Future directions for investment: Social work with older people

Part of the TCSW business case for social work with adults

Authors: Professor Alisoun Milne, Dr Mary Pat Sullivan, Dr Denise Tanner, Dr Sally Richards, Professor Mo Ray, Dr Liz Lloyd, Christian Beech and Professor Judith Phillips

with The College of Social Work

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Introduction

In the comprehensive report, *Social work with older people: a vision for the future* (*the Vision report)* we make the case for social work with older people and their families. Given the joint challenge of the UK's ageing population and public sector austerity measures we argue that now is the time to invest in specialist social work with older people and address the multilayered, complex issues that face many frail elders, their families and an overstretched health and social care economy.

In this shorter supplementary report, we focus mainly on *Future directions for investment: Social work with older people*.[1] We not only believe strongly that there is a future for social work with older people, but that it is a necessity for health and social care services, professionals and providers and most importantly, for current and future generations of older people and family carers. Our overarching goal is to make the case for investment in specialist social work with older people, (re-) establish its aims, purpose and rationale, and reinvigorate academic and professional interest in it as a core dimension of the UK's strategy to support its ageing population.

Part of the case for investment is an economic one. Specialist social work with older people offers value for money, particularly in relation to: preventing (further) deterioration in older people's health and quality of life; reducing the use of expensive acute services; facilitating more effective use of health and social care resources; and leading and engaging with communities, families and users to develop sustainable care and support. The authors of the two reports feel very strongly, however, that the economic case is only part of the argument. While committed to building a strong economic case, the authors are concerned that this does not eclipse the broader moral, legal, and professional case for social work with older people or become synonymous with narrow and uncritical notions of effectiveness.

- Section 1 offers a context.

[1] Like all the papers in the The College of Social Work's 'Business case' series, this is a discussion paper and TCSW does not necessarily endorse all of the views expressed in it.

- Section 2 outlines the international evidence base for specialist social work with older people.
- Section 3 outlines the contribution of specialist social work to older people's health and wellbeing in the UK.
- Section 4 summarises future directions for social work with older people and their families.

We begin by providing a definition of specialist social work with older people and then offer key dimensions of the context in which social work with older people is embedded.

What is specialist social work with older people?

Social work with older people requires the core 'skill set' that all social workers possess to be supplemented by an additional set of specialist skills and specialist knowledge. 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. 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 knowledge a specialist 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; research with/for older people including evidence about what interventions are effective in work with older people and their carers. Knowledge about local services is also important.

Section 1: Context

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, 2011). There are over 10 million[2] older people in the UK (17 per cent of the total), a figure estimated to rise to over 16.4 million by 2033.

While 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, it is also the case that the prevalence of ill health and long-term conditions increases with advancing age. Among 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). Frail older people tend to typically have three or four long-term conditions. Dementia is a prominent age related condition that significantly undermines wellbeing and often results in dependency. Currently the number of older people in the UK living with dementia is 820,000, a figure projected to rise to over 1.7 million by 2051.

UK surveys suggest that there are over 6 million family carers in the UK. A third of all carers are older and a growing number are very elderly (i.e. aged 75 years or over); many are spouses. Research suggests that older carers provide £15bn in unpaid care; 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

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

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 estimated 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, 2013). There will also be growing numbers of older people facing difficult decisions in situations of risk, dependency, uncertainty, transition, and managing multiple health problems.

Service usage

Older people are the largest group of users of health care and social services. Sixty five per cent of NHS spend is on people aged over 65. Almost two-thirds of all – both general and acute – hospital beds are occupied by older people at any one time and they often remain in hospital for longer than younger patients. Up to a quarter of all hospital admissions of older people are people with dementia (Age UK, 2013). Emergency admissions of older people have also increased. In the year 2012–13 nearly a quarter of 'finished consultant episodes' (period of hospital care under a single consultant) involved people aged 75 or over. There were 4.2m of these episodes for those aged 75 and over, compared with 17.7m for all patients. This group of patients grew much more rapidly than other age groups. Between 2002–03 and 2012–13, numbers of hospital episodes for people aged 75 and over rose by 61 per cent compared with 39 per cent for the population as a whole (Health and Social Care Information Centre, 2013).

