial role of navigator, co-ordinator and facilitator of end-of-life care (Paget and Wood, 2013). Social workers are also seen as vital participants in the process of developing new social models of end-of-life care, better suited to the needs of older people, which build on the resources and networks surrounding the dying person (Brown and Walter, 2013).

Widespread public concern about the quality of care at the end of life have led to initiatives such as the launch of the NHS National End of Life Care Strategy (2008) and the NHS National End of Life Care Programme to raise the profile and standards of end-of-life care. Nevertheless, despite these policies and some recognition of the number of people who die in old age, there is little evidence that practitioners or commissioners and policy makers beyond those with specialist interest in palliative care have fully appreciated the scale of the challenge (Gott and Ingleton, 2011). Any significant improvement in care for people dying in old age is likely to require not just a transformation in service provision and in attitudes towards people at the end of life but also sustained engagement with technical and ethical dilemmas and with the complexity of individual need. The specific roles and challenges for social work in this arena have been summarised by Margaret Holloway, Social Care Lead for the National End of Life Care Programme (see Box 11).

Box 11: The role of social work in end of life care

'The challenge for social work in mainstream community settings is to grasp its essential role in supporting older people in achieving a dignified end, in continuing to uphold their personhood whatever the degree of dependence, and facilitating them and their carers in making and operationalising choices throughout this final phase of life.'

'The challenge for hospice and palliative care social work is to highlight the relative neglect of older people, many of whom may have no one else to advocate for them…'

'Social work has the skills of communication, negotiation, support and advocacy; it is committed to respecting, valuing and empowering the service user; it is pivotally placed within health and social care service delivery and in hospices whose practice is founded on a holistic model which embraces all areas of need.'

Holloway (2009) p.721.

Key opportunities

+ Later life is characterised by transitions – in roles, relationships and identities, in environment, living arrangements and social participation. Research shows that social workers have expertise in helping people manage transitions through a combination of practical and emotional support, managing anxieties, and acting as a bridge between settings. Positive transition experiences are less likely to generate further health and social difficulties.

+ Social workers' communication and other skills in eliciting understanding of the older person's life and wishes, exploring options, and facilitating choice and control are key to positive and sustainable decision making in later life; they also promote autonomy and dignity.

+ Evidence from North America suggests that employing social workers in care homes has various benefits, including advocacy for residents and the monitoring of care quality. This is an as yet untapped opportunity for social work in England.

+ Effective assessment and support for carers of older people – many of whom are older people themselves – is pivotal to reducing or preventing the use of expensive health and social care resources, including institutional care. Supporting carers is also cost-effective in terms of promoting the health and wellbeing of carers themselves and may enable them to continue to care for longer.

+ Research highlights the need for ongoing support for carers, including older carers, so that a proactive approach can be taken to address difficulties early and prevent the need for crisis intervention which is costly and tends to have negative outcomes. Engaging social workers in preventive work with carers to anticipate future needs is likely to reap considerable therapeutic and financial benefits.

+ Gerontological social workers have a number of specific skills and roles in working with people with dementia and their carers at various stages, including early intervention, diagnosis, support planning and rehabilitation. As this group of people are at high risk of institutional care, interventions that extend the length of time of community living can achieve significant gains in cost-effectiveness as well as quality of life.

+ End-of-life care is another transitional point at which social work input can make a considerable difference to the lives of older people and their families. Social workers can undertake the crucial role of advocate, navigator, co-ordinator, and facilitator, enabling older people to achieve a dignified end.

Section 4: Conclusion and ways forward

The challenges presented by contemporary demographic trends, and the potential for social work to respond to these, cannot be overestimated. To a large extent, increased life expectancy has meant more years spent in relatively poor health in old age and, although strenuous efforts are being made to reduce levels of morbidity and to extend good health to later life, there is a pressing need for greater attention to the needs of today's older people. The need for effective professional social work is pressing. Contemporary demographic trends are expected to continue and social workers have an important role to play as the social and cultural impacts of an ageing population are felt and the older population becomes more diverse as well as more numerous. Taking into account current developments in professional social work education and practice and drawing on the evidence from overseas, we see gerontological social work as having enormous potential.

