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# Community Care and Professions: What is the Role of Social Work?

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**Abstract** Driven by a synthetic analysis of some of the factors that contribute to the outline of new social care scenarios, which require organisational and management layouts inspired by relevant, appropriate and innovative systems of health governance, this paper offers a theoretical reflection on the role of social work within the processes of planning and supply of social services, in community care contexts. Attention is focused on the concepts of self-care, interdisciplinarity and professional integration as determinants of the cultural transition to "relational" care models, which replace the formal and reductionist logic of "service" with approaches inspired by "dialogistic rationality" of the planning of *health and social* rehabilitation programmes "tailored" to specific needs, in order to strengthen users' resilience. Besides the obsolete "technocratic" vision of planning (in particular health policies), which strongly affects professional reflection and the renewal of practices that are *congenitally* non-standardisable and, let alone, routinised, said approach shuns the normative and bureaucratic determinism of well-established procedures and, in particular, seems to "challenge" social professions to claim a crucial role, symmetric and fully equivalent to that of medical and health professions in defining health needs, which is essential for the personalisation, contingency and concomitant rooting of intervention measures.

**Keywords** Community care, Professional identity, Health and social integration, Interdisciplinarity, Social work

## 1. Introduction

In the main international documents on the matter, the activation of "holistic" regeneration programmes for health governance processes has emerged, starting from the past century, as a priority and strategic objective of a system that is called to adopt a *socio-ecological* approach towards the well-being of individuals and communities. The acquisition and enhancement of skills that are essential to remove individual, organisational and community obstacles preventing full access to resources aimed at improving the quality of life contributes to define a complex and articulate welfare scenario, which puts the measureless multidimensionality of the need for health before the technical/clinical discretionary power of diagnostic categories.

On this matter, some of the admonitions in the Ottawa Charter are explicit: "The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, *beyond its responsibility for providing clinical and curative services*. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individual and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components" [1]. In these recommendations, the reference to a complete and unequivocal sociological definition of the concept of *self-care* [2] is crucial. This definition definitely transcends and surpasses the utilitarian limits of theoretical models of health service inspired by the consumerist rhetoric imported from the economic and business field: "Patients are no longer, and should not be considered as 'passive recipients' of care; they need to be actively 'involved' in their treatments, and engaged in a partnership of respect with their clinicians. Furthermore, most people want a personalised service 'tailor made to their individual needs'. To advance the necessary changes, 'patient choice' needs to be and 'will be strengthened. 'Choice' must be made to 'happen' and it must be 'real'. Indeed, it must be 'underpinned', and 'widened and deepened' throughout the entire system of care. Above all, the promotion of choice will help to drive up 'standards' of care and treatment" [3].

*Community care* is the inspiring principle and regulative ideal of a type of care that fully acknowledges such suggestions and gives *health literacy* and, more in general, community *empowerment* a strategic value for the

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programming and management of policies for the promotion of the quality and effectiveness of care measures. The responsibility for the "achievement" and pursuit of well-being conditions is *shared* and is not a prerogative of medical and health professions: the role of social workers and community volunteers is as crucial for the implementation of self-care processes.

In other words: "Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the *empowerment of communities*, their ownership and control of their own endeavours and destinies. Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support" [4].

On a theoretical level, there are many reasons that induce to "transfer" health services for individuals to the community. Here are the most remarkable ones: the demographic and epidemiological transition of peoples (drop in birth/death rates and consequential increase in chronic-degenerative pathologies), as well as the decrease in economic and human resources that can be employed to face criticality; the need to de-institutionalise treatments through the spontaneous activation of communities in support of their members; the emergence of State project directives envisaging "mixed" and welfare society (associations, voluntary work, families, profit/non-profit organisations) organisational models for promotion, prevention, treatment and rehabilitation; the specific commitment of each worker to contributing to the mediation and "government of the demand"[1] for health [5], by systematising an *interdisciplinary* cognitive practice aimed at the quality and humanisation of services.

Despite the substantial and unanimous concurrence on the programmatic plausibility and reasonableness of designing territorial systems suitable to support care programmes effectively "combining" health services and social protection actions, the desirable innovation seems to present a number of "weaknesses" on a practical level. This paper aims to offer a contribution to the debate on this matter, focusing its attention on the role of social work in a context of a persisting *lack of homogeneity* among the cultures and professional identities involved in integration, which still lack coordination and are rather inclined towards mistrust and poor mutual legitimation.