Older people also account for nearly 60 per cent of the £16.1bn spent on social care by local authorities (Department of Health (DH), 2010). In 2010–11, 60 per cent of all adults (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).

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 pay their own fees (Dening and Milne, 2011). Four fifths of the care home population is estimated to have dementia; most care home residents are very frail and highly dependent.

Life course and age related disadvantage

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 and shorter life expectancy. 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, 2010). In 2009, 42 per cent of older people reported that they 'struggled' to afford essential items such as food and fuel (Age UK, 2013). Older women, long-term carers, and older people from minority ethnic groups are at particular risk of experiencing poverty.

Age discrimination has a profoundly negative impact on older people's wellbeing. Research by Age UK (2013a) 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. Examples include: the prominence of drug based therapies over talking therapies for older people with depression, lack of respect for older people's dignity and privacy on hospital wards, and the assumption that older people's needs can be met by 'off-the-peg' packages of practical services. The very limited involvement of social workers in

the needs assessments of, and intervention with, older service users and their families is also an example (Ray *et al.,* 2014).

Policy issues

Social work, particularly social work with older people, has been undermined by successive policy changes over the last 20 years.

Community care reform, introduced in the 1990s, is widely regarded as the 'beginning of the end' for social work. Community care was ideologically wedded to the marketisation of welfare; cost containment and the allocation of resources to those in 'greatest need' became a legitimate goal of social services departments. 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 was 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.

The delivery of personal social services within a care management framework remained a key feature of the 'modernisation agenda' that dominated the early 2000s. During this time 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 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.

Personalisation

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 key 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, 2012a; HM Government, 2013).

Although there is evidence that personal budgets result in improved outcomes for some adult service users, for example people with learning disabilities, the ability of older people with high support needs to benefit from them is limited (Netten *et al*., 2012). Take-up of personal budgets has been low, care costs tend to be higher, family carers find the system overly complex, and many older service users prefer to use more trusted 'traditional' services, including social work (Moran *et al.,* 2013).

There are mixed accounts of the role of social work in the arena of self-directed care. 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 evidence indicates that self-directed care is intended to *substitute* for social work (Centre for Workforce Intelligence, 2012).

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 who require highly skilled and knowledgeable specialist social work input to achieve sustainable outcomes (McDonald, 2010). Practice dominated by administrative procedures or that is underpinned by an assumption that self-directed care is appropriate for all service users is ill equipped to deliver sustainable personalised care for many older people (Richards, 2000).

[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.

A related paradox relates to the 'lack of fit' between the aforementioned policy goals of choice, independence and autonomy and the complex needs profile of the majority of older service users, such as a person with advanced dementia. The market driven marginalisation of life course related causes of need (see above) – such as poverty and disadvantage – is also relevant. These issues are prominent features of the profile and contexts of most older people who are eligible for support from social services and yet are (largely) invisible in the current models of assessment and support (Glasby, 2012).

The Care Bill

The *Care Bill* brings together existing care and support legislation into a single legal framework. It is expected to become law during Spring 2014. It focuses on wellbeing, prevention, carers' rights, choice and personalisation and offers a number of opportunities for social work (DH, 2012; HM Government, 2013).

The Government's vision for social work in this new policy arena is set out in the white paper *Caring for Our Future* (DH, 2012): 'Social workers have a crucial role to play in the reformed care and support system. The role of social work is being transformed in order to focus on interpersonal support, to promote choice and control, and to better meet people's needs and goals' (p51). The Association of Directors of Adult Social Services and DH Report, *The Future of Social Work in Adult Social Services in England* (2010), defines the social work role as: supporting people to live as independently as possible and promoting user choice and control over the care and support needed to overcome the difficulties presented by disability, age and/or mental ill health.

The Report specifically defines social work's distinctive contribution as making sure that services are personalised and that human rights are safeguarded through:

- 'Building professional relationships and empowering people as individuals in their families and communities;
- Working through conflict and supporting people to manage their own risks;

- Knowing and applying legislation;
- Accessing practical support and services; and
- Working with other professionals to achieve best outcomes for people' (Association of Directors of Adult Social Services and DH, 2010: pp.2-3).

