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PART I

The Social Work Context

CHAPTER 1

Critical themes and issues in ageing

CHAPTER OVERVIEW

- Social workers work with older people who are likely to have complex and high support needs – but older people are far from a homogenous group.
- Those in the older population are characterised by diversity and difference in terms of their structural location (for example birth cohort, gender, ethnicity, culture) as well as in their individual biographies.
- There remain significant differences in life expectancy between men and women.
- While the age structure of black and minority ethnic groups is still rather younger than that of the white majority population, this is slowly changing.
- There are considerable differences in health experiences among older people. While significant numbers of older people report living with a long-term condition – or conditions – most older people also describe their health as good.
- It is estimated that 1.5 million older people are occupied with informal care and a significant number of those people care for someone with whom they live.
- The diversity of ageing experience sets the scene for diverse social work practice that must be underpinned by an open-minded approach and a commitment to challenge stereotyped assumptions about ageing and age-based discrimination.

Introduction

In this chapter we set the scene for the context of social work with older people by outlining the key themes and issues in ageing. We deliberately take a critical gerontological approach from the outset.

This is in preference to presenting basic facts and figures and outlining the problems that older people face. Although social workers need to know the details and consequences of population ageing, they also need to reframe some perspectives through which older people have been stereotyped, for example as burdens on society by virtue of their numbers and being dependent on family members. By the nature of their role and tasks social workers work with older people with the most complex needs, but they need to take a wider perspective in order to understand the diversity of ageing and to view experiences in later life in a positive light, rather than treating ageing necessarily as a negative experience. Even when people face crises, the strengths they have developed and demonstrated throughout their life course need to be acknowledged and worked with by social work practitioners. It is imperative that social workers understand and take a critical approach in their practice if they are to work effectively with older people in an anti-discriminatory way.

It is important, first, to look at the people we are talking about and the situations faced by an ageing population. After defining and critically evaluating the concepts of 'ageing' and 'old age', we look at the diversity of the older population in terms of structural factors such as gender, ethnicity and class. We then move on to look at variations in how people experience ageing and later life based on differences in location, housing and living arrangements and health. All these factors, along with more individual factors such as relationships and social support, will have an impact on their quality of life. The challenge for social workers is to operate within this diverse context in a positive way, challenging the myths that ageing is inevitably a period of decline and that older people with complex needs can no longer experience a good life.

Defining ageing: What is 'old'?

There have been shifting definitions of 'old' throughout history. Whereas 200 years ago someone aged 40 might have seemed 'old', today they would be considered 'young' or in the prime of their life. Legal institutions and bureaucracies tend to define 'old' by chronological age, often as a means of demonstrating eligibility for particular services, for example age-related eligibility for free bus passes or pensions. Definitions and expressions of age also differ across

cultures. For instance, in Bosnia old age is not linked to chronological age or external appearance but a 'loss of power' (Vincent, 2003: 15), referring to both physical and social strength.

Longevity has been the success story of modern society, with more of the population living longer into old age. General improvements in public health, housing, food supplies and working conditions have greatly improved our standard of living. This has meant that more people have survived beyond infancy and lived into adulthood, stretching the definition of 'old'. A boy born in 1901 could expect to live to 45 and a girl to 49; today these figures are 77.2 and 81.5 years respectively (ONS, 2009). There are almost half a million people in Britain aged 90 or over and the numbers of centenarians in the UK has more than quadrupled, from 2600 in 1981 to 11,600 in 2010 (ONS, 2010b). It is the rapid increase in the proportion of the 85-plus age group in comparison to older people in general that is significant for the planning of social and health care services, as disability tends to increase with later life. Whether as a society we will be able to sustain such increases in longevity is a moot point, however, as obesity in childhood, inadequate diet and lack of exercise with increases in alcohol consumption all threaten this trend.

Our subjective assessment of age is, however, governed by the ways in which ageing may be defined or constructed. For example, we may be informed by chronologically based definitions of age such as formal retirement ages, eligibility for subsidised public transport and winter fuel allowances, or age-based access to health care and health screening. Perceptions of old age may focus on notions of dependency and vulnerability; in our own profession, we have a tendency to focus on dysfunction in older age as a means of determining eligibility for services, which is too often at the expense of recognising the strengths and resources on which older people are able to draw in later life. While this book will inevitably focus on the kind of needs that social work practitioners working with older people are likely to encounter in their practice, we must not forget that any discussion about ageing should be underpinned by an understanding of its diversity and a recognition that older people are not a homogenous group. On the contrary, while research may report trends or patterns in the experience of ageing, it remains the case that ageing should be seen as an experience unique to the individual and characterised by heterogeneity.

As we discuss later in this chapter, social resources through family and friends are an important factor in later life.