1 As Pencheon says, "demand management is the process of identifying where, how, why, and by whom demand for health care is made and then deciding on the best methods of managing this demand (which might mean curtailing, coping, or creating demand) such that the most cost effective, appropriate, and equitable health care system can be developed. Critically, it depends on understanding how the behaviour of those who express the demand - citizens and professionals - is changing. It is concerned with making more appropriate use of the health services (not necessarily reducing it or making it cheaper)".

## 2. A "Grey Area" in Community Care: Professional Integration

Despite being an imperative bound to strongly restrict government policies in this sector, the multiple proposals for the activation of "integrated" care programmes are not immune from the risk of inflating the meaning itself of integration, at the same time debasing its peculiarities. In actual fact, without a sound analytic paradigm, the concept of integration seems to elude an appropriate explanatory definition of its components; it is often restricted to a generic lexical explanation of the term or to linguistic stipulations, not infrequently declined on the synonymous front of interdependence and cooperation, which may be only useful to descriptively illustrate its content, in accordance with its ordinary use. The consequent methodological chaos is compounded by an academic plethora of studies and observations, in which the extent of the personalisation, self-care and assessment of the services' recipients is not adequately explored. Such a semantic indeterminateness is most likely due to more complex issues that are not easy to solve.

Actually, integrated care *contests* professional identity; the holistic approach to care, which permeates its essence, calls for *functional release* (role release) and *role expansion*[2]; the acquisition and development of practices inspired by a common philosophy of action among professionals (from *cure* to *care*) entails eclecticism and transcendence of disciplinary boundaries.

The existing literature widely proves how the "success" of interprofessional collaboration is a rather elusive subject of in-depth analyses and a rather evocative subject of a complex, virtually congenital *relational variability* of care work. Although collaboration itself evokes trust and harmonious collective actions oriented towards the achievement of shared objectives, the main results of the studies aimed at the identification of theoretical references that may improve their understanding reveal conceptualisations that are very different from one another and poorly connected, without there being any serious attempt to define the best forms of patient integration within care teams[3].

Professional identity and the concept of interdisciplinarity represent one of the main areas of study: whereas the first generally refers to the acquisition of knowledge, skills and approaches connected with a particular "vocation" [8], the latter refers to a systematic and logically coherent process of re-construction of concept maps, methods of investigation

2 In the first case, the professional accepts the possibility that "other" specialists may deal with areas in which he/she has received specific training; in the second case, the eventuality that a professional role includes functions other than those related to its specific profile is accepted [6].

3 In an attempt to clarify its meaning and identify its most coherent operational approaches, Roberts *et al*. assert the persistence of a *semantic stagnation* of interdisciplinarity: the term is frequently used to refer to collaboration activities among specialists with the same professional background (e.g. cooperation among paediatricians, paediatric cardiologists and surgeons in the treatment of young patients suffering from congenital heart disease) [7].

and operational modes, often *alternative* to those usually employed by *single* professionals.

One of the main challenges of interdisciplinarity is precisely that of easing tension between paradigms and operational approaches, which are (only) apparently different and, for the purposes of complementarity, require the same legitimation, in order to protect the scientific pluralism, professional responsibility[4] and social quality of an integrated care system. Given that the prefix *inter* does not refer to juxtaposed disciplinary plurality[5] but rather to the shared appropriation of a participatory space in which the interdependence[6] of knowledge and skills may generate adequate solutions, the constitution of an interprofessional group implies commitment of "mutual translation" of problems and programmes.

At a closer look, it is a question of reducing *friction* among identities since, especially that of social work, is a matter "of a complex struggle to define itself within the context of a health system with many other powerful players" [9].

In the complex sociological debate on the process of deprofessionalisation, this friction is traditionally connected with the concept of "exclusionary closure"[7] [10] and is extensively ascribable to "jurisdiction" [11], i.e. the normative and structural control of specific areas of competence. Power and autoregulation are considered as peculiarities of professional communities that are characterised by "the sharing of common credentials, general interest in maintaining acquired privileges, the same specialised training and the same personal identity" [12]. Attention is mainly focused on the distinctiveness of skills as the interpretative key to social care work: each professional group socialises its members to values, attitudes, approaches to problem solving and languages that allow characteristic cognitive and behavioural styles to sediment; culture crystallises these peculiarities and represents the social heritage [13] of single professional communities that, due to the isolation of training, "remains obscure to other professions" [14].