Other policy goals will also influence the roles and contribution of social workers working with adults. The 'integration agenda' is one such example: this is focused on joint working between health, social care and housing, and shifting resource from the acute care sector into primary and community care.

In the last section of this report (Section 4) we discuss the specific roles of social workers with older people and the issues that their particular skill set and expertise can address.

Section 2: Specialist social work with older people – international evidence

In this section we explore the evidence for effective social work practice with older people – in what ways and with which groups. International evidence is beginning to demonstrate the value, both economic and social, of investing in specialist gerontological practice. The evidence demonstrates the potential for social work's positive impact on the success of integrated health and social care services delivery. The examples drawn on here are those that have relevance in terms of organisation of services in England and where we can draw parallels to the social work role.

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.

Specialist interventions

A recent report on evidence of effective care co-ordination models for older people with multiple chronic conditions and functional limitations was published in the US (Eldercare Workforce Alliance and N3C, 2013). As described in the report, the key elements for effective care co-ordination models were 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) summarised in Box 1.

In this American programme 'transition coaches' were allocated to support a group of individuals who had been discharged from hospital following a variety of diagnoses. Significantly lower rehospitalisation rates were reported at 30 days after discharge. The transition coaches facilitated the roles of service users and carers in

independent self-care, and how to communicate with professionals when their health needs changed.

The overall annual cost of CTI was $74,310. The authors estimate net annual cost savings, through the reduction in hospital readmissions, of $295,594 across the health and social care economy. The authors add:

> *'This comparison is probably conservative for several reasons. The health delivery system that participated in this trial had already made great progress in reducing hospital readmission. Thus, there would be greater potential for additional reductions in [a] health delivery system that had not reached this level of achievement. In addition, there may be unmeasured costs of reducing hospitalisation that are not accounted for in this calculation.'* (Coleman et al., 2006 p.1827)

Box 1

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, 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, recognising '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.

In terms of effective gerontological social work interventions the following example offers an excellent case in point (further examples are identified in Table 1 later in this section).

In another American study, social workers were employed as ‘problem-solving therapists’ for patients with depression who were already receiving healthcare for other conditions at home (Gellis and Bruce, 2010) (see Box 2). Problem-solving therapy provided information and education on depression and enabled service users to develop problem-solving strategies for dealing with the stress arising from their health conditions. According to the authors, depression is ‘rampant’ among older adults who are confined to their homes by health problems and/or disability, and their very confinement can be a barrier to accessing care for their depression. They point to benefits of action and the costs of failing to act:

> *‘Left untreated, depression leads to deterioration in physical functioning, exacerbation of medical conditions, and increased risk for suicide… The data provide promising findings that may improve the provision of depression care for homebound elderly patients diagnosed with heart disease. The brief, low cost, and reimbursable features of the depression care service model make it especially appealing to home health care settings across the nation.’* (Gellis and Bruce, 2010 p.471)

Box 2

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 and easily adapted to accommodate people with co-morbid physical health problems and 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*.

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

A Canadian study considered the social work role in relation to risk factors for older people discharged from hospital, particularly as local policies are frequently to discharge them 'quicker' and 'sicker' from acute care facilities than used to be the case (Preyde and Brassard, 2011). Earlier recognition of risk factors, like depression, poor cognition, previous hospital admissions and lack of social support, could ensure a successful transition from hospital to home and reduce the chances of a costly readmission to hospital.

The authors concluded that assessment tools for hospital discharge should have a much more significant social work component than tended to be the case. Psychosocial factors important to functioning and adaptation such as distress or depression were often absent from assessment tools. Low socio-economic status, living alone, carer depression and stress, and inadequate living conditions frequently resulted in adverse health outcomes. In the authors' judgement:

'The elderly population often depends on community resources and their family for support when discharged to their home but when these social supports are not available, complications may arise including hospital readmission… Effective discharge planning may enhance the alignment of the patient to effective intervention, delay deterioration, prevent readmission and adverse outcomes, and lead to improved quality of life.'
(Preyde and Brassard, 2011 pp.452-461)

Research evidence also points to the potential for cost benefits when social workers are placed in hospital accident and emergency departments (Ponto and Berg, 1992). This American study found that the presence of social workers competent in brief counselling, referral and resource finding for patients and families was helpful in responding to a wide range of presenting problems, including attempted or threatened suicide, domestic violence, acute psychiatric symptoms, assault and homelessness. Various factors limited the ability to determine a clear cost-benefit analysis, though the authors concluded that social work services could be provided at 'minimal cost to the hospital' with a strong potential for monetary and non-monetary benefits.