Social workers have an important *proactive* role to play within community based programmes designed to promote and maintain social engagement, good health and wellbeing. The social, economic and environmental determinants of good health are of crucial importance in preventing decline and disability where possible and potentially social workers have an important role to play in this regard. The bio-psycho-social focus of the social work profession places it in an ideal position to take up the challenges posed by societal ageing. The skills of social workers in promoting relationships can maximise opportunities for older people to continue living as part of families and communities. Importantly, social workers are able to offer support to those who are least well connected, the most isolated and vulnerable of older people. The evidence from North America points to the value of a family focus on enabling older people to manage the transitions associated with health problems and with associated treatment and care systems. Perceiving older people as individuals *in relation to others* is a crucial part of this picture and is entirely consistent with the current development of social work capabilities.

Older people's lives are shaped by change in their physical abilities, their relationships and, for many, their living arrangements. Most people go through major transitions in later life, associated with changes in health and mobility as well as bereavement and widowhood. Expertise in supporting people through change and

transition is central to professional social work and could be developed to a much greater extent through specialist gerontological social work. It could prevent complications that arise during such transitions, such as poor mental health associated with a lack of social support; it could maximise the effectiveness of acute hospital treatment and it could make the process of transition smoother and less prone to logjams and other problems.

Social workers have several years of working jointly with colleagues in health services. The partnerships that have developed over the years provide evidence of the profession's flexibility and effectiveness in promoting holistic approaches to treatment and care. There is significant scope to further develop and extend the profession's leadership role in joint working, in line with contemporary efforts to break down barriers between health and social care. Indeed, it is in the context of joint working with colleagues in health and other community services that the benefits of social work can be fully realised. Social workers can help to achieve maximum gains from these provisions by facilitating access, supporting use, developing links and crossing boundaries. Our vision is for this function to be developed further.

Older people face discrimination and many people experience an increase in disadvantage and vulnerability as they age. The professional values of the social work profession and its commitment to social justice place it in an ideal position to provide advocacy and to uphold older people's rights to the goods and services they are entitled to. The vulnerability of older people within health and social care services has been a shown in stark relief recently while abuse within families and communities continues to be a major concern. Social workers have a crucially important role to play in responding to abusive situations but also in educating the public and tackling abuse more broadly.

In order to pursue these agendas and to take forward the development of gerontological social work we propose three key intersecting areas that need to be addressed: practice, education and research.

First, it is our view that a greater recognition on the part of social work agencies and their practitioners of the needs and rights of older people is required. For reasons outlined in this report, it is evident that gerontological social work has become

profoundly marginalised in practice and is at risk of disappearing altogether as a specialist area of social work. There is a pressing need to reverse this trend and re-establish gerontological social work expertise for current and future generations of older service users and their families (TCSW, 2012). Generally, there is a culture of low expectation concerning the quality of life of older people, particularly when they are in poor health and dependent on others for support. The marginalisation of social work with older people is, it could be argued, a part of this wider ageist picture.

There is a parallel need for ageing related subjects and research to be embedded in social work training and education. The twin challenges facing UK social work programmes are a lack of interest in working with older people and a limited focus on ageing in the curriculum (Richards *et al.*, 2013). Developing specialist capacity in teaching is vital if gerontological social work is to be rebuilt, an issue compounded by the limited number of social work academics with an interest in gerontology.

Tackling the research deficit is a third – urgent – issue. Social work's own capacity to undertake research is limited and while there is a growing body of work in the field of 'social care' (e.g. from SCIE), there is little explicit research focused on social work with older people. There is a primary need for investment in research activity driven by gerontological social work academics and practitioners committed to demonstrating the contribution of social work to the lives and wellbeing of older people as well as to the health and social care economy. Much could be learned from North America where a strategy to rebuild research in gerontological social work was successfully implemented in the 1990s (Gutheil *et al.*, 2009) – this work is reviewed in detail in Section 2 of this report. There is also a need to explore how findings from large-scale research initiatives such as the New Dynamics of Ageing are relevant to, and for, social work with older people.

Specialist, evidence-based gerontological social work has great potential as part of the future of the profession and in enhancing the lives and wellbeing of older people and their families. As argued in this report, there are many ways in which the contribution of social workers to services for older people could be developed. Indeed, it is our view that it *should* be developed if older people are not to (continue to) be marginalised and neglected. Success in meeting the goal of maintaining older people in their own homes will be a hollow victory if their lives are reduced to mere

maintenance of basic functions. We argue also that the development of gerontological social work is not only highly desirable for these reasons but also that it is achievable and cost-effective, since better informed professional interventions could have a preventive function (Allen and Glasby, 2013).

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