In particular, it is worth underlining that the medical profession tends to condensate its cultural peculiarities within an authoritarian rather than relational structure (medical dominance), both in its relations with patients and with related professions. This means that the main result taken into consideration by doctors is saving a patient's life, not his/her quality of life; prevention and treatment of chronic diseases are not attractive enough for the medical intellectual challenge and yet require interprofessional teams of which doctors are often not enthusiastic members. The value differences, mostly unexpressed and often invisible to the various members of the team dealing with a problem, can create communication barriers among professions; and these barriers cause a great sense of impotence in some health professionals.

Existing professional systems in the health and social field are undergoing a great spur to radical change; nevertheless, several researchers have pointed out that the tendency to claim exclusive pre-emption rights in certain "fields" remains: the presence of different professional alliances and multiple coalitions reveals the closed and cyclically static nature of decision-making processes transferred to an authority level; marginalisation "is still a feature of social work in the institutional health setting" [15].

In the same way, the persistence of intervention practices and protocols related to "managerial" styles of regulation and governance of the procedures for the supply of services (standardisation of needs, performance indicators, attention to costs) means that each professional acts "in solitude", applying his/her specific institutional mandate, in a fixed organisational position, thereby distorting the so-called *social generativity* of care processes called for by post-instrumental organisational paradigms. Furthermore, to the complete detriment of the development of partnership and participation practices in community care contexts, the ideological conflicts among professional skills, exacerbated by the fragmentation of activities, characterise the *tribalism* of professional groups, which, due to the stereotyped perception of their respective skills and to different intervention philosophies, certainly represents an aptitude barrier to the independence of social professions.

In this perspective, which foundations can *inclusive* dynamics of interdisciplinarity be related to?

And, what is more, which paradigms can we draw from in order to regain the role that distinguishes social work?

## 3. Conclusions. What Kind of Assertiveness for Social Work?

Social workers are trained to work within systems, but a model for their role with other professionals within the health care system does not explicitly exist: "unfortunately, the social worker is viewed as just one of many "adjunct" professionals involved in health care delivery. Often the roles that social workers perform overlap with other disciplines" [16] [17].

Nevertheless, several studies on the analysis of the value conflict between social work and health work highlight that

4 Reference is made to one of the key components of the social-health system, which implies professionals that are aware of their obligation to be answerable for their actions, in accordance with an assigned and socially recognised skill (social accountability).

5 Juxtaposition is typical of multidisciplinarity and refers to the "accumulation" of different skills, used in a common cognitive or practical venture without any of them having to alter its concept perspectives or methodological instruments, merely providing its results.

6 In current literature, interdependence represents a key element of the care team. Among the various forms of sharing (sharing, partnership) that can be observed in a collaboration context, interdependence calls for the collective action, synergetic commitment and common desire of professionals to face the growing complexity of health problems.

7 With this expression, Anne Witz refers to the ability of a professional group to limit the number and type of followers in order to protect and increase the market value of the service offered, precluding the work of other professions that offer similar and/or related services.

most doctors need to consult with operators working in the "mediation" of the psychological and social needs of their patients. Furthermore, it must be pointed out that, in turn, social workers use the scientific and diagnostic/therapeutic skills of specialists as a fundamental premise for the definition of the psychological, environmental, social and cultural well-being of users [18].

This might be seen as a faint signal from which to start filling a paradigmatic gap or, to be more precise, a historic axiological distance, typical of the professional relationship among sectors that are, as said, only apparently different.

As Auslander says, "in recent years we have witnessed the beginnings of a paradigm shift, with the gradual introduction of new concepts, theories and frameworks into the health care system. This is expressed, first of all, in a change in our nomenclature, from medical care to health care, signifying a shift from a pathogenic focus to a salutogenic one, striving not only to make people well, but to preserve that wellness. Numerous experts agreed that this gradual shift has its roots in a number of factors, among them the inability of the biomedical model to fully explain the etiology of numerous health problems and its weakness in addressing the needs of patients with chronic conditions" [19].

So if, on the one hand, clinical semiotics calls for the determinism of statistically significant evidence which, within the limits of bureaucratisation, eludes the individual susceptibility and auto-determination of the patient, on the other hand, the "social logic" of help calls for the assertiveness of professionals that can claim an identity able to replace the therapeutic mainstream (cure) with the holistic value of health and of disease (care).