Table 1

Social work intervention	Outcomes	Investigators
Carer health education and support	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 co-ordination for stroke patients	Significant improvements in medical utilisation with potential for cost savings (e.g. decreased reliance on ER services and increased utilisation of outpatient physician services).	Claiborne, 2006

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.	Boult *et al*., 1994; Engelhardt *et al*., 1996; 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

International research on the outcomes of social work interventions with older people is developing at a rapid pace. While research on the cost-effectiveness of social work is still at an early stage, some of the lessons clearly apply to the integration of health and social care in the UK. Social work with older people should be viewed in the context of the health and social care economy as a whole. If older people are to live independent, more fulfilled lives as part of their own communities – rather than spend time unnecessarily in hospital – a much more creative deployment of social work's core skills will be needed.

Section 3: The contribution of specialist 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 UK research evidence is difficult to find. Also social work is often 'part' of a whole service or team and its specific contribution can be difficult to distil. Despite such challenges, detailed engagement with social work research and practice 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. It also provides insights into the conditions that support or undermine the effective deployment of social work skills.

The business case for social work with older people emerges at various points in this section, particularly in relation to the use of prevention and early intervention strategies to avoid admission to hospital or residential care unless it is necessary. It highlights some of the financial evidence for the cost benefits of interventions for which social workers either are or should be responsible.

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; it is also key to supporting quality of life and to the well-targeted and effective use of resources (Richards, 2000). There is evidence that social workers are performing this task in a range of critical contexts and settings. For example, 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 entry to long term/residential care. 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, but also improve access to social and health care services. An evaluation of the impact of an Accident

and Emergency (A&E) based social worker found indications of a reduction in the proportion of older patients discharged from A&E without any follow-up service and a rise in the number of patients assessed and given treatment without admission (McLeod *et al.*, 2003). However, the researchers warn that 'under-resourced health and social care outside hospital meant that in most cases input from the A&E social worker either unravelled in a short period of time or had not led into sufficiently comprehensive care' (McLeod *et al.*, 2003 p.800). The message from this, and a related project in Sweden, is that the effectiveness of social work in A&E depends on an adequate infrastructure of health and social care services being in place to address the complex and intertwined needs experienced by this particular group of older service users, many of whom have serious multiple medical problems (McLeod *et al*., 2003; McLeod and Olsson, 2006).

A related challenge links to mistrust of 'the care system'. Research with older people aged 80 years or over who had experienced more than two emergency hospital admissions in the previous five years identified a reluctance to engage with services, even when they needed and knew about them (Themessl-Huber *et al*., 2007). Among the reasons for this were concerns that care services would undermine their independence. Such concerns are borne out by recent research which found 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 (Callaghan and Towers, 2013).

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 an (often elderly) family carer.

In its *State of Care* report (November 2013), the Care Quality Commission (CQC) noted that the needs of older people who receive care in their own home were

becoming more complex, in good part as a result of the increased prevalence of dementia. The report acknowledges that assessments of need in these circumstances are challenging and observes that the necessary staff development, appraisal and supervision are not happening consistently across the country. It states that, ‘Assessing the care needs of people in their own homes is highly specialised and requires distinctive approaches that recognise the unique nature of the setting where care is delivered’ (Care Quality Commission, 2013 p.33). The role of social work in ensuring that assessments are accurate, grounded in a shared understanding of the aspirations and circumstances of service users and carers, embedded in an understanding of the health conditions and social circumstances of users and carers, and that avoid an unnecessary slide into higher dependency forms of care is pivotal in circumstances such as these.