Nevertheless, family life has changed with rising divorce rates, reconstituted families, later marriages and age-gapped families, along with geographical distance between generations. This also means that different generations and cohorts will experience family life very differently. Unlike any previous generation, a larger percentage of older people over the age of 60 will be entering old age as divorced, will have had experience of second or multiple marriages and partnerships and may have a large network of step-children and grandchildren. With remarriage and divorce, older people may experience a transition to other intimate partnerships.

Increasingly, healthy older people enjoy activities that have traditionally been associated with 'youth' and continue to enjoy hobbies in which they have participated throughout their life course as well as starting new interests. These experiences are no longer exceptional.

Older people contribute significantly in all areas of social life, for example through ongoing provision of support (practical, emotional, financial) to adult offspring or to grandchildren and other family members needing care. They also participate in a range of citizenship roles (for example the magistracy, parish councils, prison monitoring boards; all of which, however, still have age cut-off points) and through the provision of human resources, skill and expertise in the voluntary sector.

At the other extreme, there are older people who have experienced poverty for much or all of their lives. Social exclusion from, for example, good-quality housing, regular paid work, access to health care and living in vibrant and well-resourced communities is often an associated consequence of living in poverty. In older age, people may experience a continuity of poverty, which could be worsened by ageing (for example as a result of widowhood or the experience of illness). Older people may have managed during their lives but may experience poverty in retirement because they do not have access to adequate pensions. Around 17 per cent of people receiving state pensions are defined as living in poverty, with single, retired females being most at risk of poverty or living on a severely reduced income (www.poverty.org.uk). This problem is exacerbated by the consistently low take-up of benefit entitlements (such as pension credit, council tax relief and housing benefit). Approximately one third of all pensioner households entitled to pension credit are not claiming it (that is, 1.3 million households) and two-fifths of all pensioner households entitled to council tax benefit are not claiming that (that is, 1.7 million households) (www.poverty.org.uk).

Older women: The 'feminisation of ageing'

The world of 'old age' is traditionally a world of women. Differences in the proportions of men and women in old age arise from women's higher life expectancy. At all ages, the older population is disproportionately female. However, the ratio of women to men among people aged 65 and over is falling. In 1983 there were 155 women aged 65 and over for every 100 men of the same age. Currently, there are 130 women for every 100 men aged 65 and over. By 2033 this figure is expected to be 117 women for every 100 men (ONS, 2010).

The reasons for the difference in longevity remain unclear, but include the greater likelihood of men experiencing life-threatening illness resulting in death compared to women, who are more likely to experience long-term, chronic and disabling conditions. Increased longevity for women, together with features common to women's lives, results in particular consequences for older women. For example, traditionally women have tended to marry or partner with men older than themselves and this means they are more likely to care for their husbands, as well as to be widows. In 2006, for example, 62 per cent of men aged 75 and over were married compared to 28 per cent of women; 27 per cent of men aged 75 and over were widowed compared to 60 per cent of women (ONS, 2007). Chambers (2005) has commented that widowhood is a normative expectation for heterosexual women as they move into older age. It also follows that women experience widowhood for longer than their male counterparts are widowers. Without the possibility of getting care from their spouse, widows who become disabled and ill are more likely than men to enter residential care (ONS, 2010). The same is true for women who have never married. So 6 per cent of older women aged 65 and over live in residential care, compared to 3 per cent of men in the same age group. The figure rises to 23 per cent of women aged 85 and over, compared to 12 per cent of men in the same age group (ONS, 2010).

Women are also more likely to have had sparse or interrupted work records. Apart from during the war, in the 1930s, 1940s and 1950s married women were discouraged from working. Significant disruption to working life to provide care for children and other family care giving remains a common experience for women. Given the potential for interruptions to work, and a reliance at least some of the time on part-time work, women are much less likely to have contributed to their own pensions, or their pension contributions

are inadequate (ONS, 2010). There is greater reliance on state pension provision among older women, and older women living alone are likely to be the most deprived. A larger proportion of women than of men receive less than the full basic state pension (BSP). In 2008, 34 per cent of female pensioners (2.3 million women) received 60 per cent of full BSP or less, compared with 2 per cent of male pensioners (under 0.1 million) (ONS, 2010).

Starting in 2010, Parliament has enacted a number of pension reforms, designed to transform the nature of state pension provision so that, for example, 95 per cent of both men and women pensioners should be on full BSP by 2050. Acquiring a pension through a husband's earnings is becoming increasingly risky because of the propensity for divorce and the evidence base highlighting the likelihood of greater financial vulnerability for women living alone in older age (ONS, 2010; Burholt and Windle, 2006). The National Pensioners Convention has argued for a gender-oriented pensions policy that addresses the inequalities in income caused by employment patterns and caring commitments, as well as providing survivor benefits in recognition of the gendered mortality differential and likelihood of being a widow (www.pcs.org.uk, 2008).