The effects of such a claim are multiple and rather important with a view to planning health policies that are actually effective: the establishment of a positive concept of health, ascribable, as just said, to the aetiological inexhaustiveness of the biomedical model and to the criticality of Evidence-based Medicine[8]; the evolution into a bio-psycho-social pattern; the supplementary function of social operators in health and social activities; the progressive transition from a pathogenic to a salutogenic orientation [20]; the consequent revaluation, within the processes of promotion of community care, of concept constructs connected with the independence, resilience, empowerment and development of citizens' social capital.

In this perspective, the increasing recognition of the contribution of service users and *carers* within care processes challenges the "benevolent paternalism" of medical performances, founded on the systemic exclusion of "laymen" from the definition of needs and of the most appropriate answers for their satisfaction; the identification and recognition of multiple disciplinary perspectives leads to tolerant horizons in the social panorama in which interchange favours the development of a common language and concept structure founded on values that go beyond those specific to each profession. In a broader sense, the meaning of reflective practice places social and health professionals in a permanent investigation dimension which subjects intervention methodologies to a continuous critical re-examination, in search for innovative solutions to starting problems. In fact, "to be a professional is not to have all the answers. Rather, a professional is someone who can reflect on tentative solutions, collaborate with others on the possible avenues available, and risk making mistakes because mistakes are an inevitable part of building new roads" [21].

Indeed, the soundness of each interdisciplinary project appears to be, at least in the early stages, rather fragile: besides the inevitable diversity of individual attitudes and motivation for a virtuous *operational conjunction*, one of the factors that most frequently contributes to its failure is, as mentioned above, inattention to "cognitive maps" (basic concepts, observational categories, methodologies and investigation techniques) conventionally used by each member of the team. If, paradoxically, two professionals of a different discipline and culture might "*see* the same thing without *looking* at the same thing" [22], the understanding of this conflict represents a crucial factor which triggers permanent professional learning processes, functional to the adjustment and negotiation of skills.

The basis of the heuristic value of interdisciplinary work is to be found in these issues.

As it has been attempted to demonstrate, interdisciplinarity involves the encounter of different opinions, an effort towards their mutual integration, the awareness of their partiality and, in the health and social field, of their indispensability for the understanding of health/disease experiences, which are extremely complex and multifactorial. Besides putting an end to the competition among "easy" isolationisms, the interdisciplinary practice helps professionals to acquire and develop an epistemological attitude towards "curiosity" and the convergence of evidence and models, thereby creating and regenerating permanent "dialoguing networks".

Indeed, one of the necessary conditions for the development of the best interdisciplinary health and social "transactions" is the unanimous reference to the concept of person. In particular, the unitariness that characterises its essence represents a dominant idea of integration. It "embodies a new and more powerful concept abstraction that does not find its natural habitat in an established discipline" [23], favouring the construction of a homogeneous language, i.e. mutual readability and knowledge capitalisation, otherwise fragmented. With regard to a real risk of discontinuity and division of social planning fields, which often "tend to find self-referential solutions in the mission of the bodies and Plans, ever less often in the questions and problems of the people" [24], the centrality of the person and the multidimensionality of the need expressed to the services urgently call for a scenario change that dissuades social

8 The literature available on this matter seems to confirm the persistence of a lively debate among hardliners and moderates on certain problematic issues of the EBM approach. Among these, the impossibility of "truth tables" and indisputable evidence for clinical reality, which is intrinsically contingent; depersonalisation of the medical act; the need to add the significance of the experience of the disease and of patients' perspectives to statistical significance.

professionals from a subordinate and explicitly executive role within the decision-making process, thereby increasing their proactive opportunities and their ability to free themselves from managerial colonisation.

In practice, this means regenerating the meaning of the help relationship based on new "cultural" grounds.

It is therefore imperative that social work participates and becomes an essential part of the planning process and of the experimentation of "straightforward", shared organisational models founded on brave and responsible actions of "deconstruction" of habits. A “definition *a priori* and a fixed structure of the services” [25] is not acceptable in community care contexts. Instead, a "relational" management of needs must replace the unsuccessful "reparatory" concept of health and social care, which is emblematic of the traditional separation between the two spheres and can generally be ascribable to reductionist criteria of "homogenisation" of discomfort.

Thus, the nerve centre of the reflexivity of social professions is represented by the ability to strengthen the "social capital" of the care system [26] and catalyse processes for the institutional redefinition of care quality: a care oriented towards the reduction in the normative self-referentiality of the "control" of the services provided that focuses on the *proximity* of a system aimed at increasing contract capacitation and the empowerment of "competent communities".

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