Spending on crisis or reactive services has been at the expense of developing preventive or early intervention 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* (DH, 2012). Social work has a key role to play in delivering this agenda.

Evaluation of the *Partnership for Older People Projects* (POPPs) has demonstrated benefits from preventive interventions (see Box 3). 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 3

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.,* 2009 pp.7-8).

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, carers and with other professionals and organisations and in mobilising community resources (Ray and Phillips, 2012).

There is therefore considerable potential for social workers 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 which rests (often) on the development of empathy and an appreciation of the range and types of informal and formal support available (Richards, 2000). It also depends on effective communication – perhaps with somebody who has impaired communication – engagement and relationship building skills with users and carers, the capacity to conduct a detailed and accurate

assessment, and advocacy. These are core social work skills.

When the POPPs programme looked at the economic case for prevention, the best results were obtained at the more intensive end of the 'prevention continuum' where social work has most to contribute. A cost-benefit analysis found that savings were most pronounced on secondary and tertiary prevention initiatives for older people 'at risk' of hospital admission, rather than on low-level primary prevention services such as gardening and handyperson schemes (Windle *et al.*, 2009). POPPs interventions resulted in a reduction of overnight stays in hospital of almost half with cost reductions of £2,166 per person (see Box 3). In its fourth annual State of Care report, the Care Quality Commission (2013) suggested that at least 530,000 'emergency admissions' of older people to hospital in 2012–13 could be prevented if either their conditions had been managed and/or treated more effectively and/or at an earlier stage in the community or because they arose from poor treatment or neglect.

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. The needs of older people who are eligible for help from social services are often complex, calling for a mixture of different interventions, approaches and support. 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 the alcohol misuse that may be linked to managing it. Facilitating older people's access to appropriate and timely preventive services can reduce the need for home care support, prevent falls, and delay or prevent admission to care homes; it can also provide relief for carers, thus helping them to maintain their own health and wellbeing and continue to care for longer (Allen and Glasby, 2013).

Referring to the work of Chris Ham (2010), Allen and Glasby (2013) consider the impact of the integrated health and social care arrangements in the Torbay Care

Trust. Data suggest that Torbay has the lowest use of hospital bed days in the region and the best performance in terms of lengths of stay:

- Use of emergency beds for people aged 65 and over is 2,025/1,000 population in Torbay, compared with an average of 2,778/1,000 population in the south-west region overall.
- In the south-west, Torbay has the lowest rate of emergency bed day use for older people with two or more admissions and the second lowest rate of emergency admissions for older people with two or more admissions.
- Residential care makes up the majority of adult social care spending, but Torbay has the second lowest proportion of people aged 65 or over discharged from hospital to care homes in the south-west.

Good intermediate care facilities and providing intensive rehabilitation services are among the 'essential ingredients' of the effective Torbay mix. Evaluations have shown that intermediate care acts as a 'bridge' between hospital and home, between states of health (illness to recovery or management of chronic illness), and between sectors (acute care, primary health care, social care and housing) (Allen and Glasby, 2013).

But Allen and Glasby (2013) argue that the tendency of intermediate care services is to focus on hospital discharge rather than prevent or forestall hospital admissions in the first place. They also suggest that more allowance should be made for the role of social workers, stating that: '… there also seems to be a tendency to focus on the physical and practical aspects of rehabilitation rather than broader social and emotional aspects of care' (p.913).

Two of the critical junctures affecting the success of re-ablement are: the effectiveness of 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. 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.

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).

To date social work has 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. This is largely driven by the raising of thresholds for accessing local authority social services support. 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

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; Ray *et al.,* 2014). 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.

Indeed, the *Caring for our Future* White Paper made specific mention of community development as a significant future role for social workers, since they combine knowledge of community resources, skills in inter-agency working, and engaging

people who are socially invisible or excluded with specific skills in building the capacities and confidence of others (DH, 2012). As The College of Social Work's business case for social work with adults discussion paper says:

> *'Local authorities still spend too much on residential care for people who could live independently with the right support. One way to save money on residential care is to give social workers a prominent role in assessment and community development, taking an "asset-based" approach to assessment that rests on a deep knowledge of the strengths of the individual, the family and the community.'* (TCSW, 2012 p.3)

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 stringent local authority eligibility criteria; the support provided by local authorities 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 *et al.* 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 4).