Although the social networks of older women are more extensive than men's, the majority of older women whom social workers meet live alone. For women increasing age is closely associated with living alone: over 60 per cent of women aged 75 and over live alone (ONS, 2010). Research has suggested a relationship between loneliness and sociodemographic factors, including being female, being widowed and living alone (Victor *et al.*, 2005).

Until the 1980s women were invisible in social policy. However, this situation has changed and care services are increasingly gender sensitive. In residential care, for example, women over the age of 85 are over-represented, along with those older people who have previously lived alone. Increasingly, issues over the funding of long-term care, the closure of care homes and the movement of older people between care homes, when they can no longer afford to pay or where homes have closed, have had a disproportionately negative impact on women.

There is circularity in the feminisation of the caring relationship. Many of those living in care homes are cared for by women who may be engaged in informal care (for relatives) as well as in a formal (paid) capacity (Cameron and Phillips, 2003). Work routines in care homes may facilitate part-time employment to

enable women to manage other caring responsibilities, and the pay and conditions are often at the national minimum. The scene is set for future generations of women engaged in this type of work to experience the poverty of their older counterparts.

Cuts in community services, particularly in relation to transport, are also likely to affect women significantly. Women are more likely to rely on public transport than men and generally have less opportunity to drive cars than men, thus, in later life, accessibility becomes a heightened issue, particularly for women living at some distance from services and family.

Ageing men

The experience of ageing for men remains largely invisible in policy and practice terms. Data and research on men are often contextualised in relation to the differences between men and women (for example in terms of the differential mortality rates already discussed in this chapter). This comparative research tends to portray men in many respects as less 'well off' than women; for example, women are reported to be better at forming social networks and so men, in comparison, are regarded as potentially at risk of isolation and loneliness. While there is some research on ageing men and masculinity (e.g. Calasanti and King, 2007a), the experience of ageing men is relatively under-researched.

In terms of responses in practice, men appear to be poorly served. Women are more likely to be widowed and to live longer than men, so men are often in the minority and attention to the needs of ageing men in, for example, care environments may not be well developed. Greater attention has been given to men who provide informal care to their partners (e.g. Davidson *et al.*, 2003; Calasanti and King, 2007a).

Ethnicity

In 2008 British minority ethnic groups comprised 9 per cent of England's population, with 3 per cent of people within those groups aged 65 and over. While the age structure of black and minority ethnic groups is still rather younger than that of the white majority population, this is slowly changing. Some ethnic minority groups are 'older' than others. For example, while 13 per cent of

the black Caribbean population was aged 65 and over in 2008, this applied to only 4 per cent of the Pakistani population and 2 per cent of the black African population (Age Concern, 2008). Such differences can be explained by variations in migration history, gender composition and mortality.

Patterns of migration also point to different experiences for groups of black and minority ethnic people. The experience of ageing must be underpinned by an awareness of diversity rather than assumptions about homogeneity. While there are parallels in needs and aspirations between elders from the majority group, there exist specific areas of difference and/or concern arising from language and culture, faith and the consequences and experience of racism. Research on outcomes valued by older people (Glendinning, 2007) highlighted that while older people from a diverse range of backgrounds value similar outcomes, the priority given to specific outcomes is likely to be influenced by, for example, the importance attached to meeting religious and cultural needs. Black and minority elders are often disadvantaged in knowing what services are available and are likely to avoid services that they perceive as being culturally inappropriate or geared around the needs of the majority group (PRIAE, 2005). Although it is likely that minority ethnic groups will benefit from increased personalisation of services in order that they may access care and support according to their need and preference, specific outreach strategies and support may be required to ensure equal access (Newbigging and Lowe, 2005).

Health

A further area of difference between older people is in relation to their health; such diversity will increasingly be significant for social workers to appreciate as health becomes a major area in assessment, and inter-professional practice with health care professionals is a key ingredient in social work practice.

Point for reflection

- Why might older people define their health more positively than more 'objective' measures of their physical health might indicate?
- How do you define health and wellbeing? How might definitions of health and wellbeing change at different points on the life course?

Those in the older population vary considerably in terms of their health. However, most older people have one or more long-standing illnesses. In 2006, 63 per cent of people aged 65–74 and 70 per cent of those aged 75 and over reported living with a long-standing illness (ONS, 2010). Of medication prescribed in the UK, 45 per cent is for people aged 65 and over and 36 per cent of those aged 75 and over take four or more prescribed drugs (SCIE, 2005). Nevertheless, when older people are asked to describe their overall health state, a high proportion tend to rate their health as either good or very good. This is because older people tend to define health using a wider range of criteria than the absence of illness or disability; being able to carry on with their usual roles and responsibilities and do what they want to do are fundamental considerations for older people in their assessment of health and wellbeing.