Box 4: 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.

Bowers *et al.* (2013) found considerable economic as well as social benefits from their approach. For example:

- Pooled budgets provided economies of scale for individuals by sharing risks and pooling the costs of personal as well as infrastructure support.
- Timebanks, a system of reciprocal exchange that uses time as currency, can generate savings, improve skills and employability, and reduce reliance on health and social care support. A conservative estimate is that the £450 cost per participant of running a timebank generates over £1,300 of economic benefit per person in return.
- 'Shared Lives' schemes delivering support based on mutuality are cheaper than alternatives like residential care. Research has shown that this model could generate net savings of £13m by reducing the need for costlier services.
- Some well organised mutually supportive communities have estimated that they save local authorities £750,000 a year as a result of reduced need for social care funding and support.

Drawing on strengths-based approaches in communities has the potential to utilise the skills of social workers in new ways, for example in helping people with complex needs to play a fuller part in the life of their communities and not simply rely on 'care packages' to offer support. Social work support can help people to become less isolated and find new ways to contribute to their community or to find volunteering or employment opportunities. Giving back and reciprocity are key elements of these initiatives.

Additionally there is an opportunity for social work assessments to take a much more holistic view of individual wellbeing, in line with the principles of the Care Bill (HM Government, 2013). This should include physical and mental health but also family relationships, employment, housing, active citizenship and community resources. Developing community resources, connecting older people to services when these are needed and providing an ongoing supportive relationship through times of change can make it possible for older people to remain in 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 and encourages engagement (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 in mainstream services and for social workers to play a key role in contributing to rolling out this approach more widely. The creation of social enterprises and of social work practices for adults offers opportunities for learning and development building on innovative developments such as these.

Council commissioning practices appear to have been a barrier to progress. Local authorities will need courage to turn away from traditional models and commission instead 'for innovation' (Bowers *et al.*, 2013). It requires creative, long-term funding arrangements and a marketplace open to enterprise for community-based mutual support schemes to flourish.

Preventive safeguarding

The social work role in safeguarding is often reactive in response to suspected mistreatment or neglect. 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 by using the development of trust relationship to address the older person's concerns and explore, with them, realistic ways to prevent risks deepening. This is underlined by research suggesting that older people may conceal risks because of fears that this will jeopardise their independence; these fears are borne out by what happens in practice but could be challenged if earlier intervention was facilitated (Mitchell *et al.*, 2012).

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, vulnerability and/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).

By intervening before a crisis develops, preventive safeguarding strategies can enable older people to stay independent for longer and forestall early admission to residential care. Again innovative commissioning and investment in community development social work can make a difference. As Faulkner and Sweeney (2011) state: 'Both services and individuals benefit from having contact with a range of people in the community. Reducing isolation through links with the community can mean that there are more people who can be alert to the possibility of abuse as well as provide links to potential sources of support for adults at risk and family carers' (p.24).

TCSW's business case discussion paper refers to Central Bedfordshire's social work practice pilot (2012). This experimented with 'network meetings' run by social workers with service users, their families and other associates, where safeguarding concerns had arisen. Emily White, the council's safeguarding vulnerable adults manager, said: 'A standard response to situations where the caring role has broken down may be to increase services, if only for monitoring purposes, or even to remove the person to residential care. This will rarely be the person's first choice, and is an expensive option. If individuals and their families can be supported to find their own solutions that avoid the input of council-commissioned services, these are not only likely to be more personalised, but could see a reduction in costs to local authorities. Social workers are equipped to be able to support individuals to think about their options and provide that additional support to ensure their goals are met over a period of time' (TCSW, 2012 pp.11-12).

Support for 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).

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 and prevent breakdown (Age UK, 2010). One study with carers between the ages of 76 and 92 concluded: ‘Many carers…were 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 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. Three-quarters of people with dementia living in the community are supported by family carers.

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).

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 and that of their families and carers (Milne *et al.,* 2008).

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 over 80, 91 per cent when deaths of women aged over 60 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.