Nevertheless, health problems do affect a larger number of people in later life. For example, Action on Hearing Loss (formerly the Royal National Institute for Deaf People; 2009) indicates that 6.5 million people over 60 in the UK have age-related hearing loss. Among people aged 70 and over, 71.5 per cent have some kind of hearing loss and 50 per cent have moderate or serious hearing impairment. Visual impairment is also more likely to become an issue as people age. Among the oldest age groups, the Royal National Institute of Blind People suggests that 50 per cent of people live with sight loss, caused most commonly by age-related conditions such as macula degeneration, glaucoma, cataracts and diabetic retinopathy (RNIB, 2010).

Practice focus

Deaf awareness?

Katya is an older woman living with her husband of 50 years. Originally from the Ukraine, she has lived in a small town in the West Midlands for over 30 years, where she has built up a large network of friends through her work, church activities and other hobbies. She has one daughter and two grandchildren. Katya was diagnosed with presbycusis (age-related hearing loss) and was prescribed hearing aids.

Over the past few months Katya's mood and behaviour have changed. She has become less sociable and seems to go out less often and to fewer places. Her friends have noticed that she avoids going to places where there is a lot of background noise (for example coffee shops, restaurants, the pub). She confided in a close

friend that she feels foolish because she cannot hear in environments with lots of background noise and increasingly feels as if she cannot take part in conversations. She believes that people have started to exclude her or that they tend to shout at her if she does not hear the first time. She is embarrassed when she cannot hear and feels foolish when people shout at her. Katya has found her hearing aids difficult to adjust to and was disappointed that they did not solve the hearing problems she experienced. She has come to the conclusion that these difficulties must be a part of old age and that there is nothing she can do about them.

The proportion of older people who report long-term illness or disability that restricts daily activities increases with age. The impact of conditions such as arthritis on mobility is well known, with an incidence in women of approximately 250 in 1000 of the population aged between 65 and 74, and 113 in 1000 in the population of men (Arthritis Care, 2007). Mental ill-health may also be an experience in older age; this may be because a person has had long-standing mental health needs and has aged with them, or because they have developed mental ill-health in later life. While dementia, for example, can affect people through the whole life course, its prevalence is much higher in older age. Social workers working with older people will inevitably encounter those with cognitive impairment associated with dementia and so it is imperative that practitioners have a sound grasp of the knowledge and skills required to work positively with people living with dementia.

While depression can affect anyone through the life course, it is more common in older people than in any other age group. The Mental Health Foundation (2010) estimates that 10–15 per cent of older people living in the community show symptoms of depression, but this figure rises to approximately 40 per cent when considering older people living in care homes (Eisses *et al.*, 2005). Many people living with dementia may also have depression, which often goes undiagnosed in these circumstances. The potential for age-based discrimination in the context of mental health is an issue that is of concern to older people affected, their families and practitioners (Kings Fund, 2005). This has considerable implications for social work practice given the importance ascribed to challenging structural oppression and discrimination.

Messages from research

The psychosocial impact of vision loss on older people (Nyman *et al.*, 2010)

This research reviewed 174 research papers to assess the evidence of psychosocial impacts on older people with vision loss. The findings indicate the following:

- Older people with vision loss are more at risk of reporting symptoms of depression and lower mental health, and being diagnosed with clinical depression, than are their sighted peers.
- The risk of depressive symptoms is higher in those with worse visual functioning.
- Social functioning is likely to be reduced in individuals with vision loss, but not social network size or social activity.
- Interventions that address psychosocial needs directly are more effective than rehabilitation that addresses them indirectly through instrumental support.

Implications for practice

In conjunction with rehabilitation, emotional needs should be considered, which might include referring the person for counselling or group support services in addition to informal support. The authors conclude that the evidence base is at present insufficient to recommend a particular form of emotional support.

Class and income

In old age the effect of class and income is amplified through retirement. Class influences lifestyles in older age. Additionally, the lower the socioeconomic status of an older person, the more likely it is that they will experience ill-health. ONS (2010) highlights that inequalities in health persist, with 30 per cent of those aged 50 and over living in social rented accommodation in England and Wales reporting a long-term condition. Men and women in social classes III manual and IV and V are more likely than those in non-manual social classes to have a mental health problem.

Similarly, research findings suggest that mental health problems in later life tend to decrease with increasing income, thus areas of wealth and prosperity see a lower prevalence of mental health

problems (Asthana and Halliday, 2006). Contributing to an occupational pension, owning property, accruing savings and retiring on a high income (Thompson, 1995) will also influence financial resources in later life. In the past 30 years the increasing importance of a non-state pension has resulted in a growing inequality between those who have and those who do not have occupational pensions. Redundancy, unemployment, care for dependent children or adults all have a significant impact on the ability of people to accrue such a pension. Low public pensions are increasingly meaning a reliance on means-tested top-up benefits, with a quarter of all older people in Britain dependent on Pensioner Credit, or entitled to it but not claiming it (www.poverty.org.uk).

Location

The socioeconomic and demographic factors discussed above divide the older population in a number of ways. In addition, the experience of ageing is also affected by diversity in where older people live, for example between rural and urban environments and between different countries. Although it is beyond the scope of this book to highlight global differences in ageing, placing Britain relative to other countries does throw some light on the relative position of older people in the country today.

The majority of the world's population of older people (61 per cent) live in poorer countries, many where life expectancy remains below 50. For example, life expectancy at birth in Afghanistan, the Central Republic of Africa and the Democratic Republic of Congo is 48 (www.who.int/imp, 2009). In 2004 about 1.2 billion people globally were living on an income of less than \$1 per day and about 100 million of those are older than 60 (Petersen, 2004).

Trends in Britain reflect more general trends at a European level. Low fertility levels and extended longevity mean that the EU population is ageing, particularly those over age 80. At the same time, the population of working age is dwindling; in 2001 the old age dependency ratio (the population aged 65 and over as a percentage of the working age population 15–64) had risen to 24.6 per cent, an increase of 4 per cent in 10 years (Eurostat, 2002). This continuing trend will have implications for social policy in all EU member states and, even with the more balanced demographics of the new accession states, will remain a significant issue on the migration agenda.

Moving from a European level to a country level, significant differences in the experiences of ageing are found in urban and rural areas. For some older people there is a choice of migrating to warmer climates of other countries or to the seaside.

Older people living in rural areas may face a lack of services and difficulties accessing any limited provision. The experience of those living in rural areas is influenced by factors such as poor transport, centralisation of services and resources, and lack of service provision (Scharf and Bartlam, 2006). Older people living in rural communities may express need in terms of loneliness and isolation, accentuated by depopulation, the purchase of local houses as second homes and holiday houses, and the loss of personal networks through geographical mobility and bereavement. Clearly, there is a need for care and support services to develop in the context of familiarity with the area and the population that they serve. While it may seem common sense to focus resources on centralised and traditional day care for older people in the nearest town, for those living in rural settings travelling to town for a few hours may feel unfamiliar, stressful and unnecessary, as well as having little to do with their interests and aspirations. There is thus a need to reconsider traditional approaches to providing support services for older people that respond positively to their needs and aspirations by, for example, supporting or encouraging the development of local resources or small-scale community projects.

Ageing in the inner city, however, does not necessarily mean that older people will have easy access to a range of support services. Many older people live in deprived inner-city areas with poor resources. In their study of ageing in three deprived inner-city areas, Scharf *et al.* (2005) highlighted that 34 per cent of respondents identified a lack of social clubs or community centres for older people in the neighbourhood. Other locations that superficially appear to be satisfactory may also not meet the needs of older people; urban regeneration, for example, can create environments suitable for professionally mobile couples but result in facilities that are important to other citizens exiting the area. Suburban areas may also suffer from poor transport links; out-of-town shopping centres may cause the demise or deterioration of more traditional town centre shopping areas that are accessible to older people without public transport. The World Health Organisation promotes the recognition of 'age-friendly' cities, which it defines as having an inclusive and accessible urban environment that promotes 'active ageing' (World Health Organisation, 2010).

It is clear that the experience of ageing is influenced at least in part by where people age. Research has demonstrated consistent health inequalities among older people by region and area. For example, mortality rates differ by geographical region, with the highest life expectancies in the South East and South West of England and the lowest in Scotland and the North West and North East of England. At a local area level, the borough of Kensington and Chelsea heads the highest life expectancy at age 65, with males expected to live a further 23.7 years and females a further 26.5 years. Glasgow City had the lowest life expectancy at age 65, with men being expected to live a further 13.9 years and women 17.6 years (Nelson, 2006). Similarly, Scotland consistently displays the highest rates of chronic heart disease and South England the lowest.

Location may also be an important factor encouraging movement in later life. For several decades, retirement migration has been a feature of British society. Typically, areas where the proportion of people above retirement age is higher than 20 per cent are concentrated along coastal areas of the country, for example Cornwall (Tomassini, 2005). Some local authority districts such as Christchurch in Dorset and Rother in East Sussex have a population profile that includes over 30 per cent of people over retirement age. Increasingly, wealthier older people are moving abroad to places such as Southern Spain and Italy to savour the benefits of the climate. However, this is also likely to lead to a number of potential problems in respect of future welfare provision.

Long distances come into sharp focus for ethnic communities engaged in transnational caring. Increased transnationalism means that it is necessary to reconsider the ways in which we define households along the ideas of co-residency and physical unity and to take into account the possibility of physical separation. A scholarship of transnational caring – how caring is achieved in spite of geographical distance – is developing in recognition of these newer forms of caring (Estes *et al.*, 2003). Schiller *et al.* (1992: 5) describe such people as ‘transmigrants’, who link their country of origin and their new country of settlement, sustaining familial, social and economic relationships and taking actions such as decision making across boundaries. An awareness of the potential complexity of family ties, care and support arrangements for people from minority ethnic backgrounds is clearly a critical issue for social work practice.