In England and Wales an increasing majority of deaths occur in hospitals or in other institutional settings, a trend that is likely to continue without major changes in end of life care provision (Gomes and Higginson, 2009). The trend is most marked for deaths in old age with a fall of 13.3 per cent in deaths at home for the age group 75 and over in the period 1974–2003 (p.36). People with dementia, heart and respiratory disease – conditions that are more common in late life – are at particular risk of dying away from home (National Audit Office, 2008). Survey findings consistently report that most people would prefer to die at home; this is now recognised in policy and is a key driver of end-of-life care practice (Holloway and Taplin, 2013). Social work has an important contribution to make in enabling and supporting older people who wish to die at home. This is recognised in the National End of Life Care Programme, which includes strengthening the specialism of palliative care social work as an objective of its social care framework (NEoLCP, 2010).

This recognition of the important role of palliative care social work is timely, as in many areas social workers have virtually disappeared from end-of-life care (Holloway and Taplin, 2013). 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).

With small amounts of specialist training, and the support of their managers, social workers in pilot projects have demonstrated that contributing to end-of-life care can be embedded in their everyday practice with beneficial consequences for their practice as a whole. Developing the knowledge and confidence which enabled them to use their core skills to support dying people and their families to articulate and achieve their choices for end of life care also gave the social workers immense job

satisfaction (National End of Life Care Programme/The College of Social Work, 2012).

Section 4: Future directions: social work with older people and their families

There are a number of key drivers underpinning the critical need to invest in developing specialist social work with older people in order to meet the existing and future needs of the UK's older population.

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 requires both skilled personalised intervention to assess and meet their needs and also a practice that 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). The bio-psycho-social focus of the social work profession places it in a pivotal position to address some of the key challenges posed by societal ageing.

Older people's lives are often shaped by changes in health status, relationships and living arrangements, as well as major transitions such as retirement, bereavement and widowhood. Expertise in supporting people through multiple changes and transition is a core gerontological social work skill, associated with preventing (further) deterioration, improved mental health, enhanced levels of resilience and social support. This work is most effective when done in partnership with professional colleagues from health. Social workers have a long tradition 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.

Recognising the importance of providing comprehensive, personalised support services to older service users with complex needs and their families is a second issue. 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 growing in number and, without access to a specialist social work service, they will have no professional voice to champion their cause in respect of social justice and inequality or defend and promote their right to high quality care.

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 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, which have a diminished 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). Specialist social work with older people has the capacity to maximise the effectiveness of multidisciplinary treatment and care inside the hospital; it is also linked with earlier hospital discharge, lower levels of readmission and more sustainable post discharge support.

A fifth issue is related to community based work. Social workers have an important proactive and preventive role to play within community based programmes designed to promote and maintain social engagement, good health and wellbeing. These include 'asset-based' approaches that strengthen personal, social and community resources, thus building resilience and increasing older people's ability to manage difficulties when they arise. 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 older people. The evidence from North America identifies the value of a 'family focus' in 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 a social work approach to assessment and providing support. 'Community facing' social work also fits with the current policy focus on working in partnership with health promotion, putting older people in touch with arts-based projects, choirs and other groups to promote health and wellbeing (see the POPPS project in Section 3 as a key example).

A sixth issue relates to social justice. We noted above that older people face widespread age discrimination, including inside health and social care services. This contributes directly to an increase in older people's vulnerability to mental ill health and marginalisation. The professional values of social work demand that it challenges discrimination(s), addresses disadvantages, whatever their source, and

advocates for older people's right to have their care needs properly identified, understood and met.

Specialist evidence-based social work has considerable potential to enhance the lives and wellbeing of older people and their families and produce better outcomes at lower costs to the overall health and social care economy. Social work not only needs to be viewed as an integral part of the wider care system, but also as 'the first point of contact in identifying, preventing, and rectifying a range of health and social care issues' (Holmes *et al.,* 2013, p.16). We argue that investing in social work, health and social care will alleviate the acute pressures on intensive services such as inpatient care, extend the potential of community based care, reduce preventable admissions to care homes, and meet the needs of older people and their carers more effectively, efficiently and sustainably.

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