Housing and communities

In considering issues in ageing that have particular relevance for social work, housing is a key factor. National policy is underpinned by the principle of enabling older people to retain their independence and autonomy and, wherever possible, to remain in their own homes. Housing has a crucial role to play in this equation as people 'age in place'. Housing conditions and housing tenure also play significant roles in the quality of life. The Joseph Rowntree Foundation (Garwood, 2010) highlights the importance of good-quality housing to health and wellbeing and the compelling case for integrated inter-professional work between social workers, health practitioners and housing providers. There is great diversity in housing wealth, with 15 per cent of older home owners being income and equity poor, and 5 per cent being both income rich and equity rich. Further diversity in housing can be seen in relation to ethnicity, housing status and rural/urban location (Heywood *et al.*, 2002).

While the majority of homes are in reasonable condition, some poor housing remains and there are signs that new problems are emerging, particularly for older and low-income, long-term resident home owners and private tenants. The English Housing Conditions Survey (Department for Communities and Local Government, 2009) notes that 84 per cent of older people reported to live in non-decent housing reside in private-sector housing. While the number of younger home owners is reducing, home ownership among older people is high at around 75 per cent, 84 per cent for people aged between 60 and 70 (Adams, 2010). Low-income home owners may experience significant difficulties in maintaining their homes, especially if they live in older housing that is more likely to need costly repairs and adaptations.

In the past, sheltered housing has been seen as a viable alternative for older people who may identify a need for some support. The initial intentions of sheltered provision to provide companionship and community life as well as enable independence backfired, however, with an increasing tendency for tenants to rely on the warden or to need greater levels of support than sheltered housing was able to give. More recently, the development of 'extra care sheltered housing' (ECSH) has grown to a provision of over 30 000 units of extra care in England in 2006. Croucher *et al.* (2006), in a detailed literature review on ECSH, found that residents attached value to the combination of independence and security; however,

some differences of opinion between tenants and support staff as to what constituted independence were noted. Croucher's research concluded that while ECSH provided some important opportunities for companionship and support, very frail people and those with sensory and cognitive impairments remained consistently on the margins of social engagement. It remains to be seen in the longer term whether ECSH offers older people with high support needs a home for life or whether the need to move to a care home continues to be an issue as older people's care needs become more complex.

There are a number of gaps in research exploring appropriate models of housing provision. For example, there remains a need to continue to examine ways to support people living with dementia to remain in their own homes with appropriate support. The research on extra care housing also needs to be developed in order to produce robust measures of wellbeing outcomes (Croucher *et al.*, 2006; Valley *et al.*, 2006).

Retirement communities have seen a recent major expansion in the UK. Essentially, retirement villages offer, in various forms, independent housing with leisure and community facilities and may include care services, including in some schemes nursing home care.

Separate from housing but of increasing significance is the work on the 'meaning of home'. 'Home' has been regarded as a domestic setting with all its associated memories, but less attention has been applied to this principle once older people have entered residential care.

The significance of home is, however, taking precedence in housing policy to encourage initiatives for people to remain in their own homes. The use of technology is starting to have an impact on housing provision for disabled people too. There have been a number of initiatives in this arena that assist older people. Three are briefly outlined below.

- Lifetime homes to meet the needs of all the family are of increasing significance, initially termed 'multi-generational housing' to promote the theme of 'home for life' (Kelly, 2001: 57). It is claimed that such housing enables greater mobility through larger space, better standards, planning and fixtures, while locating such housing in accessible areas will also improve a feeling of neighbourhood community. For example, one of the criteria inside the home is space for a

wheelchair to turn in all ground-floor rooms, the sitting room to be at entrance level and sufficient space downstairs for a bed or the conversion of a room into a bedroom. Contrary to the universal myth that all older people could downsize in later life, many older people will need as much space as earlier in their lives to maintain their lifestyles (Appleton, 2002).

- For existing old homes, 'Care and Repair' or 'Staying Put' schemes have been initiated. Resale value is an issue with many owners in terms of whether they will be able to market a property with a stair lift and other adaptations (Adams, 2010).
- Assistive technology has been installed to facilitate independent living and, for example, support risk taking and risk-management strategies. Examples include longer-term traditional devices such as social alarms and alarm pull-cord systems. More recently, automatic lighting, temperature-monitoring devices and medicine monitoring have become readily available. Movement-activated technology using passive infra-red devices (switching lights on and off automatically in response to movement), automatic taps and route-finding and orientation devices have proved to be of considerable help to older people, for example with cognitive impairment.

How older people use and perceive spaces in their communities is crucial for their quality of life. A study by Scharf *et al.* (2002) illustrated the significance of environment, indicating that older people who live in deprived neighbourhoods are more vulnerable to crime than those living in other neighbourhoods. Of the people participating in their survey, 40 per cent had been victims of one or more types of crime in the two years prior to the interview. While crime surveys repeatedly show that older people are relatively unlikely to be victims of crime, this study showed otherwise, particularly for ethnic minorities. Vulnerability to crime is linked to poverty and social inequality, as many studies over the years have suggested (Hough, 1995; Silverman and Della-Giustina, 2001; Scharf *et al.*, 2002).

Older people's perceptions of place were also affected by their experience of crime or fear of crime. Waters and Neale (2010) found in qualitative research with older people that personal safety concerns were overwhelmingly related to the social connotations of

specific community locations. This meant that participants indicated social fears involving concern about declines in their own communities, as well as a more generalised belief in the decline in standards in wider society.

Transportation in terms of walking, driving and use of the public transport system are crucial issues for many older people. Older people can be excluded from transport systems either financially, temporally (unable to get to activities at night), personally or spatially (unable to get to destinations). The goal of transport policy should be to offer all members of society safe, satisfactory and environmentally friendly transportation resources at the lowest possible socioeconomic cost, while at the same time integrating those with functional impairments into all parts of society. To make public transport attractive, it must be adapted to the needs of travellers. The design of public transport must proceed from a holistic perspective and presuppose that people have very different needs and preferences when they travel. This implies a demand for high trip frequency, efficiency and good information about travel options, combined with high-level service and an accessible outdoor environment with short distances to bus stops and train stations. An 'age-friendly' city is one that facilitates active participation, sustains independence and reduces isolation (Help the Aged, 2007). These factors must be underpinned by accessible and affordable transport that is reliable and safe to use, as well as being inclusive to older people who have more complex mobility, health and sensory needs.

The circumstance of older people who are vulnerable to homelessness or who are homeless are generally under-recognised, a fact that is reflected in the lack of comprehensive statistical evidence showing the extent of the problem. The UK Coalition on Older Homelessness (www.olderhomelessness.org.uk, 2004) defines older homeless people as 'those who are 50 plus and are sleeping rough or living in appropriate temporary accommodation, or are at risk of homelessness'. Older homeless people are a marginalised group who remain invisible in policy debates and the development of service provision (Pannell *et al.*, 2002). Again, this perhaps highlights the ways in which our stereotyped assumptions of ageing and the experiences that older people may encounter inform our thinking and behaviour. It is the case, however, that older homeless people often have very complex needs as well as considerable support and occupational needs (Wilcock, 2006). As an example, older people discharged from prison are likely to have complex

needs in terms of their resettlement, which are very likely to include insecure domicile or homelessness. Recoop (2010) highlights that older people are often separated from support networks and communities as a result of their imprisonment or offending behaviour, which means that they often have very few resources from which to draw support on release.

Care homes

The history of residential care has been well documented (Means and Smith, 1985, 1998; Phillips, 1992; Means et al., 2003; 2008). Of women aged over 65, 6 per cent live in communal establishments such as care homes, compared to 3 per cent of men aged 65 and over (ONS, 2010). This figure rises to 23 per cent for women aged 85 and over and 12 per cent of men, which reflects the gender difference in mortality as well as the likelihood that women's potential access to caring resources will be depleted by widowhood and greater longevity. It will perhaps remain the case that for some people with the most complex needs, a collective care establishment such as a nursing home may be an appropriate housing option. However, social policy is increasingly directed towards older people receiving support at home so that they may remain at home if that is their choice.

If this aspiration is to become a reality, then there are complex issues to be overcome in terms of the attitudes that informal and formal carers may have about the 'best' place for an older person with complex needs to live, alongside a requirement to develop comprehensive support for older people with complex needs so that they receive reliable and appropriate home-based care and support. It remains the case, for example, that large numbers of older people are admitted to residential care straight from hospital (CSCI, 2007), which points to a greater need for opportunities for rehabilitation, intermediate treatment and ongoing assessment as well as comprehensive support services for older people in their own homes. This raises complex issues about affording the current cost of 24-hour live-in care for older people against the current cost of residential care (the latter, in most cases, being cheaper). It remains unlikely that a resource allocation system (RAS) would allocate sufficient funds for an older person to purchase sleep-in or waking care through the night in their own home, especially on a long-term basis.

Social support

In studies of the family and the community life of older people, the role of the family in supporting older people is central (Wenger, 1984; Phillipson *et al.*, 2001). Similarly, older people themselves play significant reciprocal roles within their families, spanning, among other things, care giving, financial assistance and emotional support. Friends are also important, particularly for those without family (Phillipson *et al.*, 2001). In communities friends also play important roles as citizens or volunteers. When older people are asked about who is important in their lives, family and friends are rated highly; less so are community members such as vicars; in contrast, formal support services such as health and social workers are inconsequential in the lives of the majority of older people (Phillipson *et al.*, 2001).

It is estimated that each week, around a quarter of families with children under 15 use grandparents to provide child care (Age Concern, 2004). Grandparents are a potentially crucial source of support for children who are looked after. Research exploring the circumstances of 270 looked-after children found that 45 per cent of kin carers were grandparents. From this sample, 31 per cent of carers identified that they were living with a long-term illness or disability and 75 per cent indicated that they were experiencing financial hardship (Farmer and Meyers, 2005).

Providing care is also time consuming, with 1.7 million carers devoting at least 20 hours a week to caring and 855 000 of these spending over 50 hours in this role. Consequently, the impact on carers' employment can be severe. In the Carers UK survey (Carers UK, 2010), around six out of ten carers had given up work to provide care. The consequences of the loss of income and pension accrual for women in terms of providing security in their own old age can therefore be significant (Evandrou and Glaser, 2003).

There are a number of further factors in care giving that have an impact on the experiences for both carer and care recipient, such as the history of the past relationship and the quality of that relationship (the relationship may be based on years of abuse between father and child, with the roles of abuser and abused now reversed); prognosis and trajectory of the illness or condition requiring care; and the carer's attitude (Nolan *et al.*, 1998).

One of the difficulties in establishing the number of carers in the population is the inconsistency in the definition of a 'carer', both in research studies and in the census. Census figures have varied

between 6.8 million (1991) and 5.2 million (2001). The current census definition (2001) asks if ‘you provide unpaid personal help for a friend or family member with a long-term illness, health problem or disability’. Respondents are asked to include problems that are due to old age. Personal help is defined as including assistance with basic tasks such as eating or dressing. Unpaid carers, generally spouses, other family members, friends and others in the community, are usually designated under the term ‘informal carer’, although this is misleading as there is little that is ‘informal’ about this role. On the other hand, those grouped under ‘formal’ carers are paid and are often perceived as part of the low-waged, low-skilled social care workforce. Efforts to raise the profile and professional standing of social care workers have been considerable, but remuneration for this group remains low and often around the national minimum wage.

Carers UK (2008) suggests that as many as 1.5 million people over 60 provide informal care. Older people who provide informal care are more likely to have health needs themselves, as well as being more likely to provide co-residential care. This means that care is not necessarily delimited by, for example, geographical separation and so co-resident carers are more likely to provide care over 24 hours, as well as being more likely to assist with personal and intimate care as well as supervision and monitoring overnight.

Conclusion: Implications for social work

The diverse situations and heterogeneity of older people provide a backdrop to social work. It is crucial to acknowledge the diversity in social, cultural, economic, financial, political, gender, generational and ethnic circumstances, among others. This collage of circumstances and experience also has a temporal dimension, as present circumstances are shaped by a lifetime of events, relationships, economic and social circumstances as well as class, gender, ethnicity, race and location.

Social workers meet older people from all lifestyles through their personal and professional relationships, yet they are more likely to work with those who experience poverty, ill-health, depression, dementia and unresolved traumas from earlier years, along with those in greatest need. It is imperative that social workers place their work in context and do not view older people from a negative and ageist perspective.

Given that most older people do not need social workers or come into contact with them, why is social work with older people important? What are the reasons for social work and what is the remit of the social worker in the lives of older people? Chapter 2 turns to why social work has a distinct role and contribution to play in the lives of older people.

Putting it into practice

- 1 Think about an older person you know. How does their experience differ from yours? How have gender, class, income, culture and location influenced their experiences in later life? You may find it helpful to interview them about significant life events and their experience of later life.
- 2 Investigate a cross-section of newspapers covering the main news items of the week. To what extent are older people evident in the news? What images and situations are portrayed in the media? How can these images be challenged or promoted?

Further resources

Carers UK (2008) *Carers' Policy Briefing: The National Strategy for Carers*, London: Carers UK, <http://www.carersuk.org/Professionals/ResourcesandBriefings/Policybriefings>, accessed 7 September 2011.

A comprehensive review of the economic, practical and psychosocial implications of providing informal care.

Evans, M. and Whittaker, A. (2010) *Sensory Awareness and Social Work*, Exeter: Learning Matters.

An introductory text for readers interested in learning more about sensory impairment and issues for practice with people who have sensory impairment.

Phillips, J. E., Ajrouch, K. J. and Hillcoat-Nalletamby, S. (2011) *Key Concepts in Social Gerontology*, Bristol: Policy Press.

An accessible guide to gerontological concepts, knowledge and research.

Action on Hearing Loss (formerly RNID), www.actiononhearingloss.org.uk

Lots of useful practical information, research and policy response documents on all matters relating to hearing loss.

Arthritis Care, www.arthritis.org.uk

Information about the many types of arthritis, including a lot of useful downloadable information sheets about living with arthritis, as well as information on current research, policy and practice.

Royal National Institute of Blind People, www.rnib.org.uk

Contains information on research, practical information, pages for carers and supporters and information about support groups and services.



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